Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M1 (April data)

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Table of Contents

Segmentation dashboard: selected indicators

		Segmentation performance (*nationally reported position - Q3 25/26*)					Latest performance (*monthly internal data*)			
Domain	**Indicator**	**Performance**	**Segmentation national ranking**	**NOF score**	**Segmentation measurement period**	**Segmentation reporting data inclusion date**	**Latest monthly performance**	**Latest monthly performance target (operational plan)**	**Latest monthly performance vs plan**	**Period of latest monthly performance**
Operational Performance	1. Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	79.59	21/123 (low is good)	1.00	Rolling 3-month	December 2025	81.7	77.9	Compliant	April 2026
	2. Percentage of patients treated for cancer within 62 days of referral	64.83	91/118 (low is good)	3.30	Rolling 12-month	December 2025	56.5	71.1	Non compliant	March 2026
	3. Percentage of patients waiting over 52 weeks	2.50	101/131 (low is good)	3.37	End of period	December 2025	1.8	2.0	Compliant	April 2026
	4. Number of patients waiting over 52 weeks		N/A - Not used for segmentation (leading indicator)				1,599.0	1,609.0	Non compliant	April 2026
Quality Performance	5. Summary Hospital Level Mortality Indicator			2.00	Rolling 12-month		92.1	100.0	Compliant	January 2026
Financial Performance	6. Variance year-to-date to financial plan	0.00	33/134 (low is good)	1.00	Year to date	December 2025	-46.4	0.0	Compliant	April 2026
	7. Planned surplus/deficit score	-1.02	57/134 (low is good)	3.00	Annual plan	April 2025				

Key for NOF score: 1 = Highest performing quadrant, 4 = Lowest performing quadrant

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 1 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 is under review to incorporate the ICB Operating Model and priorities of the 10 Year Health Plan. When finalised the IPR will be refreshed to incorporate further changes. 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 Power BI dashboard is included for selected Segmentation Indicators (on page 3).

We achieved key measures related to patient safety and care experience, including zero never events, fewer c-diff cases vs the monthly threshold, zero MRSA cases. VTE assessments were better than the national target 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). Safeguarding training compliance for adults and children (L1-L3) were achieved.

Achieving 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. Rates remain better than National and Shelford averages. Vacancy and turnover rates performed better than targets. Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. We did not meet the non-medical appraisals target since the new appraisal cycle has commenced. We met targets for core skills training demonstrating commitment to staff development and achieved our time to hire standard.

Performance against the operating plan trajectory for A&E in month 1 was compliant (above plan) (all types and type 1 within 4 hours) and compliant for the % of patients waiting over 12 hours (both Segmentation indicators). In month 1, the % of pathways over 52 weeks (segmentation indicator), met the operating plan trajectory, as did the patient number of over 52-week waiters. Total RTT % performance within 18 weeks (Segmentation indicator), and the percentage of patients within 18 weeks for first OP attendances narrowly did not meet the operating plan. Performance in month 12 met the operating plan target for the Faster Diagnosis Standard but did not meet the operating plan target for Cancer waits within 62-days (Segmentation indicators). Focus continues to reduce the number of patients over 62 days and reduce the total Patient Tracking List. NB. Cancer performance is reported one month in arrears. Diagnostic performance (% within 6 weeks) was below the operating plan in month 1, though total activity for each modality was above plan.

Key headlines from the M1 financial position are as follows:

- ***Reported deficit*** The plan in month 1 was for a £6.6m deficit which the Trust achieved.
- ***Underlying deficit*** the non-recurrent opportunities deployed in the month 1 position total £1.4m which means the Trust's underlying position is a deficit of circa £8.0m at month 1.
- ***Workforce*** worked WTE's at 14,044 are 320 WTE under budgeted plan at month 1 and have reduced by 204 since last month
- ***Cash*** is £26.5m above plan. The main driver for this variance is the net cash funding held for capital expenditure at the end of month 1 (from 2025/26) which is due to be spent in cash terms in the early part of 2026/27. The cash plan for 2026/27 is showing the pressure on cash will return, once timing issues have unwound from 2025/26.
- ***Efficiencies*** have under delivered to plan by £0.4m, reflecting timing lag between scheme identification (e.g. procurement) and reliance on non-recurrent savings to deliver planned savings. The variance is predominantly on recurrent efficiencies (£0.3m adverse to plan).

Of the indicators currently measured in the IPR, indicators that triggered are detailed further using standardised assurance template. These indicators, which include those failing to meet performance standards or showing deteriorating SCV, are listed in summary on the following page and elaborated within the relevant domain in section 3, and include tiering requirements were relevant. The data quality ratings of the assurance templates range from 'satisfactory' to 'sufficient', as defined in section 5a.

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

- Sickness Absence Rate (Rolling 12 months)
- Non-Medical Appraisals
- % Patients with Sepsis Attending ED Received Timely Antibiotics
- % of Complaints Responded to Within 25 Days
- Bed Utilisation General & Acute
- Percentage of Patients Discharged on Discharge Ready Date
- BPPC £ %
- BPPC Volume %

Common cause variation and missed target

- Information Governance Training
- Freedom of Information (FOI) % Responded in Time
- Priority 1 Incidents
- Sickness Absence Rate (In Month)
- Reactivated Complaints
- FFT % Likely to Recommend – OP
- No of Corridor Care Patient in IP wards at 8am
- No of Corridor Care Patient in ED > 45min
- Cancer 62-Day Combined Standard
- Percentage of Patients Discharged on Discharge Ready Date
- % Diagnostic Waits Waiting 6 weeks or more
- Number of Patients Put Onto a PIFU

Special cause variation - improving

- % of RTT Patients waiting for a first appointment
- % of RTT Patients Waiting Within 18 weeks
- RTT Standard: >52-week Incomplete Pathways
- Year-To-Date Financial performance Surplus/Deficit

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).*

E. coli bacteraemia: Current performance remains at 18 cases in April, in line with recent months and last year despite a national rise. E. coli bacteraemia: Improvement activity focuses on catheter management and monitoring case themes in an ageing, more complex population. E. coli bacteraemia: Ongoing assurance is provided via IPC reporting to PSEC through HIPCC, chaired by the DIPC, with oversight through BAF 4 and sufficient data quality.

MSSA and MRSA bacteraemia: Current performance improved to zero MSSA and zero MRSA cases in April following 10 MSSA cases in March, reflecting statistical fluctuation. MSSA and MRSA bacteraemia: Improvement activity continues through IPC support for IV line assessment/documentation and the established multi-site MRSA screening process. MSSA and MRSA bacteraemia: Ongoing assurance is provided via IPC reporting to PSEC through HIPCC, chaired by the DIPC, with oversight through BAF 4 and sufficient data quality.

C. difficile infection and IPC surveillance: Current performance shows nine healthcare-associated C. difficile cases in April, a 40% year-on-year reduction, alongside an ongoing risk relating to surveillance capability. C. difficile infection and IPC surveillance: Improvement activity includes antimicrobial stewardship, environmental cleaning trials, and preparatory work for ICNet implementation. C. difficile infection and IPC surveillance: Timescales include ICNet Phase 1 over 6–9 months and further integration in 2027, with assurance via IPC reporting to PSEC through HIPCC.

ED delays in antibiotic administration: Current performance was 86% compliance in April, with 12 of 14 sepsis patients receiving timely antibiotics and two experiencing delays. ED delays in antibiotic administration: Improvement activity includes monthly audit, Sepsis Team support, and targeted work on venous access, responsibilities, triage and PGD. ED delays in antibiotic administration: Timescales and assurance are through an updated ED action plan overseen by the Sepsis Working Group and monitored by the DCMO, with a new service framework expected later this year.

Complaints Performance; Complaints volume continues to increase, with 234 complaints received in April (6.3% increase), alongside improving response performance with median response times reducing to 28 days, increased closure rates and fewer reopenings, though pressures on the 25-day KPI remain; Structured thematic analysis via PEEC and targeted escalation at 40 and 60 days are strengthening divisional accountability and focusing on long-outstanding cases; Performance is reviewed weekly with oversight through PEEC and Delivery Committee to support recovery and sustained improvement.

Hospital Acquired Pressure Ulcers Performance has improved with hospital-acquired category 3 incidents reducing to 6 in April, demonstrating sustained proactive management; A system-wide QIP and enhanced harm review processes are being embedded to drive learning, alongside strengthened governance through Harm Free Assurance Forum; Ongoing weekly monitoring with escalation through Clinical Governance Committee and Delivery Committee provides assurance of continued improvement.

Friends and Family Tests remains strong with outpatient responses accounting for 71% of returns and a high recommendation rate of 93.7%, with consistent positive and negative themes identified; Divisional reporting and development of enhanced collection methods and strategy aim to improve engagement and response quality; Continuous monitoring with regular reporting through multiple governance forums including PEEC, PSEC, and SLIC ensures sustained oversight and assurance.

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RTT 52 Weeks: Performance is 1.77% against a 2.0% plan with continued reduction in long waiters but residual >65-week pathways remain; actions include insourcing, outsourcing, WLIs, delivery funding for capacity and a trust-wide objective to see first appointment patients by week 40; assurance is via weekly Check & Challenge, Elective Delivery Group and Divisional Performance Reviews.

RTT 65 Weeks: Performance remains at 47 against a nil target despite overall improvement; actions focus on specialty-level recovery including ENT insourcing, gynaecology pathway redesign, OMFS activity increases and delivery action plan tracking; assurance is through weekly Check & Challenge, Elective Delivery Group and monthly Divisional Performance Reviews.

Cancer Gynaecology Pathway: Performance is challenged by referral growth, pathway delays and limited hysteroscopy sustainability impacting access and staging; actions include pathway redesign, additional clinics and slots, recruitment, new SOPs and regional pathway collaboration; assurance is through defined timelines (April–August 2026) and oversight via Regional Tiering meetings.

Cancer Urology Pathway: Performance is constrained by insufficient biopsy capacity, diagnostic delays, PET instability and theatre capacity limitations; actions include workforce expansion, outsourcing pathology, pathway redesign, increased theatre lists and oncology capacity; assurance is through phased completion milestones to June–August 2026 and Regional Tiering meetings.

Discharge / Flow (D2A): Performance shows delays in discharge readiness linked to capacity constraints and increased complexity, though regional comparative performance remains strong; actions include targeted ward reviews, system escalation pathways, community capacity redesign and improvement programmes on discharge processes.

Diagnostics 6 Weeks: Performance is 21.9% against a 20% plan with continued diagnostic backlogs and variation across modalities; actions include over-delivery targets, validation, capacity expansion and specialty-specific recovery plans across endoscopy, neurophysiology, audiology and ultrasound; assurance is through weekly Check & Challenge, Elective Delivery Group and Divisional Performance Reviews. Activity volumes across all modalities is above plan for M1.

Priority 1 incidents Recent network connectivity and internet access incidents disrupted services across OUH due to external fibre faults and firewall changes; actions included rapid routing changes, supplier resolution, and configuration fixes to restore services; incidents were resolved within defined timeframes with oversight linked to BAF 6.

Information Governance and Data Security Training compliance is 90.0% in M1 with no divisions meeting the 95% target; actions focus on addressing 1,623 non-compliant staff, leveraging divisional oversight and reporting tools, with improvement expected during the appraisal cycle; performance is overseen by the Digital Oversight Committee with ongoing monitoring.

Sickness absence remains above target at 4.1% (rolling 12 months 4.2%), although stable and below national benchmarking, with absence driven primarily by mental health, respiratory and musculoskeletal conditions; actions focus on strengthened divisional reporting, targeted interventions for high-absence areas, enhanced Occupational Health and HR support, improved return-to-work processes, and manager training, with delivery through ongoing governance via TME, HR governance forums and divisional meetings.

Appraisal compliance is low at 13.2% but improving compared to the same point last year and expected to increase during the appraisal window; actions centre on enhanced divisional reporting, communications and engagement, leadership support, promotion of appraisal resources and quality-focused guidance, with oversight through TME, HR governance and divisional meetings.

2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

	Common cause variation	Special cause variation - improving	Special cause variation - deterioration	Other (where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)
Quality, Safety and Patient Experience	• Reactivated Complaints • FFT % Likely to recommend OP • Pressure ulcers per 1,000 beddays (Cat 2) Hospital Acquired • Reactivated complaints Not achieving target		L: • % of complaints responded to within 25 working days • % patients with Sepsis receiving timely antibiotics in accordance with NICE Not achieving target H: • Number of complaints per 10,000 bed days • Number of complaints Not achieving target	No SPC Not achieving threshold
Growing Stronger Together	• Sickness and absence rate (in month) Not achieving target	L Not Achieving target	H: • Sickness and absence rate (Rolling 12 Months) Not achieving target	
Operational performance	• % Diagnostic Waits waiting 6 weeks or more • % of RTT of patients waiting for a first appointment • Cancer 31, and 62 Day Combined Standard (2WW, Symptomatic and screening referrals) • Corridor Care in ED and Wards Not achieving target	L: • % of RTT Patients Waiting within 18 weeks Not Achieving target	L: • Percentage of Patients discharged on discharge ready date Not achieving target H Not achieving target	
Corporate Support Services	• Efficiency Delivery £'000 • Priority 1 incidents • Freedom of Information (FOI) % Responded to Within Target Time • In-month financial performance Surplus/ Deficit £'000 • Information) Governance and Data Security Training compliance Not achieving target	H: • Year to date financial performance Surplus/ Deficit £'000 Not achieving target	L: • BPPC £ % • BPPC Volume % Not achieving target	No SPC Not achieving threshold

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience

Data updated on: 15/04/2026 00:05:52

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	Mar-26	0.32	0.44	0.00	1.57	0.00		
19.00	MRSA Cases: HOHA+COHA	✓	Yes	Apr-26	0	1	0	3	0		
20.00	C-Diff Cases: HOHA+COHA Per 10,000 Beddays		Yes	Apr-26	3.05	3.50		6.77	0.24		
21.00	C-Diff Cases: HOHA+COHA	✓	Yes	Apr-26	9	11	10	22	1		
22.00	E. Coli Cases: HOHA+COHA Per 10,000 Beddays		Yes	Apr-26	6.10	5.54		9.65	1.43		
23.00	E. Coli Cases: HOHA+COHA		Yes	Apr-26	18	18		31	5		
24.00	MSSA Cases: HOHA+COHA		Yes	Apr-26	0	6		13	0		
25.00	Number Of Never Events	✓	No	Apr-26	0	0	0	1	-0		
26.00	Non-Thematic Patient Safety Incident Investigations		No	Apr-26	1	2		7	-3		
27.00	PSII Overdue Actions		Yes	Apr-26	21	32		55	10		
28.00	VTE- Submitted Performance	✓	Yes	Apr-26	95.4%	95.2%	95.0%	95.7%	94.6%		
29.00	% Of Emergency Admissions 65yrs + Receiving Cognitive Screen		Yes	Apr-26	69.4%	63.7%		71.5%	56.0%		
30.00	% Patients With Sepsis Attending ED Receiving Timely Antibiotics In Accordance With NICE Guidelines	✗	Yes	Apr-26	85.7%	86.8%	90.0%	110.7%	62.9%		
31.00	CAS Alerts Breaching Deadlines At End Of Month And/Or Closed During Month Beyond Deadline	✓	No	Apr-26	0	0	0				
32.00	Medication Incidents Causing Moderate Harm, Major Harm Or Death As Reported On Ulysses		Yes	Apr-26	3	3		8	-2		
33.00	HSMR Excluding Hospices	✓	No	Jan-26	92.1	90.7	100.0	93.7	87.6		
34.00	Summary Hospital-Level Mortality Indicator	✓	No	Dec-25	0.9	78.8	100.0	80.0	77.5		
35.00	Neonatal Deaths Per 1,000 Total Live Births	✗	Yes	Mar-26	6.13	2.81	3.20	6.38	-0.76		
36.00	Stillbirths Per 1,000 Total Live Births	✓	Yes	Mar-26	2.78	3.07	4.00	7.11	-0.96		
37.00	National Patient Safety Alerts Not Completed By Deadline		No	Apr-26	0	0					
39.00	Number Of Active Clinical Research Studies Hosted		Yes	Feb-26	1471	1429		1460	1399		
40.00	Number Of Active Clinical Research Studies (Commercial)		Yes	Feb-26	408	398		415	381		
41.00	Number Of Active Clinical Research Studies (Non Commercial)		Yes	Feb-26	1063	1031		1050	1013		
42.00	Number Of Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Apr-26	55.88	46.15		58.16	34.14		
43.00	Number Of Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Apr-26	49.10	39.77		52.43	27.11		
44.00	Number Of Non-Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Apr-26	6.77	6.38		13.37	-0.60		
45.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 2)	✓	Yes	Apr-26	1.32	1.98	1.90	2.82	1.15		
46.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 3)	✗	Yes	Apr-26	0.20	0.25	0.20	0.41	0.09		
47.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 4)	✓	Yes	Apr-26	0.00	0.01	0.00	0.01	0.01		
48.00	Pressure Ulceration Incidents Per 1,000 Beddays (Present On Admission Cat 1+)		Yes	Apr-26	9.96	9.75		12.77	6.73		
49.00	Patient Falls (Moderate And Above) As Reported On Ulysses		Yes	Apr-26	7	4		9	-1		
50.00	Patient Falls (Moderate And Above) As Reported On Ulysses Per 1,000 Beddays		Yes	Apr-26	0.24	0.12		0.29	-0.04		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
51.00	Health And Safety Related Incidents - Assault, Aggression And Harassment		Yes	Apr-26	194	190		269	112		
52.00	Adult Safeguarding Activity		Yes	Apr-26	936	1481		2025	938		
53.00	Children's Safeguarding Activity		Yes	Apr-26	312	526		770	282		
54.00	Adult Safeguarding Activity And Children's Safeguarding Activity		Yes	Apr-26	1248	2007		2574	1441		
55.00	Safeguarding (Children) Training Compliance L1 - L3	✓	Yes	Apr-26	90.5%	90.5%	90.0%	93.0%	88.0%		
56.00	Safeguarding (Adults) Training Compliance L1 - L3	✓	Yes	Apr-26	92.4%	91.8%	90.0%	94.2%	89.3%		
57.00	Total Deliveries In Month	-	Yes	Apr-26	597	601	625	706	496		
58.00	Babies Born		Yes	Apr-26	607	611		718	504		
59.00	Maternity Bookings (Planned + Unplanned)	-	Yes	Apr-26	704	690	750	835	544		
60.00	Inductions Of Labour From IView		Yes	Apr-26	126	124		169	78		
61.00	Midwife Ratios (Birth Rate / Staffing Level)	✓	Yes	Apr-26	22.7	24.4	22.9	28.9	19.9		
62.00	Number Of Learning MDT Reviews Instigated		Yes	Apr-26	0	2		6	-2		
63.00	Percentage Of Learning MDT Reviews Within 42 Days		Yes	Mar-26	100.0%	56.8%		176.4%	-62.9%		
64.00	After Action Review (AAR)		No	Apr-26	13	14		24	4		
65.00	Percentage Of AAR's Within 14 Days		Yes	Apr-26	63.6%	27.5%		64.1%	-9.2%		
66.00	Number Of Complaints		Yes	Apr-26	236	166		222	110		
67.00	Number Of Complaints Per 10,000 Beddays		Yes	Apr-26	79.92	52.93		71.63	34.24		
68.00	Reactivated Complaints	✗	Yes	Apr-26	13	15	1	26	3		
69.00	% Of Complaints Responded To Within 25 Working Days	✗	Yes	Apr-26	19.0%	43.4%	85.0%	65.3%	21.5%		
70.00	Number Of RIDDORs	✓	Yes	Apr-26	0	5	5	11	0		
71.00	Friends & Family Test % Likely To Recommend - IP	✓	Yes	Apr-26	95.8%	94.9%	95.0%	96.4%	93.3%		
72.00	Friends & Family Test % Likely To Recommend - OP	✗	Yes	Apr-26	93.7%	93.8%	95.0%	94.8%	92.8%		
73.00	Friends & Family Test % Likely To Recommend - ED	✓	Yes	Apr-26	86.9%	81.6%	85.0%	86.7%	76.5%		
74.00	FFT Maternity % Positive (Births)	✓	Yes	Apr-26	100.0%	81.9%	90.0%	123.5%	40.3%		
75.00	Inpatient FFT (Response Rate)		Yes	Apr-26	19.8%	21.4%		24.8%	18.1%		
76.00	Outpatient FFT (Response Rate)		Yes	Apr-26	9.2%	9.6%		10.4%	8.7%		
77.00	ED FFT (Response Rate)		Yes	Apr-26	15.1%	16.7%		19.1%	14.3%		
78.00	Maternity FFT (Response Rate; Births)		Yes	Apr-26	5.8%	2.8%		7.0%	-1.5%		
79.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars JR	✓	Yes	Apr-26	99.2%	94.6%	95.0%	100.2%	89.1%		
80.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars CH	✓	Yes	Apr-26	96.8%	95.7%	95.0%	103.2%	88.2%		
81.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars NOC	✓	Yes	Apr-26	100.0%	95.7%	95.0%	106.6%	84.7%		
82.00	Incident Rate Of Violence And Aggression (Rate Per 10,000 Beddays)		Yes	Apr-26	65.70	60.38		86.74	34.02		
83.00	Trust Level: CHPPD Vs Budget		Yes	Apr-26	55.9	11.7		41.3	-17.9		
84.00	Trust Level: CHPPD Vs Required		Yes	Apr-26	12.9	-0.3		19.6	-20.2		

Integrated Performance Report (SPC)

Data updated on: 16/04/2026 00:06:59

Operational Performance

No specified section

SPC Chart | Show SPC legend

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	Mar-26	4.8%	7.1%		9.7%	4.4%		
86.0	Proportion Of Ambulance Arrivals Delayed Over 60 Minutes		Yes	Mar-26	0.6%	0.5%		1.4%	-0.3%		
87.0	ED 4Hr Perfromance - All	✓	Yes	Apr-26	81.7%	75.7%	78.0%	82.0%	69.4%		
88.0	Mean Ambulance Handover Time In Seconds For All Handovers At Trust Level	✓	Yes	Mar-26	994	1067	1180	1144	990		
89.0	ED 4Hr Perfromance - Type 1	✓	Yes	Apr-26	75.8%	67.8%	69.1%	75.5%	60.1%		
90.0	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins	✗	Yes	Apr-26	292	296	0	314	277		
91.0	No Of Corridor Care Patients In IP Wards At 8am	✗	Yes	Apr-26	10	6	0	29	-18		
92.0	Proportion Of Type 1 Attendances Spending More Than 12 Hours In An Emergency Department	✓	Yes	Apr-26	0.9%	3.2%	4.4%	5.0%	1.4%		
93.0	Proportion Of Patients Discharged From Hospital To Their Usual Place Of Residence		Yes	Apr-26	95.6%	95.6%		96.0%	95.2%		
94.0	% Of RTT Patients Waiting For A First Appointment	✗	Yes	Apr-26	67.4%	66.6%	69.1%	68.5%	64.6%		
95.0	% Of RTT Patients Waiting Within 18 Weeks	✗	Yes	Apr-26	62.1%	58.5%	63.0%	60.1%	57.0%		
96.0	% Of RTT Patients Waiting Over 52 Weeks	✓	Yes	Apr-26	1.8%	2.7%	2.0%	3.0%	2.4%		
97.0	RTT Standard: >52-Week Incomplete Pathways	✓	Yes	Apr-26	1599	2874	1650	3267	2481		
98.0	RTT Standard: >65-Week Incomplete Pathways	✗	Yes	Apr-26	47	376	0	508	243		
99.0	RTT Number Of Incomplete Pathways	-	Yes	Apr-26	90210	87376	82503	89903	84849		
100.0	RTT Number Of Incomplete Pathways (<18 Weeks)	✓	Yes	Apr-26	55998	51616	51977	53049	50184		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
101.0	% Of RTT Patients Waiting Over 52 Weeks For Community Services		Yes	Apr-26	2.3%	2.9%		4.2%	1.7%		
.0	Cancer 28 Day Combined Standard (2WW ,Breast Symptomatic And Screening Referrals)	✓	Yes	Mar-26	82.9%	78.8%	80.0%	83.5%	74.1%		
.0	Cancer 31 Day Combined Standard (First And All Subsequent Treatments)	✗	Yes	Mar-26	75.5%	80.2%	87.0%	88.6%	71.8%		
104.0	Cancer 62 Day Combined Standard (2WW, Consultant Upgrade And Screening)	✗	Yes	Mar-26	56.5%	60.3%	71.1%	69.9%	50.7%		
105.0	62-Day Cancer Standard: Incomplete Pathways >62-Days		Yes	Apr-26	293	376		448	303		
106.0	% Diagnostic Waits Waiting 6 Weeks Or More	✗	Yes	Apr-26	21.9%	22.7%	4.9%	27.7%	17.7%		
107.0	Diagnostic Activity Vs 2019/20		Yes	Apr-26	129.3%	133.8%		146.1%	121.6%		
108.0	Total Outpatient Attendances (SUS)	-	Yes	Mar-26	115214	111780	117191	136157	87403		
109.0	Bed Utilisation General & Acute	✗	Yes	Apr-26	88.7%	93.3%	95.0%	96.5%	90.2%		
110.0	Average Non Elective LOS Trust Level For IPR (Average So Cannot Aggregate Up)	✗	Yes	Mar-26	6.5	6.9	6.3	7.6	6.1		
111.0	Number Of Non-Discharged Patients Put Onto A PIFU	✗	Yes	Apr-26	1057	1028	5860	1253	804		
112.0	Cancelled Operations Within 24hrs (Non-Clinical Reasons)		Yes	Apr-26	0.3%	0.3%		0.5%	0.1%		
113.0	Cancellations Not Re-Booked Within 28 Days		Yes	Apr-26	33.3%	13.7%		34.4%	-6.9%		
114.0	Elective DC Spells - SUS	-	Yes	Mar-26	7292	6792	7200	8375	5209		
115.0	Elective IP Spells - SUS	-	Yes	Mar-26	1623	1506	1591	1828	1185		
116.0	Average Delay (Exclude Zero Delay) Of Discharges	✓	Yes	Mar-26	5.3	5.8	6.2	7.1	4.5		
117.0	Percentage Of Patients Discharged On Discharge Ready Date	✗	Yes	Mar-26	86.3%	88.2%	89.8%	89.9%	86.5%		

Integrated Performance Report (SPC)

No specified domain
No specified section

Data updated on: 22/04/2026 12:09:50

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
[redacted]	Vacancy Rate	✓	Yes	Apr-26	6.6%	5.9%	7.7%	7.2%	4.6%		
[redacted]	Turnover Rate	✓	Yes	Apr-26	7.8%	9.2%	12.0%	9.5%	8.8%		
12.0	Turnover Rate With No Exclusions		Yes	Apr-26	11.4%	10.9%		11.4%	10.5%		
[redacted]	Sickness Absence Rate (Rolling 12 Months)	✗	Yes	Apr-26	4.2%	4.1%	3.1%	4.2%	4.1%		
14.0	Non Medical Appraisals	✗	Yes	Apr-26	13.2%	76.2%	85.0%	93.0%	59.4%		
15.0	Sickness Absence Rate (In Month)	✗	Yes	Apr-26	4.1%	4.4%	3.1%	5.1%	3.7%		
16.0	Core Skills Training Compliance	✓	Yes	Apr-26	92.5%	91.8%	85.0%	92.7%	90.8%		
17.0	Time To Hire (Average Days)	✓	Yes	Apr-26	36.7	46.1	53.0	55.4	36.9		

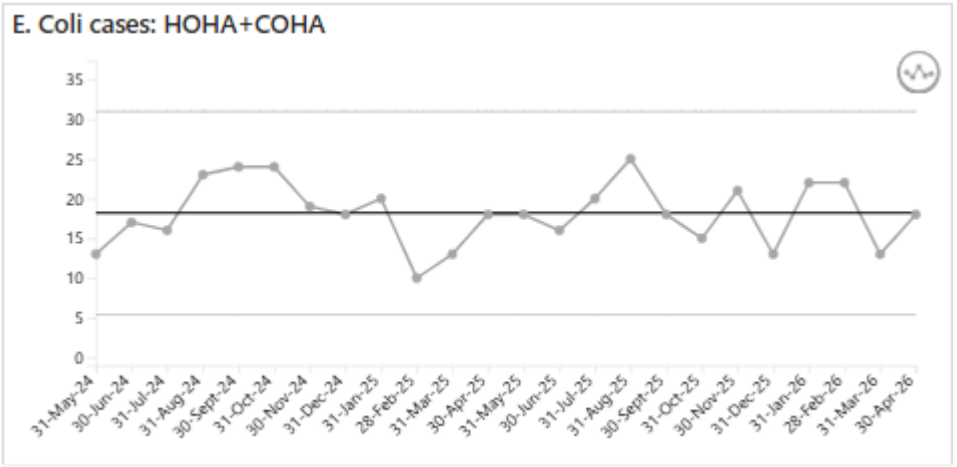
SPC Chart | Show SPC legend

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
1	CQC Overdue Actions ('Must Do')	✓	No	Apr-26	0	0	0	0	0		
2	Legal Services: Number Of Claims		Yes	Apr-26	25	21		36	7		
3	Information Governance And Data Security Training	✗	Yes	Apr-26	90.1%	90.6%	95.0%	92.2%	89.0%		
4	Data Security & Protection Breaches		Yes	Apr-26	31	30		48	11		
5	Externally Reportable ICO Incidents	✓	No	Apr-26	0	0	0	0	-0		
6	All IG Reported Incidents		Yes	Apr-26	35	32		49	14		
7	Freedom Of Information (FOI) % Responded To Within Target Time	✗	Yes	Apr-26	70.8%	60.9%	80.0%	85.6%	36.2%		
8	Data Subject Access Requests (DSAR)	✓	Yes	Apr-26	82.6%	72.7%	80.0%	92.0%	53.4%		
9	Priority 1 Incidents	✗	No	Apr-26	2	1	0	3	-1		
118	Adjusted In-Month Financial Performance Surplus/Deficit £'000		Yes	Apr-26	-8008.7	-6893.3		-3205.8	-10580.8		
119	BPPC £ %	✗	Yes	Apr-26	50.3%	63.2%	95.0%	66.8%	59.7%		
120	BPPC Volume %	✗	Yes	Apr-26	33.9%	38.8%	95.0%	42.6%	35.1%		
121	Cash £'000	✓	Yes	Apr-26	42436	21508	15917	33925	9091		
122	Efficiency Delivery £'000	✗	Yes	Apr-26	4941.0	7066.7	5371.1	14117.3	16.0		
123	In-Month Financial Performance Surplus/Deficit £'000	✗	Yes	Apr-26	-6610.4	-9.3	-6564.0	4890.4	-4909.1		
124	In-Month ICS CDEL Capital Expenditure	-	Yes	Apr-26	2707.8	7625.9	8699.1	19158.3	-3906.5		
125	Year-To-Date Financial Performance Surplus/Deficit £'000	✗	Yes	Apr-26	-6610.4	-13032.3	-6564.0	-6411.9	-19652.7		

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

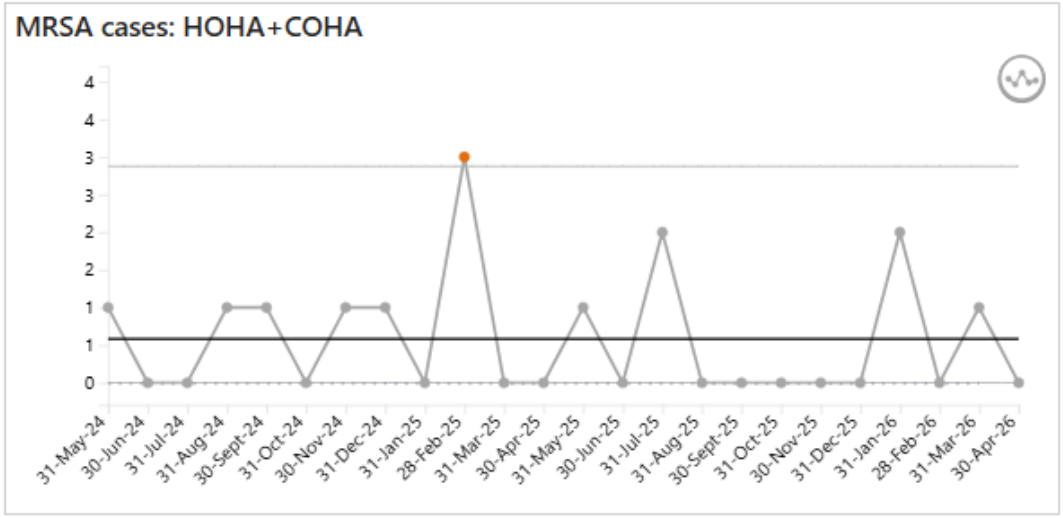
03. Assurance reports

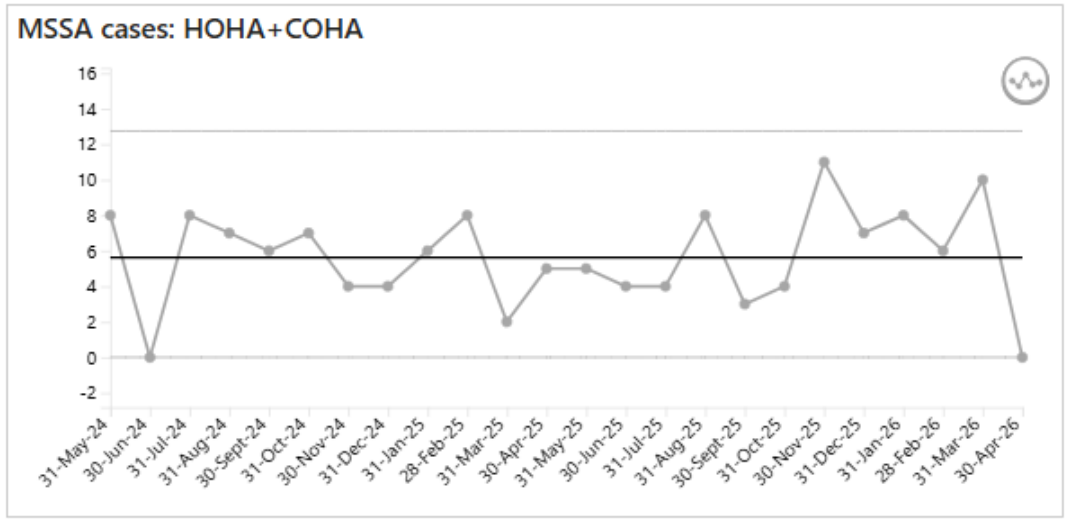
3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks	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 18 cases of *E. coli* reported in April (11 HOHA and 7 COHA). We have not received annual infection thresholds from NHS England for 2026/7 yet and we await the Q4 update of the NHS Oversight Framework Acute Trust league table, however this number of cases is in line with recent months and identical to last April's number. It is in the context of a rise in cases nationally.	***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 none of April's cases appear to have been catheter-related. The changes in patient demographics with an ageing population (18.6% of the total population was aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011), and more people at risk because of comorbidity or treatment such as immunosuppression, make targets especially challenging. Nationally, rates continue to rise.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

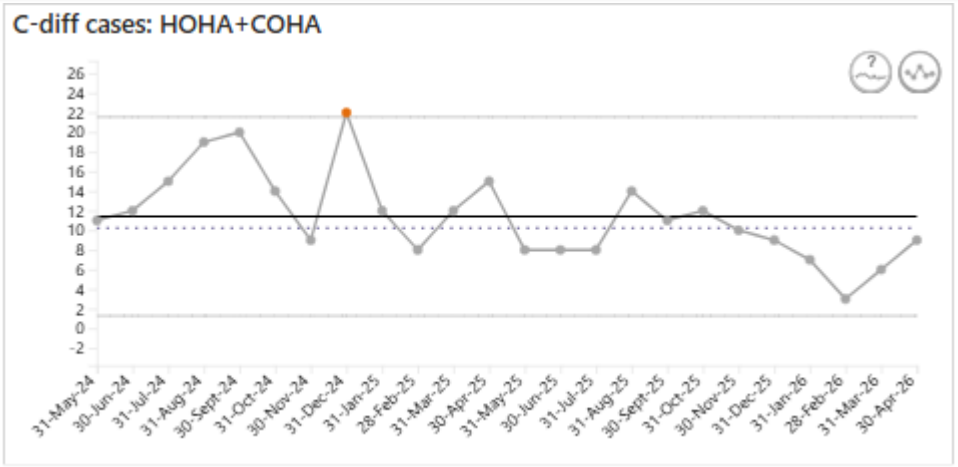
3. Assurance report: Quality, Safety and Patient Experience

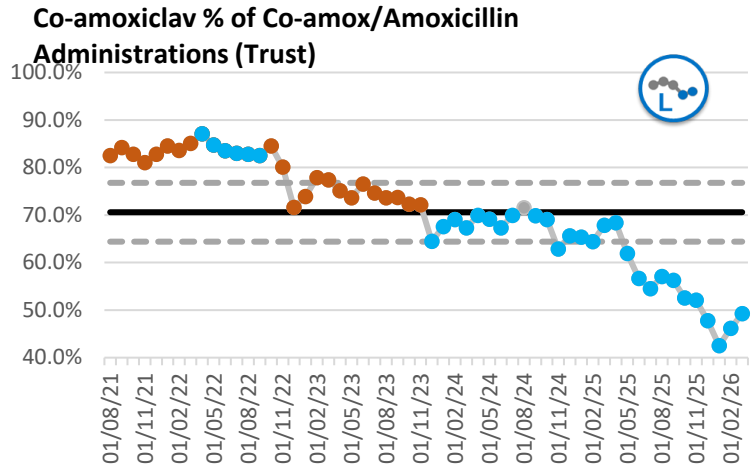




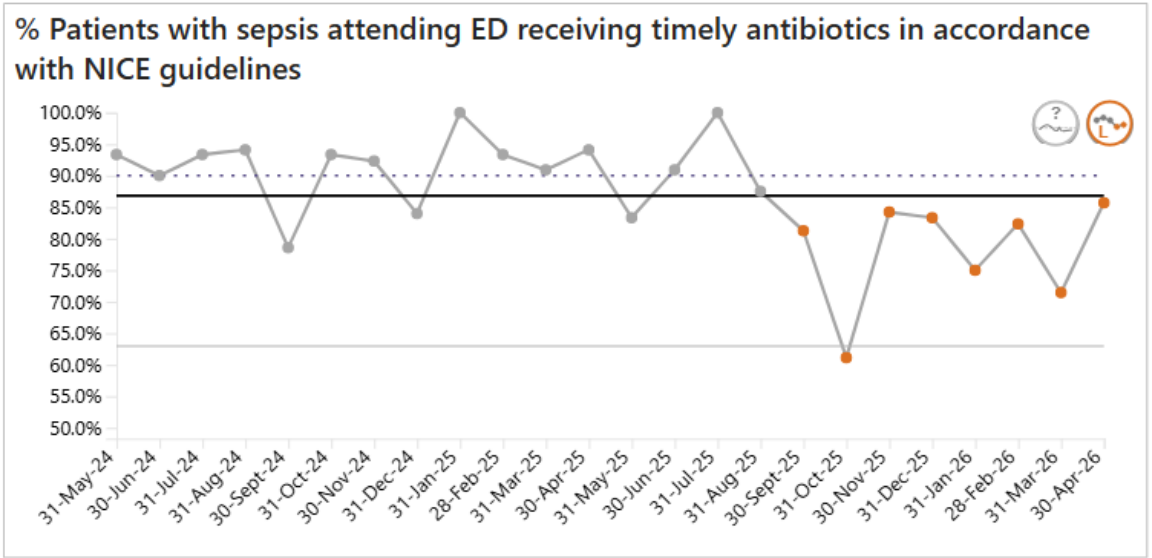
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MSSA bacteraemia: There were no cases of healthcare associated MSSA bacteraemia to report in April (10 cases in March). This is random statistical fluctuation. **MRSA Bacteraemia:** There were no cases of MRSA bacteraemia to report in April.	**MSSA bacteraemia**: The IPC team continue to support wards with their action plans on improving the assessment and documentation of IV lines. The new MRSA screening process with multi-site swabbing to improve the sensitivity of detection of MRSA colonisation is now well-embedded.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

3. Assurance report: Quality, Safety and Patient Experience



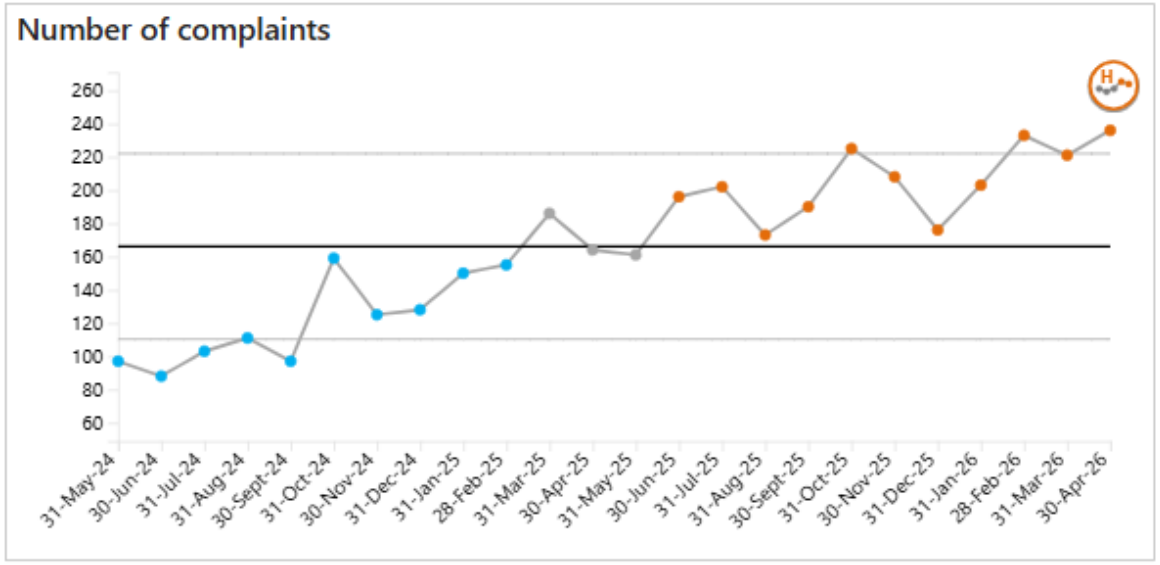


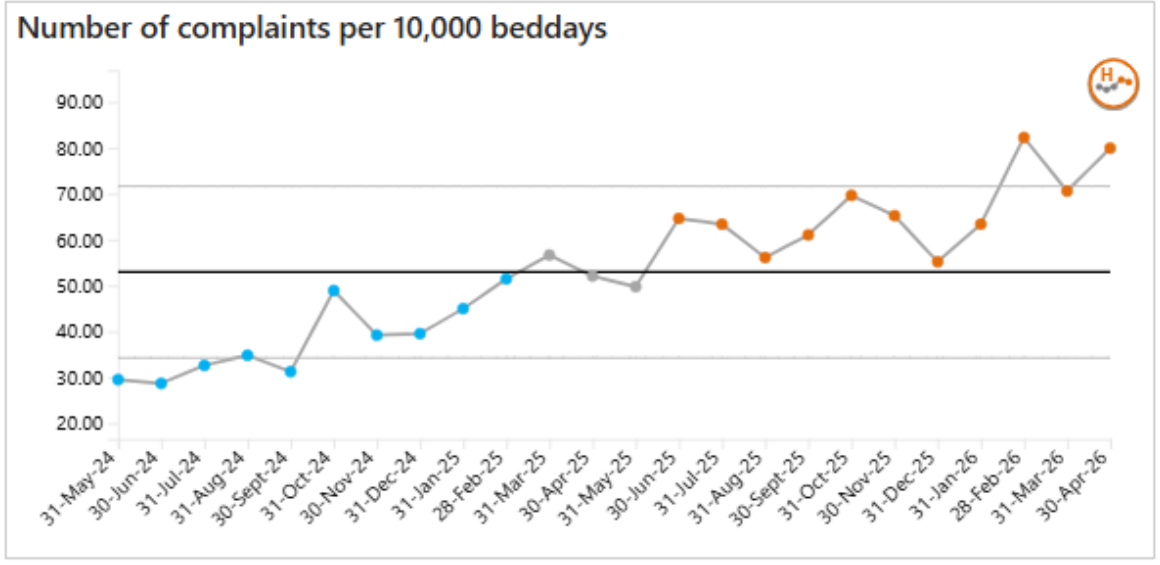
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***C. difficile* infection:** OUH reported nine healthcare-associated *C. difficile* cases (six HOHA and three COHA) in April to the UK Health Security Agency (UKHSA). April last year saw 15 cases, so this is a 40% year-on-year reduction which continues our downward trend in *C. diff* numbers. We await the Q4 update for the NHS Oversight Framework Acute Trust league table, but our score in Q4's data is anticipated to be 1.00 (the lowest possible score) as we ended the year below threshold. **IPC Surveillance:** While the lack of a comprehensive surveillance system remains high on the Trust risk register, initial preparatory work and discussions on the installation and integration of ICNet have begun. The assignment of a Project Manager from IM&T to the process is awaited and will be crucial to maintaining progress.	***C. difficile* infection:** A continued focus on good antimicrobial stewardship will be required to maintain our significantly improved *C. diff* position. Additionally, we are currently trialling 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. **IPC Surveillance**: Implementation of Phase 1 of ICNet to take place over next 6-9 months, followed by 2nd phase (integration of surgical data to support SSI surveillance) in 2027.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
ED Delays in Antibiotic Administration March 2026 ***In April 2026, 12/14 (86%) of patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines NG253.*** 2 patients who met high-risk sepsis criteria experienced a delay in receiving antibiotics within the recommended one-hour timeframe. Both patients were reviewed on time by medics but there was a delay in prescription and administration. It is unclear whether administration was documented retrospectively.	Ongoing review with monthly audit. Report to AGM clinical governance meetings each month. The Sepsis Team continue to screen and review patients within working hours (07:30-5pm), supporting the front-line service with delivery of the sepsis care bundle as needed. The team work with the ED governance lead nurse consultant to review those with delays and provides a deeper dive into any factors causing delay within ED such as corridor care nursing, staffing and ED acuity. These issues are then reported back into the clinical area for improvements and learnings. Sepsis Team has met with new ED sepsis lead in April and discussed the main issues: - Venous access - Defining responsibility among ED vs AGM teams for AGM patients in the Emergency Department - Recognition of acuity using the new ED triage system - Sepsis PGD	The sepsis team are working with the new ED sepsis lead and clinical governance lead to finalise an updated action plan, and how ED will implement this in practice. The action plan and sepsis performance are overseen by the Sepsis Working Group, chaired by the Sepsis Clinical Lead. Progress is being monitored by the DCMO. Publication of a new Modern Service Framework (MSF) for sepsis is expected later this year.		

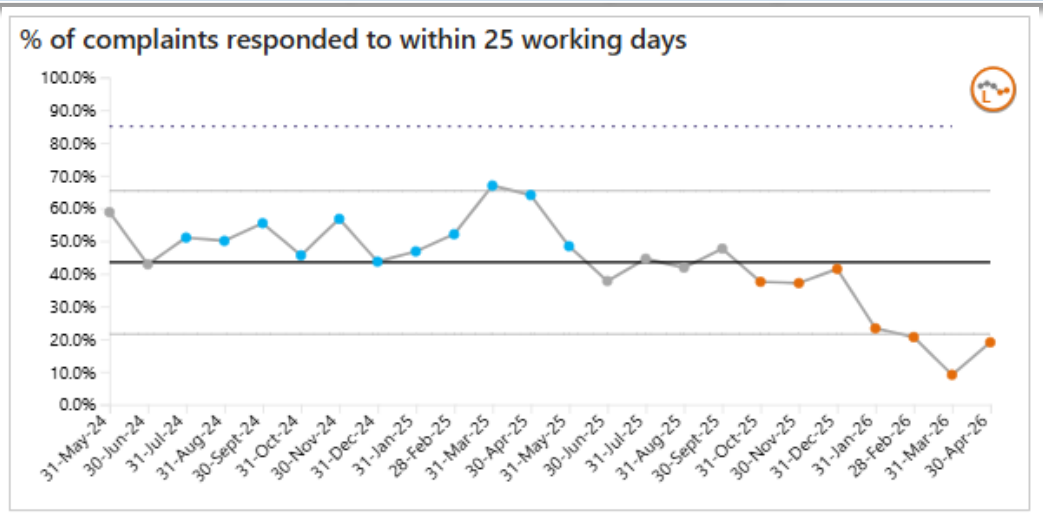
3. Assurance report: Quality, Safety and Patient Experience, *continued*

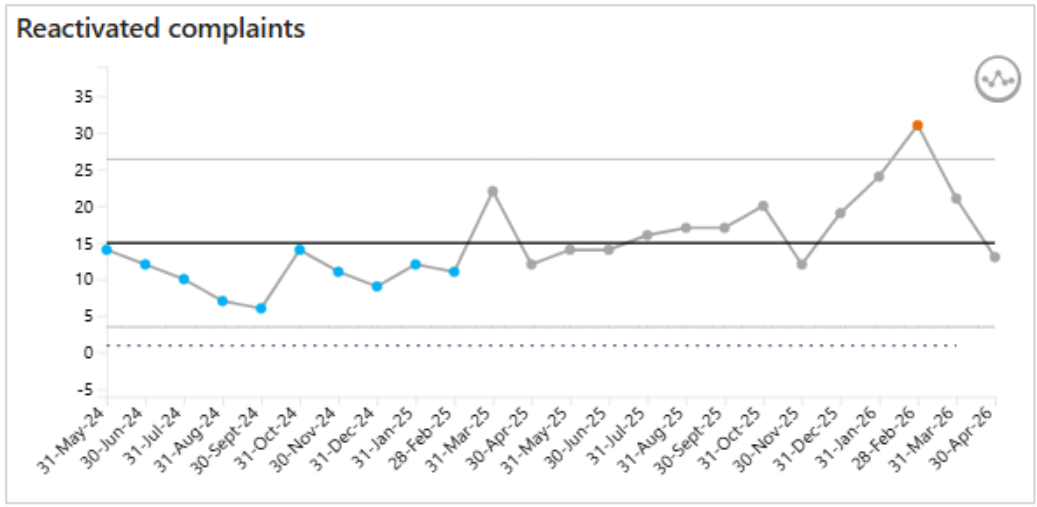




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In April the Trust received 234 formal complaints. As indicated in the charts above, this reflects a sustained increase in underlying demand, which is both a local and national issue, with similar trends reported across the NHS. Complaints are also becoming more complex, frequently spanning multiple episodes or divisions, contributing to an estimated 12% increase in investigation time. In addition, the emergence of AI-generated complaints, recognised nationally, is reducing clarity of issues raised and increasing the need for clarification. Together, rising volume and complexity place pressure on the Trust's ability to consistently meet the 25-day response KPI.	The top five complaint categories remained consistent with previous months: Clinical Treatment (n=60/25.6%), Communications (n=43/18.3%), Appointments (n=37/15.8%), Values and Behaviours (n=18/7.6%) and Facilities (n=15/6.4%). Complaints relating to Trauma and Orthopaedics (n=30), Emergency Medicine (n=29), Corporate services (particularly car parking and Subject Access Request delays) (n=25), and Children's services (n=13) represented the highest volume areas during April. Targeted meetings are in place with these areas, involving the CNO and CMO teams, to ensure focused oversight and continued progress.	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*

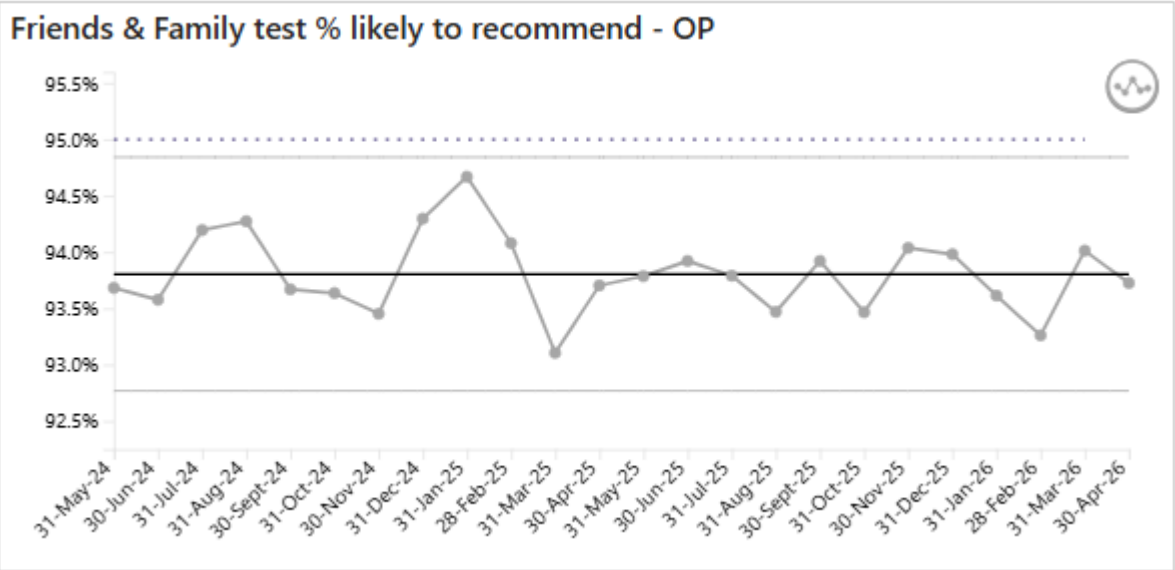
3. Assurance report: Quality, Safety and Patient Experience, *continued*





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
In April 2026, OUH received a total of 234 formal complaints, continuing the special cause variation (shift) and contributing to ongoing challenges with meeting the 25-day KPI.	The Trust achieved a median response time of 28 days for complaints in April 2026, an improvement from 29 days in March. This provides assurance that, despite an increasing number of complaints, the majority of breaches are by a small margin, enabling a more focused and proportionate approach to managing a limited number of longer-running cases within specific services. This supports clearer accountability and targeted intervention where required. Complaint sign-off and closure performance improved significantly, with 242 complaints closed in April, representing a 98% increase compared to March (n=122). Reopened complaints reduced further to 13 cases (5.5%), down from 19 in March, indicating improved response quality and clarity despite ongoing demand pressures. Reopened complaints further decreased in April, with 13 complaints (5.5%) reopened, compared to 19 in March. Of the complaints reopened in April, 5 of them were within the MRC Division, with 4 cases reopened for NOTSSCAN, 2 cases for Corporate services and 1 each for CSS and SUWON. Reasons as to why a complainant wishes to reopen their complaint, include wanting to meet with senior staff to discuss the response face to face, further questions that they wish to have a response to or that they do not agree with the findings of the investigation and subsequent response.	Ongoing, reviewed weekly. New escalation triggers have been introduced with Divisions required to discuss complaints that are not resolved at 40 days and again at 60 days at PEEC. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses made up 10,263 of all responses received (71%) in April 2026, with a recommendation rate of 93.7%. 2. The top positive themes during April for Outpatients were Staff Attitude, Implementation of Care, and Admission. The top negative themes were Catering, Waiting List 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 online collection methods and improved response rates are being considered and will be further supported by the Patient Experience and Engagement Strategy that is currently in development.	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 April, with planned versus actual fill rates of 95.65% (day) and 99.05% (night), providing assurance that staffing levels were maintained safely. Where fill rates fell below 90%, all shifts were reviewed and mitigated at Matron level or above, with no shifts 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 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 these nurse/midwifery-sensitive harm indicators are directly related to staffing levels. The April review confirmed across all divisions, there were no instances of nurse/midwifery-sensitive harm indicators directly linked to nursing or midwifery staffing levels. The HR data is being reviewed, as following amendments to budgets, the data is inaccurate.

SUWON – No harms were related to staffing. All red flags were reviewed. Net hours non-aligned with KPI on SEU-F roster, relate to a student, not substantive workers. Two rosters were above the Annual Leave KPI. One due to emergency annual leave being granted, the other due to leave having been approved before nurse transferred onto this roster.

MRC – No harms were related to staffing. Following close monitoring and education by the DDN, there were just two red flags not reviewed during April. Although ward 5A had 7 falls, they were all no or minor harm. No specific trend has been found, but this is being monitored closely by the DN and Deputy. One ward was late publishing the roster, an oversight by the Matron, however, the roster publication is back on track for the next roster.

NOTSSCAN – No harms related to staffing. Review and closure of red flags continues to improve, however, due to unforeseen circumstances, the Nuffield Orthopaedic site had no Matron to review this month. The DN will ensure moving forward this is monitored weekly. Net hours for Head & Neck ward relate to managed additional time worked to cover leave. This will be resolved in the next roster. The rosters at the Nuffield Orthopaedic site were not approved for payroll, due to the unforeseen absence of the Matron and one Deputy, with the remaining Deputy covering another role and site. Annual leave was above the KPI on four rosters. Upon review, this was due to emergency annual leave being granted after the roster had been published.

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

CSS – There were no issues or concerns for April.

Maternity – One birth experienced a change in place of planned birth due to staffing. All community on call midwives were working, but unfortunately demand was higher than availability. As a result, the patient experience was not optimum, but no harm came to mother or baby. The net hours discrepancy relate to a student midwife, incorrectly allocated to the Bereavement roster which will be corrected for next month. Annual leave is low on two rosters, however, this was the end of the leave year, and all leave had been used.

Nurse and Midwifery Sensitive Indicators Directly Impacted by Staffing Levels
The DNs have reviewed and approved the staffing levels for April 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
There continue to be some discrepancies in the vacancy data in ESR and the ledger. However, the divisions have worked closely with their finance teams to ensure staffing numbers utilised are aligned with the CNO approved safe staffing requirements following the establishment reviews for inpatient wards. Alignment work is ongoing in ESR and the roster templates.

Unavailability
All areas that experienced high 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. Please note any change to staffing establishments recently agreed, have not yet been reflected in HR Data. Therefore, the vacancy reported is likely to be higher than it is.

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. There is an error in the data for Maternity and CSS, however, this will be corrected and resume next month.

Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
The Trust has commenced developing actions tailored to improving roster efficiency and effectiveness in nursing and midwifery. This work will ensure a balanced skill mix during each shift. Assurance of ongoing oversight and assurance that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing 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

April 2026	Care Hours Per Patient Day				Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 23.3.26- 19.4.26				FFT - Total responses in each category for each ward					
Ward Name	Actual Care staff	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	2.6	7.94	10.09	10.7	100.00%	3				4	1	0	1	2.68%	18.93%	2.37%	10.13%	12.54%	Yes	0.17%	8.00	14.66%	15	4	2	0	2	0
HH Childrens Ward	2.8	6.29	9.14	16.6	94.44%		9		1	0	0	0	0	13.52%	12.58%	5.72%	4.78%	17.65%	Yes	-1.61%	8.00	17.08%	41	5	1	0	0	0
Kamrans Ward	0.5	7.66	10.93	11.3	100.00%		22			0	0	0	0	8.55%	2.82%	1.93%	7.43%	15.34%	Yes	2.22%	8.71	14.33%	6	0	0	0	0	0
Melanies Ward	2.9	7.51	11.15	10.6	100.00%		4			0	0	0	0	-0.82%	9.07%	5.43%	8.48%	11.45%	Yes	0.45%	8.71	16.90%	16	4	0	1	0	0
Robins Ward	2.3	8.23	10.01	11.6	83.33%		5			3	1	0	1	13.88%	30.05%	3.75%	3.81%	17.16%	Yes	-3.23%	8.71	16.34%	30	2	0	0	1	0
Tom's Ward	1.6	7.63	10.31	9.7	100.00%					6	2	0	0	14.53%	4.82%	4.85%	7.82%	21.21%	Yes	-1.15%	8.71	12.28%	26	5	0	1	0	0
Neonatal Unit	1.1	19.92		17.7						16	3	0	0	16.43%	5.74%	6.03%	4.25%	22.20%	Yes	-1.90%	8.43	14.13%	2	0	0	0	0	0
Paediatric Critical Care	2.5	27.59		27.1		1				24	7	0	0	14.32%	3.41%	5.94%	5.10%	19.37%	Yes	0.09%	9.43	14.16%	0	0	0	0	0	0
BIU	2.7	5.99	6.05	7.4	98.89%			8		4		0	0	12.88%	4.73%	3.05%	4.59%	16.88%	No	2.35%	9.00	15.85%	0	0	0	0	0	0
HDU/Recovery (NOC)	0.0	4.82		9.8						2		0	0	11.11%	8.94%	10.09%	0.00%	14.89%	No	-0.39%	7.86	13.79%	0	0	0	0	0	0
Head and Neck Blenheim Ward	1.9	6.54	7.59	8.2	98.89%		3	1		0		0	3	2.50%	0.00%	3.29%	0.00%	5.46%	Yes	-3.81%	9.29	13.70%	9	1	0	0	0	0
HH F Ward	3.4	7.05	9.08	7.9	100.00%					1		2	1	3.79%	0.00%	4.08%	0.00%	3.79%	No	-0.95%	8.86	16.08%	22	2	0	0	0	0
Major Trauma Ward 2A	3.6	8.67	9.01	9.4	93.33%					6		0	1	18.04%	10.12%	3.87%	6.67%	23.50%	No	-0.06%	8.29	17.24%	16	1	0	0	0	0
Neurology - Purple Ward	4.1	7.62	9.21	8.2	100.00%			4		1		1	4	2.52%	11.74%	4.75%	0.00%	2.52%	Yes	1.94%	9.43	15.82%	14	2	0	0	0	0
Neurosurgery Blue Ward	4.2	8.46	10.45	9.6	100.00%		2			1		0	2	7.95%	0.00%	4.92%	2.18%	11.81%	Yes	2.25%	9.43	13.53%	24	3	0	0	0	0
Neurosurgery Green/IU Ward	5.9	9.69	10.65	9.8	100.00%			1		0		1	2	7.37%	6.65%	5.38%	2.76%	9.92%	Yes	0.67%	8.43	18.48%	2	0	0	0	0	0
Neurosurgery Red/HC Ward	5.0	10.93	11.64	11.7	100.00%					0		0	0	-6.09%	8.83%	6.39%	4.54%	0.20%	Yes	-1.05%	9.43	13.10%	8	2	0	0	0	0
Specialist Surgery I/P Ward	2.8	6.90	7.05	8.3	100.00%			1	1	4		0	3	8.72%	4.25%	4.75%	1.51%	10.10%	Yes	2.31%	9.43	15.43%	7	0	0	1	0	0
Trauma Ward 3A	3.5	8.65	8.91	9.2	81.11%					1		1	2	8.14%	6.76%	4.00%	3.86%	11.68%	No	-0.05%	8.29	15.39%	11	3	0	1	0	1
Ward 6A - JR	3.0	7.03	7.05	7.3	100.00%		3	6		4		2	2	4.93%	0.00%	3.87%	2.21%	7.03%	Yes	-1.98%	7.86	17.97%	7	1	0	0	0	0
Ward E (NOC)	2.8	5.30	6.87	8.0	98.89%			1		1		0	0	-6.03%	0.00%	7.29%	10.68%	5.30%	No	2.19%	9.00	14.07%	34	1	1	0	0	0
Ward F (NOC)	2.9	5.80	7.42	7.3	81.11%	5	1			0		0	5	11.42%	15.31%	6.61%	3.11%	14.17%	No	-0.42%	8.86	16.44%	6	0	1	0	0	0
WW Neuro ICU	2.8	28.00		35.6						2		1	0	-10.34%	8.22%	5.47%	10.48%	1.22%	Yes	0.13%	7.71	17.05%	0	0	0	0	0	0

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

Oxford University Hospitals NHS Foundation Trust

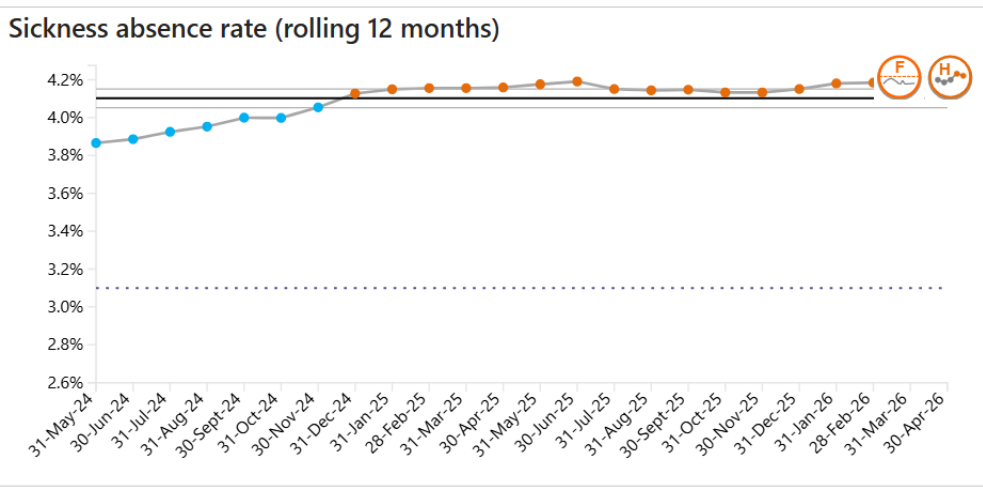
April 2026	Care Hours Per Patient Day				Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 23.3.26- 19.4.26				FFT - Total responses in each category for each ward					
Ward Name	Actual Care staff	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	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	3.8	8.36	8.85	8.4	100.00%		14	5	2	0		1	7	-2.17%	0.00%	2.95%	4.12%	2.04%	Yes	0.25%	9.71	13.72%	18	2	0	0	0	0
Ward 5B SSW	4.3	8.36	8.95	8.8	100.00%		12		3	0		0	4	6.43%	0.00%	2.70%	2.11%	8.41%	Yes	-0.03%	9.43	14.59%	1	0	0	0	0	0
Cardiology Ward	2.2	8.24	7.84	8.9	100.00%	1	19	5	2	4		0	3	11.52%	3.38%	4.87%	7.91%	18.52%	Yes	-1.70%	8.29	14.88%	5	0	0	0	0	0
Cardiothoracic Ward (CTW)	2.2	7.43	6.49	7.1	98.89%		5		1	2		1	2	12.52%	5.90%	4.12%	6.79%	18.45%	Yes	-0.13%	8.43	15.39%	23	3	0	0	0	0
Complex Medicine Unit A	4.5	8.94	11.63	8.7	98.89%		5		2	1		2	5	5.82%	4.40%	6.68%	4.64%	10.19%	Yes	1.42%	9.29	13.18%	2	0	0	0	0	0
Complex Medicine Unit B	4.7	9.48	10.73	8.9	100.00%					0		0	4	3.58%	9.23%	6.15%	7.08%	10.40%	Yes	0.83%	9.71	15.45%	5	1	0	1	0	0
Complex Medicine Unit C	4.1	8.21	11.16	8.5	100.00%	1		2		1		2	2	6.97%	8.98%	2.04%	2.29%	9.10%	Yes	-0.57%	9.71	12.94%	23	1	0	0	0	0
Complex Medicine Unit D	3.9	8.63	9.1	8.7	98.89%					1		3	2	9.70%	5.15%	4.69%	0.00%	9.70%	Yes	-0.85%	9.71	11.95%	2	2	0	0	0	0
CTCCU	0.0	21.59		22.0						4		4	0	12.84%	10.40%	4.40%	5.71%	17.82%	Yes	1.50%	6.43	13.13%	0	0	0	0	0	0
Emergency Assessment Unit (EAU)		8.89	8.55		97.78%					3		0	6	9.30%	14.01%	6.52%	3.36%	12.97%	Yes	-1.31%	8.57	14.63%						
JR Emergency Department		19.84								7		0	3	14.14%	11.73%	3.65%	2.64%	16.85%	Yes	0.16%	9.57	12.61%	550	128	33	27	39	6
HH EAU		9.20	7.11		96.67%					1		2	1	6.57%	2.77%	6.12%	2.34%	11.96%	Yes	1.67%	8.71	13.83%	1	0	0	0	0	0
HH Emergency Department		23.16								3		0	2	1.83%	5.46%	3.58%	7.32%	10.21%	Yes	-0.10%	8.71	14.30%	355	104	30	17	20	0
HH Juniper Ward	4.0	7.46	9.46	8.1	98.89%					0		1	3	1.37%	3.35%	3.99%	1.69%	4.57%	Yes	0.73%	9.43	15.62%	13	4	0	13	0	0
HH Laburnum	4.2	8.00	10.31	8.4	100.00%					2		1	5	-0.16%	0.00%	3.23%	1.83%	1.67%	Yes	1.71%	9.43	14.79%	17	4	0	17	0	1
HH Oak (High Care Unit)	4.8	10.83		11.4	96.67%		1	1		1		0	4	-1.46%	0.00%	4.42%	9.25%	10.12%	Yes	-0.94%	9.43	12.79%	10	0	0	0	0	0
John Warin Ward	4.6	10.06	9.64	9.8	100.00%		6	1		0		0	3	7.85%	12.18%	3.61%	2.39%	10.05%	Yes	-0.64%	9.43	15.50%	34	3	0	1	0	0
OCE Rehabilitation Nursing (NOC)	4.4	10.19	10.66	9.6	100.00%		2	1		0		0	1	9.49%	4.05%	4.70%	0.00%	12.04%	Yes	-1.64%	9.29	15.28%	4	2	0	4	0	0
Osler Respiratory Unit	4.9	11.98	9.52	12.0	100.00%		1			1		1	1	1.49%	5.11%	3.83%	1.37%	2.84%	Yes	-0.16%	9.43	16.24%	15	2	1	15	0	0
Ward 5E/F	4.8	9.58	8.91	9.8	100.00%		9	3	19	1		2	5	10.42%	6.03%	4.57%	1.81%	12.04%	Yes	0.01%	9.71	12.05%	0	0	0	0	0	0
Ward 7E Stroke Unit	3.6	9.20	9.57	9.4	100.00%		1	7		0		2	4	0.82%	9.02%	5.82%	1.52%	3.54%	Yes	0.10%	9.29	14.05%	29	1	0	0	0	0

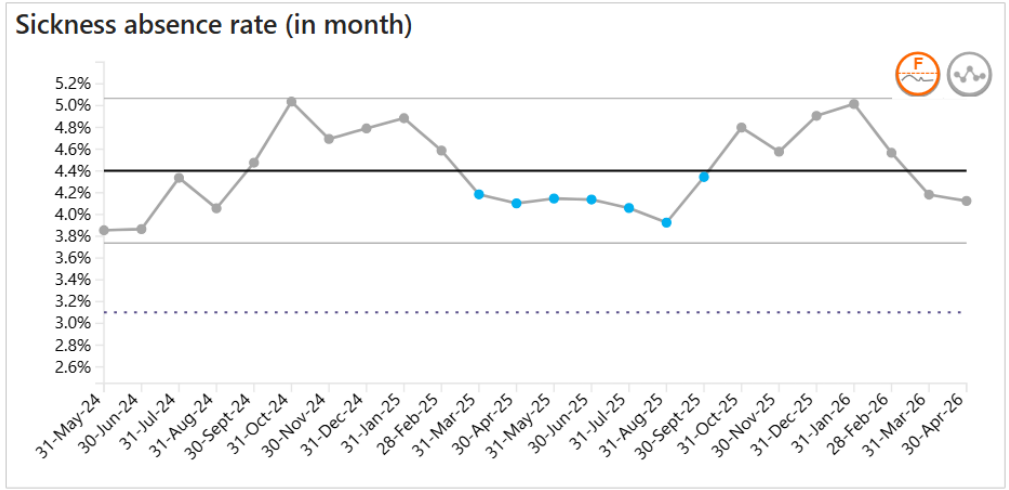
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

Oxford University Hospitals NHS Foundation Trust

April 2026	Care Hours Per Patient Day				Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 23.3.26- 19.4.26				FFT - Total responses in each category for each ward					
Ward Name	Actual Care staff	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)	3.4	7.95	8.67	8.8	100.00%		21	1	5	2		1	2	1.53%	4.13%	5.89%	4.76%	8.57%	Yes	-1.78%	9.29	13.78%	20	6	0	0	0	0
Gynaecology Ward - JR	3.0	5.01	5.62	8.7	98.89%			1		0		0	3	5.00%	9.58%	2.75%	0.00%	5.00%	Yes	-1.53%	9.43	14.10%	21	1	0	0	0	0
Haematology Ward	3.0	7.56	7.67	9.7	100.00%			1	1	2		0	2	6.10%	17.71%	5.48%	8.32%	13.91%	Yes	-1.65%	7.71	15.76%	7	3	0	0	0	0
Katharine House Ward	3.9	9.61	8.19	10.0	100.00%		11		2	0		1	2	13.65%	10.67%	5.54%	0.00%	15.92%	Yes	0.36%	9.43	16.05%	0	0	0	0	0	0
Oncology Ward	2.4	7.69	8.04	7.9	98.89%			1		5		3	4	10.91%	4.30%	2.94%	4.29%	14.73%	Yes	0.26%	7.29	14.12%	0	0	0	0	0	0
Renal Ward	2.8	7.59	7.94	9.3	100.00%		2			0		1	1	14.13%	15.77%	5.44%	0.00%	14.13%	Yes	0.06%	8.43	14.89%	6	1	0	0	0	0
SEU D Side	3.4	7.66	8.25	8.5	100.00%					0		0	4	14.48%	6.59%	4.61%	2.14%	17.98%	Yes	-0.42%	9.14	13.12%	25	5	2	0	0	0
SEU E Side	3.0	7.66	7.92	8.2	100.00%			2		1		1	1	21.55%	19.24%	8.64%	3.21%	26.59%	Yes	-1.63%	9.14	14.68%	17	2	2	0	0	0
SEU F Side	2.8	6.95	8.10	7.4	100.00%			2		0		0	0	23.21%	7.74%	2.86%	0.00%	25.70%	Yes	-17.96%	9.14	14.29%	26	3	1	0	0	0
Sobell House - Inpatients	2.8	7.85	7.88	8.1	100.00%		21	1		1		3	2	13.67%	5.01%	5.20%	2.92%	18.72%	Yes	2.07%	9.29	15.19%						
Transplant Ward	3.1	8.93	7.45	9.8	96.67%					3		0	1	20.73%	7.91%	5.86%	2.12%	25.21%	Yes	1.00%	9.57	18.90%	15	0	0	0	0	0
Upper GI Ward	2.0	9.42	7.12	7.6	100.00%		1			2		0	4	9.87%	0.00%	3.62%	2.16%	11.81%	Yes	-1.90%	8.57	16.85%	20	3	0	0	1	0
Urology Inpatients	3.4	8.32	8.62	8.6	100.00%		14	1		0		0	3	10.75%	7.96%	5.12%	3.26%	16.57%	Yes	-2.54%	8.57	15.12%	89	7	0	1	1	0
Wytham Ward	1.8	6.81	7.24	6.8	100.00%					1		1	0	16.70%	8.88%	6.05%	0.00%	16.70%	Yes	-3.16%	8.29	19.33%	19	3	1	0	0	0
MW Intrapartum Team	2.1	14.58		15.9				38						13.41%	7.74%	4.52%	6.39%	20.15%	Yes	-3.29%	7.86	9.58%						
MW Level 5	2	5.40		5.2															Yes	-0.19%	7.86	13.05%						
MW Level 6	2	4.60		7.0										-24.35%	13.23%	5.17%	4.08%	-19.28%	Yes	0.09%	7.86	12.09%						
MW Level 7 (Bereavement)	1.2	-		5.1															Yes	59.31%	7.86	8.43%						
CSS																												
OCC/CICU	4.3	26.60		25.7	100.00%	-	-	-	-	8		4	0	15.04%	13.73%	4.64%	3.57%	20.02%	Yes	-1.17%	8.29	15.32%						

3. Assurance report: Growing Stronger Together

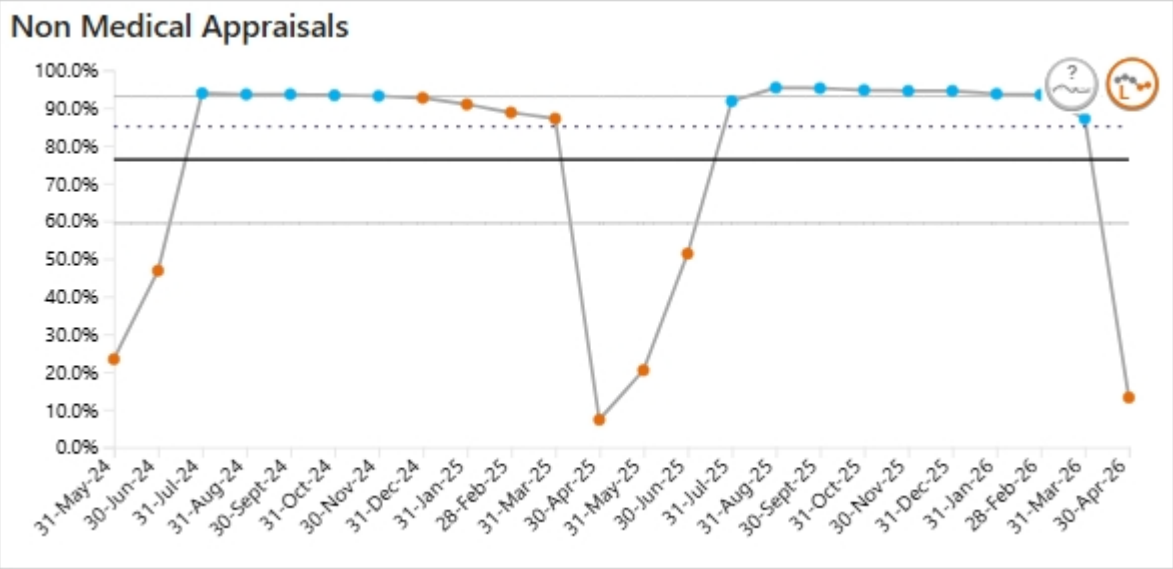




Benchmarking: November 2025 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

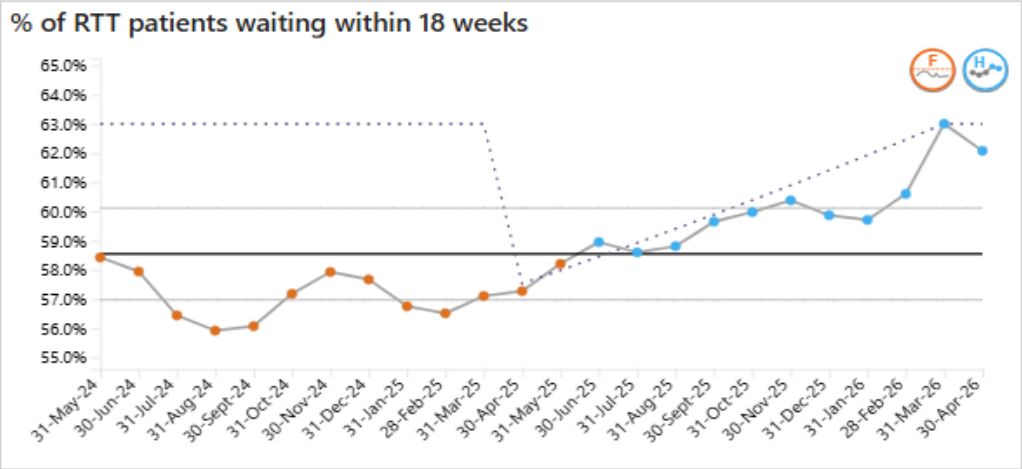
OUH: 4.43% **National: 5.77%** **Shelford: 4.99%** Buckinghamshire Healthcare NHS Trust: 4.28% Royal Berkshire NHS Foundation Trust: 3.61% Oxford Health: 5.43% South Central Ambulance Service: 7.50%

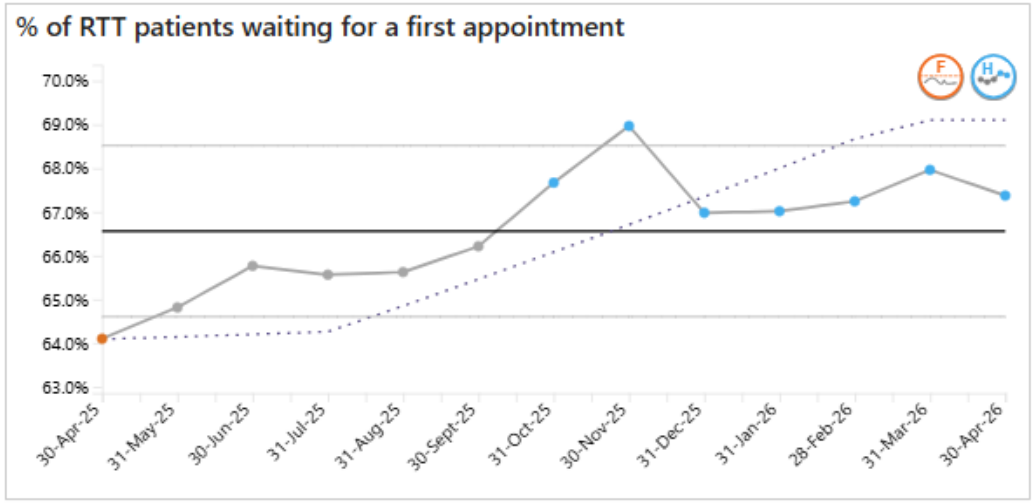
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.2% in April 26 – the same rate as March 25. The monthly sickness rate has decrease to 4.1% from 4.2 in previous M12 . The key reasons for sickness top 5 continue to be :- • Mental, Behavioural or Neurodevelopmental • Respiratory system • Musculoskeletal or Connective Tissue • Digestive system • Injury, Poisoning or External causes Long-term sickness top 5 reasons:- • Mental, Behavioural or Neurodevelopmental • Musculoskeletal or Connective Tissue • Injury, Poisoning or External causes • Neoplasms • Not elsewhere classified	• Divisions receive a monthly report detailing the top 10 reasons for absenteeism. These reports are used to inform targeted action plans, with particular focus on Cost Service Units (CSUs) demonstrating higher-than-average absence rates. • Work is ongoing in partnership with Occupational Health to support both managers and staff in understanding and addressing the primary causes of absence. A key priority is providing tailored support for individuals experiencing long-term sickness absence, with the aim of facilitating a safe and sustained return to work. • Managers are notified when employees trigger absence alerts and are provided with guidance on managing these cases effectively. HR continues to promote training for line managers to strengthen capability and confidence in sickness absence management. • Return-to-Work (RTW) processes have been streamlined, with updated forms and improved narrative guidance to support more effective conversations during RTW interviews. Local workshops remain in place to build manager capability, complemented by ongoing Occupational Health input through monthly meetings to proactively address emerging issues. • Regular monthly meetings with the Wellbeing Lead help identify additional support requirements, while work is underway to standardise naming conventions for sickness absence reasons to improve consistency in reporting and analysis.	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



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
M1 compliance is currently at 13.1%, which is above to last year's figure of 7.3% for M1 2024. Colleagues in the Divisional Workforce receive weekly reports detailing progress and the names of compliant and non-compliant staff. Compliance is expected to increase as the Trust is currently within the appraisal window, with further improvement anticipated as activity accelerates following the commencement of the new appraisal cycle.	• We offer a full range of communication, resource, and leadership support for managers and appraisees. • The Chief Officers have provided updates and a call for action at team briefings and senior leadership team briefings. • The culture and leadership team are delivering fortnightly webinar's on how best to prepare for an appraisal, and to date, over 950 people have attended. These sessions are also supported by online training for appraisers and appraisees. • There is targeted support being provided within the divisions for areas where in the staff survey, it was raised that the quality of appraisal could be improved. • There are regular divisional communications being sent, encouraging all managers and staff to book and prepare for their appraisals. • Advice is being provided on how to conduct an appraisal for staff who have different career aspirations and that everyone should have an appraisal conversation. • Appraisal compliance is being monitored at divisional performance reviews. • The Divisional Workforce Team and divisional SLT's are reviewing appraisal compliance progress at directorate performance reviews to ensure appraisals are being booked and held.	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, *continued*



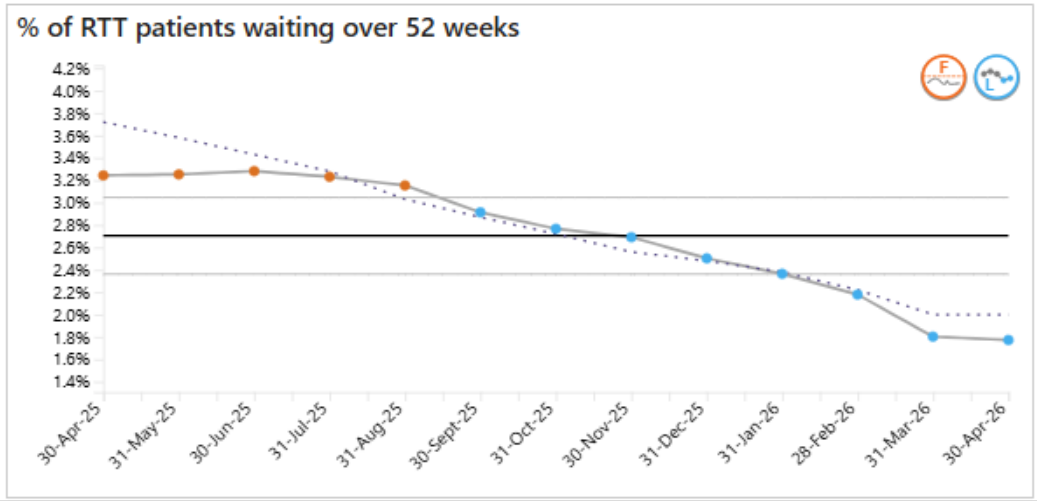


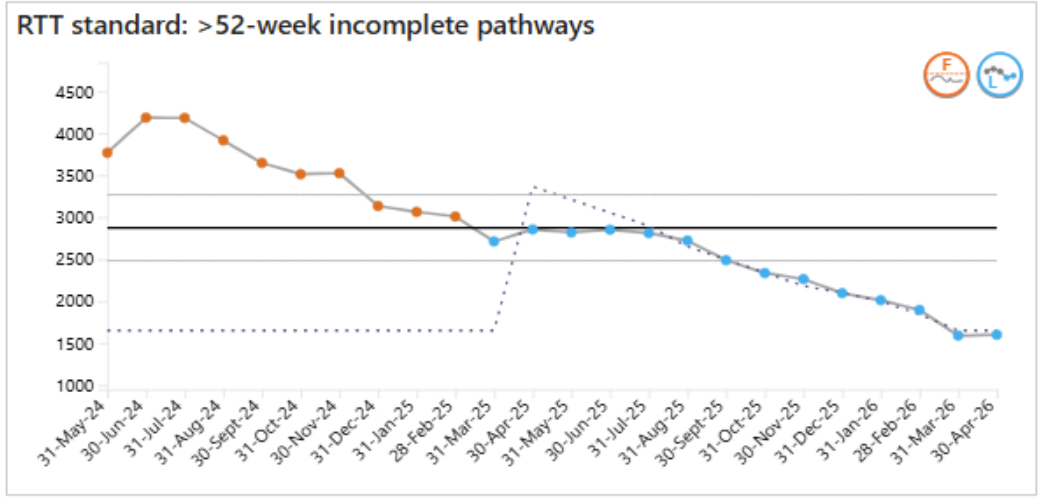
Benchmarking: RTT Admitted Treatment Within 18 Weeks March 2026

OUH: 46.2% | National: 53.4% | Shelford: 59.6% | BHT: 52.6% | RBH: 91.9%

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
The number of patients waiting less than 18 weeks as a proportion of the total waiting list was 62.1% at the end of April against an operational plan of 63.1%. 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 90,210 with *67.37% of patients awaiting a first appointment below 18-weeks. *using the weekly NWL submission officially however when using the monthly return, performance was 68.18%	The Trust is below plan by 1% for patients waiting within 18 weeks as at the end of April. The key focus is on treating patients with the longest waits across all specialties. The Trust has shown improvement in the last six months. Validation continues – utilisation of resources for administrative validation to scrutinise pathways above 18-weeks. Closely reviewing the prioritisation of all resources for patients waiting above 18-weeks, and to support another exercise of Patient Engagement validation across all specialties for the 18 weeks and above cohort. With focus moving away from total waiting list to instead the longest waiting patients, we acknowledge this to be the main contributing factor for an increased waiting list size against plan for April. An Outpatient Improvement Programme and a Theatres Improvement Programme are in place. Roll-out plans in place for additional specialties to use a digital outcome form from April which supports 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. Utilising Elective Pathway Manager tool to constructively address inconclusive validation outcomes such as missing letter or clinical input required by all specialities. Additional elective capacity through the Surgical Elective Centre (L1) operational plan assumed July this is now September and L2 is subject to revenue requirements and Board & 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 % over 52 weeks: March 2026

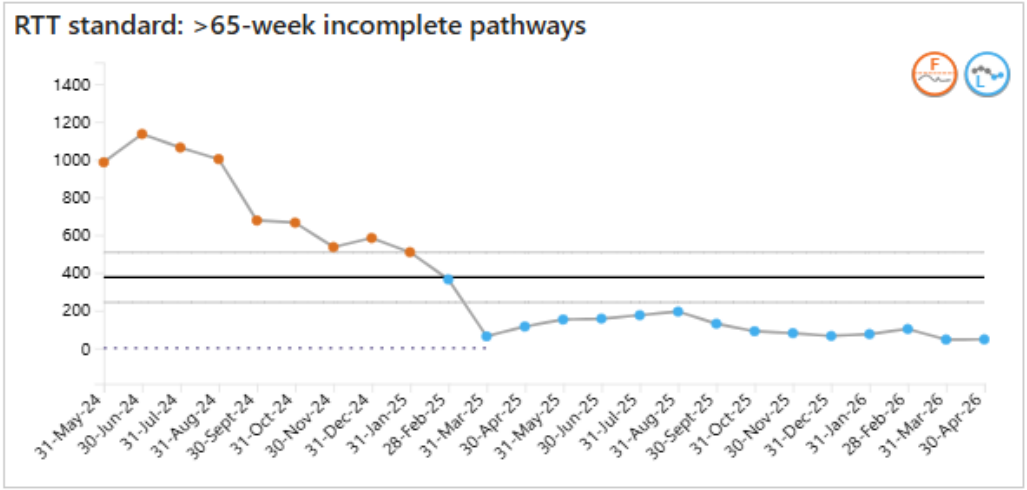
OUH: 1.8% National: 0.97% Shelford: 0.92% BHT:0.13% RBH: 0.10%

Benchmarking 52 week breaches: March 2026

OUH: 1,587 National: 409 (median) Shelford: 941 (median) BHT: 1 RBH: 1

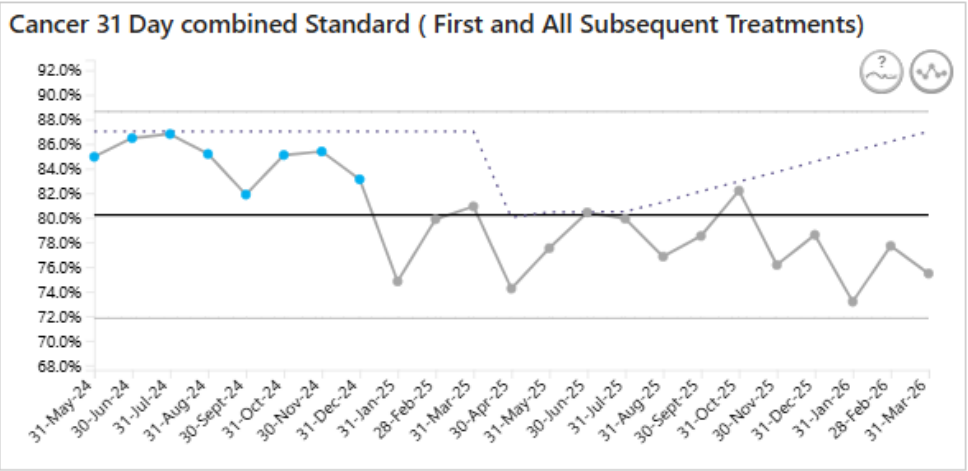
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks as a proportion of the total waiting list was 1.77% at the end of April against an operational plan of 2.00%. The lowest performance (positive) in the last 12 months. Performance exhibited special cause of improvement due to periods of performance outside the lower control limit. Incomplete RTT pathway size waiting over 52-weeks is 1,599 for April against a plan of 1,609. Over 65-weeks contributing to the position by 47 pathways against a target of nil.	The Trust continues the positive trajectory in reducing the patient numbers and % of patients waiting over a year for treatment. April 52 week percentage of total waiting list plan was achieved, including volume by 10 patients. Delivery Funds are in place to increase fixed term capacity to support delivery of the operating plan, with all schemes being mobilised. Specifically schemes underway include: - Insourcing for Dermatology, Neurophysiology - Outsourcing for Breast Surgery, MRI, Ophthalmology, - WLIs for Cardiology, Urology, General Surgery, Orthopaedic, OMFS, Audiology - AVT – will add 1 patient extra per clinic when deployed on phased basis Trust-wide objective set for all pathways awaiting 1st appointments to be seen by week 40 (35 for some specialities) as a minimum. Services that are challenged with delivering this objective are being evaluated through weekly check and challenge meetings led by the COO. And Service level reviews by the Divisional Tri / Quads. Activity is above plan and specifically for the focus on 1st OPA which illustrates our deliberate move to increase this specific activity as a deliberate approach to improving our access waiting times for patients.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

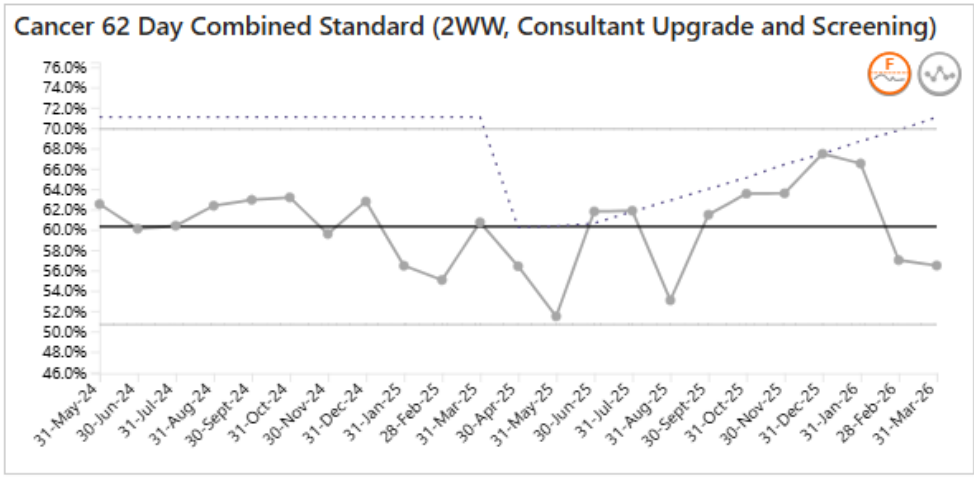
3. Assurance report: Operational Performance, *continued*



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 47 at the end of April. 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 April. **Focus remains on longest wait patients:** **>104 weeks - nil** incomplete pathways reported. **>78 weeks - 2** incomplete pathways reported. One has been treated in early May, and one has a transient illness therefore rescheduled in early June. **>65 weeks – 47** incomplete pathways reported which is a increase from the previous month by 1 pathway. 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. This service will be reviewing their next interventions following the peer review that took place in March 2026 with NHSE (at our request). **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 to take effect in M4. This remains a challenged speciality and is likely to remain so for a period of time, there is no mutual aid supported. **Oralmaxillio 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: Cancer 31 Day All Stages March 2026				
OUH: 75.5%	National: 95.9%	Shelford: 89.4%	BHT: 86.1%	RBH: 90.9%

Benchmarking: Cancer – Patients Treated Within 62 of Referral March 2026				
OUH: 56.47%	National: 74.07%	Shelford: 72.53%	BHT: 71.46%	RBH: 78.87%

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
Cancer performance for 31 days Decision to Treat was 75.5% in March 2026 against an operational plan of 87.0% and below the national standard of 96.0%. OUH ranked 134th out of 135 Providers and last out of the 10 Shelford Group. Performance is reported two months in arrears due to the extended reporting period for this indicator.	**Cohort 4 (March 2026):** 3-Tumour sites workshop held 20th March for Bladder, NSS and SACT. 100-day plans agreed for Bladder and NSS with SACT taking a strategic approach for longer term gains. Day 100 updates for these areas scheduled to be reviewed at Cancer Improvement Group on 26th June 2026. **Cohort 3 (Nov 2025): 3-Tumour Site Workshop held on 26th November** focussing on UGI and Renal with a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. Day 100 plans took take place at cancer strategy group on 27th March 2026. Initiatives to be continued locally with divisional oversight **Cohort 2 (Aug 2025):** focussing on LGI with updates following Day-100 presented on 19th December. Urology also locally undertaken and presented in the same forum for governance and support. Ongoing actions to continue at local level with the ability to escalate to Cancer Improvement Group every month by exception. **Cohort 1 (May 2025): 50-Day Sprint extension completed** to achieve remaining change ideas shared updated in November with a continuation of some schemes to be tracked locally with escalations to be raised through the Cancer Improvement Group meetings	Cancer Improvement Group – June 2026		

3. Assurance report: Cancer Addendum (Gynaecology)

Oxford University Hospitals NHS Foundation Trust

Indicator Name	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026
Cancer 28 Day FDS Combined Standard												
Generic Gynaecology Directorate	46.27%	49.24%	49.87%	56.70%	51.20%	50.84%	58.10%	63.64%	61.05%	59.63%	74.22%	73.02%
Cancer 31 Day Combined Standard												
Gynaecological - Cervix	62.50%	58.33%	71.43%	90.00%	80.00%	81.82%	87.50%	70.00%	75.00%	100.00%	88.89%	50.00%
Gynaecological - Other	50.00%	40.00%	77.78%	100.00%	60.00%	100.00%	50.00%	33.33%	0.00%	66.67%	66.67%	50.00%
Gynaecological - Ovarian	76.92%	88.89%	90.91%	75.00%	87.50%	90.91%	93.75%	100.00%	85.71%	58.33%	100.00%	84.62%
Gynaecological - Uterus	50.00%	44.44%	66.67%	85.71%	45.45%	42.86%	77.78%	70.59%	66.67%	48.15%	50.00%	70.37%
Cancer 62 Day Combined Standard												
Gynaecological - Cervix	50.00%	66.67%	50.00%	50.00%	66.67%	50.00%	0.00%	0.00%	66.67%	50.00%	28.57%	0.00%
Gynaecological - Other	66.67%		20.00%	100.00%		0.00%	0.00%		0.00%	100.00%	0.00%	0.00%
Gynaecological - Ovarian	54.55%	42.86%	33.33%	0.00%	50.00%	84.62%	75.00%	100.00%	55.56%	36.36%	100.00%	41.67%
Gynaecological - Uterus	9.09%	10.53%	25.00%	18.18%	0.00%	33.33%	26.67%	0.00%	0.00%	9.09%	0.00%	27.27%

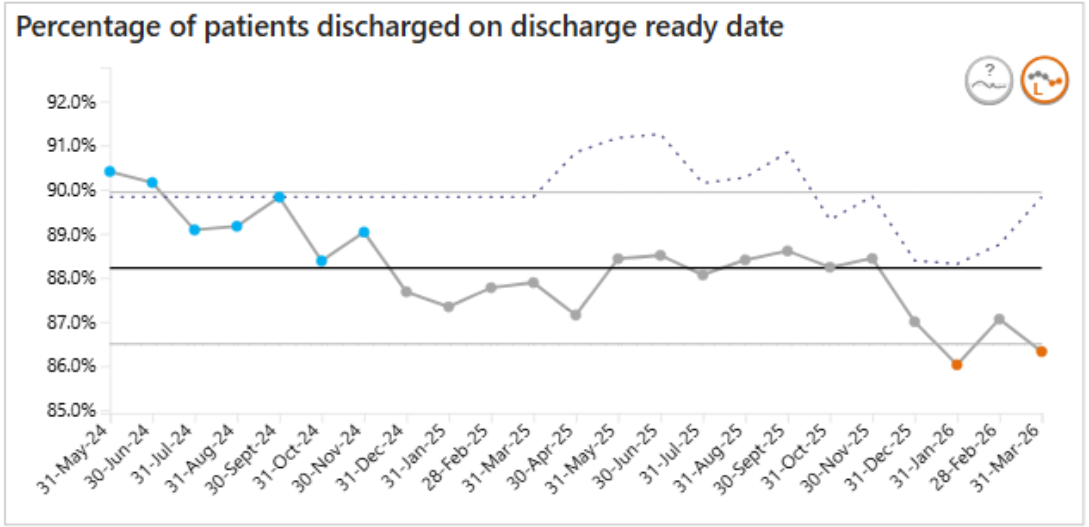
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
1. +18% yearly referral growth 2. Hysteroscopy wait times 3 weeks 3. High proportion of patients converting to GA hysteroscopy 4. Wait times for Oncology at 4 weeks 5. Delay to diagnosis following hysteroscopy 6. Staging time averages 17-days 7. Wait times for surgery 8. Lack of sustainable Hysteroscopy	1. New cross-BOB proforma agreed with TVCA is in progress. Temporary change to USC referral catchment – from Feb 2. Implement pre-hysteroscopy clinic, Adopted HVLC standards for additional hysteroscopy per session. Recruited locum consultant for hysteroscopy. Pilot Ambient voice to increase pre-hysteroscopy slots 3. Implemented penthrox to improve pain management. Introduced new kit to better facilitate a one-stop. Extra lists to catch up with GA backlog 4. Putting on additional 14 slots on Saturdays. Additional 10 slots weekly from October 5. Introduced SOP to inform patients benign/cancer if clear at point of hysteroscopy 6. Rapid pre-MDT for straightforward cases – trial completed no real savings. Looking at other options to streamline the MDT 7. Regional mutual aid requested but no uptake. Brachy has moved to fortnightly. Additional consultant recruited with start date anticipated in August. Working cross division to introduce same day POA slots. Joint consultant post with RBH withdrawn due to no suitable candidates.	1. TVA to confirm 2. Completed 3. Completed 4. Completed 5. Completed 6. April 2026 7. August 2026 All reviewed via Regional Tiering meetings		

3. Assurance report: Cancer Addendum (Urology)

Indicator Name	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026
Cancer 28 Day FDS Combined Standard												
Urological	37.50%	36.95%	45.05%	46.74%	54.96%	49.15%	57.41%	59.29%	63.76%	54.63%	63.76%	61.02%
Cancer 31 Day Combined Standard												
Urological - Bladder	66.67%	83.87%	79.17%	83.33%	84.62%	91.67%	65.00%	82.61%	71.43%	64.00%	73.68%	76.00%
Urological - Kidney	50.00%	62.50%	68.97%	48.28%	57.58%	55.17%	75.86%	80.00%	81.48%	64.00%	66.67%	71.43%
Urological - Other	100.00%		50.00%		100.00%	100.00%		50.00%		100.00%	100.00%	
Urological - Penile		100.00%					100.00%					
Urological - Prostate	83.75%	81.33%	77.65%	79.14%	70.39%	80.00%	75.37%	67.06%	75.00%	75.00%	67.23%	68.81%
Urological - Testicular	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	83.33%	60.00%	71.43%	100.00%
Cancer 62 Day Combined Standard												
Urological - Bladder	54.55%	40.00%	12.50%	27.78%	14.29%	30.77%	10.53%	13.33%	60.00%	33.33%	0.00%	33.33%
Urological - Kidney	21.05%	15.38%	33.33%	45.45%	16.22%	22.22%	38.89%	11.11%	55.56%	29.17%	31.25%	15.91%
Urological - Other			100.00%		0.00%			0.00%		100.00%	100.00%	
Urological - Penile							100.00%					
Urological - Prostate	50.45%	25.56%	44.17%	41.33%	39.67%	43.94%	50.00%	51.92%	51.91%	66.67%	45.83%	47.80%
Urological - Testicular		100.00%	100.00%	100.00%	100.00%	100.00%	66.67%		100.00%	100.00%	100.00%	100.00%

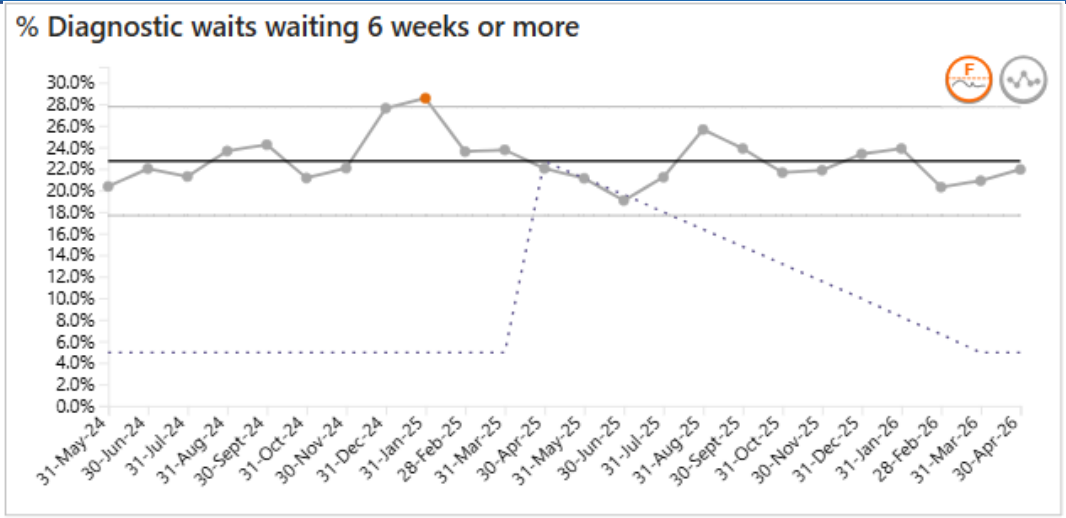
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
1. Weekly biopsy slots only meet ~60% of demand 2. 9% yearly growth in referrals 3. Multiple steps and accumulating delays at the front of the pathway 4. Pathology turnaround times averaging 10 days, and 'long tail' of patients at 20 days 5. Periodic issues with PET provision creates some instability in middle of the pathway 6. Lack of Theatre capacity 7. Average 3 week wait for Prostate Oncology appointment 8. Wait times for Oncology at 4 weeks	1. Secured rota to improved resident Dr cover for sessions. Recruited an additional ANP to increase capacity. Approved biopsy COTD policy to reduce unused slots 2. TVCA to mobilise CQG approved NICE guidelines on the USC form for >80 year olds 3. Established post-MDT clinic to reduce delays. Recruited additional GPSI and CNS. New pathway live to reduce PET delays. Identifying suitable patients at referral for straight-to-oncology pathway for high PSA pts. 4. Outsourcing some pathology work. Recruited to Urology histopathologist vacancy. 5. Supply split between 2 suppliers to minimise impact of failures. Q4 sprint funding for PET. Working on embedding new Curium cyclotron to further stabilise supply 6. Running 2x extra Sunday lists per month. Extended Renal list to 8pm. Recruited additional locum consultant to pick up lists. Ongoing RARP list extensions to 8pm & running weekend lists. Explored mutual aid for MK RARPs with Marsden but disbanded due to no capacity 7. Addition rooms and locum Medical Oncologist. Additional PSFU for ClinOnc underway. Additional ClinOnc doctor started in February 8. Putting on additional 14 slots on Saturdays, reducing waiting times from 4-weeks to 2-weeks. Additional 10 slots weekly from October.	1. Completed 2. TVCA TBC 3. June 2026 4. Completed 5. August 2026 6. Completed 7. Completed 8. Completed All reviewed via Regional Tiering meetings		

3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The percentage of patients NOT discharged on their Discharge Ready Date reflects the increased proportion of patients who have been discharged on Pathways 1-3 from inpatient beds. The Discharge To Assess (D2A) pathway reached capacity from a social work perspective for large packages mid-way last year. Combined with the reduction of Short Stay Hub Beds (SSHB) resulted in long delays for some patients on Pathways 1 and 2. In addition, the complexity of discharges across all pathways has increased over time. This correlates with deterioration shown in the above chart. However, despite this the Oxfordshire system performs well with consistently the lowest percentage of patients not meeting the National Criteria to Reside in the South-East Region.	• Ward areas with the lowest percentage of patients discharged on their discharge ready date have been reviewed; they have seen an increase in very long delayed patients due to a small number of unique cases. • The broader root cause is being addressed with system partners with movement from very large community packages to SSHB with a clear focus on trajectories for length of stay for this bed base which is being tracked monthly via the Urgent and Emergency Care (UEC) sit rep. • Out of County Delays and escalation pathway, involving COO at an earlier stage. • Quality Improvement Project on reducing cancelled discharges. The group met the target ahead of the deadline and have achieved further improvement exceeding the target. An end of project report has been produced with some PDSA's moving to 'business as usual' and recommendations for further improvements. • New Extended Length of Stay improvement cycles to reduce the number of extended length of stay patients occupying open beds.	January 2026 – complete Oxfordshire system Urgent Care Delivery Group - ongoing Ongoing TWUCG & Oxfordshire system Urgent Care Delivery Group March 2026 - complete June 2026		

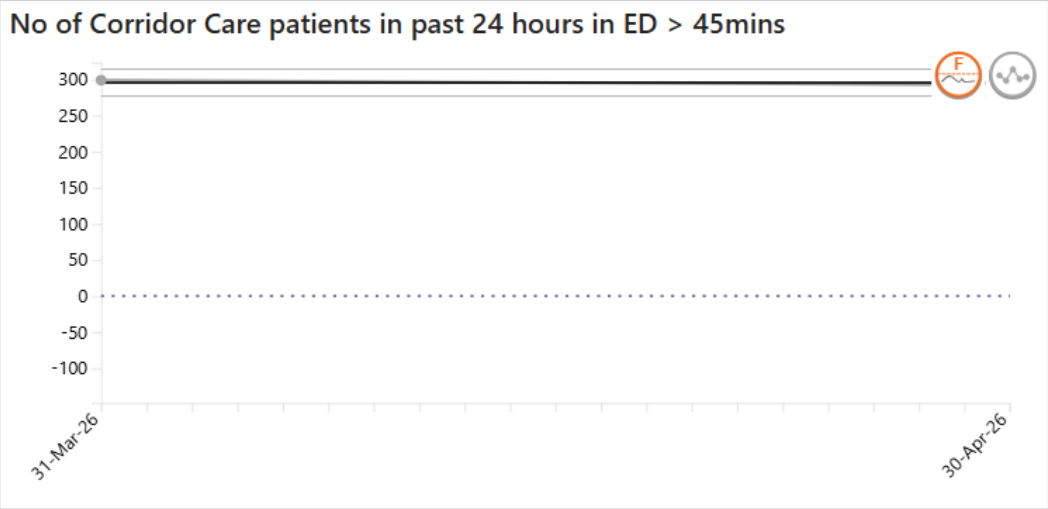
3. Assurance report: Operational Performance, *continued*

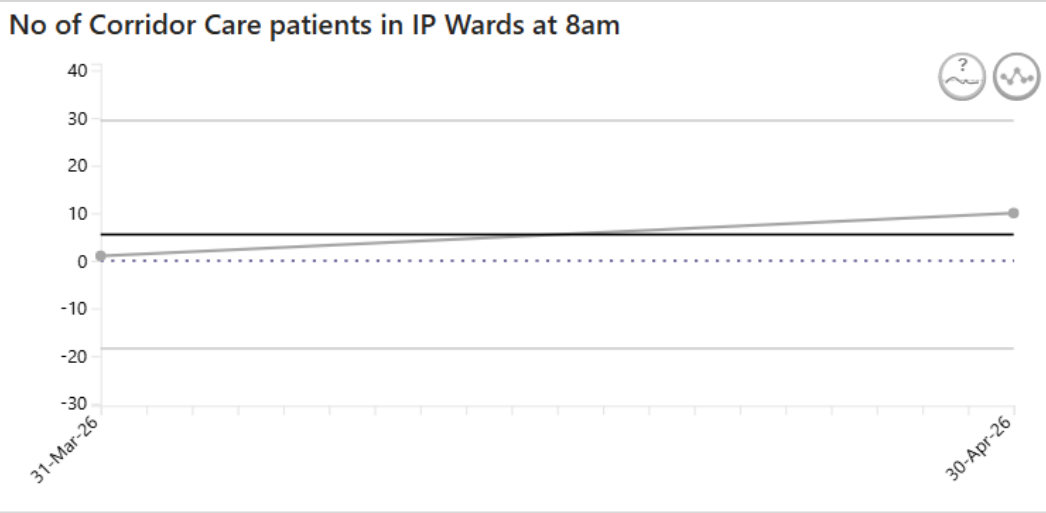


Benchmarking: Diagnostics – 6 Week Standard March 2026				
OUH: 20.88%	National: 15.06%	Shelford: 24.05%	BHT: 21.45%	RBH: 13.25%

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 21.9% at the end of April against an operational plan of 20.0%. Performance exhibited common cause of variation.	All modalities have been asked to over deliver where possible to support "total" delivery. Focus has remained 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. Undertaken Patient Engagement to obtain list of patients willing to be scheduled at very short notice – this is due to be refreshed and sustained for 2026-27. Additional capital for newer scopes (with efficiency) have been delivered in March. 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 Review of clinical pathway 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 underway at the Horton for a dedicated facility. Brackley booth delivered. CDC activity planned for mobilisation. Validation plan in place with recruitment replacement of 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		

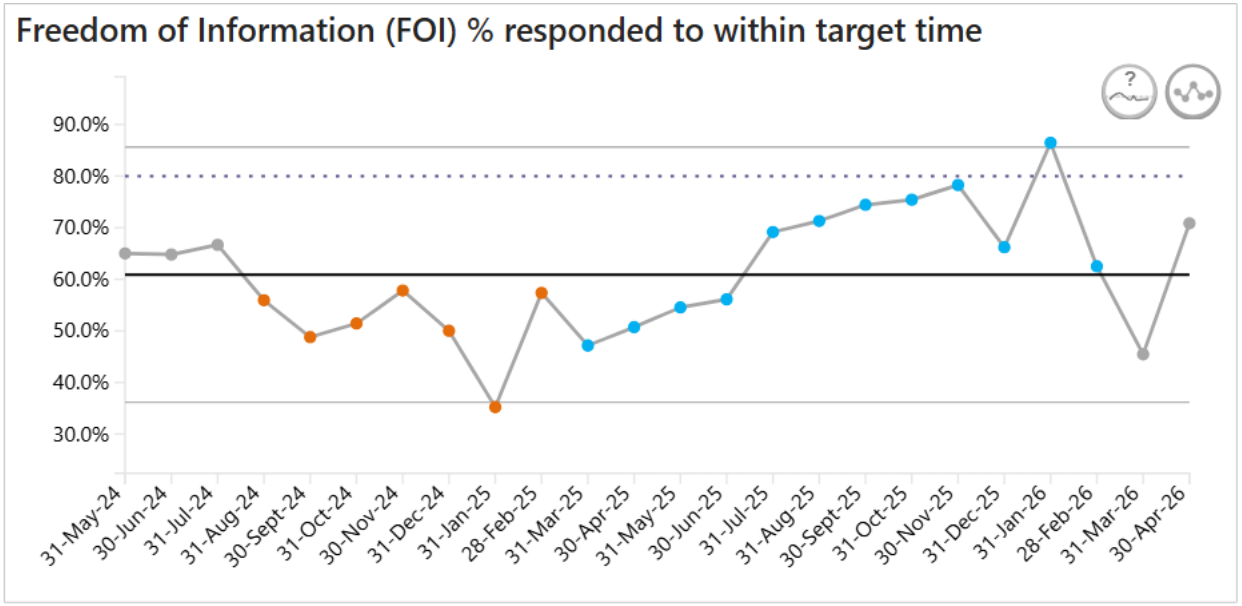
3. Assurance report: Operational Performance, *continued*





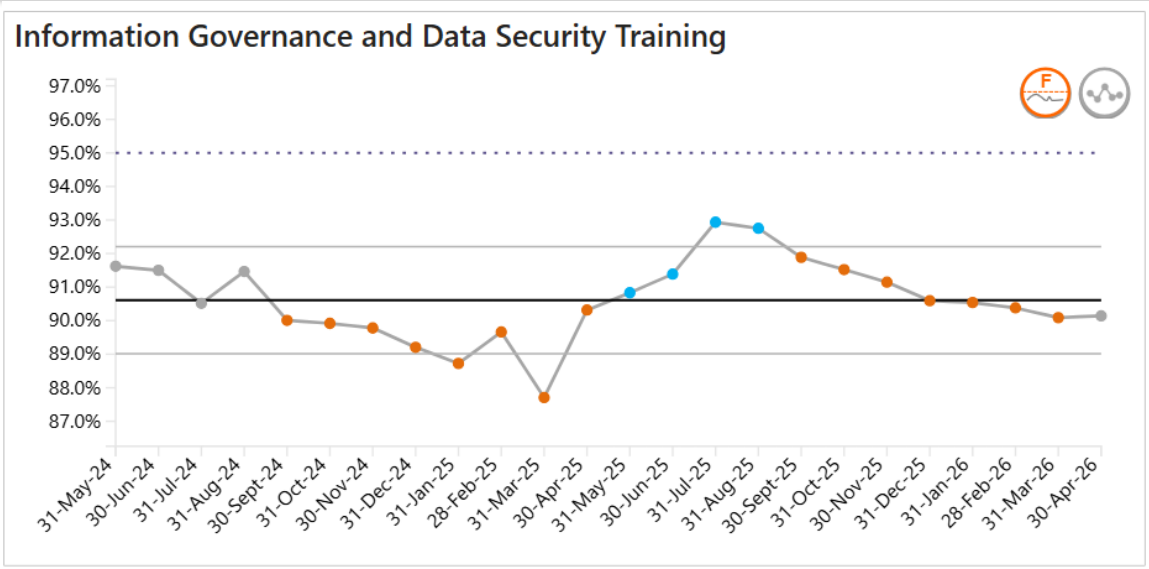
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
When the emergency and assessment units become congested, to maintain flow at the front door and ensure timely ambulance 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 not available on the wards. Providing care to our patients in corridors is far below the standard of care that we aspire for our patients.	**** Corridor Care Taskforce initiated May 2026 **** Two improvement groups have been established, one focusing on urgent actions within the Emergency Departments, the second focusing on urgent actions for improvement within the ward areas. Once initial action complete the groups will combine to co –author a Full Capacity Protocol. Further clarity is required from NHSE regarding definition and exceptions.	TWUCG - TBC		

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
M1 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 70.8% 24 valid cases were received in M1 – a further significant drop against recent months but expected as the new e-Case system requires requesters to identify themselves before making a submission. 11 new cases were closed on time – in total 42 cases were closed as efforts to close complex overdue cases continue.	The second stage of the e-Case rollout has also started, enabling increased visibility of performance around open FOI cases to local SMEs, divisional management and chief officers – this will enable enhanced local management and escalation of complex cases and cases at risk of breaching.	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*

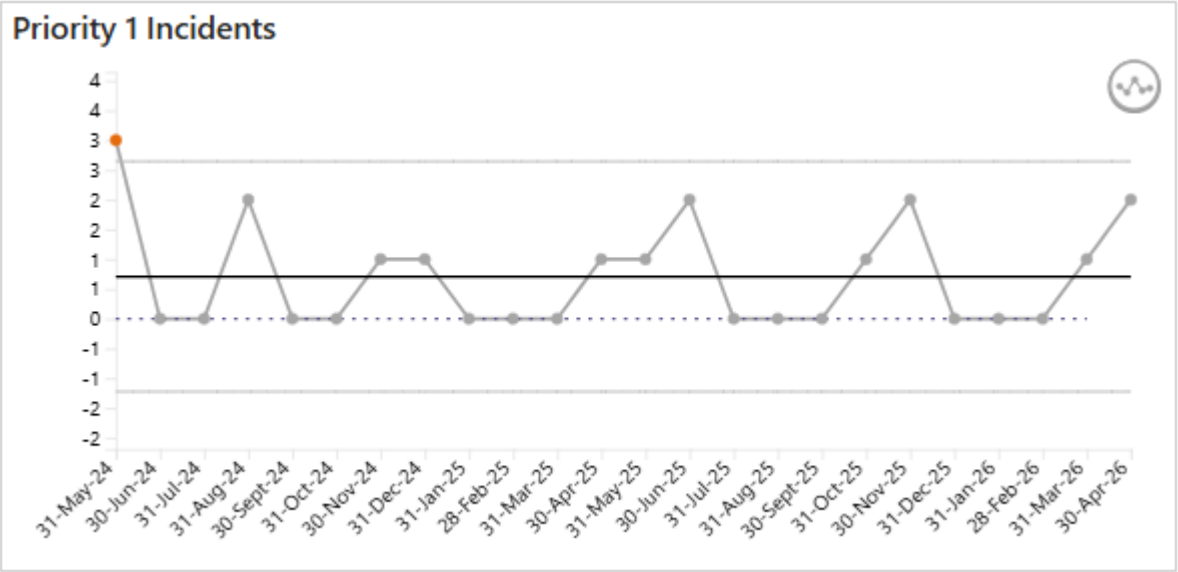
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
Education and Training	67	21	68.7%
R&D	165	29	82.4%
NOTSSCAN	3495	460	86.8%
MRC	3271	364	88.9%
SUWON	3406	362	89.4%
Clinical Support Services	2353	232	90.1%
Corporate	1144	113	90.1%
Operational Services	207	19	90.8%
Estates	185	9	95.1%

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
Data security and Protection Training (DSPT) compliance was 90.0% in M1. No divisions are achieving 95% and this month's performance exhibits common cause variation. R&D, MRC and NOTSSCAN are below 90%.	1623 staff are currently non-compliant. Compliance rates are cyclical and increase during the appraisal window, which has just opened so an increase over he next few months is expected. All divisional governance teams have visibility of their staff training levels and are able to access reports which name non-compliant individuals to help them manage the situation.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

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



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
INC0384555 / PRB0040818 – 20/04/2026 – Network Connectivity Issues OUH colleagues experienced difficulties accessing network services, including internet connectivity, VPN access and other externally hosted systems / applications. Virgin Media confirmed a regional fibre fault caused upstream network disruption impacting the OUH amongst a broad geographical region of impact. INC0385296 / PRB0040819 – 21/04/2026 – Internet Access Issues Users experienced issues accessing external websites and networked services / applications across the OUH. This was linked to the JR Internet Firewall Upgrade (CHG0032899) which took place between 20:00 - 23:00 on 21/04/2026.	Digital implemented routing changes during the day to mitigate the majority of the issues being reported, and this work was completed by 17:00 on 20/04/2026. Virgin Media resolved the issue at 03:45 on the 21/04/2026, once Digital had validated the fix and restored routing to its pre-incident configuration, the issued was fully resolved at 09:13 on 21/04/2026. The issue was resolved at 12:30 on 22/04/2026 after applying the required configuration changes on the JR Firewall.	N/a	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*

- MRSA Screening compliance

5. 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*

5. 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