Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M5 (August data)

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 5 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the NHS England Segmentation and Oversight Framework. The 2026/27 NHS Oversight Framework has been reviewed to incorporate the ICB Operating Model and priorities of the 10-Year Health Plan. The integration of Segmentation outcomes and performance is referenced within the assurance reports, where relevant, noting that the period of measurement can differ from the IPR measures. 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 and the internal NHS Oversight Framework Power BI dashboard is included (on pages 6 to 9).

We achieved key measures related to patient safety and care experience, including fewer pressure ulcer incidents per 1,000 bed days for hospital acquired categories 2, 3 and 4 and our mortality indicators (SHMI and HSMR - excluding hospices) were below 100, indicating fewer deaths than expected.

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 (Cancer, UEC, standard work, QI learning hub). No never events were recorded and safeguarding training compliance for adults and children (L1-L3) were achieved.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. We met the non-medical appraisals target as well as targets for core skills training, demonstrating commitment to staff development. We also achieved our time to hire standard. Workforce metrics including, staff sickness rates, vacancies, and turnover contributes to better patient care and reduced costs from temporary staffing. Our sickness absence rate was worse than threshold for the month and rolling 12-month position, and the monthly position (which exhibited Common Cause Variation (CCV). Rates remain better than National and Shelford averages. Turnover rates performed better than the Trust target and exhibited improving Special Cause Variation (SCV). The vacancy rate did not meet the performance target and exhibited deteriorating SCV.

Performance against the operating plan trajectory for A&E waits within 4 hours was non-compliant (below plan) in month 5 for all types (81.0% vs 84.0%) and for type 1 attendances (75.7% vs 77.9%). Performance met the operating plan trajectory for the % of patients waiting over 12 hours (2.1% vs 2.3%). Both A&E all types and 12-hour performance are Segmentation indicators but measured relatively on national performance rather than performance versus the operational plan. In month 5, the % of pathways over 52 weeks (Segmentation indicator), met the operating plan trajectory (1.7% vs 1.9%), as well as the number of patients over 52-weeks (1,519 vs 1,520). The percentage of patients within 18 weeks for first OP attendances did not meet the operating plan (68.1% vs 67.0%), but the performance for all patients waiting within 18 weeks, which is a Segmentation indicator, achieved the operating plan trajectory (62.2% vs 62.0%). Performance in month 4 met the operating plan target for the Faster Diagnosis Standard (83.4% vs 80.0%) and the 62-day Cancer Standard (64.3% vs 62.1%), both of which are Segmentation indicators. NB. Cancer performance is reported one month in arrears. Diagnostic performance for the DM01, which is a Segmentation indicator, did not meet the operating plan trajectory in month 5 for the % of patients over six weeks (21.6% vs 19.5%).

The plan in month 5 was for a £1.7m deficit. The Trust achieved £1.7m deficit in-month but was unable to recover the variance to plan in month 4 of £2.2m. The underlying deficit at month 4 was £9.3m.

The following are the key headlines for the 2026/27 CIP programme in month 5: Planned target: £9.8m, Achievement: £10.1m, Favourable Variance: £0.3m. The Trust is over delivering non-recurrent CIP by £1.6m offset by under delivery of recurrent CIP of £1.3m. The Trust planned £7.0m recurrent savings and reported £5.7m.

- Budget WTE are 14,338 for month 5 with worked WTE at 14,122 overall showing vacancies of 266 WTE (128 less than month 4). This delivered divisional non-recurrent CIP. Bank use increased to 686 WTE.
- Non-pay (excluding passthrough items) is £1.6m better than plan. Non-recurrent benefits of £1.4m PFI insurance credits and £0.8m in MRC Division relating to Cardiology TAVI GRNIs closed. PFI deductions of £0.4m continue to offset.
- Cash was £12.3m at month 5, which was £29.2m below plan. The plan was set on the 25/26 profile which included a significant pay award payment in month 5. The cash plan for 2026/27 suggests that the pressure on cash will return in line with the increased efficiency requirement in the latter part of the year.

The rate of CIP identification and delivery will need to improve rapidly in ALL divisions to avoid further spending control.

Indicators identified for assurance reporting are detailed further using standardised assurance templates. Criteria for assurance reporting includes indicators failing to meet performance standards or showing deteriorating SCV. The 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 in section 4. Development indicators for the IPR currently include MRSA screening.

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

- Vacancy Rate
- Sickness Absence Rate (Rolling 12 months)
- Number of Complaints
- % of Complaints Responded to Within 25 Days
- Freedom of Information (FOI) % Responded in Time
- Data Subject Access Requests (DSAR)

Common cause variation and missed target

- E.Coli cases
- MRSA cases
- MSSA cases
- C-Diff cases
- Information Governance and Security Training
- Sickness Absence Rate (In month)
- Reactivated Complaints
- FFT % Likely to Recommend – OP, IP, & ED
- PFI audits (JR & CH)
- Cancer 62-Day Combined Standard
- Corridor Care Patients in ED >45 mins

Special cause variation - improving

- ED 4hr Performance – All and Type 1
- Proportion of Type 1 Attendances Spending More than 12 hours in ED
- % of RTT Patients waiting for a first appointment
- % of RTT Patients Waiting Within 18 weeks
- RTT Standard: >65-week Incomplete Pathways
- Diagnostic (DM01) waiters over six weeks

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).*

MSSA bacteraemia: There were seven cases reported, four fewer than at the same period last year. One MSSA case associated with an intravascular line in a patient transferred to OUH from another Trust. The case was reviewed and no learning for OUH was identified.

MRSA Bacteraemia: There was one case reported from an ongoing infection originating from another organisation, bringing the total to one more case than at the same time last year.

***C. difficile* infection:** Although slightly above threshold for M5, performance has improved, with eleven healthcare-associated C. difficile cases reported in August—six HOHA and five COHA, which was 13 fewer cases than at the same point last year. Progress is being supported by strengthened antimicrobial stewardship, particularly reduced co-amoxiclav use, alongside the rollout of a combined cleaning and disinfection product across the JR site and subsequently the Horton. Further improvements are being supported through the phased implementation of ICNet for IPC surveillance and work to develop antimicrobial stewardship reporting availability through Power BI.

***E. coli* bacteraemia**: Performance improved in July, with 17 cases of E. coli reported—six HOHA and 11 COHA—representing 13 fewer cases than at the same point last year and an improvement from five fewer cases last month. Good catheter management remains a focus and there are no clear themes or interventions to reduce the rate of E. coli bloodstream infections in secondary care.

Complaints responded to within 25 days: 23.2% of complaints were responded to within 25 working days in M5. Performance exhibited deteriorating Special Cause Variation (SCV). Complaints are becoming more complex, increasing investigation times and staff workloads. Although AI-generated complaints can help people raise concerns, they may also make issues harder for investigators to understand. Work with NHS England is exploring the impact of AI on complaints and targeted meetings continue with services involving the CNO and CMO teams. Reactivated complaints displayed common cause variation and were equal to the mean in M5, which was 16.

FFT (IP, OP and ED): Friends and Family scores (% positive) recorded performance below the Trust target in M5 for IP (93.1%), OP (94.2%) and ED (82.2%), each exhibited Common Cause Variation (CCV). Positive feedback most frequently highlighted staff attitude, admission and the implementation of care, while negative feedback focused on car parking, cancelled admissions and procedures, and discharge. Each Division will continue to review patient experience through the Patient Experience and Engagement Committee. Priorities include promoting collection methods, increasing response rates and introducing the Patient Experience Survey.

PFI audits: The percentage of total audits undertaken that achieved 4 or 5 stars was below the 95% standard at the John Radcliffe, at 93.04% and at the Churchill Hospital, at 90.28%. All the failed audits were rectified on both sites.

Sickness absence Rolling sickness absence is 4.3% (monthly rate 4.6%), unchanged from the previous month and remaining above the Trust target of 3.1%. Actions to address sickness absence performance include monthly analysis of the top causes of absence, targeted action plans for CSUs with higher-than-average absence, and tailored support for colleagues on long-term sick leave to facilitate safe, sustainable returns to work. Managers receive support through notifications, guidance, training, streamlined Return-to-Work processes and local workshops. Work is also under way to standardise absence categories, improving reporting, consistency and trend identification.

Vacancy has improved to 7.8% in Month 5, down from 8.0% in Month 4, although this was above the Trust target of 7.7%. Actions to improve workforce performance include targeted recruitment for areas with the highest vacancy levels, regular pipeline reviews, and local recruitment and retention plans for hard-to-recruit roles. Teams are improving recruitment, candidate conversion and career development while monitoring vacancies, operational risks and retention to strengthen workforce supply.

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ED 4hr performance: Performance in M5 was 81.0%, below the operating plan target of 84.0%. Performance exhibited improving SCV. During M5 there was sustained demand, heat-related National Health Alerts and increased ED activity. The department was also challenged by high-intensity surges in non-ambulance arrivals, alongside increased patient acuity, mental health presentations and workforce sickness absence. Actions include analysing the completed 'Perfect Week' at the Horton site, undertaking a further 'Perfect Week' in the Children's Emergency Department, and conducting a deep dive into delays, particularly for patients awaiting onward bedded care. The Level 1 UEC redevelopment will expand EAU and EEMAC capacity, improve flow models and support the UTC merger with Oxford Health NHS Trust; interim mitigations are being developed to address the delay to completion ahead of winter.

Type 1 attendances over 12 hrs: 2.1% of patients attending ED waited over 12 hours in M5, which was better than the operating plan target of 3.0%. Performance exhibited improving SCV. A review of UEC performance is underway, focusing on conveyance avoidance, alternative pathways and collaborative work with SCAS. Adult social care capacity and staffing improvements continue but have so far had limited impact on non-criteria-to-reside figures.

Corridor care: Corridor care in the ED improved in August, although it remains concentrated at JR and is still above the desired standard. Ward corridor care has not occurred outside SEU since April, with SEU showing improvement and no episodes since June.

62-day Cancer performance: Performance in M5 (due to national reporting lag) was 64.3% and better than the operating plan target of 62.1%. Performance exhibited CCV. Actions in place include continuing the cancer improvement programme by reviewing tumour site MDTs through the MDT Streamline toolkit, implementing lean-working recommendations and maintaining liaison with the Cancer Management and Quality Improvement teams. Tracking of the three priority actions will also continue through weekly Cancer Delivery Action Group meetings, supported by analytical evidence and key recovery actions.

RTT patients within 18 weeks: Performance was 62.2% in M5, achieving the operating plan trajectory (62.0%). Performance exhibited improving SCV. Patients with the longest waits are continuing to be prioritised. Other actions include validation of pathways over 18 weeks, and implementation of outpatient and theatres improvement programmes. The digital outcome form roll-out is supporting greater use of Patient Initiated Follow ups(PIFU), while additional capacity has been identified from insourcing in several specialties and elective capacity through the Surgical Elective Centre.

RTT patients % over 52 weeks: met the operating plan trajectory (1.7% vs 1.9%), Performance exhibited improving SCV. Specific actions are in place for ENT, Gynaecology and Oral-Maxillio Facial services and, along with other specialties, are reviewed within the Delivery Action Plan.

Diagnostics (DM01) over 6 weeks: Performance was 21.6% in M5 and did not meet the operating plan trajectory (19.5%) and exhibited improving SCV. Action plans for challenged modalities include Endoscopy, Neurophysiology, Audiology and Non-obstetric ultrasound.

FOI responses within target time: Cases closed within target time decreased to 25.7% in M5 and exhibited deteriorating SCV. Fifty-five outstanding cases from "What Do They Know" were added in M5 because E-Case is not synced with the website; these require priority attention. Team capacity will increase to support case management via vacancy cover in the Information Governance team.

Data Subject Access Requests within target time: SAR requests responded to within target time was 40.1% in M5 and exhibited deteriorating SCV. The volume rose by 25% to 1,213 and performance was impacted by the end of maternity cover, annual leave and unplanned absence. The ICO has requested a further update in October.

Information Governance and Data Security Training: Performance was 91.2% in M5, and was below the 95.0% standard, and exhibited CCV. Actions include promoting Divisional reports to identify and manage staff still to complete training and increasing cyber awareness through Cyber Awareness Month in October and quarterly campaigns. This includes signposting to mandatory training and other materials.

1. OUH NOF dashboard

Oxford University Hospitals NHS Foundation Trust

Overview of dashboard

The OUH NHS Oversight Framework Power BI Report is a strategic performance assurance tool that consolidates NHS Oversight Framework metrics into a single interactive dashboard. It was developed to provide early visibility of likely NOF outcomes, support executive decision-making, strengthen Board assurance, highlight emerging performance risks and improve the quality of Integrated Performance Reporting.

Although most NOF indicators are also covered in the IPR SPC dashboard format, a separate and specific NOF dashboard is required since the measurement interval of NOF measures differs from monthly, to quarterly to annually depending on the measures and because scoring predominately, but not exclusively, uses national ranking or other criteria rather than performance against the operational plan. This means that a dedicated NOF dashboard can provide a clearer summary of the latest reported position. Additionally, by combining official NOF measures with the latest OUH operational data and information available from external sources, the report enables proactive management of performance before national results are formally published.

Summary of performance

In Q1 2026/27 OUH was placed in Segment 3 with an average score of 2.34 and ranked 55th out of 134 providers. The OUH capability rating was Amber/ Green. A summary of each of the Domain scores are provided below, including the identification of indicators linked to Domain scores 3 or 4.

Access to services: Quartile score 3

Our Access to Services domain score deteriorated from 2.12 to 2.68, moving OUH from quartile 2 to quartile 3. Indicators with scores 3 or over included:

- % patients waiting less than 18 weeks 3.20/ rank 95
- % patients waiting more than 52 weeks 3.53/ rank 100
- % of patients treated for cancer within 62 days 3.63/ rank 100

Effectiveness and experience of care: Quartile score 4

Within Effectiveness of care and population health (new) the domain score was 4 (lowest scoring 25%). Indicators with scores of 4 included:

- % of patients readmitted within 30 days of discharge 4/ rank 97
- % of acute patients making a supported quit attempt with an in-house tobacco dependence treatment service. 4/ (no national rank due to banding classifications)

Patient Safety: Quartile score 2

- improved from Quartile 3 in the previous quarter to Quartile 2 (second highest scoring 25%)

Finance, Productivity and innovation: Quartile score 2

- improved from Quartile 3 in the previous quarter to Quartile 2 (second highest scoring 25%)

People: Quartile score 1

- remained in Quartile 1 (highest scoring 25%, though the average score deteriorated from 1.70 to 1.81)

Experience of care (new): Quartile score 2

- Quartile 2 in Q1 (second highest scoring 25%)

1. OUH NOF dashboard

Oxford University Hospitals NHS Foundation Trust

Access to services

Subject area	Indicator	Scoring/ contextual	Segmentation measurement period	NOF unit	NOF value	NOF score	NOF quarter	NOF rank	NOF median	NOF lower quartile	NOF upper quartile	OUH latest performance (leading indicator)	OUH period of latest performance	Chief Officer lead
Urgent care	% of patients admitted, discharged or transferred within 4 hours	Scoring	Quarterly – aggregated quarterly position.	%	81	2.06	Q1 2026/27	22	75.6	70.85	79.75	79.47	Q2 to date (M4&5)	COO
Urgent care	% of patients spending over 12 hours in department	Scoring	Quarterly – aggregated monthly figures.	%	1.95	1.3	Q1 2026/27	13	10	5.35	12.68	2.43	Q2 to date (M4&5)	COO
Cancer care	% of cases meeting the 28 day faster diagnosis standard	Scoring	Quarterly – aggregated quarterly position	%	82.7	1	Q1 2026/27	24	79.51	75.16	82.25	83.4	M4 2026/27	COO
Cancer care	% of cases treated within 62 days of referral	Scoring	Quarterly – aggregated quarterly position.	rate	63.48	3.63	Q1 2026/27	100	70.39	65.22	77.39	64.34	M4 2026/27	COO
Diagnostics	% of diagnostic referrals waiting over 6 weeks	Scoring	Quarterly – latest month in the period.	%	21.02	2.89	Q1 2026/27	83	17.06	9.47	27.32	21.6	M5 2026/27	COO
Elective care	% of cases waiting over 52 weeks for care	Scoring	Quarterly – latest month in the period.	%	1.89	3.53	Q1 2026/27	100	1.07	0.47	1.85	1.69	M5 2026/27	COO
Elective care	% of cases waiting up to 18 weeks for care	Scoring	Quarterly – latest month in the period.	days	62.48	3.2	Q1 2026/27	95	65.45	62.32	69.6	62.2	M5 2026/27	COO
Elective care	% of cases waiting over 52 weeks for care (Community)	Scoring	Quarterly – latest month in the period.	%	3.58	3.1	Q1 2026/27	53	0.72	0.01	7.61	3.86	M4 2026/27	COO
Elective care	% of cases where a patient is waiting less than 18 weeks (Community)	Scoring	Quarterly – latest month in the period.	%	48.36	3.43	Q1 2026/27	68	81.06	65.07	87.8	44.85	M4 2026/27	COO

Effectiveness and experience of care, and population health, prevention and reducing inequality

Subject area	Indicator	Scoring/ contextual	Segmentation measurement period	NOF unit	NOF value	NOF score	NOF quarter	NOF rank	NOF median	NOF lower quartile	NOF upper quartile	OUH latest performance (leading indicator)	OUH period of latest performance	Chief Officer lead
Outcomes	Rate of pregnant women with a delayed planned induction per 1,000 deliveries	Scoring	Quarterly – aggregate sitreps.				Q1 2026/27					No update available		CNO
Outcomes	Summary Hospital Mortality Indicator	Scoring	Rolling 12-month.	score	2	2	Q1 2026/27					91	M4 2026/27	CMO
Experience	CQC inpatient survey satisfaction rate	Scoring	Annual.	score	2	2	Q1 2026/27					No update available		CMO
Experience	NHS staff survey advocacy rate	Scoring	Annual.	rate	6.79	2.02	Q1 2026/27	46	6.67	6.19	6.91	Q25a 72.8% vs avg. 71.6%, Q25c, 58.2% vs avg. 57.8%, Q25d, 70.7% vs avg. 60.8%	2025	CPO
Patient flow	Number of patients cared for in corridors	Contextual	Quarterly – aggregated quarterly figures.				Q1 2026/27					National data not yet published		CNO
Preventing ill health	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Scoring	Quarterly (rolling 12-month period).	%	0	4	Q1 2026/27	97	24.76	2.54	45.8	100% (note -date series not complete before M1 26/27. Under investigation	M1 2026/27	CMO
Preventing ill health	% of patients readmitted within 30 days of discharge	Scoring	Annual.	score	4	4	Q1 2026/27					No update available		CMO

1. OUH NOF dashboard

Oxford University Hospitals NHS Foundation Trust

Patient safety

Subject area	Indicator	Scoring/ contextual	Segmentation measurement period	NOF unit	NOF value	NOF score	NOF quarter	NOF rank	NOF median	NOF lower quartile	NOF upper quartile	OUH latest performance (leading indicator)	OUH period of latest performance	Chief Officer lead
High quality care	Breadth and depth of clinical audit outliers	Scoring	Quarterly.	score	1	1	Q1 2026/27					No update available		CMO
Safe culture	NHS staff survey raising concerns sub-score	Scoring	Annual.	%	6.31	2.62	Q1 2026/27	73	6.32	6.14	6.51	No update available		CPO
Safe outcomes	Number of cases of MRSA in the last 12 months	Scoring	12-month rolling.	%	8	3.6	Q1 2026/27		3	1	6	No update available		CMO
Safe outcomes	Rate of c-difficile	Scoring	12-month rolling.	score	2	2	Q1 2026/27					No update available		CMO
Safe outcomes	Rate of e-coli	Scoring	12-month rolling.	score	3	3	Q1 2026/27					No update available		CMO
Safe outcomes	% of patients to acquire a new grade 3 or 4 pressure ulcer	Contextual	Quarterly – latest available data.				Q1 2026/27					No update available		CNO
Safe outcomes	% of safety incidents resulting in harm	Contextual	Quarterly – latest month available.				Q1 2026/27					No update available		CMO
Safe outcomes	Rate of inpatient falls that cause harm	Contextual	Annual.				Q1 2026/27					No update available		CNO

People

Subject area	Indicator	Scoring/ contextual	Segmentation measurement period	NOF unit	NOF value	NOF score	NOF quarter	NOF rank	NOF median	NOF lower quartile	NOF upper quartile	OUH latest performance (leading indicator)	OUH period of latest performance	Chief Officer lead
People and culture	Healthcare worker flu vaccination rate	Scoring	Quarterly.	%	52.5	1.96	Q1 2026/27	48	50.35	44.73	54.5	No update available		CMO
People and culture	National education and training survey satisfaction rate	Scoring	Annual.	score	77.18	77.18	Q1 2026/27	54	76.34	73.54	78.8	No update available		CMO
People and culture	NHS staff standards score	Scoring	Annual.	score	7.64	7.64	Q1 2026/27	37	7.52	7.42	7.65	No update available		CPO
People and culture	NHS staff survey engagement theme score	Scoring	Annual.	%	6.85	2.13	Q1 2026/27	51	6.8	6.55	6.96	No update available		CPO
People and culture	Sickness absence rate	Scoring	Quarterly – aggregated monthly figures.	%	4.44	1.27	Q1 2026/27	16	5.36	4.78	5.86	4.5	M4-5 26/27	CPO
Workforce	Temporary staffing cost relative band	Scoring	Quarterly.	score	1	1	Q1 2026/27					No update available		CPO

1. OUH NOF dashboard

Oxford University Hospitals NHS Foundation Trust

Finance, productivity and innovation

Subject area	Indicator	Scoring/ contextual	Segmentation measurement period	NOF unit	NOF value	NOF score	NOF quarter	NOF rank	NOF median	NOF lower quartile	NOF upper quartile	OUH latest performance (leading indicator)	OUH period of latest performance	Chief Officer lead
Finance	Planned surplus or deficit	Scoring	Annual.	%	0	1	Q1 2026/27	8	-0.38	-2.92		No update available		CFO
Finance	Variance to plan year-to-date	Scoring	Quarterly.	%	0.07	1	Q1 2026/27	8		-0.95	0.01	No update available		CFO
Finance	Combined finance score	Scoring	Quarterly.	score	1	1	Q1 2026/27					No update available		CFO
Innovation	% of clinical trials set up within 90 days	Scoring	Quarterly.	rate	21.74	4	Q1 2026/27	99	50	29.63	70	No update available		CMO
Innovation	Data Quality Maturity Index	Scoring	Quarterly – latest monthly position.	index	92.9	2.59	Q1 2026/27	69	93	90.5	95	No update available		CDIO
Productivity	Relative cost difference (National Cost Collection Index)	Scoring	Annual.	rate	99.63	1	Q1 2026/27	61	100.14	94.28	105.78	No update available		CFO
Productivity	Implied productivity growth	Contextual	Quarterly – year-to-date compared with same period previous year.				Q1 2026/27					No update available		CFO

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
Quality, Safety and Patient Experience	• E.Coli cases • MRSA cases • MSSA cases • C-Diff Cases • Reactivated Complaints • FFT % Likely to recommend OP, IP, and ED Not achieving target		• % of complaints responded to within 25 working days Not achieving target • Number of complaints Not achieving target	*(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)* No SPC Not achieving threshold
Growing Stronger Together	• Sickness and absence rate (in month) Not achieving target	Not Achieving target	• Vacancy Rate • Sickness and absence rate (Rolling 12 Months) Not achieving target	
Operational performance	• No of Corridor Care Patients in Past 24hrs in ED >45min • Cancer 62-Day Combined Standard Not achieving target	• ED 4hr% (all & type 1) • % RTT patients < 18 weeks • % RTT 1st OP patients < 18 weeks Not Achieving target • ED attendances > 12hrs • % patients wating > 52 weeks • Patients >65 weeks • Diagnostics >6 weeks Not Achieving target	Not achieving target Not achieving target	
Corporate Support Services	• Information) Governance and Data Security Training compliance Not achieving target	Not achieving target	• Freedom of Information (FOI) % • Data Subject Access Requests Not achieving target	No SPC Not achieving threshold

Integrated Performance Report (SPC)

NHSE Segmentation Indicator

Safety, Effectiveness, and Patient Experience

No specified section

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
18.00	MRSA Cases: HOHA+COHA Per 10,000 Beddays	✗	Yes	Aug-26	0.32	0.46	0.00	1.62	0.00		
19.00	MRSA Cases: HOHA+COHA	✗	Yes	Aug-26	1	1	0	3	0		
20.00	C-Diff Cases: HOHA+COHA Per 10,000 Beddays		Yes	Aug-26	3.52	3.19		6.23	0.16		
21.00	C-Diff Cases: HOHA+COHA	✗	Yes	Aug-26	11	10	9	20	1		
22.00	E. Coli Cases: HOHA+COHA Per 10,000 Beddays		Yes	Aug-26	5.44	5.47		9.44	1.50		
23.00	E. Coli Cases: HOHA+COHA	✗	Yes	Aug-26	17	18	14	31	5		
24.00	MSSA Cases: HOHA+COHA		Yes	Aug-26	7	6		13	0		
25.00	Number Of Never Events	✓	No	Aug-26	0	0	0	1	-1		
26.00	Non-Thematic Patient Safety Incident Investigations		No	Aug-26	0	2		6	-3		
27.00	PSII Overdue Actions		Yes	Aug-26	12	29		49	9		
28.00	VTE- Submitted Performance	✓	Yes	Aug-26	96.0%	95.4%	95.0%	96.2%	94.7%		
29.00	% Of Emergency Admissions 65yrs + Receiving Cognitive Screen		Yes	Aug-26	68.9%	66.1%		73.1%	59.2%		
30.00	% Patients With Sepsis Attending ED Receiving Timely Antibiotics In Accordance With NICE Guidelines	✓	Yes	Aug-26	100.0%	85.8%	90.0%	110.7%	60.8%		
31.00	CAS Alerts Breaching Deadlines At End Of Month And/Or Closed During Month Beyond Deadline	✓	No	Aug-26	0	0	0				
32.00	Medication Incidents Causing Moderate Harm, Major Harm Or Death As Reported On Ulysses		Yes	Aug-26	0	3		8	-3		
33.00	HSMR Excluding Hospices	✓	No	May-26	93.7	92.5	100.0	94.7	90.3		
34.00	Summary Hospital-Level Mortality Indicator	✓	No	Apr-26	91.0	89.2	100.0	91.0	87.4		
35.00	Neonatal Deaths Per 1,000 Total Live Births	✗	Yes	Jun-26	3.28	3.09	3.20	7.32	-1.14		
36.00	Stillbirths Per 1,000 Total Live Births	✓	Yes	Jun-26	1.64	2.88	4.00	6.97	-1.20		
37.00	National Patient Safety Alerts Not Completed By Deadline		No	Aug-26	0	0					
39.00	Number Of Active Clinical Research Studies Hosted		Yes	Aug-26	1403	1421		1448	1393		
40.00	Number Of Active Clinical Research Studies (Commercial)		Yes	Aug-26	381	394		407	382		
41.00	Number Of Active Clinical Research Studies (Non Commercial)		Yes	Aug-26	1022	1026		1044	1008		
42.00	Number Of Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Aug-26	45.79	45.28		57.91	32.64		
43.00	Number Of Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Aug-26	38.42	39.04		51.85	26.24		
44.00	Number Of Non-Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Aug-26	7.36	6.23		11.60	0.86		
45.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 2)	✓	Yes	Aug-26	1.28	1.91	1.90	2.74	1.08		
46.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 3)	✓	Yes	Aug-26	0.16	0.25	0.20	0.40	0.09		
47.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 4)	✓	Yes	Aug-26	0.00	0.00	0.00	0.00	0.00		
48.00	Pressure Ulceration Incidents Per 1,000 Beddays (Present On Admission Cat 1+)		Yes	Aug-26	9.00	9.71		12.36	7.06		
49.00	Patient Falls (Moderate And Above) As Reported On Ulysses		Yes	Aug-26	4	4		10	-2		
50.00	Patient Falls (Moderate And Above) As Reported On Ulysses Per 1,000 Beddays		Yes	Aug-26	0.13	0.13		0.31	-0.05		
51.00	Health And Safety Related Incidents - Assault, Aggression And Harassment		Yes	Aug-26	200	194		272	116		
52.00	Adult Safeguarding Activity		Yes	Aug-26	1538	1558		2129	988		
53.00	Children's Safeguarding Activity		Yes	Aug-26	509	493		753	232		
54.00	Adult Safeguarding Activity And Children's Safeguarding Activity		Yes	Aug-26	2047	2051		2778	1323		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
55.00	Safeguarding (Children) Training Compliance L1 - L3	✓	Yes	Aug-26	91.8%	90.5%	90.0%	92.5%	88.5%		
56.00	Safeguarding (Adults) Training Compliance L1 - L3	✓	Yes	Aug-26	92.8%	91.9%	90.0%	93.9%	89.9%		
57.00	Total Deliveries In Month	-	Yes	Aug-26	586	598	625	702	494		
58.00	Babies Born		Yes	Aug-26	593	608		715	501		
59.00	Maternity Bookings (Planned + Unplanned)	-	Yes	Aug-26	595	679	750	839	519		
60.00	Inductions Of Labour From IView		Yes	Aug-26	142	122		172	73		
61.00	Midwife Ratios (Birth Rate / Staffing Level)	✓	Yes	Aug-26	22.8	23.7	22.9	28.0	19.5		
62.00	Number Of Learning MDT Reviews Instigated		Yes	Aug-26	2	2		5	-2		
63.00	Percentage Of Learning MDT Reviews Within 42 Days		Yes	Aug-26	0.0%	48.3%		163.0%	-66.5%		
64.00	After Action Review (AAR)		No	Aug-26	10	14		23	5		
65.00	Percentage Of AAR's Within 14 Days		Yes	Aug-26	37.5%	28.4%		63.7%	-6.8%		
66.00	Number Of Complaints		Yes	Aug-26	214	189		251	126		
67.00	Number Of Complaints Per 1,000 Beddays		Yes	Aug-26	6.85	6.02		8.28	3.77		
68.00	Reactivated Complaints	✗	Yes	Aug-26	16	16	1	28	4		
69.00	% Of Complaints Responded To Within 25 Working Days	✗	Yes	Aug-26	23.2%	39.5%	85.0%	59.7%	19.2%		
70.00	Number Of RIDDORs	✓	Yes	Aug-26	3	6	5	11	-0		
71.00	Friends & Family Test % Likely To Recommend - IP	✗	Yes	Aug-26	93.7%	94.7%	95.0%	96.5%	92.8%		
72.00	Friends & Family Test % Likely To Recommend - OP	✗	Yes	Aug-26	94.0%	93.8%	95.0%	94.9%	92.8%		
73.00	Friends & Family Test % Likely To Recommend - ED	✗	Yes	Aug-26	83.1%	81.5%	85.0%	86.5%	76.5%		
74.00	FFT Maternity % Positive (Births)	✓	Yes	Aug-26	100.0%	86.2%	90.0%	103.1%	69.3%		
75.00	Inpatient FFT (Response Rate)		Yes	Aug-26	12.9%	20.1%		24.0%	16.2%		
76.00	Outpatient FFT (Response Rate)		Yes	Aug-26	6.5%	9.3%		10.3%	8.3%		
77.00	ED FFT (Response Rate)		Yes	Aug-26	10.0%	15.0%		18.5%	11.5%		
78.00	Maternity FFT (Response Rate; Births)		Yes	Aug-26	0.3%	3.0%		8.8%	-2.8%		
79.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars JR	✗	Yes	Aug-26	93.0%	94.7%	95.0%	100.1%	89.4%		
80.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars CH	✗	Yes	Aug-26	90.3%	96.1%	95.0%	103.9%	88.3%		
81.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars NOC	✓	Yes	Aug-26	100.0%	96.3%	95.0%	104.3%	88.3%		
82.00	Incident Rate Of Violence And Aggression (Rate Per 10,000 Beddays)		Yes	Aug-26	64.04	61.82		89.68	33.96		
83.00	Trust Level: CHPPD Vs Budget		Yes	Aug-26	42.9	18.1		44.1	-7.9		
84.00	Trust Level: CHPPD Vs Required		Yes	Aug-26	14.4	-0.6		20.7	-21.9		

Integrated Performance Report (SPC)

NHSE Segmentation Indicator

Operational Performance

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
85.0	Proportion Of Ambulance Arrivals Delayed Over 30 Minutes		Yes	Jul-26	5.1%	6.5%		8.8%	4.2%		
86.0	Proportion Of Ambulance Arrivals Delayed Over 60 Minutes		Yes	Jul-26	0.4%	0.5%		1.3%	-0.4%		
87.0	ED 4Hr Perfromance - All	✗	Yes	Aug-26	81.0%	76.2%	84.0%	82.0%	70.5%		
88.0	Mean Ambulance Handover Time In Seconds For All Handovers At Trust Level	✓	Yes	Jul-26	1014	1056	1180	1138	974		
89.0	ED 4Hr Perfromance - Type 1	✗	Yes	Aug-26	75.7%	68.4%	77.9%	75.8%	61.1%		
90.0	No Of Corridor Care Patients In IP Wards At 8am	✓	Yes	Aug-26	0	6	0	30	-18		
91.0	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day, All Sites		Yes	Aug-26	12.3	14.1		25.2	3.0		
92.0	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day, Horton Site		Yes	Aug-26	0.5	1.2		3.0	-0.6		
93.0	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day, John Radcliffe Site		Yes	Aug-26	11.8	12.8		24.8	0.9		
94.0	Proportion Of Type 1 Attendances Spending More Than 12 Hours In An Emergency Department	✓	Yes	Aug-26	2.1%	3.0%	2.3%	5.1%	1.0%		
95.0	Proportion Of Patients Discharged From Hospital To Their Usual Place Of Residence		Yes	Aug-26	95.3%	95.6%		96.1%	95.2%		
96.0	% Of RTT Patients Waiting For A First Appointment	✓	Yes	Aug-26	68.1%	66.8%	67.0%	68.6%	65.0%		
97.0	% Of RTT Patients Waiting Within 18 Weeks	✓	Yes	Aug-26	62.2%	59.4%	62.0%	60.7%	58.1%		
98.0	% Of RTT Patients Waiting Over 52 Weeks	✓	Yes	Aug-26	1.7%	2.5%	1.9%	2.8%	2.2%		
99.0	RTT Standard: >52-Week Incomplete Pathways	✓	Yes	Aug-26	1519	2473	1520	2795	2152		
100.0	RTT Standard: >65-Week Incomplete Pathways	✗	Yes	Aug-26	54	211	0	309	113		
101.0	RTT Number Of Incomplete Pathways	-	Yes	Aug-26	89940	88192	81874	90316	86069		
102.0	RTT Number Of Incomplete Pathways (<18 Weeks)	✓	Yes	Aug-26	55941	52705	51977	54094	51316		
103.0	% Of RTT Patients Waiting Over 52 Weeks For Community Services		Yes	Aug-26	4.9%	3.2%		4.5%	1.8%		
104.0	Cancer 28 Day Combined Standard (2WW ,Breast Symptomatic And Screening Referrals)	✓	Yes	Jul-26	83.4%	79.4%	80.0%	85.1%	73.7%		
105.0	Cancer 31 Day Combined Standard (First And All Subsequent Treatments)	✗	Yes	Jul-26	80.7%	79.0%	82.0%	87.7%	70.2%		
106.0	Cancer 62 Day Combined Standard (2WW, Consultant Upgrade And Screening)	✓	Yes	Jul-26	64.3%	60.7%	62.1%	71.2%	50.2%		
107.0	62-Day Cancer Standard: Incomplete Pathways >62-Days		Yes	Aug-26	337	360		433	288		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
108.0	% Diagnostic Waits Waiting 6 Weeks Or More	✗	Yes	Aug-26	21.6%	22.6%	19.5%	27.3%	17.9%		
109.0	Diagnostic Activity Vs 2019/20		Yes	Aug-26	128.1%	135.6%		149.6%	121.6%		
110.0	Total Outpatient Attendances (SUS)	-	Yes	Jul-26	112826	112226	117191	135002	89451		
111.0	Bed Utilisation General & Acute	✓	Yes	Aug-26	92.2%	92.9%	90.8%	96.4%	89.4%		
112.0	Average Non Elective LOS Trust Level For IPR (Average So Cannot Aggregate Up)	✗	Yes	Jul-26	6.6	6.8	6.3	7.7	5.9		
113.0	Number Of Non-Discharged Patients Put Onto A PIFU	✗	Yes	Aug-26	1495	1015	5860	1255	774		
114.0	Cancelled Operations Within 24hrs (Non-Clinical Reasons)		Yes	Aug-26	0.2%	0.3%		0.5%	0.1%		
115.0	Cancellations Not Re-Booked Within 28 Days		Yes	Aug-26	18.8%	13.7%		39.8%	-12.3%		
116.0	Elective DC Spells - SUS	-	Yes	Jul-26	7352	6835	7200	8355	5316		
117.0	Elective IP Spells - SUS	-	Yes	Jul-26	1584	1508	1591	1855	1160		
118.0	Average Delay (Exclude Zero Delay) Of Discharges	✓	Yes	Jul-26	6.0	5.7	6.2	6.9	4.5		
119.0	Percentage Of Patients Discharged On Discharge Ready Date	✗	Yes	Jul-26	88.1%	87.8%	90.0%	89.6%	86.1%		

Integrated Performance Report (SPC)

NHSE Segmentation Indicator

Workforce

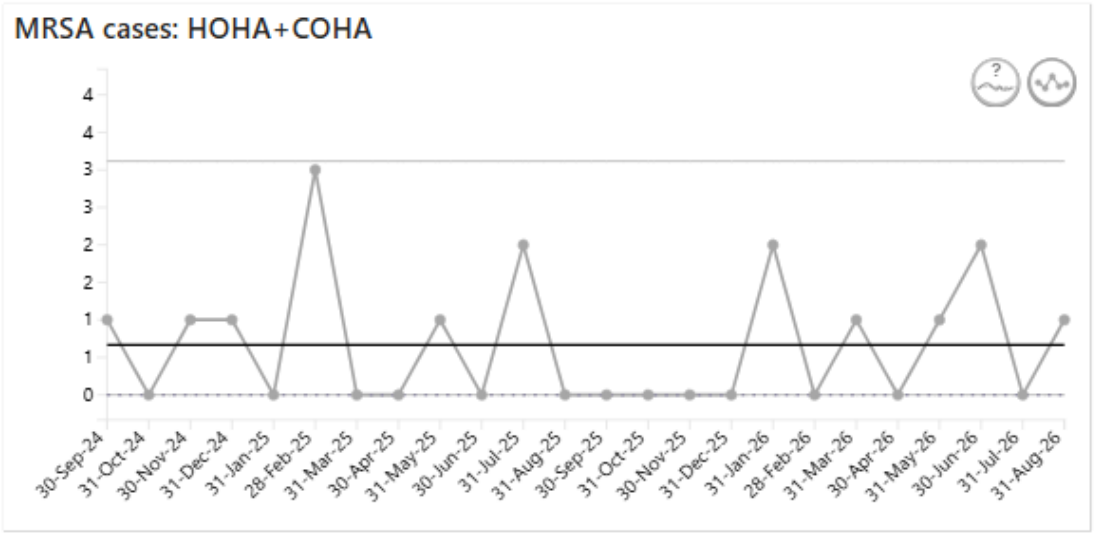
Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
10.0	Vacancy Rate	✗	Yes	Aug-26	7.8%	6.0%	7.7%	7.0%	4.9%		
11.0	Turnover Rate	✓	Yes	Aug-26	7.6%	8.8%	12.0%	9.1%	8.4%		
12.0	Turnover Rate With No Exclusions		Yes	Aug-26	9.5%	10.6%		11.0%	10.2%		
13.0	Sickness Absence Rate (Rolling 12 Months)	✗	Yes	Aug-26	4.3%	4.2%	3.1%	4.2%	4.1%		
14.0	Non Medical Appraisals	✓	Yes	Aug-26	92.8%	77.5%	85.0%	100.6%	54.4%		
15.0	Sickness Absence Rate (In Month)	✗	Yes	Aug-26	4.4%	4.5%	3.1%	5.1%	3.9%		
16.0	Core Skills Training Compliance	✓	Yes	Aug-26	93.6%	92.1%	85.0%	93.0%	91.1%		
17.0	Time To Hire (Average Days)	✓	Yes	Aug-26	47.9	45.1	53.0	54.6	35.7		

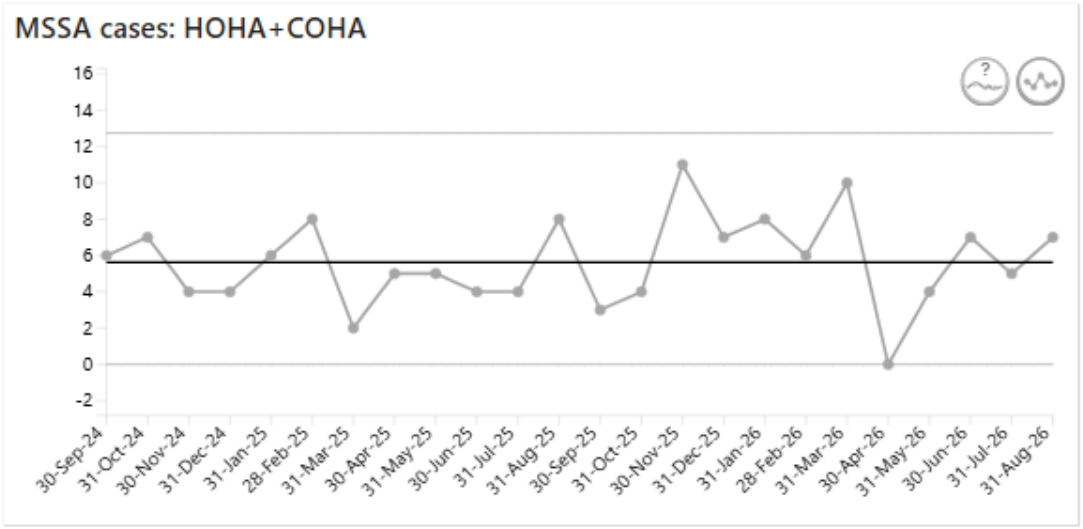
Assurance, legal services, digital and finance

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
1	CQC Overdue Actions	✗	No	Aug-26	1	0	0	0	0		
2	Legal Services: Number Of Claims		Yes	Aug-26	28	21		37	6		
3	Information Governance And Data Security Training	✗	Yes	Aug-26	91.2%	90.5%	95.0%	91.7%	89.4%		
4	Data Security & Protection Breaches		Yes	Aug-26	30	28		48	9		
5	Externally Reportable ICO Incidents	✓	No	Aug-26	0	0	0	1	-0		
6	All IG Reported Incidents		Yes	Aug-26	32	30		48	12		
7	Freedom Of Information (FOI) % Responded To Within Target Time	✗	Yes	Aug-26	25.7%	59.4%	80.0%	88.1%	30.6%		
8	Data Subject Access Requests (DSAR)	✗	Yes	Aug-26	40.1%	72.4%	80.0%	91.6%	53.1%		
9	Priority 1 Incidents	✓	No	Aug-26	0	1	0	2	-1		
120	Adjusted In-Month Financial Performance Surplus/Deficit £'000		Yes	Aug-26	-9490.9	-7603.9		-3772.1	-11435.7		
121	BPPC £ %	✗	Yes	Aug-26	62.6%	61.2%	95.0%	65.9%	56.5%		
122	BPPC Volume %	✗	Yes	Aug-26	40.8%	36.7%	95.0%	40.6%	32.9%		
123	Cash £'000	✗	Yes	Aug-26	12305	23073	41512	43009	3136		
124	Efficiency Delivery £'000	✓	Yes	Aug-26	10055.0	7545.5	9788.1	14410.1	681.0		
125	In-Month Financial Performance Surplus/Deficit £'000	✓	Yes	Aug-26	-1711.0	260.5	-1742.0	5498.8	-4977.9		
126	In-Month ICS CDEL Capital Expenditure	-	Yes	Aug-26	2490.3	7827.2	1944.1	19414.7	-3760.4		
127	Year-To-Date Financial Performance Surplus/Deficit £'000	✗	Yes	Aug-26	-22966.0	-12694.2	-20785.9	-6665.9	-18722.5		

03. Assurance reports

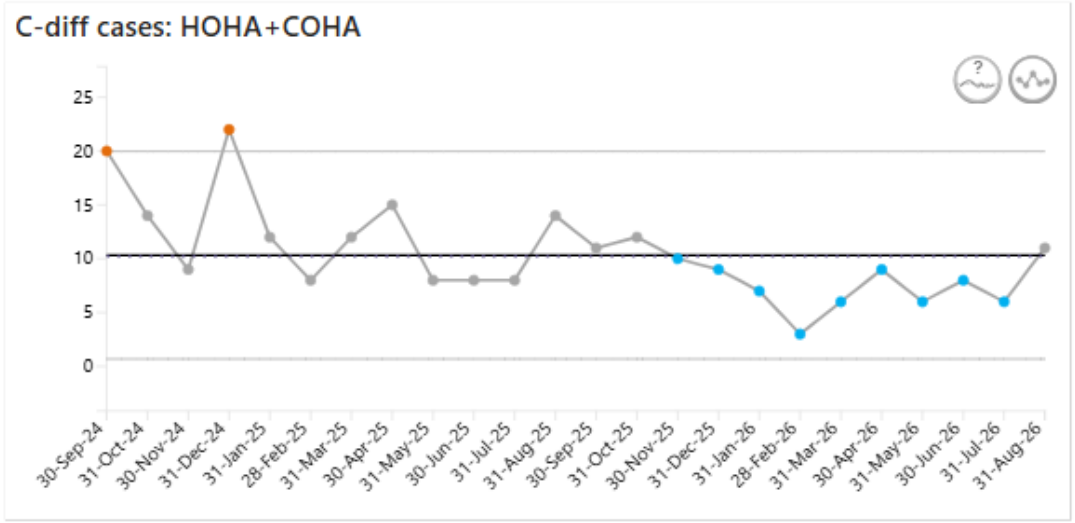
3. Assurance report: Quality, Safety and Patient Experience

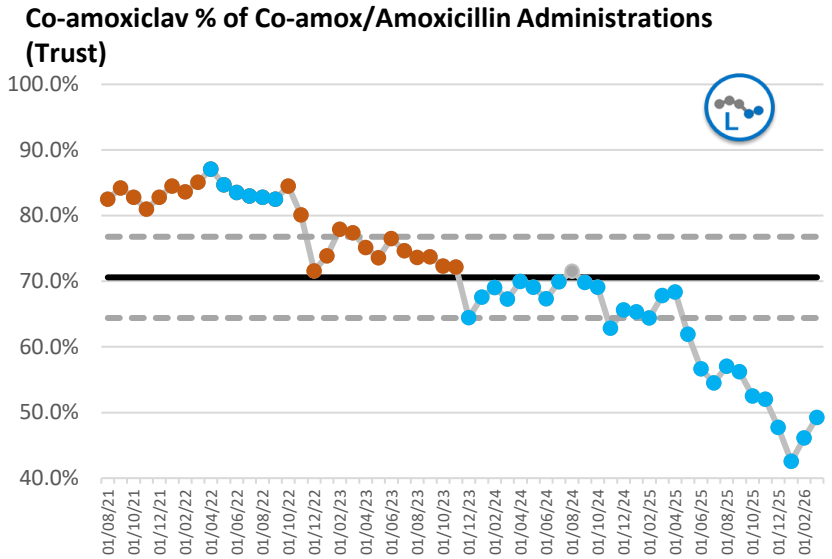




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MSSA bacteraemia: There were seven cases of healthcare associated MSSA bacteraemia in August. We have seen four fewer cases than by the same time last year (improved from three cases last month). **MRSA Bacteraemia:** There was one MRSA bacteraemia in August; this was an ongoing infection in a previous case whose initial care was in another organisation. This means we have had one more case than by the same time last year. The number of MRSA bacteraemia cases assigned to OUH between July 2025 and June 2026 (eight cases) gave the Trust a score of 3.6 in the NHS Oversight Framework Acute Trust league table, a deterioration from 3.32 from the previous quarter when there had been six cases.	There was just one MSSA case associated with an intravascular line this month, in a patient transferred to OUH from another Trust. No learning for OUH was identified. There was 1 case associated with a PICC line. Decolonisation and MRSA screening remain themes for learning.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

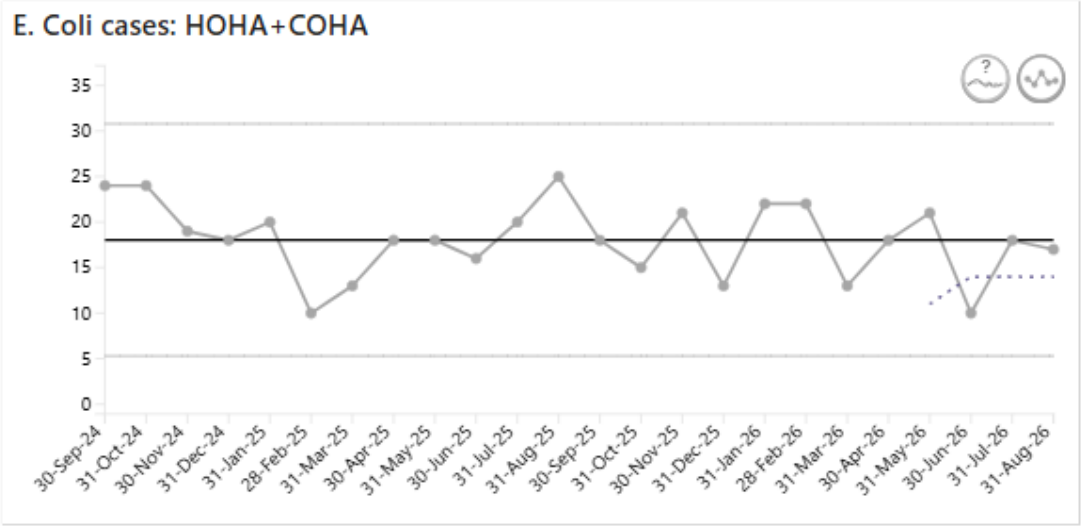
3. Assurance report: Quality, Safety and Patient Experience





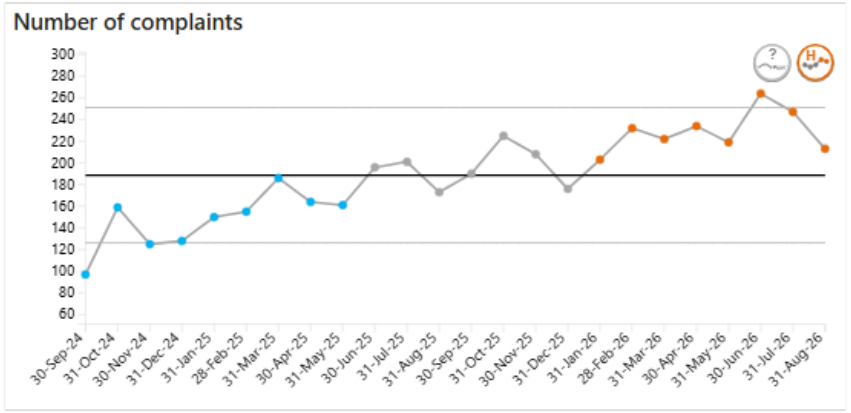
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***C. difficile* infection:** OUH reported eleven healthcare-associated *C. difficile* cases (six HOHA and five COHA) in August, meaning we have seen 13 fewer cases than by the same time last year (improved from ten cases last month). The OUH C. *difficile* threshold from the NHS England Standard Contract for 2026/7 is set at 98 cases, which is a challenging 25 cases lower than last year's threshold (123). Our case count last year was 109. We are currently one case below trajectory for this threshold. Our latest quarterly position in the NHS Oversight Framework Acute Trust league table shows a score of 2 (down from 1.00) because, despite meeting our threshold for last year, the NOF rating is now using this year's more challenging threshold as a denominator. **IPC surveillance:** While the lack of a comprehensive surveillance system remains high on the Trust risk register, work on the installation and integration of ICNet has begun, with multiple workstreams convened to drive this. The go-live is planned to be mid-December, however a later date is now considered likely due to software integration complexities. **AMS data:** Currently unable to update antimicrobial stewardship (AMS) graphs and dashboards as the Tableau platform on which it was hosted was withdrawn.	***C. difficile* infection:** A continued focus on good antimicrobial stewardship (AMS) will be required to maintain our significantly improved *C. difficile* position. Improved AMS reducing the use of co-amoxiclav is likely to be a major contributor to the fall in *C. difficile* case counts. We are rolling out a combined cleaning and disinfection product for environmental cleaning which should provide ongoing background efficacy against *C. diff* spores and may thus have an impact on case numbers. This is now in place across the JR site and will roll out at the Horton next. **IPC surveillance**: Implementation of Phase 1 of ICNet is taking place as fast as possible within the constraints of working with external parties, followed by 2nd phase (integration of surgical and devices data to support SSI surveillance) in 2027. **AMS data:** The Data and Analytics team are supporting a solution to provide some options to re-instate AMS data availability using PowerBI.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

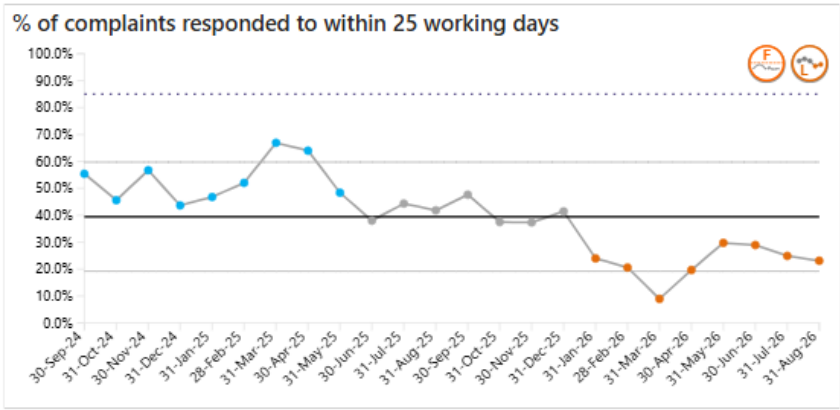
3. Assurance report: Quality, Safety and Patient Experience

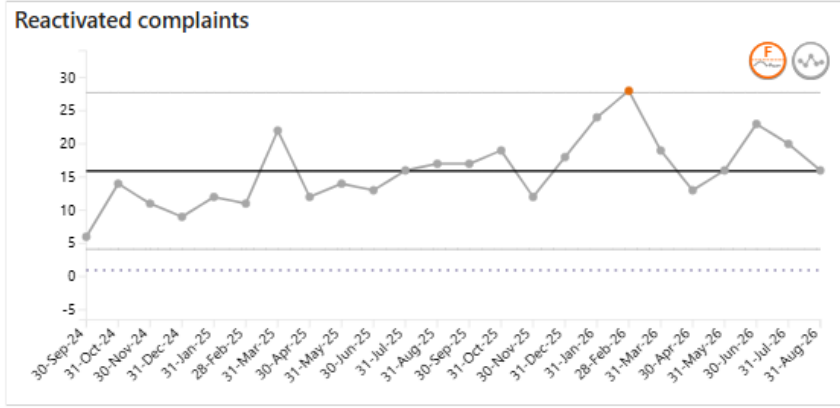


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***E. coli* bacteraemia**: There were 17 cases of *E. coli* reported in July (6 HOHA and 11 COHA). There have been 13 cases fewer than by the same time last year (improved from five cases fewer last month). Our latest quarterly position in the NHS Oversight Framework Acute Trust league table shows a score of 3. The OUH E. coli threshold from the NHS England Standard Contract for 2026/7 is set at 165 cases which is unchanged from last year when our case count was 220. We remain 15 cases above the trajectory for this threshold.	***E. coli* bacteraemia:** Apart from good catheter management, there are no clear themes or interventions to reduce the rate of *E. coli* bloodstream infections in secondary care, and catheters are not currently a significant theme in our cases. The number of infections associated with urine has dropped over recent months, but this has been offset by a rise in hepatobiliary infections. A deeper look into these cases found no connection with waiting times for hepatobiliary procedures.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

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

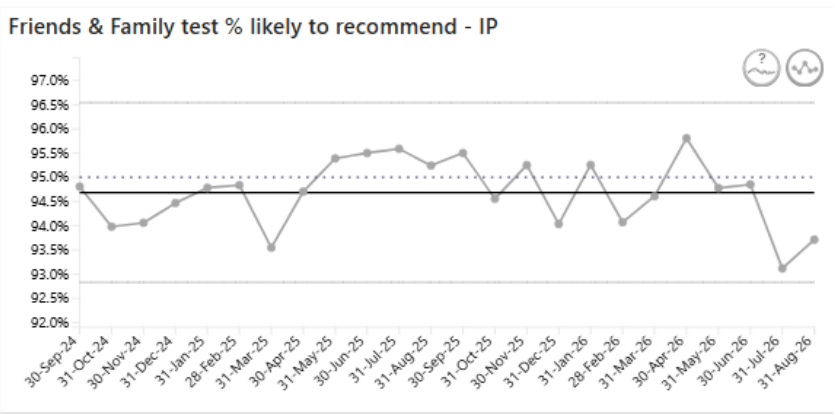


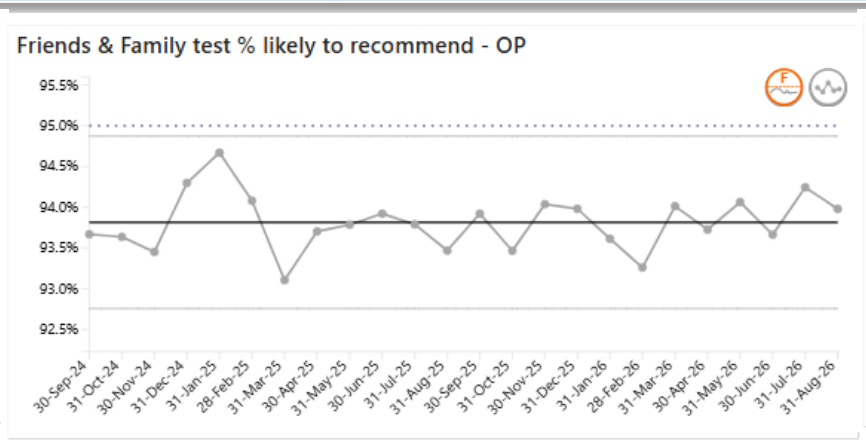


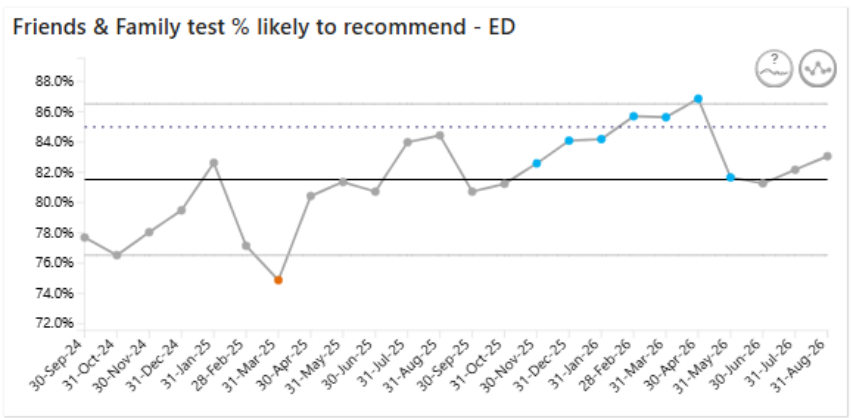


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust received 213 formal complaints in August in comparison to 246 in July. Although the number received in August demonstrates a decrease of 13% compared to July, the number of complaints received each month since January 2026 is above the process mean. The Trust should plan on the basis that the underlying monthly rate has shifted to approximately 230, around 25% above the historic mean. Reports from NHS organisations nationally show a comparable direction of travel, with confirmatory data expected from NHS England in October 2026. In August 2026 the number of complaints closed reduced to 191, compared to 251 complaints closed in July, This represents a decrease of 23.9%. 26.7% of complaints closed in August met the 25-working day standard, against a target of 85%. The two-year median response time increased slightly to 34.65 days. The Trust's median of complaints responded to for August increased to 31 days. Complaint complexity continues to increase, adding to investigation time and to the demands placed on staff undertaking investigations. Complainants are increasingly using AI tools to document their concerns, and while this is welcomed to support patients who may not have felt able to raise concerns previously, it is causing issues for investigators to understand the issues being raised as the AI tools tend to overly complicate an issue. Work is underway with NHS England to better understand the use of AI in complaints.	The top five categories within complaints recorded in August were Clinical Treatment (47, 22%), Communications (47, 22%), Appointments (24, 11.7%), Admission and Discharge (19, 8.9%) and Values and Behaviours (15, 7.04%). Communications, Appointments, and Values and Behaviours together account for 86 complaints, or 40.3%. These relate to how care is organised and communicated rather than to the clinical care given. The following areas received the highest number of new complaints in August: Emergency Medicine (24, 11.2%) Gynaecology (21, 9.8%) Trauma & Orthopaedics (21, 9.8%) Corporate services (15, 7%) Neurosciences (13, 6.1%) Targeted meetings continue with these services, involving the CNO and CMO teams. From September the Trust will additionally report complaints as a rate per 1,000 attendances or spells by specialty, so that oversight is directed at the services performing worst rather than the busiest.	Actions are ongoing and reviewed weekly, with oversight through the Patient Experience and Engagement Committee (PEEC) and Delivery Committee oversight. The risks are recognised and actively managed through process improvement and strengthened governance, with continued focus on delivering sustained compliance with the 25-day KPI.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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







Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses made up 6,195 of all responses received in August 2026, with an approval rate of 94.0% 2. ED responses made up 868 of all responses in August, with an approval rate of 83.1% 3. Inpatient / Daycase responses made up 1,957 of all responses in August, with an approval rate of 93.7% 4. Overall, the Trust received 8,891 responses – a response rate of 17.6%. 92.88% responses were positive. 5. The top positive themes were staff attitude, admission and implementation of care. The top negative themes were car parking, cancelled admissions and procedures and discharge.	1. Each division presents an update on patient experience, including FFT data and themes at the Patient Experience and Engagement Committee bi-monthly. 2. Further work to promote collection methods and improved response rates will be explored as an early priority of the recently endorsed Patient Experience and Engagement Plan, along with a new Patient Experience Survey.	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 Engagement Committee [PEEC] 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*

Summary of challenges and risks

Trust-wide nursing and midwifery staffing remained at Level 2 (Amber) throughout August. The following departments declared level 3 for one day shift: 6A Vascular, John Warin Ward (JWW) and Specialist Surgery Inpatient (SSIP) ward, along with MRC division. The mitigation for these departments was overseen by Matrons. The Neonatal unit declared level 3 on 3 day shifts and 3 night shifts. Support was given by other critical care units to support partial mitigation. Planned versus actual fill rates of 94.15% (day) and 98.5% (night), providing assurance that staffing levels were maintained safely. When fill rates fell below 90%, all shifts were reviewed and mitigated at Matron level or above, and no shifts were left at risk. Monthly triangulation of staffing metrics and nurse-sensitive indicators confirmed no harm directly attributable to staffing across all divisions. This demonstrates effective operational grip, supported by twice-daily Trust-level reviews and clear accountability arrangements.

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

Staffing metrics for nurses and midwives, including nurse-sensitive indicators, are consistently reviewed and validated with Divisional Directors of Nursing (DN) and Deputy Divisional Director of Nursing (DDN). Each monthly review, triangulates all relevant data in accordance with National Quality Board standards and assesses whether the nurse/midwifery-sensitive harm indicators are directly related to staffing levels. The August review confirmed across all divisions, there were no instances of nurse/midwifery-sensitive harm indicators were directly linked to nursing or midwifery staffing levels. The HR data for August was unavailable at the time the report was reviewed. Any concerns with data will be reported in September report.

SUWON – The division saw a rise in category 3 pressure ulcers. 2 reported for the same person. After review, all measures were in place, therefore deemed unavoidable. A further incident reported, whereby following investigation, it was found that documentation was lacking. This is being addressed within the division with support from the tissue viability team. Outstanding staffing red flags have now been reviewed and actioned. Rostering KPI's were largely achieved. One ward missed manager approval for payroll. There were extenuating circumstances relating to this, therefore it is not anticipated this will be missed in the future. There were some areas that had a support worker fill rate of less than 90%. Assurance from Deputy DN has been given that no shift was left unsafe. Support was given by specialist nurses, ward managers, educators and supervised students.

MRC – No harms were related to staffing. CMU-C had multiple falls recorded, all with minor or no harm. These incidents have all been reviewed and discussed at harm free meetings. All staffing red flags outstanding on this report, have now been reviewed and updated. JR-ED is outside of net hours KPI. Upon review, this relates to students and military staff, not substantive hours. Stroke ward exceeded roster KPI for Annual Leave. The DDN is addressing this with the ward manager to ensure, in future, leave is within KPI.

NOTSSCAN – No harms related to staffing. One children's ward was showing open staffing red flags, along with one for Trauma 3A. These have now been reviewed and updated. Two wards missed the roster lead time by one day. One department was not approved for payroll by the manager, due to a gap in senior leadership in the team. Cross cover has now been arranged to avoid the situation reoccurring. One ward had some unused substantive hours, which has now been addressed by the Matron.

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

CSS – There were no issues or concerns for August. All rostering KPI's were met.

Maternity – There is a variance between the actual CHPPD compared to the budget across maternity as the need for additional staff has not yet been included in the budget. Additional shifts therefore had to be created to ensure appropriate staff across the departments. One birth experienced a change in place of planned birth due to staffing. The patient experience was not optimum, but no harm came to mother or baby. Staffing red flags raised were all reviewed. Roster KPI's were almost achieved. The rosters missed the publication date by one day. One ward has annual leave above the KPI, however, this is due to this team being very small, with only one person on leave. The Deputy Head of Midwifery has oversight of this roster, and no concerns with the high percentage.

Nurse and Midwifery Sensitive Indicators Directly Impacted by Staffing Levels
The DDNs have reviewed and approved the staffing levels for August as correct. They confirmed staffing levels did not directly impact nurse-sensitive indicators, and thus, no exception reporting is required for this month

Recruitment and Vacancies
Alignment work is ongoing in ESR and the roster templates.

Unavailability
All areas that experienced unavailability of workforce, due to vacancies, maternity leave, or long-term sickness (according to HR data), were mitigated 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.

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. The August data was not available at the time the report was reviewed. Any concerns relating to the data will be included with the September report. .

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 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 at Trust level triangulated with other Trust level metrics allows the Board to see where there are increased capacity and acuity, (required) versus budget.	N	***Sufficient*** Information reported at required level. 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.

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

Oxford University Hospitals NHS Foundation Trust

August 2026 v2	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury 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%	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
NOTSSCaN																												
Bellhouse / Drayson Ward	7.94	8.99	9.7	100.00 %	3	0	0	0	4	2	0	0	-2.50%	23.00%	1.60%	12.50%	20.00%	Yes	1.27%	7.71	17.08%	14	4	0	0	1	0
HH Childrens Ward	6.28	9.88	22.1	98.92 %	0	2	0	0	2	0	0	0	21.30%	12.20%	6.80%	17.90%	35.40%	Yes	0.72%	8.86	17.57%	14	2	0	0	0	0
Kamrans Ward	7.65	10.76	8.8	100.00 %	0	9	0	2	0	0	0	0	6.80%	0.00%	3.20%	13.10%	31.30%	Yes	1.11%	8.86	14.12%	1	0	0	1	0	0
Melanies Ward	7.53	11.24	10.9	100.00 %	0	2	0	0	0	0	0	1	-13.80%	2.10%	3.10%	14.40%	2.60%	Yes	0.52%	8.86	17.37%	13	2	0	0	0	0
Robins Ward	8.23	9.61	12.2	100.00 %	0	6	0	0	2	0	0	0	17.40%	11.90%	3.70%	22.70%	48.30%	Yes	0.29%	8.86	15.21%	19	1	1	1	0	0
Tom's Ward	7.63	9.94	8.7	100.00 %	0	4	0	0	1	0	0	0	15.30%	10.00%	2.40%	0.00%	25.70%	Yes	0.62%	8.86	17.34%	10	1	0	0	0	0
Neonatal Unit	19.92		15.8						10	2	0	0	14.40%	8.60%	7.40%	9.40%	38.60%	No	-1.97%	8.43	15.03%	0	0	0	0	0	0
Paediatric Critical Care	27.59		33.2						11	2	0	0	-12.30%	7.00%	5.60%	3.10%	17.10%	Yes	0.90%	7.71	16.32%	0	0	0	0	0	0
BIU	5.99	7.19	7.1	100.00 %	0	0	10	0	0		0	3	-9.80%	0.00%	3.90%	18.90%	31.80%	Yes	-0.22%	9.57	14.73%	0	0	0	0	0	0
HDU/Recovery (NOC)	4.82		9.4		0	0	0	0	0		0	0	12.90%	13.40%	10.50%	6.70%	36.20%	Yes	-0.85%	8.71	15.72%	0	0	0	0	0	0
Head and Neck Blenheim Ward	6.54	7.21	8.0	100.00 %	0	2	0	0	1		0	0	9.40%	0.00%	4.40%	0.00%	9.40%	Yes	1.62%	8.43	15.01%	2	0	0	0	0	0
HH F Ward	7.02	8.88	8.0	100.00 %	0	0	0	0	0		2	1	-1.20%	3.90%	4.40%	0.00%	3.50%	Yes	-1.87%	8.29	15.00%	4	2	0	0	0	0
Major Trauma Ward 2A	8.67	9.32	9.3	100.00 %	0	1	0	0	6		0	3	7.50%	0.00%	3.50%	10.30%	29.50%	Yes	-0.37%	7.71	15.07%	2	3	1	1	0	0
Neurology - Purple Ward	7.62	9.75	8.8	100.00 %	0	0	1	0	2		0	6	12.80%	0.00%	3.80%	0.00%	18.30%	Yes	0.98%	9.43	14.67%	2	1	0	0	0	0
Neurosurgery Blue Ward	8.47	9.74	9.0	100.00 %	0	0	2	1	1		1	2	11.50%	11.00%	7.70%	6.00%	32.20%	Yes	3.24%	9.43	17.92%	16	0	2	1	1	0
Neurosurgery Green/IU Ward	9.59	9.79	9.8	100.00 %	0	0	0	0	1		0	0	9.30%	14.50%	5.10%	0.00%	22.40%	Yes	1.87%	9.43	12.23%	7	0	0	0	0	0
Neurosurgery Red/HC Ward	10.93	11.95	11.7	100.00 %	0	0	2	0	0		1	1	-0.50%	4.40%	6.90%	9.20%	17.70%	Yes	-0.16%	9.43	14.89%	1	0	0	0	0	0
Specialist Surgery I/P Ward	6.90	6.99	7.3	100.00 %	0	0	0	0	3		0	4	8.60%	7.50%	6.00%	7.80%	26.20%	Yes	1.77%	8.29	15.41%	8	1	0	1	1	0
Trauma Ward 3A	8.65	9.04	9.2	100.00 %	1	0	0	0	2		1	0	9.00%	10.40%	4.50%	0.00%	27.60%	Yes	1.45%	7.86	18.30%	7	1	2	0	1	0
Ward 6A - JR	7.03	7.30	7.3	100.00 %	0	1	0	0	1		1	3	9.80%	0.00%	4.30%	18.80%	30.50%	Yes	-0.57%	8.43	16.62%	16	3	0	0	0	0
Ward E (NOC)	5.30	6.69	7.4	100.00 %	0	0	0	0	1		0	3	-27.40%	0.00%	7.30%	16.50%	0.60%	Yes	2.14%	8.57	14.67%	31	7	1	0	1	0
Ward F (NOC)	5.80	8.31	7.2	93.55 %	0	4	0	0	1		1	2	3.30%	29.30%	4.80%	0.00%	33.30%	Yes	1.92%	8.57	16.58%	0	0	0	0	0	0
WW Neuro ICU	27.97		34.1						3		1	0	2.70%	7.50%	5.10%	13.10%	32.90%	Yes	-0.76%	7.86	15.56%	0	0	0	0	0	0

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

Oxford University Hospitals NHS Foundation Trust

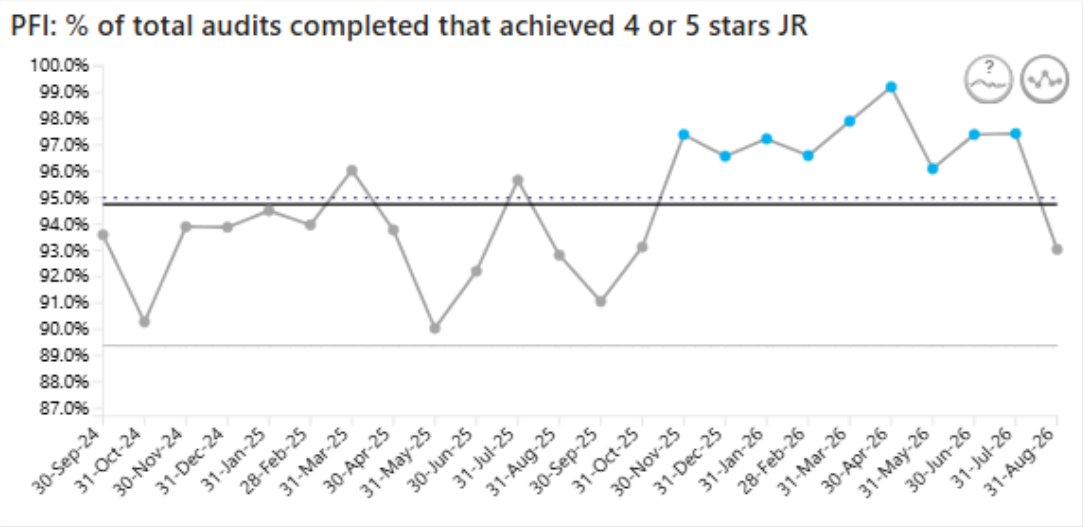
August 2026 v2	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury 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%	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
MRC																												
Ward 5A SSW	8.36	8.35	8.1	100.00 %	0	16	2	2	1		1	2	23.40%	6.60%	2.70%	0.00%	23.40%	Yes	-0.73%	9.00	13.67%	3	2	0	0	0	0
Ward 5B SSW	8.36	8.50	8.8	100.00 %	0	10	0	1	0		2	2	25.30%	0.00%	2.70%	0.00%	45.90%	Yes	0.94%	9.00	12.61%	3	0	0	0	0	0
Cardiology Ward	8.24	7.68	8.7	100.00 %	2	18	7	2	3		0	4	6.20%	5.30%	4.10%	8.10%	18.80%	Yes	-0.12%	8.29	14.47%	4	1	0	0	0	0
Cardiothoracic Ward (CTW)	7.43	6.29	6.8	100.00 %	0	5	3	0	0		0	2	-0.10%	5.00%	3.80%	5.00%	10.00%	Yes	-0.25%	8.43	16.06%	17	4	0	1	0	0
Complex Medicine Unit A	8.94	10.21	8.1	98.92 %	0	0	3	4	0		0	1	2.60%	7.20%	7.20%	0.00%	17.80%	Yes	2.35%	9.29	15.98%	1	0	0	0	0	0
Complex Medicine Unit B	9.48	10.06	8.4	100.00 %	1	4	3	3	1		0	2	2.70%	7.80%	6.00%	15.60%	17.90%	Yes	0.87%	9.29	13.67%	0	0	0	0	0	0
Complex Medicine Unit C	8.21	10.58	8.6	100.00 %	0	1	3	0	0		0	7	3.90%	6.80%	2.70%	0.00%	22.30%	Yes	1.04%	9.29	13.86%	11	2	1	0	0	0
Complex Medicine Unit D	8.63	6.96	8.3	98.92 %	0	0	3	1	0		0	3	12.10%	4.20%	4.10%	7.20%	31.10%	Yes	2.15%	7.86	14.79%	32	6	0	0	0	0
CTCCU	21.59		22.7		0	0	0	0	3		0	0	22.20%	18.50%	6.10%	5.20%	38.60%	Yes	-0.55%	9.57	16.90%	1	0	0	0	0	0
Emergency Assessment Unit (EAU)	8.89	8.45		87.10%	0	2	3	1	2		1	0	13.10%	10.80%	6.80%	6.20%	34.50%	Yes	-0.16%	9.29	14.39%						
JR Emergency Department	19.84				0	0	0	0	5		0	4	20.60%	15.50%	3.90%	0.90%	31.40%	Yes	3.46%	9.29	14.68%	0	0	0	0	0	0
HH EAU	9.20	7.11		96.77 %	1	2	0	0	3		2	4	-3.40%	0.00%	7.10%	2.40%	14.30%	Yes	-0.77%	8.86	14.15%	0	0	0	0	0	0
HH Emergency Department	87.10				0	0	0	0	3		0	0	-8.10%	9.20%	4.50%	16.70%	24.90%	Yes	1.01%	8.86	14.58%	0	0	0	0	0	0
HH Juniper Ward	7.46	9.05	8.0	100.00 %	0	0	0	0	0		0	4	-3.70%	0.00%	5.30%	4.70%	19.10%	Yes	1.30%	9.43	15.69%	0	0	0	0	1	0
HH Laburnum	8.00	9.80	8.8	100.00 %	1	1	0	1	1		2	3	-1.50%	0.00%	4.20%	0.00%	25.10%	Yes	0.35%	9.43	15.35%	2	1	0	2	0	0
HH Oak (High Care Unit)	10.78		10.7	100.00 %	5	5	0	0	0		0	2	-10.00%	6.40%	7.30%	13.80%	27.30%	Yes	0.44%	9.43	16.85%	0	0	0	0	0	0
John Warin Ward	10.06	9.94	9.4	100.00 %	0	12	5	1	3		0	2	-7.80%	6.80%	3.70%	7.00%	47.00%	Yes	-2.60%	8.86	17.02%	8	1	0	0	0	0
OCE Rehabilitation Nursing (NOC)	10.21	9.42	9.3	100.00 %	0	0	3	0	0		0	5	-7.20%	0.00%	6.10%	6.50%	20.00%	Yes	-2.96%	9.29	15.05%	3	0	0	3	0	0
Osler Respiratory Unit	11.98	9.53	11.5	100.00 %	0	11	1	0	0		3	2	4.50%	4.70%	4.00%	0.00%	18.70%	Yes	-1.53%	7.86	16.22%	6	2	0	6	0	0
Ward 5E/F	9.58	8.77	10.5	100.00 %	0	7	1	1	3		4	3	24.20%	8.40%	5.20%	12.50%	43.20%	Yes	0.58%	9.00	15.09%	4	2	0	4	0	0
Ward 7E Stroke Unit	9.20	9.10	9.0	100.00 %	2	1	6	1	2		2	2	14.00%	14.20%	9.60%	5.50%	32.20%	Yes	-0.93%	9.43	19.59%	14	0	0	1	0	0

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

Oxford University Hospitals NHS Foundation Trust

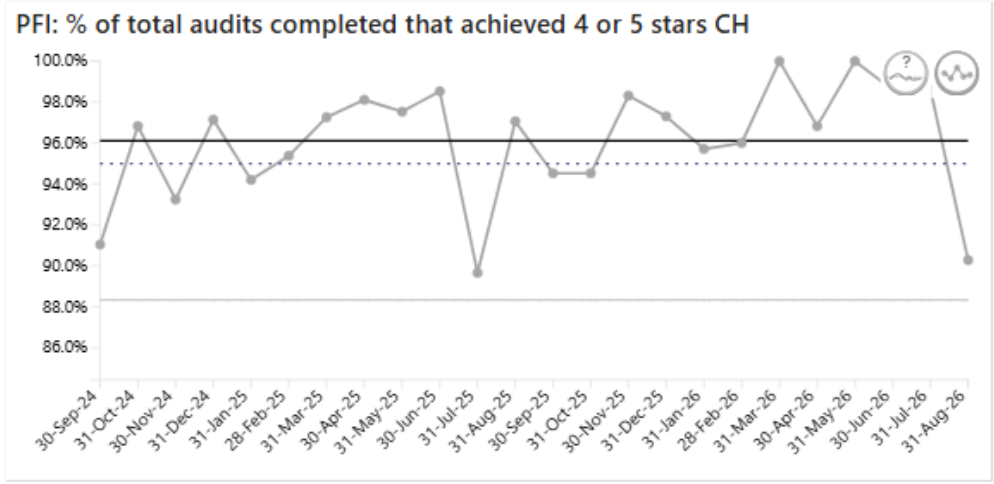
August 2026 v2	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury 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%	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't know
SUWON																												
Gastroenterology (7F)	7.95	7.86	8.2	98.92 %	0	29	5	1	3		2	5	15.80%	13.40%	6.70%	12.50%	42.10%	No	0.51%	8.29	16.32%	7	8	0	1	1	0
Gynaecology Ward - JR	5.02	5.37	8.1	98.92 %	0	0	0	0	4		0	2	8.40%	0.00%	4.00%	0.00%	14.30%	Yes	0.17%	8.86	14.25%	0	0	0	0	0	0
Haematology Ward	7.56	8.66	9.8	100.00 %	0	17	3	0	7		1	1	6.70%	12.50%	4.10%	4.40%	33.60%	Yes	-0.12%	8.57	16.53%	7	1	0	0	0	0
Katharine House Ward	9.70	8.88	10.8	100.00 %	0	6	1	1	1		1	2	0.00%	0.00%	4.20%	0.00%	18.00%	Yes	1.84%	8.57	12.34%	0	0	0	0	0	0
Oncology Ward	7.68	7.67	7.4	98.92 %	0	4	0	0	1		3	4	-2.70%	3.80%	3.10%	15.50%	21.40%	Yes	-0.34%	8.57	17.48%	2	0	0	0	0	0
Renal Ward	7.60	7.59	8.1	97.85 %	0	6	0	0	0		0	0	24.90%	0.00%	4.10%	0.00%	52.80%	Yes	1.03%	8.71	14.64%	1	0	0	0	0	0
SEU D Side	7.70	7.71	7.6	100.00 %	0	0	0	0	3		0	2	11.60%	0.00%	5.30%	0.00%	22.20%	Yes	-0.23%	8.86	14.92%	6	2	0	0	0	0
SEU E Side	7.66	7.88	7.9	100.00 %	0	0	3	0	2		0	1	11.70%	14.10%	9.30%	0.00%	17.40%	Yes	-1.27%	8.86	16.18%	7	6	0	0	1	0
SEU F Side	6.94	8.93	7.9	100.00 %	1	0	2	0	0		1	5	13.80%	4.50%	3.30%	0.00%	19.30%	Yes	-1.05%	8.86	12.88%	9	1	0	0	0	0
Sobell House - Inpatients	7.75	8.35	8.5	100.00 %	0	1	2	0	0		4	5	32.50%	28.40%	7.40%	0.00%	50.40%	Yes	1.72%	8.57	15.79%						
Transplant Ward	8.80	7.71	7.8	98.92 %	0	16	0	0	8		0	1	41.60%	22.90%	6.30%	0.00%	41.60%	Yes	-1.38%	8.86	15.03%	11	1	0	0	0	0
Upper GI Ward	9.44	7.38	7.6	100.00 %	0	10	0	0	2		2	3	13.00%	8.80%	3.10%	4.50%	19.70%	Yes	-0.59%	9.29	15.04%	7	0	0	1	0	0
Urology Inpatients	8.32	8.60	8.1	100.00 %	1	0	1	0	1		0	3	7.10%	7.50%	3.20%	0.00%	20.80%	Yes	1.41%	9.43	16.18%	0	1	0	0	0	0
Wytham Ward	6.82	7.13	7.2	100.00 %	0	2	6	0	1		0	1	15.00%	0.00%	6.90%	0.00%	33.40%	Yes	-0.41%	9.29	17.84%	7	4	2	1	0	1
MW Intrapartum Team	14.58		17.2		0	0	28	2					-19.20%	17.80%	8.70%	0.00%	4.00%	Yes	-1.60%	7.71	12.01%						
MW Level 5	5.40		4.7		0	0	0	0										Yes	0.14%	7.71	15.76%						
MW Level 6	4.60		8.2		0	0	6	0					-9.40%	12.40%	6.70%	4.00%	34.40%	Yes	-0.02%	7.71	13.83%						
MW Level 7 (Bereavement)	-		9.1		0	0	1	0										Yes	0.36%	7.71	25.46%						
OCC/CICU	26.60		34.4	100.00 %	-	-	-	-	4		2	0	10.90%	13.40%	5.20%	6.30%	28.10%	Yes	-1.36%	8.29	8.88%						

3. Assurance report: Estates, Facilities and PFI



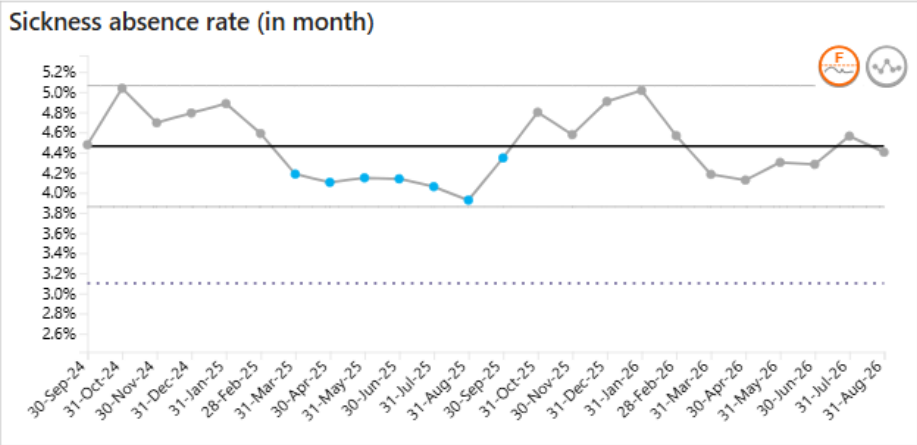
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In August 2026, the combined PFI % cleaning score by site (average) for the JR was 96.35% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, with JR sitting at 93.04% which is below the 95% Trust target. In total, at the JR, 230 audits were conducted,16 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.	Mitie completed les than the planned number of audits at the JR in August 2026. 239 audits were scheduled and 230 completed. This decrease is due to the last day of the month being a Monday.FR1 audits are always scheduled by the week commencing date and so have been scheduled in August and completed in September yet remain complaint.. Mitie had 16 of the 230 audits fail to achieve the set Trust target under domestic and clinical. However, all the failed audits are rectified. Of the 16 failed audits 11 were in ED, these are invariably caused by cleaning elements that are the responsibility of clinical staff. Measure are currently being put in place to support the clinical teams in this matter. The other failed audits seem to be one-time failures in different areas at JR. 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 the JR. 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*

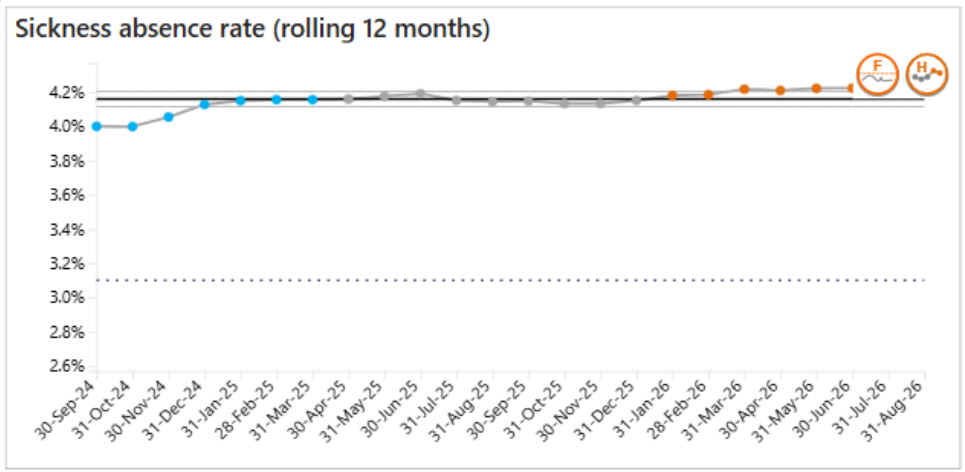
3. Assurance report: Estates, Facilities and PFI



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 August 2026, the combined PFI % cleaning score by site (average) for the CH was 95.97% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, with CH sitting at 90.28% which is below the 95% Trust target. In total, at the CH they conducted 72 audits, 7 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.	G4S completed more than the planned number of audits at the CH in August 2026. CH were scheduled to complete 68 audits and completed 72. G4S had 7 audits that did not achieve the set Trust target under domestic and clinical. However, all the failed audits are rectified, resulting in an improvement in the reported percentage. In August at CH, it was noted that there were some staffing and supervision challenges caused by short term staffing issues, while most were FR1 they did not fail again in the following auditing periods. 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 the CH 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



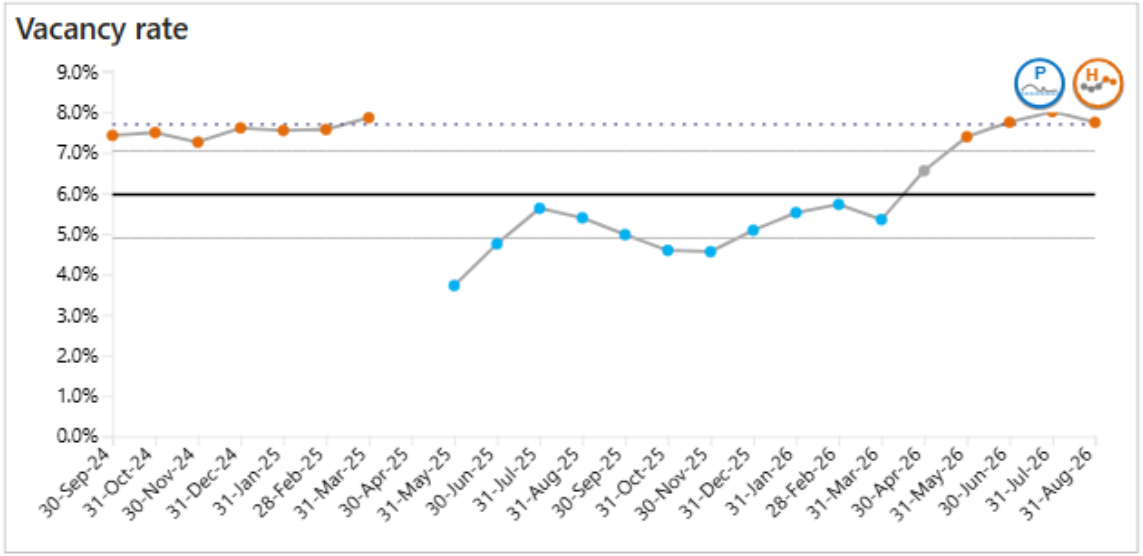


Benchmarking: May 2026 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.09% **National: 5.15%** **Shelford: 4.41%** Buckinghamshire Healthcare NHS Trust: 3.74% Royal Berkshire NHS Foundation Trust: 3.01% Oxford Health: 4.88% South Central Ambulance Service: 6.66%

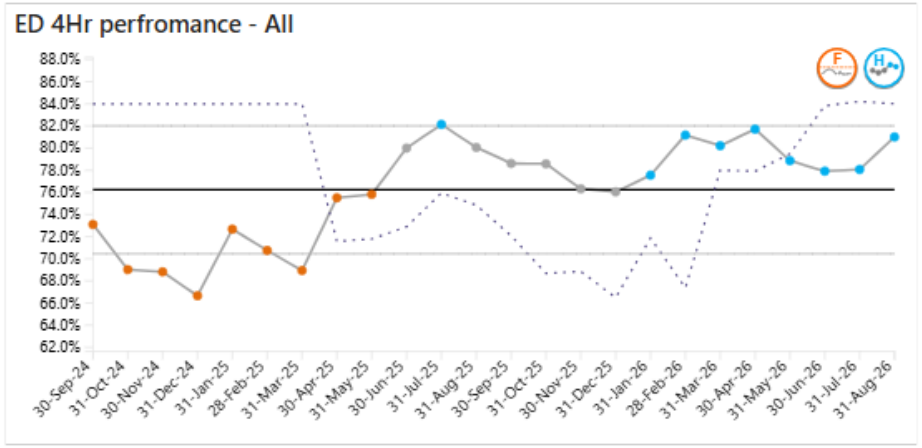
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality rating
Rolling sickness absence is 4.3% (monthly rate 4.6%), unchanged from the previous month and remaining above the Trust target of 3.1%. Variation persists across divisions, with NOTSSCaN recording the highest absence rate (5.5%), SUWON 4.5%, MRC 4.4%, CSS 4.0% and the lowest CORP (3.8%). The top 5 key reasons for sickness continue to be: 1. Mental, Behavioural or Neurodevelopmental 2. Musculoskeletal or Connective Tissue 3. Injury, Poisoning or External causes (Includes surgery) 4. Respiratory system 5. Digestive system Long-term sickness top 5 reasons:- 1. Mental, Behavioural or Neurodevelopmental 2. Musculoskeletal or Connective Tissue 3. Injury, Poisoning or External causes 4. Not elsewhere classified 5. Neoplasms	• Divisions receive a monthly report outlining the top 10 reasons for sickness absence. These reports are used to inform targeted action plans, with a particular focus on Cost Service Units (CSUs) reporting higher-than-average absence levels. • Work continues in partnership with Occupational Health to support both managers and staff in understanding and addressing the key drivers of absence. A priority area remains providing tailored interventions for colleagues experiencing long-term sickness absence, with the aim of enabling a safe and sustainable return to work. • Managers receive absence trigger notifications and are provided with guidance to support effective case management. HR continues to promote line manager training to strengthen capability and confidence in managing sickness absence consistently and proactively. • Return-to-Work (RTW) processes have been streamlined through updated documentation and enhanced guidance to support more meaningful and effective RTW conversations. Local workshops remain in place to build management capability, supported by ongoing Occupational Health engagement through regular monthly meetings to proactively identify and address emerging themes. • In addition, regular meetings with the Wellbeing Lead help identify further opportunities for support, while work continues to standardise sickness absence reason categories to improve consistency, reporting quality, and analysis across the organisation.	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

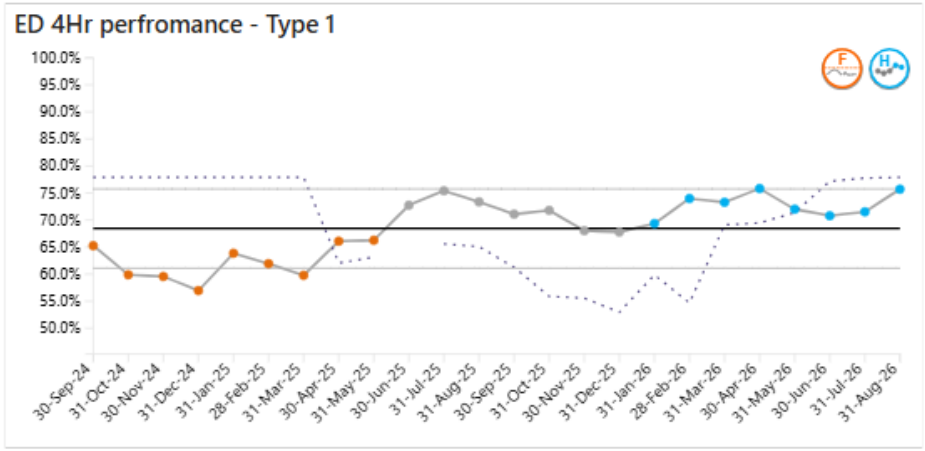
3. Assurance report: Growing Stronger Together



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust vacancy rate has improved to 7.8% in Month 5, down from 8.0% in Month 4, although it remains marginally above the Trust KPI of 7.7%. Improvement has been seen across most divisions, with CSS reducing from 8.9% to 7.7% and NOTSSCaN reducing from 9.2% to 8.9%. MRC continues to report the lowest vacancy rate at 6.2%, remaining below target. While vacancy performance has improved overall, recruitment challenges remain in a number of services and vacancy levels continue to require active management to mitigate operational pressures.	• Targeted recruitment campaigns continue in specialities and services experiencing the highest vacancy levels. • Recruitment pipeline reviews are undertaken regularly to identify and address delays in filling posts • Divisions are implementing local recruitment and retention plans focused on hard-to-recruit roles • Workforce teams continue to support managers to maximise recruitment activity and improve candidate conversion rates • Apprenticeship pathways and career development opportunities are being utilised to strengthen workforce supply. • Vacancy performance is monitored through divisional workforce reviews and escalation processes where vacancy levels present operational risks. • Ongoing focus is being maintained on retention initiatives to reduce turnover and minimise future vacancy growth.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 2331 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

3. Assurance report: Operational Performance

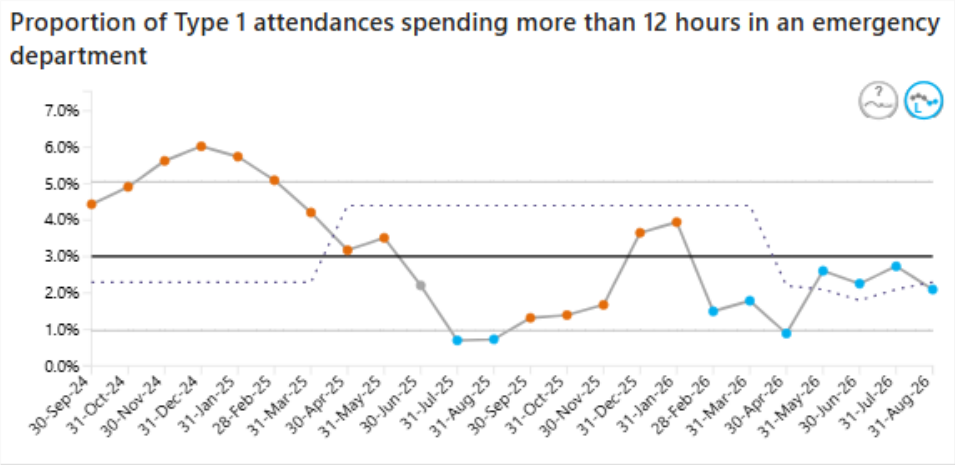




Benchmarking: ED – Attendances within 4 hours (all) August 2026				
OUH: 81.01%	National: 74.22%	Shelford: 77.55%	BHT: 77.72%	RBH: 75.37%

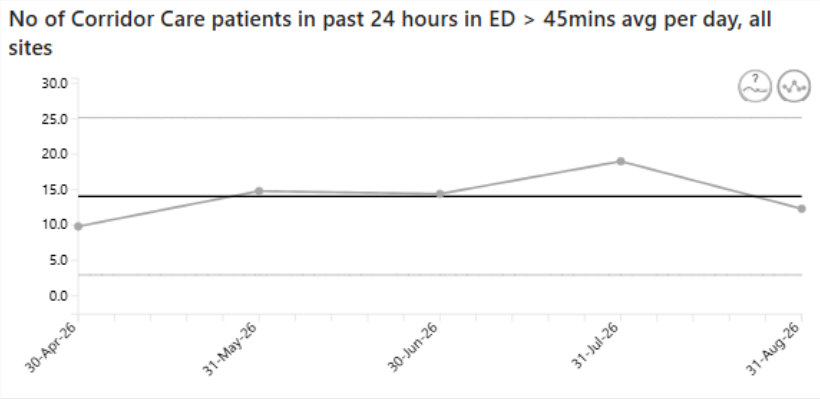
Benchmarking: ED – Attendances within 4 hours (type-1) August 2026				
OUH: 75.7%	National: 60.3%	Shelford: 58.1%	BHT: 68.4%	RBH: 64.3%

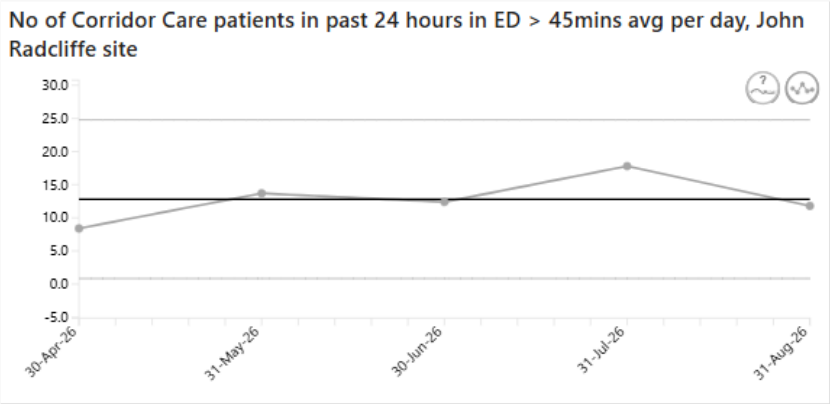
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register
Urgent and emergency care performance remained adverse to plan in August due to sustained increases in demand and significant operational pressures relating to red and amber heat related National Health Alerts. Year to date Emergency Department (ED) type 1 activity is up by 2.9% at the John Radcliffe Hospital (JRH) and 5.1% at the Horton when compared to the same period last year. It should be noted that the type 1 growth in June, July and August have been significantly higher than the average at 7.4%, 5.5% and 6.6% at the JRH. YTD, attendances for all types (type 1, 2 and 3) were 3.3% higher than last year (April to August). Growth has been from non-ambulance arrivals with periods of high arrival intensity, where large numbers of patients presented within short timeframes. These concentrated surges in demand increased departmental occupancy, reduced available operational capacity, and created challenges in maintaining timely assessment, treatment, and patient flow. Operational resilience was further impacted by increased medical and nursing workforce sickness absence, an increase in acuity and dependency of emergency attendances and mental health presentations. The admitted pathway continues to be delayed due to the sustained high number of delayed discharges on the wards. This has resulted in the medical and surgical 'take' being in ED for long periods, further inhibiting ED performance.	• A 'Deep Dive' into urgent care performance in May/June 26 has been completed. Analysis of patient cohort underway noting an increase in under 50's walk-ins. Action 1 – A 'Perfect Week' for the Horton site has been completed week commencing 14 September. Further actions to be confirmed following analysis of the findings. Action 2 – A 'Perfect Week' is planned in October for Children's Emergency Department Action 3 – 'Deep dive' into increasing number of delays, particularly those waiting for onward bedded care. • Level 1 UEC redevelopment to expand Emergency Assessment Unit (EAU) and Extended Emergency Medicine Ambulatory Care (EEMAC) capacity and improved flow models in addition to a UTC merger with Oxford Health NHS Trust to improve capacity and access. This redevelopment is running behind plan, with mitigations being developed to support winter.	TWUCG – 7/10/2026 UCDG – 13/10/2026 TWUCG - November UCDG 29/09/26 Level 1 Redevelopment Programme Board – Q4	

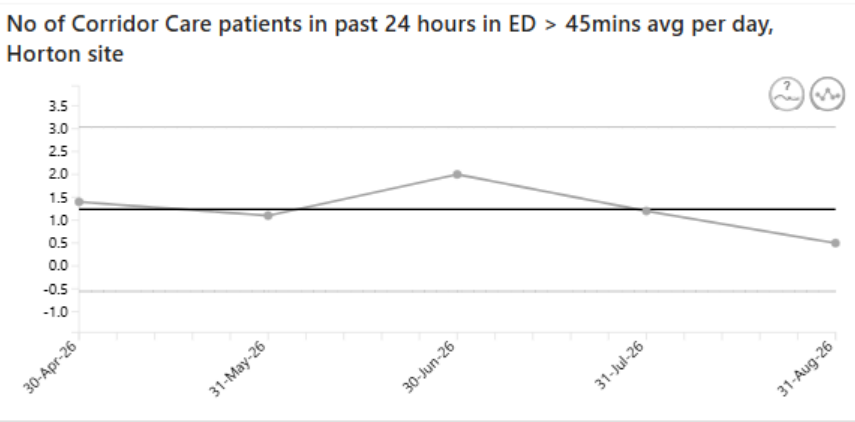


Benchmarking: ED – Proportion of attendances over 12 hours August 2026				
OUH: 2.1%	National: 10.0%	Shelford: 5.2%	BHT: 9.7%	RBH: 3.1%

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
The proportion of patients with an ED length of stay less than 12 hours improved in August at 97.9% and was within plan. By site, the Horton achieved 99.85% and the JR 97.11%. As previously noted, the increase in type 1 activity was the largest contributory factor. Flow out of the ED has been a challenge at the JR whilst we attempt to overcome an increased number of patients not meeting the criteria to reside and an increase in acuity resulting in delayed transfer to inpatient beds.	• A 'deep dive' into May's UEC performance overall is underway with learning and action shared internally and with system partners (see previous slide for detail on actions) • Conveyance avoidance and strategies to support crews to utilise alternative pathways is a key area of focus. Collaborative work with SCAS is planned to support this with representation in the JR ED • Improvements and developments are ongoing within adult social care and provider capacity and staffing with limited impact to date on overall non criteria to reside figures.	TWUCG Sept & Oct TWUCG July Ox UCDG September		

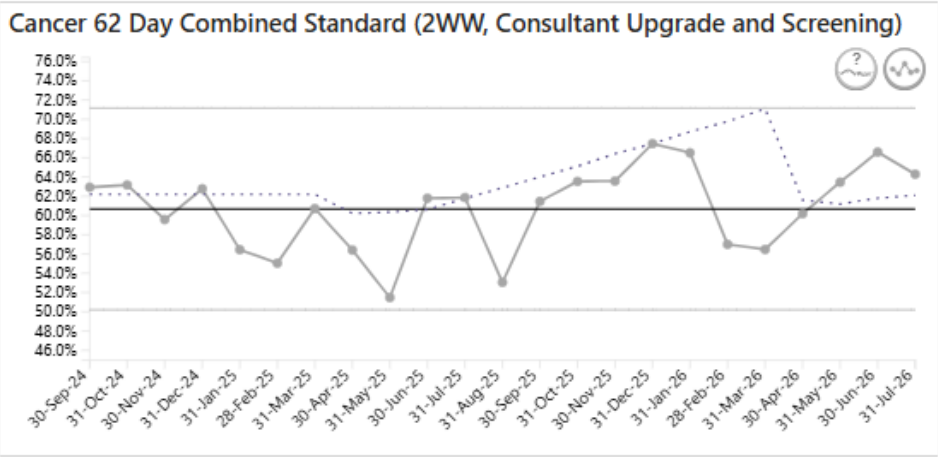






Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
When the emergency and assessment units become congested, to maintain flow at the front door and ensure timely ambulance handover, patients are placed in the corridor. Within ward areas, to facilitate early morning flow out of the Emergency Department, patients who are for discharge are sat out in a suitable space. This can be in the corridor if the Discharge Lounge is not used, or alternative day room if not available on the wards. In addition, the Surgical Emergency Unit (SEU), to support ED historically placed patients in the corridor to support flow. Providing care to our patients in corridors is far below the standard of care that we aspire for our patients and is below the expectations of the public. As well as patient and staff experience implications, there is also clinical risk to our patients. Despite the ongoing urgent and emergency care pressures, the average number of patients cared for in an ED corridor improved in August and is seen predominantly at JR. The Horton has very minimal episodes of corridor care and is related to space restrictions and estate. Whilst this was an improved position, is still far from our ambition and the standard of care that we aspire to provide to our patients. There have been no episodes of ward corridor care since April outside of SEU. Early signs shows good improvement however in SEU with no episodes since 24 June. It is also important to note that the average ambulance handover time has reduced by 2minutes 30seconds in the year to date demonstrating OUH's prioritisation and partnership working.	**** Corridor Care Taskforce initiated May 2026 **** In line with national guidance, OUH has taken the following steps to prioritise the reduction of corridor care across all clinical areas: ○ Established two Corridor Care Taskforce Groups, led by the Deputy Director of Urgent and Emergency Care. One taskforce group focused on the Emergency Department, while the other focuses on Ward areas. Improvements to escalation, process, governance and data quality were achieved. ○ A new combined Corridor Care taskforce was then established in August with representatives from all Divisions, key areas where corridor care has been significant, and the Corporate Division, and continue to ensure that quality improvement (QI) methodology and data are used to inform decision-making and measure progress. ○ The taskforce meets fortnightly to ensure actions and key priorities are progressing at pace. ○ A self assessment against the GIRFT Corridor Care Improvement Guide has been undertaken in August and will form the basis of the improvement work. ○ Four priority work streams have been identified following this review:- Discharge Lounge, ED Streaming, Full Hospital Protocol and Healthcare Professional referrals to SCAS. ○ National GIRFT seminars attended to gain insight into the current national picture and incorporate emerging learning across OUH.	Alternate TWUCG meetings update with completion of workstreams planned for November 2026	ED – 2375 SEU - 3460	

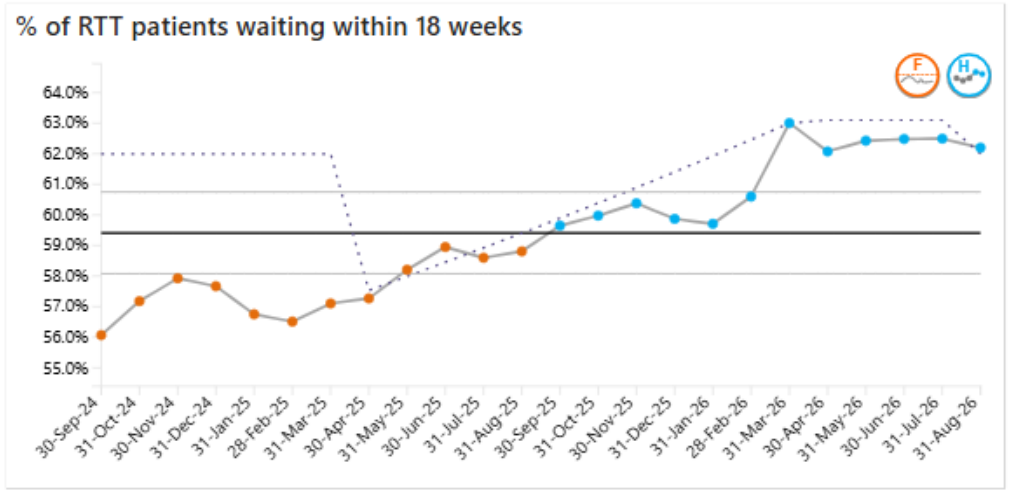
3. Assurance report: Operational Performance, *continued*

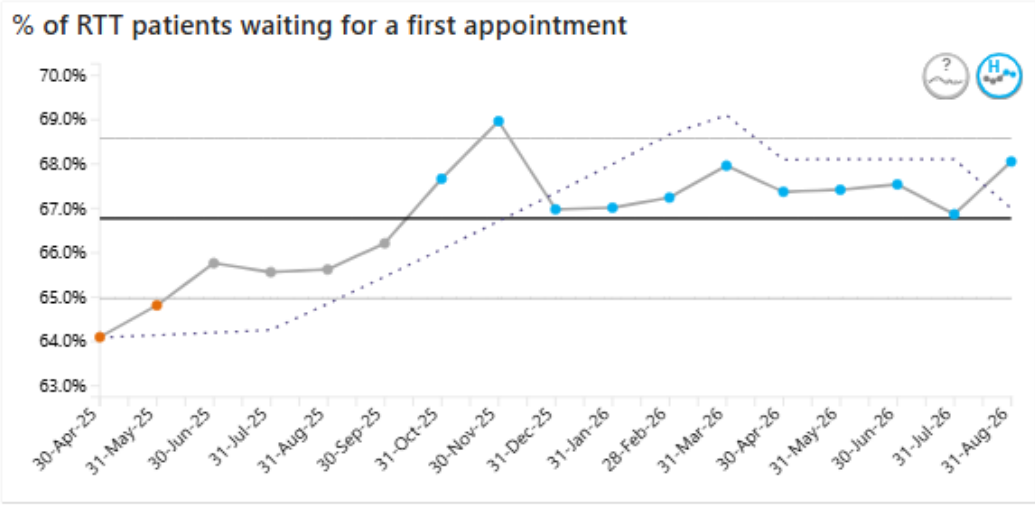


Benchmarking: Cancer – Patients Treated Within 62 of Referral July 2026				
OUH: 64.34%	National: 72.48%	Shelford: 68.46%	BHT: 58.64%	RBH: 81.42%

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
Performance in M5 was 64.3% and better than the operating plan target of 62.1%. Performance exhibited Common Cause Variation. Performance is reported two months in arrears due to the extended reporting period for this indicator.	**Currently on plan for 62-day, though below national expectation.** **MDT Streamline:** Demand and Capacity toolkit developed by an external supplier to review every Tumour Site MDT to identify inefficiencies and recommend lean working for optimal utilisation. Tumour site liaison and meetings being held along with Cancer Management and Quality Improvement teams. **Weekly Cancer Delivery Action Group:** CDAG meeting held every week with 3/4 tumour sites at a time, tracking progress of top 3 priorities selected by the group. Key Recovery Actions based on Key Lines Of Enquiry evidenced by analytic reports. **Haematology Workshop (Sep 2026):** Scheduled for Tuesday 29th September **Sarcoma Workshop (Sep 2026):** Held 9th September with change ideas identified to further improve performance **Brain Workshop (Jun 2026):** Held 18th June to drive sustainable improvements to move in the top quartile nationally for 28-day Faster Diagnosis standard and treat all patients within 62-days. Monthly updates via weekly CDAG ensure top priority interventions in process. **Cohort 4 (Mar 2026):** 3-Tumour sites workshop held 20th March for Bladder, NSS and SACT. 100-day plans completed in June for Bladder and NSS with SACT taking a strategic approach for longer term gains. Service to continue progressing plans for ongoing interventions and identify new ideas.	Cancer Strategy & Improvement Group – September 2026		

3. Assurance report: Operational Performance, *continued*



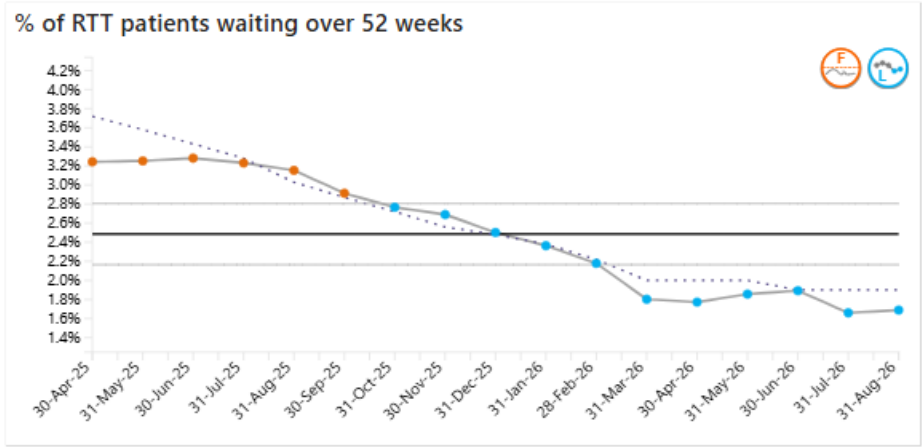


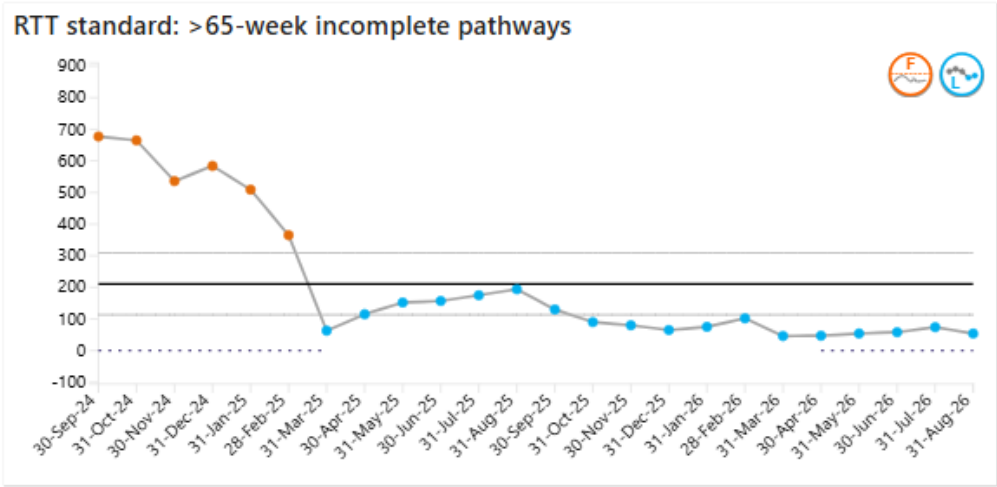
Benchmarking: RTT Patients Waiting within 18 Weeks July 2026 NOF Q1 score of 3.20

OUH: 62.50% National: 66.01% Shelford: 66.84% BHT: 63.74% RBH: 83.27%

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 less than 18 weeks as a proportion of the total waiting list was 62.2% at the end of August against an operational plan of 62.0%. Performance exhibited special cause of improvement due to more than six consecutive periods of performance above the mean. Total incomplete RTT pathway waiting list size was 89,940 for August with *68.1% of patients awaiting a first appointment below 18-weeks. *using the weekly NWL submission officially however when using the monthly return, performance was 68.4%	The key focus is on treating patients with the longest waits across all specialties. The Trust has shown improvement in the last six months. We remain on plan (within 1% of RTT) from M1 to M5. Validation continues – utilisation of resources for administrative validation to scrutinise pathways above 18-weeks. With focus moving away from total waiting list to instead the longest waiting patients. An Outpatient Improvement Programme and a Theatres Improvement Programme are in place. Digital outcome form roll-out all specialties continues with vast majority in place (lead time to fully conclude tbc), supporting clinicians to place eligible patients on a Patient Initiated Follow-Up (PIFU), creating capacity for patients clinically required to be seen and potential to converting follow-up slots to new slots thus driving productivity opportunities. Additional Insourcing solutions are planned from August onwards in ENT, OMFS, Gynaecology and Dermatology. Additional elective capacity through the Surgical Elective Centre (Level 1) operational plan assumed July; this is now Q3 and Level 2 is subject to revenue requirements, Board and ICB approval.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly 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*



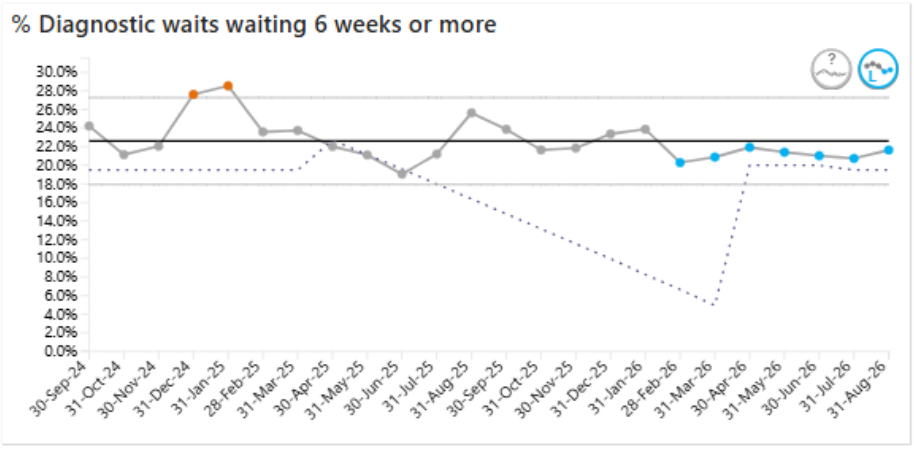


Benchmarking: RTT Patients Waiting over 52 Weeks July 2026 NOF Q1 score of 3.53

OUH: 1.66% | National: 1.10% | Shelford: 0.84% | BHT: 0.10% | RBH: 0.10%

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 54 at the end of August. Performance exhibited a positive special cause of variation due to exceeding below the lower control limit. We remain committed to eliminating patients waiting over 65 weeks but did not deliver this for August. **Focus remains on longest wait patients:** **>104 weeks - nil** incomplete pathways reported. **>78 weeks - 1** incomplete pathways reported. Patient scheduled in October following several attempts to bring forward. **>65 weeks – 54** incomplete pathways reported which is an decrease from the previous month (74) by 20 pathways. Focus remains in place to deliver nil pathways. Other less challenged services have moved to recovering **52-week backlog and 18-week performance.**	**ENT services**: Audiology insourcing in place to support with backlog recovery. Insourced ENT clinics continues. All new appointments in the 52-week cohort have been scheduled. Additional senor level validation being undertaken. The addition of administrative time to support this has been welcomed. Service is reducing its backlog steadily. **Gynaecology services:** Additional theatre slots scheduled, insourcing focusing on outpatients. Locum specifically assigned to focus on delivering 40-weeks in outpatients for endometriosis. Undergoing clinical pathway redesign in effect from M4. This remains a challenged speciality and is likely to remain so for a period of time, there is no mutual aid supported. **Oral-Maxillio Facial services:** Additional activity underway. Share of septorhinoplasty cases between appointed consultant and senior specialist. A few **other specialities** who have a small number off breaches each contributing - specialities have been asked to address each month as this is not acceptable. **Delivery Action Plan**: Live and populated against specialty level trajectories – introducing new framework for tracking deliverables in conjunction with weekly check and challenge meetings.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly 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*

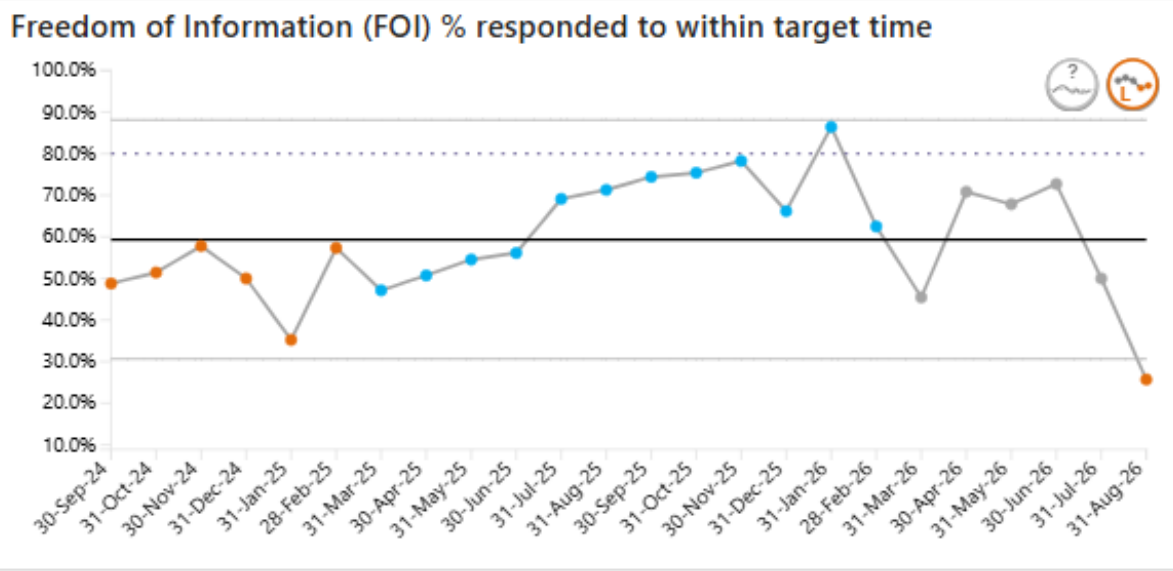


Benchmarking: Diagnostics waits over 6 Weeks July 2026 NOF Q1 score of 2.89

OUH: 20.72% National: 18.63% Shelford: 23.12% BHT: 19.17% RBH: 9.02%

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
The number of patients waiting more than 6 weeks as a proportion of the total waiting list was 21.6% at the end of August against an operational plan of 19.5%. Performance exhibited common cause of variation.	All modalities asked to over deliver where possible to support “Trust total" delivery. Focus remains on the under 17-year-old cohort as well as total waiting list. Specialities are reviewing the "longest waiting" patients to determine if clinical and administrative validation could be applied. The teams are working to the end of September to complete this work based on the administrative capacity across all Elective pathways. **Endoscopy:** Oversight of list utilisation and ensure maximum opportunity is delivered and maintained. Patient Engagement exercise completed to obtain list of patients willing to be scheduled at very short notice. Improved focus on validation, with particular focus on 13-week long waits and completing Root Cause Analysis targeting admin improvements, booking discipline and patient engagement. **Neurophysiology:** Stabilisation of workforce by supporting return to full staffing (e.g. phased return staff) Accelerating recruitment pipeline where gaps remain whilst maximising existing capacity including expansion of insourcing Clinical pathway reviewed to assess whether all referrals require neurophysiology testing and explore alternative appropriate pathways **Audiology:** Delivery Fund scheme to insource capacity and is delivering an additional 500 units of activity per month. Estates work completed at the Horton for a dedicated facility. First clinic held on 21st August. CDC activity commenced in Feb. Validation plan in place with newly recruited band 6 to deliver the agreed changes. **Non-obstetric Ultrasound**: Delivery Fund scheme has supported sufficient capacity to tackle demand. Performing above plan, which is offsetting some of the other modalities under performance	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews		

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

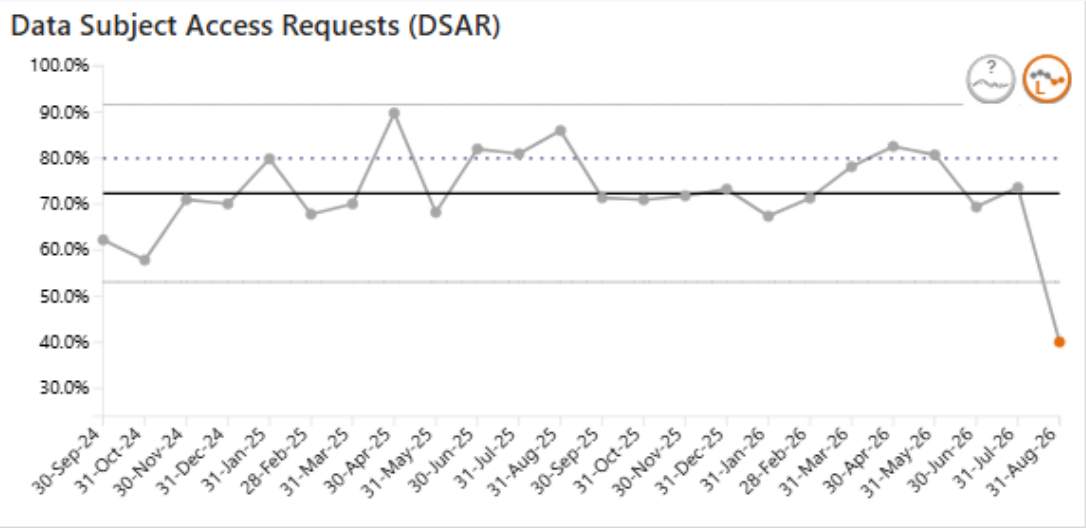


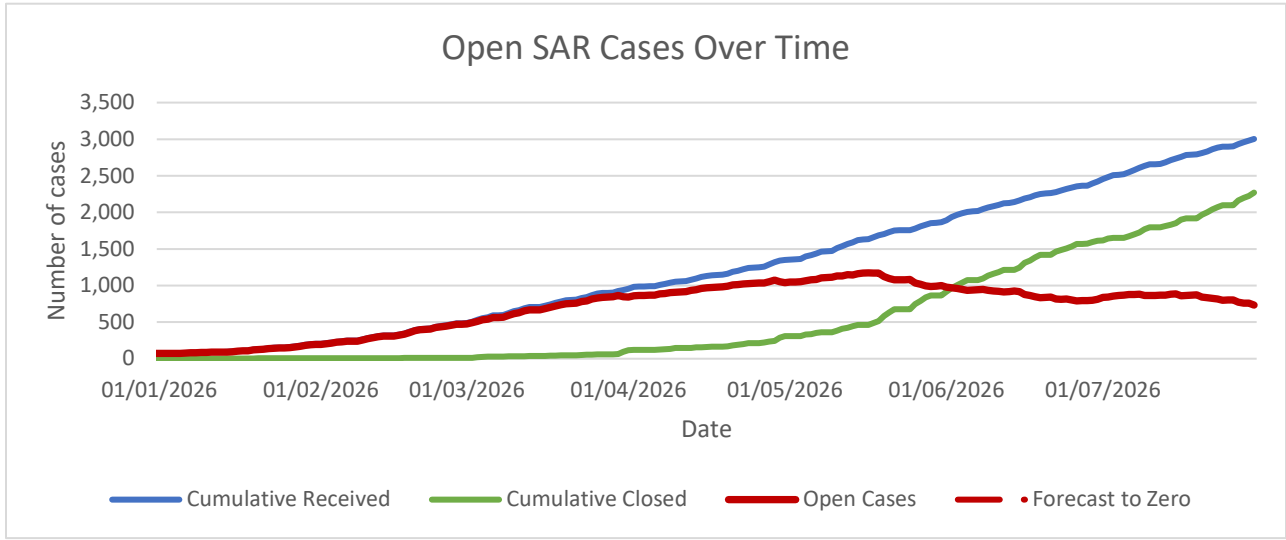
Breakdown of open FOI cases by area

Clinical Support Services		10
Maternity		8
Chief People Officer		6
SuWOn		5
Data and Analytics		5
Estates and Facilities		5
Information Technology		3
Legal Services		2
Workforce		2
Procurement		2
Secure Data Environment		2
Patient Experience		1
Research and Development		1
Chief Operating Officer		1
Digital		1

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
M5 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 26%. 36 new cases were received in M5, of which 9 were closed on time – in total 26 cases were closed as efforts to close complex overdue cases continue. E-Case is not synced to "What Do They Know" so 55 outstanding cases from that website were added to the total this month and need to be worked as a priority. The rise of AI LLMs is increasing the complexity of requests received, as requests are frequently imprecise or incorrect, making them hard to interpret, requiring clarification from the requester, who often does not understand the question they have submitted.	Maternity cover for the vacancy in the IG team has started and is being trained – the number of cases being closed as a whole is now accelerating. Feedback from divisional and departmental colleagues who had their e-Case onboarding has been positive, and feedback has been passed to the developers to facilitate further improvement. This will enable enhanced local management and escalation of complex cases and cases at risk of breaching. The ICO have issued guidance on dealing with AI requests, but the feedback to them has been that it needs to be much more robust – we are awaiting their response to this.	Updates provided to Digital Oversight Committee and Delivery 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*

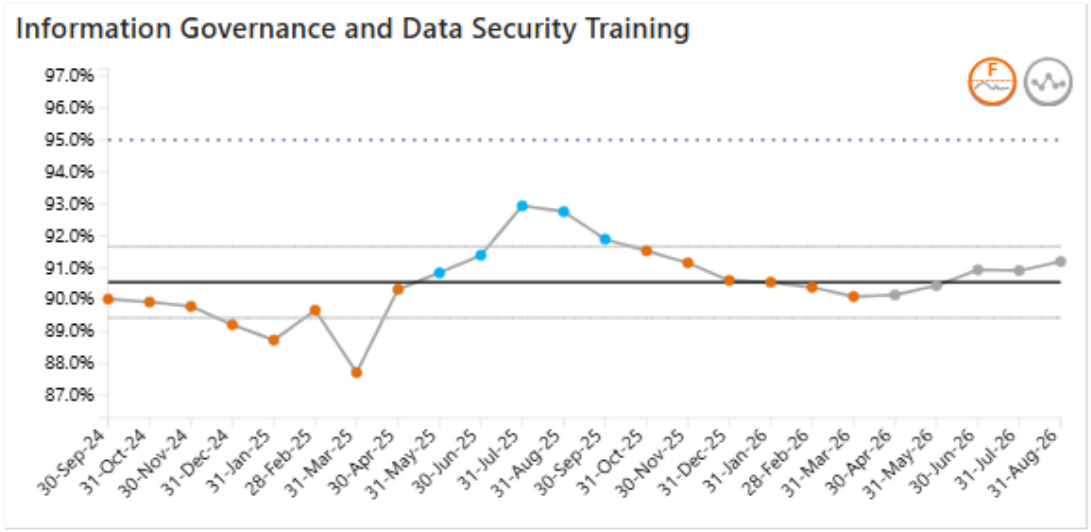
3. Assurance report: Corporate support services – Legal Services, *continued*





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 M5, the Trust received 1,213 SAR requests—25% more than M4—and closed 486 on time. The medical SAR team continued clearing the backlog, with 65 of 673 new requests completed on time. The ICO acknowledged the Trust's 31 July update and requested another in October. Performance was affected by maternity cover ending on 19 August and staff annual leave and unplanned absence. Medical SARs closed: 514. Overdue cases fell to 144 from 184 in M4, down from a peak of 808. Occupational Health closed 100% of their 255 cases on time PACS closed 67% of their 327 on time – this unusually low figure (they are usually over 95%) was a result of clinical pressures and annual leave.	E-Case is now well embedded and updated processes to reflect the Data Use and Access Act are in place and realising benefits –	Updates provided to Digital Oversight Committee and Delivery Committee	BAF6	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



Division	Employ	Heads Ou	% Compl
Operational Services	207	13	93.7%
Estates	175	12	93.1%
Corporate	1164	106	90.9%
SuWON	3290	302	90.8%
MRC	3194	302	90.5%
Clinical Support Services	2292	227	90.1%
NOTSSCAN	3397	384	88.7%
Research and Development	165	26	84.2%
Hosted Services DIV	47	8	83.0%
Operating Expenses	11	4	63.6%
Education and Training	63	35	44.4%

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 91.2% in M5 – a 0.3% increase on M4. The expected increase in compliance as a result of appraisals has been minimal this year, the peak of 91.2% is below the Trust's appraisal completion rate of 93.8% suggesting that a number have been marked as complete even though the IG training was not current. No divisions are achieving 95% and this month's performance exhibits common cause variation. Corporate, NOTSSCAN, R&D and Education are below 90%	1420 staff are currently non-compliant, a decrease of 67 on M4. All divisional governance teams have visibility of their staff training levels and can access reports which name non-compliant individuals to help them manage the situation. Cyber awareness activity is being re-energised as part of the new OUH Cyber Security Strategy, starting with Cyber Awareness Month in October and with quarterly campaigns to follow. This will include signposting to mandatory training (currently a joint Information Governance / Cyber course) and wider awareness material.	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

4. Assurance framework model a) *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*

4. Assurance framework model b) Assurance reports and Framework for Assurance

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