Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M4 (July 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 month 4 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, and key measures included within the NHS England Segmentation and Oversight Framework. Segmentation outcomes and performance are referenced within the assurance reports, where relevant, noting that the period of measurement can differ from the IPR. There are also differences in segmentation scoring based on national ranking and/or performance in relation to the annual plan. Segmentation indicators are identified within this report by the presence of a purple circle.

We achieved key measures related to patient safety and care experience, including the our hospital acquired infections which were lower than trajectory for C-diff cases and we met our target for timely antibiotics in ED for patients with Sepsis. Pressure ulceration indicators were achieved for hospital acquired category 4 incidents but were above the threshold for category 3 incidents.

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 adults (L1-L3) was achieved.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In July, we met targets for and core skills training, and non-medical appraisals 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 showed rates lower than the National and Shelford averages, and the second lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets and exhibited improving Special Cause Variation (SCV).

Performance against the operating plan trajectories for RTT (% within 18 weeks (OP), % over 52 weeks, and the waiting list size were compliant, but we were off trajectory for RTT % within 18 weeks (all pathways), which is a Segmentation indicator, and diagnostic waits. Performance was also off plan in July for the Faster Diagnostic Standard, which is also a Segmentation indicator. Performance in July was also better than the operating plan trajectories for Cancer waits within 62-days, A&E performance within 4 hours, and patients spending more than 12 hours in the department. A&E performance within 4 hours exhibited improving SCV and was better than the National and Shelford Group averages.

Income and Expenditure (I&E) was a £1.0m in-month deficit at the end of Month 4 (July), which was £0.2m better than plan. The plan included a £7.0m savings requirement in July, recurrent savings have improved to 58% of the reported in-month cash releasing savings. Cash was £13.5m at the end of July, £4.6m higher than the previous month and £9.9m higher than planned.

Of the 117 indicators currently measured in the IPR, 26 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

- % of RTT patients waiting within 18 weeks
- Number of non-discharged patients onto PIFU
- VTE-Submitted Performance
- Reactivated complaints

Common cause variation and missed target

- RTT number of incomplete pathways <18 weeks
- Cancer 31 Day Combined Standard
- Cancer 28 Day Combined Standard
- Pressure ulceration per 10,000 bed days (Cat 2)
- Pressure ulceration per 10,000 bed days (Cat 3)
- MRSA Cases
- % of complaints responded to within 25 working day
- FFT % likely to recommend OP, and ED
- PFI: % cleaning score by site (average) CH
- Sickness and absence rate (rolling and in month)
- Freedom of Information (FOI) % responded in target

Special cause variation - improving

- RTT standard: >65-week incomplete pathways
- Midwife ratios (birth rate/staffing level)
- Information Governance and Data Security Training
- RTT patients > 65 weeks

Other*

- Number of Never Events
- Non-Thematic Patient Safety Inc Investigations
- Priority 1 incidents

**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)*

In July, VTE risk assessment compliance fell to 93.8%, below the national target of 95%. Actions are being taken to address performance issues, including prioritising discussions in Clinical Governance Committees and developing collaborative policies. Specific initiatives include the MDT VTE task group's efforts in maternity care and improvements in Oxford Critical Care. The median completion time for VTE assessments was 146 and 133 calendar days, exceeding the target of 42 days. More staff are being trained to reduce the time to arrange and conduct VTE assessment.

In July, four new **non-thematic Patient Safety Incident Investigations** (PSIIs) were confirmed. Actions are underway to improve the timeliness of PSII completion and ensure learning is implemented. The Learning Multi-Disciplinary Team Response (LMDTR)meetings had a median completion time of 146 and 133 calendar days, exceeding the target of 42 days. After Action Reviews (AARs)had a median completion time of 19.5 days, exceeding the target of 14 days. More staff are being trained to reduce the time to arrange and conduct LMDTR and AAR meetings.

The one **Never Event,** raised as a PSII, involved a patient who received a right-sided local anaesthetic block whilst under general anaesthesia, when a left-sided block was intended. Immediate actions to improve future performance of never events include urgent communication to all Divisional and Directorate leadership teams, a Trust-wide Safety Message emphasising the importance of 'Stop Before You Block' (SBYB), and a survey of anaesthetists to understand experience, practice, and challenges around Safety Checks in Peripheral Nerve Blocks. A PSII has been initiated and will be linked to a recent similar incident to ensure joined-up learning. A meeting with stakeholders was scheduled for 28th August to discuss the issues surrounding both cases

In July, the Trust reported deteriorating SCV in **health and safety-related incidents**, including assault, aggression, and harassment. Actions to address this performance include reinforcing the No Excuses Campaign, enhancing reporting, and providing staff training. The Trust continues to face challenges in high-throughput, unscheduled-care areas, particularly in Emergency Departments. Within the Emergency Departments, actions to address these issues include mandatory conflict resolution training and advanced de-escalation techniques.

The **incidence of pressure ulcers** increased in July 2025, with a rise in Category 2-3 incidents. Incidents in categories 2 and 3 were higher than the performance threshold for July. Actions to address performance include ongoing harm reviews and compliance audits.

The **midwife-to-birth ratio** exceeded the recommended rate in July 2025. Actions to address these issues include recruitment drives and optimising rostering.

Compliance with the 25-day KPI for complaints improved in July to 44.1% and the volume of complaints continues to increase. Actions to improve performance include ongoing review processes and risk register ratings, the use of Power BI for data analysis and exploration of AI tools.

The **percentage of friends and family** likely to recommend services for outpatients and inpatients did not meet performance standards. Actions to improve performance include developing a dashboard for FFT and increasing data reporting frequency.

In July, the **combined PFI percentage** of total audits that achieved 4 or 5 stars for the Churchill was 89.66%, below the 95% target. The audits that failed the 4-star requirement were promptly corrected. No specific trends or repetitive failures were noted, with issues spread across both clinical and domestic responsibilities.

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

Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

Not achieving target

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Special cause variation - improving

- RTT standard: >65-week incomplete pathways
- Midwife ratios (birth rate/staffing level)
- Information Governance and Data Security Training
- RTT patients > 65 weeks

Other*

- Number of Never Events
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The **sickness absence performance** (rolling 12 months) was 4.2% in July 2025, exhibiting common cause variation. The in-month sickness rate also displayed common cause variation at 4.1% for months 3 and 4. Divisions are reviewing the top 20 absences and working on action plans to reduce sickness absence. The focus is on areas with consistent absenteeism, and collaboration with Occupational Health. Managers are alerted about staff triggering absenteeism, and HR is promoting sickness absence management training. Monthly meetings with the Wellbeing lead are held to identify additional areas where support may be required.

The **cancer performance** for the 31-day combined standard for first and subsequent treatments was 80.4% in June 2025, which is below both the operational plan and national standards. Certain tumour sites are non-compliant, and the trust ranks 127th out of 134 providers.

The **28-day cancer performance** standard was 77.0% in June 2025, which was below the operational plan of 77.6% and in segment 3 of the NHSE framework. Challenges include complex tertiary level patients, capacity for surgery, diagnostics, and oncology, and late inter-provider transfers. Specific actions taken to improve performance include tumour recovery plans and the scheduling of the cohort 2 tumour site workshop on 22nd August.

The **incomplete pathways** for 65-week and 78-week exceeded the target values of zero. Actions to improve performance include initiatives in audiology, urology, orthopaedic services, and patient engagement validation.

The percentage of **diagnostic waits over 6 weeks** was 21.2% in July, exhibiting deteriorating special cause of variation and higher than the performance target of 18.0%. Challenges in audiology, endoscopy, neurophysiology, and ultrasound services are detailed, along with actions taken to address these issues.

Data Security and Protection Training (DSPT) compliance was 93% in July, showing further recovery towards the 95% target. No divisions are currently achieving the target, but all have improved with only Research and Development remaining below 90%. Actions include improving visibility of staff training levels, access to reports naming non-compliant individuals, and a reminder to all staff in M6.

Freedom of Information (FOI) performance was 69.1% in July, below the 80% target. The Trust faces significant challenges in managing FOI requests, and has an Enforcement Notice from the ICO. Actions include procuring a new system for managing FOI cases, changing the distribution of FOIs across the Trust, and recruiting temporary resources to assist with the backlog.

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 • Reactivated complaints • % of complaints responded to within 25 working days • FFT % Likely to recommend – OP and ED • PFI: % cleaning score by site (average) CH • Pressure ulceration per 10,000 bed days (Cat 3) and (Cat 2) • MRSA Cases: HOHA+COHA	Not Achieving target • Midwife ratios (birth rate/staffing level)	Not achieving target • VTE Submitted Performance Not achieving target • Health and safety related incidents • Number of complaints • Number of complaints per 10,000 bed days	No SPC Not achieving threshold • Non-thematic patient safety investigations • Number of Never Events
Growing Stronger Together	Not achieving target • Sickness and absence rate (in month) • Sickness and absence rate (rolling 12 months)			
Operational performance	Not achieving target • RTT number of incomplete pathways (<18 weeks) • Cancer 31-day combined Standard (First and all Subsequent Treatments) • Cancer 28-day combined Standard (First and all Subsequent Treatments	Not Achieving target • RTT patients > 65 weeks	Not achieving target • % of RTT patients waiting within 18 weeks • 62-day Cancer Standard: >62 days Not achieving target • % Diagnostic waits under 6 weeks	
Corporate Support Services	Not achieving target • Freedom of Information % responded to within target time • Efficiency Delivery £'000 • In-month financial performance Surplus/Deficit £'000	Not achieving target • Information Governance and Data Security Training compliance • Year-to-date financial performance surplus/Deficit £'000	Not achieving target • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % • Cash £'000	No SPC Not achieving threshold

2. b) SPC indicator overview summary

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Jul-25	0.6	-	-	0.2	-0.5	0.8
MRSA cases: HOHA+COHA	Jul-25	2	0	No	1	-1	3
C-diff cases: HOHA+COHA per 10,000 beddays	Jul-25	2.5	-	-	3.5	0.4	6.7
C-diff cases: HOHA+COHA	Jul-25	8	10		11	2	21
MSSA cases: HOHA+COHA	Jul-25	4	-	-	6	-1	12
Number of Never Events	Jul-25	1	0	No	0	-	-
Non-Thematic Patient Safety Incident Investigations	Jul-25	4	0	No	2	-	-
VTE- Submitted performance	Jul-25	93.8%	95.0%	No	95.2%	94.0%	96.4%
% of emergency admissions 65yrs + receiving cognitive screen	Jul-25	60.9%	-	-	58.5%	50.6%	66.4%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Jun-25	90.9%	90.0%		90.4%	70.9%	109.9%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jul-25	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Jul-25	1	-	-	2	-2	7
HSMR Excluding Hospices	Jun-25	94.6	100.0		85.6	-	-
Summary Hospital-level Mortality Indicator	Jun-25	91.0	100.0		91.9	-	-
Neonatal deaths per 1,000 total live births	Jun-25	2.2	3.2		3.2	-1.1	7.5
Stillbirths per 1,000 total Live births	Jun-25	1.6	4.0		3.8	-0.2	7.7
National Patient Safety Alerts not completed by deadline	Jul-25	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Jul-25	0.0	-	-	0.0	0.0	0.0
Number of active clinical research studies hosted	Jul-25	1418	-	-	1420	1184	1655
Number of active clinical research studies (commercial)	Jul-25	392	-	-	382	312	451
Number of active clinical research studies (non commercial)	Jul-25	1026	-	-	1038	870	1206
Number of incidents with moderate harm or above per 10,000 beddays	Jul-25	42.3	-	-	38.8	22.9	54.6
Number of patient incidents with moderate harm or above per 10,000 beddays	Jul-25	38.6	-	-	34.4	17.7	51.1
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Jul-25	3.8	-	-	4.4	-1.9	10.7
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Jul-25	23.5	19.0	No	18.6	7.2	30.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Jul-25	3.5	2.0	No	2.1	0.4	3.8
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Jul-25	0.0	0.0		0.1	-0.2	0.3
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Jul-25	109.8	-	-	89.1	56.8	121.4
Patient falls (moderate and above) as reported on Ulysses	Jul-25	3	-	-	4	-2	10
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Jul-25	0.9	-	-	1.2	-0.8	3.1
Health and Safety related incidents - Assault, Aggression and harassment	Jul-25	201	-	-	164	88	239

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: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adult safeguarding activity	Jul-25	1820	-	-	1021	695	1348
Children's safeguarding activity	Jul-25	438	-	-	611	306	916
Adult safeguarding activity and Children's safeguarding activity	Jul-25	2258	-	-	1633	1153	2113
Safeguarding (Children) training compliance L1 - L3	Jul-25	91.0%	90.0%		88.6%	83.9%	93.2%
Safeguarding (Adults) training compliance L1 - L3	Jul-25	92.0%	90.0%		46.3%	38.4%	54.2%
Total Deliveries in month	Jul-25	603	625	-	613	540	685
Babies born	Jul-25	612	-	-	622	549	695
Maternity Bookings (planned + unplanned)	Jul-25	743	750	-	703	545	861
Inductions of labour from iView	Jul-25	128	-	-	139	96	182
Midwife Ratios (birth rate / staffing level)	Jul-25	24.9	22.9	No	25.5	21.4	29.6
Learning MDT Reviews presented at SLIC	Jul-25	2	-	-	2	-	-
After Action Review (AAR)	Jul-25	14	-	-	14	-	-
Number of complaints	Jul-25	202	-	-	121	69	173
Number of complaints per 10,000 beddays	Jul-25	63.4	-	-	37.9	23.2	52.6
Reactivated complaints	Jul-25	16	1	No	11	2	19
% of complaints responded to within 25 working days	Jul-25	44.1%	85.0%	No	45.2%	24.6%	65.8%
Number of RIDDORs	Jun-25	7	5	No	5	1	9
Friends & Family test % likely to recommend - IP	Jul-25	95.6%	95.0%		95.0%	93.7%	96.3%
Friends & Family test % likely to recommend - OP	Jul-25	93.8%	95.0%	No	93.8%	93.0%	94.6%
Friends & Family test % likely to recommend - ED	Jul-25	84.0%	85.0%	No	79.1%	72.8%	85.5%
FFT maternity % positive (births)	Jul-25	81.8%	90.0%	No	72.0%	45.6%	98.4%
Inpatient FFT (Response Rate)	Jul-25	20.6%	-	-	24.4%	21.1%	27.7%
Outpatient FFT (response rate)	Jul-25	9.9%	-	-	8.3%	6.5%	10.1%
ED FFT (Response Rate)	Jul-25	16.3%	-	-	22.1%	17.4%	26.9%
Maternity FFT (response rate; births)	Jul-25	4.4%	-	-	8.5%	0.9%	16.0%
PFI: % of total audits completed that achieved 4 or 5 stars JR	Jul-25	95.7%	95.0%		93.2%	83.9%	102.4%
PFI: % of total audits completed that achieved 4 or 5 stars CH	Jul-25	89.7%	95.0%	No	94.5%	84.2%	104.8%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	Jul-25	100.0%	95.0%		96.4%	88.5%	104.2%
Incident rate of violence and aggression (rate per 10,000 beddays)	Jul-25	63.0	-	-	47.8	24.0	71.6
Trust level: CHPPD vs budget	Jul-25	19.9	-	-	-14.9	-62.7	32.8
Trust level: CHPPD vs required	Jul-25	1.4	-	-	-5.7	-25.6	14.2

2. b) SPC indicator overview summary

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)

Operational Performance Summary: All

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Jun-25	4.7%	-	-	8.8%	4.6%	13.0%
Proportion of ambulance arrivals delayed over 60 minutes	Jun-25	0.2%	-	-	0.9%	-0.2%	2.1%
ED 4Hr perfromance - All	Jul-25	82.1%	75.9%		67.9%	59.8%	76.0%
ED 4Hr perfromance - Type 1	Jul-25	75.4%	65.6%		60.8%	51.7%	69.9%
Proportion of patients spending more than 12 hours in an emergency department	Jul-25	0.6%	4.4%		4.5%	2.3%	6.7%
Proportion of patients discharged from hospital to their usual place of residence	Jul-25	95.7%	-	-	95.2%	94.4%	96.0%
% of RTT patients waiting for a first appointment	Jul-25	65.6%	64.3%		65.1%	63.4%	66.7%
% of RTT patients waiting within 18 weeks	Jul-25	58.6%	58.9%	No	60.8%	58.7%	62.9%
% of RTT patients waiting over 52 weeks	Jul-25	3.2%	3.3%		3.3%	3.2%	3.3%
RTT standard: >52-week incomplete pathways	Jul-25	2811	2897		2754	2414	3094
RTT standard: >65-week incomplete pathways	Jul-25	175	0	No	639	405	874
RTT number of incomplete pathways	Jul-25	87002	88210	-	79359	76554	82163
RTT number of incomplete pathways (<18 weeks)	Jul-25	50982	51977	No	50867	49557	52176
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Jun-25	77.0%	77.6%	No	78.1%	73.2%	83.0%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Jun-25	80.4%	80.5%	No	82.7%	74.1%	91.4%
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Jun-25	61.8%	60.6%		61.3%	52.6%	69.9%
62-day Cancer standard: incomplete pathways >62-days	Jul-25	433	-	-	346	266	425
% Diagnostic waits waiting 6 weeks or more	Jul-25	21.2%	18.0%	No	16.9%	12.3%	21.4%
Diagnostic activity vs 2019/20	Jul-25	136.7%	-	-	124.9%	113.0%	136.7%

Integrated Performance Report (SPC)

Operational Performance Summary: All

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Total outpatient attendances - EM32in the 25/26 plan	Jun-25	115991	111864	-	111839	102279	121399
Bed Utilisation General & Acute	Jul-25	93.2%	93.0%		94.9%	91.5%	98.2%
Average Non elective LOS Trust level for IPR (average so cannot aggregate up)	Jun-25	6.5	6.2	No	6.6	-	-
Number of non-discharged patients put onto a PIFU	Jul-25	991	1666	No	1174	304	2044
Cancelled operations within 24hrs (non-clinical reasons)	Jun-25	0.3%	-	-	0.4%	0.2%	0.6%
Cancellations not re-booked within 28 days	Jun-25	12.0%	-	-	12.9%	-12.0%	37.8%
Elective DC spells - SUS	Jun-25	6793	6873	-	6750	6037	7463
Elective IP spells - SUS	Jun-25	1475	1519	-	1516	1238	1794
Average delay (exclude zero delay) of discharges Trust level for IPR (average so cannot aggregate up)- EB46 in the 25/26 plan	Jun-25	5.8	6.3		7.9	-	-
Percentage of patients discharged on discharge ready date - EB45 in the 25/26 plan	Jun-25	95.9%	91.3%		95.8%	95.2%	96.5%

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

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

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

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

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Turnover rate with no exclusions	Jul-25	11.4%	-	-	11.6%	11.1%	12.0%
Vacancy rate	Jul-25	5.6%	7.7%		6.8%	4.7%	8.9%
Turnover rate	Jul-25	9.1%	12.0%		10.8%	10.4%	11.2%
Sickness absence rate (rolling 12 months)	Jul-25	4.2%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	Jul-25	91.7%	85.0%		76.2%	39.2%	113.1%
Sickness absence rate (in month)	Jul-25	4.1%	3.1%	No	4.2%	3.3%	5.1%
Core skills training compliance	Jul-25	92.1%	85.0%		90.5%	88.7%	92.4%
Time to hire (average days)	Jul-25	41.0	53.0		49.2	37.2	61.3

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Jul-25	-5778.2	-	-	-4901.7	-7863.6	-1939.9
BPPC £ %	Jul-25	60.6%	95.0%	No	80.9%	73.9%	87.9%
BPPC Volume %	Jul-25	32.8%	95.0%	No	65.6%	57.6%	73.6%
Cash £'000	Jul-25	13526	3647		28439	7463	49415
Efficiency delivery £'000	Jul-25	9432.0	6957.0		5881.5	-851.9	12614.9
Elective recovery funding (ERF) value-weighted activity % In month	Mar-25	101.9%	-	-	102.1%	91.6%	112.5%
In-month financial performance Surplus/Deficit £'000	Jul-25	-960.9	-1175.0		-666.6	-12580.6	11247.5
In-month ICS CDEL capital expenditure	Jul-25	2109.0	3583.5	-	3376.5	-7800.4	14553.4
Year-to-date financial performance Surplus/Deficit £'000	Jul-25	-9203.6	-9471.0		-14532.8	-24348.9	-4716.7

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

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Jul-25	92.9%	95.0%	No	90.9%	89.1%	92.7%
Data Security & Protection Breaches	Jul-25	41	-	-	28	8	47
Externally reportable ICO incidents	Jul-25	0	0		0	-	-
All IG reported incidents	Jul-25	38	-	-	30	13	46
Freedom of Information (FOI) % responded to within target tim	Jul-25	69.1%	80.0%	No	56.9%	29.8%	83.9%
Data Subject Access Requests (DSAR)	Jul-25	78.3%	80.0%	No	70.2%	51.0%	89.4%
Priority 1 Incidents	Jul-25	0	0		1	-	-

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

Latest Indicator Period: Jul-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Jul-25	26	-	-	19	5	34

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

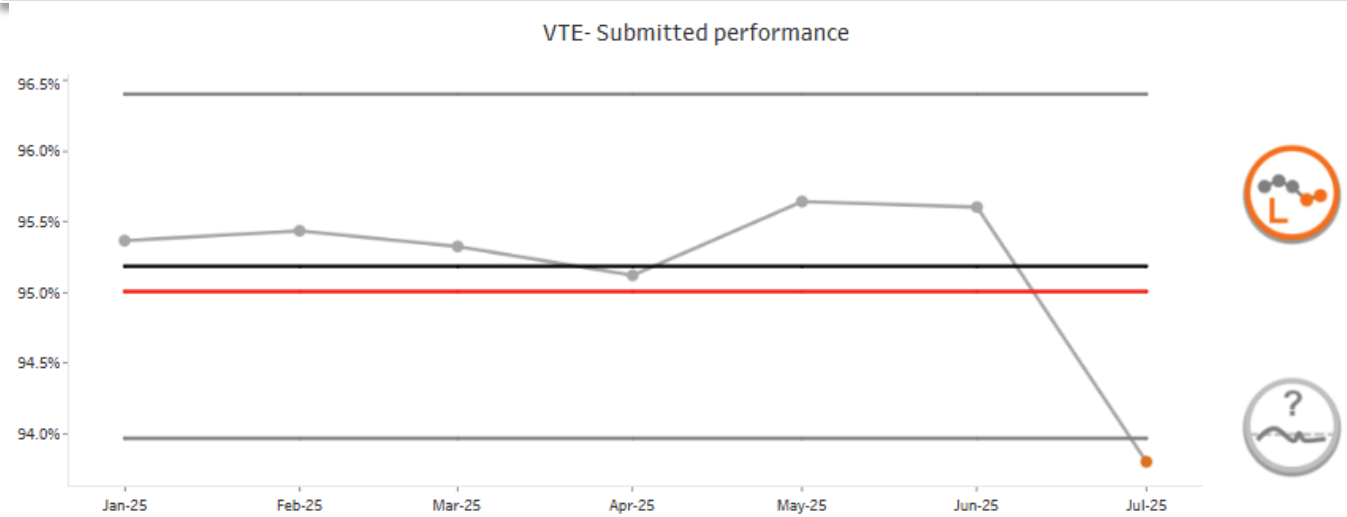
Latest Indicator Period: Jul-2025

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

03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks

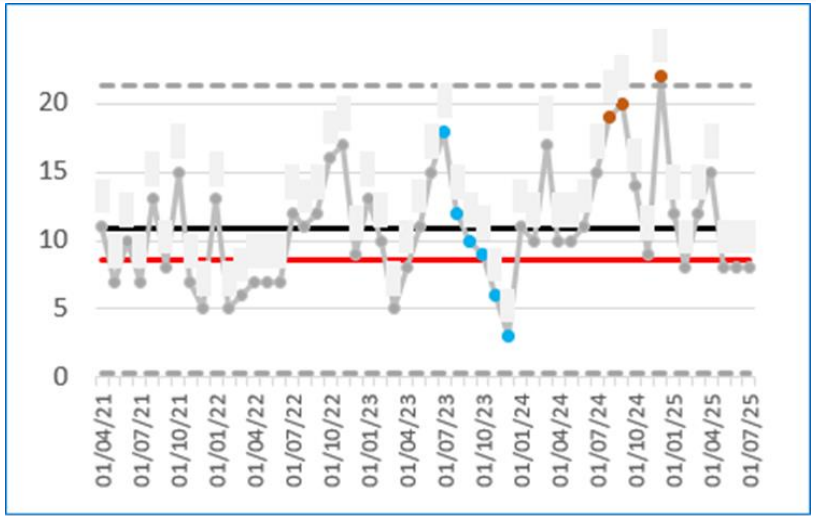
The national target in the NHS, is for at least 95% of all admitted patients aged 16 and over to receive a VTE risk assessment within 14 hours of admission (NICE NG89). Mandatory data collection was reinstated in April 2024 (after a pause during COVID-19).

In July OUH compliance fell below the national target to 93.8% (a drop of 1.2%).

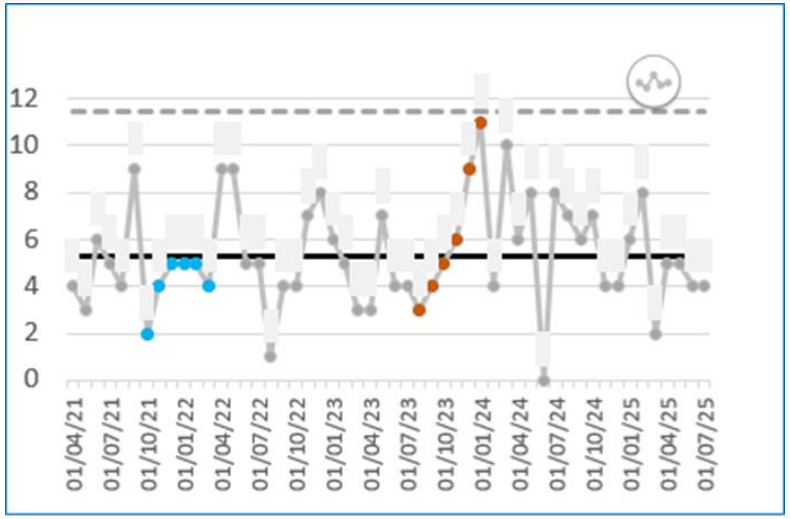
Delayed VTE risk assessment and prophylaxis represents a greater risk of a patient developing a potentially preventable Hospital Associated Thrombosis (HAT). Pharmacological VTE prevention reduces the risk of VTE by about 50% (variably depending on patient cohort). The later a patient receives their pharmacological therapy, the higher the risk of a HAT.

Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
The issue has been discussed as a priority in the Clinical Governance Committee, and all Divisions asked to review and address performance.			
SUWON- An entire Divisional Governance meeting has focussed on VTE's. Challenges identified include postponement of procedures leading to incorrect withholding of anticoagulation; incorrect documentation leading to missed doses; poor e- learning compliance in some groups. Proposed potential solutions/actions include development of a whiteboard project to flag patients who have not received their anticoagulants. A collaborative policy development is ongoing between services and Haematology to improve dose management.	Collaboration with Haematology to improve dose management		
In Maternity, an MDT VTE task group are leading on an initiative to achieve 100% of VTE assessments within 14 hours. There were some issues with VTE assessments on BadgerNet, therefore, they have digitality reviewed BadgerNet vs Cerner VTE assessment tools which has led to a revision of clinical guidance to optimise compliance. Next steps are an audit and education.	VTE Task group Maternity Governance meetings Divisional Governance meeting		
NOTSSCAN-Two Directorates were over 95% with the remaining three being below this threshold. The Children's Directorate remains an outlier, likely due to the much lower proportion and number of eligible patients (averaging 18 per month) which may lower awareness and prioritisation of VTE assessment and prophylaxis. The Clinical Director (CD) for Children's has been contacted to better understand the barriers and identify any necessary actions and support required. For adult areas, support has been offered, and the Division are confident that the 95% threshold will be met next month.	Divisional Meetings and CD support for each Directorate. August data will be scrutinised to see if this method is working.		
MRC- The dip in performance compared to usually high compliance may be influenced by industrial action. There is also data cleansing to be undertaken for future months' reports. Work is ongoing to ensure this is prioritised. In August Cardiac Directorate developed and delivered a new medic induction program that included VTE.	Interventional Radiology M and M meeting		
CSS-In Oxford Critical Care (OCC) there has been a focus on improvement. Compliance improved in July to 95.3% from 87% in June. For radiology, compliance was 76% in July with 6 assessments completed outside of the 14-hour window. Improvement work is ongoing to ensure the radiologist provides patient-specific VTE prophylactic guidance for day case patients that require an overnight stay as part of the handover process. This was discussed in the last Interventional Radiology M & M meeting	All Divisions report progress to CGC		

3. Assurance report: Quality, Safety and Patient Experience



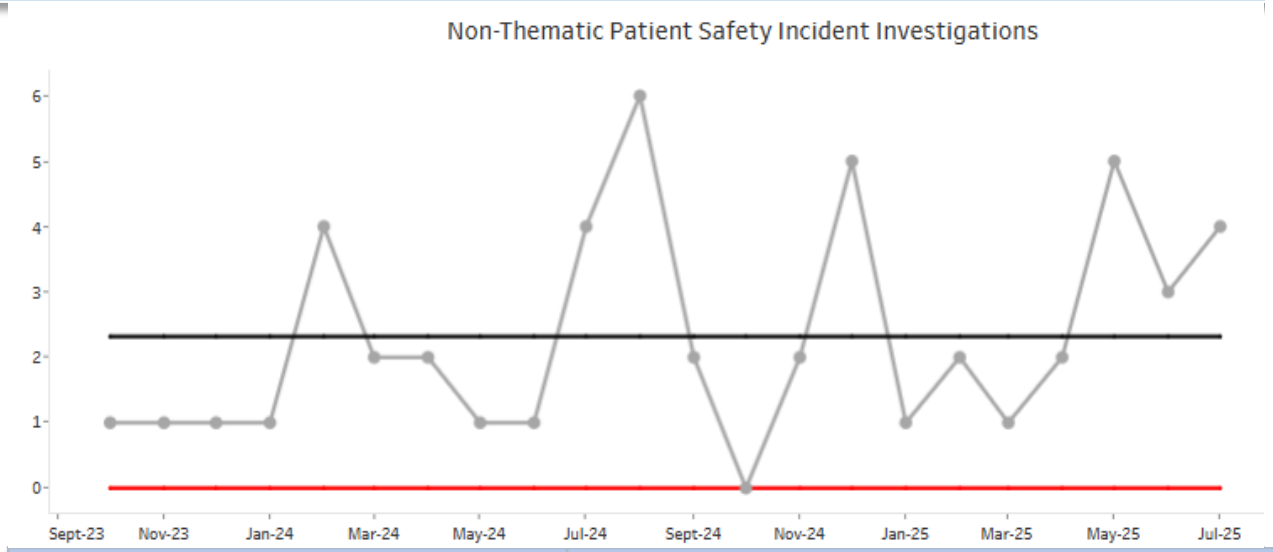
Statistical Process Control (SPC) chart of OUH apportioned C. difficile infection counts (April 2021- July 2025)

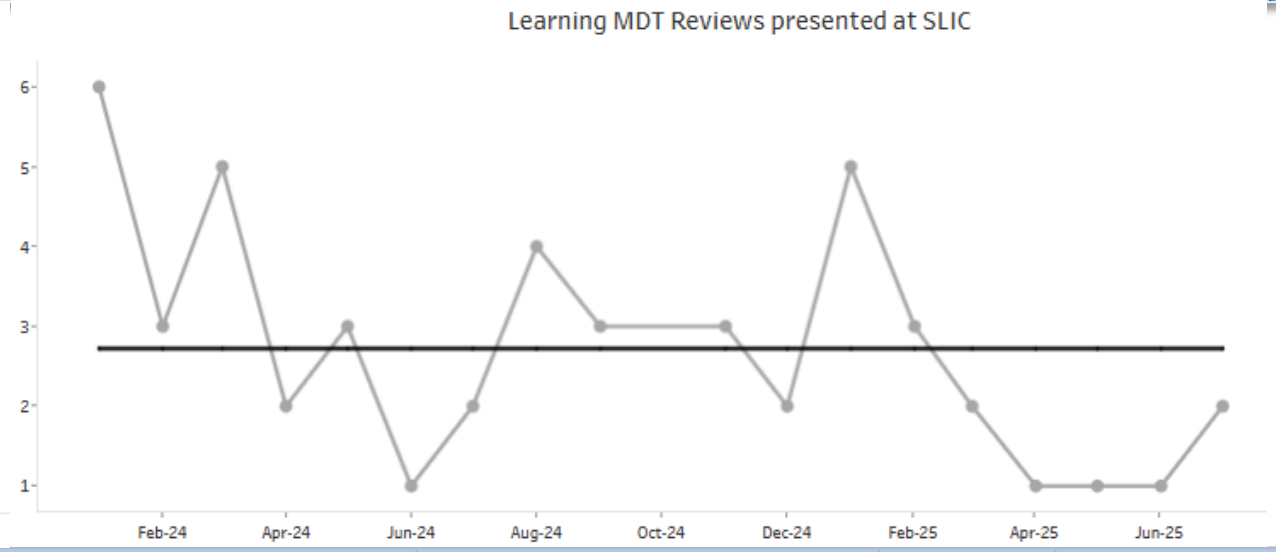


SPC MSSA HOHA and COHA Cases (April 2021-July 2025)

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
MRSA Bacteraemia – There were 2 COHA cases of MRSA bacteraemia reported in July. The 1st case was a complex post-surgical Urology patient with learning identified around removal of cannulas when no longer in use. The 2nd case was a child with a haematological malignancy – no learning for prevention was identified. **MSSA bacteraemia –** The improvement in numbers seen at the end of 2024/25 has been maintained. **Clostridium difficile** – for the first time since March 2020 the number of C. difficile cases reported to end of July 2025 is under the trajectory set by NHSE. This coincides with a reduction in the prescription of broad-spectrum antibiotics in the Trust, and the implementation of a project to improve clinical cleaning in acute medicine. **National Patient Safety Alert** received regarding Burkholderia spp. contamination of non-sterile alcohol-free skin cleansing wipes. 51 cases in the UK national outbreak including 2 Oxford cases. Affected products found in the Trust (first aid kits). **Safe Water Management** – no progress with closing 2019 Churchill PFI SIRI actions since April 2025; only 7/21 actions closed.	**Staffing –** Successful recruitment of substantive IPC lead nurse / manager in July; the new appointee will start in October. **NPSA and UKHSA briefing note re Burkholderia contamination** Information and guidance about use of wipes to be added to information leaflets for patients with intravenous lines in community. A Trust communication has been issued for departments to check their first aid kits and dispose of affected products. **IPC Surveillance** – the lack of an IPC surveillance system remains high-risk on the Trust Risk Register. The OUH Digital Engineering service launched a web-based information management system to provide partial mitigation in May; however this does not provide a sufficient or long term solution. A business case for a replacement IPC software system is being updated, but funding for this has not yet been identified.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC. Question added to H&S Ulysses assurance audit for August and September to capture feedback that first aid kits have been checked.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

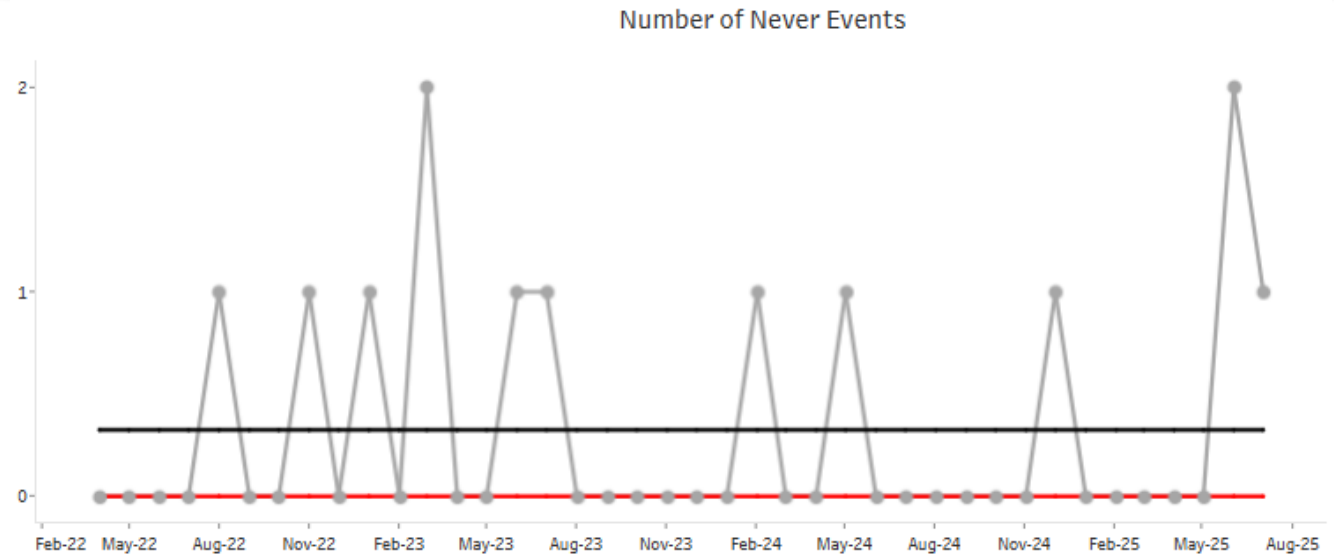
3. Assurance report: Quality, Safety and Patient Experience





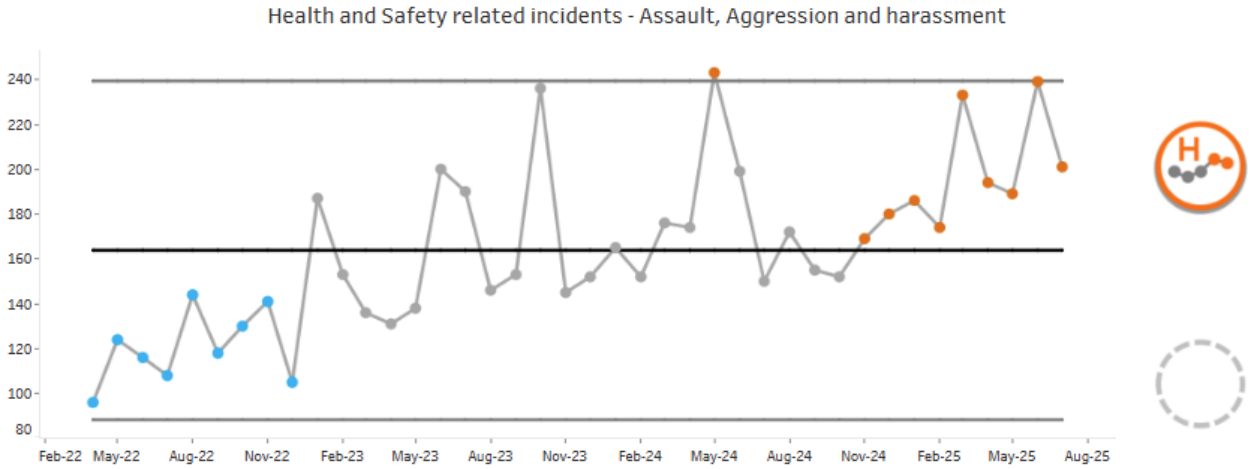
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Four new non-thematic PSIIs were confirmed in July. • One is a Never Event detailed on the following slide, The other three concerned: • A patient who had a witnessed fall resulting in a subdural haematoma • A patient who absconded from ED and was found unharmed on the roof of a hospital building • A baby who was born in poor condition following an emergency caesarean section who later died. The learning and improvement will be shared once the PSIIs have concluded.	A total of 50 non-thematic PSIIs have been confirmed since October 2023, 22 (44%) of which have been fully completed and a final report circulated. Actions are underway to improve the timeliness of PSII completion and to ensure learning is implemented and improvements in safety can be demonstrated. LMDTRs have a target of 42 calendar days from the reporting of the incident to holding the meeting. The time to complete both the LMDTR meetings which were tabled at SLIC in July 2025 was beyond this target, at 146 and 133 calendar days. For the first of these, the decision was made to do a LMDTR approximately 4 months after the incident was reported, when the local manager reviewed comments from a standard incident questionnaire – from this point it only took 14 calendar days to complete the meeting. For the second case the precise history is less clear, but again it is evident from the Ulysses record that the decision to undertake a LMDTR was not made until information had been sought and reviewed locally. AARs have a target of 14 calendar days from the reporting of the incident to holding the meeting. The median time to complete AAR meetings was 19.5 days in July. More staff are being trained in conducting learning responses with the aim of reducing the time to arrange and conduct LMDTR and AAR meetings. Targets and adherence are monitored at the PSIRF Improvement Group.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. A quality improvement project has been created to address this. 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. Challenges relating to actions arising from PSIIs are reported to Clinical Governance Committee, and in July 2025 a total of 37 PSII actions were overdue.	BAF 4 CRR 1122	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Quality, Safety and Patient Experience



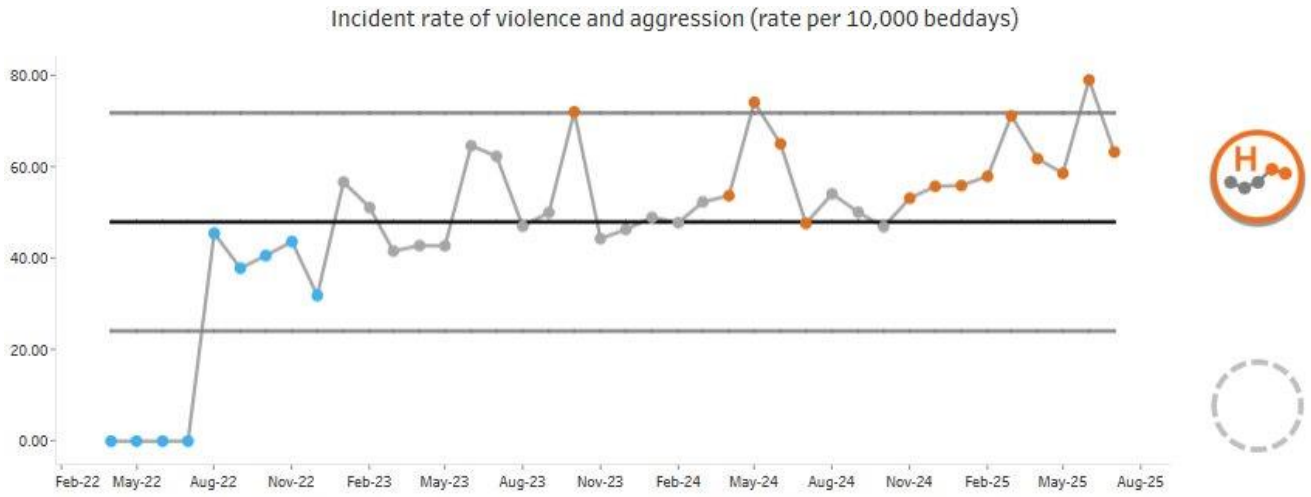
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
One Never Event was raised as a PSII in July. This concerned a patient who received a right-sided local anaesthetic block whilst under general anaesthesia, when a left-sided block was intended (Wrong Site Surgery).	Immediate actions to address the risk of wrong site block include: • Urgent communication to all Divisional and Directorate leadership teams alerting them to the 2 wrong site blocks in a short period due to failure to do 'Stop Before You Block' (SBYB) and asking them to ensure the importance of SBYB is urgently reinforced to all relevant teams and discussed at relevant CSU and Directorate Clinical Governance meetings. • A Trust-wide Safety Message emphasizing the importance of SBYB and linked to our policy. • Survey of anaesthetists to understand experience, practice and challenges around Safety Checks in Peripheral Nerve Blocks. • A PSII has been initiated and will be linked to the recent PSII into a similar incident to ensure joined up learning. • A meeting with stakeholders will be held on 28th August to discuss the issues surrounding both cases.	Timetables for completion of these investigations and associated reports are set with the lead investigators.		

3. Assurance report: Quality, Safety and Patient Experience



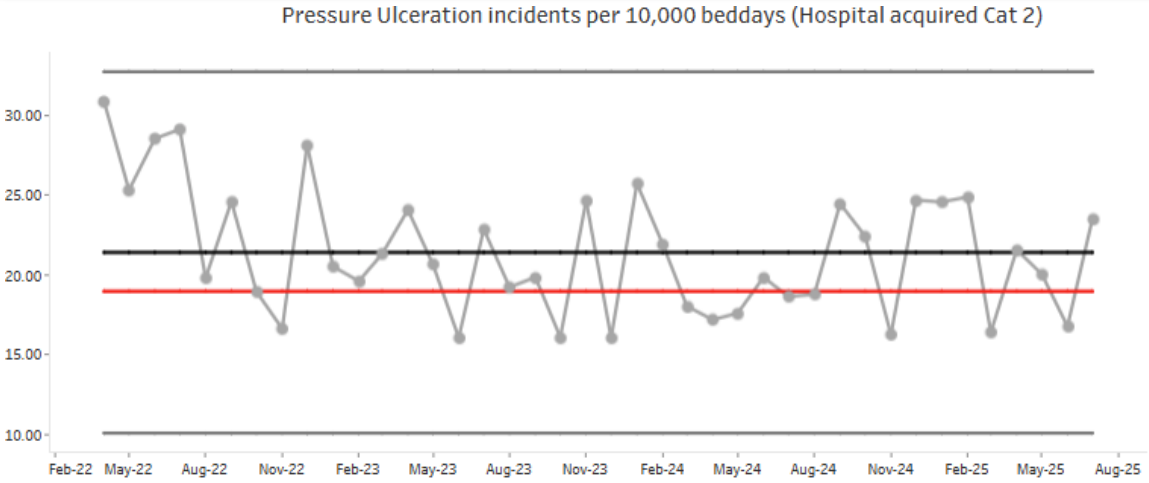
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
There were 63 Health and Safety incidents relating to assault, aggression and violence per 10,000 bed days in July, which is a reduction of 15 incidents compared to June. The indicator exhibited special cause variation due to two out of the last three points being within one sigma of the upper control limit. As indicated there has been an increase in reported incidents of violence and aggression over the past 12 months. Incident rates reached special-cause variation in May / June 2025. This rise is partly due to improved reporting ("No Excuses" campaign) and annual seasonal increases. Challenges and risks include: • Patients' clinical conditions leading to agitation or loss of control. • Patients under influence of substances (alcohol/drugs) or with certain psychiatric conditions causing unpredictable or aggressive behaviour. • Emotional triggers – often tied to wait times, crowded environments, or receiving bad news. • Inherent aggression or abusive attitudes in a minority of patients/visitors • Continued on Slide 3	Leaders continue to encourage staff not to accept abusive behaviour and increased reporting is a positive outcome of the No Excuses Campaign. **Mitigation Measures Currently in Operation** (Summary List): • Zero-Tolerance Policy & Campaign: "No Excuse for Abuse" posters, patient-facing messaging, and reinforcement by leadership. • Encouraged Reporting: Simplified incident reporting processes and strong messaging that all abuse must be reported (with no stigma). • Regular Analysis & Oversight: Monthly violence reduction meetings at divisional and Trust level to monitor trends and implement actions • Clinical Teams within Directorates manage clinically attributed aggression through individual care planning, undertaking a level of enhanced observation, and utilising security support. • Update to Divisional Director Nurse and Senior Nursing team i.e., Matron/Deputy Matron on day of event with appropriate follow-up support to clinical staff, patients, and relatives. • Divisional reporting to H&S Committee bi-monthly and opportunity to raise concerns / identify common themes. • Body-Worn Cameras: Deployed in high-incident areas to deter aggression and collect evidence.; Personal Safety Alarms: Lone-worker devices distributed to community staff for emergency help. • Environmental Adjustments: Risk assessments in departments to reduce triggers (e.g., improved waiting conditions, clear signage, alarm systems).	VAR group should reinstate monthly meetings (No meeting for past 2 months). ED V&A Staff Safety Group meets fortnightly, and this model is being rolled out throughout other directorates.	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months*

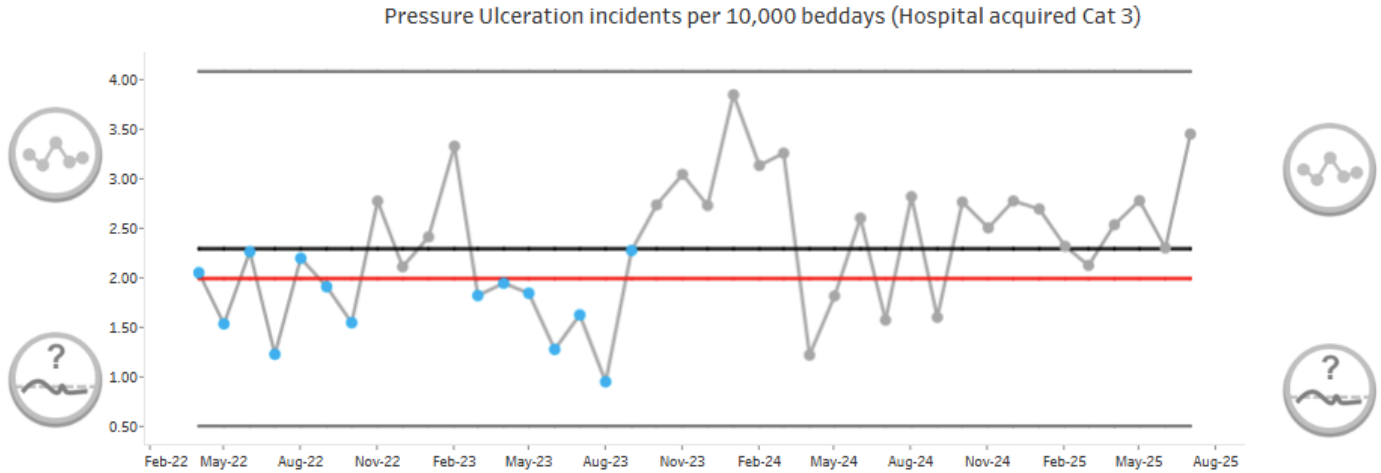
3. Assurance report: Quality, Safety and Patient Experience



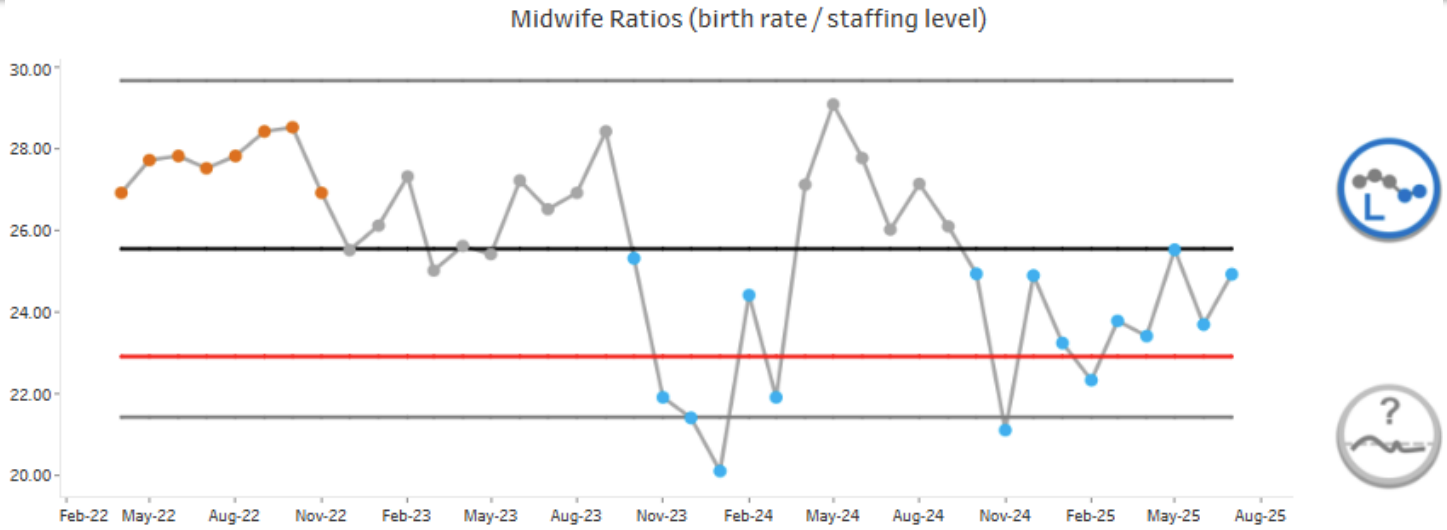
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
Continued from slide 2 Overall, the trend is most pronounced in high-throughput, unscheduled-care areas: • **Emergency Departments (**JR /HGH) – highest volume and increasing (accounts for over half of incidents); **Acute/Emergency Assessment Units** – significant increases, multiple incidents per day in some cases; **General Medicine wards** (e.g. Neurosciences - attributed to the clinical condition of the patient and them lacking capacity) • **SuWOn Theatres** three sites (CH, Horton and WC), are witnessing incidents on V&A reported attributed to patients/relatives and staff. On some occasions, single patients have contributed high numbers of reported incidents. Incidents involving relatives, friends, and other visitors may reflect the concerns they hold regarding the patient. The Ulysses system is available to facilitate reporting of such events. Ongoing safety huddles and staff training highlight the importance of engaging security personnel when support is needed.	Each of these interventions contributes to a safer environment. OUH's multi-pronged approach – combining prevention, protection, and prosecution – is aimed at reversing the trend of rising violence and ensuring staff can work in a setting of respect and safety. The issue is taken extremely seriously at all levels, and efforts are ongoing (including an **upcoming National Violence Prevention Summit being planned by OUH's team in October 2025 to share best practices**). Through these concerted actions, the Trust is striving to foster a culture where clinicians are safe and supported, and aggression towards healthcare staff is never accepted as "normal. The Trust Security Manager has not been in post for some months, resulting in reduced opportunity for: • Staff Training: Mandatory conflict resolution training (with >95% uptake); advanced de-escalation, breakaway technique, and restraint training for key staff groups. • Security Presence: 24/7 Security team on-site; early involvement in escalating situations; close liaison with police (including on-site support for ED at times) • Behavioural Contracts: Use of Acceptable Behaviour Agreements for patients/visitors who have exhibited aggression, setting clear conduct expectations. The new Trust Security Manager has recently taken up post and it is anticipated they will quickly appraise requirements to support V+A interventions / reinstate measures above. A business case for additional Security staff is in progress.	VAR group should reinstate monthly meetings (No meeting for past 2 months). ED V&A Staff Safety Group meets fortnightly, and this model is being rolled out throughout other directorates.	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months*

3. Assurance report: Quality, Safety and Patient Experience



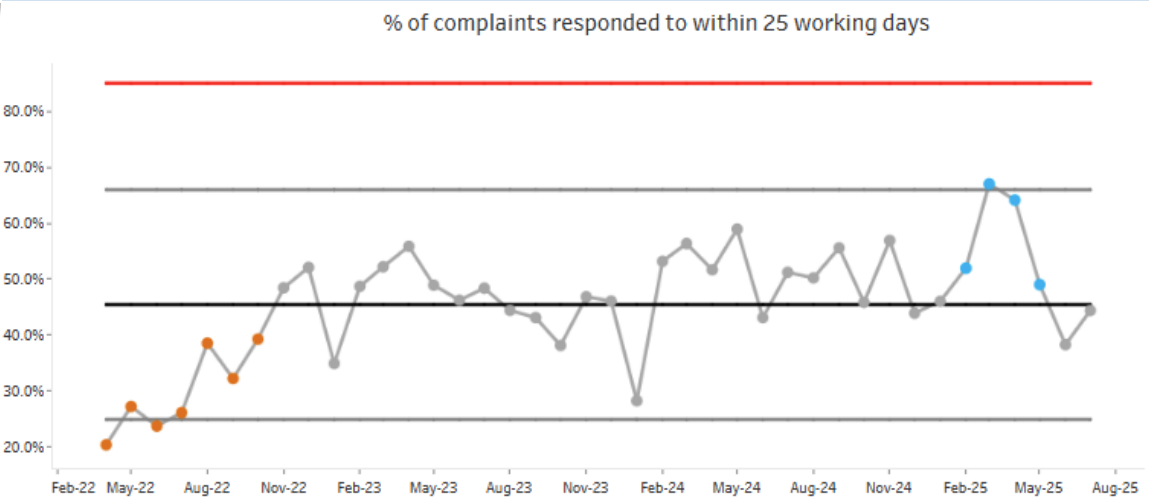


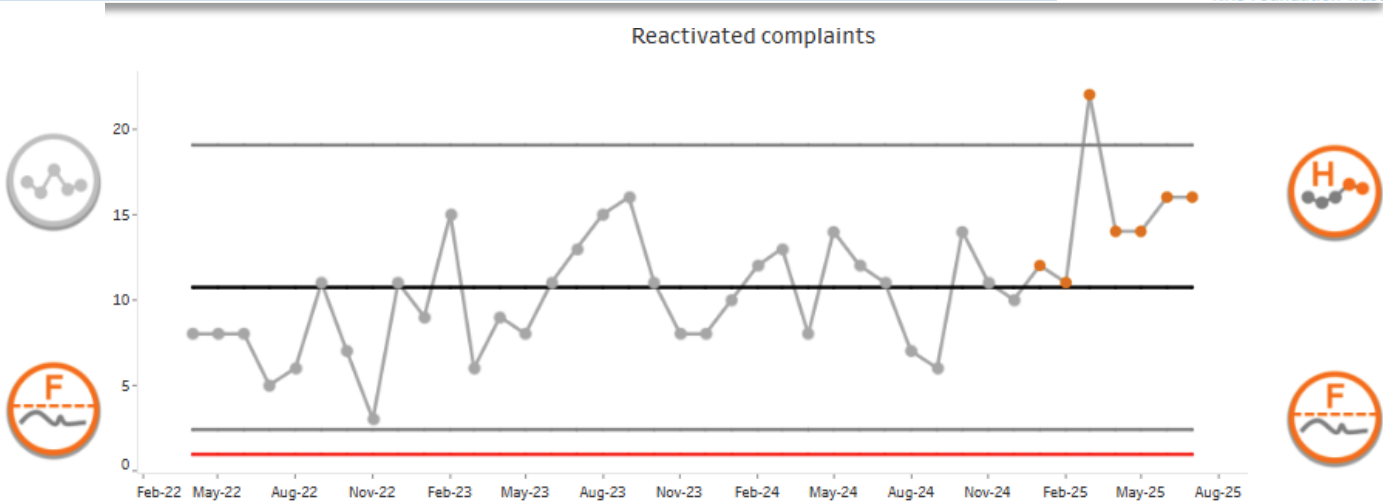
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust continues to demonstrate a proactive and data-informed approach to the prevention and management of pressure ulcers. In July 2025, the data indicates an increase in Category 2 pressure ulcer incidents from 53 in June to 69 in July, which is an increase of 16. There were 11 incidents of HAPU Category 3, an increase in 4 from 7 reported in June. There were no reported incidents of Category 4 HAPUs	• Oversight is maintained through the Harm Free Assurance Forum, with escalation to the Clinical Governance Committee. • In depth harm reviews will be undertaken in areas with consistent challenges in delivering a sustained reduction. • Compliance with monthly pressure ulcer prevention audits showing an upward trend from June 2025, with all eligible inpatient areas demonstrating a 93.6% compliance in July. • A comprehensive Harm Free Quality Improvement Plan (QIP) has been developed, integrating learning from pressure ulcers, falls, nutrition and hydration. This cross-cutting approach is designed to foster shared learning and systemic improvement and will be ratified and implemented in August. • Data reporting to be reviewed by the TV team	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*



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
In July 607 mothers birthed at OUH, 9 more than the previous month The midwife to birth ratio was 1:24.91 which is above the Birthrate Plus recommendation of 1:22.9 and inclusive of all NHSP vacancy/unavailability backfill spend and clinical hours allocated by specialist roles. Unavailability remains a challenge for the service with a current 25.92wte (7.8%) on Maternity leave. This is predicted to peak to 32.17wte (10.1%) in Q3 2025/26 which is at the peak of high activity for the service.	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. The service has offered 27 Band 5 midwife positions, with interviews ongoing to cover 25.92 WTE maternity leave. An additional advert for 12 WTE is out, and targeted recruitment is in progress. These actions align with national plans to support this year's newly qualified midwives through a rapid graduate programme. Daily staffing meetings continue to ensure safe staffing across the service and enable tactical mitigations and trigger escalation as needed. Maternity safe staffing % fill rates improvement plan continues in collaboration with the Trust Safe Staffing team, this includes a weekly review of accuracy of planned V's actual fill rates and a tactical staff education programme. An upward improvement trajectory is noted for July. Further controls for NHSP authorisation now implemented for agreement at Matron level and above only. Additional community night on-calls are now consistently rostered. 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: ➢ Recruitment to birthrate plus uplift, ➢ Staff retention strategies ➢ Reduction of NHSP spend. Positive trajectory towards full recruitment by October 2025. Weekly monitoring of: ➢ Accuracy of Safe Staffing fill rates ➢ Community on-call hours required ➢ Community based births ➢ NHSP spend	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

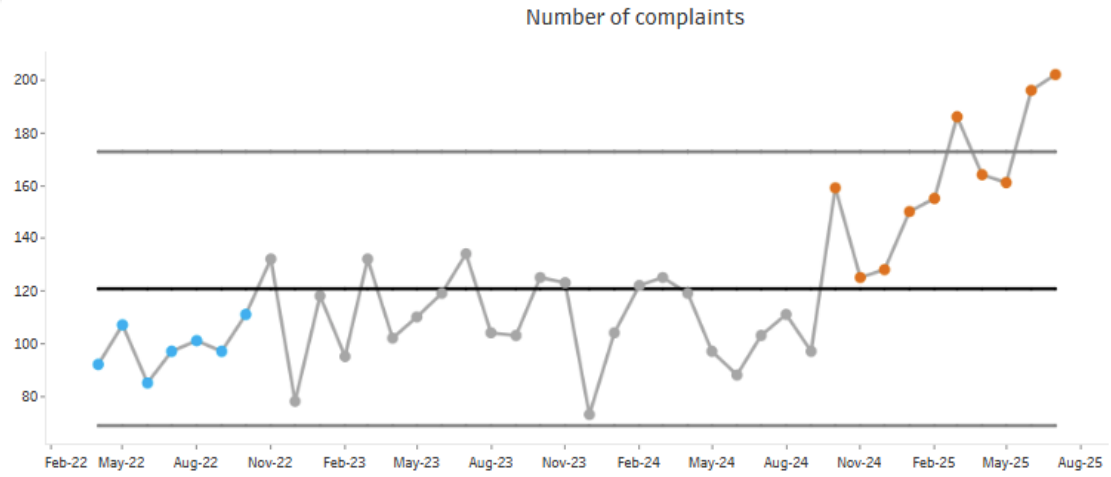
3. Assurance report: Quality, Safety and Patient Experience, *continued*

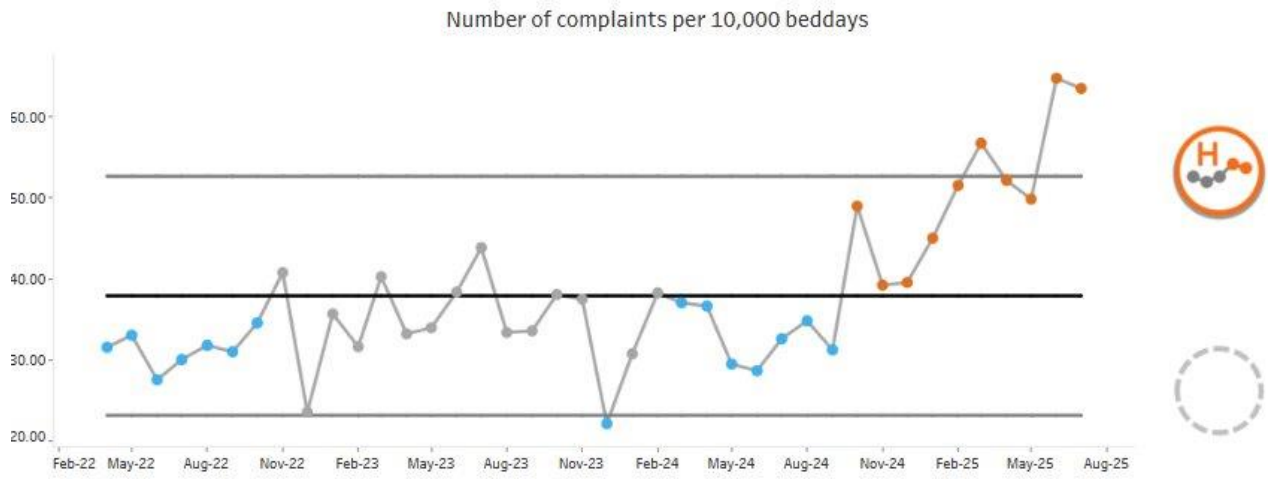




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In July 2025, OUH received a total of 202 formal complaints continuing the special cause variation (shift) and contributing to ongoing challenges with meeting the 25-day KPI.	Compliance with the 25-day KPI increased from 37% in June 2025 to 44% in July 2025. In total, 233 complaints were successfully closed in July, compared to 158 in June. A weekly report detailing all open complaints with a breakdown of compliance with time-related targets for each of stage of the process continues to be circulated to the divisions to facilitate prioritisation and timely progression of their respective complaints. Additionally, weekly meetings are held with the Divisional Directors of Nursing who work with the Clinical Leads and Divisional Medical Directors to escalate complaint cases that are in breach. The complaints team are currently working with the Head of Patient Experience and Informatics Lead to complete further analysis of the process targets to identify bottlenecks with a view to identify process improvement opportunities. Anecdotal evidence from other Shelford Trusts indicates similar trends across the NHS. OUH are undertaking further analysis of trends in complaint types to identify possible drivers that could be addressed. 202 complaints were received in July, of which 15 (7%) were reopened cases from previous complaints requiring reinvestigation. This is consistent with last month where 17 (8%) were also reopened. The consistent trend of reopening rates provides assurance that, despite the increasing volume, complainant satisfaction with the quality of the investigation and written response remains unchanged. Reopening a case when a complainant expresses concerns remains an important mechanism to ensure vital findings have not been missed and complainants have all questions answered. This reflects a positive culture within OUH.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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

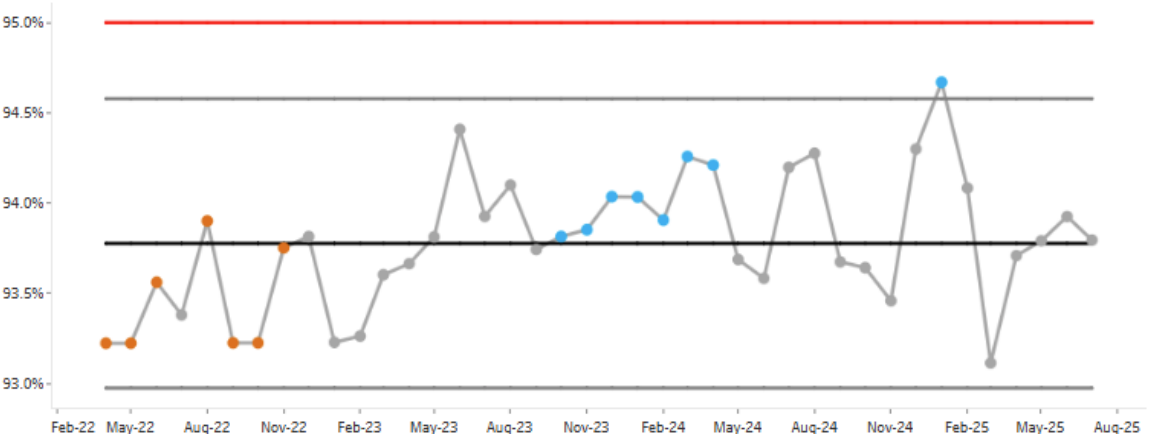




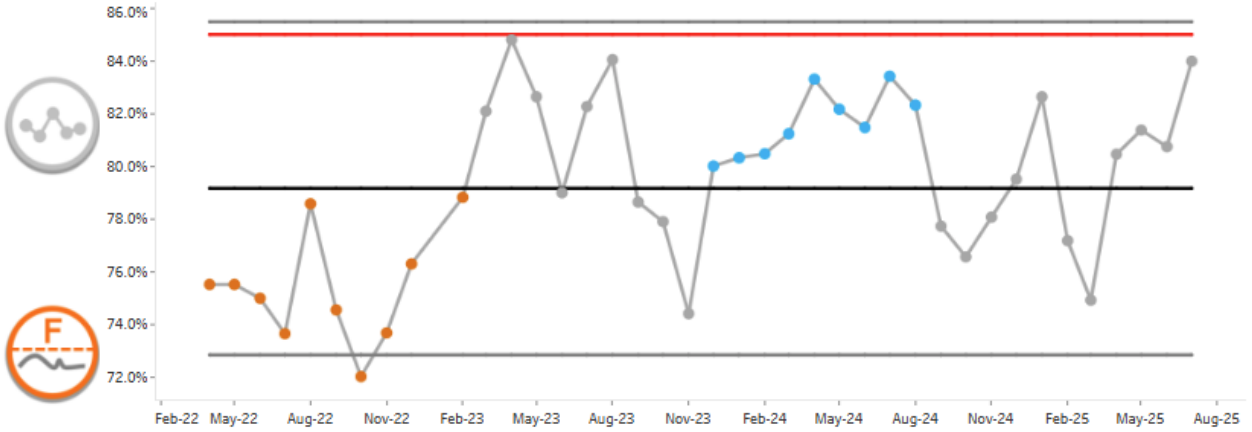
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Continuation of this trend in the volume of patient complaints will result in challenges in organisational capability to meet the 25-day KPI.	The comprehensive thematic data provided by the Power BI Complaints dashboard allows divisions to analyse the causes of their complaints and assess their performance in achieving the 25-day resolution target. 202 complaints were received in July, the top five categories of these complaints were: Clinical Treatment (n=56/27%), Communications (n=39/19%), Values and Behaviours (n=25/12%), Patient Care (n=22/11%) and Appointments (n=17/8%). The Complaints team will continue to work with the divisions to understand the key drivers behind these themes and to facilitate identification of improvement opportunities to enhance patient experience and reduce complaints with known causes. In addition, work is to be undertaken to explore the development of an AI tool with Microsoft, to aid in the investigation and learning elements of complaints.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Friends & Family test % likely to recommend - OP



Friends & Family test % likely to recommend - ED



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. Outpatient responses accounted for 11,803 of the total responses received, and the recommend rate has decreased to 93.8% in July, compared to 93.9% in June. 2. The top positive themes during June for outpatients was staff attitude, implementation of care, and admission. The top negative themes were waiting list, discharge and cancelled admission / procedures. 3. ED response numbers were 1461, with a positive recommend rate of 84.0% which has increased in comparison to 80.7% in June. 4. The top positive themes during July for ED was staff attitude, implementation of care and admission. The top negative themes were car parking, discharge and catering.	1. A dashboard for FFT is being developed by the performance team. 2. Each division presents an update on patient experience, including FFT data and themes at the PE forum monthly. 3. A deep dive into FFT over an 18-month period has been undertaken to look at specific areas that need support with increasing response number and recommend rates. This will be reported to PEFC in September.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 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]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Family Carer Forum, [PEFC] and the Trust Governors Patient Experience and Membership Committee (PEMQ).	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Oxford University Hospitals NHS Foundation Trust

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 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 twice daily and was maintained at Level 2 (Amber) throughout July 2025. Paediatric Critical Care Unit (PCCU) declared level 3 one night shift. 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 92.55% during the day and 97%% 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. The figures reflect that many wards across the trust are working with minimum, rather than, optimum staffing levels.

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 July review confirmed across all divisions that there were no instances of nurse-sensitive harm indicators directly linked to nursing or midwifery staffing levels. The HR data is being reviewed, as following the amendment to budgets, based on M11, the data is inaccurate. The division will work with HR and finance teams to ensure budgets are aligned with safe staffing requirement following the establishment reviews and CNO approval. It is hoped the data will be updated and accurate by September.

SUWON – Rostering KPI's- some areas need to improve the roster lead time; this is being monitored carefully and education given to improve. Upper GI ward also has a net hours difference outside of the KPI, which relates to RAF staff and students. Gynae ward CHPPD is slightly lower due to increased day cases. UGI and Wytham have had less patients, but due to location and logistical layout, could not reduce staffing for safety reasons. Delays in education posts review is causing some issues with new starter support and this has been escalated.

MRC – The rostering KPI's for the division are good. The missed payroll approval was due to a matron being unexpectedly absent. This will be addressed by a more formal deputisation in future. The open red flags have now been reviewed. There were no concerns that the nurse sensitive indicators reported, related to unsafe staffing. EAU roster was aligned to Annual Leave KPI at the time of publication, however, due to emergency leave being requested and approved, this resulted in being over the KPI at the end of the roster period.

NOTSSCAN – Roster efficiencies and KPI adherence are being closely monitored by the DDN, Three missed payroll approvals were due to matron being on AL, two within the same Directorate. This will be addressed by a more formal deputisation in future. Ward 6A had an increase in reported falls this month. The governance team are reviewing each case, to determine if there are any common themes or related to staffing concerns. The review is not yet complete. Fill rates of less than 90% were seen for some of the children's wards and Paediatric Critical care. Upon review, this relates to shift tiles not required, not being cancelled. Ward Managers are being further educated on the importance of updating rosters.

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

CSS – JR ICU – 20 medication incidents reported. One resulting in minor harm, related to a temporary workforce staff nurse, which has resulted in an investigation with suspension of the worker whilst this takes place. For all other incidents, there was no harm to patients. Incidents have been discussed with staff members and additional training and education provided.

Maternity – Delays in Induction of Labour were not related to staffing concerns.
In the roster KPIs, all rosters were delayed by one week, as senior staff scrutinised rosters to ensure staffing was adequate to cover summer pressures, including the redeployemnt of office and education staff.

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

Recruitment
Following the recent budget allocations, there continue to be some discrepancies between the vacancy data and the ledger. However, the divisions have worked closely with their finance teams to ensure that staffing numbers are aligned with safe staffing requirements following the recent establishment reviews, and finance will now commence work to reconcile the Ledger, once this is complete work will start to align ESR with the Ledger and in turn the roster templates.
There continues to be a strong pipeline of recruitment in all areas and this is closely monitored and maintained.

Vacancies
Following the budgets being set at outturn and CIPs applied, the finance ledger which in turn produces the data for ESR are inaccurate in terms of vacancies in all areas. Work is ongoing to reconcile this for the nursing inpatient areas following the CNO establishment reviews.

Unavailability
All areas experiencing a high unavailability of workforce, 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 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*

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*** 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)

July 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs (14.7.25 - 10.8.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	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%
NOTSSCaN																					
Bellhouse / Drayson Ward	8.95	10.88	11.5	100.00%	1	-	-	-	2	1	0	0	27.33%	25.79%	2.80%	2.07%	28.83%	Yes	3.88%	8.71	15.33%
HH Childrens Ward	9.36	9.35	14.5	98.92%	-	16	-	1	2	1	0	0	6.46%	8.22%	4.50%	13.72%	19.29%	Yes	0.10%	8.71	16.91%
Kamrans Ward	7.67	10.80	9.6	100.00%	-	12	-	-	4	0	0	0	19.71%	6.80%	1.33%	2.72%	21.89%	Yes	0.87%	9.57	12.54%
Melanies Ward	9.75	12.06	11.6	94.62%	2	-	-	-	0	0	1	0	17.19%	11.06%	5.03%	0.00%	17.19%	Yes	0.76%	9.57	14.60%
Robins Ward	10.68	13.95	13.3	100.00%	-	6	-	-	2	0	0	0	16.39%	14.90%	6.34%	3.99%	19.72%	Yes	0.88%	8.71	11.09%
Tom's Ward	8.05	9.48	8.7	100.00%	-	2	-	-	3	0	1	1	5.68%	0.00%	2.97%	3.86%	9.32%	Yes	3.64%	9.57	15.25%
Neonatal Unit	19.92		15.5		-	-	-	-	11	1	0	0	18.79%	7.81%	5.86%	4.33%	22.31%	Yes	-3.12%	9.43	14.60%
Paediatric Critical Care	27.60		31.3		-	-	-	-	3	0	2	0	29.54%	7.73%	5.15%	6.41%	34.06%	Yes	0.73%	7.86	12.86%
BIU	6.05	5.98	8.1	100.00%	-	-	-	-	1		0	1	0.51%	4.63%	3.45%	8.88%	9.34%	Yes	0.65%	8.43	11.51%
HDU/Recovery (NOC)	9.04		21.7		-	-	-	-	1		0	0	12.50%	11.58%	7.34%	4.26%	16.23%	No	-1.52%	7.43	13.79%
Head and Neck Blenheim Ward	7.29	8.12	8.2	93.55%	-	-	-	-	2		0	1	13.09%	0.00%	2.51%	0.00%	13.09%	Yes	-2.21%	8.43	14.05%
HH F Ward	7.39	9.23	8.2	100.00%	-	-	-	-	1		0	1	1.83%	5.61%	4.17%	2.17%	3.96%	Yes	0.39%	8.57	14.84%
Major Trauma Ward 2A	9.11	9.22	9.1	94.62%	-	13	-	-	2		1	1	15.91%	11.72%	4.77%	1.86%	17.47%	No	2.13%	7.71	15.11%
Neurology - Purple Ward	8.95	9.83	8.6	100.00%	5	-	4	-	0		0	4	18.50%	11.90%	6.05%	3.07%	21.00%	Yes	1.80%	8.57	12.13%
Neurosurgery Blue Ward	8.96	11.14	10.2	100.00%	-	-	-	-	0		0	3	6.25%	7.38%	3.14%	0.00%	6.25%	Yes	1.82%	8.29	15.73%
Neurosurgery Green/IU Ward	12.39	10.03	10.2	100.00%	1	-	2	-	1		2	0	0.06%	2.97%	4.94%	2.49%	2.55%	Yes	2.78%	8.43	12.17%
Neurosurgery Red/HC Ward	12.30	12.97	12.3	97.85%	3	-	-	-	1		2	3	5.32%	11.69%	4.53%	2.78%	7.96%	Yes	0.22%	8.57	13.46%
Specialist Surgery I/P Ward	7.28	7.58	8.3	80.65%	-	-	-	-	5		0	2	11.19%	2.56%	3.18%	6.29%	16.78%	Yes	1.51%	8.43	13.33%
Trauma Ward 3A	9.14	9.11	9.2	92.47%	-	26	2	-	1		3	1	8.95%	10.12%	8.55%	4.17%	12.75%	No	2.10%	7.71	13.03%
Ward 6A - JR	7.54	7.92	7.6	100.00%	1	-	1	-	7		6	8	-6.58%	4.72%	2.74%	4.29%	-2.01%	Yes	1.24%	8.43	14.00%
Ward E (NOC)	6.30	6.82	8.8	100.00%	-	-	-	-	1		0	1	-4.77%	5.91%	6.43%	2.81%	-1.82%	Yes	1.35%	8.57	17.47%
Ward F (NOC)	6.65	7.70	8.1	100.00%	-	4	-	-	1		1	1	-3.04%	0.00%	5.10%	0.00%	-3.04%	Yes	-1.49%	10.29	15.55%
WW Neuro ICU	27.88		27.8		-	-	-	-	2		3	0	-3.10%	10.63%	5.03%	4.11%	1.13%	Yes	-0.13%	6.86	15.00%

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

Oxford University Hospitals NHS Foundation Trust

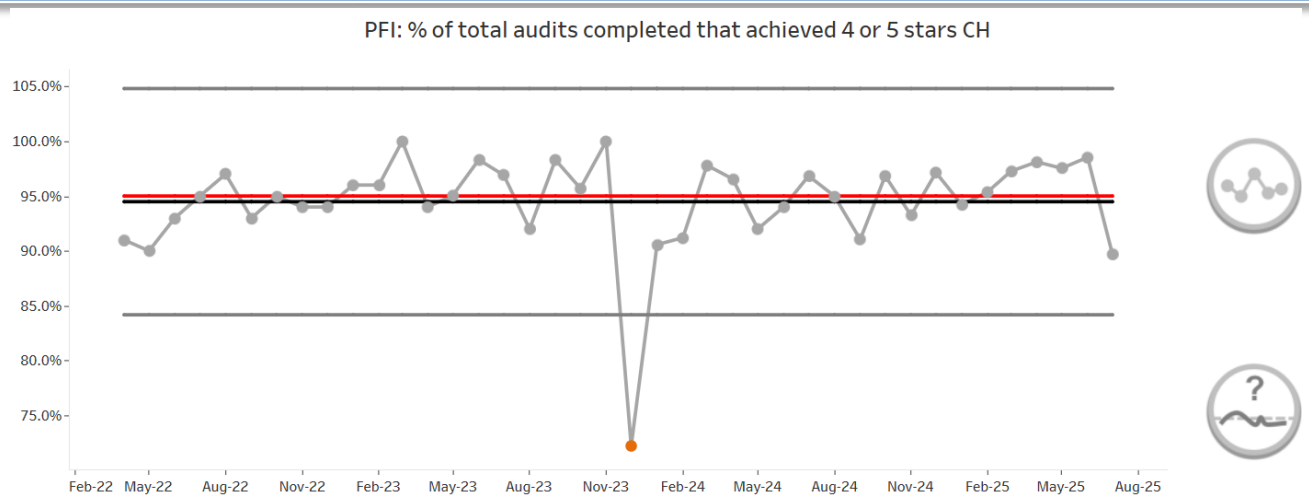
July 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs (14.7.25 - 10.8.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation 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%
MRC																					
Ward 5A SSW	8.88	8.47	8.1	94.62%	11	7	5	3	1		3	6	4.39%	5.93%	4.17%	8.07%	12.10%	Yes	1.18%	8.57	13.68%
Ward 5B SSW	8.88	8.79	8.2	100.00%	13	-	1	-	4		4	5	4.55%	10.18%	3.24%	0.00%	4.55%	Yes	2.84%	8.57	15.84%
Cardiology Ward	7.85	8.01	8.3	100.00%	1	6	10	4	3		0	5	10.29%	12.84%	7.26%	0.00%	12.31%	Yes	-1.93%	8.29	14.17%
Cardiothoracic Ward (CTW)	7.82	7.04	7.2	100.00%	9	-	-	-	1		0	0	3.18%	0.73%	3.37%	2.25%	5.36%	Yes	-0.94%	7.86	13.01%
Complex Medicine Unit A	8.94	11.02	8.1	97.85%	-	7	1	2	0		1	0	4.67%	9.60%	6.88%	2.17%	10.43%	No	1.19%	8.71	12.35%
Complex Medicine Unit B	10.15	9.56	8.9	100.00%	-	2	-	2	0		4	4	-3.97%	8.35%	4.84%	2.29%	-0.13%	No	2.63%	8.71	15.38%
Complex Medicine Unit C	8.75	10.42	7.9	100.00%	-	1	-	2	2		0	4	6.69%	6.68%	3.88%	6.22%	14.67%	No	-0.33%	8.71	11.73%
Complex Medicine Unit D	9.21	9.21	8.1	100.00%	-	1	2	1	1		2	1	7.88%	19.91%	6.80%	0.00%	9.29%	No	1.39%	8.71	14.27%
CTCCU	21.10		20.5		-	-	-	-	9		1	0	8.17%	8.34%	4.79%	2.22%	13.58%	Yes	-0.16%	8.00	14.08%
Emergency Assessment Unit (EAU)	9.23	8.63		95.16%	2	-	-	-	4		0	6	5.11%	11.55%	6.16%	1.17%	7.63%	Yes	-0.14%	9.00	18.37%
HH EAU	9.77	7.25		96.77%	-	-	-	-	0		0	6	5.14%	7.31%	5.61%	1.16%	7.59%	Yes	2.50%	8.57	14.03%
HH Emergency Department	22.83				-	-	-	-	3		0	1	3.76%	6.28%	3.38%	4.87%	8.45%	Yes	-2.77%	8.00	13.86%
JR Emergency Department	19.84				-	-	-	-	4		0	4	13.65%	14.85%	4.59%	3.30%	16.98%	Yes	-0.39%	8.86	12.23%
HH Juniper Ward	8.07	11.44	8.2	100.00%	-	-	-	-	0		5	9	4.48%	5.88%	4.96%	4.74%	12.04%	Yes	-0.69%	9.71	14.00%
HH Laburnum	9.65	10.08	8.6	100.00%	-	-	-	-	0		0	8	0.57%	7.34%	6.67%	4.58%	6.86%	Yes	-0.36%	9.29	15.36%
HH Oak (High Care Unit)	10.58		13.9	94.62%	6	-	1	-	2		5	3	0.52%	4.68%	6.14%	15.29%	15.72%	Yes	-0.58%	9.71	13.40%
John Warin Ward	10.21	10.59	9.7	100.00%	2	5	7	-	1		1	1	2.66%	7.63%	4.35%	12.37%	14.70%	Yes	-0.71%	8.86	14.49%
OCE Rehabilitation Nursing (NOC)	10.54	9.89	9.7	100.00%	1	-	5	1	0		0	3	1.98%	12.27%	4.99%	1.61%	4.35%	Yes	-1.06%	8.43	16.45%
Osler Respiratory Unit	14.45	8.52	12.2	100.00%	-	2	4	1	5		5	2	-0.31%	6.65%	4.41%	2.73%	3.25%	Yes	-0.05%	8.86	12.66%
Ward 5E/F	11.01	9.52	10.5	100.00%	10	-	-	-	0		2	6	-4.34%	15.97%	5.12%	3.30%	0.83%	Yes	-0.89%	8.57	14.69%
Ward 7E Stroke Unit	10.93	8.83	9.6	100.00%	5	-	-	-	0		1	5	0.37%	10.88%	4.68%	2.05%	2.41%	Yes	-3.11%	8.00	14.63%

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

Oxford University Hospitals NHS Foundation Trust

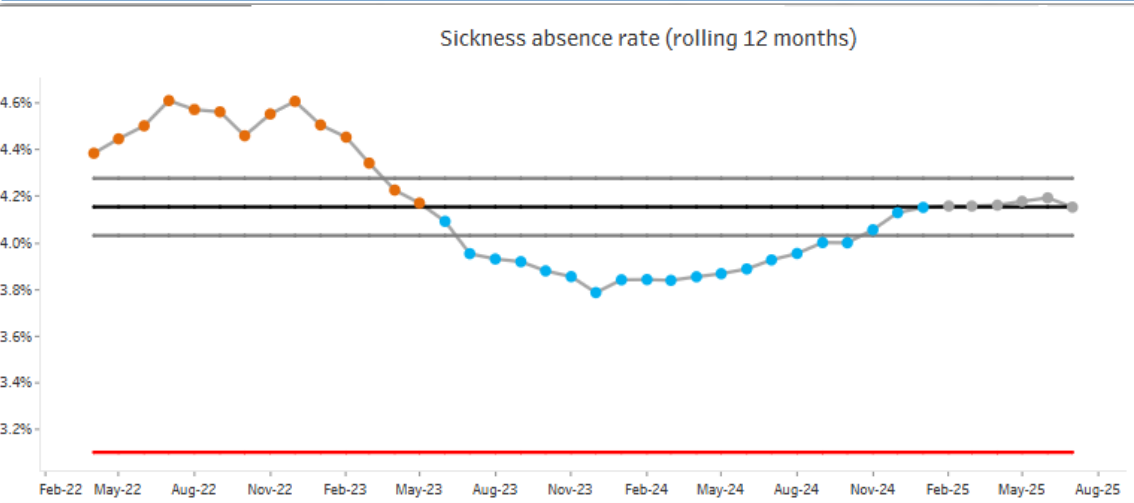
July 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs (14.7.25 - 10.8.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation 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%
SUWON																					
Gastroenterology (7F)	7.50	8.23	8.5	100.00%	-	32	3	-	6		1	4	13.81%	12.52%	6.78%	4.98%	18.11%	Yes	-3.07%	7.86	15.32%
Gynaecology Ward - JR	5.14	5.88	8.4	100.00%	1	-	-	-	1		0	3	0.38%	9.98%	5.80%	2.74%	3.11%	Yes	-1.10%	8.57	14.05%
Haematology Ward	7.64	8.36	9.2	100.00%	-	3	3	-	5		0	6	23.92%	15.19%	7.07%	4.68%	27.47%	Yes	0.74%	6.57	12.35%
Katharine House Ward	9.21	8.85	10.3	100.00%	-	5	2	-	2		5	1	13.05%	10.15%	4.19%	4.97%	17.37%	No	0.77%	8.57	13.60%
Oncology Ward	7.71	8.40	8.0	98.92%	-	-	1	-	1		4	7	8.53%	5.84%	3.72%	3.10%	11.37%	Yes	0.89%	9.00	14.26%
Renal Ward	7.70	8.32	9.1	100.00%	-	3	2	-	1		2	1	13.42%	16.96%	3.21%	10.76%	22.73%	Yes	0.66%	7.29	12.97%
SEU D Side	8.69	8.46	8.6	100.00%	-	-	-	1	4		2	2	16.34%	4.60%	4.77%	4.58%	20.18%	Yes	0.18%	8.57	12.38%
SEU E Side	8.40	8.80	8.5	100.00%	-	-	-	-	4		1	1	21.64%	9.55%	6.41%	0.00%	21.64%	Yes	0.44%	8.57	12.10%
SEU F Side	7.51	8.52	7.7	100.00%	1	-	-	2	2		1	2	18.19%	0.00%	3.18%	0.00%	18.19%	Yes	-2.34%	8.57	16.05%
Sobell House - Inpatients	8.02	8.53	8.3	100.00%	-	13	-	-	5		4	5	6.40%	5.66%	4.81%	9.57%	15.35%	Yes	-1.41%	7.86	13.06%
Transplant Ward	9.43	8.00	8.6	100.00%	4	4	-	-	6		0	0	13.01%	5.18%	6.85%	0.00%	13.01%	Yes	1.86%	8.86	10.68%
Upper GI Ward	9.54	7.34	8.3	100.00%	3	-	-	-	2		3	4	2.34%	2.60%	5.44%	13.45%	15.48%	Yes	-7.89%	9.29	14.71%
Urology Inpatients	8.84	9.71	9.1	100.00%	-	6	-	1	1		3	0	18.39%	3.53%	4.88%	0.00%	18.39%	Yes	-2.64%	6.43	13.32%
Wytham Ward	7.63	7.29	7.5	100.00%	1	9	2	-	4		0	0	-8.09%	7.52%	4.58%	14.92%	8.03%	Yes	-5.78%	9.29	8.68%
MW Delivery Suite	13.50		18.1		1	-	66	-										Yes	-2.81%	7.00	10.68%
MW Level 5	5.66		4.8		-	-	-	-										Yes	0.06%	7.00	11.21%
MW Level 6	4.78		7.2		-	-	-	-										Yes	-2.28%	7.00	15.64%
MW The Spires	15.51		19.0		1	-	-	-										Yes	-2.13%	7.00	13.08%
CSS																					
JR ICU	31.12		25.6	100.00%	-	-	-	-	20		1	0	13.17%	10.55%	4.19%	5.26%	17.74%	Yes	-0.28%	8.86	13.21%

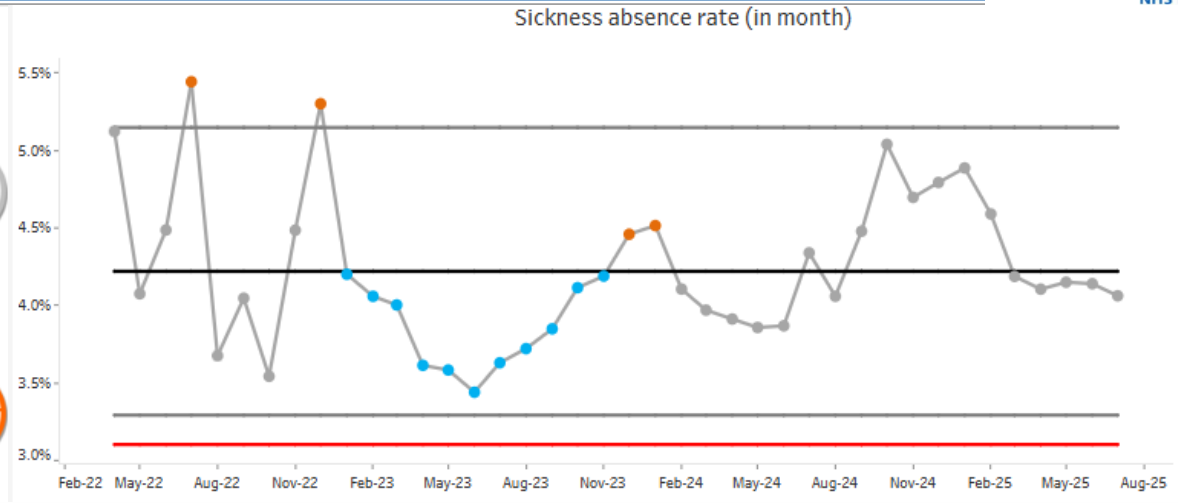
3. Assurance report: Estates, Facilities and PFI



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In July 2025, the combined PFI % cleaning score by site (average) for the Churchill was 95.21% 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 89.66% which is below the 95% Trust target. In total, at the Churchill, 58 audits were conducted, 6 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. 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.	Unfortunately, G4S did not complete the planned number of audits at the Churchill in July 2025. 71 audits were scheduled and 58 completed. Audits not completed are quarterly audits and still in the quarterly period of July – Sept. The FR4 quarterly audits that have not been completed are still in the quarterly period of July – September so will be completed in August or September. Six of the 58 audits failed to achieve the set Trust target under domestic and clinical. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. There is no pattern or trend in the six departments that fell below 4* on the first audit. We continue to work closely with IPC, G4S and the ward/department leads and are completing additional audits with the management, increased supervision from G4S and clinical staff when areas are cleaned. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how.	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at Churchill. 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. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Growing Stronger Together



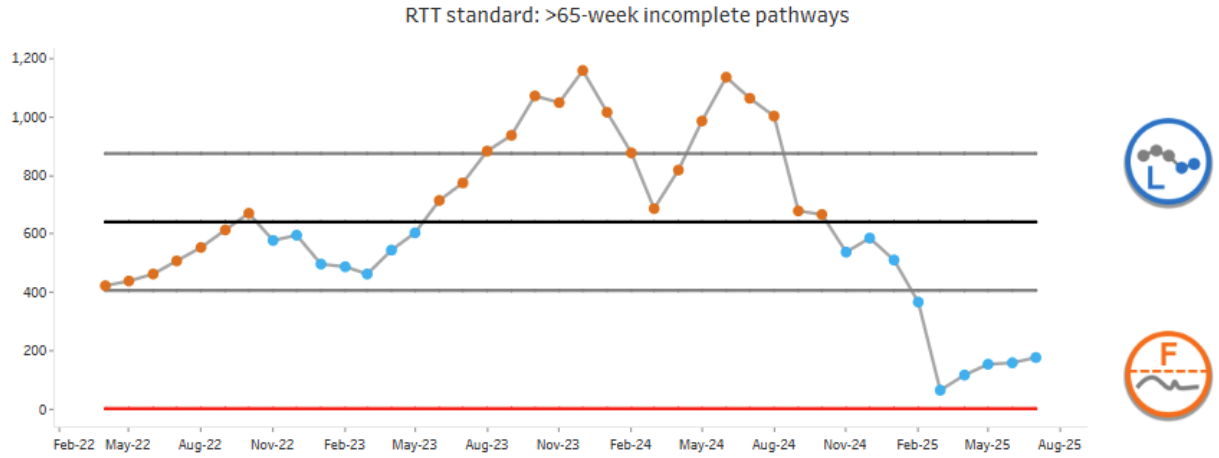


Benchmarking: February 2025 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

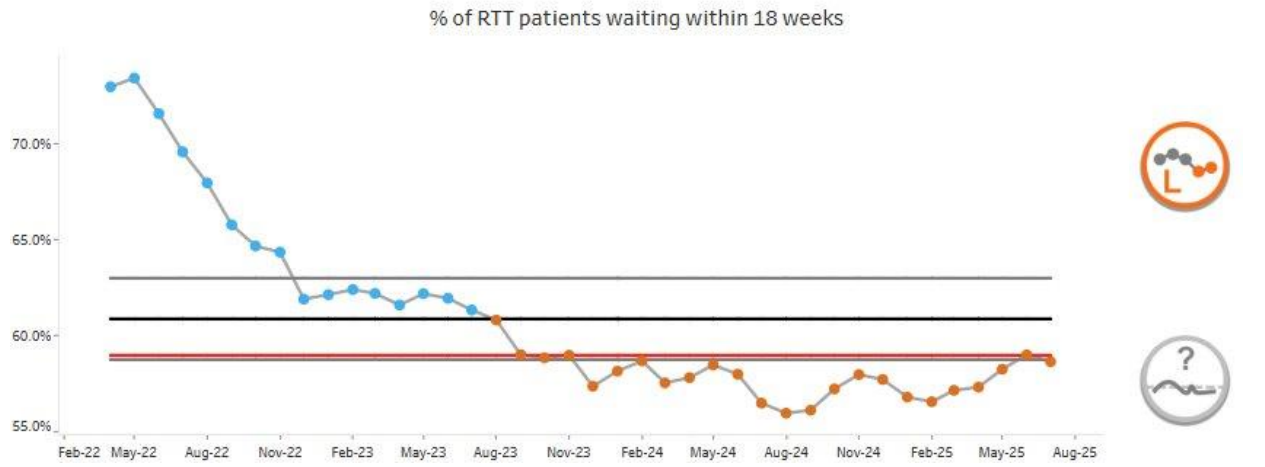
OUH: 4.36% **National: 5.34%** **Shelford: 4.67%** Buckinghamshire Healthcare NHS Trust: 4.08% Royal Berkshire NHS Foundation Trust: 4.12% Oxford Health: 4.8% South Central Ambulance Service: 6.79%

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 4.2% on July 25 and remained steady at 4.2% for months 3 and 4. We expect this to decrease further as we are out of winter period. The monthly figure has remained steady at 4.1% for months 3 and 4. In the month, the key reasons for sickness top 5:- • Respiratory System • Mental, Behavioural or Neurodevelopmental • MSK • Digestive system • Injury, Poisoning or External causes Long-term sickness top 5 reasons:- • Mental, Behavioural • MSK • Injury, Poisoning or External Causes • Neoplasms • Not elsewhere classified	• Divisions receive a monthly report on top 20 absences and develop action plans to reduce these numbers. • We are focusing on the top Cost Service Units (CSUs) that have consistent absenteeism. • We are collaborating with Occupational Health to assist managers and staff in reviewing the top three reasons for absenteeism. • There is a call to action regarding long-term sickness, ensuring that staff receive the support needed to return to work successfully. • Managers will be alerted about staff who have triggered absenteeism, with guidance provided to support them through the sickness absence process • HR is proactively promoting sickness absence management training to help managers implement the new procedures effectively • HR is closely working with managers to ensure that Return-to-Work (RTW) meetings are completed. • Sickness absence workshops are ongoing to provide continued support for managers. • Occupational Health colleagues will continue to offer support during monthly meetings to address issues and implement proactive measures. • Monthly meetings with the Wellbeing lead are held to identify additional areas where support may be required. • Work is ongoing on naming conventions for sickness reasons. • The reasons for classifying sickness have been revised for this month and are now linked to the relationships defined at the ICD (International Classification of Diseases) level.	Governance - TME via IPR, HR Governance, Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1616 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in the previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

3. Assurance report: Operational Performance, *continued*



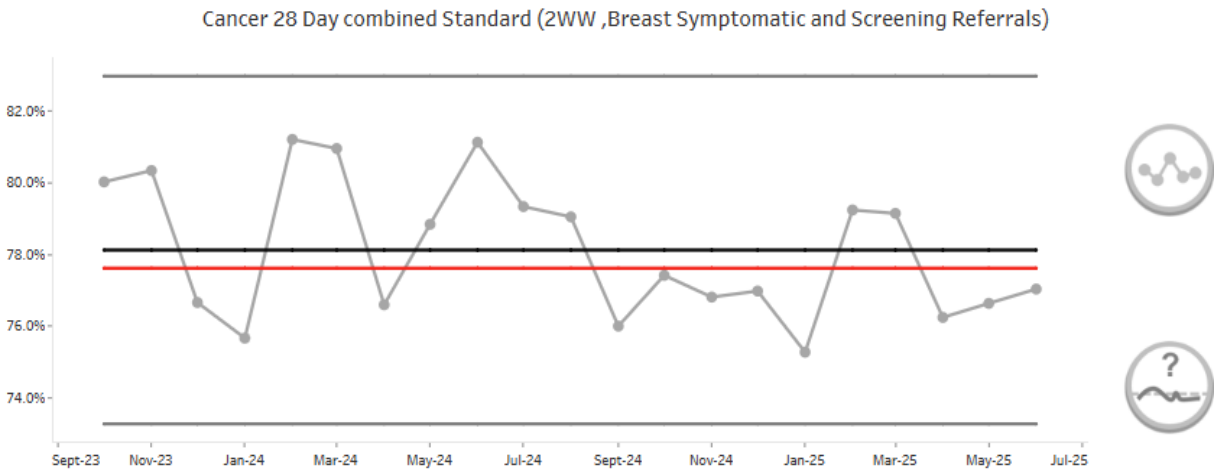
Benchmarking >65-week: June 2025				
OUH: 157	National: 67	Shelford: 86	BHT: 0	RBH: 2

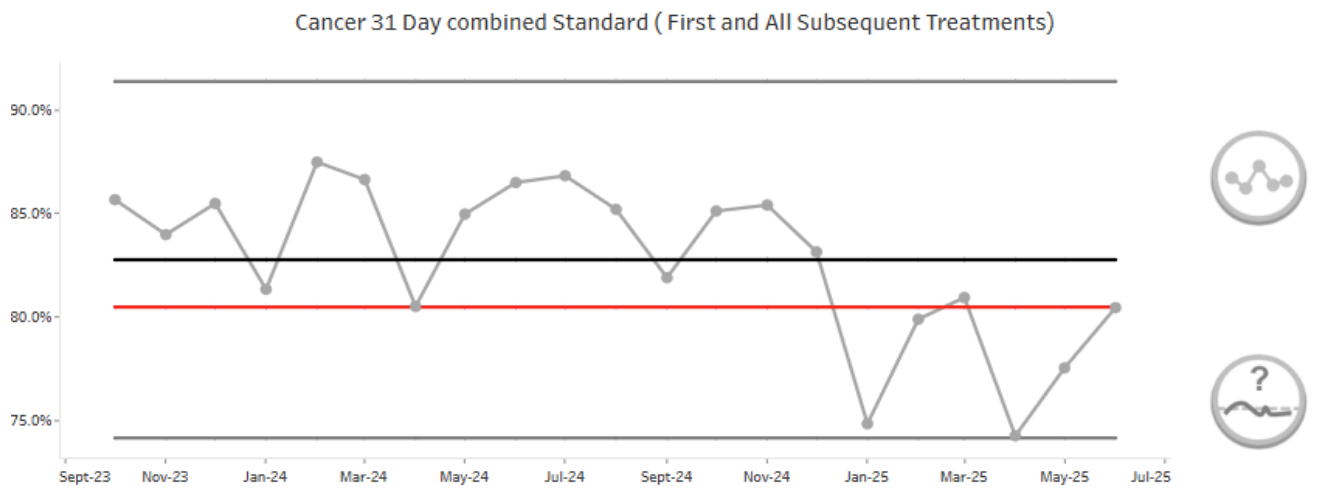


Benchmarking >18-week %: April 2025				
OUH: 58.95%	National: 62.4%	Shelford: 61.2%	BHT: 58.01%	RBH: 79.92%

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 65 weeks to start consultant-led treatment was 175 at the end of July. Performance exhibited special cause of improvement due to >six consecutive periods of performance below the mean and exceeding the lower process control limit. **>104 weeks - Nil** incomplete pathways reported. **>78 weeks - 3** incomplete pathways reported. all capacity related **>65 weeks – 175** incomplete pathways reported which is an increase from the previous month by 18 pathways and did not achieve trajectory plan. Focus remains in place to deliver nil pathways beyond 65-weeks. Services have moved to recovering **52-week backlog.**	**ENT services**: Audiology insourcing is helping with backlog recovery. Insourced ENT clinics continues. All new appointments in the 52-week cohort are being scheduled in H1. Patient Engagement waiting list validation commenced in May and has supported the removal of patients requesting to come off the list. **Urology services**: Insourcing continues, focusing on outpatients and diagnostics. Patients waiting for HOLEP procedure offered mutual aid have been transferred but reporting remains with OUH. Patient Engagement waiting list validation commenced in June has supported the removal of patients requesting to come off the list. **Orthopaedic services:** Weekend lists continue and show good recovery. Patient Engagement waiting list validation commenced in June for Spinals and Orthopaedics and has supported the removal of patients requesting to come off the list. **Patient Engagement Validation:** Relaunched 2025/26 52-week cohort with 1st appointments (about 10k referrals), following LMC protocol to discharge non-responsive patients after 3 communication attempts within 40 days. Circa 4.5% removed and c.50% willing to travel to another Provider in BOB – list submitted via APC for capacity within BOB. **Recovery Action Plan**: Live and populated against specialty level trajectories for delivery of the forecast.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*





Benchmarking: Cancer 28 Day Faster Diagnosis June 2025				
OUH: 77%	National: 78%	Shelford: 77.6%	BHT: 80.0%	RBH: 78.9%

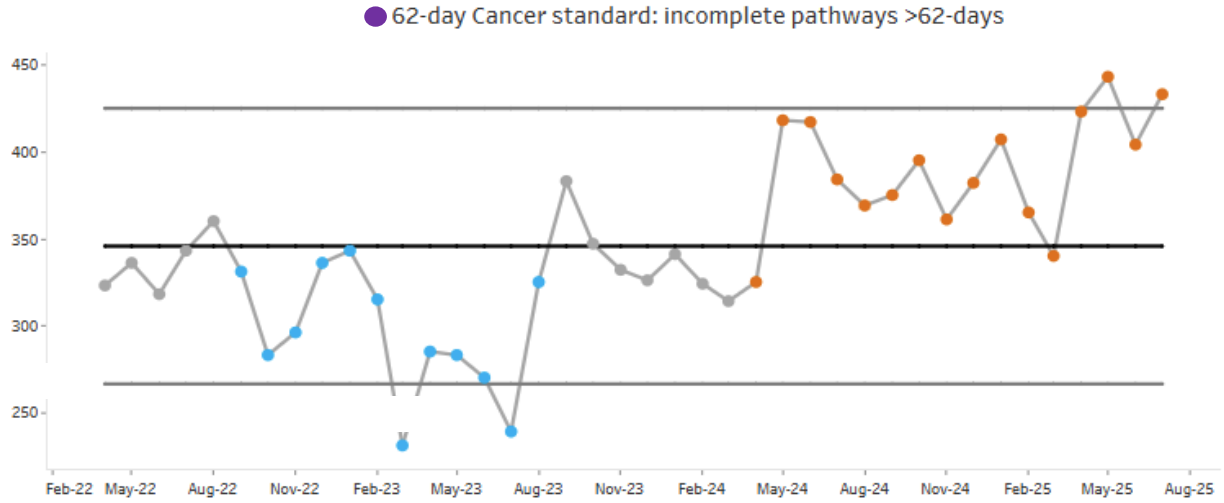
Benchmarking: Cancer 31 Day Faster Diagnosis June 2025				
OUH: 80.4%	National: 94.4%	Shelford: 90.7%	BHT: 80.8%	RBH: 93.3%

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 31 days Decision to Treat was 80.4% in June 2025 against an operational plan of 80.5% (0.01% variance) and below the national standard of 96.0%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Children's, Haematology – Acute Leukaemia, UGI Oesophagus and Stomach, Urological Testicular are non-compliant for this standard in June. OUH ranked 127th out of 134 Providers in June and 9th out of the 10 Shelford Group. UGI – Hepatobiliary is nationally ranked bottom out of 119 Providers, Lung is nationally ranked 121st out of 122 and Lower GI is nationally ranked 120th out of 123. Urology Prostate is ranked 113th out of 120 Providers.	As per next slide.	As per next slide.	As per next slide.	As per next slide.

3. Assurance report: Operational Performance, *continued*

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

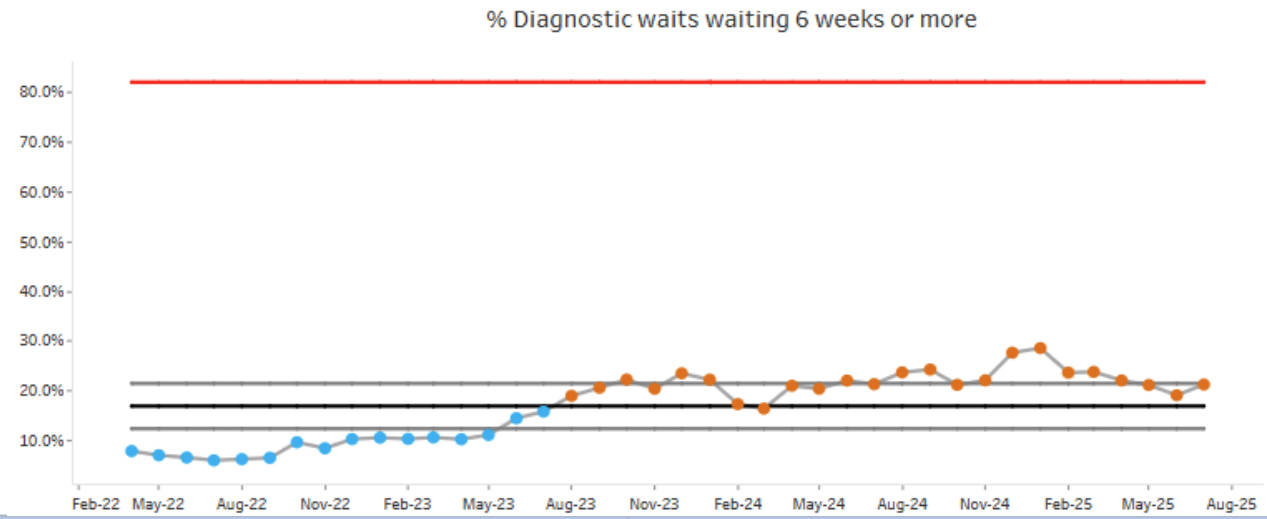


Benchmarking: Cancer 62 Day All Routes (May 2025)
OUH: 61.80%
National: 69.8%
Shelford: 62.8%
BHT: 62.28%
RBH: 70.25%

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	Risk Register	Data quality rating
Cancer performance against the 62 days combined standard was 77.0% in June 2025, and below the operational plan of 77.6%. Performance is reported one month in arrears due to the extended reporting period for this indicator. Measured over a 12-month period the indicator was in Segment 3. All tumour sites apart from Brain/CNS, Breast, Children's, Lung, NSS, Sarcoma and Skin are non-compliant for this standard in June. **Challenges identified:** • Complex tertiary level, slow patients (5%) • Capacity for surgery, diagnostics and oncology (76.5%) • Late inter provider transfers (17%) • Patient reasons (2.5%) **>62-day incomplete PTL** census 6th August 2025 is 408 patients and 10.5% as a proportion of the PTL.	**Cohort 2: 3-Tumour Site Workshop scheduled 22nd August** focussing on LGI a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. **Cohort 1: Day-100 updates** will be presented at the Cancer Improvement Group meeting on **Friday 29th August**. **Performance of >62-day PTL vs plan –** recovery includes cross-cutting elements: • Incomplete and late Inter-Provider Transfer review and escalation to referring Providers • Surgical capacity through theatre reallocation • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication • Pathway mapping of tumour sites against Best Practice Timed Pathways **Waiting List Census 06/08/2025:** **Urology** remains the highest deficit to plan for >62-days (174) predominantly due to the increase in referrals linked to public figure awareness. Running additional MRI results clinics, recruiting additional staff for more activity such as flexi's. Shared learning from BHT. Additional sessions in histopathology, additional theatre lists on Sundays and evenings. **Gynaecology** – several change ideas undergoing mobilisation including new referral proforma, ambient voice technology pilot in pre-hysteroscopy clinics, become pilot for WID-easy test, ring-fenced theatre lists **Lung -** – several change ideas undergoing mobilisation including patient engagement to mitigate missed appointments and cancellations, clinical representation at PTL meetings to rapidly troubleshoot bottle-necks at pathway level, additional theatre lists to increase from fortnightly to weekly.	Cohort 2: 31/12/2025 Cohort 1: 30/09/2025 Ongoing 30/11/2025 (individual) 30/09/2025 (cohort 1) 30/09/2025 (cohort 1)	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

3. Assurance report: Operational Performance, *continued*

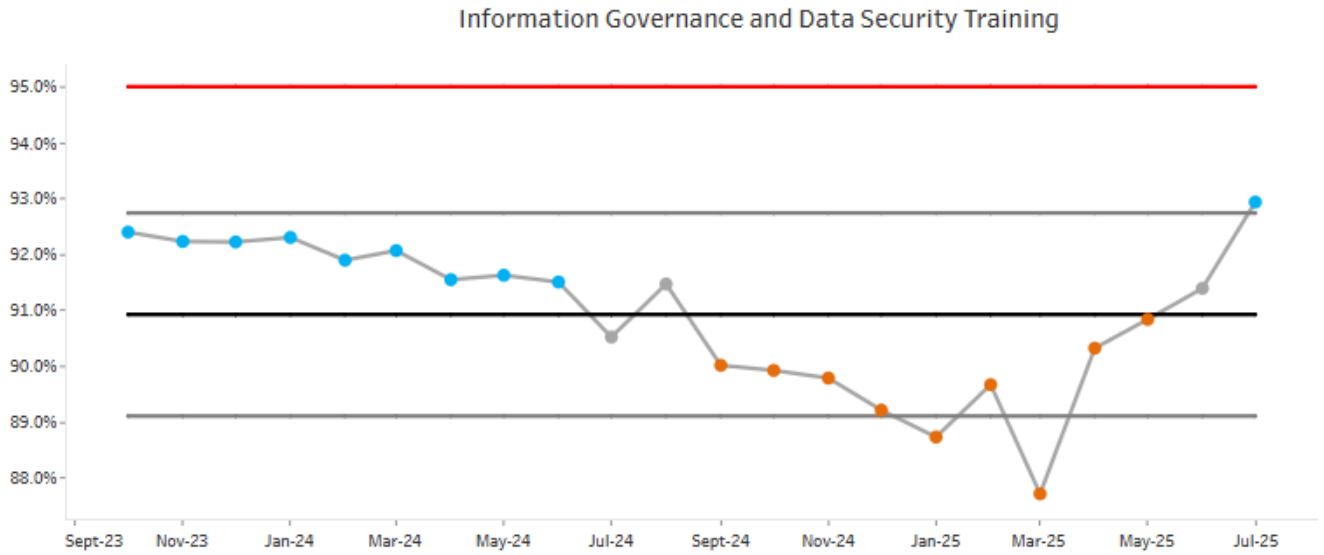


Benchmarking: Cancer 31 Day All Stages (May 2025)
OUH: 19.05% (OUH Internal Target 21.1%)
National: 17.5%
Shelford: 18.2%
BHT: 23.82%
RBH: 10.31%

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 21.2% in July. The indicator exhibited special cause variation due to performance being above the mean for more than six successive periods, as well as below the lower process control limit. The indicator however has achieved the plan of 18.0% in July. **Audiology:** • Demand above capacity since ENT pathway changes • Clinical staffing gaps • Capacity shortfall for children's audiology tests **Endoscopy:** • Capacity shortages to meet demand • Lapsed Planned patients retriggering as a reportable **Neurophysiology**: • Capacity mismatch with demand. **Ultrasound**: • Difficulty recruiting to sonographer vacancies • Increased demand • Reduced sessions due to NHSP changes	**Audiology:** • Extended insourcing for adult audiology • Business case to reconfigure Community Paediatric and Acute Paediatric being prepared for submission to TME • Filled several vacancies with start dates in May/June. • Location identified at the Horton to install funded VRA Booth's • Audiology is no longer on trajectory of delivering plan. **Endoscopy:** • Nurse endoscopist is now independently working since April. • Delivery fund utilised and scheme fully allocated for additional capacity above baseline. • Job plans reviewed introducing additional endoscopy list in place of outpatient clinic • Clinical triage continued into 2025/26 **Neurophysiology**: • Replacement of Insourcing supplier commenced 9th May • Additional sessions considered where possible • 4PA clinician returning from a sabbatical in June has resigned. PA's on hold as no longer in budget. **Ultrasound: Most accelerated recovery of all modalities with 557 less breaches than last month** • Additional capacity through insourcing agreed and monitoring closely • Sessional tracker in place monitoring substantive gaps as well as NHSP uptake. • Workforce plan developed with TME approved case for converting the ERF scheme to substantive posts.	Assurance meeting monitor all actions on a weekly basis **Audiology:** Will not deliver plan due to Paediatrics by March. Expect to deliver during 2026/27. **Endoscopy:** Agreement of additional capacity are being finalised to confirm delivery of plan **Neurophysiology:** Will deliver plan by March. **Ultrasound:** On plan to deliver	BAF 4 Link to CRR 1136 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

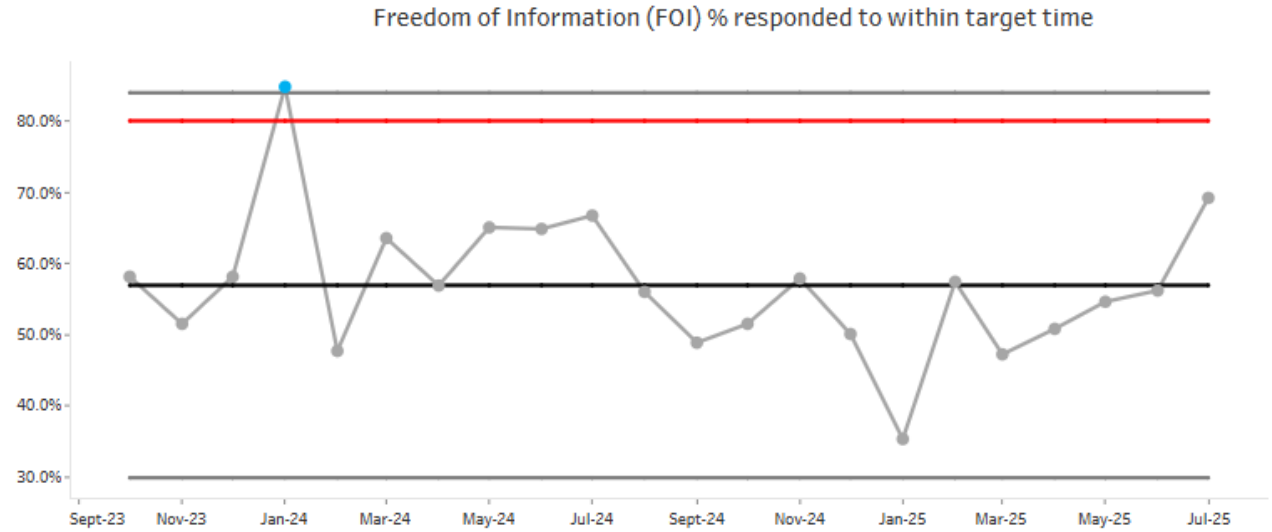
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3557	319	91.00%
Surgery Women and Oncology	3337	263	92.10%
Medicine Rehabilitation and Cardiac	3311	278	91.60%
Clinical Support Services	2346	162	93.10%
Corporate	997	64	93.60%
Operational Services	212	7	96.70%
Estates	194	12	93.80%
Research and Development	150	18	88.00%

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 93% in M4 – this is a further recovery towards the target of 95%. No divisions are achieving 95% but all have seen an increase – only R&D remains below 90% and Operational Services are above target at 96.7% . The annual appraisal window is a driver for training to be completed – as the window was extended into August there should be a further improvement visible in M5	1123 staff are currently non-compliant, a reduction of over 200 from M3. All divisional governance teams have visibility of their staff training levels and are able to access reports which name non-compliant individuals to help them manage the situation. A further all staff reminder will be sent in M6 to encourage	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Historic case backlog:

01/05/2025	897
01/06/2025	855
14/07/2025	575
14/08/2025	230

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
M4 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 69.1% and exhibited common cause variation. 160 valid cases were received in M4, of which 94 have been closed, 65 of which were closed on time. This is the highest number received in one month by OUH. Colleagues across the sector have been in contact to report that they have also received record numbers of requests The Trust is facing significant challenges in managing FOI requests, prompting the Information Commissioner's Office (ICO) to issue an Enforcement Notice requiring OUH to respond with a plan by 14th May and implement that action plan by 31st October 2025. There were approximately 900 FOIs open and beyond the target response time. These cases must be assessed and have either been answered or refused by 31st October.	The IG team are actively engaged in procuring an appropriately designed system to manage FOI cases as the current one is not fit for purpose. This is being done in conjunction with Legal Services A change in the way FOIs are distributed across the Trust is being implemented – each Division will have two nominated contacts who receive all FOIs for them to then pass on to the relevant people within their area. This will ensure more rapid identification of data holders, and allow divisions to monitor and manage their own cases. The first deadline for requestors to reply to indicating whether they still wanted the requested data has passed, and 625 cases have been discarded as no response has been received. Work to identify and recruit temporary resources to assist with the backlog is ongoing, since TME support was provided.	Completion of all actions: 31st October 2025 Updates provided to Digital Oversight Committee and TME	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

4. Development indicators

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

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

Sufficient	Satisfactory	Inadequate

Oxford University Hospitals NHS Foundation Trust

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales	Risk Register (Y/N)	Data quality rating
This section should describe the reason why the indicator has been identified for an assurance report and interpret the performance with respect to the Statistical Process Control chart, if appropriate. Additionally, the section should provide a succinct description of the challenges / reasons for the performance and any future risks identified.	This section should document the SMART actions in place to address the challenges / reasons documented in the previous column and provide an estimate, based on these actions, when performance will achieve the target. If the performance target cannot be achieved, or risks mitigated, by these actions any additional support required should be documented.	This section should list: 1) the timescales associated with action(s) 2) whether these are on track or not 3) The group or committee where the actions are reviewed	This section notes if performance is linked to a risk on the risk register	This section describes the current status of the data quality of the performance indicator

2. Framework for levels of assurance:

Levels of assurance: model
1. Actions documented with clear link to issues affecting performance, responsible owners and timescales for achievement and key milestones
2. Actions completed or are on track to be completed
3. Quantified and credible trajectory set that forecasts performance resulting from actions
4. Trajectory meets organisational requirements or tolerances for levels of performance within agreed timescales, and the group or committee where progress is reviewed
5. Performance achieving trajectory