Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 30 September 2026**

**TB2026.80**

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| **Title:** | **NHS Oversight Framework 26/27** |

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|---|---|
| **Status:** | **For Information** |
| **History:** | **NHS Oversight Framework Q3 update. TME on 27 August 2026** |

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| **Board Lead:** | **Chief Operating Officer** |
| **Presenter:** | **Felicity Taylor-Drewe, Chief Operating Officer** |
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| **Confidential:** | **No** |
| **Strategic Pillar:** | **Performance** |

## Executive Summary

1. The updated NHS Oversight Framework reflects the ambitions of the 10-Year Health Plan and the Medium-Term Planning Framework, balancing short-term delivery with longer-term sustainability.
2. For 2026/27, Integrated Care Boards (ICBs) will be segmented (segments 1-4) in parity with providers, strengthening accountability for delivery of NHS priorities.
3. Providers will continue to be segmented (segments 1-4) alongside 'ranking' nationally in their respective field.
4. High-performing organisations will be supported with more autonomy and can access agreed incentives, including eligibility for the Advanced Foundation Trust model and certain capital freedoms.
5. Organisations needing the greatest support will receive targeted support and, where required, increased scrutiny and regulatory action. This will include entry to the National Provider Improvement Programme or Intensive Recovery Programme.
6. This Framework is for one year as the operating model continues to evolve and the approach will be updated again for 2027/28 to reflect any further changes to roles across NHS England, DHSC, ICBs and providers and technical changes in metric definitions.
7. The technical guidance for the NHS Oversight Framework 2026/27 was published 9 July, this paper makes a number of recommendations based on this. Within this guidance the documentation describes contextual and scoring for each indicator.
8. A review of the new metrics for 2026/27 against the current OUH Integrated Performance Report (IPR) has identified that, of the 30 'scoring' indicators, 14 indicators are currently reported in IPR, seven are reported separately to Trust Board but not included in the IPR, and nine new indicators are not currently reported in IPR. Of the six contextual measures (not scoring) two are currently reported in the IPR and four are not currently reported in the IPR. In addition, some scoring indicators are those that we would contribute to and would like to monitor even though they are held at ICB level. For example, inequalities metrics which would recognise our position relative to others for outcomes.
9. It is proposed that, within the IPR, a full dashboard of all scoring and contextual indicators is included from August 2026 to replicate the 2026/27 scoring methodology and measurement period. This will provide TME and the Trust Board with oversight of current performance aligned with the National Oversight Framework 'at a glance'.
10. Benefits of this proposed development includes equivalent measurement periods, which varies in the National Oversight Framework from monthly, quarterly and annual reporting. Additionally, the dashboard will align with the external reporting standards of the National Oversight Framework and highlight, from previous

quarterly updates, the distance between OUH performance and segment boundaries. This will provide vital information on opportunities to improve segment performance as well as risks to deteriorating segments, and corresponding effects on the overall Segmentation score.

11. Assurance reporting in the proposed new dashboard will focus on indicators with a score in segment 3 and 4 and utilise existing IPR assurance templates for consistency.

12. New indicators from the Framework will also be added to the IPR metrics, where feasible, for monthly measurement.

13. New metrics within the National Oversight Framework will be incorporated within the Performance Management and Accountability Framework. In addition to the IPR, this will involve adding the new metrics to the reports overseen by supporting performance Committees and Groups, including the Outpatient Improvement Group, Trust Wide Urgent Care Group, the Elective Delivery Group, Divisional Performance Reviews and the Clinical Governance Committee.

## Recommendations

14. The Trust Board is asked to:

- Note the summary of the NHS Oversight Framework, the new measures and governance arrangements
- To approve the publication of a new summary within the IPR that aligns for:
    - New indicators
    - The timing methodology applied in ‘scoring’ methodology
    - Consistent use of templates
    - Accountable officers in line with the existing metrics
- Note continued monitoring within the OUH Performance Management and Accountability Framework.

## Contents

## NHS Oversight Framework 26/27

### 1. Key features of the NHS Oversight Framework and changes from 2025/26

1.1. NHS England has published the NHS Oversight Framework 2026/27, setting out how Integrated Care Boards (ICBs) and NHS providers will be monitored, assessed and supported under the new NHS operating model. The framework supports the ambitions of the NHS 10-Year Health Plan and is intended to create a simpler, more transparent and rules-based approach to oversight, with clearer expectations, incentives and consequences.

### 2. Key changes made to the framework for 2026/27 compared to 2025/26

2.1. Alignment of the segmentation approach for ICBs and providers: ICBs were not segmented in 2025/26 due to a recognition of structural changes taking place, but they will be during 2026/27. There will be an ICB league table but potentially, not until the end of the year.

2.2. Updates to the oversight metrics: aligned to the Medium-Term Planning Framework.

2.3. Refinement to the delivery segmentation methodology: to bring stability to segmentation and allow for easier tracking of improvement (thresholds rather than quartiles).

2.4. Clearer oversight response model: linking delivery segmentation, organisational capability, and ongoing monitoring to engagement, support, incentives, and consequences.

2.5. Simplification of Segmentation: back to a 1 to 4 model. In 2025/26, ‘segment 5’ was applied to providers with segment 4 performance and ‘red’ capability. Removing the segment 5 label improves clarity and consistency, with providers with segment 4 performance and ‘red’ capability, still being eligible for participation in the National Provider Improvement Programme (NPIP).

2.6. New Intensive Recovery Programme (IRP) with national team working with regions to agree the scope of this and alignment with NPIP.

### 3. Key features of the NHS Oversight Framework in 2026/27

3.1. National direction requires ICBs to move fully into the role of strategic commissioners.

3.2. NHS England to hold direct oversight of NHS providers.

3.3. Oversight arrangements across England are moving towards greater consistency with a rules-based approach, a more disciplined escalation model, and clearer performance expectations.

3.4. Provider oversight combines an assessment of delivery against defined metrics and allocation of a segment (1 to 4); and an assessment of leadership, governance, and delivery capability.

3.5. The oversight response is driven by the outputs of the segmentation, capability assessment and other considerations from ongoing monitoring to guide engagement intensity, potential incentives, support, and (where necessary) intervention.

3.6. ICB oversight in 2026/27 will be delivered through a combination of: quarterly performance segmentation across six domains; statutory Annual Assessment and routine monitoring.

3.7. Regional oversight of ICBs will cover all aspects of ICB commissioning including those for which they have delegated responsibility as undertaken by the (South-East) Office of Pan ICB Commissioning (OPIC) on behalf of the 4 ICBs and will be guided by: NOF, Strategic Commissioning Framework & Development Programme.

3.8. Roles of each organisation are summarised in the table below.

**3.9. Table 1: Organisational oversight responsibilities**

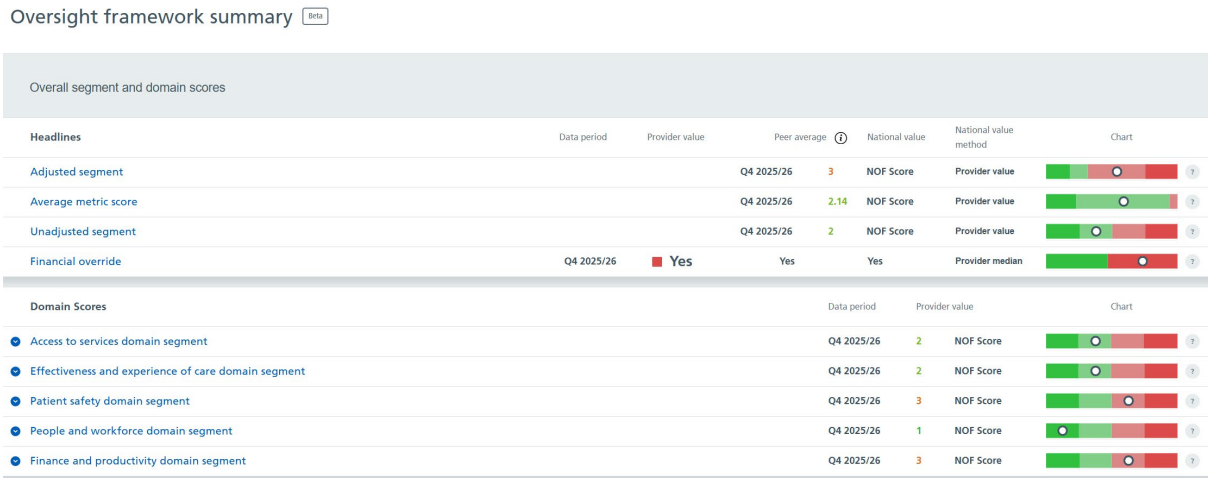
| Organisation | Oversight Responsibilities |
|---|---|
| **NHS England National** | • **Setting overarching oversight policy**<br>• Ensuring **consistency** of implementation including **moderation** of capability assessments<br>• **Calculation** of oversight segments<br>• Agreeing the use of support and intervention, including diagnostics, when this would require national resources<br>• Coordinating cross-boundary risks and issues that require a national view (for example, where risks span multiple systems or regions) |
| **NHS England Regional** | • **Strategic and tactical oversight of providers** i.e. formal board capability and daily performance management<br>• Leading day-to-day oversight of provider and ICB delivery<br>• Making assessments of NHS organisational capability<br>• Calibration of support and intervention based on analysis of regional risk profile<br>• **Quarterly review of oversight arrangements against NOF segmentation and capability is required to be taken through RSG and reported to national team with any key changes.**<br>• Escalating major issues where these constitute sufficient risk or complexity<br>• Undertaking and coordinating **Annual Assessments of ICB** performance and capability<br>• Enacting the use of **regulatory enforcement powers** in line with guidance and governance |
| **ICBs** | • **Contract-managing** and assuring commissioned services (including those commissioned on behalf of NHS England) and using contractual levers to address non-delivery<br>• **Self-assessing** capability and performance<br>• Operating **a 'no surprises' approach** and escalating major issues where these constitute sufficient risk or complexity |
| **Providers** | • **Accountable for delivery and improvement** across all domains<br>• Assuring delivery of contracted services and statutory functions in line with Insightful Board expectations<br>• **Self-assessing capability and performance** and maintaining effective quality governance, including learning and improvement following patient safety incidents in line with the Patient Safety Incident Response Framework<br>• Operating **a 'no surprises' approach** and escalating major issues where these constitute sufficient risk or complexity |

## 4. Indicators measured in 2026/27

4.1. As at Q4 2025/26, under the previous metrics measured within the National Oversight Framework, OUH was in Segment 3, due to the financial override. Domain scores ranged from 1 to 3, as shown in the figure below, with a further range of performance against each metric within the domains.

Appendix 2 identifies the provider values and NOF score against each area within domain segments. If all things remained the same, without the financial override OUH could / would have been placed in segment 2.

## 4.2. Figure 1: Quarter 4 2025/26 Oversight framework summary




**Source: Model Health System**

4.3. All new metrics have been reviewed by NHSE to ensure alignment with the Medium-Term Planning Framework ambitions for 2026/27 as well as wider integration with strategic direction as set out in the 10 Year Health Plan.

4.4. Delivery metrics are classed as scoring or contextual. Scoring metrics are robust, comparable and are used in the calculation. Contextual metrics are informative but not comparable or not yet sufficiently mature; they are used to support how NHS England responds to segmentation rather than informing the calculation itself.

4.5. There are 86 metrics included in the NHS Oversight Framework, 35 which are applicable to Accurate Trusts and for the OUH there are 30 scoring indicators.

4.6. Changes from 2025/26 metrics are summarised in the table below and include 10 more indicators for Acute Trusts.

4.7. **Table 2: NHS Oversight Framework metric changes compared to 2025/26**

| Domain | Changes from 2025/26 Metrics |
|---|---|
| Population health, prevention & inequalities | • More weight on screening, early diagnosis and modifiable risk factors.<br>• Clearer visibility of deprivation and ethnicity gaps to support targeted action. |
| Access (providers) / Allocating resources (ICBs) | • Elective, urgent care, cancer and mental health remain central.<br>• Greater focus on how resources are allocated to manage demand and flow across pathways. |
| Experience of care | • Metrics better capture discharge, length of stay and out-of-area placements.<br>• Patient and staff experience measures continue to inform oversight. |
| Effectiveness of care | • Metrics reflect whether care delivers outcomes, not just activity.<br>• Reinforcing proactive, community-based management of long-term conditions |
| Patient safety | • Wider use of safety and harm-related indicators alongside quality metrics.<br>• Staff voice and safety culture measures reinforce learning and improvement. |
| Finance, productivity & innovation | • Stronger alignment with value, productivity and financial discipline<br>• Metrics reflect data quality and the PMs ambitions on research |
| People | • Focus on staff engagement and wellbeing in line with the ambitions of the new staff standards<br>• People measures reinforce leadership, wellbeing and improvement capability. |

## 5. Review of new metrics for 2026/27 against IPR reporting and planned developments

5.1. The technical guidance clarifies that there are indicators that relate to contextual and those that are scoring, The latter are ones whereby Segmentation applies.

**Of the 30 scoring indicators for the OUH in 2026/27 a review has identified**

5.1.1. 14 indicators currently reported in IPR

5.1.2. 7 reported separately to Trust Board but not in the IPR

5.1.3. 9 new indicators not currently reported in IPR.

**Of the six contextual measures (not scoring)**

5.1.4. 2 are currently reported in the IPR and

5.1.5. 4 are not currently reported in the IPR.

5.2. It is proposed that, within the IPR, a full dashboard of all scoring and contextual indicators is included from August 2026 to replicate the 2026/27 scoring methodology and measurement period within the National Oversight Framework. This will provide TME and the rust Board with oversight on current performance aligned with the National Oversight Framework. Importantly, this will include:

5.2.1. Measurement period differences to the IPR. The IPR includes monthly data for nearly all indicators, which is helpful for identifying adverse changes or improvements as soon as possible with the aid of Statistical Process Control (SPC) charts. The National Oversight Framework includes different measurement periods, from monthly to quarterly to annually. As a result, the proposed dashboard will

conform to the way in which performance is reported externally within the National Oversight Framework. This will be presented in addition to all current measurement indicators.

5.2.2. The proposed new National Oversight Framework dashboard will highlight, with reference to the latest published quarterly position, the distance the OUH performance is from segment boundaries. This will provide important information on opportunities to improve segments as well as risks to deteriorating segments, particularly with reference to the latest monthly information in the IPR. It is noted that this cannot predict future segmentation since this is influenced by the performance of all Acute providers, which is not known until after the quarterly updates are published. However, the insights will be useful to identify improvement or deterioration and potential risks to the overall OUH NOF Segment performance at the earliest opportunity. As a result, this proposal will strengthen Trust governance due to improved visibility of performance information in the context of the National Oversight Framework indicators, shown in a dedicated dashboard within the IPR. The proposed dashboard will also monitor selected metrics not applicable for Segmentation for the OUH and applied only at an ICB level. This will include, for example, health inequalities metrics which would recognise our position relative to others for outcomes.

5.3. Addition of new indicators not currently reported in the IPR. Where appropriate, new National Oversight Framework indicators will be included in the main IPR metrics where performance can be measured monthly.

5.4. Assurance reporting from the new dashboard will be linked to indicators in Segment 3 or 4, as identified by the new National Oversight Framework dashboard in the IPR.

5.5. New metrics within the National Oversight Framework will be incorporated within the Performance Management and Accountability Framework. In addition to the IPR, all relevant National Oversight Framework indicators will be included in supporting Committees and Groups. This will include the Outpatient Improvement Group, Trust Wide Urgent Care Group, the Elective Delivery Group, Divisional Performance Reviews and the Clinical Governance Committee.

**5.6. A summary of the status of each of the indicators is shown on the following pages, grouped by indicators reported and not reported in the IPR, and by scoring vs contextual status).**

*14 indicators reported in IPR (scoring indicators)*

| Metric | Status | Included in IPR | Definition | Measurement period | Governance group(s) |
|---|---|---|---|---|---|
| % of cases meeting the 28 day faster diagnosis standard | Scoring | Yes | Percentage of cases receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat (FDS clock stops) within 28 days following an urgent cancer referral. | Quarterly – aggregated quarterly position | IPR, Divisional Performance Reviews, Elective Delivery Group, Delivery Committee, and Cancer Improvement Group |
| % of cases treated within 62 days of referral | Scoring | Yes | Percentage of cases receiving a first treatment for cancer within 62 days following an urgent referral. | Quarterly – aggregated quarterly position. | IPR, Divisional Performance Reviews, Elective Delivery Group, Delivery Committee, and Cancer Improvement Group |
| % of diagnostic referrals waiting over 6 weeks | Scoring | Yes | Of the total diagnostic waiting list the percentage of referrals with a waiting time of six weeks or longer. | Quarterly – latest month in the period. | IPR, Divisional Performance Reviews, Elective Delivery Group and Delivery Committee |
| % of cases waiting over 52 weeks for care | Scoring | Yes | Of the total elective (RTI) waiting list, the percentage of cases with patients who have been waiting more than 52 weeks. | Quarterly – latest month in the period. | IPR, Divisional Performance Reviews, Elective Delivery Group and Delivery Committee |
| % of cases waiting up to 18 weeks for care | Scoring | Yes | Of the total elective (RTI) waiting list, the percentage of patients who have been waiting for 18 weeks or less. | Quarterly – latest month in the period. | IPR, Divisional Performance Reviews, Elective Delivery Group and Delivery Committee |

| | | | | | |
|---|---|---|---|---|---|
| % of patients admitted, discharged or transferred within 4 hours | Scoring | Yes | Percentage of all types emergency department attendances to be admitted, transferred to another provider or discharged within four hours of arrival. | Quarterly – aggregated quarterly position. | IPR, Divisional Performance Reviews, Trust Wide Urgent Care Group and Delivery Committee |
| % of patients spending over 12 hours in department | Scoring | Yes | Percentage of patients exceeding 720 minutes from arrival at an emergency department to admission, transfer or discharge. | Quarterly – aggregated monthly figures. | IPR, Divisional Performance Reviews, Trust Wide Urgent Care Group and Delivery Committee |
| Summary Hospital Mortality Indicator | Scoring | Yes | The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number expected to die based on England figures. | Rolling 12-month. | IPR and Clinical Governance Committee |
| Planned surplus or deficit | Scoring | Yes | Overall planned surplus/deficit for the financial year once deficit support funding is removed. | Annual. | IPR plus other reporting to Trust Board, and Divisional Performance Reviews |
| Variance to plan year-to-date | Scoring | Yes | Variance between the YTD planned surplus/deficit and actual surplus/deficit. | Quarterly. | IPR plus other reporting to Trust Board, and Divisional Performance Reviews |
| Number of cases of MRSA in the last 12 months | Scoring | Yes | 12-month rolling counts of MRSA bacteraemia. | 12-month rolling. | IPR, Clinical Governance Committee and Hospital Infection Prevention and Control Committee |
| Rate of c-difficile | Scoring | Yes | Composite measure of prevalence of Clostridioides difficile infections. | 12-month rolling. | IPR, Clinical Governance Committee and Hospital Infection Prevention and Control Committee |

| | | | | | |
|---|---|---|---|---|---|
| Rate of e-coli | Scoring | Yes | Composite measure of prevalence of E.coli bacteraemia. | 12-month rolling. | IPR, Clinical Governance Committee and Hospital Infection Prevention and Control Committee |
| Sickness absence rate | Scoring | Yes | Percentage of working days in the previous quarter where staff are sick and unable to work. | Quarterly – aggregated monthly figures. | IPR and Divisional Performance Reviews |

*Seven indicators not reported in the IPR but reported separately to Trust Board (scoring indicators)*

| Metric | Status | Included in IPR | Definition | Measurement period | Governance group(s) |
|---|---|---|---|---|---|
| CQC inpatient survey satisfaction rate | Scoring | No | The banded score relating to satisfaction of inpatients for each trust. | Annual. | Trust Board |
| NHS staff survey advocacy rate | Scoring | No | Combined staff survey scores covering patient priority, recommendation as workplace and standard of care. | Annual. | Trust Board |
| NHS staff survey raising concerns sub-score | Scoring | No | NHS Staff Survey "raising concerns" sub-score. | Annual. | Trust Board |
| Healthcare worker flu vaccination rate | Scoring | No | Number of frontline healthcare workers who received an NHS administered flu vaccination. | Quarterly. | Trust Board |
| National education and training survey satisfaction rate | Scoring | No | Percentage of respondents reporting a positive overall experience. | Annual. | Trust Board |
| NHS staff standards score | Scoring | No | Composite NHS Staff Survey sub-score associated with NHS Staff Standards. | Annual. | Trust Board |

| | | | | | |
|---|---|---|---|---|---|
| NHS staff survey engagement theme score | Scoring | No | NHS Staff Survey staff engagement theme sub-score. | Annual. | Trust Board |

*Nine new indicators not currently measured in IPR (scoring indicators)*

| Metric | Status | Included in IPR | Definition | Measurement period | Governance group(s) |
|---|---|---|---|---|---|
| 30 day readmission rate band | Scoring | No | Percentage of patients readmitted to inpatient capacity within 30 days of being discharged shown as a comparative banding compared with the national average. | Annual. | IPR and Clinical Governance Committee |
| Rate of pregnant women with a delayed planned induction per 1,000 deliveries | Scoring | No | The rate of deliveries with a delayed induction (6+ hours) per 1,000 deliveries. | Quarterly – aggregate sitreps. | IPR and Clinical Governance Committee |
| Combined finance score | Scoring | No | Combined financial position taking account of planned and actual position. | Quarterly. | IPR and separate reporting to TME and Trust Board |
| % of clinical trials set up within 90 days | Scoring | No | Percentage of NIHR portfolio studies recruiting first participant within 90 days. | Quarterly. | IPR and Clinical Governance Committee |
| Data Quality Maturity Index | Scoring | No | DQMI score – average percentage of valid and complete entries across datasets. | Quarterly – latest monthly position. | IPR and Digital Oversight Committee |
| Relative cost difference (National Cost Collection Index) | Scoring | No | National Cost Collection Index adjusted for Market Forces Factor. | Annual. | IPR and separate reporting to TME and Trust Board |

| | | | | | |
|---|---|---|---|---|---|
| Breadth and depth of clinical audit outliers | Scoring | No | Banded score based on range of outlying clinical audits (see Appendix 3), severity and duration. | Quarterly. | IPR and Clinical Governance Committee |
| Temporary staffing cost relative band | Scoring | No | Banded score between 1–4 based on use of bank and agency staff. | Quarterly. | IPR and separate reporting to TME and Trust Board |
| % of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service | Scoring | No | Percentage of people seen by an in-house tobacco dependence treatment service who commence a supported quit attempt. | Quarterly (rolling 12-month period). | IPR and Clinical Governance Committee |

*Six contextual measures (not scoring), two currently reported in the IPR and four not currently reported*

| Metric | Status | Included in IPR | Definition | Measurement period | Governance group(s) |
|---|---|---|---|---|---|
| % of cases waiting up to 18 weeks for care vs target | Contextual | Yes | As part of the Medium Term Planning Framework each trust has an individual target. | Quarterly – latest month in the period. | IPR, Divisional Performance Reviews, Elective Delivery Group and Delivery Committee |
| Number of patients cared for in corridors | Contextual | Yes | Total number of patients in the period cared for in corridors. | Quarterly – aggregated quarterly figures. | IPR, Divisional Performance Reviews, and Trust Wide Urgent Care Group |
| Implied productivity growth | Contextual | No | Change in implied productivity compared with a baseline period. | Quarterly – year-to-date compared with same period previous year. | IPR and Productivity Committee |
| % of patients to acquire a new grade 3 or 4 pressure ulcer | Contextual | No | Percentage of hospital spells/community caseload with a new grade 3 or 4 pressure ulcer. | Quarterly – latest available data. | IPR, Divisional Performance Reviews and Clinical Governance Committee |

| | | | | | |
|---|---|---|---|---|---|
| % of safety incidents resulting in harm | Contextual | No | Percentage of all patient safety incidents resulting in low, moderate, severe or fatal harm. | Quarterly – latest month available. | IPR, Divisional Performance Reviews and Clinical Governance Committee |
| Rate of inpatient falls that cause harm | Contextual | No | Percentage of inpatients who suffer a new hip fracture while an inpatient. | Annual. | IPR, Divisional Performance Reviews and Clinical Governance Committee |

## 6. Segmentation and league tables

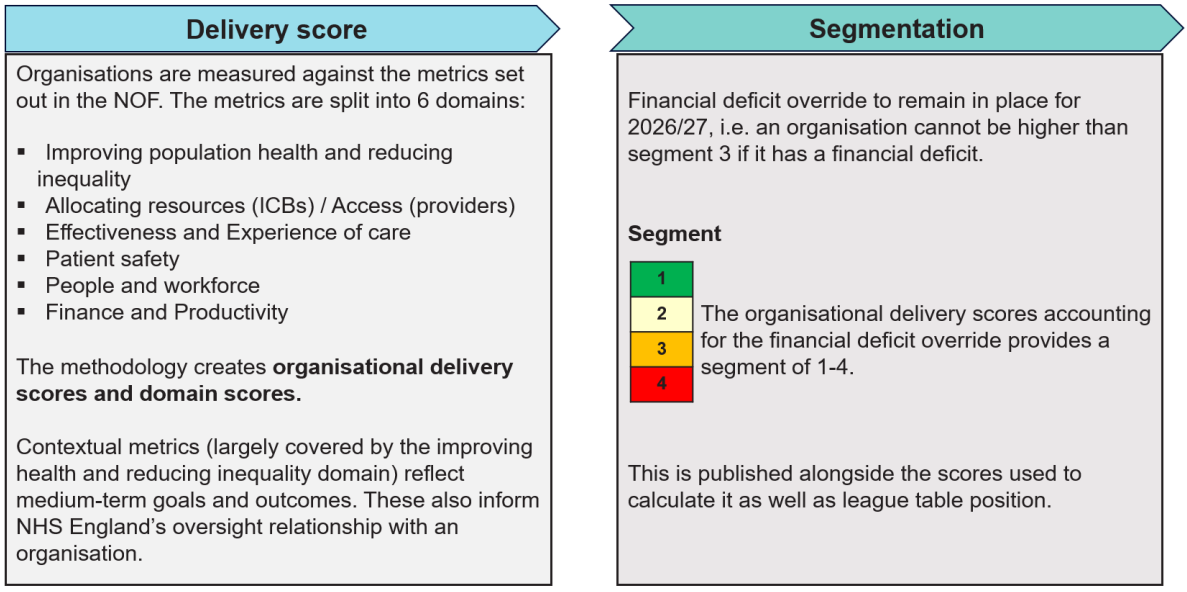
6.1. Each organisation is assigned a segment between 1 and 4 based on performance of scoring metrics within the six domains to generate an organisational delivery and domain score (see figure below).

6.2. Organisational delivery scores, including adjustment for financial deficit overrides which result in an organisation not being able to achieve higher than segment 3 if it has a financial deficit, provides a segment of 1 – 4, and illustrates a high-level view of the breadth of challenges it faces.

6.3. Organisations in segment 1 are likely to have a narrow range of issues, while those in segment 4 have the broadest range of challenges.

6.4. Segmentation data is also used to rank organisations relative to others of the same type in a published league. League tables allow organisations and the public to understand performance relative to appropriate peers, both overall and across a range of specific areas.

6.5. **Figure 1: Link between delivery score and segmentation**




Source: NHSE

## 7. Capability assessments

7.1. As part of the NHS Oversight Framework, NHS England is required to annually assess NHS trusts' capability and a key element of this includes, Trust Boards completing a self-assessment of their organisation's capability across six areas derived from The Insightful Provider Board. This includes:

7.1.1. Strategy, leadership and planning

7.1.2. Quality of Care

7.1.3. People and culture

7.1.4. Access and delivery of services

7.1.5. Productivity and value for money

7.1.6. Financial performance and oversight

7.2. Capability assessments provide NHS England with a structured view of an organisation's leadership, governance and ability to deliver sustained improvement. They consider how effectively boards set direction, manage risk, use data and insight, engage with partners and translate plans into delivery. The assessments aim to complement delivery segmentation by focusing not on what an organisation has delivered, but on its capacity to improve, and are used alongside delivery information and other considerations from ongoing monitoring to determine the appropriate oversight response.

7.3. NHS England regional teams review the self- assessment and evidence behind it, along with other information, to derive a view of the organisation's

capability and give a rating of Red/Red Amber/Amber Green/Green. Ratings are published on league tables.

7.4. The assessment alongside National Oversight Framework segmentation enables NHS England to judge what actions or support are appropriate for each Trust.

7.5. Capability assessments are conducted annually, with quarterly reviews and may be revised in-year in light of new or emerging information.

7.6. Provider self-assessments are completed annually; however, capability ratings may be revised in-year where new information emerges.

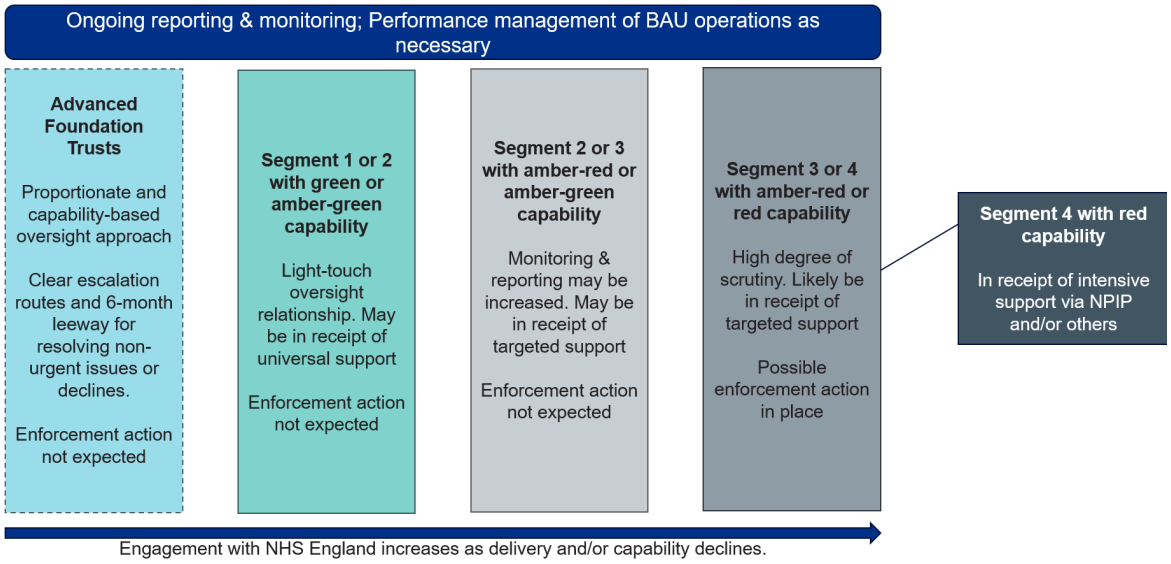
## 8. Oversight arrangements

8.1. NHS England's regional teams lead the oversight of ICBs and providers, and the intensity of oversight is informed by both an organisation's delivery segment and its capability, ensuring a proportionate and joined-up approach to improvement and risk. This relationship may also be informed by other relevant information from ongoing monitoring or escalation.

8.2. Organisations in higher segments and with lower capability are likely to receive the most intensive oversight and support or intervention. Conversely, organisations in lower segments with higher capability are likely to benefit from lighter-touch oversight arrangements and be potential candidates for greater freedoms and incentives.

8.3. The section below illustrates typical oversight relationships. It does not replace regional judgement, which will take account of organisational context and risk.

### 8.4. Table 2: Oversight response: Performance and capability




Source: NHSE

8.5. NHS England's oversight approach is designed to recognise and reward strong delivery and capability, and to apply fair but firm consequences where delivery or capability is persistently low. The incentives, support and consequences set out below are applied through clear national and regional governance arrangements, described in the next section.

8.6. **Incentives**: organisations that consistently demonstrate strong delivery and effective leadership benefit from greater freedoms and incentives. This may include eligibility to apply for advanced foundation trust status, access to additional capital flexibilities in line with capital planning guidance and lighter-touch processes for taking on responsibility for NHS Property Services estates, where appropriate, in line with NHS property guidance. These organisations are also expected to play a leading role in supporting improvement across the system, including sharing good practice in the areas where they excel.

8.7. **Support**: where organisations face challenges in delivery and/or capability, NHS England will increase scrutiny and provide proportionate, targeted support to help secure improvement. For providers, this includes bespoke support from regional teams, where appropriate, as well as access to improvement support offers such as the Get It Right First Time (GIRFT) programme, alongside NHS IMPACT and the GIRFT Academy, which are available to all organisations to strengthen improvement capability.

8.8. **Consequences**: where performance and/or capability remain persistently low, or where risks escalate, freedoms may be curtailed and formal consequences applied. This may include mandated improvement support and/or enforcement action. Where providers have long-standing financial and operational issues, they may be considered for entry into an intensive recovery programme. Other consequences may apply where appropriate, including ineligibility for very senior managers (VSM) pay awards in line with the VSM pay framework and enforcement action in line with NHS enforcement guidance (such as undertakings, discretionary requirements, additional licence conditions or other measures). This approach ensures proportionate intervention, supports improvement and safeguards public resources

## 9. Oversight governance

9.1. Oversight decisions are made through a clear and proportionate governance model that balances national consistency with regional judgement. NHS England regions are responsible for leading day-to-day oversight of ICBs and providers, agreeing support and improvement plans, and where required, initiating performance management activity and the use of enforcement powers. Regions review the oversight response for each

organisation at least quarterly in line with the refresh of segmentation data and bring together multidisciplinary teams to ensure oversight decisions are made consistently and take account of all relevant factors. Regional teams may make changes to oversight responses at any time to address emerging events.

9.2. Certain decisions require national moderation or approval to ensure consistency, the appropriate use of powers or access to national resources, including the approval of provider capability ratings. These decisions are taken through the relevant NHS England governance, informed by regional recommendations and supporting evidence. This approach ensures that oversight decisions are timely, proportionate and aligned with national expectations, while remaining responsive to local context and risk.

9.3. Key dates associated with segmentation and Provider capability ratings are included in Appendix 1.

## 10. Advanced foundation trusts

10.1. Advanced foundation trusts will benefit from proportionate, risk-based oversight. This includes a time limited period (up to 6 months) to resolve non-urgent issues without escalation. Where serious concerns arise (for example, a 2-segment fall or a ‘red’ capability rating over 2 quarters), the oversight response is adjusted accordingly. Advanced foundation trust status may also be reviewed in line with the criteria set out in the forthcoming advanced foundation trust guidance.

## 11. Recommendations

11.1. The Trust Board is asked to:

- Note the summary of the NHS Oversight Framework, the new measures and governance arrangements
- To approve the publication of a new summary within the IPR that aligns for:
    - New indicators
    - The timing methodology applied in ‘scoring’ methodology
    - Consistent use of templates
    - Accountable officers in line with the existing metrics
- Note continued monitoring within the OUH Performance Management and Accountability Framework.

## 12. Appendix 1: Timetable of segmentation and Provider capability ratings

### Segmentation

- Delivery segmentation is generated every quarter using data from the previous quarter.
    - April to June (quarter 1)
- Data from quarter 4 of the previous year is generated and validated. Quarter 4 provider and ICB delivery segments are published.
    - July to September (quarter 2)
- Data from quarter 1 is generated and validated. Quarter 1 provider and ICB delivery segments are published.
    - October to December (quarter 3)
- Data from quarter 2 is generated and validated. Quarter 2 provider and ICB delivery segments are published.
    - January to March (quarter 4)
- Data from quarter 3 is generated and validated. Quarter 3 provider and ICB delivery segments are published.
    - In-year oversight actions (continuous)
- Oversight actions take place throughout the year and are informed by delivery segmentation, provider capability and emerging risks.

### Provider capability ratings

- Provider capability ratings are generated annually but may be reviewed and updated at any time.
    - May to June (quarter 1)
- Providers complete a self-assessment covering strategy (board), quality, delivery, people, productivity and finance
    - July to August (quarter 2)
- Regional teams carry out a review, considering track record, board awareness of issues, plans to address issues and third-party information
    - October (quarter 3)
- Provider capability ratings are finalised and moderated.

## 13. Appendix 2: OUH published performance 2025/26 Q4

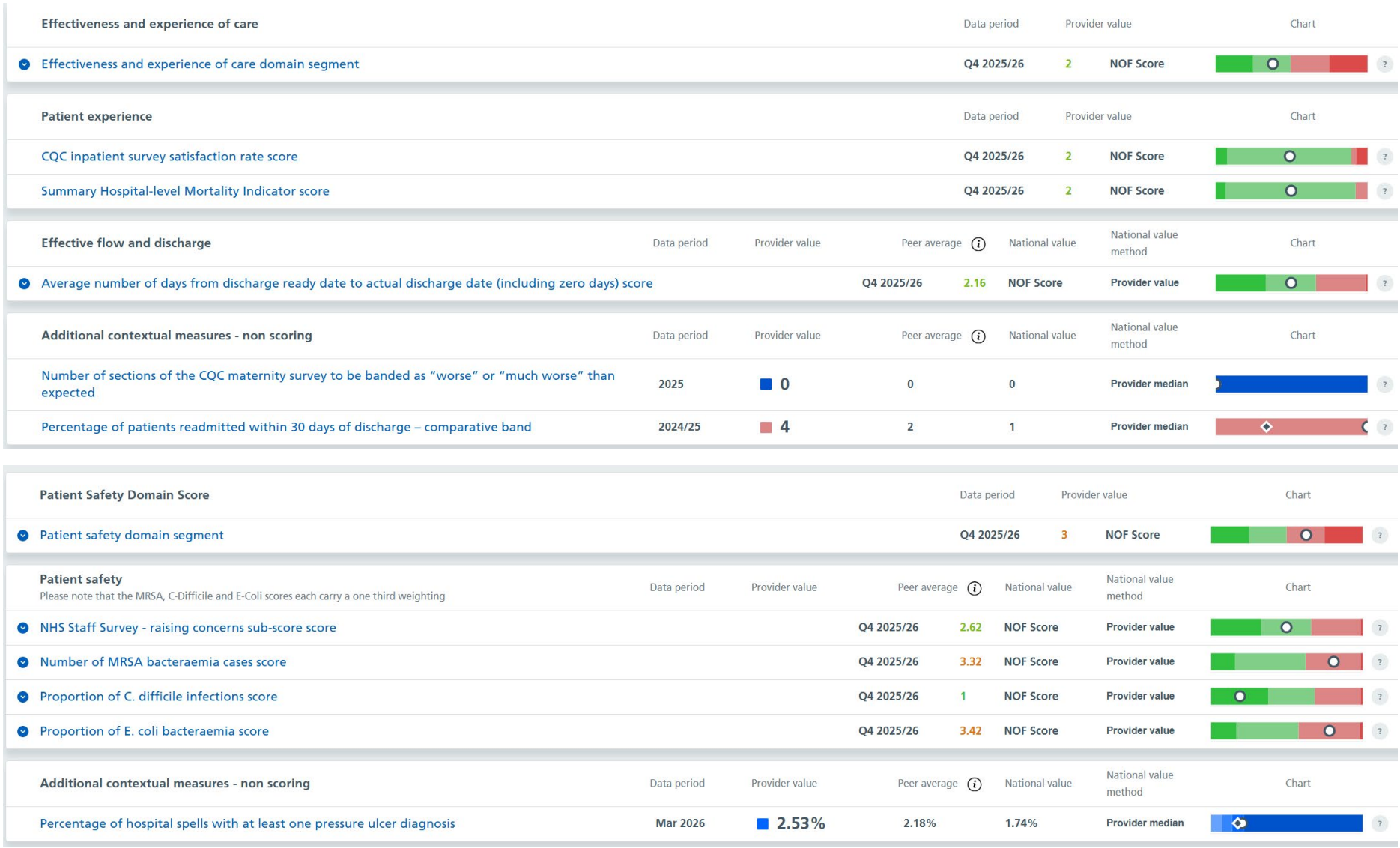
Oversight framework summary Beta

Overall segment and domain scores

| Headlines | Data period | Provider value | Peer average | | National value | National value method | Chart |
|---|---|---|---|---|---|---|---|
| Adjusted segment | | | Q4 2025/26 | 3 | NOF Score | Provider value | |
| Average metric score | | | Q4 2025/26 | 2.14 | NOF Score | Provider value | |
| Unadjusted segment | | | Q4 2025/26 | 2 | NOF Score | Provider value | |
| Financial override | Q4 2025/26 | Yes | Yes | | Yes | Provider median | |

| Domain Scores | Data period | Provider value | | Chart |
|---|---|---|---|---|
| Access to services domain segment | Q4 2025/26 | 2 | NOF Score | |
| Effectiveness and experience of care domain segment | Q4 2025/26 | 2 | NOF Score | |
| Patient safety domain segment | Q4 2025/26 | 3 | NOF Score | |
| People and workforce domain segment | Q4 2025/26 | 1 | NOF Score | |
| Finance and productivity domain segment | Q4 2025/26 | 3 | NOF Score | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Access to services domain segment | | | Q4 2025/26 | 2 | NOF Score | | |
| **Elective Care** | Data period | Provider value | Peer average | | National value | National value method | Chart |
| Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score | | | Q4 2025/26 | 2.93 | NOF Score | Provider value | |
| Difference between planned and actual 18 week performance score | | | Q4 2025/26 | 1 | NOF Score | Provider value | |
| Percentage of patients waiting over 52 weeks for elective treatment score | | | Q4 2025/26 | 3.1 | NOF Score | Provider value | |
| Percentage of patients waiting over 52 weeks for community services score | | | Q4 2025/26 | 2.87 | NOF Score | Provider value | |
| **Cancer Care** | Data period | Provider value | Peer average | | National value | National value method | Chart |
| Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral score | | | Q4 2025/26 | 1 | NOF Score | Provider value | |
| Percentage of patients treated for cancer within 62 days of referral score | | | Q4 2025/26 | 3.76 | NOF Score | Provider value | |
| **Urgent and Emergency Care** | Data period | Provider value | Peer average | | National value | National value method | Chart |
| Percentage of emergency department attendances admitted, transferred or discharged within four hours score | | | Q4 2025/26 | 1 | NOF Score | Provider value | |
| Percentage of emergency department attendances spending over 12 hours in the department score | | | Q4 2025/26 | 1.32 | NOF Score | Provider value | |



| Effectiveness and experience of care | Data period | Provider value | | Chart |
|---|---|---|---|---|
| Effectiveness and experience of care domain segment | Q4 2025/26 | 2 | NOF Score | |

| Patient experience | Data period | Provider value | | Chart |
|---|---|---|---|---|
| CQC inpatient survey satisfaction rate score | Q4 2025/26 | 2 | NOF Score | |
| Summary Hospital-level Mortality Indicator score | Q4 2025/26 | 2 | NOF Score | |

| Effective flow and discharge | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| Average number of days from discharge ready date to actual discharge date (including zero days) score | Q4 2025/26 | 2.16 | | NOF Score | Provider value | |

| Additional contextual measures - non scoring | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| Number of sections of the CQC maternity survey to be banded as “worse” or “much worse” than expected | 2025 | 0 | 0 | 0 | Provider median | |
| Percentage of patients readmitted within 30 days of discharge – comparative band | 2024/25 | 4 | 2 | 1 | Provider median | |

| Patient Safety Domain Score | Data period | Provider value | | Chart |
|---|---|---|---|---|
| Patient safety domain segment | Q4 2025/26 | 3 | NOF Score | |

| Patient safety<br>Please note that the MRSA, C-Difficile and E-Coli scores each carry a one third weighting | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| NHS Staff Survey - raising concerns sub-score score | Q4 2025/26 | 2.62 | | NOF Score | Provider value | |
| Number of MRSA bacteraemia cases score | Q4 2025/26 | 3.32 | | NOF Score | Provider value | |
| Proportion of C. difficile infections score | Q4 2025/26 | 1 | | NOF Score | Provider value | |
| Proportion of E. coli bacteraemia score | Q4 2025/26 | 3.42 | | NOF Score | Provider value | |

| Additional contextual measures - non scoring | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| Percentage of hospital spells with at least one pressure ulcer diagnosis | Mar 2026 | 2.53% | 2.18% | 1.74% | Provider median | |

| People and workforce | Data period | Provider value | | Chart |
|---|---|---|---|---|
| People and workforce domain segment | Q4 2025/26 | 1 | NOF Score | |

| Retention and Culture | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| Sickness absence rate score | Q4 2025/26 | 1.26 | NOF Score | Provider value | |
| NHS staff survey engagement theme sub-score score | Q4 2025/26 | 2.13 | NOF Score | Provider value | |

| Additional contextual measures - non scoring | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| National Education and Training Survey "Overall experience" survey score | 2025 | 77.18% | 77.18% | 78.21% | Provider median | |

| Finance and productivity | Data period | Provider value | | Chart |
|---|---|---|---|---|
| Finance and productivity domain segment | Q4 2025/26 | 3 | NOF Score | |

| Finance<br>Please note that only the combined finance score contributes to the domain score | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| Combined finance score | Q4 2025/26 | 2 | NOF Score | Provider value | |
| Planned surplus/deficit score | Q4 2025/26 | 3 | NOF Score | Provider value | |
| Variance year-to-date to financial plan score | Q4 2025/26 | 1 | NOF Score | Provider value | |

| Productivity<br>Please note: In Q1 2025/26, the implied productivity metric for ICBs applied only to acute trusts. This was later expanded to all trust types, so Q1 figures are not directly comparable with later quarters. | Data period | Provider value | Peer average | National value | National value method | Chart |
|---|---|---|---|---|---|---|
| Implied productivity level score | Q4 2025/26 | 2.58 | NOF Score | Provider value | |

## 14. Appendix 3: Clinical Audit outlier indicator: audits in scope

The banded score for the clinical audit outlier indicator is based on a range of outlying clinical audits. This considers the number of audits the trust is outlying in, the severity of the outlier and length of the outlier status.

Outlier status is not currently available as a single published dataset but is intended to be released by NHSE in future. In the interim outliers can be identified through individual clinical audit publications and these will be reported within the proposed National Oversight Framework dashboard.

The audits in scope for this measure in 2026/27 are:

1. Stroke (SSNAP)
2. National joint registry (NJR)*
3. Bowel cancer (NBOCA)
4. Emergency laparotomy (NELA)
5. National vascular registry (NVR)
6. National hip fracture database (NHFD)
7. National maternity and perinatal audit (NMPA)
8. National neonatal audit programme (NNAP)
9. Prostate cancer audit (NPCA)
10. Epilepsy 12
11. Care at the end of life (NACEL)
12. Dementia (NAD)
13. Early inflammatory arthritis (NEIAA)
14. Paediatric diabetes (NPDA)
15. COPD and asthma (NRAP)
16. Cardiac (NICOR)*

*Non NCAPOP