NHS
Oxford University Hospitals
NHS Foundation Trust

# TRUST BOARD IN PUBLIC

# TRUST BOARD IN PUBLIC

10 September 2025

09:30 GMT+1 Europe/London

Seminar rooms 4A/4B George Pickering Centre, John Radcliffe Hospital.

# AGENDA

# 1. AGENDA

## REFERENCES

Only PDFs are attached

00 TB2025.00 Agenda Trust Board in Public 10 September 2025 v6 (1).pdf

Oxford University Hospitals
NHS Foundation Trust

# Trust Board in Public Agenda

There will be a meeting of the Trust Board in Public on **Wednesday 10 September 2025** from **09:30 to 12:00** in Seminar Rooms 2A/2B of the George Pickering Education Centre, John Radcliffe Hospital.

**Prof Sir Jonathan Montgomery, Trust Chair**

## Introductory Items

| Agenda Ref | Time | Item | Presenter | Mins | Paper |
|---|---|---|---|---|---|
| 1. | 09:30 | Welcome, Apologies and Declarations of Interest | Trust Chair | 3 | Verbal |
| 2. | 09:33 | Minutes of the Meeting Held on 9 July 2025 | Trust Chair | 2 | TB2025.72 |
| 3. | 09:35 | Chair's Business | Trust Chair | 10 | Verbal |
| 4. | 09:45 | Chief Executive's Report | Acting Chief Executive Officer | 10 | TB2025.73 |

## Patients

Strategic Objective: To create a culture of continuous improvement in all we do and of excellence in research, training and education.

Strategic Objective: To make effective use of our digital capability to enhance patient care and staff efficiency, and productivity.

Strategic Objective: To have an estate that meets the highest levels of regulatory compliance and enhances our offer for patient care and staff wellbeing by adopting novel ideas and methods that embrace the sustainability goals.

| Agenda Ref | Time | Item | Presenter | Mins | Paper |
|---|---|---|---|---|---|
| 5. | 09:55 | Patient Perspective | Chief Nursing Officer | 15 | Verbal |
| 6. | 10:10 | Maternity Service Update Report / Perinatal Quality Surveillance Summary Report (to include Perinatal Improvement Programme) | Chief Nursing Officer / Director of Midwifery | 15 | TB2025.74 |

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|---|---|---|---|---|---|
| 7. | 10:25 | Patient Experience Annual Report 2024/25 | Chief Nursing Officer | 10 | TB2025.75 |
| 8. | 10:35 | Infection Prevention and Control Annual Report | Chief Medical Officer | 10 | TB2025.76 |
| 9. | 10:45 | Learning from Deaths Annual Report | Chief Medical Officer | 5 | TB2025.77 |
| N/A | 10:50 | BREAK | N/A | 10 | N/A |

**People**

Strategic Objective: To make OUH a great place to work; one that promotes equality, diversity and inclusion, encourages talent and development, and enables freedom to speak up without fear of futility or detriment.

| Agenda Ref | Time | Item | Presenter | Mins | Paper |
|---|---|---|---|---|---|
| 10. | 11:00 | Combined Equality Standards Report 2025 (incl. WRES/WDES/GPG/EDS) | Chief People Officer | 10 | TB2025.78 |
| 11. | 11:10 | Responsible Officer's Revalidation Annual Report | Chief Medical Officer | 5 | TB2025.79 |
| 12. | 11:15 | Health and Safety Annual Report | Chief Nursing Officer | 5 | TB2025.80 |
| 13. | 11:20 | Freedom to Speak Up Policy | Chief People Officer | 5 | TB2025.81 |

**Performance**

Strategic Objective: To consistently achieve all operational performance standards and financial sustainability.

| Agenda Ref | Time | Item | Presenter | Mins | Paper |
|---|---|---|---|---|---|
| 14. | 11:25 | Integrated Performance Report M4 | Chief Officers | 20 | TB2025.82 |
| 15. | 11:45 | Finance Report M4 | Chief Finance Officer | 10 | TB2025.83 |

## Partnerships

Strategic Objective: To work in partnership at Place and System level for the benefit of our patients and populations with effective collaboration to reduce health inequalities and fulfil our role as an anchor institution.

| Agenda Ref | Time | Item | Presenter | Mins | Paper |
|---|---|---|---|---|---|
| 16. | 12:05 | Winter Preparedness Plan *to include:*<br>• Winter Plan Board Assurance Statement | Chief Operating Officer | 5 | TB2025.84 |
| 17. | 12:10 | Urgent and Emergency Care Oxfordshire System Dashboard | Chief Operating Officer | 5 | TB2025.85 |

## Regular Reporting

| Agenda Ref | Time | Item | Presenter | Mins | Paper |
|---|---|---|---|---|---|
| 18. | 12:15 | Regular Reporting Items | N/A | 5 | N/A |
| 18a. | N/A | • Trust Management Executive Report *to include:*<br>○ Energy Policy<br>○ SAS Doctor Pay Progression | Acting Chief Executive Officer | N/A | TB2025.86 |
| 18b. | N/A | • Integrated Assurance Committee Report | Trust Chair | N/A | TB2025.87 |
| 18c. | N/A | • Consultant Appointments and Sealing of Documents | Acting Chief Executive Officer | N/A | TB2025.88 |
| 19. | 12:20 | Any Other Business | Board Members | 5 | Verbal |
| 20. | 12:25 | Date of Next Meeting<br>Wednesday 12 November 2025 | Trust Chair | 0 | Verbal |

## 2. WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST

# 3. MINUTES OF THE MEETING ON 9 JULY 2025

## REFERENCES

Only PDFs are attached

02 TB2025.72 Public Board 9 July 2025 Minutes Draft.pdf

**Trust Board Meeting in Public**

Minutes of the Trust Board Meeting in Public held on **Wednesday 9 July 2025**, George Pickering Education Centre, John Radcliffe Hospital

**Present:**

| Name | Job Role |
|---|---|
| Prof Sir Jonathan Montgomery | Trust Chair, [Chair] |
| Mr Andrew Crowther | Acting Chief Executive Officer |
| Dr Ben Attwood | Chief Digital and Information Officer |
| Ms Laura Bick | Director of Workforce [deputising for Chief People Officer] |
| Prof Andrew Brent | Chief Medical Officer |
| Ms Yvonne Christley | Chief Nursing Officer |
| Mr Paul Dean | Non-Executive Director |
| Mr Jason Dorsett | Chief Finance Officer |
| Dr Claire Feehily | Non-Executive Director |
| Ms Claire Flint | Non-Executive Director |
| Mr Mark Holloway | Chief Estates and Facilities Officer |
| Ms Sarah Hordern | Vice Chair and Non-Executive Director |
| Ms Katie Kapernaros | Non-Executive Director |
| Prof Tony Schapira | Non-Executive Director |
| Prof Gavin Screaton | Non-Executive Director |
| Prof Ash Soni | Non-Executive Director |
| Ms Felicity Taylor-Drewe | Chief Operating Officer |
| Ms Joy Warmington | Non-Executive Director |

**In Attendance:**

| | |
|---|---|
| Dr Laura Lauer | Deputy Head of Corporate Governance, [Minutes] |
| Dr Neil Scotchmer | Head of Corporate Governance |
| Dr Ansaf Azhar | Director of Public Health and Communities, Oxfordshire County Council [Minute TB25/07/06 only] |
| Ms Milica Redfearn | Director of Midwifery [Minute TB25/07/07 only] |

**Apologies:**

| | |
|---|---|
| Mr Terry Roberts | Chief People Officer |

## TB25/07/01 Welcome, Apologies and Declarations of Interest

1. The Chair welcomed those observing the meeting and noted that the Council of Governors was well-represented.
2. Apologies were received as recorded above.
3. The Trust Board Register of Interests for 2025/26 had been updated as follows: Ms Flint joined the Board of the UK Atomic Energy Authority on 1 June 2025; Ms Kapernaros stood down from the Board of Manx Care on 31 May 2025; Prof Schapira joined the Board of the Royal National Orthopaedic Hospital on 1 July 2025. *Post-meeting note: due to an administrative oversight, it was not noted that Mr Dean ceased to be a Trustee of The Oxford Trust on 6 June 2025.*

### Thames Water Incident

4. The Chief Operating Officer (COO) reported that, following notification of the burst water main in Oxford, the Trust had enacted its business continuity plan at 13:00 on 8 July and declared a critical incident at 16:00.
5. Repairs were ongoing and the situation was being kept under review. Thames Water tankers had been on site to ensure supply at the John Radcliffe Hospital. No impact was reported at the Nuffield Orthopaedic Centre and Churchill Hospital.
6. The Board extended its thanks to estates and operational teams for their effort to ensure patient impact was minimised.

## TB25/07/02 Minutes of the Meeting Held on 14 May 2025 [TB2025.54]

7. Two corrections were noted:
   a. The attendance list would be amended to show that Ms Kapernaros was present at the meeting; and
   b. Paragraph 11 would be amended to make clear that the Trust Chair was a member of the Health and Wellbeing Board and had recently been appointed Vice-Chair.
8. Subject to those changes, the minutes were approved. *Post-meeting note: the minutes were corrected as above.*

## TB25/07/03 Matters Arising and Review of the Action Log [TB2025.55]

### Actions Closed

9. TB25-004 Elective Performance Standards – would be the subject of a Board Seminar session on the afternoon of 9 July.
10. TB25-006 Learning from Deaths – the Chief Medical Officer had circulated information regarding charity support to Board members.

11. TB25-007 People Plan Year 4 – Chief People Officer had circulated the requested update on metrics.

12. TB25-007 (misnumbered) Guardian of Safe Working – this action would be completed via an Integrated Assurance Committee (IAC) Deep Dive and was on the IAC Action Log as an open action.

**TB25/07/04 Chair's Business**

Staff Recognition Awards

13. The event highlighted moving stories of patient care and staff dedication. The Chair expressed his thanks to Oxford Hospitals Charity for their support of this annual event.

Nurses, midwives, allied health professionals, healthcare scientists, pharmacists and clinical psychologists (NMAHPPS) Conference

14. The conference attracted around 250 attendees and showcased a wide range of research.

NHS 10 Year Plan

15. The intention was to bring an assessment of the Trust's position against key areas of the plan to the Annual Members' Meeting on 18 September 2025. This would include:

a. mechanisms for hearing patient and staff voice and how this feedback was used;

b. work in the analogue to digital space and hospital to community shift and the difference this had already made;

c. refreshing the Trust's anchor institution role;

d. assessment of published league tables; and

e. the financial challenge, including delivering a 3% fund to support innovation.

**TB25/07/05 Chief Executive's Report [TB2025.56]**

NHS 10 Year Plan

16. The publication of the plan had coincided with the Trust's refresh of its strategy. The Acting Chief Executive Officer (Acting CEO) welcomed the Plan's ambition and focus on empowering patients, autonomy and accountability.

17. Place-based partnerships could provide a roadmap to an integrated health organisation (IHO); the shape of the IHO would emerge through discussions. The Trust would remain open-minded as the criteria/conditions for IHO were developed and would keep delivery for patients at the forefront of its thinking.

18. It was anticipated that activity in Q2 would focus on refreshing the clinical strategy and operational baseline performance, with detailed planning in Q3.

19. The Trust would continue to maximise opportunities to improve performance in particular specialities, whether through “Super Surgery Days” or utilising capacity of the Surgical Elective Centre when this opened. These interventions would be clinically led.

20. Communicating the three key shifts outlined in the plan, along with relevant KPIs, would be important. It was suggested that LinkedIn communications to staff and the regular Acting CEO report to the Trust Board could be useful vehicles for this.

Report of the Dash Review of Patient Safety Across the Health and Care Landscape

21. The publication of the review was noted.

22. Discussion focused on two recommendations: patient and community input to the planning and design of services and strengthening and streamlining mechanisms to listen to, and act on, staff voice.

23. This presented an opportunity in the context of the 10 Year Plan to create a more integrated feedback system, which reduced duplication and improved staff and patient experience.

Other updates

24. The Acting CEO expressed his thanks to Mr Holloway, who would be leaving the Trust to take up a new post with the national team as Director of National Estate Delivery. He paid tribute to Mr Holloway’s strong and visible leadership.

25. The Trust’s annual Staff Recognition Awards, national recognition received by members of staff and service areas, and NMAHPPS in Research Conference were highlighted.

26. The Acting CEO reported improvements in service delivery and patient care, including the opening of the Radiotherapy Centre in Milton Keynes.

27. The People Plan 2025-28 had been published; the Trust’s plan was well-aligned to the NHS 10 Year Plan.

## TB25/07/06 Director of Public Health Annual Report

28. The Chair welcomed Dr Azhar, Director of Public Health and Communities to present his annual report.

29. Dr Azhar focused on the opportunities for the system of Anchor institutions to break the cycle of poor mental health and unemployment among young people. This was particularly stark in areas of deprivation.

30. He noted that a healthy workforce would be necessary, as by 2040, nearly 40% of people would be living with a long-term condition but the number of working age people would have only increased by 4%.

31. He stressed the positive role that satisfying work could have on mental health. He encouraged the Trust to use its Anchor status to set a national example by inclusive recruitment to tackle inequality, valuing diversity, and mental health support in the workplace.

32. Discussion focused on:

    a. The Trust as an Anchor institution to work at scale to address health inequalities and support inclusive recruitment;

    b. Delivering services through large local employers to support healthy workplaces; and

    c. Integrated Health Organisations based on assets not institutions.

33. The Trust Board thanked Dr Azhar for the report. *Post-meeting note: Dr Azhar would meet the Trust's Young People's Executive (YPE) to discuss supporting the mental health of young people.*

### TB25/07/07 Maternity Items

34. The Chief Nursing Officer (CNO) referenced the rapid national investigation into maternity and neonatal services at 10 trusts announced by the Secretary of State for Health and Social Care. Terms of reference were expected to be published in July and the report in December 2025.

35. Trust maternity care had been the subject of local and some national publicity as a result of a local campaign group. The anonymous testimonies on the group's website had been reviewed; these indicated clear themes around patient experience and communication. The Trust had written to the group and offered to meet; it was hoped that a meeting would be held before September.

36. The CNO reported that the rapid quality review held in April 2025 with all regulatory bodies represented had not identified any safety concerns with the service. The review had recommended that the Integrated Care Board review all maternity services in Oxfordshire over the next 12 months.

37. Senior support was being provided to maternity and neonatal teams with a focus on learning and improvement. The Director of Midwifery noted that the service had access to 0.5 WTE psychologist and the numbers of professional midwifery advocates, who provided mentoring and support, had grown to 26. Leadership was actively engaged with the Trust's Wellbeing team.

Maternity Safe Staffing Biannual Report [TB2025.57]

38. The Director of Midwifery reported that Trust was on trajectory to meet the Maternity and Perinatal Incentive Scheme (MPIS) staffing target by the end of Q2.

39. The CNO confirmed that the Trust had processes in place to ensure flexible working requests, periods of maternity and other forms of leave did not negatively impact safe

staffing levels. These were closely managed. She confirmed that the service had been permitted to overrecruit to compensate for periods of leave.

40. Progress toward full establishment had been slower than anticipated. 54 WTE had been recruited over the past 12 months and retention figures were improving. In September, a new intake of 27 graduate midwives would commence in post.

41. The CNO confirmed that the process of matching rosters to data in the electronic staff record and finance had been completed.

42. The Trust Board:

- Noted the contents of the report, which demonstrated that there was an effective system of midwifery workforce planning to the required standard, in line with the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Perinatal Incentive Scheme (MPIS) for safety action 5.
- Noted the evidence that Midwifery staffing budget reflected establishment as calculated by BirthRate Plus®.
- Approved and took assurance from this report that there has been an effective system of Midwifery workforce planning and monitoring of safe staffing levels for Q3 and Q4 of 2024/25 inclusive.

Maternity Service Update Report [TB2025.58]

43. The Director of Midwifery reported that there were 38 more births than in the previous month. The service's figures for 3rd and 4th degree tears, post-partum haemorrhages and avoiding term admissions to neonatal units (ATAIN) remained stable.

44. There were three suspected cases of hypoxic-ischemic encephalopathy (HIE). Two had been referred to Maternity and Newborn Safety Investigations (MSNI); parental consent had not been received for the third.

45. There were no occasions when 1:1 care was not provided in labour.

46. Two midwives had been recognised with DAISY awards. Figures for service user experience continued to improve; this was welcomed.

47. All actions from last year's Antenatal and Newborn Screening quality review had been completed and had been well received by NHS England.

48. The Trust Board noted the report.

Perinatal Quality Surveillance Summary Report [TB2025.59]

49. The Director of Midwifery reported that, of the four cases reviewed, one was graded as C due to the timing of induction of labour and had been referred to MSNI.

50. When asked how the Trust would address the quality of discharge communication, the Director of Midwifery referred to a postnatal Quality Improvement project.

51. The Trust Board noted the report.

### TB25/07/08 Learning from Deaths Report Q4 [TB2025.60]

52. The Chief Medical Officer (CMO) reported that the Trust's Hospital Standardised Mortality Ratio (HSMR) remained "lower than expected" but that an increase had been observed. This increase was not attributable to a change in the methodology and it was believed to relate to the depth of coding of frailty and comorbidities at the John Radcliffe site. A working group, chaired by a Deputy CMO, and which included representatives from coding and patient safety teams was looking at the detail. The review would form part of the next Learning from Deaths report to the Trust Board or would be raised exceptionally if there was a concern.

53. It was not clear whether there was a change in the caseload, change to documented notes, or coding generated from the notes and it was important that the Trust Board kept an open mind.

54. Data from Telstra (Dr Foster) indicated three outlying diagnosis groups for review by the group: senility and organic mental disorders (delirium), acute cerebrovascular disease, and septicaemia (except in labour) . The CMO noted that two specialities – Stroke medicine and Geriatric medicine – had shown a decline in the expected rate and could be at relative risk.

55. The Integrated Assurance Committee (IAC) had received a report into the Trust's approach to the recording, counting, coding and reporting of activity under the NHS Payment System and commissioned NHS contracts. This report had shown that comorbidities recorded for the first episode of care where not recorded for future episodes of care. An adjustment had been made for elective care but a fix was not yet in place for non-elective care. It was agreed that IAC should receive a further update on non-clinical coding and counting.

**ACTION FOR IAC: Chief Finance Officer to provide an update on non-clinical coding and counting, including progress toward rectifying identified issues.**

56. The Trust Board noted:

- the Learning from Deaths update for Quarter 4 (2024/25)
- the findings from Telstra in relation to the increase in HSMR.

### TB25/07/09 Biannual Nursing Establishment Review [TB2025.61]

57. The CNO presented the review which had been conducted using recognised national standards; these had been triangulated against professional judgement. The review concluded that the Trust's nursing establishment – registered, unregistered, and associated care roles – was safe.

58. Areas directly related to patient care had already been adjusted in line with the review; there was further work to be done in other areas, including managing the review process, and the Trust Board would be briefed on this as part of the later seminar session.

59. The CNO paid tribute to nursing leaders in the Trust who had embraced a bottom-up review using evidence-based tools. The process was one of collaboration and there was anecdotal evidence that it had been well-received.

60. The Trust Board reviewed and endorsed the findings and recommendations from the 2024/2025 establishment review.

### TB25/07/10 Integrated Performance Report M2 [TB2025.62]

61. The Acting CEO explained that the report would be refreshed to better align with the new national Performance Assessment Framework and to provide closer to real-time data.

62. He noted that elective care was on plan and urgent care performance was better than expected. Cancer remained a challenging area.

Cancer Performance

63. Increased demand meant that performance was under pressure; it was noted that demand was greater than NHS England planning guidance had instructed trusts to plan for.

64. The COO acknowledged that 28-day performance had declined in M2; there was some evidence that performance was recovering in M3. The Trust prioritised patients with cancer, meaning that the majority of the backlog was made up of people who were waiting to be told they did not have cancer.

65. A radiotherapy gap affecting 62-day performance had been identified and was being addressed with Thames Valley Cancer Alliance funding. In parallel with this, Quality Improvement work to maximise capacity was underway.

66. Three specialities were noted to be under particular pressure: breast, gynaecology, and urology. A gynaecology improvement programme was having a positive effect. A substantial backlog remained in urology in both cancer and benign pathways and one-off recovery actions may be required.

67. Discussions across the system to optimise pathways were ongoing. It was suggested that a Deep Dive to understand cancer demand, Trust and system capacity should be scheduled. *Post-meeting note: scheduled for 24 September 2025 Board Seminar.*

68. She assured the Trust Board that all long-waiting patients were reviewed, including those recently referred, and prioritised to ensure the longest-waiting patients with greatest clinical need were treated first.

Complaints

69. It was noted that the rate of complaints appeared to have increased and the rate these were resolved had decreased. The CNO explained that the volume from M1 had affected the M2 figures.

70. Teams were working hard to recover the position, but complaints had become more complex and recent operational pressures increased the challenge of timely response.

Freedom of Information Requests

71. Following receipt of the Information Commissioner's Office Enforcement Notice, the Trust put in place a comprehensive action plan. All actions were on track.

72. The Chief Digital and Information Officer updated the Trust Board on the backlog: 880 had been reduced to 660. Anyone who made a request in 2022 had been contacted to ask if they still required a response.

73. The Trust Management Executive would consider a proposal to address the backlog. To put the service on a more sustainable footing, named contacts in Divisions and directorates had been identified.

74. The increase in both volume and complexity of requests made this very challenging; it was hoped that making health data available via the NHS app, as set out in the 10 Year Plan, might have an impact on the volume of requests.

75. The Trust Board noted the report.

**TB25/07/11 Finance Report M2 [TB2025.63]**

76. The focus on the report was now on actions taken by management to address financial performance. The Chief Finance Officer (CFO) reported that the contract value for High Cost Drugs and Devices had been agreed.

77. Since the circulation of the report, Divisional budgets had Delivery Fund support added and this reduced the Divisional overspend from £6.7m to £4.8m. The main cause of the variance to plan was unachieved savings from Cost Improvement Programmes (CIPs). The CFO offered to share the revised Divisional position.

**ACTION: CFO to circulate restated M2 Divisional position.**

78. The CFO confirmed that 100% of CIPs had been identified by June 2025 to meet NHS England's requirement for payment of deficit support funding. The CFO told members that a higher internal CIP target of around 105% was proposed to allow for non-delivery of some schemes or deferral of others to the next year's savings plan. All schemes were tracked from identification to implementation.

79. Members agreed that IAC should seek assurance on Divisional performance against plan on behalf of the Trust Board.

80. The Trust Board noted the report.

## TB25/07/12 Research and Development Governance and Performance Annual Report [TB2025.64]

81. The CMO presented the report and expressed this thanks to the Trust's Research and Development team.

82. The benefits of research were not limited to current and future patients; it formed part of the NHS 10 Year Plan, it benefited staff through increased opportunities, the organisation through its association with Oxford Brookes University and the University of Oxford, and the nation through its alignment with the Life Sciences Strategy.

83. The Trust Board heard that performance was substantially below the national target in a key research metric: studies being recruited to time and target. If the national target was not met, the Trust would likely lose research income.

84. The CMO outlined the improvement actions to improve Trust performance. This included smoothing pinch points (diagnostics, pharmacy), developing NMAHPP contributions through the Trust's strategic partnership with Oxford Brookes University, enhancing governance and strengthening monitoring, and creating an agile research environment with streamlined processes. The Trust aimed to reach the 80% target by the end of the year and had put governance in place to monitor progress.

85. The need for close collaboration with the University of Oxford had been highlighted during the Oxford Biomedical Research Centre mid-year review. The CMO's efforts in building the partnership were highlighted.

86. Discussion focused on:

    a. Ensuring patients had access to the most appropriate trials, even if those were not based in Oxford;

    b. The use of technology to improve patient participation in studies;

    c. How research participation could address health inequalities and how this was monitored;

    d. Patient and funder representation in research governance.

87. The Trust Board noted the report.

## TB25/07/13 Framework Travel and Transport Strategy for the John Radcliffe [TB2025.65]

88. The strategy had been discussed by the Trust Board in a seminar session and reviewed by the Trust Management Executive and Investment Committee.

89. The Trust Board:

- Approved the Framework Transport Strategy (FTS) for submission to the Local Planning Authority to meet SEC discharge of planning conditions; and
- Noted the plan for an intra-Trust working group to be established and that this group will develop a John Radcliffe site and Trust-wide FTS for approval in due course.

### TB25/07/14 Urgent and Emergency Care Oxfordshire System Dashboard [TB2025.66]

90. The Trust Board noted the dashboard.

### TB25/07/15 Emergency Preparedness Annual Report [TB2025.67]

91. Discussion focused on the Trust's ability to contact patients by text in emergencies. It was confirmed that this was possible, but dependent on patients keeping their contact details up to date. There was also a cost implication of using a text service.
92. The Trust Management Executive had clearly articulated its expectation that all services should have a business continuity plan that was up to date. Those still outstanding would be followed up.
93. The Trust Board noted the report.

### TB25/07/16 Regular Reporting Items

TB/25/07/16a Trust Management Executive Report [TB2025.68]

94. The Trust Board noted the report.

TB25/07/16b Integrated Assurance Committee Report [TB2025.69]

95. The Trust Board noted the report.

TB25/07/16c Consultant Appointments and Sealing of Documents [TB2025.70]

96. The Trust Board noted the report.

### TB25/07/17 Any Other Business

97. The British Medical Association had announced industrial action dates in respect of the resident doctor pay dispute.
98. The Chair thanked Mr Holloway for his contributions while Chief Estates and Facilities Officer and wished him well in his new national role as Director of Estate Delivery.

### TB25/07/18 Date of Next Meeting

99. A meeting of the Trust Board was to take place on **Wednesday 10 September 2025**.

# 4. CHAIR'S BUSINESS

# 5. CHIEF EXECUTIVE'S REPORT

## REFERENCES

Only PDFs are attached

04 TB2025.73 Chief Executive Officer's Report.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

## Trust Board Meeting in Public: Wednesday 10 September 2025

## TB2025.73

| | |
|---|---|
| **Title:** | **Chief Executive Officer's Report** |

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|---|---|
| **Status:** | **For Information** |
| **History:** | The content of this report has largely been discussed in other forums, including Board committees, but has been amalgamated for the first time in this report |

| | |
|---|---|
| **Board Lead:** | **Chief Executive Officer** |
| **Authors:** | **Matt Akid, Director of Communications & Engagement, and Caroline Sykes, Programme Manager, CEO Office** |
| **Confidential:** | **No** |
| **Key Purpose:** | Performance |

# Chief Executive Officer's Report

## 1. Purpose

1.1. This report outlines the main developments since the last public Board meeting on 9 July, under our four strategic pillars: People, Performance, Patient Care, and Partnerships.

## 2. People

### Trust Board news

2.1. I am pleased to inform the Board that Lisa Hofen has been appointed as our new Chief Estates & Facilities Officer. She will be joining OUH on 27 October.

2.2. Lisa is currently Director of Infrastructure Delivery at Coventry University and previously spent 20 years working for the University of Oxford in a variety of senior roles including Head of Strategic Facilities Management. Her knowledge and experience will strengthen the Trust Board and provide leadership for our teams working in Estates and Facilities across OUH, including PFI colleagues.

2.3. Robert Steele will be Acting Chief Estates & Facilities Officer until Lisa joins us in October.

2.4. We look forward to welcoming colleagues who work at OUH Cowley to our next quarterly Meet the Chief Officers engagement event on 16 September.

2.5. Our third Quarterly Recognition event was held on 5 August at the John Radcliffe Hospital in Oxford. Invitees included staff nominated for a Monthly Recognition Award, teams and individuals nominated via our Reporting Excellence programme, and colleagues whose long service was recognised. I was joined by Yvonne Christley, our Chief Nursing Officer, and Douglas Graham, Chief Executive Officer of Oxford Hospitals Charity whose generous support makes our staff recognition programme possible.

2.6. More than 1,000 staff attended two virtual Q&A sessions in July which I hosted together with Chief Officers to talk through the Government's new 10 Year Plan for the NHS, to discuss what it means for us here at OUH, and how we will refresh our OUH Strategy to align with the national plan.

2.7. Over the coming months we will engage with a wide range of stakeholders in order to hear from as many people as possible during our strategy refresh.

**Values Based Appraisal window**

2.8. I am delighted to report that 95.2% of eligible staff (all colleagues except doctors who have a medical appraisal) had an appraisal conversation during this year's window, which was open from 1 April to 14 August. This is the highest appraisal rate that we have achieved at OUH.

2.9. Appraisals are a very important opportunity for colleagues to reflect on the last year, celebrate their successes, and plan for the next 12 months. I would like to thank you to everyone for their help, support and commitment to ensure that more than 10,000 staff had a high quality, values based appraisal conversation this year.

**Annual Public Meeting**

2.10. Our Annual Public Meeting takes place on Thursday 18 September in Tingewick Hall at the John Radcliffe Hospital in Oxford – refreshments will be available from 5.30pm and the meeting will start at 6pm.

2.11. It will include presentations on the extraordinary story of a baby 'born twice' by surgeon Mr Hooman Soleymani Majd and on a new treatment pathway which is enhancing cancer care in OUH's two Emergency Departments by consultant nurse Kay McCallum.

2.12. Everyone is welcome to attend – pre-event registration is available via Eventbrite.

**Staff awards**

2.13. Isabel Pallera, a specialist biomedical scientist in the Neuropathology department at OUH, won the Rising Star Award at the Institute of Biomedical Science (IBMS) Awards 2025 on 4 July. Read Isabel's nomination and the judges' note on the IBMS website – Rising star.

2.14. The Trust's internal communications campaign in support of the refreshed OUH Staff Recognition programme is shortlisted for the Institute of Internal Communication (IoIC) Awards 2025. The Trust will receive an Award of Excellence and is in the running to win the 'Best Employee Experience Programme' category at the IoIC Awards ceremony on 18 September.

2.15. Congratulations to our OPTIN trial team, from the Physiotherapy Research Unit at the NOC, on being shortlisted for the Chief Allied Health Professions Officer's Awards 2025. Winners will be announced on 14 October.

2.16. The OUH Rewards Advent Calendar internal communications campaign is shortlisted for the Healthcare People Management Association (HPMA) Excellence in People Awards 2025. The Trust is in the running to win the 'Browne Jacobson Award for Excellence in Employee Engagement' category at the HPMA Awards ceremony on 20 November.

2.17. Two OUH teams are shortlisted for the *Health Service Journal* (*HSJ*) Awards 2025 on 20 November – the Spine Awake Surgery Oxford Protocol in the 'Acute Sector Innovation of the Year' category and the Oxfordshire Breathlessness Diagnostic Pathway pilot, with a number of partner organisations, in the 'Modernising Diagnostics Award' category. Read more in our news story.

## 3. Performance

3.1. A comprehensive Integrated Performance Report (IPR) is included in the Board papers for this meeting. The IPR sets out how we are performing against the plans we have agreed with NHS England and against national standards more broadly.

### Finance

3.2. Income and Expenditure (I&E) was a £1m in-month deficit at the end of Month 4 (July), which was £0.2m better than plan.

3.3. The plan included a £7m savings requirement in July, as our level of recurrent savings has improved in-month.

3.4. Cash was £13.5m at the end of July, £4.6m higher than the previous month and £9.9m higher than planned.

## 4. Operational Performance

### Elective Care

4.1. Work continues on reduction of waiting times and a recovery action plan is in place to reduce Referral to Treatment (RTT) times. At the end of July, 175 patients were waiting longer than 65 weeks. All specialities are working to deliver the plan, which includes the delivery of a reduction of patients waiting more than 52 weeks. This includes a real focus on first outpatients appointment for all patients in the patient cohort of 52 week waiting patients, where significant progress has been made to date. This is including, but not limited to, actions including a patient engagement validation exercise for first appointments being undertaken, and overall validation of our total waiting list. Our referral growth compared to the previous year is 2.9% to date.

### Urgent and Emergency Care

4.2. Our Urgent and Emergency Care performance was 82.1% in July for all types. This exceeds the national target and our planned performance trajectory for the year. This has been supported by the excellent improvement work within our Emergency Departments and in hospital patient flow. Most notably as a result of this work, there has been a reduction in the percentage of patients with a length of stay in ED of over 12 hours to just 1% in July, this is after a specific piece of work to support a zero tolerance to 12 hours for a patient in the department. We are driving further improvements now in using any breaches as an opportunity for thematic review and we have a specific improvement plan for improvements in four-hour access standard for children and young people.

### Cancer

4.3. Cancer performance against the 28 Day Faster Diagnosis Standard and 62-day combined standard (Month 3 - June) is below the operational plan, by 0.6%. Cancer performance is reported one month in arrears due to a nationally extended reporting period. For August the unvalidated data indicates that 28-day performance is above plan and above standard. Key challenges include capacity for surgery, diagnostics and oncology together with delayed inter-provider transfers. Specific actions taken to improve performance include tumour recovery plans, tumour site specific workshops and pathway mapping against best practice timed pathways, and addressing surgical capacity through theatre reallocation.

## 5. Patient Care

### Successful ‘Super Surgery Day’ at the Horton General Hospital

5.1. A total of 15 patients underwent successful day case hernia surgery, all within just nine hours, during a single, high-efficiency theatre list at the Horton General Hospital in Banbury in July.

5.2. This ‘Super Surgery Day’ was designed to deliver rapid hernia treatment to a high number of patients, ensuring timely and efficient care. All patients were able to return home on the same day and gave positive feedback about their experience. The full story is available to read on the Trust website.

**OUH performs well in Cancer Patient Experience Survey**

5.3. Cancer patients have rated the level of care which they received at OUH as 9 out of 10 for the fourth year in row and praised the dignity and respect with which they were treated by staff, according to the results of the national Cancer Patient Experience Survey which were published in July.

5.4. The survey asks a variety of questions about people's experience of care, including how involved they feel in decisions about their care, whether the information they are given is easy to understand, and how supported by staff they feel. Thank you to all staff working in Cancer Services who contributed to these encouraging patient survey results.

**Patient safety and staff wellbeing prioritised during industrial action**

5.5. Thank you for the combined effort of colleagues who maintained excellent care and patient safety during the five-day period of industrial action by resident doctors in the last week of July, together with those who supported the preparations, including teams who postponed and rebooked patient appointments. We were able to minimise disruption to our patients while ensuring that all care was safe and appropriate, and maintaining the wellbeing of our staff. However, I would like to apologise to any patients who did experience any disruption to their care during this period.

**From addiction to advocacy – a patient story**

5.6. A former Hepatitis C patient presented her story at the Trust Board meeting in May. She had a long history of substance misuse and drug addiction from a young age, which also led to other issues including brushes with the law and spending time in prison, until in 2019 she decided she wanted to change her life for the better.

5.7. Engaging with the charity Turning Point in Oxford and with treatment and support from the OUH community nursing team following her diagnosis, she now volunteers with the Hepatitis C Trust to break down stigma and barriers to people living with addiction accessing services.

5.8. Trust Board members were blown away by this powerful testimony and our Communications team have worked with the former patient, whose name has been changed to protect her privacy, to share her story more widely to encourage people to get tested for Hep C. You can read her story in full on the Trust website.

## 6. Partnerships

### Neonatal Transfer service celebrates 10th anniversary

6.1. The Southampton Oxford Neonatal Transfer service (SONeT) celebrated its 10th anniversary in July. Staffed by neonatal nurses, doctors, ambulance crews and administrators, SONeT is a joint initiative between the neonatal intensive care units at OUH and at University Hospital Southampton NHS Foundation Trust.

6.2. In the last 10 years, the team has transferred or supported more than 10,000 newborns across hospital sites in the south.

6.3. Thank you to all colleagues who help deliver this valuable service in partnership with clinical teams across the Thames Valley and Wessex regions.

### Friends of the Horton support lymphoedema patients at Katharine House

6.4. The League of Friends at the Horton General Hospital, also known as Friends of the Horton, recently made a generous donation of £16,000 to lymphoedema care at Katharine House Hospice. This donation has funded two pieces of specialist equipment for the hospice's newly established lymphoedema clinic room, enhancing the quality of care for patients with complex needs, while helping staff to provide care more effectively and efficiently. Read more on the Trust website.

### Spotlight on our partnership with Oxford Hospitals Charity

6.5. The benefits of having pleasant outdoor spaces on our hospital sites for patients, visitors and staff to enjoy are clear, and this has been a recent focus for the Oxford Hospitals Charity team.

6.6. On the Churchill Hospital site, where many of our cancer services are based, the Jane Ashley Garden has been completely refurbished, with new planting throughout and lots of extra seating areas. The Charity is hosting an evening event on 23 September to celebrate the re-opening of this valuable space which cancer patients and their families are already enjoying.

6.7. The Children's Ward at the Horton General Hospital in Banbury has benefited from a magical makeover of its outdoor play area and the Women's Centre at the John Radcliffe Hospital now has a new garden near the entrance. Both new areas are being officially opened this month.

6.8. The NOC also has a new green walking route with an accompanying app to help rehab patients on the road to recovery.

6.9. A big thank you to Oxford Hospitals Charity for all their support for patients, visitors and staff at OUH.

**Oxford Biomedical Research (BRC) News**

6.10. Oxford researchers have developed the first mathematically supported cellular map of lung tissue in idiopathic pulmonary fibrosis (IPF) and uncovered key immune cell interactions that could explain why lungs fail to repair in this deadly disease with no known cure. The study was supported by the Oxford BRC.

6.11. A new UK-wide clinical study aimed at transforming liver cancer surveillance in people with cirrhosis has opened to recruitment. The AMULET study, led by the University of Oxford and supported by the Oxford BRC, is comparing a new MRI technique to standard ultrasound surveillance, in order to improve early detection of liver cancer and patient outcomes. Liver cancer incidence is increasing, with most cases arising in people with liver cirrhosis. While earlier detection means treatment is more likely to be successful, current liver ultrasound has poor sensitivity in some patients, meaning that early cancers can be missed.

6.12. An Oxford BRC-supported study has established that different biological mechanisms underlying the common heart disorder atrial fibrillation (AF) result in different characteristics and complications. The most serious complication of AF is stroke, and this research showed how using large-scale genetic data could improve our understanding of AF and potentially lead to more tailored approaches to treatment of those with irregular heartbeats.

6.13. The Alan Davidson Foundation has renewed its funding for another three years for the ACORN study, which is creating a national register of people with motor neurone disease (MND) and frontotemporal dementia (FTD). The study is led by the Oxford Motor Neurone Disease Centre in the Nuffield Department of Clinical Neurosciences and is supported by the Oxford BRC.

6.14. Three OUH nurses have completed the first stage of their clinical academic journey after presenting the findings of their Oxford BRC internship research projects. This second internship cohort of 2025 was made possible thanks to an additional £170,000 from the NIHR to spend in areas that deserved extra investment. As well as the internship, the BRC launched its Preparatory Award for a Research Career (PARC) programme with the funding.

6.15. The Oxford BRC has published a profile of Corina Cheeks, a member of its Diversity in Research patient and public involvement and engagement group and a patient and public representative on the BRC's Steering Committee, its main governance and oversight body.

**Health Innovation Oxford and Thames Valley news**

6.16. The Health Innovation Oxford and Thames Valley (HIOTV) 2024/25 impact report demonstrates the organisation's contribution with partners to improving health and wealth.

6.17. More than 10,000 NHS patients and in excess of 2,500 NHS staff benefited from HIOTV initiatives during the year.

6.18. The report features case studies illustrating HIOTV support in finding, testing, and implementing innovations. These include a number of examples with strong OUH input, notably relating to improvements in stroke care, hospital at home, and preterm births.

## Recommendations

6.19. The Trust Board is asked to:

- Note the report.

# 6. PATIENT'S PERSPECTIVE

# 7. MATERNITY SERVICE UPDATE REPORT / PERINATAL QUALITY SURVEILLANCE SUMMARY REPORT (TO INCLUDE PERINATAL IMPROVEMENT PROGRAMME)

# 8. PATIENT EXPERIENCE ANNUAL REPORT 2024/25

## REFERENCES

Only PDFs are attached

07 TB2025.75 Patient Experience Annual Report 24-25 - V9.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.75**

| | |
|---|---|
| **Title:** | **Patient Experience Annual Report 2024-2025** |

| | |
|---|---|
| **Status:** | **For Discussion** |
| **History:** | |

| | |
|---|---|
| **Board Lead:** | **Chief Nursing Officer** |
| **Author:** | **Marilyn Rackstraw Patient Experience and Engagement Lead** |
| | **Katie Harris Complaints and Patient Services Manager** |
| **Confidential:** | **No** |
| **Key Purpose:** | Assurance, Performance. |

## Executive Summary

1. This Patient Experience Annual Report presents a comprehensive overview of patient feedback received across Oxford University Hospitals NHS Foundation Trust from April 2024 to March 2025. The report highlights key themes, trends, and outcomes derived from patient experience data, and outlines the Trust's continued commitment to placing patients, families, and carers at the heart of service improvement.
2. Over the reporting period, the Trust received over 185,000 items of patient feedback through a variety of channels, including the Friends and Family Test (FFT), national surveys, complaints and compliments, Patient Advice and Liaison Service (PALS) contacts, local surveys, focus groups, and community engagement events. This feedback has been instrumental in identifying areas of excellence and opportunities for learning and quality improvement.
3. Key achievements during the year include:
4. Sustained high levels of positive feedback in FFT responses, particularly in inpatient and outpatient services.
5. Improved response times and learning from upheld complaints.
6. Establishment of the Patient Experience and Family Carer Forum [PEFC]
7. Looking ahead, the Trust will continue to strengthen its patient experience strategy by developing more inclusive approaches to feedback collection, ensuring that all voices are heard and acted upon. The focus remains on delivering compassionate, person-centred care and using patient insight as a driver of continuous improvement.

## Recommendations

8. The Trust Management Executive is asked:
    - Note the contents of the report and the associated action plan.

## Contents

# Patient Experience Annual Report 2024-2025

## 1. Purpose

1.1. The Trust gathers feedback from various sources, including interactions with people accessing services, surveys, patient stories, the Friends and Family Test (FFT), the Patient Advice and Liaison (PALS) Team, complaints, compliments received, external stakeholders, and daily contact with individuals within the hospital. This feedback provides insights into people's experiences of care and what is important to patients and those significant to them.

1.2. Although the Trust receives more feedback about positive experiences of care, it remains essential to listen and learn from all feedback. Encouraging people to share insights on improvements helps enhance the overall experience and quality of care provided.

1.3. A priority for the Trust is to be responsive to the feedback received, facilitating person-centred improvements. Feedback is crucial for delivering the organisational vision and strategy. Patient experience is integral to the Trust's operations, and it is the responsibility of each staff member to uphold the Trust values, ensuring that patients are central to all decision-making processes.

## 2. Background

2.1. Improving patient experience is a core component of delivering high-quality healthcare and is recognised as one of the three pillars of quality by the NHS, alongside clinical effectiveness and patient safety. A positive patient experience is closely linked to improved health outcomes, increased patient engagement, and reduced healthcare inequalities. As such, it is a key priority for NHS organisations and is embedded in national policy through frameworks such as the NHS Constitution, the Long-Term Plan, and the NHS Patient Experience Framework.

2.2. The NHS continues to place significant emphasis on listening to and acting upon the views of patients, families, and carers. Tools such as the Friends and Family Test (FFT), national patient surveys, local feedback systems, complaints, and patient stories provide rich insights into what matters most to people using services. Understanding these experiences is vital for identifying gaps in care, addressing variation, and driving continuous improvement.

## 3. Compliments

3.1. Compliments are defined as unsolicited expressions of gratitude or praise. Therefore, complimentary feedback from the FFT feedback is not used because these comments are solicited. Below is a selection of compliments received and shared with the teams. Compliments can serve as evidence that compassionate care is being provided:

3.1.1. Throughout the whole process, which took 5 hours, all members of staff were helpful, considerate, respectful and understanding. There was clearly an organised team working well together.

3.1.2. The Doctor and his team combined all the attributes I value as a patient which are often missing from many hospitals and primary care. Welcoming, patient confidence boosting, excellent patient information about the procedure and being highly professional in the execution. The best collective I can come up with is to describe it as 'Care Culture' of the best.

3.1.3. Everyone was so professional, caring and diligent. I was especially impressed by my anaesthetist, as he made me feel so comfortable whilst I was being cannulated, listened so well to my concerns prior to the op and met my concerns with reassurance and a considered plan, so I knew I was in safe, caring hands.

3.1.4. I would like to sincerely thank the entire team for the care provided to my child during our recent visit to the Children’s Hospital. From the moment we were admitted into the Day Care Ward, the staff were exceptional. They were incredibly friendly, informative, and made us feel very comfortable throughout the process. We deeply appreciate all their hard work and professionalism during what an important day for us was.

## 4. Complaints

4.1. The Trust aims to make its complaints process effective and empathetic, ensuring complainants feel heard and that improvements are made where necessary. The approach reflects the Health Service Ombudsman’s Principles of Good Complaints Handling.

4.2. In 2024/25 the Trust saw more complaints but also a quicker handling of them compared to 2023/24. The total number of formal complaints rose by 13% from 1,344 the previous year to 1,518 in 2024/25.

4.3. The rise in complaints likely reflects improved awareness and reporting, but it also strains the process. Most complaints were about communication, appointment delays or cancellations, and staff attitudes and behaviour.

4.4. The figure below presents the complaints by month from 1 April 2024 to 31 March 2025.

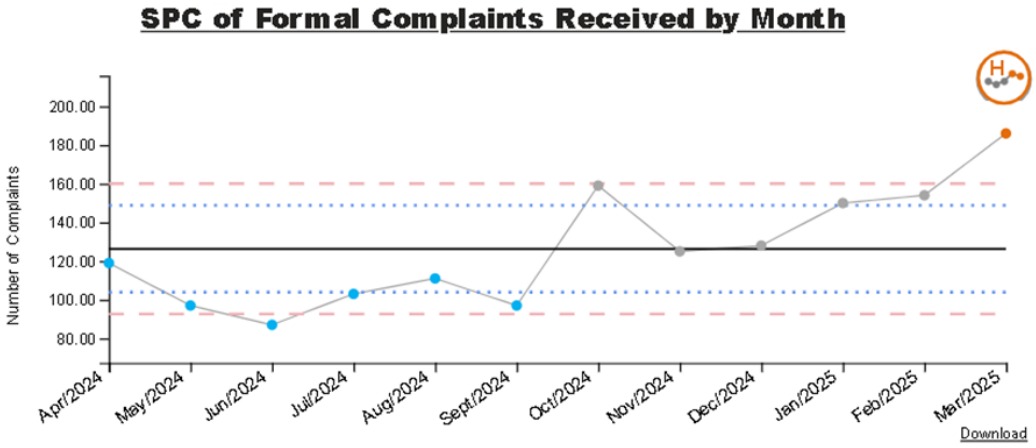



*Figure 1: Formal complaints received by month*

### Performance in Complaints

4.5. The NHS is expected to acknowledge all complaints received by Day 3, in writing. In 2024-25, the Trust updated its process to acknowledge all complaints on Day 1, allowing more time for investigation. As a result, 100% of complaints were acknowledged on the first day.

4.6. Each complainant is assigned a designated Complaints Co-ordinator who serves as their primary point of contact throughout the investigation and resolution process. The Complaints Co-ordinator also provides support to staff involved in the investigation, ensuring that all concerns are addressed comprehensively and appropriately in the response.

## 5. Response timescales

5.1. During the 2024/25 period, the Trust updated its response timeframe for complaints, shortening the deadline from 40 working days to 25 working days. The table below presents performance metrics based on the new 25-day standard.

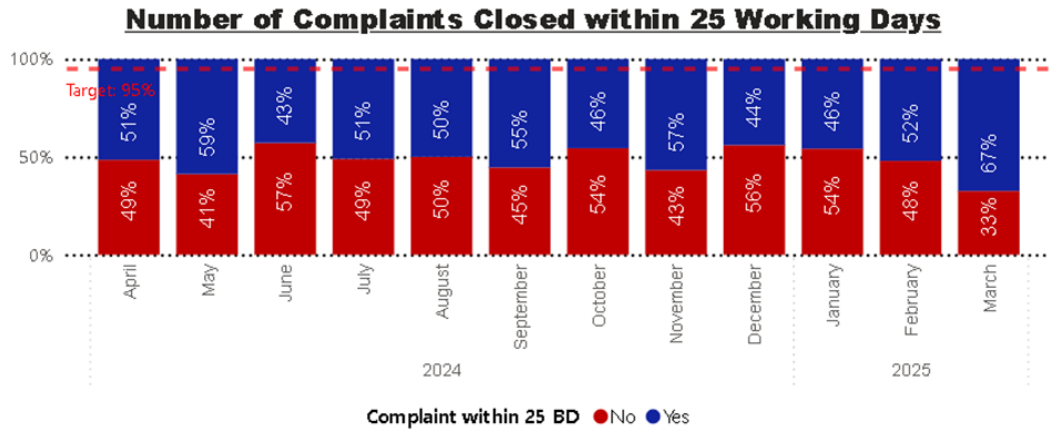



*Figure 2: Number of complaints closed within 25 working days*

5.2. Despite higher complaint volumes, response performance improved. Initially, 45-50% of complaints were resolved within 25 days, but by March 2025 this rose to 67%, up from 51% in April. This trend shows increasing efficiency in complaint handling.

5.3. There were several reasons as to why complaints have not been investigated and responded to in the required timescale, namely competing clinical priorities, and staff availability. Further work is being undertaken to improve the performance in response timescales with a performance target of 85% of all complaints to be completed in 25 working days expected to be met during 2025-26.

5.4. Performance on complaint response timescales is reported monthly to the Trust Board within the Integrated Performance Report. Additionally, the four clinical Divisions are monitored in their individual Divisional Performance reviews, with specific divisional targets for improvement set by the Trust Executives.

**Key Themes in Complaints**

5.5. All complaints are logged on the Trust's Customer Care module in Ulysses using NHS England's categories and sub-categories. Multi-faceted complaints may be assigned multiple categories. The following graph displays the top 10 complaint categories for 2024-25.

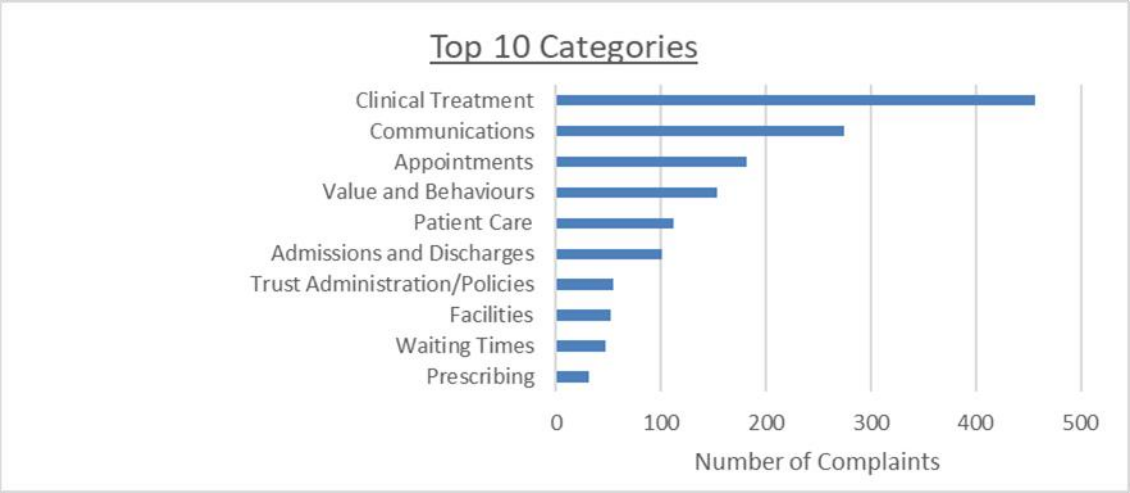



*Figure 3: Top 10 categories of the complaints raised in 24-25*

5.6. 456 complaints were recorded against Clinical Treatment in 2024-25, making it the most common category of complaint. Examples of complaints recorded in this category include Delay or Failure in Treatment, Delay or Failure to Diagnose and Injury Sustained during Treatment or Operation.

5.7. Communications was the second highest category of complaint, with 274 complaints recorded under this heading. Examples of complaints regarding Communication include Communication with Patients and Communication with Relatives.

5.8. Complaints regarding Appointments was the third highest category, with 182 complaints recorded. Reasons included Appointment Delay (inc. length of wait) and Appointment Cancellations.

**Learning from Complaints**

5.9. The Trust welcomes the opportunities provided to it from complaints, to allow for reflection, learning and making improvements. Below are some examples of learning that has arisen from complaints, and service changes/improvements made as a result:

5.10. Bowel screening – based on one patient's experience:

5.10.1. Family Cancer Clinics have been re-arranged to include urgent polyp slots to allow the medical team to see advanced polyp patients quickly in order to avoid "faceless" referral triage. This will allow the service to undertake advanced consent and to inform patients of the likely sequence of events and timescales. This has been actioned.

5.10.2. Re-wording of the endoscopy documentation software to mandate endoscopists with urgent (<12 month) requests to complete the referral form at the time of procedure. This has been actioned.

5.10.3. Development of a guideline for a minimal information set for endoscopists encountering a large or advanced looking polyp. This is in development.

5.10.4. Establishment of an advanced polyp multidisciplinary team meeting so that large polyps are subject to multiple opinions on the best course of action. This is planned.

5.10.5. IBD – based on a patient's feedback about continuity of care in the IBD service, they invited her to be a part of the patient panel.

5.11. Endoscopy – based on patient experiences:

5.11.1. The Endoscopy Management team are currently putting together a case to hopefully increase the activity in the Endoscopy Unit to ensure all patients waiting for endoscopy are seen, and with the aim to keep up with the number of diagnostic and therapeutic endoscopies required.

5.11.2. The Matron and Clinical Lead recently worked with a patient to accurately document on his record that he is on drug maintenance therapy and does not wish to receive opioids (this was previously not visibly documented). It now works the same way as a 'flag.'

### Parliamentary and Health Services Ombudsman (PHSO)

5.12. In 2024-25, the Trust continued its eight-year record of having no complaints upheld by the PHSO after its investigations. The PHSO usually upholds complaints when there is evidence of inadequate handling by the Trust.

5.13. One case escalated to the PHSO by the complainant resulted in the Trust being asked to re-examine the information already provided to the complainant. Following completion of this task, the PHSO were satisfied that the Trust had taken all reasonable steps to resolve the issues for the complainant and closed the case at their end.

5.14. The PHSO introduced their Complaints Standards in 2021, which gives Trust advice and guidance on what good complaints handling looks like. The Trust is fully compliant with these standards.

### Reopened complaints

5.15. The Trust monitors all reopened complaints each month, to understand the reasons why a complainant may request their complaint be reopened. The most common reason for someone reopening their complaint is that they wish to take the Trust up on the offer to meet to discuss the concerns and subsequent investigation in a face-to-face meeting. This is particularly useful for complaints that require a detailed exploration of a patient's journey through services, to allow for greater understanding and has been widely utilised within Maternity in the last 12 months.

5.16. Reopened complaints have been steady each month, with a slight rise in October 2024 that matches an increase in new complaints received by the Trust.

5.17. The graph below shows the rate of reopened complaints in 2024-25:

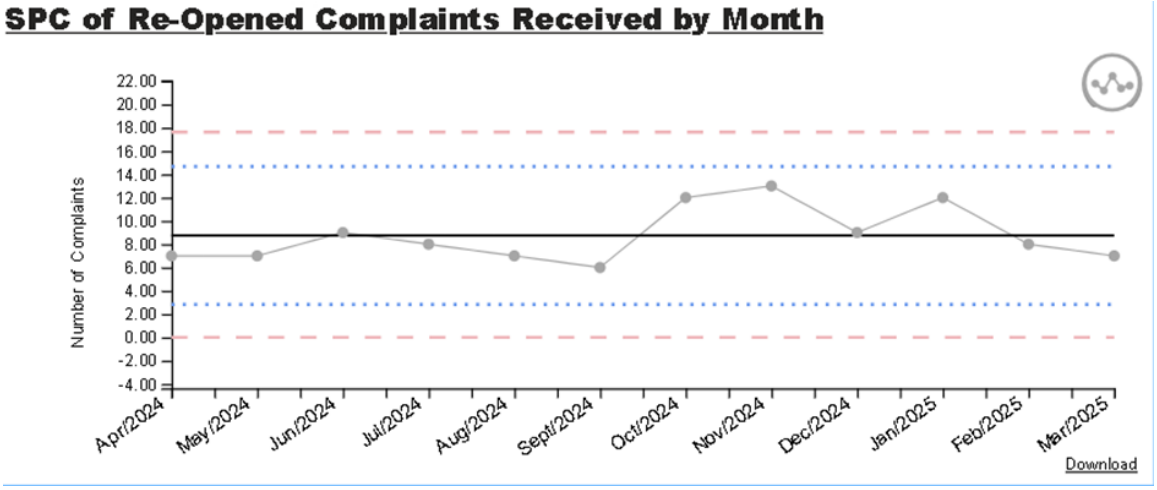



*Figure 4: Re-opened complaints received by month*

5.18. The Trust saw a slight increase in the overall number of reopened complaints in 2024/25 (n=140) compared to 2023/24 (n=132).

**PALS and Complaints Training**

5.19. In 2024, the PALS and Complaints team organised and delivered training to staff from each of the five Divisions. The sessions included practical ways of delivering early resolution to issues, as well as ways to escalate matters as needed. The training also gave staff useful advice on how to support those involved in a complaint.

5.20. Training sessions will continue in 2025-26 and will include information given to new starter staff at the Trust induction.

## 6. Friends and Family Test [FFT]

6.1. The Friends and Family Test (FFT) serves as a crucial tool for gathering anonymous feedback, underpinning the essential principle that individuals utilising NHS services should have the chance to share their experiences. Those who provide feedback through the FFT and seek a direct response are advised to contact the Patient Advice and Liaison Service (PALS).

6.2. A national standardised question is asked: 'thinking about your visit to [area visited], overall, how was your experience of our service?'

6.3. In 2024/25, the Trust received 185,020 pieces of patient feedback, representing an increase compared to the 23/24 figures of 162,699. Most patients who completed the FFT indicated that they would recommend the service they received.

| Service | Approval Rate | Disapproval Rate | Response Rate | Total No. of Feedback |
|---|---|---|---|---|
| Inpatient | 95% | 2.5% | 24% | 43,694 |
| Outpatient | 94% | 3% | 9.5% | 122,827 |
| Emergency Department | 80% | 12% | 17.9% | 18,137 |
| Maternity | 63% | 27% | 1% | 106 |
| Covid-19 | 98% | 0.4% | N/A | 256 |
| Total | 93% | 4% | 12% | 185,020 |

*Table 1: 24/25 FFT Feedback*

6.4. Outpatient services have the highest volume of patient attendance but has the lowest response rate. Over the past 12 months, we have updated our FFT posters and SharePoint site with useful information to support the teams in the promotion and collection of FFT feedback, however we would

like to continue our focus on working with teams to increase feedback in this area with the delivery of the SMART action attached to this report.

6.5. To encourage patient engagement with FFT, the Trust has developed equitable access methods, including both digital and paper-based options in multiple languages. This inclusive approach ensures all service users can provide valuable feedback. Further work needs to be done to support colleagues to promote FFT within service areas to encourage feedback. This approach was tested within maternity services and has increased uptake by over 90%.

6.6. The below shows the methods of collection that are used most.

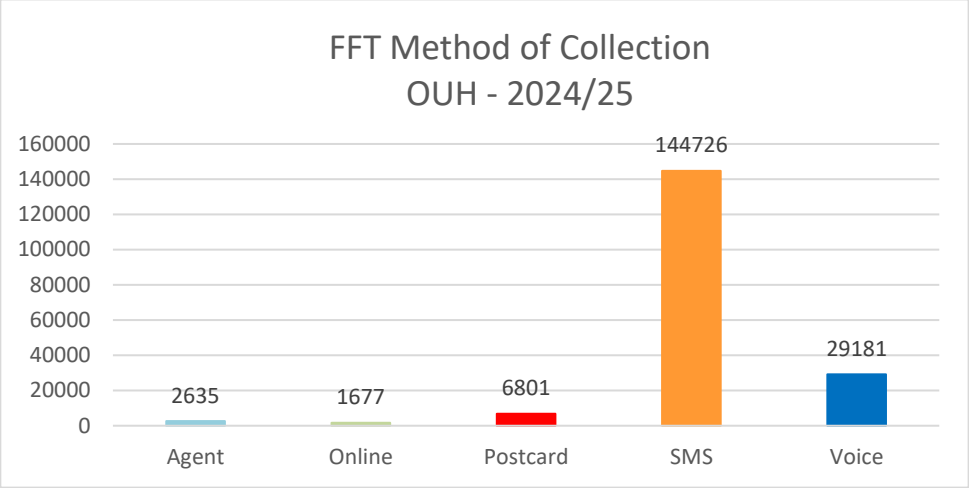



*Figure 5: FFT Method of Collection 24/25*

6.7. Individual services receive monthly reports on their FFT results and can utilise these to develop a 'You Said, We Did' poster that illustrates the actions taken based on the received feedback. In the upcoming year, we aim to enhance this initiative by gathering examples of good practices throughout the organisation, creating feedback boards, and sharing these with different areas.

6.8. Feedback and patient experience information is displayed with quality and safety data, supporting analysis and triangulation of key metrics. Information is displayed outside in wards / departments to provide transparency to all people accessing the area.

6.9. Our goal is to establish a consistent system across the Trust to be able to effectively communicate to both staff and patients around how we have used feedback to shape services. In response to FFT feedback, several practical improvements have been made. For instance, the introduction of 24-hour visiting within maternity has been positively received, providing reassurance and support to patients. Additionally, a new maternity volunteer program has been initiated, with volunteers assisting in responses to call bells, sorting linen, and engaging with service users.

6.10. A thematic analysis shows the most popular themes for the Trust

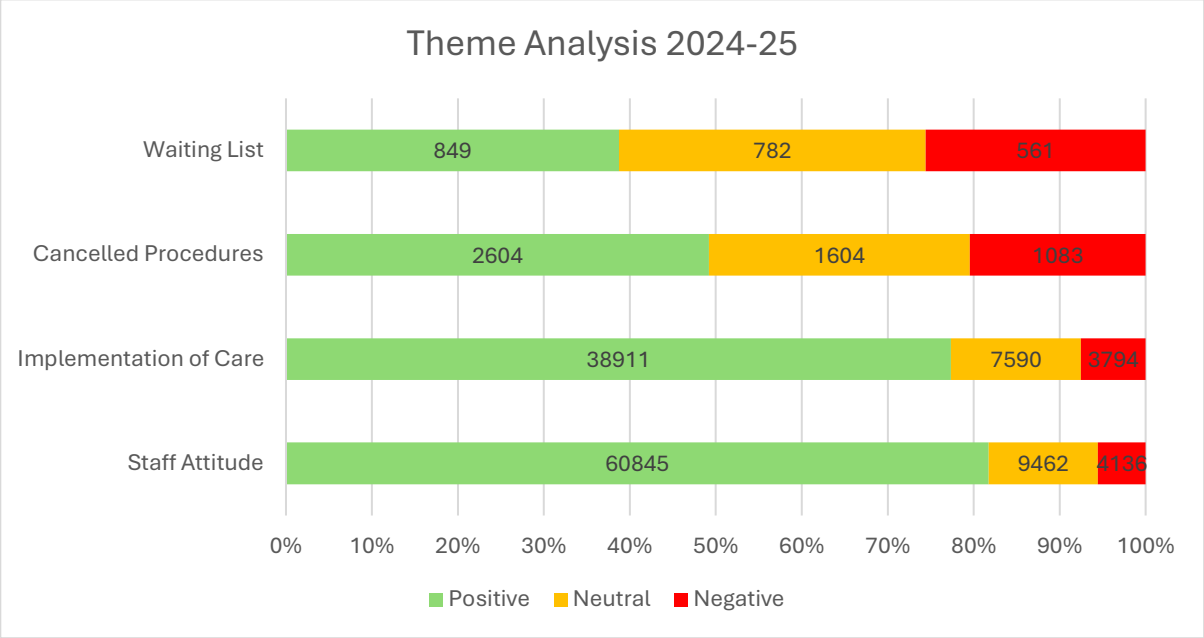



*Figure 6: Theme Analysis 2024-25*

## 7. Patient stories

7.1. Patient feedback includes capturing patient stories. From April 24, 6 patients/members of staff have presented stories in their own words, at each Trust Board. For those that have not wanted to present themselves, the clinical team have shared on their behalf.

7.2. The stories have shared the experiences of our patients including:

7.2.1. Kelly, who has diabetes and following a fracture, underwent reconstructive surgery preventing amputation of her foot. The clinical team shared their experience of providing ongoing supporting to patients with diabetes, and the importance of this.

7.2.2. Nell shared her experience of the Early pregnancy assessment unit [EPAU] following a miscarriage. Nell spoke movingly about her experience, praising the 'many small acts of kindness' from members of the EPAU team, and said how lucky she felt that her care when she lost her baby happened in an environment which didn't look or feel like a medical setting.

7.2.3. Barry, who following an accident had high risk heart surgery and needed to learn to walk and speak again. His story highlighted the treatment and care plan working with the Speech and Language Therapist and Ear, Nose and Throat [ENT] Multidisciplinary Team in the Vocal Cord Medialisation Clinic [VCMC]

7.2.4. Helen shared her story, via Here for Health, about her diagnosis of Metabolic Dysfunction-Associated Steatotic Liver Disease [MASLD] and how she was able to significantly improve her liver function and reduced her insulin dosage through lifestyle changes and personalised support from Here for Health.

7.2.5. Roger presented his and Ashleigh's story describing Ashleigh's post-natal depression, insomnia, and health anxiety, and the struggle to find a service who could help her, when Ashleigh frequently attended the Emergency Department (ED) sometimes multiple times a week. Roger attributed the high intensity users service as saving Ashleigh's life and enabling her to live her life well

7.2.6. Nigel's story was told by one his carers and the diabetes team. Charlotte and Hayley shared Nigel's story in using evolving technology to improve person centred care for people with Diabetes and how this had improved Nigel's healthcare and quality of life.

## 8. Care Quality Commission [CQC] CQC Patient Survey Programme

8.1. During 2024, the CQC undertook and published the annual Inpatient 2023, Urgent and Emergency Care [UEC] 2024 and Maternity 2024 surveys.

**Inpatient Survey 2023**

8.2. The Inpatient 2023 Survey respondents answered questions about their stay covering care quality, hospital admission, staff interactions and overall experience during November 2023. This was subsequently published in August 2024.

8.3. The Trust had a 43% response rate, which was 2% below the 2022 response rate, however a1% improvement on the national average response rate, which was 42%.

8.4. The best and worst performance relative to the Trust average are calculated comparing the Trust results against the national average across England, identifying the bottom and top five scores. The bottom and top results for OUH are shown below.

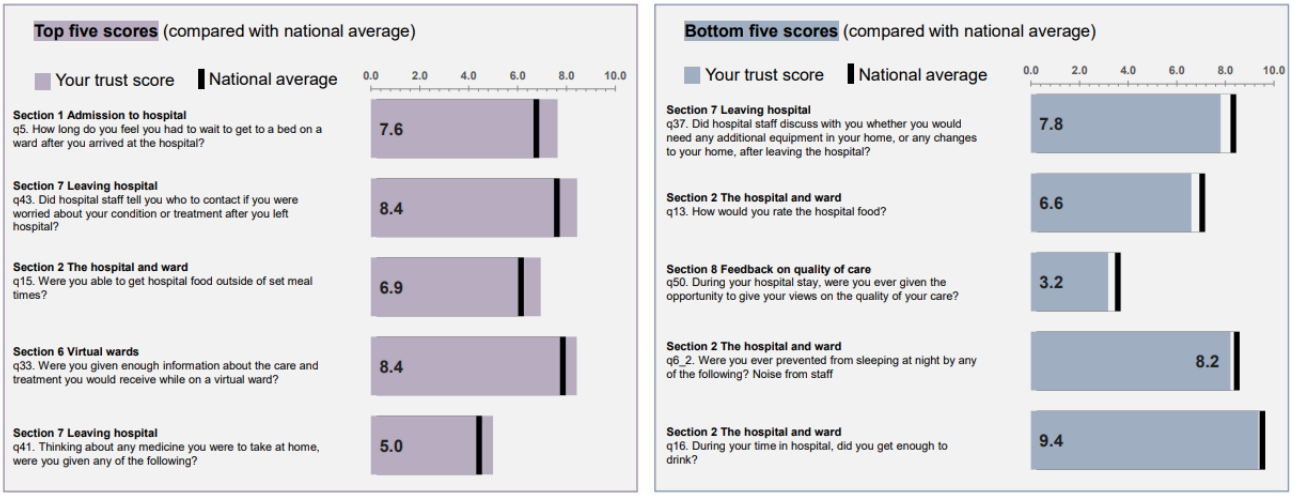



*Figure 7: Top 5 and Bottom 5 scores*

8.5. The Trust performed ‘somewhat better / better than expected’ than other Trusts in 8 questions and ‘about the same’ as other Trusts in the remaining 41 questions. No questions scored ‘worse,’ ‘much worse’ or ‘somewhat worse’ than expected.

8.6. The results have been shared with the Divisional leadership teams and improvement actions focused on the bottom 5 scores have been developed.

**Urgent and Emergency Care 2024**

8.7. The Urgent and Emergency care survey 2024 looks at the experiences of people using type 1 and type 3 urgent and emergency care services. Type 1 services include A&E departments and may also be known as casualty or emergency departments. Type 3 services include urgent treatment centres and may also be known as minor injury units.

8.8. In the Type 1 UEC survey, 950 People were surveyed with a 30% response rate. The average response rate for all trusts was 29%. The Trust scored better, and somewhat better than expected for 4 questions. The Trust scored about the same for 24 questions, and somewhat worse than expected for 1 question.

8.9. The bottom and top results are shown below.

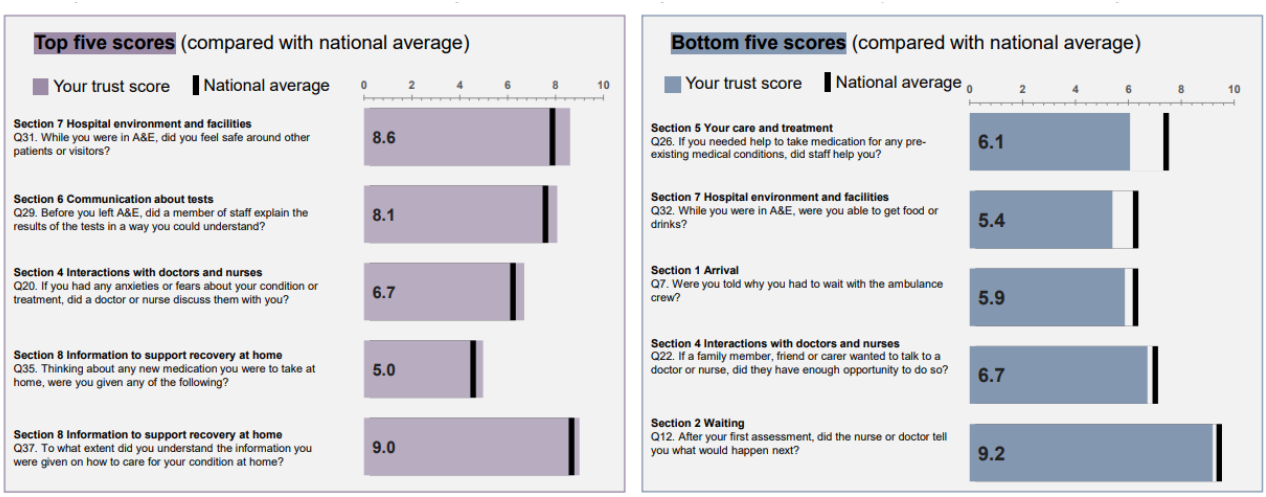



*Figure 8: Top 5 and Bottom 5 scores*

8.10. For the Type 3 UEC Survey, 580 people were surveyed with a 18% response rate. The average response rate for all trusts was 26%. The Trust scored much better, better and somewhat better in 3 questions, respectively. The Trust was about the same for the remaining 24 questions.

8.11. The bottom and top results are shown below.

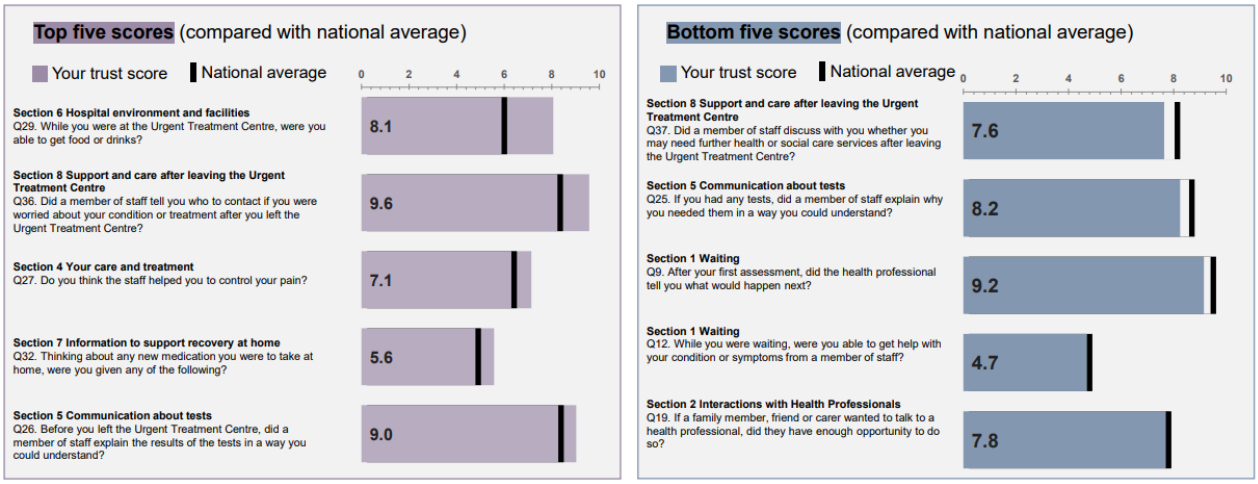



*Figure 9:Top 5 and Bottom 5 scores*

## Maternity Survey 2024

8.12. 541 people were invited to take part in the Maternity Survey, which had a 51% response rate, compared to a 41% response rate nationally. The Trust scored better than expected in 2 questions, somewhat better than expected for 1 question, about the same for 31 questions and somewhat worse than expected for 1 question.

8.13. In comparison to the previous year, the trust was significantly worse in 4 questions.

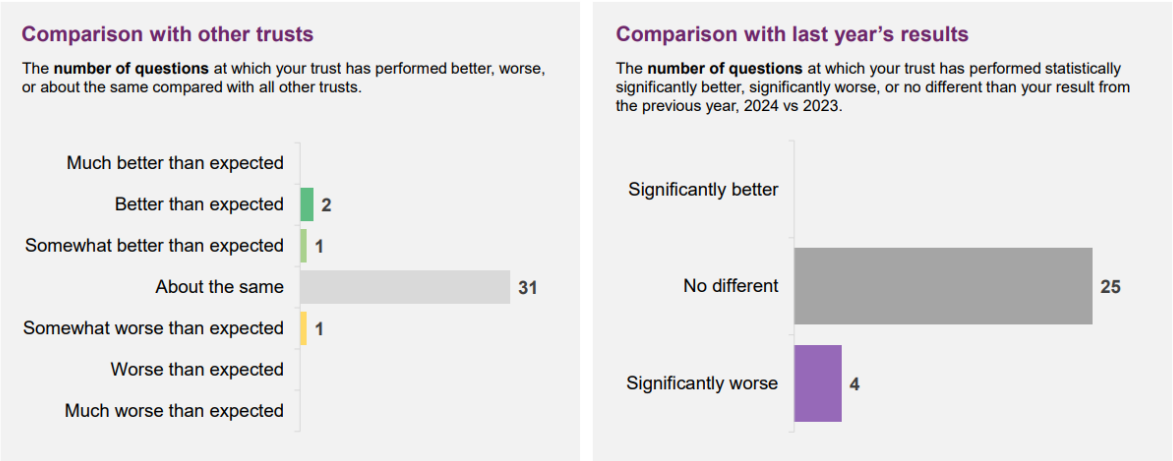



*Figure 10: Comparison with other trust and last year's results*

8.14. The Maternity Survey action plan was developed and continues to be monitored via the Triangulation and Learning Committee [TALC] that has been established within Maternity Services.

8.15. The process to ensure the development of adequate action plans following CQC National Surveys has been improved, with surveys presented at the Patient & Carer Experience Forum and a timescale agreed for the teams to present actions plans. This provides assurance of learning and improvement. Action plans for all surveys are now to be added to the Ulysses integrated governance system.

## 9. Equality Delivery System [EDS]

9.1. Neurosciences, Pharmacy, and Renal Transplant and Urology provided a presentation to a group of lay assessors on 20 November 2024. The focus was on how their services are inclusive and address the needs of patients with one or more of the nine protected characteristics. The scoring criteria and the subsequent grades given by the lay assessors for the presentations are shown below.

| **Domain one** | **Outcome** | |
|---|---|---|
| **Commissioned or provided services.** | 1A: | Patients (service users) have required levels of access to the service |
| | 1B: | Individual patients (service users) health needs are met |
| | 1C: | When patients (service users) use the service, they are free from harm |
| | 1D: | Patients (service users) report positive experiences of the service |

*Table 2: Scoring criteria*

| Neurosciences | Underdeveloped | Developing | Achieving | Excelling |
|---|---|---|---|---|
| 1A | 0 | 2 | 5 | 1 |
| 1B | 0 | 1 | 6 | 1 |
| 1C | 0 | 2 | 5 | 1 |
| 1D | 0 | 3 | 3 | 2 |
| **Pharmacy** | **Underdeveloped** | **Developing** | **Achieving** | **Excelling** |
| 1A | 0 | 4 | 3 | 1 |
| 1B | 0 | 2 | 6 | 0 |
| 1C | 0 | 2 | 6 | 0 |
| 1D | 1 | 3 | 3 | 1 |
| **Renal, Transplant and Urology** | **Underdeveloped** | **Developing** | **Achieving** | **Excelling** |
| 1A | 0 | 6 | 10 | 8 |
| 1B | 0 | 3 | 15 | 6 |
| 1C | 0 | 4 | 14 | 6 |
| 1D | 1 | 6 | 8 | 9 |

*Table 3: Grades given by the lay assessors for the presentations*

9.2. The grading was combined with the Workforce and Leadership domains and presented to the Trust Board.

9.3. The teams individually took away actions from the EDS presentations around areas for improvement which were suggested by graders, and these remain ongoing. As an example, we are working with the pharmacy team to look at a solution to enable them to collect service specific FFT feedback, and they are looking at how to create medicines information that can be translated for particular communities based on the feedback that those service users have given.

## 10. Interpreting and Translation / British Sign Language [BSL] services

10.1. Over 11,000 language interpreting sessions were provided across Trust services in 2024/25 through a combination of face-to-face and telephone interpreting.

10.2. The top five languages utilised by the Trust during 2024/25 were Tetum, Polish, Urdu, Arabic and Romanian

10.3. Devices on wheels are being trialled within several clinical areas to assess whether they enhance access for patients and staff and expedite access to interpreters.

10.4. The team has continued efforts to improve interpreting services throughout the organisation. Guidance has been developed for teams in a simplified format, including information on how to pre-book an interpreter or initiate a three-way call with a patient.

10.5. The Trust retains a specialist provider for BSL interpreting and translation services, and 392 interpreting sessions took place during the year. Additionally, a deaf awareness SharePoint page has been created, offering useful tips developed in collaboration with the deaf community.

## 11. Healthwatch

11.1. The Trust continues to appreciate the working relationship with Healthwatch in raising the profile of patients' experiences, engaging with communities, empowering their voice in healthcare and recommending changes to services, especially those people and communities whose voice is seldom heard.

11.2. During 2024/25, Healthwatch undertook four enter and view visits (Eye hospital, Oncology ward, discharge lounge, hand and plastics injury [HAPI] clinic) and conducted outreach visits on our Trust sites.

11.3. The Trust was given the opportunity to review and comment on the Healthwatch community engagement and report into Children's oral health in Oxfordshire, including the insights of those with lived experience, particularly children with special educational needs (SEND). The Trust was asked to comment on the report into people's experiences of leaving hospital in Oxfordshire, along with our ICB colleagues.

11.4. Healthwatch Oxfordshire attended the coffee morning with Action Deafness on 29th May 2024. They heard about the work of the Trust's Deaf Awareness Task and Finish group, to improve the care and experiences of patients who are deaf and hard of hearing.

11.5. Some of the improvements that have been made following the Healthwatch reports include improved signage within departments, improved patient

information and more support for patients with dietary needs, meal choices and accessing food and drink when appropriate.

## 12. Healthcare Transition/ Moving into Adult Services

12.1. Following the national publication of the Inbetweeners Report [1] in August 2023, work began to improve healthcare transition services for 14 – 19-year-olds, working in partnership with people and communities to inform and improve our services.

12.2. The aim of the project is to better understand the factors involved and improve the process and experience of Health Care Transition (HCT) within OUH and wider community. A specialist gap analysis commenced across the organisation to establish areas of exemplar practice and where services need to improve.

12.3. The patient experience team has:

12.3.1. Established an inclusive and multiagency steering group, with the aim of improving the experience of young people moving from children to adult services.

12.3.2. Developed a community of practice for clinical teams to learn exemplar practice to improve their own practice and learn from national initiatives

12.3.3. Joined the ICS Community of Practice

12.3.4. Established a link with the Southeast transition leads, who meet every 6 weeks with the aim of sharing good practice

12.3.5. Developed a Patient Participation Group [PPG] with service users and their families / carers. This is co-chaired by a young person with lived experience and one of the OUH Patient Safety Partners.

## 13. Yippee

13.1. We have held four successful Yippee meetings with positive feedback from the members that have attended and staff. We have recruited new members and hope that this upward trajectory continues with further promotion. We have developed an outline plan for upcoming projects and are looking forward to continuing to work together.

13.2. The new young governor joined the joint Trust Board and Council of Governors meeting on 13 November, and their feedback was that they felt welcomed at the meeting, the PE team is very grateful to the Council of Governors and Trust Board for supporting this positive experience.

13.3. Yippee conducted a meal tasting session with Mitie and reviewed the design of the food menus for children. The group provided feedback, leading to improvements being made in the menu design to be more visually appealing for young people.

13.4. Yippee is an important forum for young people to have a voice and be involved in decisions about how services are designed for young people and their families. A SharePoint page is being developed which will provide guidance around how colleagues can ask Yippee to help with projects / improvement programmes.

## 14. What Matters to You [WMTY]

14.1. WMTY featured at the Institute for Healthcare Improvement [IHI] Conference in early 2024 and enables patients and their families to provide feedback and raise concerns and improve experiences and healthcare outcomes. WMTY conversations help healthcare teams understand what is “most important” to patients, leading to better care partnerships and improved patient experience.

14.2. The team have:

14.2.1. Developed a film with 14 staff and patients.

14.2.2. Used this principle for the International Learning Collaborative [ILC] presentation on 8th June '24, and Safety Learning and Improvement conversations.

14.2.3. Used this approach when reviewing the Visitors Policy

14.2.4. For Phase 2 of the Shared Decision-Making project with Speech and Language Therapy/ Medialisation Clinic, we added this as a person-centred question at the end of the questionnaire.

14.2.5. We are developing a SharePoint page which will include promotional materials for teams to be able to use this approach within their local Quality improvement projects. This will be complete by 30 June 2025.

## 15. Shared Decision Making [SDM]

15.1. Decision support tools, also called patient decision aids, support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing. The team have previously worked closely with pilot areas to implement the ‘Ask 3

Questions' resource. From April 2024, we entered phase two and worked with three new teams.

## 16. Patient Participation Groups [PPG]

16.1. A regular PPG forum has been established for groups to share information and ideas. The aim is to implement a divisional reporting structure to capture and understand service users' views, which can then report through the patient experience and family carer forum. This will be developed in the coming year and will be embedded by March 2026.

## 17. Patient Information Leaflets [PIL]

17.1. The Oxford University Hospitals NHS Foundation Trust (OUH) work alongside Oxford Medical Illustrations (OMI) to produce Patient Information Leaflets (PILs) to be reviewed 3 yearly by the OUH clinician or Team who authored the leaflet.

17.2. The total number of active leaflets has decreased from 2054 to 1522 due to the review and removal of redundant leaflets and the promotion of existing external information. The number of outdated leaflets across the Trust (currently under review or pending review) has dropped from 918 in January 2024 to 251 at the time of writing. There are currently no outdated patient information leaflets that are not under review across the Trust.

17.3. Following a quality impact assessment, any leaflets (whether current or outdated) that do not meet UK accessibility standards are being removed from the Trust's website. We expect all leaflets to be reviewed, with any accessibility issues addressed by 31 May 2025.

17.4. A Patient Information Steering Group has been established which meets monthly, and a Patient Information Newsletter is circulated weekly to Directorate PIL coordinators to raise the profile and maintain the engagement of PILs across the Trust. A reading group composed of patients and FT members has been formed to review new Patient Information leaflets. Yippee and OMNVP review the children's and maternity leaflets.

17.5. Divisions have organised regular patient information workshops to sustain engagement in reviewing patient information, supported by the divisional management teams, PE team, and OMI. The updated policy has been reviewed by the Patient Information Steering Group and is presently undergoing Trust-wide consultation.

17.6. A patient information leaflet audit has been developed by the PE team to ensure that paper copies distributed in patient-facing areas are current and the latest version is being used. This audit is covered by the Care Assure

team and the OXSCA accreditation team, adopting a collaborative approach.

## 18. Translated Patient Information

18.1. The team is reviewing the availability of translated patient information due to its positive impact on access, engagement with services, health outcomes, safety, informed consent, and experience. This issue is particularly important for Maternity services, which need most of their catalogue in alternative languages. The PE team has benchmarked with Shelford Group to identify Trusts providing translated information. The Graphic Design team created a template for the Trust's interpreter provider for translations. The steering group is collaborating with the UK Association of Accessible Formats to develop a standard procedure ensuring translated information meets UK accessibility standards for publication on the Trust website.

## 19. Carers

19.1. We have held 5 carers café meetings at the JR throughout the year, attended by Dementia Oxfordshire, Carers Oxfordshire and Age UK. This has raised awareness of supporting employees who are carers and discussions are being held with the staff carers network to look at accessibility for our staff to be able to attend meetings.

19.2. In the following year, the aim is to join existing carers groups within the county that are already established and well attended as we recognise that travelling to our sites isn’t always convenient for members of the public who have caring responsibilities.

19.3. In conjunction with Carers Oxfordshire, we have established the Carers ID card which supports unpaid carers within the hospital setting meaning that carers are identified as soon as possible in the patient pathway and are involved as much or as little as they wish to be in the care and treatment of the cared for.

19.4. This also helps to ensure that carers are identifiable to staff and allows them to indicate the need for reasonable adjustments to be made to ensure they can continue any provision of care they wish to give.

19.5. We are continuing to work with Carers Oxfordshire and Oxfordshire County Council to look at how this can be scaled up and rolled out within the wider system in Oxfordshire.

19.6. This report outlines a significant range of work undertaken by the Patient Experience Team in 2024/25 to improve patient and carer experiences

across OUH. With continued focus on feedback, shared learning, accessibility, and partnership, the Trust remains committed to compassionate, person-centred care for all.

## 20. Patient Experience and Family Carer Forum [PEFC]

20.1. The Patient Experience and Family Carer Forum was established in October 2024.

20.2. PEFC was established to raise the profile of improving experiences across all Trust services, and ensuring that patients, family carers and members of the public can contribute to quality improvement projects as experts by experience.

20.3. The forum meets monthly and has a broad membership, including Carers Oxfordshire, Healthwatch Oxfordshire, Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP) Dementia Oxfordshire, and Oxford Brookes University.

## 21. Triangulation and Learning Committee [TALC] Maternity Services

21.1. Established in August 2024, the Triangulation and Learning Committee (TALC) is a pivotal element in the Trust's strategy for continuous improvement. The committee's membership is key, gathering diverse perspectives around a table regularly to approach the same themes with different tools.

21.2. Crucial to TALC is the involvement of maternity and neonatal operational members, which ensures immediate learning is shared and interventions are quickly implemented. This collaboration has not only improved service user experience but has also motivated and enhanced staff experience. Task and finish groups, such as the postnatal team, have successfully introduced initiatives like 24-hour visiting and the 'teaming' model on Level 5, which includes the Transitional Care Unit (TCU).

21.3. By working together in teams, continuity of care is achieved with time released for care rather than task-focused shifts. Recent feedback from long-term stayers on TCU highlighted the responsiveness of staff to their needs and the proactive offering of pain relief.

21.4. TALC brings accountability and the opportunity to share and learn. For example, the committee addressed a legal catheter care case with immediate action to spot-check TWOCs in postnatal areas. TALC is the most well-attended meeting in maternity and neonatal services, and its success has drawn interest from system partners eager to replicate the model.

21.5. "When others talk, listen completely," and our Triangulation and Learning Committee enables us to do just that, fostering an environment of continuous improvement and excellence in patient care.

## 22. Patient Advice and Liaison Service (PALS)

22.1. The Trust's Patient Advice and Liaison Service (PALS) team supports patients, relatives, carers and service users to raise informal concerns and requests for advice in a confidential, impartial, informal and timely manner. PALS can be contacted in person, via email or on the telephone.

22.2. PALS works closely with the Trust's Corporate Reception team, who triage straightforward enquiries, and the Trust's Complaints team, enabling issues to be escalated to a formal investigation when required.

## 23. PALS activity 2024/25

23.1. In 2024/25 the Trust's PALS team received and dealt with 2583 enquiries, which is a reduction of 16% from the number managed in 2023/24. The majority of enquiries were classified as an issue for resolution, as seen in the graph below.

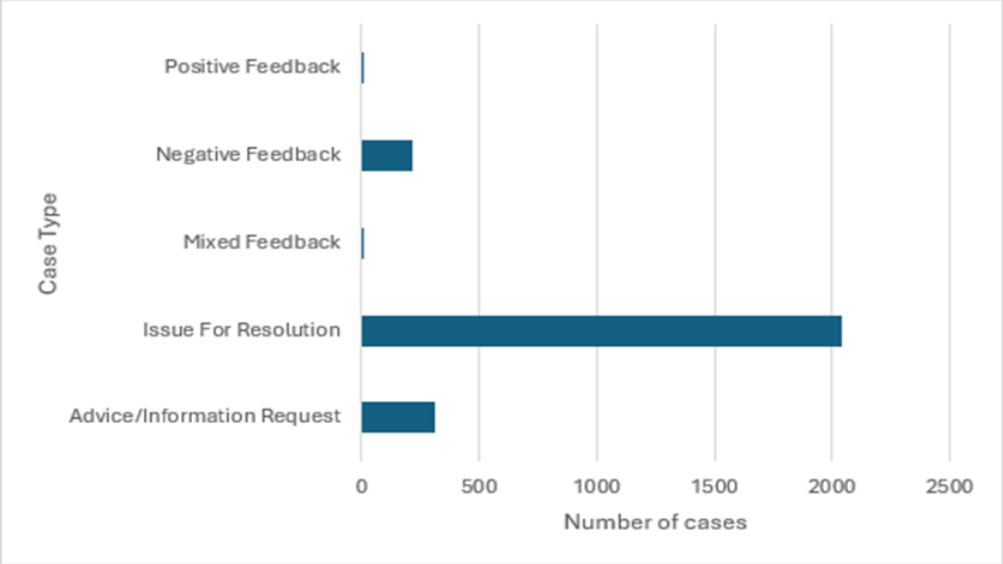



*Figure 11: Enquiries received in 24/25*

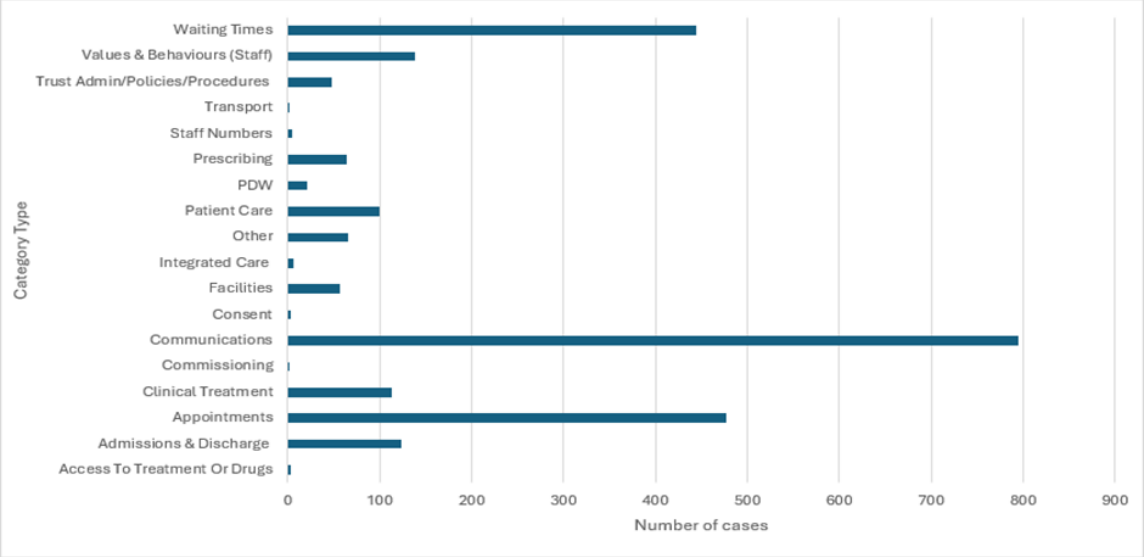



*Figure 12: Types of enquiries received in 24/25*

23.2. The vast majority of enquiries relate to Communication issues, with Appointments and Waiting Times also ranked in the top three categories.

## 24. Conclusion

24.1. This annual report demonstrates the continued commitment of the Trust to listening to, learning from, and acting on the experiences of patients, families, and carers. Over the reporting period [April 2024 to March 2025], the Trust has made significant progress in strengthening the role of patient feedback in shaping services and driving improvements.

24.2. Through a range of feedback channels including the Friends and Family Test, national and local surveys, complaints and compliments, and direct engagement with patients and communities, the Trust has gained valuable insights into what matters most to those who use its services. These insights have informed targeted quality improvement initiatives, enhanced communication and responsiveness, and supported more inclusive, person-centred approaches to care.

24.3. While many areas of positive experience have been identified, the report also highlights opportunities for improvement. In particular, improve equity of experience, and strengthen mechanisms for involving underserved and underrepresented groups. Addressing these challenges remains a priority for the year ahead.

24.4. Looking forward, the Trust will continue to embed patient experience and strengthen partnerships with patients and communities, promoting a culture of continuous learning, and ensuring that every voice is heard and valued in the delivery and development of care.

## 25. Recommendations

25.1. The Trust Management Executive is asked to:

- Note the contents of the report and the associated action plan.

**Appendix 1 SMART Action Plan**

| Specific Objective | Measurements | Achievable | Relevant | Delivery timescale | Progress |
|---|---|---|---|---|---|
| Increase FFT in outpatient areas: Implement digital FFT feedback prompts via SMS and QR codes displayed at check-out desks and waiting areas and engage staff in promoting FFT completion during discharge. | Increase FFT response rate in outpatient areas by 30% over a 3-month period. | Use existing digital infrastructure (Healthcare Communications) and involve outpatient reception staff with a simple script to remind patients. | Directly supports objectives to gather real-time patient feedback to improve outpatient care and patient experience. | Launch the initiative by 1st July 2025, with progress reviewed monthly and full evaluation by 30th September 2025. | |
| Drive service improvement based on patient feedback: support directorates to co design improvement actions in response to feedback / track you said we did initiatives to close the feedback loop | Facilitate structured workshops with directorates to review patient feedback (FFT, complaints, surveys), identify themes, and co-produce at least one improvement initiative per directorate. Track and publish corresponding *You Said, We Did* outcomes Trust-wide. | 80% of directorates to participate in at least one feedback-to-action workshop by December 2025. | Directly addresses Trust priorities for using feedback to improve care, enhances visibility of patient voice, and strengthens local ownership of | Launch workshops by July 2025.<br><br>All directorates engaged by December 2025.<br><br>Quarterly updates published starting | |

| Specific Objective | Measurements | Achievable | Relevant | Delivery timescale | Progress |
|---|---|---|---|---|---|
| | | | patient experience. | October 2025.<br><br>Annual review of impact by March 2026. | |
| Promote equality and inclusivity in patient experience: Increase engagement with under-represented and vulnerable groups. | Achieve a 25% increase in feedback submissions from under-represented groups by March 2026.<br><br>Deliver at least 3 outreach projects (e.g. listening events, translated surveys, community visits).<br><br>Co-design and launch one pilot feedback tool tailored to a vulnerable group (e.g. Easy Read FFT card, BSL video survey).<br><br>Track and report demographic breakdown of FFT responses quarterly. | Partner with local community organisations and Patient Public Involvement (PPI) leads.<br><br>Leverage existing Equality, Diversity & Inclusion (EDI) teams and networks.<br><br>Adapt current feedback tools with translation, interpretation, or accessible formats.<br><br>Allocate engagement time from Patient Experience | | Identify priority groups and partners by July 2025.<br><br>Launch first engagement initiative by September 2025.<br><br>Complete all 3 targeted projects by February 2026.<br><br>Evaluate and report outcomes by March 2026. | |

| Specific Objective | Measurements | Achievable | Relevant | Delivery timescale | Progress |
|---|---|---|---|---|---|
| Enhance staff capacity and culture around patient experience: Deliver training and resources to empower staff in collecting and using feedback. | Develop and launch an eLearning module on patient experience by October 2025.<br><br>Distribute patient experience resource packs (digital and print) to 100% of ward and department managers.<br><br>Achieve at least 80% positive post-training feedback from participants. | Collaborate with the Learning & Development team to embed training into existing CPD and induction.<br><br>Include real patient stories and local feedback examples to increase relevance and impact.<br><br>Pilot with 2 directorates before full rollout. | Directly supports the Trust's goal to embed a culture of compassionate care and continuous improvement, aligned with quality and workforce priorities. | Develop training content by August 2025.<br><br>Launch pilot training by September 2025.<br><br>Roll out Trust-wide from November 2025 to March 2026. Evaluate impact and update resources by April 2026. | |
| Achieve 85% complaint closure within 25 days | Current rate is 63% (April 2025); target is 85%. | Weekly reports and meetings with all Divisions are in place to support progress. Divisions to ensure response is sent to | Timely complaint resolution is critical for patient satisfaction and regulatory compliance. | Reach 85% closure rate by October 2025. | |

| Specific Objective | Measurements | Achievable | Relevant | Delivery timescale | Progress |
|---|---|---|---|---|---|
| | | Complaints team on Day 14 | | | |
| Conduct regular training sessions for all divisions on Complaints and PALS. | Number of sessions delivered, and the number of staff trained per quarter | Use Complaints Co-ordinators and PALS Officers as subject matter experts alongside existing training materials | Enhances staff capability and consistency in handling complaints and PALS enquiries. | Deliver training to all Divisions within 12 months | |
| Partner with Microsoft to assess AI tools for complaint handling | Completion of feasibility study and pilot implementation. | Utilise Microsoft's expertise and internal IT support | Aims to reduce delays in investigation stage, thus ensuring response times are met and improve service quality. | Complete pilot and evaluation within 9 months. \| | |

# 9. INFECTION PREVENTION AND CONTROL ANNUAL REPORT

## REFERENCES

Only PDFs are attached

08 TB2025.76 Infection Prevention and Control Annual Report 2024-25 final.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

## Trust Board Meeting in Public: Wednesday 10 September 2025

## TB2025.76

| | |
|---|---|
| **Title:** | **Infection Prevention and Control Annual Report 2024-25** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **Annual report** |

| | |
|---|---|
| **Board Lead:** | **Chief Medical Officer** |
| **Author:** | **Prof Katie Jeffery, Director of Infection Prevention & Control** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance, Policy, Performance** |

## Executive Summary

1. The Infection Prevention and Control (IPC) Annual Report reports on infection prevention and control activities in the Oxford University Hospitals (OUH) NHS Foundation Trust between April 2024 and March 2025. The report covers IPC for the four main sites - John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital - and sites across the region including satellite dialysis units, midwifery led units, radiotherapy and Katherine House Hospice.
2. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability, in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.
3. The Trust Board received bi-monthly updates via the Integrated Assurance Committee. A monthly report is submitted to the Patient Safety and Effectiveness Committee (PSEC) which reports to Trust Clinical Governance Committee.
4. The following organisms are subject to NHSE mandatory reporting: Methicillin-resistant *Staphylococcus aureus* bacteraemia (MRSA), Methicillin-sensitive *Staphylococcus aureus* bacteraemia (MSSA), *Clostridioides difficile*, and Gram-negative bloodstream infections (*Escherichia coli,* Klebsiella species*,* and *Pseudomonas aeruginosa*). In 2024-25 OUH complied with all external reporting requirements.
5. **Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteraemia**

   The Trust reported 11 cases of healthcare associated MRSA bacteraemia. NHSE has a zero-tolerance policy for healthcare associated MRSA bacteraemia.
6. **Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia**

   The Trust reported 66 cases of healthcare associated MSSA bacteraemia for 2024-25, which is a reduction of 4 cases from 2023-24. There is no threshold set by NHSE for MSSA.
7. **Clostridioides difficile (*C. difficile*)**

   The Trust reported a total of 164 cases in 2024-25 (130 in 2023-24). This was above the NHSE trajectory set at 123 cases.
8. **Gram negative blood stream Infections (GNBSI)**

   The Trust reported a total of 220 *E. coli*, 101 Klebsiella spp. and 63 *Pseudomonas aeruginosa* healthcare attributable blood stream infections in 2024-25, exceeding the trajectories set in the NHS Standard Contract.
9. **Central Line Associated Bloodstream Infections (CLABSI) surveillance**

   CLABSI surveillance is undertaken trust-wide by the IPC team.

## 10. Surgical Site Infection (SSI)

Information is submitted to the UK Health Security Agency (UKHSA) for the mandatory SSI surveillance of repair of fractured neck of femur procedures and voluntary surveillance relating to Coronary Artery Bypass Graft procedures and cardiac valve and transcatheter aortic valve implantation.

Following a review by the British Orthopaedic Association there has been a focus this year on infection in hip and knee replacement surgery, and a reduction in the SSI rate has been demonstrated.

## 11. COVID-19 & Respiratory Viruses

The IPC team continued to follow up COVID-19 and influenza positive patients. Operational pressures regularly impacted the Trust's ability to isolate all patients promptly.

## 12. The Built Environment and IPC

The IPC team has provided support in relation to both ongoing and new environmental concerns throughout 2024-25.

Water Safety at the Churchill Cancer and Haematology Hospital: Ongoing work to deliver an engineering solution to control the failings of the water system with respect to Legionella was completed in 2023-24 and remains in a period of surveillance. Point of use filters remain on all outlets within the building to maintain safe water at the point of use. The Extraordinary Water Safety Group continues to meet to ensure progress is being made. A number of key documents are yet to be provided by the subcontractor, G4S. As a result the SIRI called in 2019 has yet to have the actions closed (July 2025).

## 13. Infection Prevention and Control Surveillance Software

The company that supplied the surveillance system (ACMEipc) to the IPC team has ceased trading. In March 2025 the Microbiology laboratory team implemented a new Laboratory Information System (LIMS) and the LIMS now provides partial mitigation with daily reports for certain infections with some additional support from the EPR team. The OUH Digital Engineering Service is working on a web-based solution to provide an alert system for both pathogens (via LIMS) and patient factors (via EPR). Efforts are ongoing to identify funding to support the purchase of an IPC surveillance system with the required functionality (such as ICNET).

## 14. Investigation of Infection Prevention and Control Incidents and Outbreaks

The following outbreaks/incidents have been subject to investigation by the IPC team.

- ESBL in the neonatal unit
- Occupational exposure to TB and Meningococcus
- Measles

- Bedbugs
- Norovirus
- Influenza and COVID-19 outbreaks

**15. Antimicrobial Stewardship (AMS)**

AMS activity has included work in the following areas:

- Antibiotic consumption
- AMS ward rounds and 6 day AMS service
- *C. difficile* prevention

The team won the research category of the Antibiotic Guardian awards 2025 for their published work on the impact of AMS ward rounds.

**16. Infection Prevention and Control staffing**

The IPC Lead Nurse Manager was seconded into another role in the Trust in June 2024; together with difficulties recruiting experienced staff following the successful IPC business case, and a lack of surveillance software, 2024/25 has been a challenging year for the IPC team.

**17. Recommendations**

The Trust Board is asked to note the report.

# 1 Contents

# 1 Purpose

This report provides the Trust Board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention and Control Team between April 2024 and March 2025. The publication of the Infection Prevention and Control (IPC) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2028: Code of Practice on the Prevention and Control of Infection and related guidance (Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk). This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

## 1.1 Infection Prevention and Control Board Assurance Framework (BAF)

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act (2008). This requires demonstration of compliance with the 10 criteria outlined in the Act.

The Board Assurance Framework is ordered by the 10 criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format. This report is structured to report IPC activity and compliance against each of the 10 criteria.

The compliance ratings include the following categories: not applicable, non-compliant, partially compliant, compliant.

At the end of each section is OUH's compliance rating in line with the NHSE IPC BAF.

The Trust has more areas of compliance in 2024-25 than in 2023-24. There were no areas of non-compliance and no new areas of partial compliance in 2024-25. Areas of partial compliance are included in the IPC Strategic Plan.

## 1.2 Background

The Director of Infection Prevention and Control's (DIPC) Annual Report reports on IPC activities within the Oxford University Hospitals (OUH) NHS Foundation Trust for April 2024 to March 2025. The report covers IPC for

the four main sites - John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital - and several sites across the region, including satellite dialysis units, midwife led units and Katherine House Hospice.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare associated infections (HCAIs). We ensure that good IPC practices are applied consistently and are part of our everyday practice meaning that people who use OUH services receive safe and effective care.

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical, who play a vital role in improving the quality of staff, patient and stakeholder experience as well as helping to reduce the risk of infections. Additionally, the Trust continues to work collaboratively with several outside agencies as part of its IPC and governance arrangements including:

- Integrated Care Board/System
- Oxford Health NHS Foundation Trust
- South Central Ambulance Service (SCAS)
- Thames Valley Health Protection Team/UKHSA
- NHSE

The Hospital Infection Prevention and Control Committee (HIPCC) meets monthly. HIPCC reports to the Patient Safety and Effectiveness Committee (PSEC) and the Deputy DIPC/Lead Nurse or deputy is a member of the Clinical Governance Committee.

Committees reporting to HIPCC are:

- Decontamination Committee

Regular reports to HIPCC include:

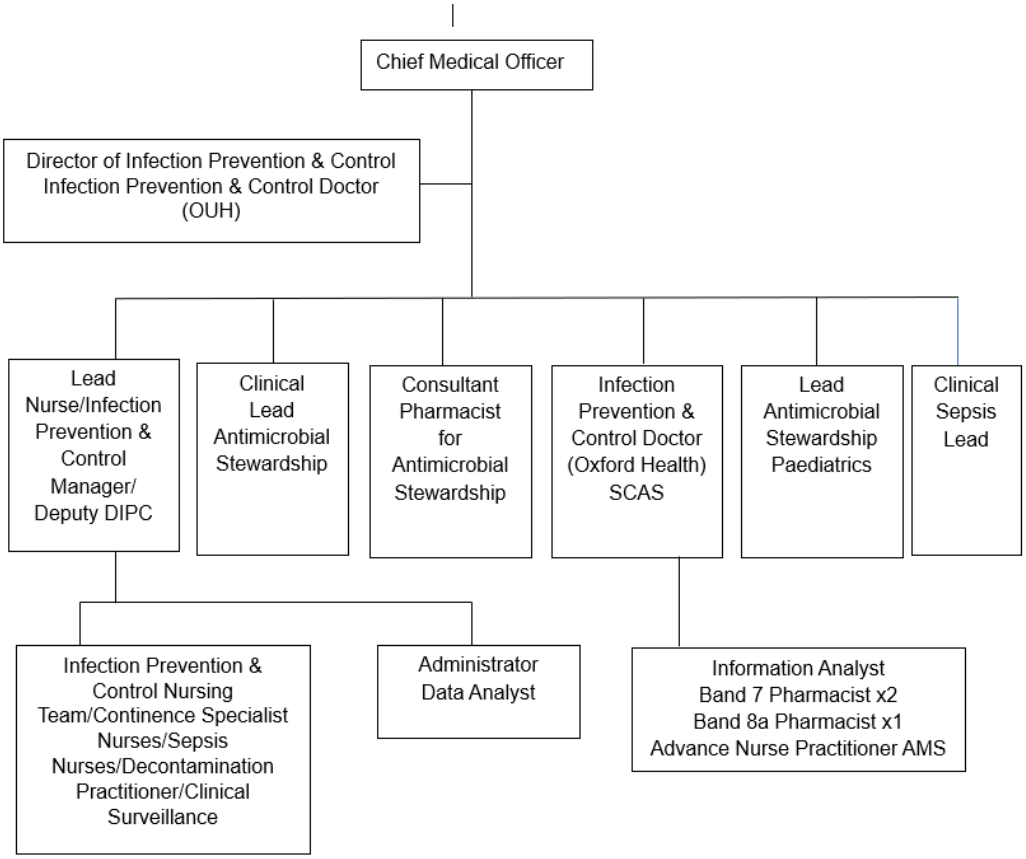
- Divisional IPC reports
- UKHSA/local Health Protection Team
- BOB ICS (Buckinghamshire, Oxfordshire and Berkshire West)
- Antimicrobial Stewardship (AMS) Team
- OUH Estates and Facilities
- Soft Facilities Management
- Centre for Occupational Health & Wellbeing (COHWB)
- Cardio-thoracic surgical site infection report
- IPC Risk Register

## 2 Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Infection Prevention and Control Staffing

Table 1: Organisational chart for the IPC team at the end of March 2025




The IPC team commenced a 7-day on-site service in the Autumn of 2024 to provide IPC support to the wards and operational teams.

There is a close working relationship with all teams across the Trust, including the Microbiology Laboratory, Clinical Infection team, Estates and Facilities, Health and Safety team, Procurement, Centre for Occupational Health and Well-being (COHWB), Communications team, clinical and managerial staff, and across the PFI structure.

The Deputy DIPC/Lead Nurse was seconded to a Divisional Nurse role in the OUH in June 2024 and appointed to the permanent post in January 2025. An interim IPC Lead was appointed from November 2024.

The Deputy DIPC/Lead Nurse chairs the Water Safety Group and is a member of the Ventilation Safety Group. There have been several projects

throughout the year that have required the expertise of the IPC team on planning and opening of new or refurbished wards and clinical areas.

A new IPC administrator was appointed starting in February 2025 following the retirement of the previous post-holder in August 2024 after more than 40 years in the Trust.

Members of the wider microbiology/infectious diseases team provide support for specific workstreams.

## 2.1 **Organisms subject to mandatory reporting**

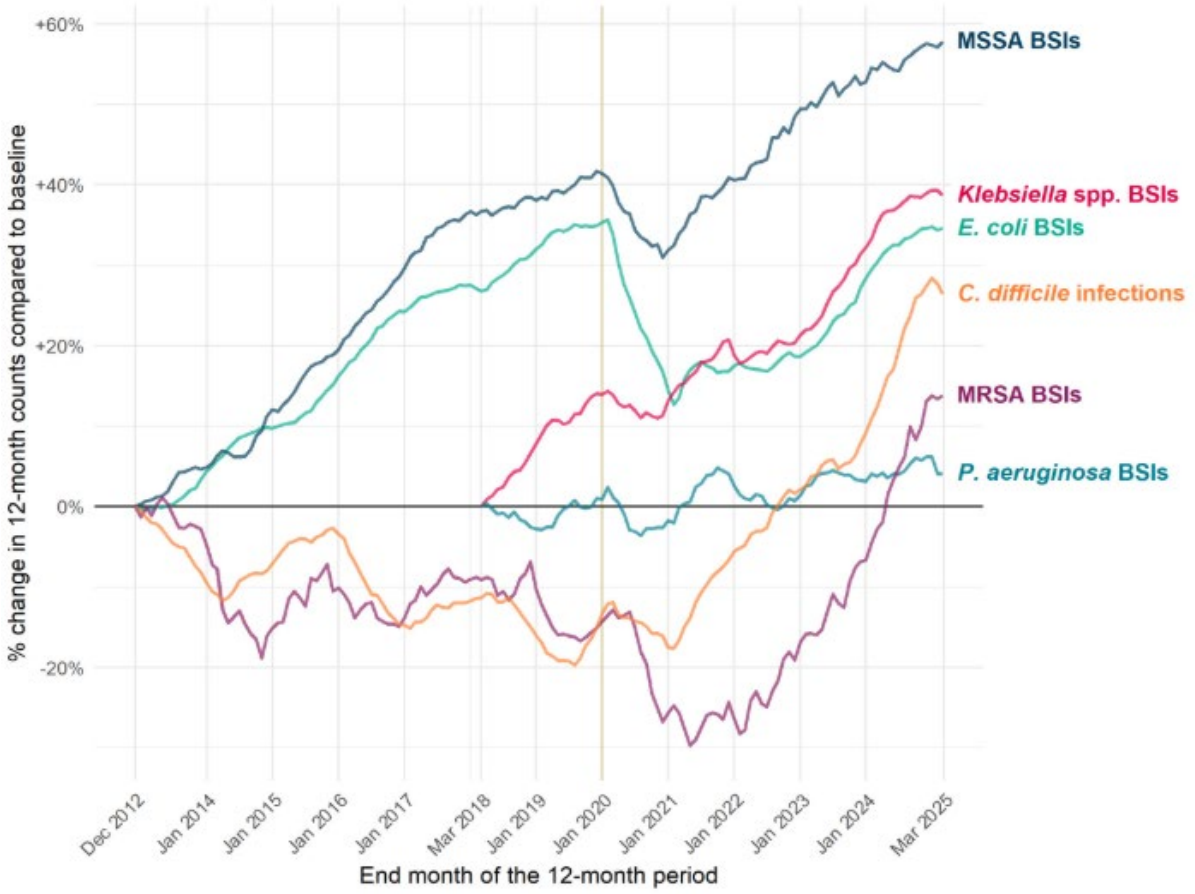
The OUH is required to report to UKHSA on the following organisms:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Methicillin-sensitive *Staphylococcus aureus* (MSSA)
- Gram negative Bloodstream Infections
- *Clostridioides difficile* (C. difficile)

## 2.2 **National overview of long-term trends in organisms subject to mandatory reporting**

National data presents a challenging picture for organisms subject to mandatory reporting. From 2021 until the latest quarter all six organisms surpass records of counts since their respective data collection began (Table 2). The increase in C. difficile infection is marked since 2023.

Table 2: National C. difficile and bloodstream infections, 12-month rolling percent change. Data shows a rise from 2012 baseline (2018 for Klebsiella spp. and Pseudomonas aeruginosa) of all organisms subject to mandatory reporting. Data to March 2025.




## 2.3 **Bacteraemia prior trust exposure categories**

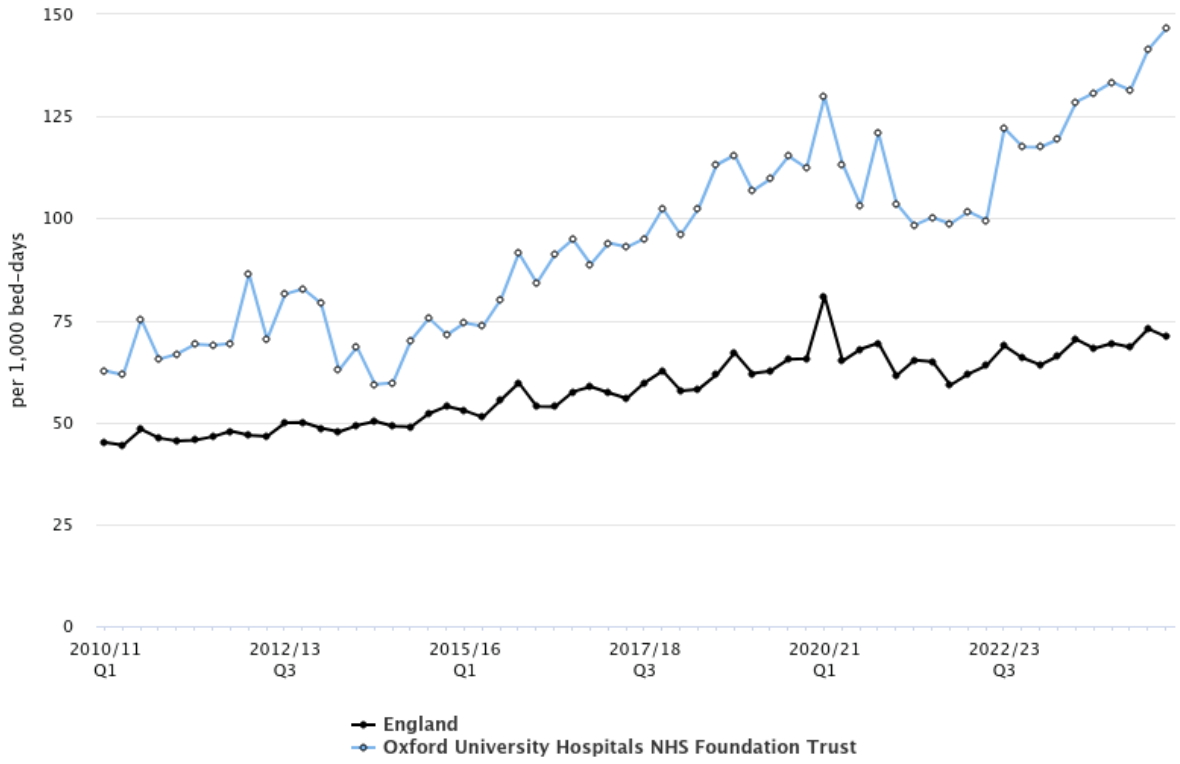
The two categories of reporting for healthcare-associated infection are:

- **Hospital-Onset, Healthcare Associated (HOHA)**: date of onset is greater than 2 days after admission (where day of admission is day 1)
- **Community-Onset Healthcare-Associated (COHA)**: is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

## 2.4 **Ascertainment of bacteraemia in the OUH**

The number of blood culture sets taken in the OUH per 1000 bed-days is almost twice the England acute Trust average (Table 3).

Table 3 Blood culture sets per 1,000 bed-days performed by reporting acute trust and financial quarter




## 2.5 **Reporting and Investigation**

HOHA and COHA cases of MRSA and MSSA bacteraemia are reported through the Trust incident reporting system Ulysses. A questionnaire is completed on Ulysses to identify any learning and the incident report is completed by the IPC team on identification of cases.

Divisions are asked to report by exception to HIPCC on action plans regarding MRSA and MSSA.

## 2.6 **Methicillin-resistant Staphylococcus aureus (MRSA)**

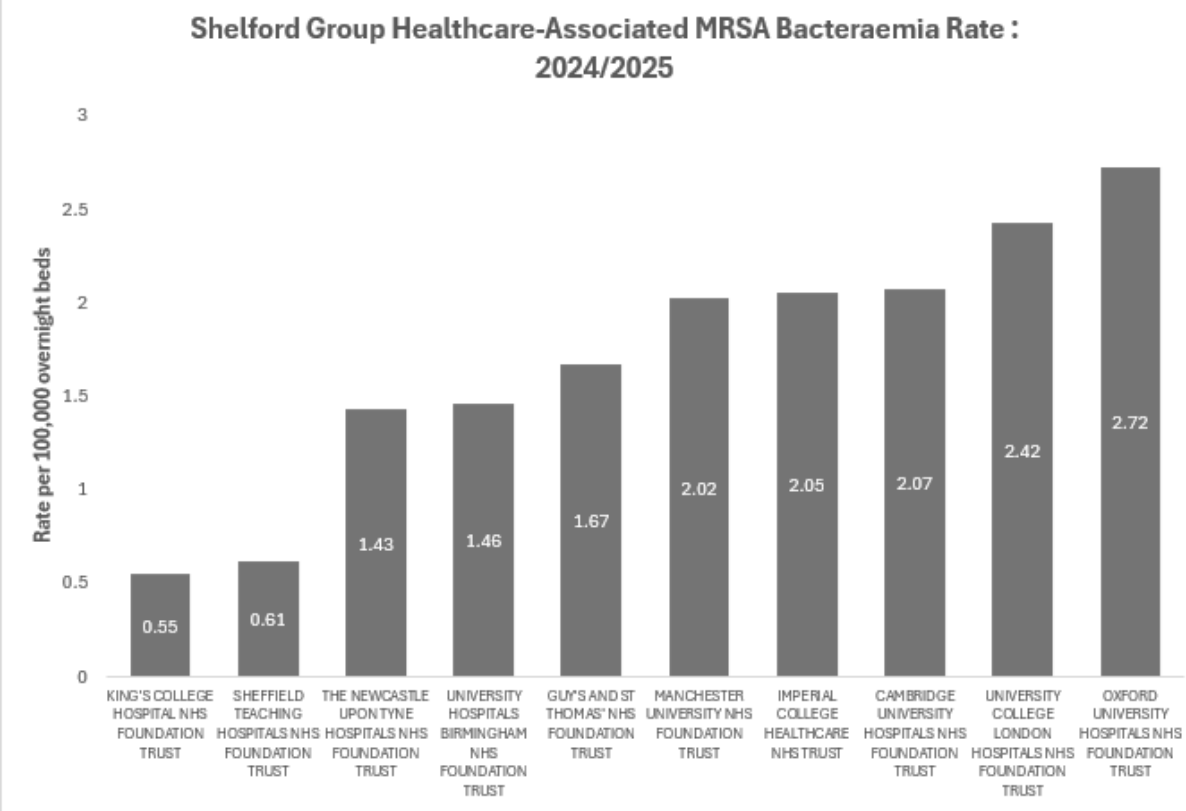
There were 8 HOHA and 3 COHA cases of MRSA bacteraemia in 2024-25. All cases have undergone a review to identify learning. Table 4 provides information on the source of infection. No learning was identified in the majority of cases. In one case there was a delay in sampling leading to a change in category from community to healthcare associated. Learning was identified in relation to line care, and cross-divisional work has been completed to ensure that decolonisation prior to line insertion is embedded in practice.

Table 4: MRSA: Breakdown of MRSA Infection Source

| Recorded Source | No of HOHA | No of COHA |
|---|---|---|
| Lines (includes peripheral, Hickman, PICC, central and midlines) | 4 | 1 |
| Unknown / unclear | 1 | 0 |
| Other (Skin or soft tissue (includes surgical site infection), urinary) | 3 | 2 |

Bar chart (Table 5) shows OUH MRSA bacteraemia rate in comparison with the Shelford group of Trusts. Our rate has deteriorated in comparison with our peer group.

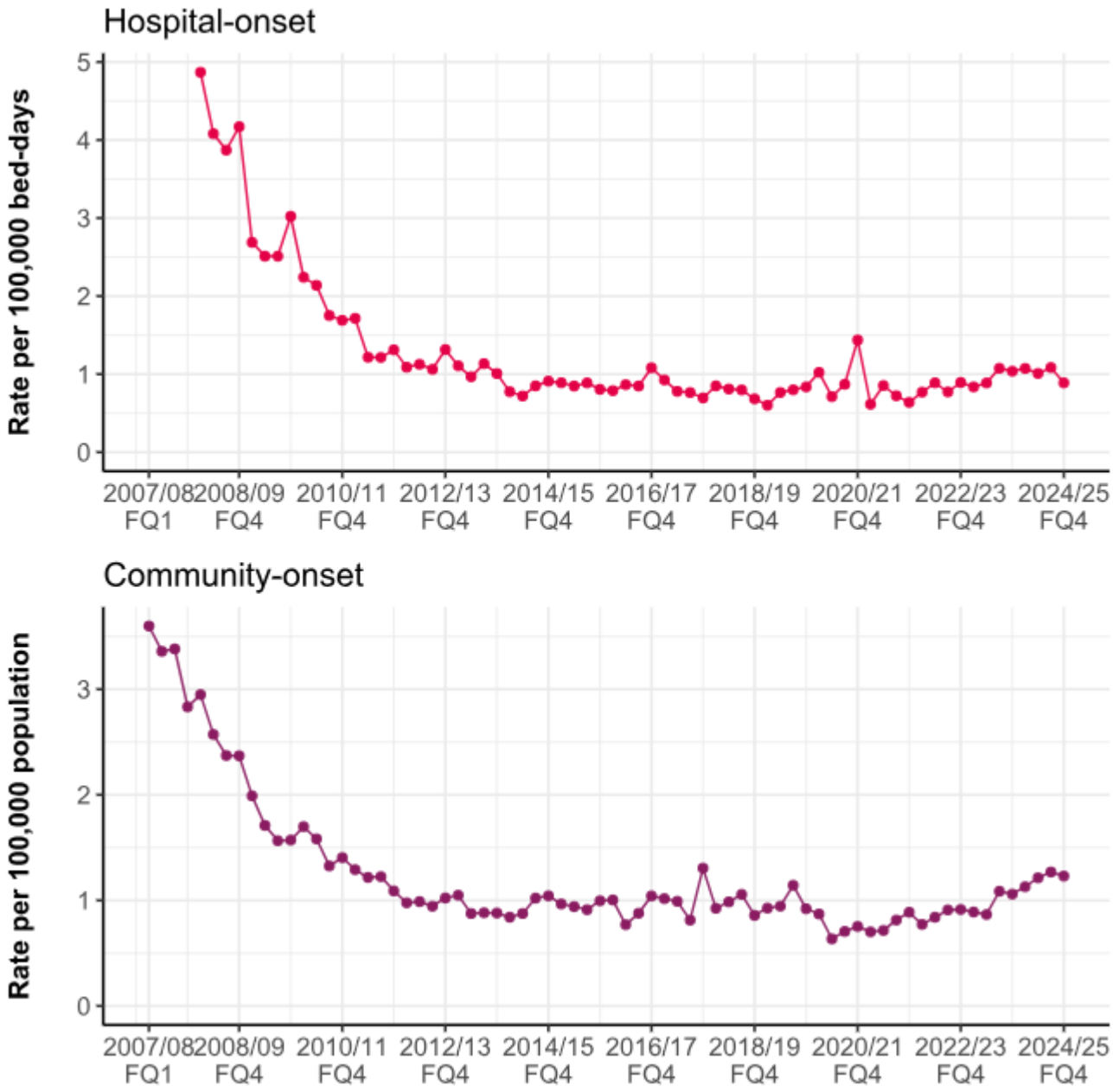
Table 5: Shelford Group Healthcare-Associated MRSA Rate 2024-25




## National MRSA Picture

When comparing October to December 2024 with the equivalent pre-pandemic period (October to December 2019), there was a 21.5% increase in total cases. This increase appears more pronounced in community cases (Table 6) but as the overall numbers are small, this needs to be interpreted with caution.

Table 6: Quarterly rates of MRSA bacteraemia (April 2008 to March 2025) (National data)



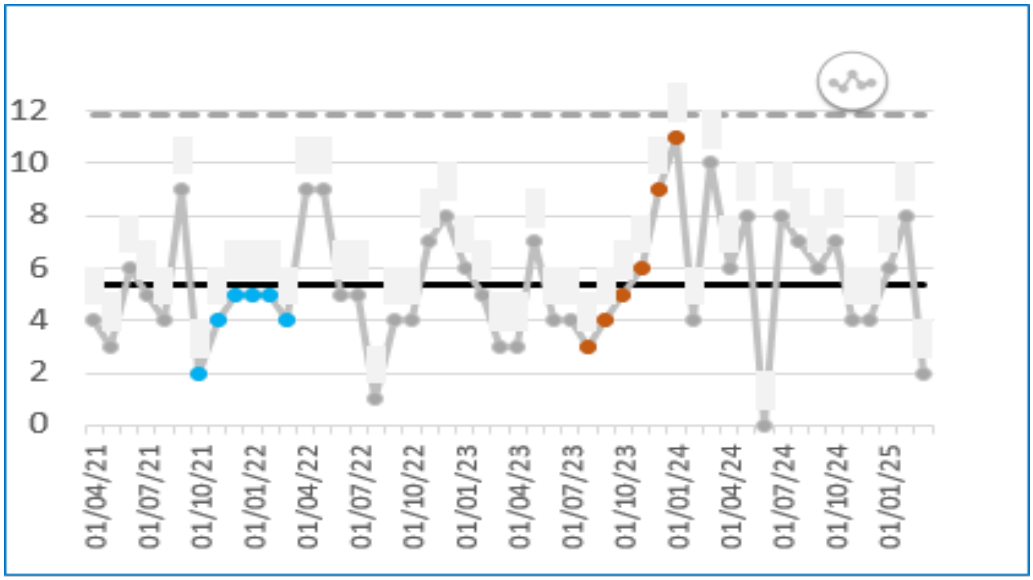

## 2.7 **Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia**

The Trust reported 46 (43 in 2023-24) HOHA cases and 19 (27 in 2023-24) COHA cases for 2024-25. The main recorded infection sources are documented below (Table 7) and remain the same as last year.

Table 7: MSSA: Breakdown of Top 3 Sources of Infection

| **Recorded Source** | **No of HOHA** | **No of COHA** |
|---|---|---|
| Lines (includes peripheral, Hickman, PICC, central and midlines) | 18 | 1 |
| Unknown / unclear | 8 | 3 |
| Skin or soft tissue (includes surgical site infection) | 3 | 5 |

Table 8: SPC HOHA and COHA associated MSSA bacteraemia (April 2021-March 2025)




Controlling the MSSA bacteraemia cases for discharges as a measure of activity shows a decline in attributable cases in 2024-25 (Table 9) to levels at their lowest for 5 years.

Table 9: OUH Healthcare associated MSSA bacteraemia cases controlled for activity (discharges)

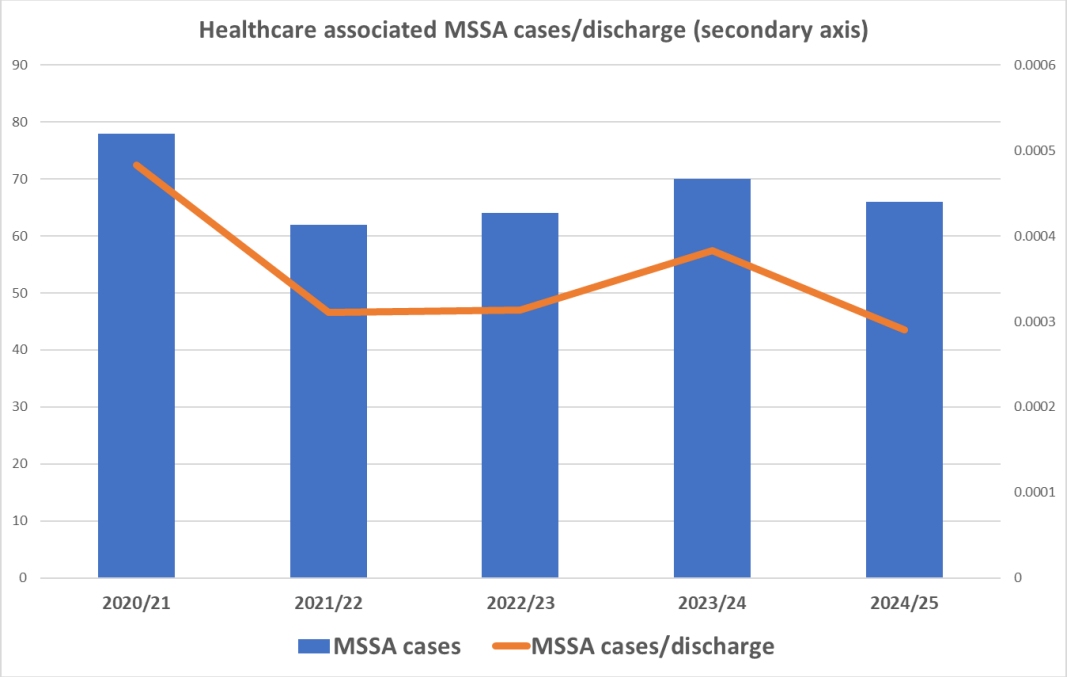
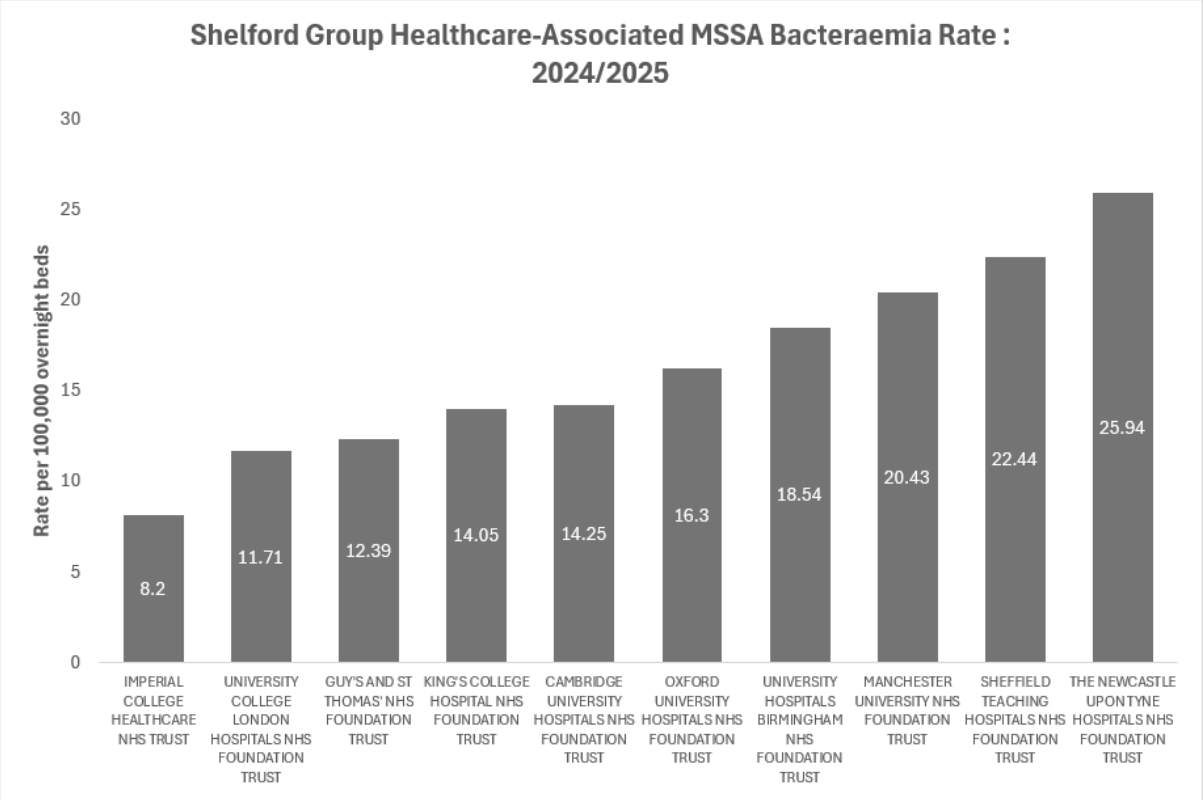


Table 10 shows OUH MSSA bacteraemia rate in comparison with the Shelford group of Trusts; our position has improved from 2023/24.

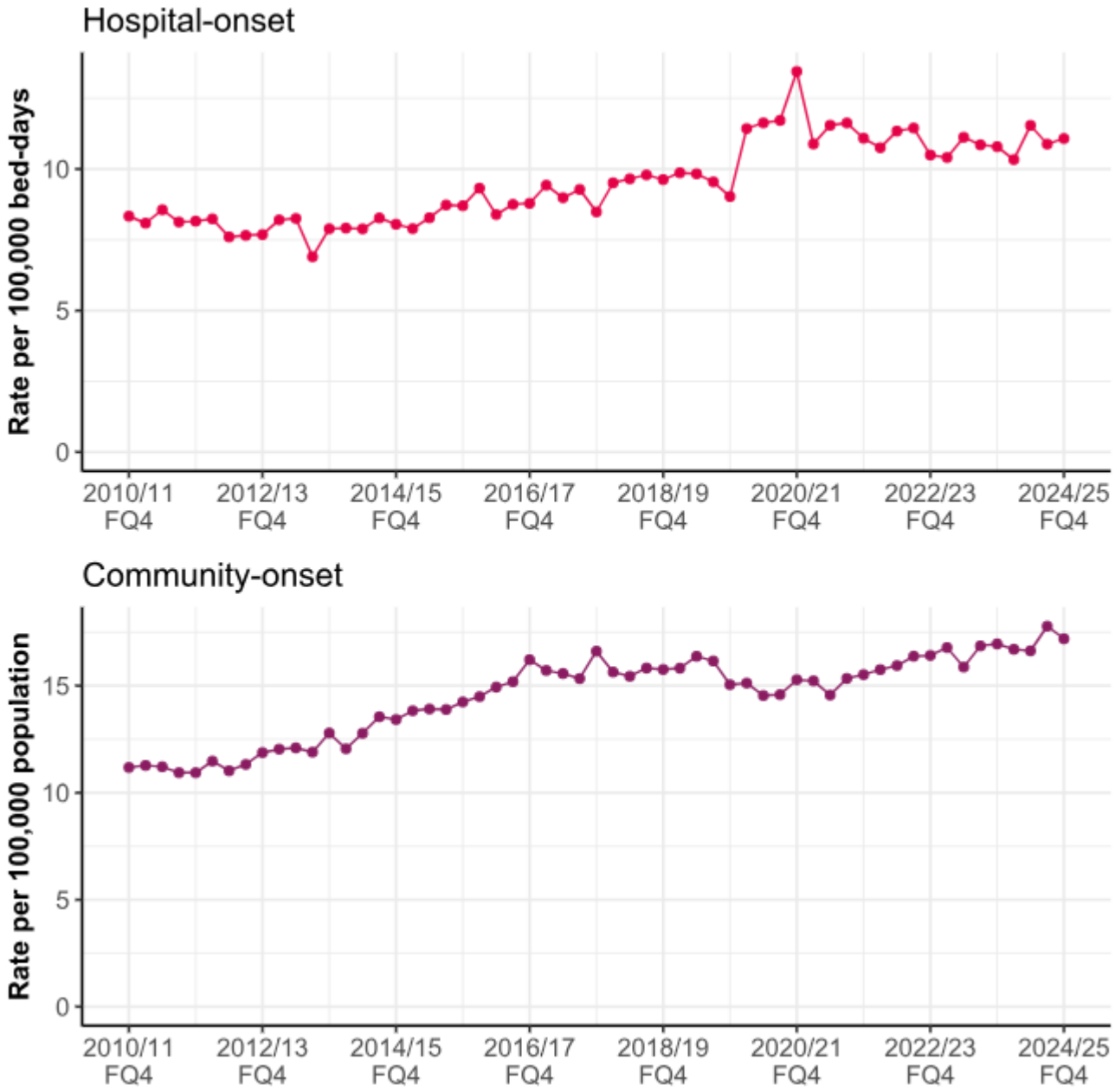
Table 10: Shelford Group Healthcare – Associated MSSA Rate 2024-25




## National MSSA picture

Comparing the most recent quarter (October to December 2024) to the same period in the previous year (October to December 2023), hospital-onset MSSA bacteraemia cases increased by 1.0% and community-onset MSSA bacteraemia cases increased by 5.1% (Table 11).

Table 11: National MSSA picture Quarterly rates of hospital and community-onset MSSA bacteraemia cases, January 2011 to March 2025




## 2.8 **Gram Negative Bloodstream Infections**

The trajectories for Gram negative bloodstream infection were set in the NHS Standard Contract for 2024-25 at 5% less than the case count during the 12 months ending March 2024 (Table 12).

The OUH reported a total of 220 *E. coli*, 101 Klebsiella spp. and 63 *Pseudomonas aeruginosa* healthcare attributable blood stream infections in 2024-25, exceeding the trajectories set in the NHS Standard Contract.

There are no clear themes or interventions to reduce the rate of rise of healthcare associated Gram negative bloodstream infections. The changes

in patient demographics with an ageing population (18.6% of the total population were 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 are likely to contribute to an increase in cases. This has now been acknowledged in the National Antibiotic plan for 2024-29.

Table 12: Health care attributable Gram-negative blood stream infections for 2022-23,2023-24 and 2024-25

| | Threshold 2024-25 | Total Cases 2024-25 | Total Cases 2023-24 | Total Cases 2022-23 |
|---|---|---|---|---|
| E. coli | 165 | 220 | 173 | 208 |
| Klebsiella | 89 | 101 | 94 | 87 |
| Pseudomonas | 59 | 63 | 63 | 56 |

Table 13: SPC HOHA and COHA associated E. coli bacteraemia (April 2021-March 2025)

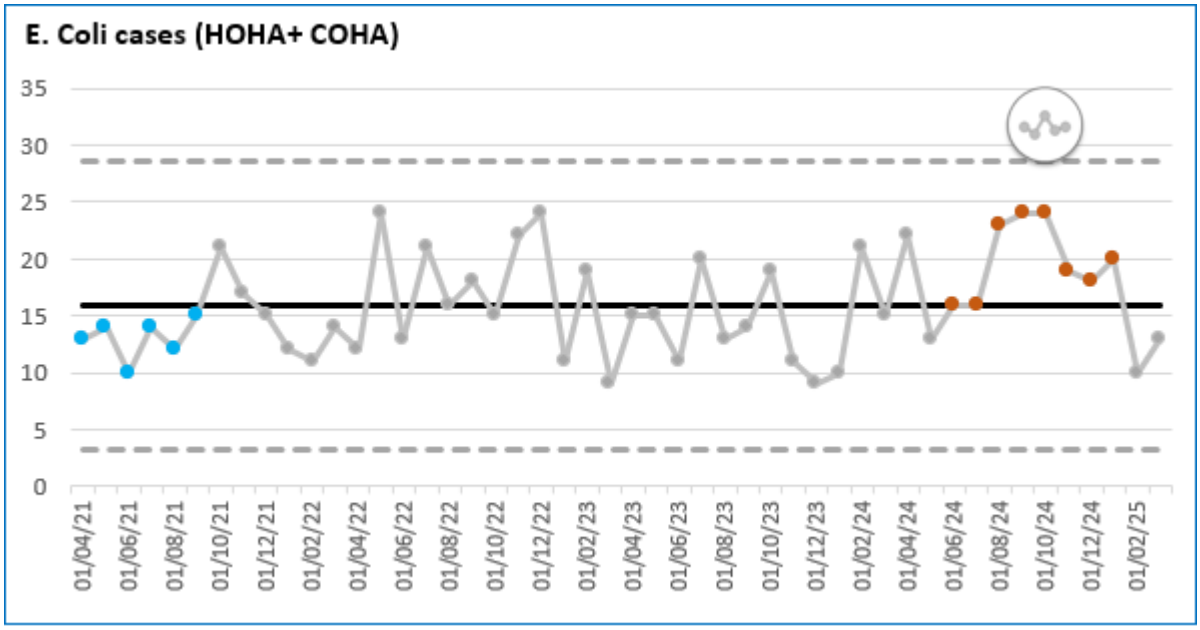


Table 14: SPC HOHA and COHA associated Klebsiella bacteraemia (April 2021-March 2025)

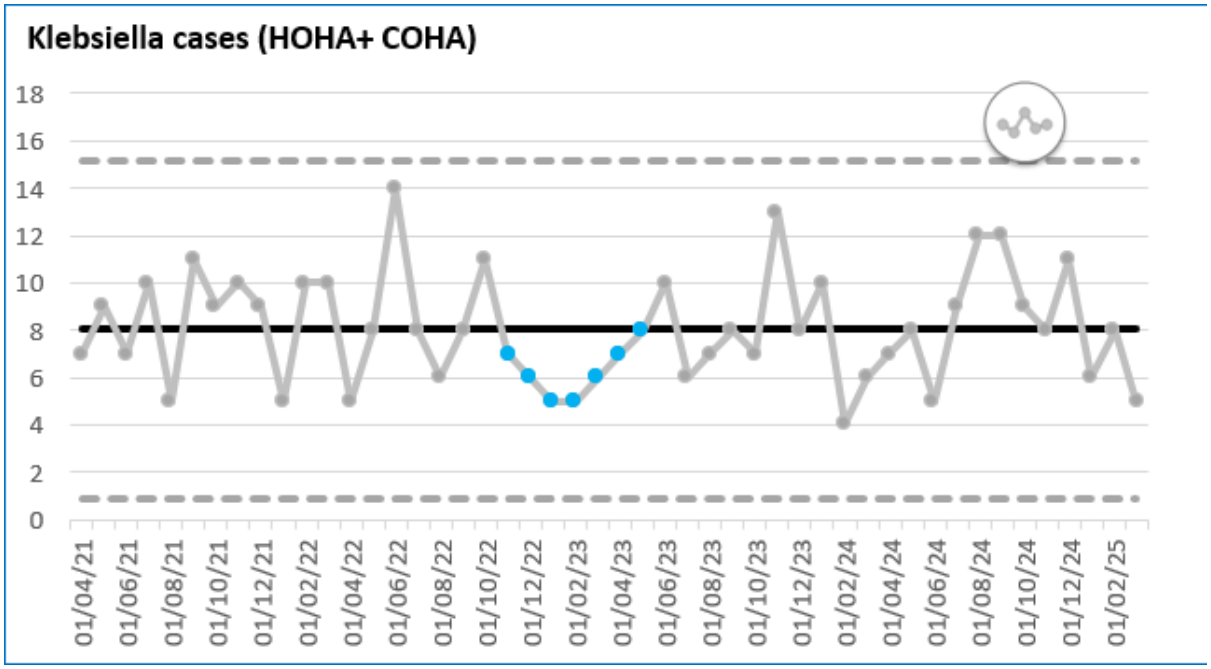



Table 15: SPC HOHA and COHA associated Pseudomonas bacteraemia (April 2021-March 2025)

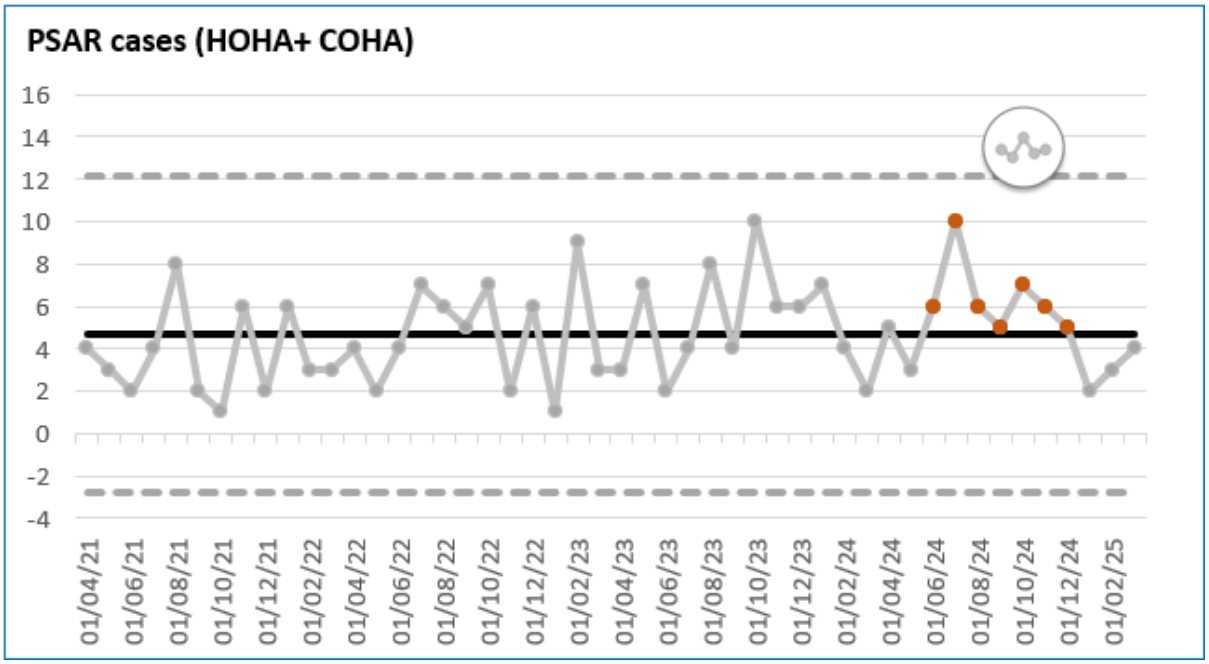


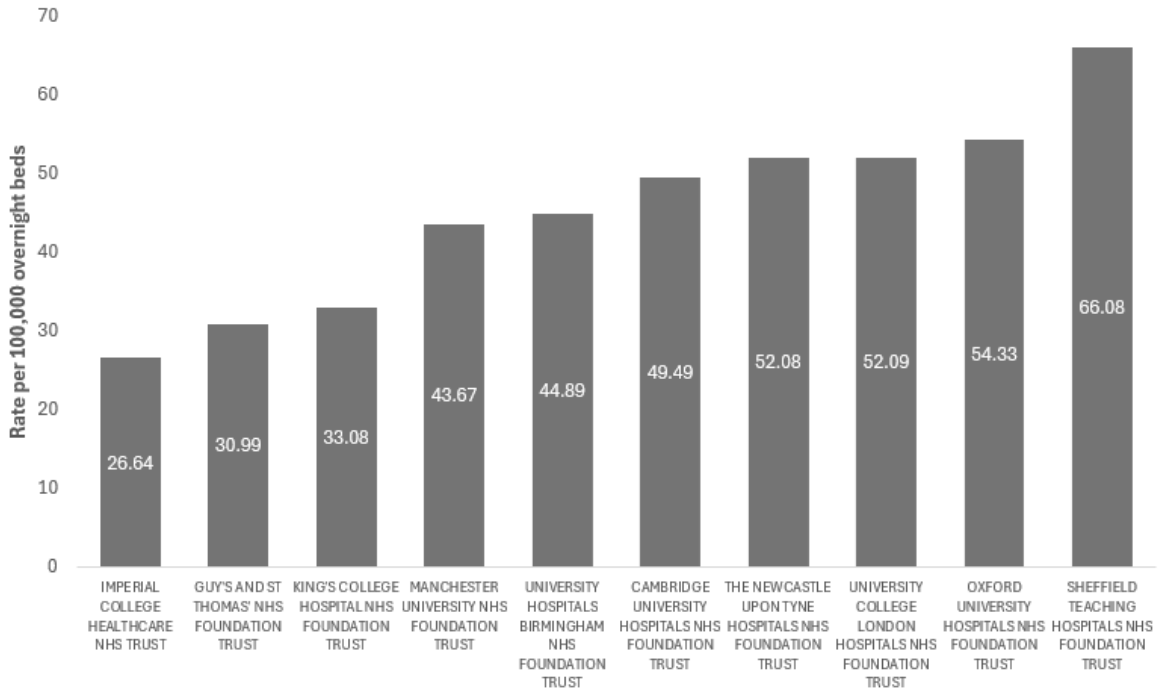
Table 16: Main Sources of Infection for Gram-negative Bloodstream Infections (HOHA)

| | Unknown | Line / device | Gastro / Gut related | Other (eg chest) | Hepato-biliary | Urinary |
|---|---|---|---|---|---|---|
| Klebsiella | 13 | 3 | 13 | 13 | 4 | 15 |
| Pseudomonas | 14 | 6 | 3 | 21 | 1 | 4 |
| E.coli | 19 | 6 | 22 | 18 | 18 | 34 |

Table 17: Main Sources of Infection for Gram-negative Bloodstream Infections (COHA)

| | Unknown | Line / device | Gastro / Gut related | Other (eg chest) | Hepato-biliary | Urinary |
|---|---|---|---|---|---|---|
| Klebsiella | 2 | 1 | 8 | 4 | 10 | 15 |
| Pseudomonas | 2 | 1 | 1 | 7 | 0 | 4 |
| E.coli | 20 | 2 | 7 | 16 | 12 | 46 |

Table 18: Shelford Group Healthcare–Associated E.coli Rate 2024-25. Oxford has the 9th highest rate out of 10 Trusts




## 2.9 *Clostridioides difficile* (C. difficile)

C. difficile review questionnaire is linked with Ulysses incident reporting. Community Onset Indeterminate Association (COIA) and Community Onset Community Associated (COCA) cases are reported on Ulysses in addition

to HOHA and COHA cases. COIA and COCA cases are investigated by the IPC team with contribution from clinical areas and the ICS as required.

**C. difficile prior trust exposure categories:**

**hospital-onset healthcare-associated (HOHA)**: date of onset is greater than 2 days after admission (where day of admission is day 1)
**community-onset healthcare-associated (COHA)**: is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the date of discharge)
**community-onset indeterminate association (COIA)**: is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the date of discharge)
**community-onset community-associated (COCA):** is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the date of discharge)

The trajectory for C. difficile infection in the NHS Standard Contract for 2024-25 was set at 5% less than the case count during the 12 months ending March 2024. The threshold for OUH apportioned cases of C. difficile for 2024-25 was set at 123 cases. OUH reported 164 cases (Table 19)

Table 19: Cumulative cases of OUH apportioned *C. difficile* (COHA and HOHA) per month (April 2024-March 2025)

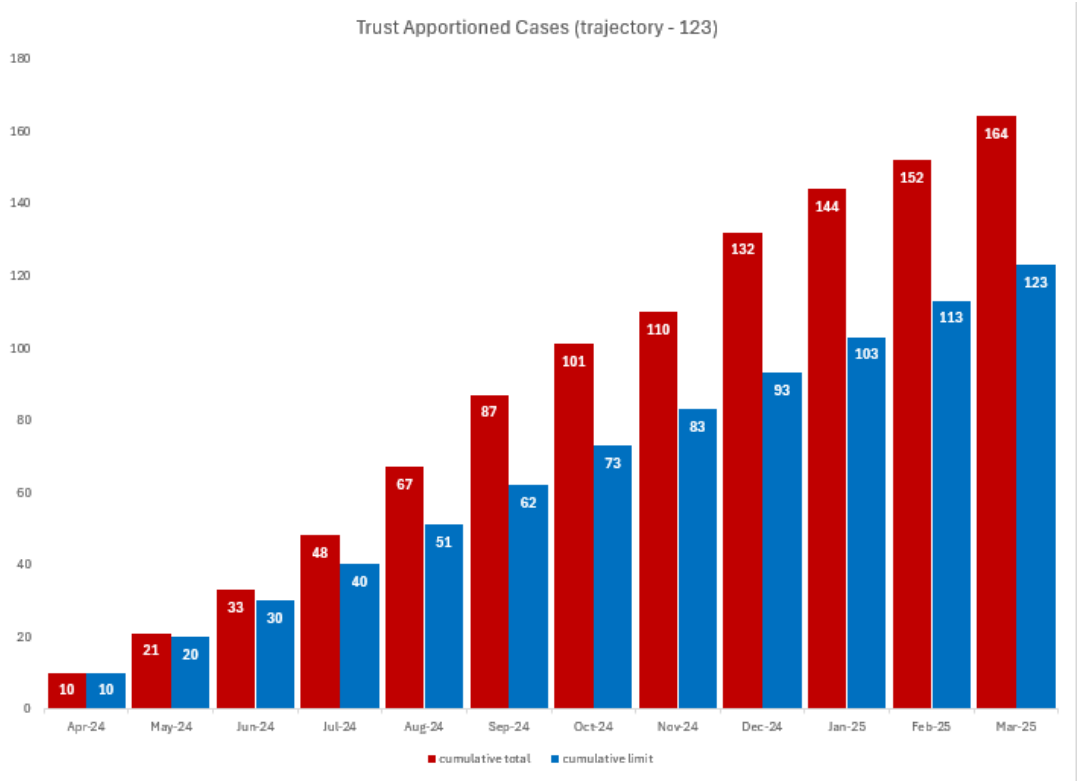


Table 20: Breakdown of C. difficile Healthcare associated cases by HOHA v COHA category (April 2024-March 2025)

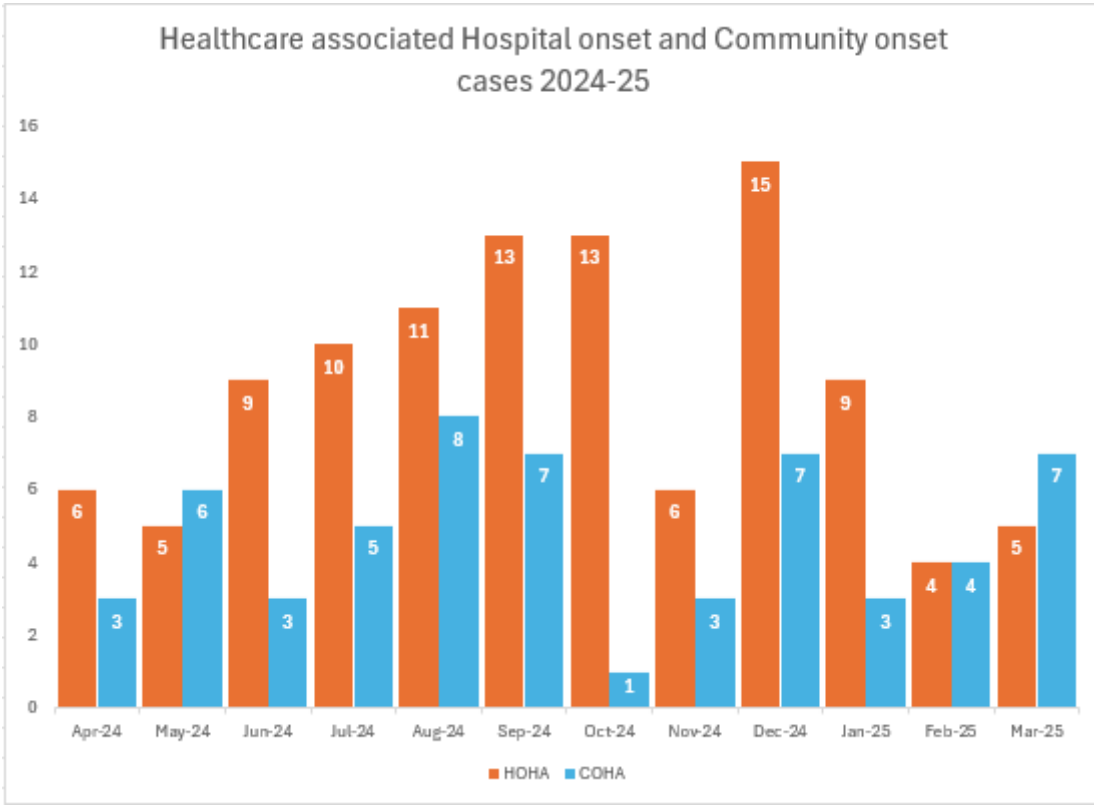
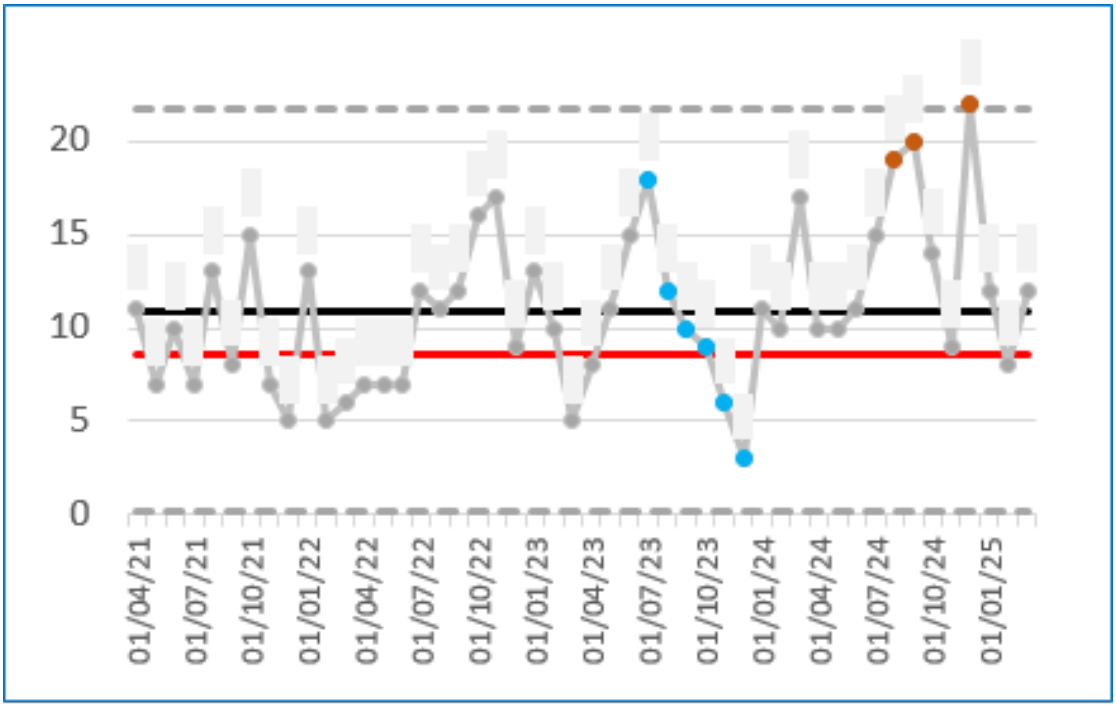



Table 21: Statistical Process Control (SPC) chart of HOHA and COHA C. *difficile* infection counts (April 2021-March 2025)



## 2.10 OUH compared to Shelford Hospitals

When comparing OUH to the Shelford groups, we are in the higher range of cases (Table 22).

Table 22: Shelford Group Healthcare–Associated C. difficile Rate 2024-25

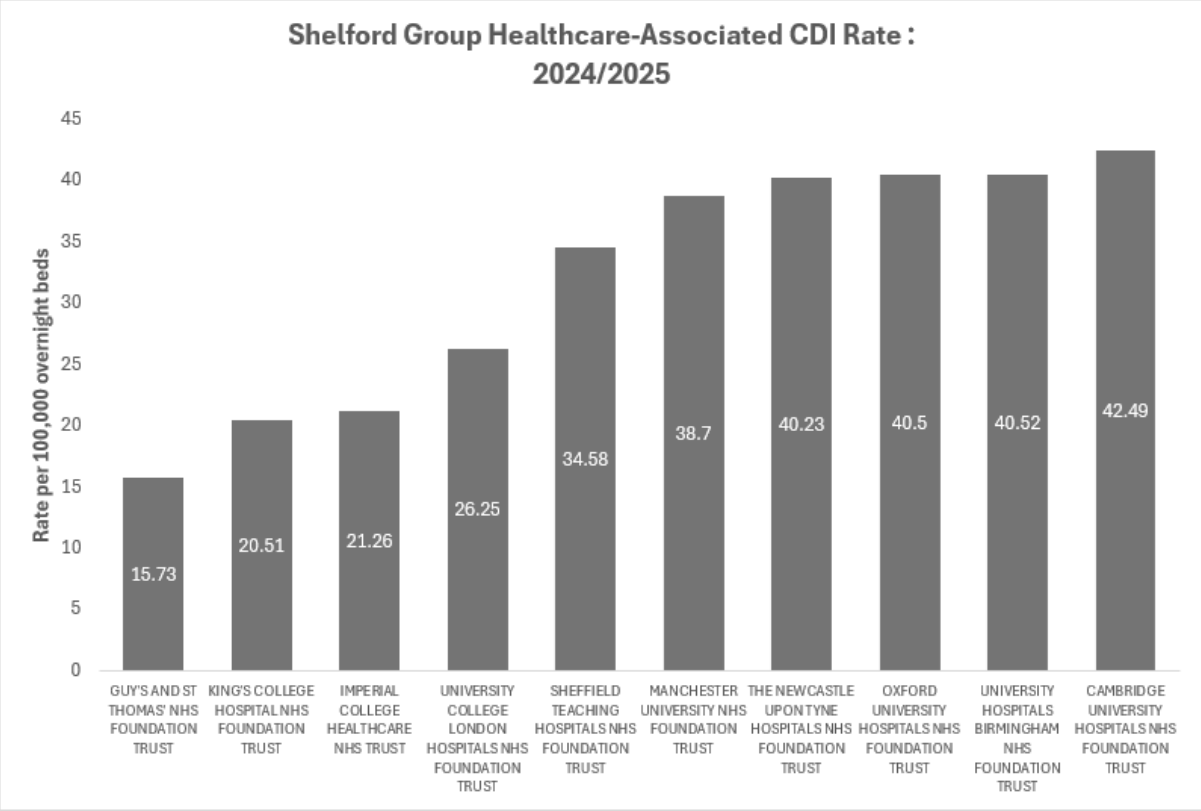



Table 23: Shelford Group Rates per 100,000 overnight beds 2021-25*. Eight out of 10 of the Shelford hospitals have seen a deterioration in the number of cases in 2024/25.

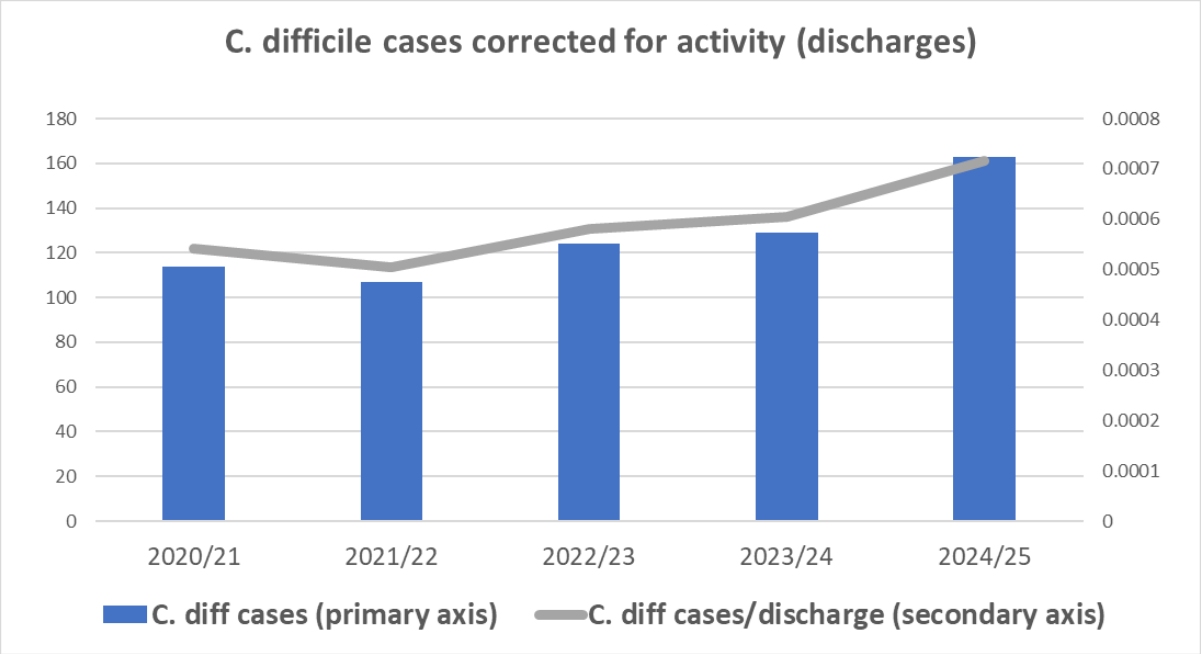
| Organisation Name | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| GUY'S AND ST THOMAS' NHS FOUNDATION TRUST | 12.36 | 13.82 | 14.30 | 15.21 | 15.73 |
| KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST | 20.08 | 19.04 | 24.03 | 20.83 | 20.51 |
| IMPERIAL COLLEGE HEALTHCARE NHS TRUST | 17.82 | 18.44 | 23.05 | 21.71 | 21.26 |
| UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST | 35.71 | 34.32 | 41.59 | 24.56 | 26.25 |
| SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST | 35.36 | 31.91 | 34.79 | 27.71 | 34.58 |
| THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST | 27.63 | 34.51 | 35.13 | 29.33 | 40.23 |
| OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 35.01 | 26.42 | 30.62 | 32.01 | 40.5 |
| UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST | 27.15 | 25.52 | 29.58 | 32.20 | 40.52 |

| | | | | | |
|---|---|---|---|---|---|
| CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST | 21.99 | 31.61 | 33.42 | 36.69 | 42.49 |
| MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | 30.31 | 27.55 | 27.14 | 36.85 | 38.7 |

*Green indicates improved performance and red worsening compared to previous year.

Table 24: OUH healthcare associated C. difficile cases corrected for activity (discharges)

Correcting the C. difficile data using discharges as a measure of OUH activity shows an increase in cases per episode of care in 2024/25.




C. difficile rates are rising nationally and the rate reported in England in March 2025 is the highest for 8 years (23.3 cases/100,000 bed days).

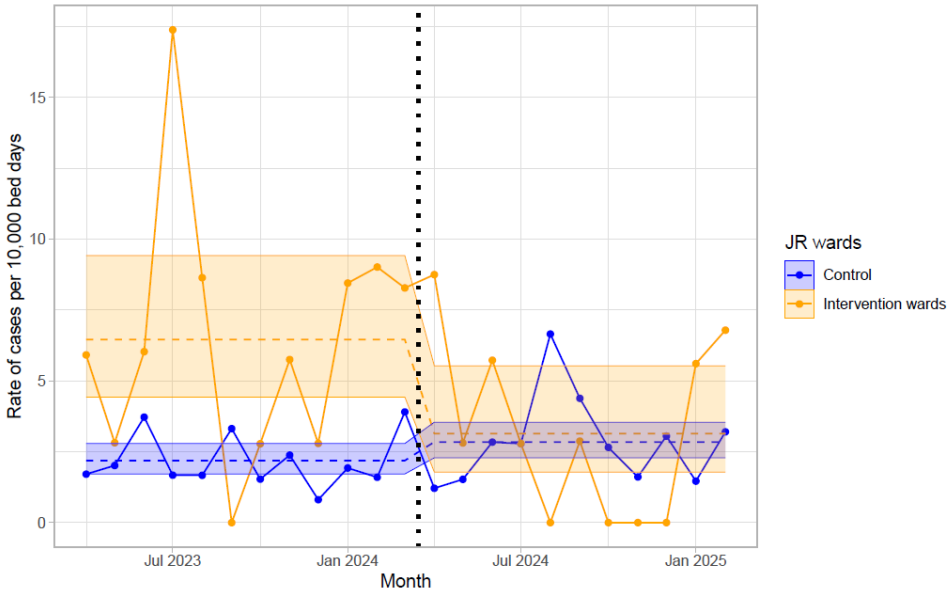
A C. difficile questionnaire is linked with Ulysses incident reporting. No major themes have been identified.

Proactive work continues in the OUH to minimise the occurrence of C. difficile infection including:

- Additional testing to identify those patients who are carriers of toxigenic strains but do not have C. difficile infection.
- Isolation of patients who are carriers of toxigenic strains as these patients can still transmit C. difficile.
- Pre-emptive treatment of patients who are carriers of toxigenic strains to reduce development of C. difficile infection and environmental contamination.

- Modification of antimicrobial guidelines to further reduce the empirical use of antibiotics such as Ciprofloxacin and Co-amoxiclav which have a stronger association with *C.difficile* infection.
- 7 day on-site infection prevention and control service, together with the 6 day antimicrobial stewardship (AMS) service which supports the microbiology team on a Saturday (see AMS section for further detail).
- Monitoring the use of antibiotics most likely to be associated with the development of *C. difficile* infection to support learning from C. *difficile* cases, and to guide which antibiotics to target on AMS rounds.
- Block booking of enhanced cleans to avoid missing enhanced cleans due to requesting.
- Questionnaire for C. difficile cases reviewed and updated to reduce time spent investigating and more on proactive work. A quarterly report from Ulysses is now available to identify themes more easily from completed questionnaires.
- A cleaning improvement project between the IPC team and medical wards at JR resulting in sustained improvement in cleaning scores. Data shows a reduction in C. difficile cases of 40% in intervention relative to control wards (p = 0.01) (Table 25). The intervention was in the wards with the highest rates of C. difficile - after the intervention rates of C. difficile in these wards went down to the lower rate usually seen in wards with lower risk patients. The IPC team plan to roll-out the intervention to other areas in the Trust 2025/26.

Table 25 Table shows the rate of C. difficile cases (y axis) per 10,000 bed days in the intervention and control wards.

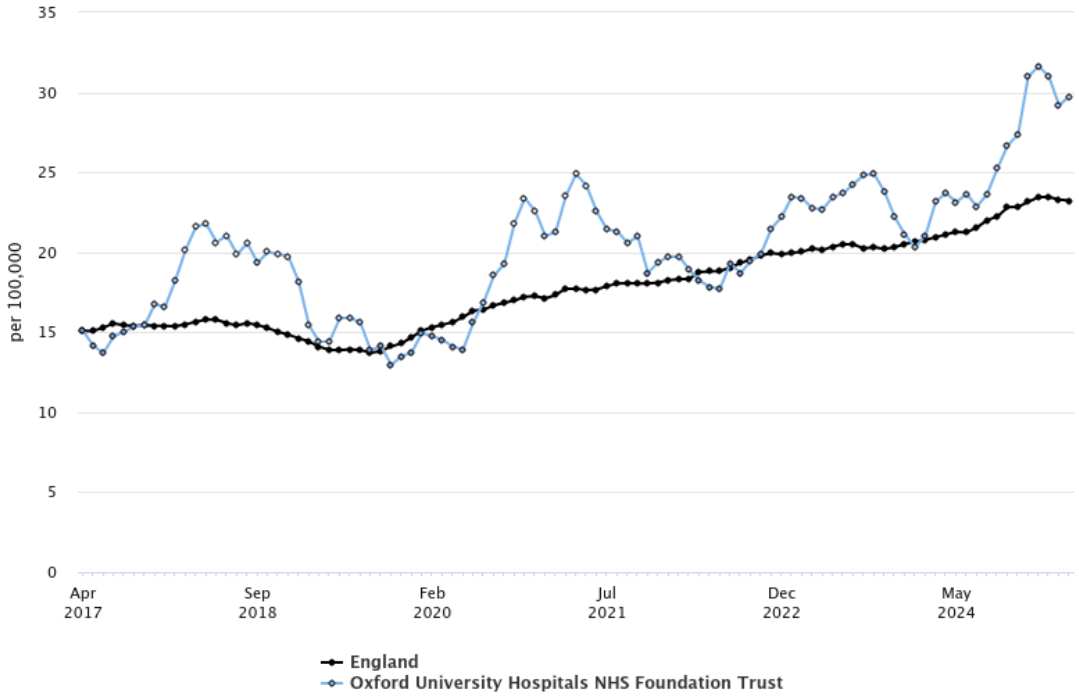


### National C. difficile data

During the quarter October to December 2024 in England:

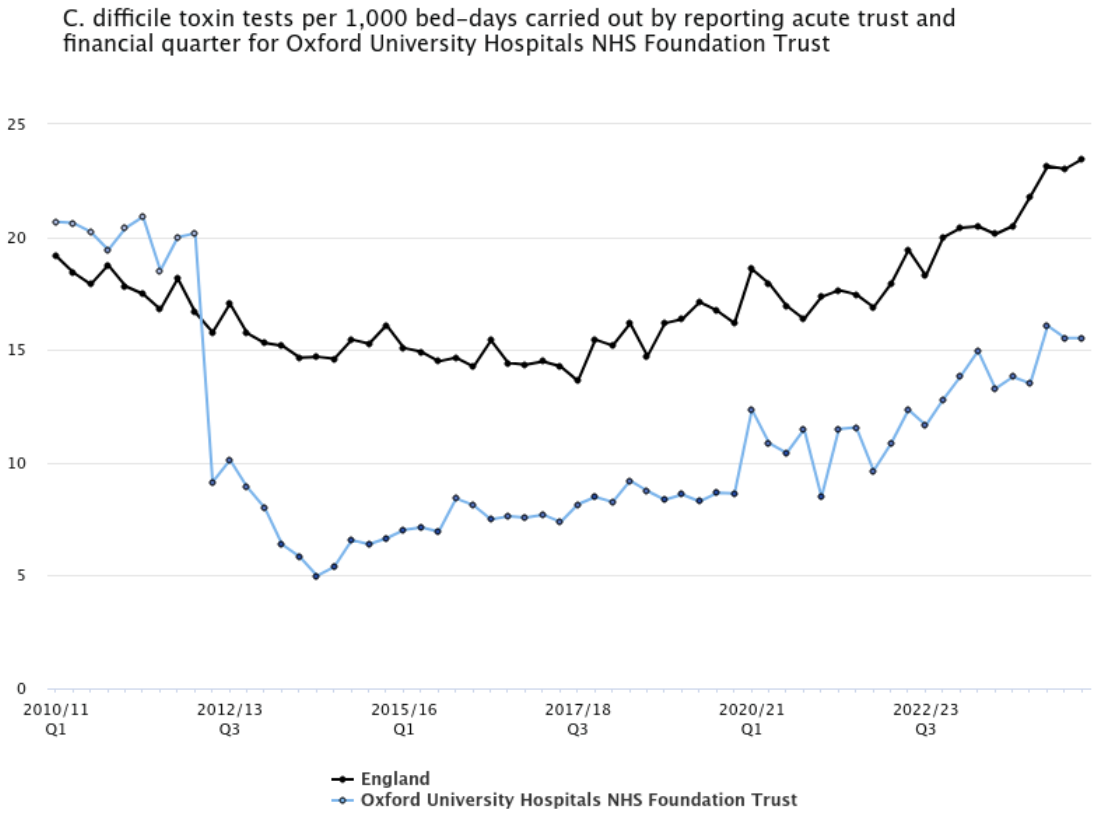
- there was a 13.7% increase compared with the same quarter last year and a 34.7% increase since the corresponding quarter in 2019
- both community- and hospital-onset rates have seen marked rises with community-onset rates increasing by 10.1% and hospital-onset rates rising by 17.7%.
- Table 26 shows the rising C. difficile rates in England as a baseline for the OUH data.

Table 26: C. difficile infection 12-month rolling counts and rates of hospital onset-healthcare associated cases for OUH




The number of stool samples processed in the OUH for C. difficile continues to increase in line with the national data over the last 4 years since the pandemic (Table 27). This includes samples from the community. This may be at least partly responsible for the local and national increase in cases (improved ascertainment).

Table 27: Number of stool samples processed for C. difficile by OUH Microbiology laboratory




## 2.11 Central Line Associated Bloodstream Infection (CLABSI) surveillance

Central Line Associated Bloodstream Infections (CLABSIs) are serious infections typically causing a prolongation of hospital stay, increased cost and risk of mortality. CLABSIs can be prevented through proper insertion techniques and management of the central line, using evidence based central venous line care bundles.

### 2.11.1 CLABSI surveillance in the Intensive Care Units

CLABSI surveillance is undertaken for all the intensive care areas by the IPC team. The CLABSI rate for all intensive care areas continues to be reviewed on a quarterly basis and results are fed-back to clinical units and Divisional governance leads.

In 2024-25 (Table 28):

- Rates in Neuro-ICU (NICU) Paediatric ICU (PICU), Cardiothoracic critical care (CTVCC) and Churchill ICU (CICU) have shown improvement.

- NICU had no episodes of CLABSIs for the last 3 quarters. Results are now well below the benchmark.
- An action plan has been implemented on newborn ICU (NBICU) in response to high CLABSI rates. Work has been done to re-establish line insertion and care bundles, and to discuss ANTT and audits.
- Churchill ICU (CICU) data continues to show the most variation due to lower patient numbers and line days than the other units.
- Cardiothoracic critical care (CTVCC) CLABSI rates continue to remain well below the benchmark.

Table 28: Annual CLABSI rates by ICU April 2018-March 2025, Rates are per 1000 line-days.

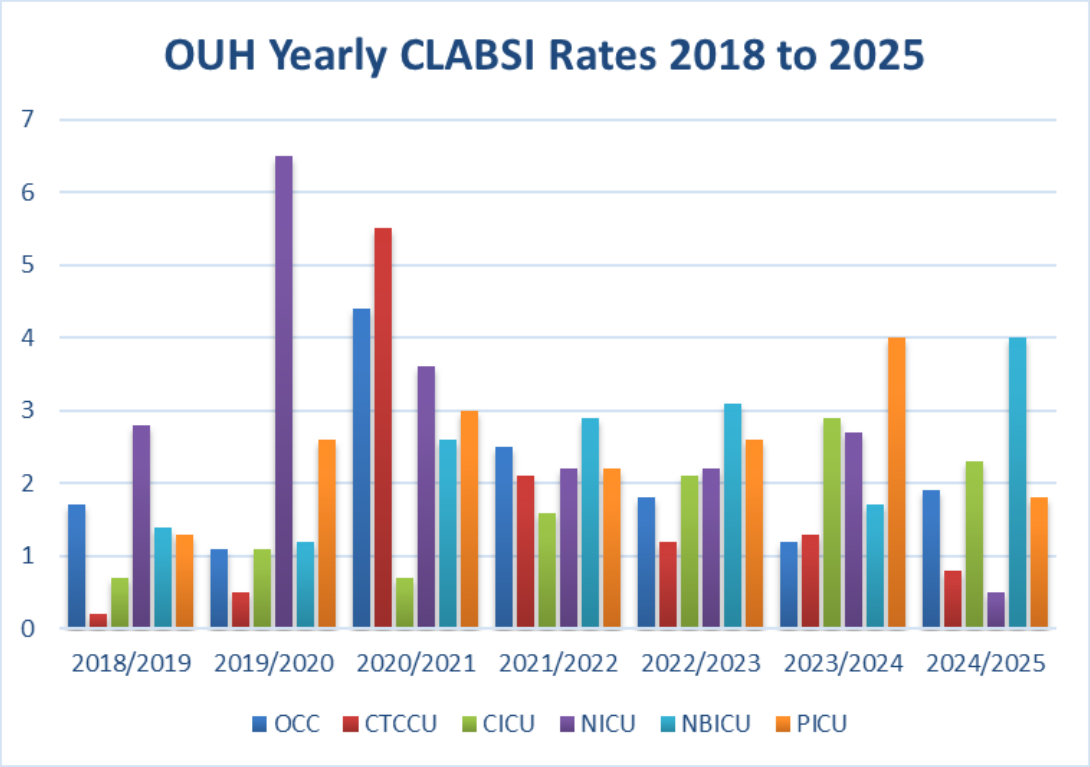



Table 29: Infection in Critical Care Quality Improvement Programme (ICCQIP) Benchmark for Intensive Care Areas

| | OCC | CTCCU | CICU | NICU | NBICU | PITU/HDU |
|---|---|---|---|---|---|---|
| **No of quarters in 2024/25 with data** | 4 | 4 | 4 | 4 | 4 | 4 |
| **Central line days** | 4265 | 3885 | 1745 | 1825 | 3961 | 2269 |
| **No of CLABSI** | 8 | 3 | 4 | 1 | 16 | 4 |
| **CLABSI/1000 central line days** | 1.9 | 0.8 | 2.3 | 0.5 | 4 | 1.8 |
| **Benchmark (ICCQIP) April 24 - Mar 25** | 1.3 | 1.3 | 1.3 | 1.3 | 1.5 | 0.5 |
| **Trend from 2023-2024** | ↑ | ↓ | ↓ | ↓ | ↑ | ↓ |

### 2.11.2 Trust wide non-ICU CLABSI surveillance

The IPC team continues to monitor Trust wide non-ICU Central line associated bloodstream infections (CLABSI) surveillance. This is a challenging dataset to maintain due to the large number of clinical departments using central venous access.

The definitions of HOHA and COHA as used for other healthcare-acquired infections reported in the Trust was not adopted for this surveillance as would exclude ambulatory encounters – many patients have long-term central venous access for dialysis or chemotherapy for example.

### 2.11.3 CLABSI prior Trust exposure categories for non ICU cases:

- Pre-48 hours: CLABSI identified within 28 hours of admission in a patient with a line already in situ and contact with OUH within last 28 days.
- Post-48 hours: CLABSI identified more than 48 hours after admission (NB line needs to have been in situ for > 48 hours).

The numbers of pre-48 hour cases remain fairly static, see table 30. Overall, during the financial year 2024-2025 in the OUH there have been 73 post-48 hour cases and 41 pre-48 hour cases. The areas of focus are the Haematology, Renal and Kamrans wards. This is in keeping with the high prevalence of central venous access, high complexity and clinical conditions cared for on these wards, which are associated with a higher risk of bacteraemia.

Data had not previously been reported in rates per 1000 line-days due to difficulty obtaining denominator data from the electronic patient record (EPR). We are now able to obtain denominator data and this has been utilised for the Haematology ward to present their CLABSI surveillance as a rate per 1000 line-days similarly to our ICU's, see Table 31. This shows that rates remain stable.

A QI project is underway on Kamrans ward to reduce incidence of CLABSI in collaboration with Paeds ID consultant and IPC team.

For the Renal ward, the Nephrology team with the IPC team identified areas for practice improvement. Dialysis line care and insertion protocols have been reviewed and protocols for skin decolonisation prior to line insertion have been developed for inpatients and outpatients.

Table 30 shows fluctuation over time for CLABSI rates on Haematology ward. The reduction in rates has not been sustained following the introduction of Biopatch in response to the spike in Q4 2022/23. A series of actions to improve practice on Haematology ward from Q1 2025, include awareness sessions for ANTT (aseptic non-touch technique), line

management, environment and hand hygiene and regular feedback to unit staff.

The IPC team will continue to monitor CLABSI trends to identify areas of concern and collaborate to reduce incidents of CLABSI.

Table 30: Trust-wide non-ICU CLABSI cases April 2024-March 2025

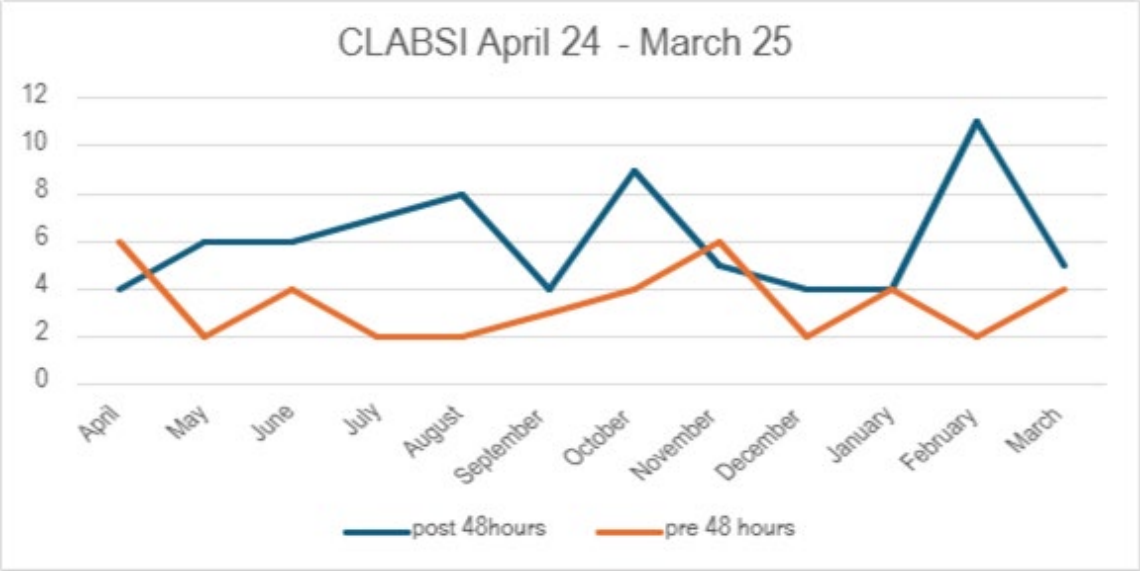
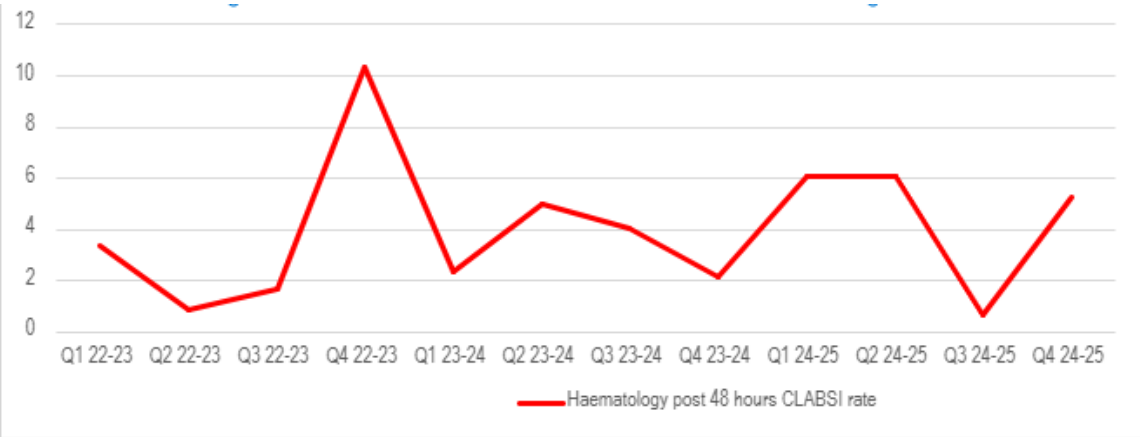


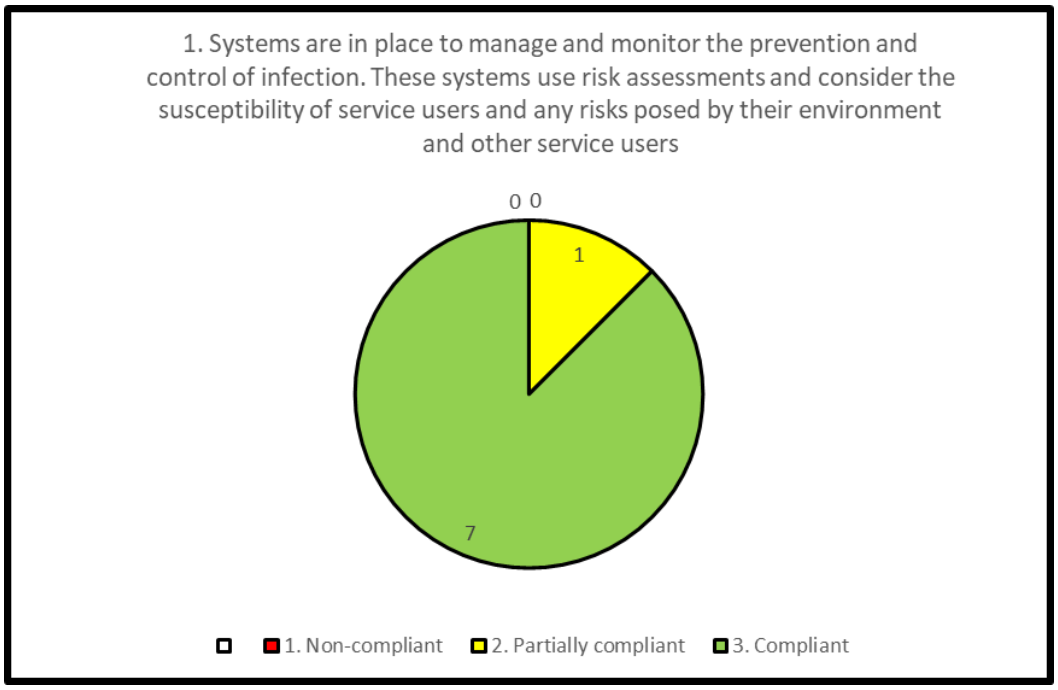

Table 31: Haematology CLABSI rates April 2022-March 2025 (rates per 1000 line days)




## 2.12 **IPC surveillance**

The company that supplied the surveillance system (ACMEipc) to the IPC team has ceased trading and the system is no longer available as the Microbiology laboratory has now switched to a new Laboratory Information Management system (LIMS) in March 2025, removing the interface. The Microbiology laboratory team are providing mitigation with daily reports for surveillance of organisms subject to mandatory reporting.

Figure 1: BAF Compliance to Criterion 1




| Partial Compliant Elements of the BAF | Reason for Partial Compliance | Actions to Achieve Compliance |
|---|---|---|
| Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the National Infection Prevention and Control Manual. | The previous IPC surveillance system was withdrawn and now non-functional with the switch to a new LIMS removing the interface. The IPC team will therefore not be alerted to data for mandatory reporting or patients being admitted with infectious organisms or new results in real time. Some mitigation in place and others being developed. See Criterion 4. | Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support. |

## 3 Criterion 2

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

## 3.1 Environmental IPC and decontamination

### 3.1.1 Water Safety Group (WSG) and Ventilation Safety Group (VSG)

The Trust's WSG and VSG meet quarterly. The IPC team are active members of both groups. Both safety groups are attended by the multidisciplinary team and our PFI colleagues. Compliance reports are produced by the Operational Estates team, and all the PFI partners. HIPCC receives reports from the Operational Estates team on water, ventilation, and environmental concerns. The Trust PFI office report on behalf of the PFI providers.

**Churchill Cancer and Haematology Hospital**

An ongoing issue with Legionella positive water samples at the PFI Cancer and Haematology Hospital on the Churchill site has been reported annually since 2018/9. This was first identified in 2015 when the Legionella risk assessment indicated hot water system circulation issues that are likely to date from construction (2009). It was recognised to be a systemic problem in September 2019 when increased surveillance showed continued presence of legionella widely within the water system. As a result, all water outlets in the Churchill PFI Cancer and Haematology hospital have had point of use filters (POUF) in place since 10 October 2019. POUFs ensure that water is safe at the point of use for both patients and staff. At the beginning of October 2019 prior to completion of POUF installation there was a single confirmed case of legionella infection in a patient who died. The timeline of events was consistent with a hospital acquired infection. Engineering works to manage this situation and provide a safe water supply have been ongoing since 2019 and have been managed via the Serious Incident Requiring Investigation (SIRI) process.

Water sampling continues to yield positive Legionella samples in the Churchill PFI building but counts are now falling; however the sampling schedule has not changed since prior to the engineering works. The root cause was thought to be a failure to maintain the flow of hot water, with cooler temperatures supporting growth of Legionella. The engineering solution has been completed this year with progress being monitored by the Extra-ordinary Water Safety Group. There is now a period of surveillance of hot water temperatures and continuing routine Legionella sampling. The POUFs remain in place.

The SIRI action plan has not yet been completed; at the beginning of April only 7 out of 21 actions have been signed off as complete by the Investigating Officer. A number of key documents are yet to be provided by the subcontractor, G4S, and then will need to be approved by the Trust Water Safety Group. At present, the WSG are unable to agree to the removal of the POUF. The Board are aware of the current lack of progress

in relation to the outstanding actions, and action has been taken to escalate the issue with the subcontractor.

**Whitehouse Renal Dialysis Unit**

Elevated levels of total viable counts (TVC) of organisms (not Legionella, Pseudomonas, E. coli or coliforms) are still present dating from the commissioning water testing for the new Whitehouse renal dialysis unit in Milton Keynes in 2023/24. POUFs remain in place on all outlets.

The Trust rent this building from Milton Keynes Council which adds a layer of complexity as there are also other tenants in the building. Temperature monitoring data showed that the cold-water supply is not in temperature range and this has been raised to Milton Keynes Council.

Engineering work has taken place to install Kemper valves to improve the turnover of the water and servicing of the taps has taken place. Further work is due to take place in 2025/26 and OUH are now undertaking the water sampling rather than Milton Keynes Council.

**Ward 5C/5D**

Since the commissioning of Wards 5C/5D at the JR, there has been an on-going issue with positive outlets for Pseudomonas. Pipework installation, observation of practice on the ward (cleaning, and use of sinks for water disposal) and maintenance standards have been reviewed.

Estates have conducted remedial work such as chlorination and changing taps and spouts. Additionally inline thermal disinfection units have been installation.

The number of outlets with high TVCs has reduced following the remedial work. POUFs remain in place on all positive outlets.

IPC and estates teams continue to meet with Ward 5C/D teams to raise awareness on the management of little used outlets.

### 3.1.2 Decontamination

The Decontamination Committee meets quarterly and covers decontamination in Sterile Services, endoscopy, decontamination of medical devices and patient equipment cleaning. This committee reports to HIPCC. There have been no major decontamination incidents to report this year.

An audit of semi-invasive and invasive ultrasound probes was carried out across the Trust between June 2023 and December 2024. In total 36 different departments were audited with the aim of verifying compliance with decontamination and assessing staff knowledge and competencies.

Following the audit an action plan was put in place to support creating and implementation of standard operating procedures for decontamination of ultrasound probes

The development of Trust wide ultrasound decontamination policy is in scope for 25/26.

### 3.1.3 Cleaning

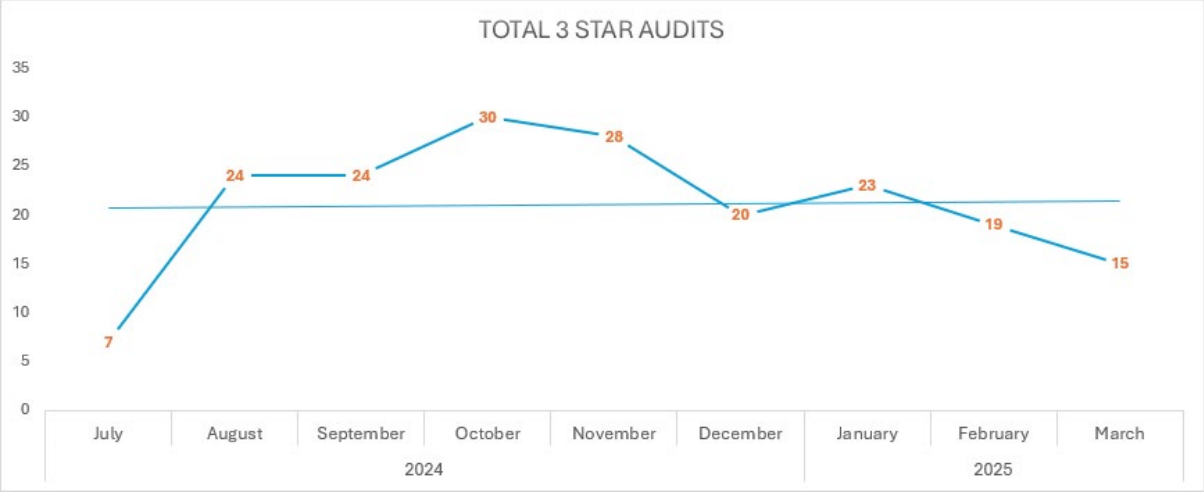
The National Standard of Cleaning has been implemented across the organisation. The IPC team, including the Clinical Decontamination Practitioner participate in cleaning audits as required. *My Audit* was introduced in July 2024 replacing the previously used Synbiotix platform for conducting cleaning audits. This new platform provides more reporting and analysis functionality and increases the coverage of rooms audited.

HIPCC receives a report from the Trust PFI office, reporting by exception those areas that have a low star rating and action plans to resolve concerns. IPC also receive an alert if an inpatient area has a 3-star rating or less. The top 7 areas with recurring 3-star rating are found in Table 32, Paediatric Critical Care (housed in Oxford Critical Care L3) and neonatal unit remain a concern. Of note using the My Audit platform data, the total number of 3-star or less audits is tracked and noted to be reducing, see Table 33.

Table 32: Locations with highest number of 3 Star or less audits, July 2024-March 2025

| Row Labels | No of 3 Star or few audits |
|---|---|
| Blk 41 - PFI - Theatres (1 to 6) | 17 |
| Blk 244 Oxford Critical Care L3 | 10 |
| Blk 41 - PFI - Theatre 7 and 8 (Mayfair Theatres - Ground Floor) | 8 |
| Blk 244 Oxford Critical Care L2 | 7 |
| Blk 41 - PFI - Theatre Recovery Area | 6 |
| Blk 105 - PFI Transplant Ward | 6 |
| Blk 06 - Neonatal ICU | 6 |

Table 33: Total number of 3 star or less audits, July 2024-March 2025

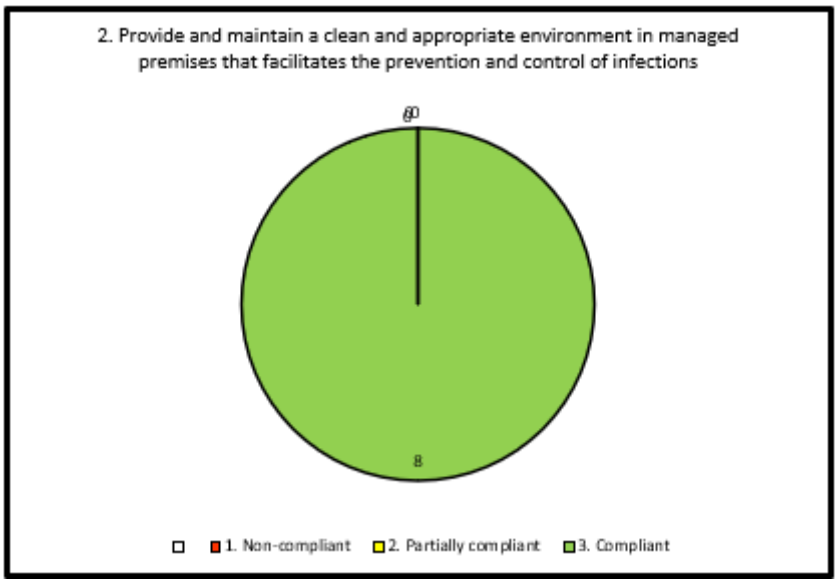



### 3.1.4 Neonatal Unit Estate

The neonatal unit has experienced intermittent outbreaks over the last three years including neonatal colonisation with extended-spectrum beta-lactamase (ESBL) producing Gram negative bacteria. Issues with the estate remain a particular concern. An action plan to facilitate an improvement in IPC on the unit is in place. A number of actions have been completed, including the purchase of new incubators, repair of the HDU flooring and creation of an incubator cleaning room. The more complex actions relating to the estate such as provision of a sluice and storage solutions, have yet to be undertaken. Work on creating an improved facility for decontamination of incubators will take place in May 2025.

The outbreak is discussed in more detail under Criterion 5.

Figure 2: BAF Compliance to Criterion 2



| Partial Compliant Elements to the BAF | Reason for Partial Compliance |
|---|---|
| N/A | |

## 4 Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

### 4.1 Antimicrobial Stewardship

In May 2024 a new National Action Plan (NAP) for Confronting Antimicrobial Resistance (AMR) was issued which will remain in place 2024-2029. The NAP has four themes, with themes 1 and 2 discussed in this section.

Theme 1 - 'Reducing the need for, and unintentional exposure to, antibiotics' includes IPC, public engagement and national surveillance of antimicrobial resistance patterns. The AMS team works closely with the IPC team to help reduce unnecessary exposure to antimicrobials. The AMS team also contributes to surveillance programs both locally and nationally.

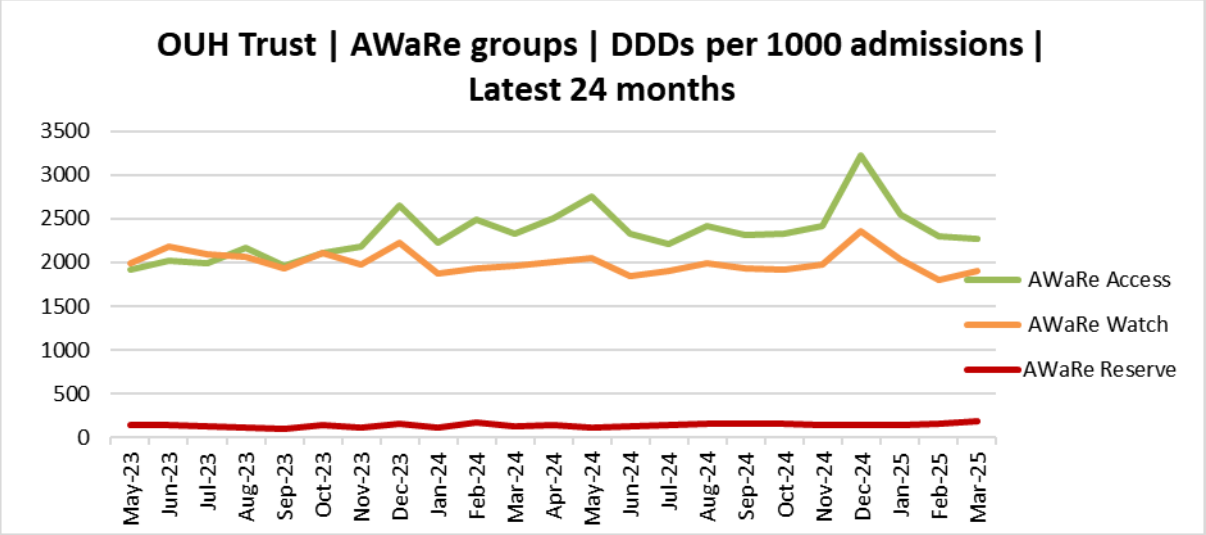
Theme 2- 'Optimising the use of antimicrobials' has an aim around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. This is one of the main objectives of the AMS team and the team are continuously introducing new initiatives to optimise antimicrobial use. Several of these initiatives are discussed below. No specific reduction has been set.

The World Health Organisation (WHO) uses the AWaRe (Access, Watch, Reserve) classification of antibiotics as a tool for monitoring antibiotic consumption. This classification categorises antibiotics into three groups - Access Watch and Reserve - based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare associated infection such as C. difficile Infection (CDI).

In 2023-24 the NHS National Contract in England specified a Trust target of a 10% reduction in consumption of antibiotics in the "Reserve" and "Watch" categories from the WHO AWaRE classification (adapted) against a 2017 (calendar year) baseline value. At the time of preparing this report, formal data from NHS England is only available up to the end of Q3 2024-25. The data showed that OUH has a 20% reduction in use of "Watch" and "Reserve" antibiotics against the 2017 baseline value. This shows that the Trust has made significant reductions in consumption of these antibiotic categories over the last financial year. For comparison the reduction reported at end of Q4 23-24 was 8.7%. The finalised data for 24-25 will be available later this year.

The consumption of antibiotic in the “Reserve, “Watch” and “Access” categories are monitored by the Antimicrobial Stewardship (AMS) Team and reported in their quarterly report to Hospital Infection Prevention and Control Committee (HIPCC). This is shown below in Table 34. Defined Daily Doses (DDDs) are used to measure consumption. The plot shows an increase in the use of “Access” antibiotics with a reduction in “Watch” but similar usage of “Reserve” antibiotics over time.

Table 34: Consumption of “Watch”, “Access” and “Reserve” antibiotics over time

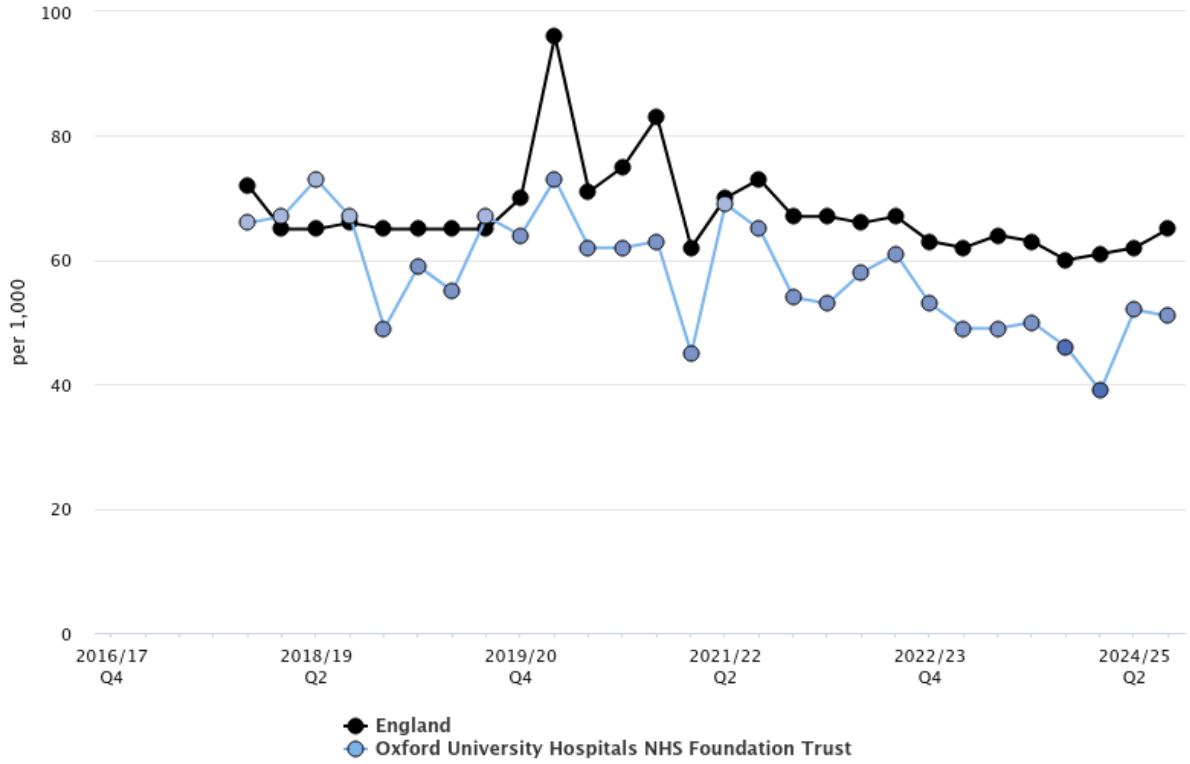



AMS activities during 2024-2025 which contributed to these changes in consumption were:

- Continued implementation of a 6 day AMS service (including adults, paediatrics and neonates) with positive feedback from clinical teams. The AMS team are recognised as part of the core weekend Micro service and support developing treatment plans for infection management, review antimicrobial TDM results and dosing, review broad spectrum antibiotic use, conduct a treatment review of patients with C. difficile and attend the microbiology ICU ward round.
- AMS ward rounds (discussed below).
- Use of data: the Orbit plus dashboard for AMS shows antimicrobial consumption at divisional, directorate and speciality levels as well as consultant level data. The dashboard has been refreshed and relaunched during 2024 and early 2025. Clinical teams are utilising this data to support their own AMS initiatives and identify areas for improvement.
- Providing AMS metrics for the monthly divisional reports to HIPCC which show the divisions consumption of antibiotic in the “Reserve, “Watch” and “Access”. These metrics have facilitated engagement from divisions with the AMS strategy for OUH.

- Education for clinical teams and divisions about their prescribing practice and consumption, including audit and individual feedback.
- Updating prescribing tools – Guidelines were reviewed and updated to reduce the use of ‘Watch’ and ‘Reserve’ antibiotics e.g. review of urology guidelines, urinary tract infection guidelines and skin and soft tissue infection guidelines.
- The AMS team support the IPC team in the Trust’s approach to preventing and managing C. difficile infection. Activities include monitoring use of antibiotics most likely to be associated with the development of C. difficile infection to support learning from C. difficile cases, including carbapenems (Table 35). The AMS team also conduct a review of medications within 24 hours of confirmation of a C. difficile infection to optimise the patient’s care.
- Carbapenems are “Reserve” broad spectrum antibiotics. Infections caused by organisms resistant to carbapenems have high mortality hence there is a global priority to reduce inappropriate exposure to carbapenems. Previously there have been CQUINs related to reducing the use of carbapenems and usage continues to be a key indicator monitored by UKHSA. The AMS team continue to undertake activities to optimise the use of carbapenems and Department of Health data (Table 35) shows that OUH use is falling and remains below the England average.

Table 35: Carbapenem prescribing DDs per 1000 admissions: by quarter and acute Trist for OUH. Graphs show that OUH prescribes carbapenems below the overall England rate.




The AMS team respond to MHRA Drug Safety Alerts. In January 2024 there was an alert regarding 'Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate'. In 2024/25 the team completed work to create a position statement for the use of Fluoroquinolones in OUH, review antimicrobial guidelines (adults and paediatrics), review stock lists and ensured that there is access to Patient Information Leaflets when patients are prescribed fluoroquinolones. The team also implemented daily reviews (6 days a week) of fluoroquinolone use to ensure appropriate use of these antibiotics. This work was presented as two posters at the European Society of Clinical Microbiology and Infectious Diseases conference 2025.

### 4.1.1 Antimicrobial Stewardship Multidisciplinary Team ward rounds

Antimicrobial Stewardship (AMS) Multidisciplinary Team (MDT) ward rounds are conducted on a weekly basis. The rounds consist of pharmacists, nurses and infectious diseases clinicians who review patients on broad spectrum antibiotics. During the AMS MDT ward round interventions are made and the nature of which are recorded.

Currently AMS MDT ward rounds are carried out regularly in the following areas:

- Haematology-Oncology
- Churchill (excluding ITU and renal transplant, conducted separately)
- JR West Wing (excluding neuro-ITU, conducted separately)

- Horton (adults)
- Paediatrics at JR
- Neonatal unit
- Paediatric Intensive care
- Horton paediatrics
- Oxford Critical Care Unit conducted separately
- Cardio-thoracic Critical care conducted separately
- Pilots: Surgical admission unit at JR.

Table 36 shows the number of ward rounds, number of patients reviewed, number of interventions suggested during the ward rounds and percentage of those interventions that were actioned between April 2024 and March 2025.

| | Number of ward rounds | Number of patients reviewed | Number of interventions | % of interventions actioned |
|---|---|---|---|---|
| Q1 | 88 | 1049 | 700 | 79.5 |
| Q2 | 91 | 1193 | 813 | 76.6 |
| Q3 | 85 | 1214 | 865 | 77.1 |
| Q4 | 80 | 1270 | 906 | 75.1 |
| **Total** | **344** | **4726** | **3284** | **77** |

The AMS team had a paper published in the Journal of Infection (2025): “The impact of antimicrobial stewardship ward rounds on antimicrobial use and predictors of advice, uptake, and outcomes”. The conclusions were that multidisciplinary AMS ward rounds reduced antibiotic use and reduced length of hospital stay by 0.6 days if the suggested intervention is followed; senior clinician input and more AMS experience increased advice uptake. The team won the research category of the Antibiotic Guardian awards 2025 for the work that they have undertaken related to the AMS ward rounds.

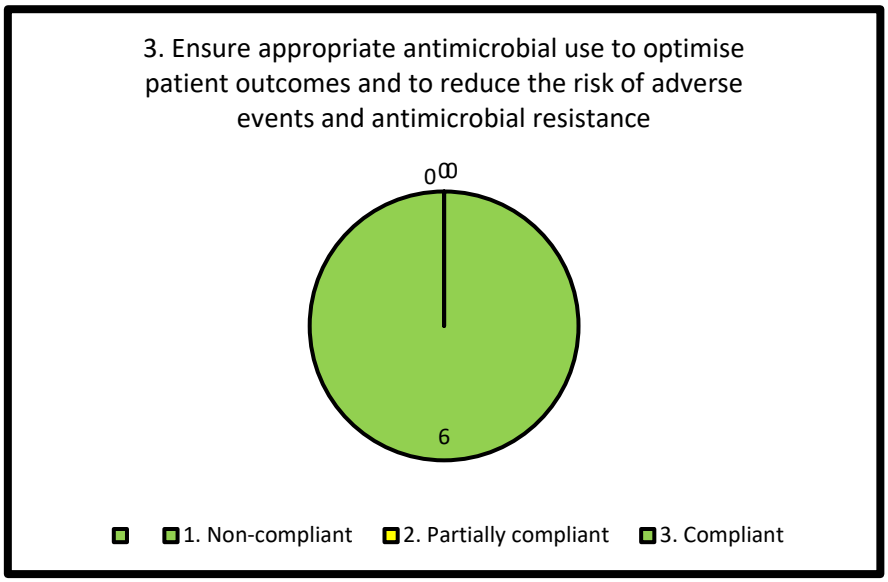
### 4.1.2 Penicillin de-labelling

The AMS team provide support for penicillin de-labelling, suggesting patients who may be suitable as part of their AMS ward rounds. Many people labelled as allergic to penicillin are not truly allergic, and being labelled can limit treatment options with potentially more effective or narrower spectrum antibiotics. The de-labelling is performed by the clinical staff on the ward. A protocol to support patient assessment and safe de-labelling is available nationally and in Trust antimicrobial guidelines. Data collection on de-labelling is complex; the figures below are for 2024-25, and are minimum figures with the margin for error in brackets.

**280** de-labelling prescriptions on EPR (up to +77)

**180** patients with associated de-labelling on EPR (up to +102)
**110** patients successfully de-labelled (up to +70)

Figure 3: BAF Compliance to Criterion 3




| Partial Compliant Elements to the BAF | Reason for Partial Compliance |
|---|---|
| N/A | |

## 5 Criterion 4

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

### 5.1 Provision of Information

The IPC team take an active role in promoting patients, staff, and visitors' safety, for example, working with the communications and media team on visual material, and the procurement team on supplies of Personal Protective Equipment (PPE) where required.

We work closely with the Chief Nursing Officer's team on the visitor policy and assessing the risk of potential nosocomial transmission for all infections, keeping in mind national guidance, and being compassionate.

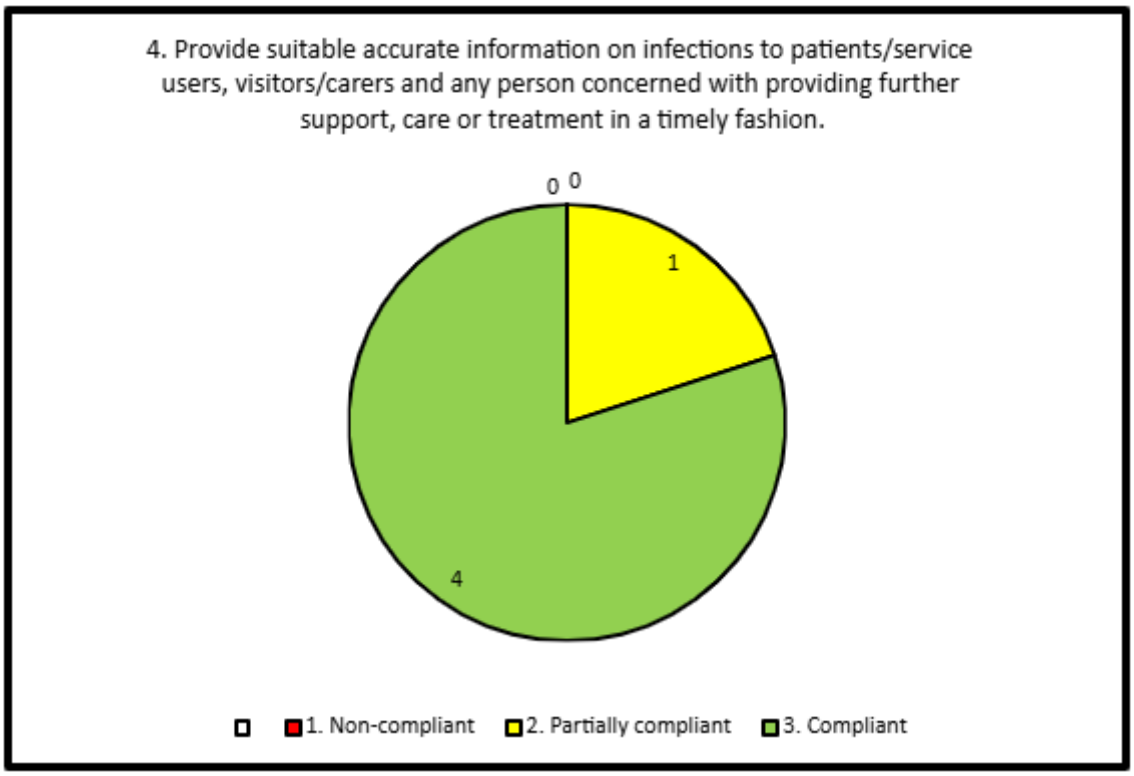
Clear signage is used in clinical areas to inform visitors, clinicians and other health care workers of infection prevention and control issues eg at entrance points to wards and side-rooms.

The Trust comms team use the external website (Home - Oxford University Hospitals) and social media (Facebook, X, Bluesky, Instagram and Threads) in the event of needing to provide urgent information on operational issues including IPC to service users/patients and visitors.

NHSE patient information leaflets and provision of links to 'NHS choices' are used for providing information to patients. The Buckinghamshire Oxfordshire and Berkshire (BOB) ICS IPC group have also produced patient information leaflets.

The Trust uses an Inter-Healthcare Infection Prevention & Control Transfer Form to provide information on infection risk to other providers.

Figure 4: BAF Compliance to Criterion 4




| Partial Compliant Elements to the BAF | Reason for Partial Compliance | Actions to Achieve Compliance |
|---|---|---|
| Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users. | No IPC surveillance system in place. Previous system was shared with Oxford Health and will therefore not be able to share relevant information across organisational boundaries. | Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support. |

# 6 Criterion 5

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

## 6.1 Infection Prevention and Control Surveillance Software

The company that supplied the IPC surveillance system (ACMEipc) to the infection prevention and control team (IPCT) has ceased trading. This system was also used by Oxford Health.

The risk of a lack of real-time IPC surveillance to support the minimisation of avoidable healthcare associated infection has been added to the risk register and escalated to relevant parties.

The Microbiology laboratory team have implemented the new Laboratory Information System (LIMS) which has provided mitigation with daily reports and alerts to certain infections have been set up with the help of the EPR team. Dialogue to support the implementation of an IPC surveillance system (such as ICNET) has taken place throughout 24-25 but no decision has been made.

## 6.2 Investigation of Infection Prevention and Control Incidents

### 6.2.1 IPC and the Neonatal unit

The neonatal unit has continued to be a cause for concern; this has been shared with the Chief Medical Officer and Chief Nursing Officer.

The incubator replacement programme was completed in May 2024 and an incubator cleaning room has since been created. Further work to provide a sluice area and improve storage is required.

Progress towards implementation of an electronic patient record system has been slow, and the unit is reliant on paper for all clinical and nursing notes. This creates clutter in the unit, and a risk of transmission from multi-use paperwork. Prescribing is now electronic (Sept 2024) which has removed multi-use paper drug charts and will facilitate antimicrobial audit.

Fortnightly MDT meetings to work through and complete actions on the IPC action plan have continued in addition to the regular IPC visits with a focus on reinforcing IPC practice in the unit and monitoring outstanding actions from the initial outbreak.

Weekly screening continues and cases of colonisation with ESBL have continued to be found; however no clinical or invasive isolates have been identified.

This year the unit has observed increased referral activity with admissions sometimes exceeding capacity. A shortage of support staff has also been reported.

### 6.2.2 Listeria monocytogenes

In 2024/25 there were 2 cases of Listeria monocytogenes bacteraemia. Immunocompromised patients, pregnant women, neonates, and adults over 65 are at the highest risk of contracting listeriosis and most at risk of severe infection.

An immunocompromised patient was admitted with Listeria monocytogenes bacteraemia. The patient had had a recent emergency (ED) encounter which was followed a week later by their hospital admission. Food consumed was investigated by Head of Soft FM Performance and Quality and our provider Mitie. No issues were identified associated with food at the time. The patient sadly died later in the month.

It was later identified that this case was linked through whole genome sequencing to a cluster of Listeria cases being investigated nationally, linked to a common food business operator providing sandwiches to NHS Trusts (including the OUH).

A sandwich had been consumed by the affected patient during the ED encounter. Food from the implicated supplier was removed from the Trust proactively as a precaution and alternative arrangements implemented. A national recall was subsequently implemented.

A second patient who had been receiving chemotherapy care in the cancer centre in the Churchill Hospital was admitted to another hospital with Listeria bacteraemia. UKHSA flagged up that the infection was potentially linked to the ingestion of contaminated food while at OUH.

The infection was not found to be linked to contaminated food served by the Trust but possibly linked to a sandwich from an external source.

These cases reinforced the importance of maintaining temperature control and the cold storage chain for food safety. IPC and Soft Facilities Management audited all Trust temperature-controlled fridges, and where required mitigation was put in place.

### 6.2.3 Bedbugs

There was an incidence of bed bug infestation in the Children’s hospital in November 2024, following a parent’s report of a rash which was suspected to be caused by bed bugs. IPC, estates PFI and pest control reviewed the ward and found a mattress which was contaminated with bed bugs. This was a designated mattress for parents/carers. The bay was closed with the temporary loss of 2 inpatient beds.

Following chemical treatment and the removal of 4 mattresses the bed bugs have been eradicated. The beds were re-opened for admissions

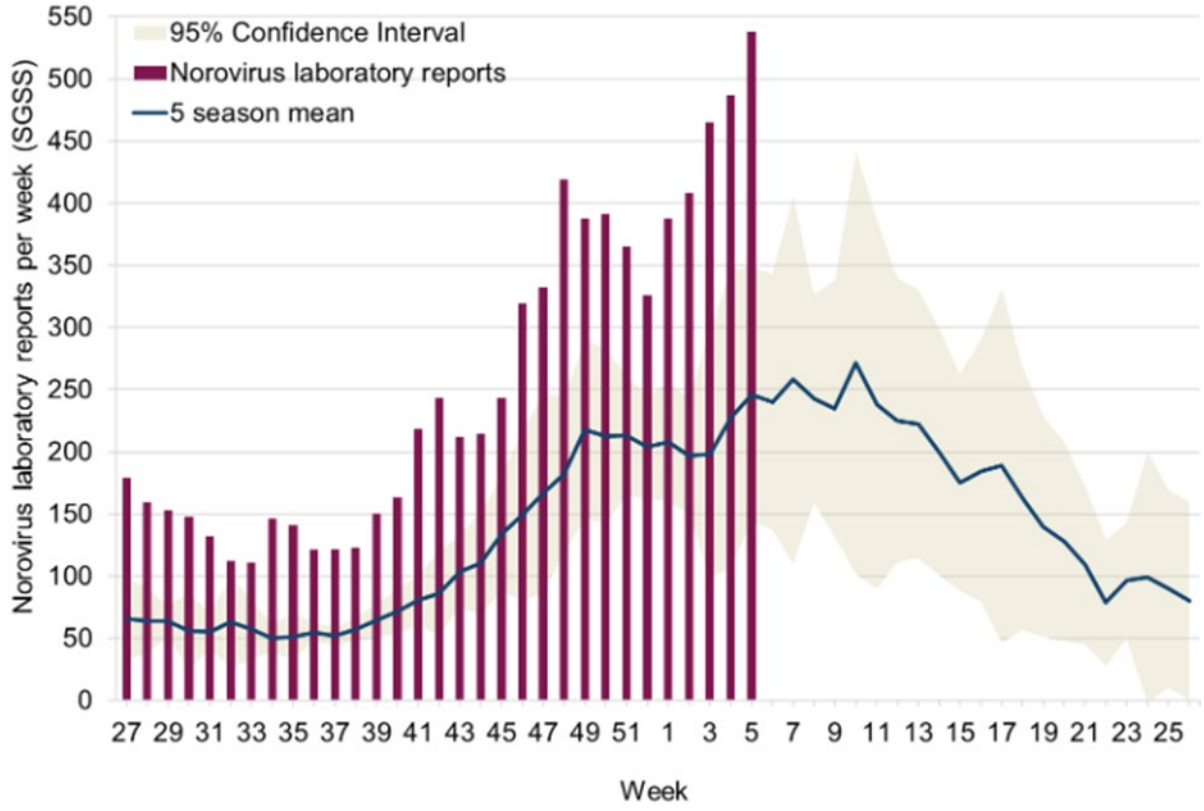
### 6.2.4 Norovirus Outbreaks

In April, May and June 2024 there were 4 outbreaks of norovirus all in acute medical wards affecting a total of 29 patients, 14 staff and 1 visitor.

The impact of norovirus on the Trust operational capacity is reduced as the IPC team are able to provide a physical presence 7 days a week, supporting and advising all affected wards, and thereby ensuring optimum patient placement and operational capacity. As a result lost bed-days have been minimised.

The incidence of norovirus in the Trust remained low in winter months. This is in contrast to the national experience (Table 37).

Table 37: Norovirus laboratory reports in England by week during the 2024/2025 season, compared with the 5 season average




### 6.2.5 Tuberculosis

Contact tracing was completed for an in-patient diagnosed with *Mycobacterium tuberculosis*. 6 patients were identified as contacts and warn and inform letters were sent to patients and GPs in line with guidance.

No staff were identified as contacts, but staff were given the opportunity to discuss any concerns with occupational health.

### 6.2.6 Salmonella

A long stay patient in Paediatric Critical Care (PCC) was found to have a bacteraemia with *Salmonella Montevideo*, an unusual organism to acquire as a nosocomial infection.

A second patient who had been on PCC but transferred to another intensive care facility then tested positive for *Salmonella Montevideo* the following day.

Investigation by the local health protection team revealed that the second patient was part of a known and long-standing outbreak of *Salmonella Montevideo* infection from a prior admission to the second facility.

Both patients were isolated appropriately and are likely to remain long-term carriers of *Salmonella Montevideo*.

No further cases of transmission were reported.

A review of IPC on the unit identified areas for improvement and an IPC/PICU task force was developed which met weekly to review IPC issues on the unit and to change practice.

The IPC team supported the unit to improve hand hygiene and cleaning scores through regular teaching and conducting weekly audits.

Lessons learnt were incorporated into the regular unit IPC meetings after 2 months and the taskforce was stood down.

### 6.2.7 Measles

There was a rapid increase in cases of measles in late 2023 driven by a large outbreak in Birmingham, with subsequent rises in London and small clusters in other regions in the first half of 2024.

A small number of cases have been manged in 2024/25 in the OUH:

In May 2024 a paediatric patient developed a fever and a rash and had a 90-minute wait in JR's Paediatric ED with other families. The clinical opinion was that this was a measles vaccine related response, as the child had been recently vaccinated, and not been in contact with anyone unwell. However UKHSA required the OUH to inform and warn contacts. This was undertaken using a text message. The reference laboratory failed to detect wild-type measles and the patient was deemed negative for measles.

Three proven measles cases and one probable case were seen in emergency settings in the OUH during 2024/25, 2 adults and 2 children.

Patients were managed with rapid isolation and appropriate precautions. All patient contacts identified were notified using text messaging (DrDoctor platform), and in the event of staff exposure occupational health assisted

with risk assessment. The Trust is not aware of any onward transmission from these cases.

**Meningococcus**

Staff exposure – see section Criterion 10.

## 6.3 Surgical Site Infection Surveillance (SSI)

### 6.3.1 Cardiac Surgery

Cardiac surgery continues to participate in voluntary surveillance and Surgical Site Infections (SSIs) information is reported to the UKHSA SSI surveillance service every quarter.

### 6.3.2 TAVI (Transcatheter Aortic Valve Implantation) surgical site surveillance

There have been no reported SSI cases for TAVI patients since surveillance commenced in 2019 (data to March 2025).

### 6.3.3 Cardiac artery bypass grafting (CABG) and non-CABG SSI surveillance

SSI data for non-CABG and CABG procedures is shown in tables 38 and 39 below. Both programmes have SSI rates well below national benchmarking (2% for non-CABG, and 4.8% for CABG).

Table 38: Non–CABG SSI RATES April 2024 to March 2025

| **Non-CABG Cardiac surgery Surgical site infections** | | | | | |
|---|---|---|---|---|---|
| **Period** | Superficial wound infections | Deep incisional wound infections | Organ / Space infections | Total | Reconciled |
| **Quarter 1 Apr-Jun 2024** | (0/107) = 0% | (0/107) = 0% | (0/107) = 0% | (0/107) = 0% | Yes |
| **Quarter 2 Jul-Sep 2024** | (1/109) =0.9% | (0/109) =0% | (0/109) =0% | (1/109) =0.9% | Yes |
| **Quarter 3 Oct-Dec 2024** | (0/101) = 0% | (0/101) = 0% | (0/101) = 0% | (0/101) = 0% | Yes |
| **Quarter 4 Jan- Mar 2025** | (0/101) = 0% | (0/101) = 0% | (0/101) = 0% | (0/101) = 0% | No |
| **Running Total** | | | | (1/418) = **0.2%** | |

Table 39: CABG SSI RATES April 2024 to March 2025

| CABG Surgical site infections | | | | | |
|---|---|---|---|---|---|
| **Period** | Superficial wound infections | Deep incisional wound infections | Organ / Space infections | Total | Reconciled |
| **Quarter 1 Apr-Jun 2024** | (1/88) = 1.1% | (1/88) = 1.1% | (0/88) = 0% | (2/88) = 2.2 % | Yes |
| **Quarter 2 Jul-Sep 2024** | (2/79) = 3.7% | (0/79) = 0% | (1/79) = 1.2% | (3/79) = 3.7% | Yes |
| **Quarter 3 Oct-Dec 2024** | (4/95) =4.2% (one donor site) (TBC) | (0/95) =0% | (0/95) =0% | (4/95) =4.2% (one donor site) (TBC) | Yes |
| **Quarter 4 Jan-Mar 2025** | (1/89) = 1.1 % (TBC) | (0/89) = 0% | (0/89) = 0% | (1/89) = 1.1% (TBC) | No |
| **Running Total** | | | | (10/351) = 2.8% | |

### 6.3.4 Trauma and Orthopaedic SSI Surveillance

Mandatory surveillance of infections in trauma and orthopaedics started in April 2004, specifying that each trust should conduct surveillance for at least one orthopaedic category for one period in the financial year.

OUH collects continuous data on repair of neck of femur at both the Horton and JR sites (Table 40).

Table 40: Fractured Neck of Femur SSI Rates – John Radcliffe and Horton sites

| | | JRH | | | | HGH | | | | National average 5 years to date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | All #NOF Operations | No. SSI cases | JR SSI rate (%) | Outlier status | All #NOF Operations | No. SSI cases | HGH SSI rate (%) | Outlier status | All #NOF Operations | No. SSI cases | National SSI rate (%) |
| 2024 | Q1 Jan-Mar | 83 | 1 | 1.2% | | 80 | 0 | 0.0% | | 97555 | 866 | 0.9% |
| | Q2 Apr-Jun | 89 | 1 | 1.1% | | 79 | 0 | 0.0% | | 98874 | 877 | 0.9% |
| | Q3 Jul-Sep | 79 | 0 | 0.0% | | 104 | 0 | 0.0% | | 99991 | 900 | 0.9% |
| | Q4 Oct-Dec | 91 | 1 | 1.1% | | 92 | 0 | 0.0% | | 101820 | 923 | 0.9% |
| 2025 | Q1 Jan-Mar | 93 | 1 | 1.1% | | 94 | 1 | 1.1% | | | | |

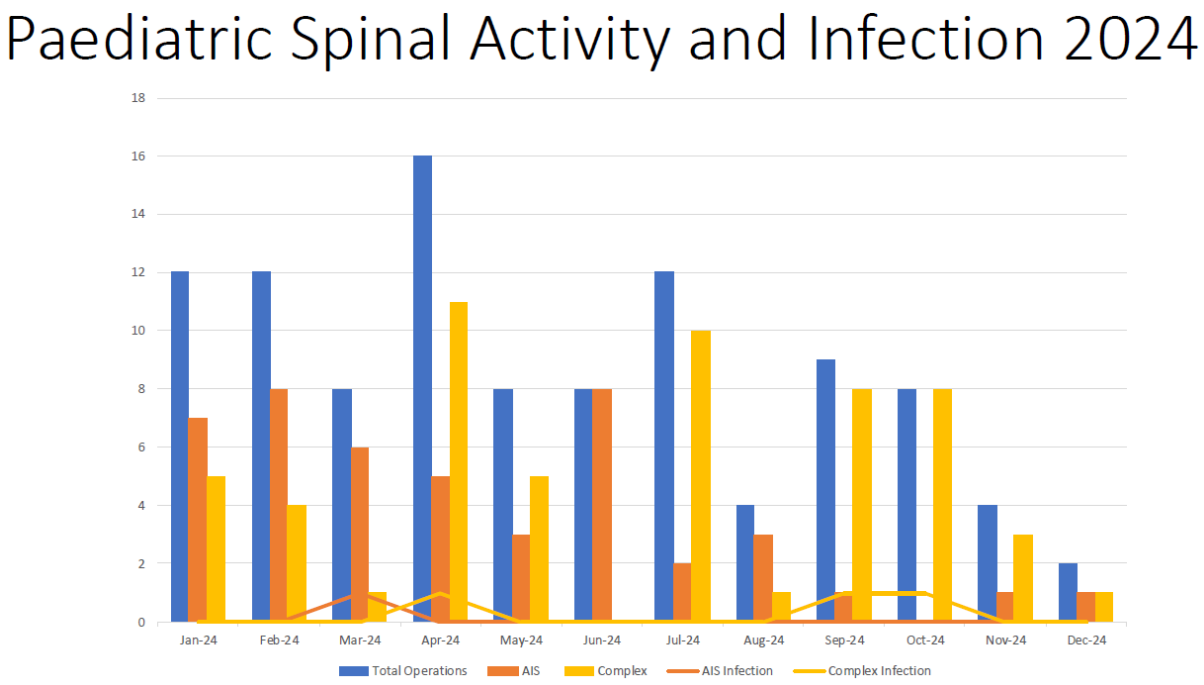
### 6.3.5 Spinal Service and Surgical Site Infection (SSI)

A review in 2023 by NHSE Specialist Commissioning of paediatric spinal surgery identified two serious concerns (a) the high rates of SSI and (b) extended waiting times for paediatric surgery. Quarterly review meetings with the Thames Valley and Wessex Surgery in Children Network were introduced. NHSE identified that the arrangement for monitoring progress would be to follow up through the contracting route as part of a Service Development Improvement Plan (SDIP). All actions have been progressed through 2024/25, and the quarterly meetings have now been stood down.

An overall reduction in spinal SSI from 9% to 2.2% (Table 41) has been achieved in 2024. The SSI prevention bundle is regularly audited with good compliance, with a weekly MDT to review patients with outcomes documented within patient record, data is collected prospectively and a discharge clinic established.

A business case was agreed for an SSI nurse to support the service at the NOC, but the funding was lost at financial out-turn and it has not been possible to recruit to the post due to the savings required in 2025/26.

Table 41: Paediatric Spinal Activity and Infections by procedure 2024




EOS Early Onset Scoliosis (Scoliosis in children under the age of 10 years)
AIS Adolescent idiopathic scoliosis
NM Neuromuscular

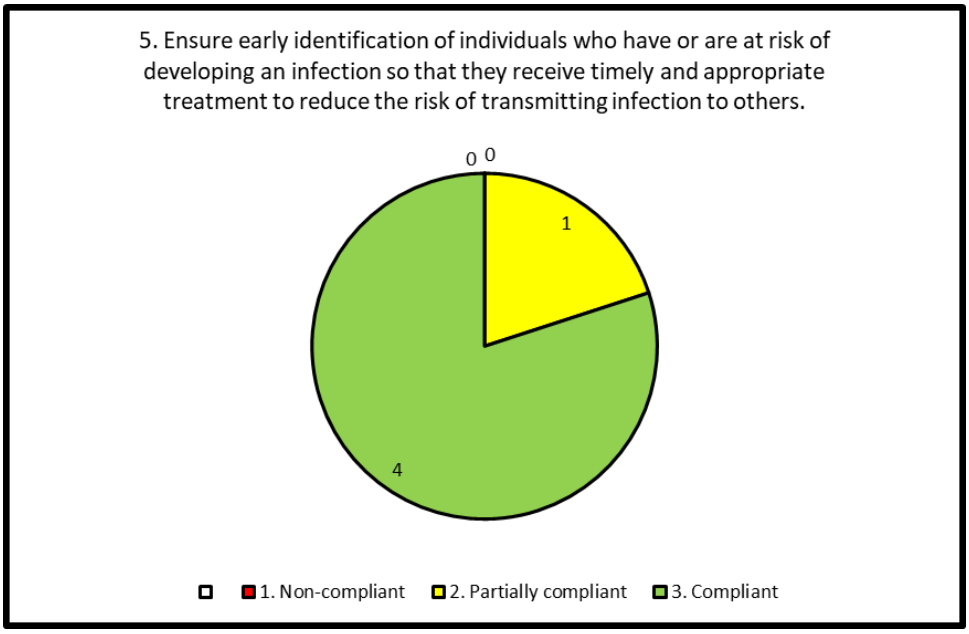
### 6.3.6 Trust wide SSI surveillance

A pilot of undertaking SSI surveillance digitally was successfully undertaken in caesarean sections and for emergency surgery patients. This will not be continued as the app has now been withdrawn by the company pending an upgrade.

Data is available at clinician and procedure level on the ORBIT surgical morbidity tracker on a number of parameters relevant to SSI such as returns to theatre.

Investment in SSI surveillance is required in order for the organisation to understand rates of SSI incidence in our patients, so patient experience and outcomes can be improved. Once SSI rates are known, interventions to reduce SSI can be monitored and evaluated, and specialities with rates outside expected norm can be supported to reduce rates.

Figure 5: BAF Compliance to Criterion 5




| Partial Compliant Elements to the BAF | Reason for Partial Compliance | Actions to Achieve Compliance |
|---|---|---|
| All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receives timely and appropriate treatment to reduce the risk of infection transmission. | Loss of IPC surveillance system, with only partial mitigation. No replacement system confirmed. | Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support. |

## 7 Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

### 7.1 Provision of information to staff

The OUH intranet hosts the IPC website which provides access to all IPC polices, guidelines and documents including a suite of ‘At A Glance’ quick reference guides.

## 7.2 IPC Training

There is an IPC eLearning package that meets the national requirements and is a Trust-wide requirement.

The IPC team offers bespoke training in a variety of ways and participates in training for medical students and doctors.

There is now a strong IPC Link Practitioner cohort of staff, who are attending IPC run workshops and completing competencies. Clinical areas have been supportive of the Links having time to attend sessions. These Link Practitioners could be an extremely useful resource should the pandemic resurface, or in the event of a new outbreak of infection.

### 7.2.1 Infection Prevention and Control Link Practitioner Workshop

In July 24 the IPC team held an IPC conference for link practitioners and staff members from the BOB network. 125 delegates attended the conference to discuss topics including C. diff, SSI and blood cultures. Feedback from delegates was universally positive.

The IPC team reached out to link practitioners to relaunch the link practitioner workshop in Q3 and Q4 of 24/25. A new curriculum has been put together following feedback from link workers and the workshops are planned to be relaunched in 2025.

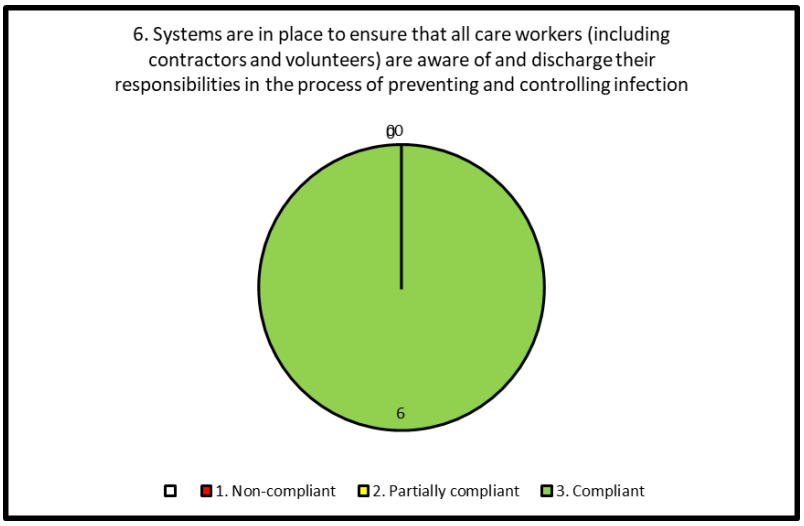
## 7.3 OUH IPC Team national positions of responsibility

The DIPC is a member of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) which advises the government on the threat posed by new and emerging respiratory viruses, Expert Advisor to the Infected Blood Inquiry, and a member of the Infectious Diseases Clinical Reference (commissioning) group.

New national roles taken on by the Consultant Pharmacist in 2024/25 include Chair of the Royal Pharmaceutical Society Antimicrobial Expert Advisory Group (AmEAG) and Membership Lead for the UKCPA.

The Senior AMS Pharmacist is Associate Members Secretary for the British Infection Association.

Figure 6: BAF Compliance to Criterion 6




## 8 Criterion 7

The provision or ability to secure adequate isolation facilities.

### 8.1 Isolation facilities

The John Warin Ward (JWW) provides isolation facilities with 4 isolation suites with positive pressure ventilated lobbies (PPVL). There is an isolation facility in the JR Emergency Department with direct access from the external environment. The critical care facility on the John Radcliffe site offers additional isolation facilities with 8 PPVL rooms.

### 8.2 High Consequence Infectious disease

The Trust made a successful application to become a centre for Airborne high consequence infectious disease (HCID) in 2023-24 and work has been undertaken this year to prepare the trust to receive patients. The Trust has an HCID group that meets monthly and maintains the HCID protocol. OUH has National HCID Airborne status which means that, following agreement with the HCID network, the unit (John Warin Ward and/or Oxford Critical Care) must be able to admit a patient (adult or child) and start treatment within six hours of a confirmed diagnosis; and to operate continuously for three weeks following unit activation with the admission of an HCID patient. The unit may be asked to take a family or up to three patients when fully operational.

The ‘go live’ date was in Q1 2025/26. to the Trust continues to receive and assess suspected cases of airborne or contact HCID.

Progress to date includes:

- Appointment of HCID clinical leads in paediatrics, paediatric critical care, infectious diseases, and adult critical care and an HCID Lead Nurse.
- Completion of enabling work on JWW to maximise storage and doors/security to separate the HCID facility from the main ward area has been completed with NHSE funding.
- 8 staff attended HCID PPE train the trainer day in June 2024 (Sheffield).
- 10 staff attended the HCID Network Day in May 2024.
- Revision of HCID plan to separate into suspected and confirmed cases.
- Review of ventilation by the Authorising Engineer for Ventilation wi the Head of Estates.
- A review visit from NHSE, the health and safety executive and EPRR (emergency preparedness, resilience and response) teams in June 2024.

## 8.3 Respiratory Viruses: Influenza, COVID-19 and RSV (Respiratory Syncytial Virus)

### 8.3.1 Influenza and COVID-19 Outbreaks

The Trust now manages patients with a positive diagnosis of COVID-19 through-out the year; this is often not the reason for admission.

There were a number of ward-based outbreaks of both COVID-19 and influenza in 2024/25. Sideroom availability for isolation of these patients on the John Radcliffe and Horton sites is limited.

IPC supported wards in cohorting of patients were possible and providing daily touch points to support enhanced cleaning, reinforce good hand hygiene practices and appropriate use of PPE.

Table 42 Graph of influenza cases by year and week number (fiscal week). Graph shows that influenza case numbers overall were high in 2024/25 over a number of weeks, but we did not experience the peak seen in 2022/23.

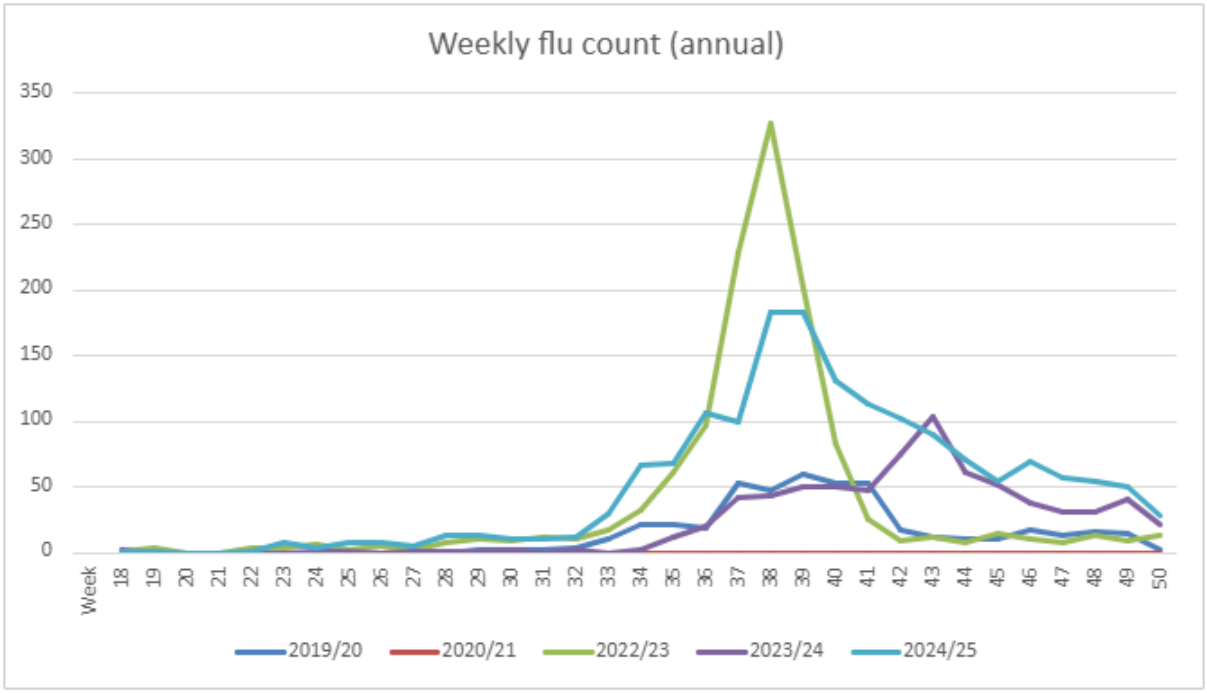



Table 43: Graph of RSV cases by year and week number (fiscal week)

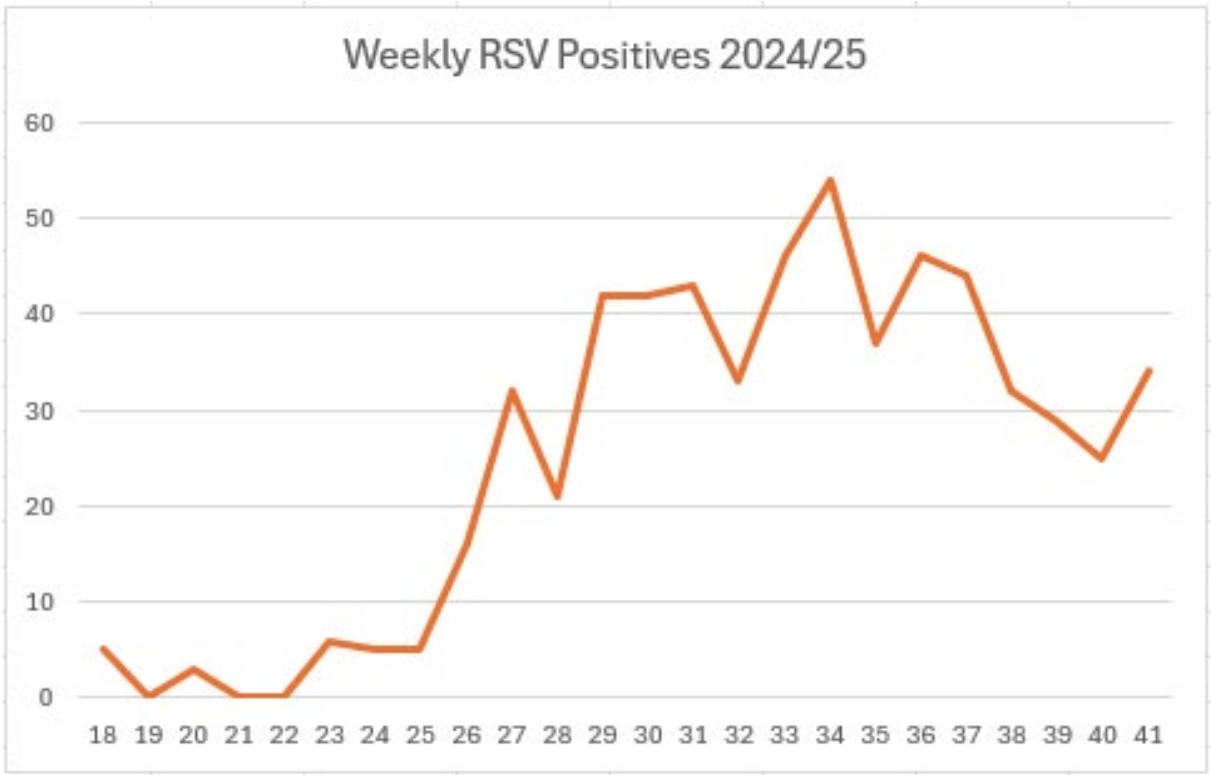
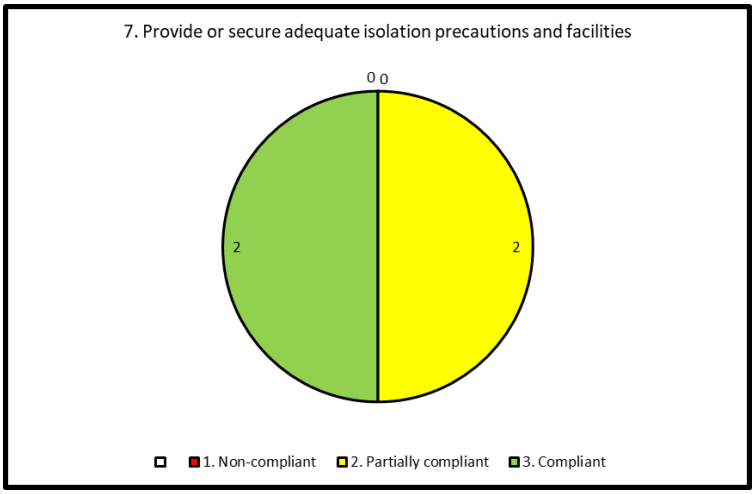


Figure 7: BAF Compliance to Criterion 7




| Partial Compliant Elements to the BAF | Reason for Partial Compliance | Actions to Achieve Compliance |
|---|---|---|
| Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status. | Loss of IPC surveillance system, with only partial mitigation. IPC need access to patient level data on side-room availability and reason for isolation to ensure decisions about patient placement and prioritisation of patients for limited side rooms is optimally informed. No replacement system confirmed.<br>Lack of recognition of biohazard flags. | Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support. |
| Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if:<br>• single rooms are in short supply and if there are two or more patients with the same confirmed infection.<br>• there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and | Loss of IPC surveillance system, with only partial mitigation. IPC need access to patient level data on side-room availability and reason for isolation to ensure decisions about patient placement and prioritisation of patients for limited side rooms is optimally informed. No replacement system confirmed.<br>Lack of recognition of biohazard flags.<br>Work done with the EPR team for the IPC team to access sideroom information via Cerner capacity management module has not been able to supply the required information. | Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with ward level data and service continuity support. |

| | | |
|---|---|---|
| processes are in place to mitigate risk. | | |

## 9 Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

### 9.1 Role of the Microbiology Laboratory

OUH has a dedicated in-house Microbiology Laboratory which provides a 24/7 service with United Kingdom Accreditation Service (UKAS) accreditation (ISO-15189). A Microbiology Consultant and SpR are available 7 days a week to provide IPC advice and support. The Microbiology clinical team also provide out of hours IPC support to Oxford Health as required. The IPC team attend the Microbiology ‘plate’ round daily, and present cases and issues for discussion.

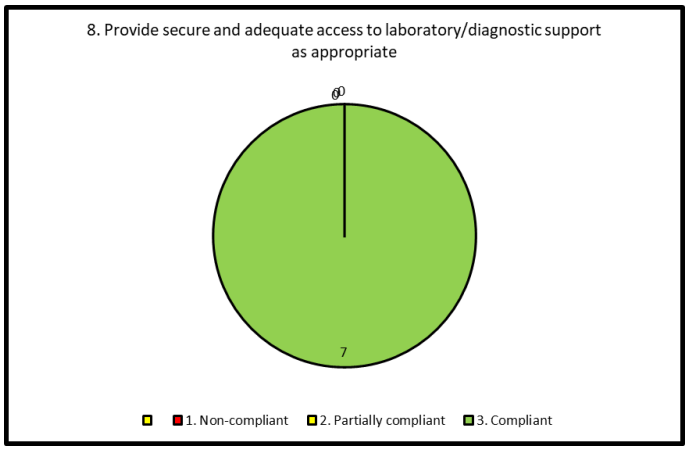
The Microbiology LIMS was replaced in March 2025, leading to the complete loss of functionality of the IPC surveillance system for real-time alert organism flagging. This has been partially mitigated by the production of daily organism reports by microbiology for IPC but with the loss of real-time reporting. EPR message box results have been set up for real-time reporting of respiratory pathogens of IPC interest. The OUH Digital Engineering Service is working on a web-based alerting system. A business case for a new surveillance system (eg ICNet) has not progressed.

The laboratory supports IPC investigations such as environmental swabbing as part of outbreak investigation.

During 2024/25 the microbiology point of care team supported by the IPC team implemented point of care respiratory virus testing in emergency admission areas (JR and Horton) to allow rapid patient diagnosis and appropriate triage, minimising operational pressures. Revised respiratory virus testing guidance was implemented to reduce the use of high-cost respiratory virus panel testing. Comparing Sept 23 -Mar 24 with Sept 24 - Mar 25, a total cost saving of £180K has been achieved by diverting tests to cheaper test panels and point of care testing without any identified negative clinical impact.

The Oxford University NIHR HPRU in Healthcare Associated Infections and Antimicrobial Resistance supports IPC Investigation with pathogen sequencing e.g. ESBL producing organisms on the neonatal unit, and ‘big-data’.

Figure 8: BAF Compliance to Criterion 8




## 10 Criterion 9

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

### 10.1 Sepsis

The sepsis team have been working as an established team of 4 since implementation of the IPC business case in 2023 and have been undertaking cross site cover of the OUH including the Churchill and Horton General Hospital.

**Paediatric Sepsis**

In September 2024, the sepsis team successfully recruited a dedicated paediatric sepsis nurse on a fixed-term basis. This appointment followed a Serious Incident Requiring Investigation (SIRI), which identified significant gaps in paediatric sepsis training and education across the Trust.

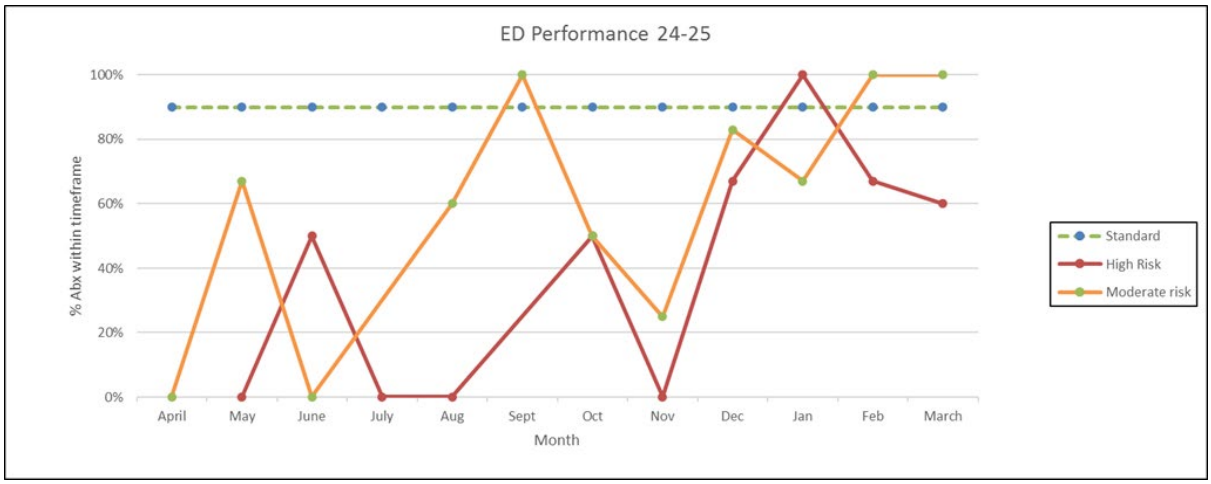
Various education and training initiatives have been developed by the sepsis team including:

- Delivery of sepsis education to the paediatric workforce, including sessions as part of the Level 2 Critical Care course and critical care teaching.
- Development of a paediatric sepsis e-learning package, which is currently under review by the lead paediatric infectious diseases consultant and the sepsis clinical lead.
- Delivery of several sepsis workshops across the Trust.

### 10.1.1 Quality Improvement

The sepsis team completed a retrospective 12-month (April 2024-March 2025) audit focusing on compliance with time to antibiotics in children presenting to the Emergency Department with suspected sepsis (Table 44).

Table 44. Paediatric Emergency Department performance against sepsis antibiotic time targets, April 2024–March 2025.

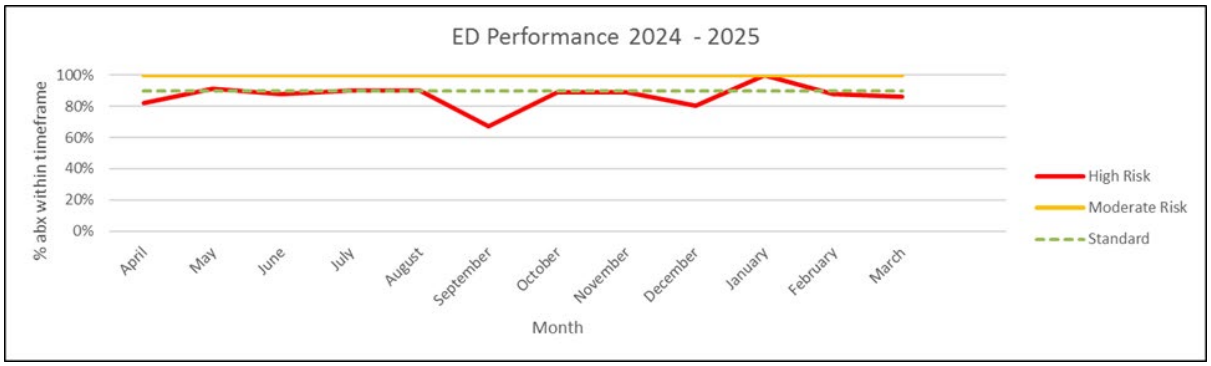



The introduction of a dedicated paediatric sepsis nurse at the end of September 2024 appears to correlate with a notable improvement in ED performance for both high- and moderate-risk sepsis patients:

### 10.1.2 Antibiotics Within One Hour of Sepsis Diagnosis

The sepsis team continues to support timely recognition and treatment of sepsis through active clinical involvement. Patients are flagged with a sepsis alert to ensure prompt assessment and timely administration of antibiotics, in accordance with NICE guidelines (Table 43)

Table 45. ED Sepsis performance – Antibiotics within 1 hour of a sepsis diagnosis in those who meet the high and moderate risk criteria for sepsis April 2024-March 2025.




OUH consistently achieved over 90% compliance with the 1-hour antibiotic target for high-risk sepsis patients in ED.

## 10.2 Ventilator Associated Pneumonia (VAP) Working Group

In 2024/25 the VAP group established an audit programme and re-introduced a VAP reduction bundle. A group has representatives from all adult and children's intensive care areas, IPC, Infectious Diseases and clinical risk practitioners.

The coding team provided the IPC team with numbers of patients coded for a VAP in 2023-24, which was 106 spells, and 53 spells in 2024/25, a 50% reduction.

Low VAP rates have been confirmed on audits of VAC (ventilator associated condition) and iVAC (infection related ventilator associated complication) Feb - July 2024 on OCC and CICU as defined by CDC criteria using automated surveillance tool.

Rates of compliance with the VAP prevention bundle are 85%-98% across 6 audits (3 per ICU (OCC and CICU).

## 10.3 Appropriate Glove Usage / Gloves Off Campaign

The IPC business case included recruitment of a decontamination practitioner. Implementation of findings from a recent decontamination audit in the endoscopy decontamination unit at the JR has resulted in cost savings of £10,000 in 2024/25 compared with 2023/24 through a reduction in the inappropriate use of sterile gloves.

## 10.4 Audits

### 10.4.1 Vascular device audit

The IPC team undertook a vascular device audit in May 2024. This took place during hand hygiene week 6th – 10th May. The team saw 679 patients and observed 356 peripheral cannulas. The results demonstrate a lower compliance in all key criteria than reported in the previous audit in November 2022.

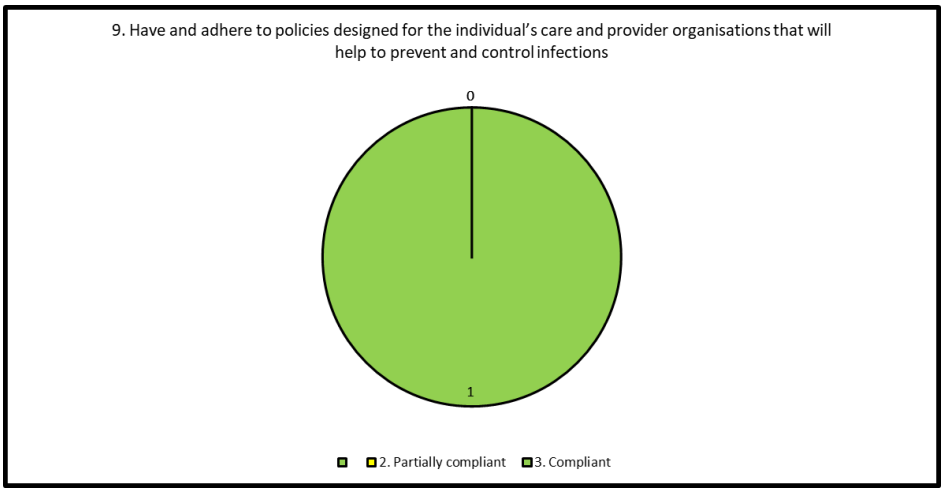
33% of peripheral cannulas were noted to be sited in the antecubital fossa (ACF). The ACF has been identified previously as a theme in association with MSSA bacteraemia, as well as peripheral cannulae inserted in emergency settings and those with prolonged dwell times (Ref: Trinh TT et al Infect Control Hosp Epidemiol. 2011).

Results have been shared at department level and areas requiring improvements advised to develop action plans. Other actions include continuing to work with education team around cannula site location, and work with the assurance team to be able to scrutinise quarterly audit results.

Table 46: Results of vascular device audit by question, comparing November 2022 and May 2024

| | Nov 2022 | May 2024 |
|---|---|---|
| Areas audited | 33 | 34 |
| Patients | 562 | 679 |
| Peripheral cannulas | 309 | 356 |
| Documented on EPR | 84% (261) | 78% (276) |
| VIP score recorded once per shift | 69% (212) | 63% (223) |
| Still indicated for use | 82% (252) | 67% (239) |
| Dressing clean, dry and intact | 91% (282) | 87% (310) |

Figure 9: BAF Compliance to Criterion 9




## 11 Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

### 11.1 Staff Health

The Centre for Occupational Health and Wellbeing (COHWB) are members of HIPCC and present a twice-yearly report, including data on needlestick injuries. Support for staff sustaining a needlestick or sharps injury is available 24/7, supported out of hours by the Microbiology on-call team. No reported blood borne virus transmission to staff has been reported in 2024-25.

In 2024-25, Winter Staff Vaccination programme was delivered by 149 peer vaccinators delivering both Influenza and COVID-19 vaccination for OUH staff.

OUH Staff Influenza and COVID-19 vaccine rates 2024-25 season:

- Final percentage for influenza vaccination in front line HCW: 43%
- Final percentage for COVID-19 vaccination in front line HCW: 27.4%
- Total No. of HCW's involved with direct patient care: 10,688.

In addition to routine staff immunisation activities, in response to the 2022 outbreak of Mpox, COHWB have supported staff immunisation for staff at risk of MPox exposure.

Mpox Vaccine: A total of 49 out of 89 eligible staff members received the Mpox vaccine between 2024 and 2025, including those attending for their second dose. During the same period, 39 staff members declined vaccination.

Measles and hepatitis B vaccination status and varicella zoster immunity is assessed for all staff on pre-employment checks.

Staff measles vaccination data was reviewed as part of the response to the current national measles outbreak. Between 2024 and 2025, COHWB tested 499 OUH staff members for measles immunity. Of these, 409 had detectable antibodies, 72 had either an equivocal result or no antibodies, and for 17 individuals, no result has been recorded by clinicians.

During the same period, we administered 16 first doses and 21 second doses of the MMR vaccine, with no single measles-only vaccinations given.

This suggests that approximately 35 individuals may have either been missed, did not attend (DNA), or are still pending follow-up.

Communication about the importance of staff immunity to measles and access to immunisation has been sent to all staff via the corporate communications system.

Measles and Shingles: There were no cases of measles or shingles contact requiring contact tracing recorded between 2024 and 2025.

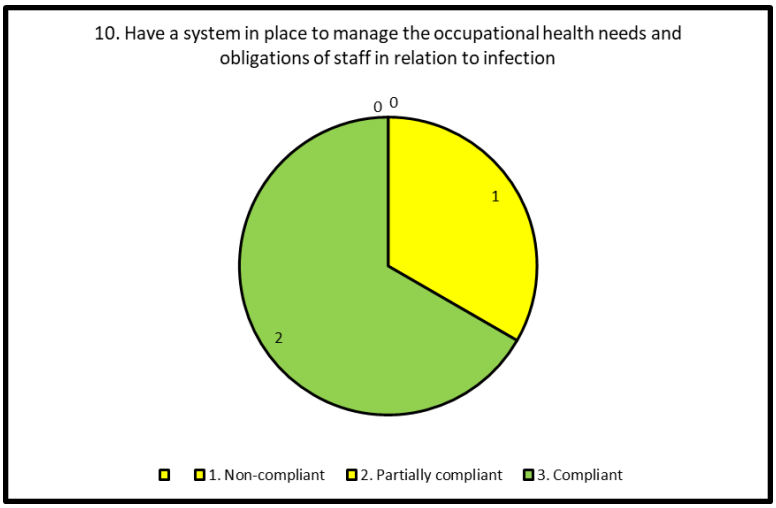
Pertussis exposure: One incident of pertussis exposure was recorded between 2024-2025. All individuals were assessed as having no significant exposure, and no further action was required.

Meningococcal exposure: Between 2024 and 2025, 4 potential incidents of staff meningococcal exposure were reported across the following departments: Theatre, Paediatric Intensive Care Unit (PICU), Emergency Department, and the Emergency Assessment Unit (EAU). Following a thorough risk assessment, it was determined that staff within the EAU did

not experience a significant exposure and therefore did not require further intervention. However, as a precautionary measure in alignment with public health guidelines, a total of 27 employees across the remaining departments received ciprofloxacin chemoprophylaxis. All appropriate protocols were followed to ensure the health and safety of staff, and there were no episodes of infection recorded.

Mycobacterium Tuberculosis exposure: Between 2024 and 2025, TB exposure was recorded among 14 staff members: 7 in the Mortuary Department and 7 within the Respiratory Medicine Unit. A recent IGRA test identified two staff members with positive results, though neither is currently experiencing symptoms of active TB. Investigations are ongoing.

Figure 10: BAF Compliance to Criterion 10




| Partial Compliant Elements to the BAF | Reason for Partial Compliance | Actions to Achieve Compliance |
|---|---|---|
| Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting. | A system of health risk management is currently not in place for skin health (COSHH Regulations). | A system of organisational (regular) skin checks is required to ensure cases of occupational dermatitis are identified. Occupational Health are currently developing a guidance document outlining the system required for organisational legal compliance. |

## 12 Conclusion

This report details the work of the IPC teams over 2024-25 and is set against the Health and Social Care Act (2015) criterion.

## 13 Recommendations

The Trust Board is asked to note the report.

# 10. LEARNING FROM DEATHS ANNUAL REPORT 2024-25

## REFERENCES

Only PDFs are attached

09 TB2025.77 Learning from Deaths Annual Report 2024-25.pdf

Oxford University Hospitals
NHS Foundation Trust

**Public Trust Board Meeting: Wednesday 10 September 2025**

**TB2025.77**

| | |
|---|---|
| **Title:** | **Learning from deaths annual report 2024/25** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **Annual report** |

| | |
|---|---|
| **Board Lead:** | **Chief Medical Officer** |
| **Author:** | **Jonathan Carruthers – Clinical Outcomes Manager,**<br>**Helen Cobb – Head of Clinical Governance,**<br>**Dr Rustam Rea – Director of Safety and Effectiveness, Deputy Chief Medical Officer** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance** |

## Executive Summary

1. During 2024/25 there were 2761 inpatient deaths reported at Oxford University Hospitals NHS Foundation Trust (OUH) with 2727 (99%) of cases reviewed within 8 weeks (as per policy). 100% of all deaths have now been reviewed.
2. The background, process and governance process for mortality reviews is detailed in this report.
3. Trust HSMR is 94.6 for April 2024 to March 2025. The HSMR is banded as 'lower than expected' (95% CL 90.2-99.1).
4. The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2024 to December 2024 is 0.91 which is banded as 'as expected.'
5. There were no diagnoses with a higher-than-expected SHMI.
6. There were no reported 'avoidable' deaths during 2024/25.
7. The current corporate risks relating to mortality are listed in the report.
8. Key actions and learning points identified in mortality reviews completed during 2024/25 are presented in this paper.
9. Quarterly reviews of Learning from Deaths were presented in November 2024, January 2025, May 2025, and July 2025. This annual report is a combination of these quarterly reports - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).

## Recommendations

10. The Trust Management Executive is asked to note the contents of this report for information, ahead of 10 September Trust Board.

## Contents

# Learning from deaths annual report 2024/25

## 1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for 2024/25.

1.2. Perinatal mortality reviews are reported separately in the Perinatal Mortality quarterly reports.

## 2. Background

2.1. OUH is committed to accurately monitoring and understanding its mortality outcomes; and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains[1] set out in the NHS Outcomes Framework:

- Preventing people from dying prematurely.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

2.2. OUH uses the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. Although these are not direct measures of the quality of care, benchmark outcome data help identify areas for investigation and potential improvement.

2.3. Trust HSMR is 94.6 for April 2024 to March 2025. The HSMR is banded as 'lower than expected' (95% CL 90.2-99.1).

2.4. The Summary Hospital-level Mortality Indicator (SHMI) for the data period January 2024 to December 2024 is 0.91 (95% CL 0.87-1.15) which is banded as 'as expected.'

2.5. There were no diagnoses depicted with a higher-than-expected SHMI.

2.6. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.

2.7. All patients undergo a level 1 or level 2 mortality review. The level 1 review is allocated to the responsible Consultant via the electronic patient record (EPR). In most departments all deaths also undergo a more comprehensive level 2 review. In a few departments with high number of deaths, a minimum of 25% of Level 1 reviews are selected at random for a Level 2 review.

[1] About the NHS Outcomes Framework (NHS OF) - NHS Digital

2.8. A Level 2 review is also completed for all cases in which concerns are identified at the Level 1 review. The level 2 review is carried out by one or more consultants not directly involved in the patient's care.

2.9. A structured judgement review (SJR) is required if the case complies with one of the mandated national criteria - NHS England » Learning from deaths in the NHS. All Inquests where there are concerns about the quality of care will have a mortality review and all SJRs that will be presented to Inquest are reviewed and discussed at MRG.

2.10. The SJR's are completed by a trained reviewer not directly involved in the patient's care.

2.11. Each Division maintains a log of actions from mortality reviews (of any type) and monitors progress against these action plans. Actions are recorded using the Ulysses system. The clinical units are responsible for disseminating learning and implementing the actions identified.

2.12. Mortality related actions are reported quarterly to the MRG and included in Divisional quality reports presented to the Clinical Governance Committee (CGC).

2.13. The Divisions also provide updates to MRG on the previous quarter's actions as part of the next quarter's mortality report. MRG reports to the Clinical Improvement Committee (CIC).

2.14. All deaths also undergo independent scrutiny from the Medical Examiner's office.

## 3. Mortality reviews completed during 2024/25

3.1. During 2024/25 there were 2761 inpatient deaths reported at OUH with 2727 (99%) of cases reviewed within 8 weeks.

**Table 1: Number of mortality reviews 2024/25**

| Reporting period | Total deaths | Reviews completed within 8 weeks | | | Total reviews completed* |
|---|---|---|---|---|---|
| | | Level 1 | Level 2 & SJR | Total | |
| 2023/24 (Q1-4) | 2762 | 2731 (99%) | 1294 (47%) | 2741 (99%) | 2762 (100%) |
| 2024/25 (Q1-4) | 2761 | 2727 (99%) | 1199 (43%) | 2727 (99%) | 2761 (100%) |

*Including reviews completed after 8 weeks

3.2. Divisions with deaths which were not reviewed within 8 weeks (as per policy) were requested to complete a Level 1 screening review; compliance was monitored via MRG. All deaths during 2024/25 have now been reviewed.

3.3. No structured review completed in 2024/25 deemed any death to be 'avoidable'.

## 4. Examples of key learning & actions from mortality reviews by quarter

4.1. **In quarter one:** Mortality reviews completed during quarter one identified issues with care during transfers across the Complex Medical Unit (CMU) wards during the night. A risk was identified with out of hours transfers and increases in patient deterioration/death. Therefore, a new Standard Operating Procedure (SOP) was developed in MRC and agreed at Directorate and Divisional governance for transfers out of hours from the CMU wards. This has ensured more appropriate and safer transfer of vulnerable patients.

4.2. **In quarter two:** Different clinical opinions in relation to one SJR highlighted the importance of involving all who were involved in the care of the patient to gain their perspective. This is particularly important if there are concerns about the care of the patient. The Trust mortality review policy and structured review training materials were updated to reflect this. These updates were presented and approved at the MRG meeting in October 2024. Any SJR to be submitted to the coroner in relation to an Inquest is also now reviewed at MRG prior to the inquest to ensure actions resulting from the learning are expedited.

4.3. **In quarter three:** In Neurosciences it was identified during one review that a patient missed a dose of Dalteparin because it was not available to administer to the patient. Although this omission was not thought to have contributed to the death of the patient, key actions were taken to avoid this happening again These included reviewing the Neurosciences stock of Dalteparin and providing training to nursing staff regarding the process for ordering urgent medications via pharmacy. These actions have been effective, with no further missed doses of Dalteparin reported.

4.4. **In quarter four:** A learning response and mortality review were conducted for a patient who deteriorated and died. It was identified that earlier recognition of the deterioration could have provided an opportunity to consider a trial of non-invasive ventilation (NIV) and facilitate referral to the respiratory team. It was agreed that this would not have affected the outcome for the patient. System for Electronic Notification and Documentation (SEND) observations will be reviewed during the ward board round to identify patients who may be deteriorating, so they can be escalated to the appropriate team. The local governance team will monitor this change in practice to ensure consistent implementation.

4.5. Quarterly Learning from Deaths reports containing more detailed summaries of the learning arising in each quarter can be found here - Board meetings and papers - Oxford University Hospitals (ouh.nhs.uk).

## 5. Examples of learning and actions from incidents and investigations with an impact of death

5.1. Review of the patient streaming area and processes in Emergency Department at the Horton General Hospital. It was identified that the nurse responsible for streaming could be easily interrupted leading to a break in their workflow with potential impact on their assessment. A screen has been installed to reduce distractions. In addition, only band 6 and 7 nursing staff are now allocated to streaming.

5.2. An amylase level is now routinely performed for all patients who present with significant abdominal pain to the Emergency Department as part of the non-specific abdominal pain Powerplan for patients who present to the ED. This will be monitored through audit and feedback at ED Clinical Governance monthly meetings.

5.3. A Quality Improvement project on the short stay wards has been commenced on managing patients who are at the end of their life. This includes looking at effective communication, symptom management, and breaking bad news to patients and families. Staff have attended teaching sessions led by the palliative care team. Simulation training has been undertaken by staff to help them to practice breaking bad news.

5.4. The Nutrition Support Nurses Team has provided education and training sessions to the Blenheim Ward nursing team focusing on post percutaneous endoscopic gastrostomy (PEG) insertion care and ongoing PEG care management. This is now part of the induction for all new nursing and resident doctors. An intranet resource page has been developed as an ongoing reference guide and was launched in June 2024.

## 6. Corporate Risk Register and related Mortality risks

6.1. Relevant mortality risks from the Corporate Risk Register can be seen below:

6.2. Failure to care for patients correctly across providers at the right place at the right time.

6.3. Trust-wide loss of IT infrastructure and systems (e.g., from Cyber-attack, loss of services etc).

6.4. Failing to respond to the results of diagnostic tests.

6.5. Patients harmed because of difficulty finding information across two different systems (Paper and digital).

6.6. Lack of capacity to meet the demand for patients waiting 52 weeks or longer.

6.7. Lack of ability to achieve the 85% of patients treated within 62 days of cancer diagnose across all tumour sites.

## 7. Mortality Review Governance

5.1 A quarterly summary of Directorate and Divisional mortality reports from their respective mortality and morbidity reviews are presented to the monthly MRG Chaired by the Director of Patient Safety and Effectiveness.

7.1. Monthly MRG summary reports are then presented to the Clinical Improvement Committee (CIC) which is Co-Chaired by the Director of Clinical Improvement and a Divisional Nurse.

5.2 CIC reports to CGC, Chaired by the Chief Medical Officer or the Chief Nursing Officer.

5.3 CGC reports via Trust Management Executive to the Integrated Assurance Committee (subcommittee of the Trust Board).

## 8. Conclusion

8.1. The Trust can report good compliance with local and national mortality review policy and guidance.

8.2.

8.3. This paper summarises some of the learning identified in the mortality reviews completed during 2024/25.

## 9. Recommendations

9.1. The Trust Management Executive is asked to note the contents of this report for information, ahead of 10 September Trust Board.

# 11. COMBINED EQUALITY STANDARDS REPORT 2025 (INCL. WRES/WDES/GPG/EDS)

## REFERENCES

Only PDFs are attached

10 TB2025.78 Combined Equality Standards Report 2025.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.78**

| | |
|---|---|
| **Title:** | **Combined Equality Standards Report 2025 (incl. WRES/WDES/GPG/EDS)** |

| | |
|---|---|
| **Status:** | **For Decision** |
| **History:** | **P&C SLT 28 July 2025** |
| | **P&C Committee 11 August 2025** |
| | **TME Thursday 14 August** |
| | **EDI Steering Group Thursday 21 August** |

| | |
|---|---|
| **Board Lead:** | **Chief People Officer** |
| **Author:** | **Tommy Snipe – Equality, Diversity, and Inclusion Manager** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Strategy / Assurance** |

## Executive Summary

1. At OUH we are committed to making improvements on equality, diversity, and inclusion (EDI) for our people. In support of this, we conduct an annual review against the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Gender Pay Gap (GPG) and are proactively delivering against the High Impact Actions (HIAs) of the NHS EDI Workforce Improvement Plan. We also maintain compliance with the Equality Delivery System (EDS). This report summarises key findings against the WRES, WDES, and GPG metrics, as aligned to the HIAs, and recommends priority areas to enable further improvement.
2. Against each of the HIAs, the following findings were made:
3. One HIA1, all Chief Officers now have identified individual EDI objectives to which they will be held individually and collectively accountable.

    - On HIA2, there has been progress made on progression for BME staff in clinical roles with increases in BME representation in Bands 8a - 8c. Also, data indicates near equity at interview stage for BME and disabled applicants. However, more work is required, as perception of equality opportunities for career progression and promotion has decreased for all staff.
    - On HIA3, there has been a small decrease in the mean gender pay gap, but a small increase in the median gap and the proportion of women in the highest paid quartile has decreased. Intersectional pay gap analysis also shows the compounding effect of sex and race inequity with BME women having the largest pay gaps. All data shows a need to support progression of BME staff and women, particularly in medical and dental roles.
    - On HIA4, there has been improvement over time on percentage of staff feeling pressure from their manager to come into work despite not feeling well enough, although a gap still exists for disabled staff. Additionally, the percentage of disabled staff who said they came in despite not feeling well enough is significantly higher than for non-disabled staff. This demonstrates a need to address presenteeism for disabled staff.
    - On HIA5, there has been a decrease in internationally educated colleagues (IECs) scores relating to learning, development, and progression, representing potential issues there. Scores relating to feeling of belonging also remain lower for IECs compared to domestically educated colleagues.
    - On HIA6, there have been minor improvements across many of the metrics relating to bullying and harassment. There was an increase of BME staff who said they experienced discrimination from managers and/or colleagues demonstrating a need to focus on addressing racial discrimination moving forwards.

4. Our EDS submission was graded by independent stakeholder panels who scored 8 outcomes as ‘Achieving’ and 3 outcomes as ‘Developing’.
5. Analysis of the metrics and a review of the current progress and planned activity (see Appendix 1) has led to the identification of five areas that the Trust should prioritise to support further improvement:
    - Data (Enabling Activity) – The Trust should undertake a campaign to address non-disclosure of protected characteristic data and create a culture where people feel safe to disclose. The Trust should also triangulate data concerning recruitment and access to development opportunities beyond the WRES and WDES metrics to identify further areas for improvement.
    - Talent Management and Career Progression (HIA2 & HIA3) – The Trust should build on People Plan commitments around career pathways to support progression for women, IECs, and BME staff. This should include consideration of positive action approaches like ring-fenced spaces on the Trust’s Leadership Development Programme.
    - Presenteeism (HIA4) – The Trust should ensure the needs of disabled staff are met in People Plan commitments to develop a wellbeing programme that reduces sickness absence and presenteeism. Consideration should be given to enabling disabled staff to feel safe to take sick leave, perhaps through use of reasonable adjustments.
    - Integration of IECs (HIA5) – The Trust should explore ways to support integration of IECs within their local teams and consider approaches, such as Cultural Competency training, that develop the capability of teams to work cross-culturally.
    - Discrimination (HIA6) – The Trust should focus on racial discrimination in upcoming phases of the Eradication of Bullying and Harassment Programme and should engage with BME staff to co-create solutions. This could include using specific examples concerning racial discrimination in implementation of the planned Active Bystander Training.

## Recommendations

6. The Trust Board is asked to:
    - Note the progress made against the HIAs; and
    - Note the WRES, WDES, and GPG metrics in the accompanying data pack, and
    - Note the EDS Gradings in Appendix 2, and
    - Commit to the recommended priorities for improvement.

## Contents

# Combined Equality Standards Report 2025 (incl. WRES/WDES/GPG/EDS)

*A note on language. When discussing ethnicity, we use the term Black and minority ethnic (BME) to be consistent with the terminology used by NHS England in the WRES and the NHS EDI Workforce Improvement Plan.*

## 1. Purpose

1.1. The purpose of this report is to:

1.1.1. Report, and provide analysis on, the success measures of the High Impact Actions (HIAs) within the NHS England Workforce Equality, Diversity, and Inclusion (EDI) Improvement Plan.

1.1.2. Demonstrate compliance with the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap Reporting Requirements (GPG), and Equality Delivery System (EDS).

1.1.3. Provide an update on progress against the HIAs and planned action to support further improvement.

1.1.4. Make recommendations for further action as required.

## 2. Background

2.1. The Trust is required to report against the WRES, WDES, and EDS annually as part of the NHS Standard Contract. Annual reporting on the GPG is required by the Gender Pay Gap Reporting Legislation.

2.2. In July 2023, the NHS England Workforce EDI Improvement Plan was published which set out 6 HIAs that NHS organisations are expected to deliver on. WRES, WDES, and GPG metrics are aligned to the HIAs.

2.3. WRES and WDES Metrics were submitted to NHS England by the deadline of 31st May 2025. The Trust is required to analyse this metrics and produce a report and action plan by 31st October 2025.

2.4. The Trust EDS report was due to be published by 28th February 2025. To support streamlining of EDI activity, the Trust decided to incorporate EDS reporting alongside other EDI reporting requirements.

2.5. GPG metrics are required to be submitted to the Government Equalities Office by 31st March 2026. There is no statutory requirement for a GPG action plan, however the Trust chooses to identify actions as part of its commitment to reducing the gap.

2.6. This report provides an analysis of the metrics aligned to each HIA and provides recommendations to support further progress as well as

improvement against the WRES, WDES, and GPG metrics. 2.6. A summary of the WRES, WDES, and GPG metrics, as aligned to the HIAs, can be found in the accompanying Combined Equality Standards Report Data Pack.

## 3. Key Findings from HIA Success Measures

3.1. This section presents some of the key findings in relation to the success measures against each HIA. This includes the 2025 WRES, WDES, and GPG metrics.

3.2. This section references metrics from the accompanying Combined Equality Standards Report Data Pack. A reference code has been given to each individual metric in the format HIAX.X.

**High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.**

3.3. There is no data related to this metric, however, since 2023 all Chief Officers have identified individual EDI objectives against which they have been held individual and collectively accountable. We are awaiting the agreement of the 2025 NED EDI Objectives; this will be the first time they have been implemented.

**High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.**

3.4. Last year's report noted the representation of BME staff in clinical roles was significantly less in Band 7 and above compared to Band 6 and below (HIA2.1). This lack of representation still exists, however there has been some increases in representation in Bands 8a (+2.3%), 8b (+3.0%), and 8c (+2.9%). This demonstrates some positive movement in increasing senior BME representation. Additionally, the relative likelihoods of appointment from shortlisting for BME and Disabled staff (HIA2.2 and HIA2.7) are within the acceptable ranges at 1.01 and 0.95 respectively, indicating the interview processes are not a barrier for these staff groups.

3.5. Despite this progress, HIA2.5 and HIA2.8 show a decrease in all staff believing the Trust provides equal opportunities for career progression and promotion, with this decrease being larger for both BME and Disabled staff. Scores for these metrics are also consistently poorer for BME and Disabled staff compared to their counterparts. Feedback gained through Growing Stronger Together sessions held with our Staff Networks,

indicates access to development opportunities and perceptions of inequities in recruitment processes are contributors to these scores.

3.6. Whilst HIA2.3 shows for the past two years there is nearly equity in the proportion of BME and white staff accessing non-mandatory training, this metric only captures data from My Learning Hub and therefore does not include development opportunities that are not logged on that system, for example, courses managed by clinical and medical education teams, apprenticeships, and other courses delivered by external providers. Triangulation of this data may help the Trust to determine whether access to development opportunities are leading to the decreases in HIA2.5 and HIA2.8.

3.7. Disability non-disclosure remains an issue with 17.95% of staff having not disclosed which impacts the accuracy of metrics using ESR data. Work on improving the disclosure rate will continue, focussing on ensuring people feel safe to disclose and that they understand the importance of disclosing.

**High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps.**

3.8. There has been a small reduction in the mean gender pay gap of 1.3% but a small increase in the median gender pay gap of 1.9% (HIA3.1). Reductions in the mean pay gap came despite decreases in the proportion of women in the two higher paid quartiles of the Trust (HIA3.4); although this is a key contributor in the worsening of the median pay gap. The reduction in mean pay gap is instead largely explained by a reduction in the proportion of women in the lowest paid quartile.

3.9. Analysis of gender pay gap by Division (HIA3.11) shows how the pay gap is largely led by the clinical and medical & dental workforce with Corporate having a mean pay gap of 0.5%. NOTSSAN has the largest mean and median pay gaps at 29.1% and 24.6% respectively, whereas SUWON's pay gaps are heavily in favour of women with a mean at -35.1% and median at -11.4%. This significant variation identifies a need to focus on local approaches to address pay gaps.

3.10. There has been a significant reduction in the mean and median bonus gender pay gaps of 40.6% and 87.6% respectively (HIA3.2). This reduction was expected as no onwards payments have been made in the financial year. This reduction in bonus pay gap can also be seen across ethnicity pay gaps (HIA3.7) and disability pay gaps (HIA3.10).

3.11. HIA3.6 shows that both the mean and median ethnicity pay gap has increased, by 4.2% and 10.7% respectively. When broken down by ethnic grouping shows that Black staff have a significantly higher pay gap than other ethnic grouping at 31.1% mean and 27.8% median (HIA3.7). This

adds to the concerns relating to progression of BME staff outlined in findings under HIA2 and demonstrates that approaches to addressing that must account for differences between ethnic groups with specific focus needed on supporting Black staff.

3.12. Intersectional pay gap analysis on sex and ethnicity (HIA3.8) has been included for the first time this year. The data shows the compounding impact of sex and racial inequity with BME women having the largest mean and median pay gaps of all groups; for example, the mean pay gap is 13.7% higher than it for BME men and 10.5% higher than it is for White Women. This demonstrates a need to ensure interventions consider intersectionality in their development.

3.13. Ethnicity pay gaps by Division (HIA3.11) again show a lower pay gap in Corporate compared to most Clinical Divisions, however to a much lesser extent with a mean gap of 12.5% and a median gap of 7.4%. This demonstrates that barriers to progression for BME staff are less restricted to the clinical and medical & dental workforce. MRC has the highest ethnicity pay gap with a mean of 23.6% and a median of 23.7%.

**High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.**

3.14. There are improvements in the percentage of staff who said they felt pressure from their manager to come into work when not feeling well enough (HIA4.1) for both disabled (2.2% decrease) and non-disabled staff (2.9% decrease). This is a positive although scores are still worse for disabled staff at 23.6% compared to 13.6% for non-disabled staff.

3.15. Whilst not WDES metrics themselves, other health and wellbeing questions from the staff survey identify further concerns relating to presenteeism for disabled staff. Notably, the percentage of staff who came into work despite not feeling well enough is significantly higher for disabled staff (70.4%) than it is for non-disabled staff (47.2%). This score has also seen a decline for all staff over the past year increasing by 0.4% for disabled staff and 3.3% for non-disabled staff.

**High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.**

3.16. Scores for internationally educated colleagues (IECs) are higher than those of domestic colleagues on questions relating to learning and development (HIA5.5-5.9). This has been the case in the previous three years.

3.17. However, this year there has been a significant decline on many of these scores, notably the percentage of staff saying there are opportunities to develop their career (HIA5.6) dropped by 6.6% to 65.9% and the

percentage of staff saying they feel supported to develop their potential (HIA5.8) dropped by 6.0% to 62.6%. Scores for domestic colleagues improved over the same period by 2.8% and 3.6% respectively. Whilst scores remain higher for IECs, the magnitude of the drop indicates a potential concern around learning and development for IECs.

3.18. IECs have lower scores than domestic colleagues on questions relating to a feeling of belonging. They score 10.2% lower on the percentage of staff that enjoy working with colleagues in their team (HIA5.3) and 2.3% lower on the percentage of staff feeling the organisation respects individual differences (HIA5.4). Both questions have also seen an in-year decline in scores for both questions by 2.2% and 6.2% respectively. This indicates further support may be required to enable IECs to integrate within the Trust and their teams.

**High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.**

3.19. Since last year, there has been minor improvements on most metrics relating to bullying, harassment and discrimination (HIA6.2-6.4 & HIA6.6-6.9), with exception of:

3.19.1. Percentage of BME staff who experienced discrimination from a manager or colleague (HIA6.4) rose by 2.3%.

3.19.2. Percentage of Disabled staff who experienced bullying or harassment from managers (HIA6.7) rose by 0.2%.

3.19.3. Percentage of non-disabled staff who said they reported their last experience of bullying and harassment (HIA6.9) dropped by 1.6%.

3.20. The overall improvements, whilst not significant (greater than 3% difference) are part of a trend over time in reduction of bullying and harassment for staff which can be seen in the data. However, there are still gaps in the experience of BME and Disabled staff compared to white and non-disabled staff across all metrics.

## 4. Progress Against the HIAs

4.1. The Trust has undertaken a range of activity to progress against the HIAs. Examples include:

4.1.1. Identifying individual EDI objectives for our Non-Executive Directors for 2025 (HIA1).

4.1.2. Implementation of Inclusive Recruitment Training with a requirement all recruitment panels include one trained member (HIA2).

4.1.3. Implementation of a comply or explain accountability measure in consultant recruitment (HIA3). The impact of this is currently being evaluated.

4.1.4. Undertaking a gap analysis against the Sexual Safety Assurance Framework and developing a programme of activity to progress this (HIA6).

4.1.5. Delivered the Better People Leaders programme to develop EDI capability of senior leaders (HIA1).

4.1.6. Progressed development and implementation of the Reasonable Adjustments policy and associated tools (HIA4).

4.1.7. Development of the IEC forum to provide a space to support IECs and for IECs to provide feedback to the Trust (HIA5).

4.1.8. Continued delivery of the Trust's Eradication of Bullying and Harassment Programme; including the launch of the Work in Confidence reporting platform (HIA6).

4.2. For a full summary of progress made against the HIAs and planned further activity, see **Appendix 1.**

## 5. Equality Delivery System

5.1. The services selected for assessment under Domain One were Pharmacy, Neurosciences, and Renal, Transplant & Urology. Evidence was collated for these services against outcomes within Domain One, and for the whole Trust against outcomes within Domains Two and Three.

5.2. Stakeholder panels were convened for each of the domains who reviewed the evidence and scored each outcome independently. The scores were then collated to provide outcome gradings. The Trust scored "Achieving" on 8 outcomes and "Developing" on 3 outcomes.

5.3. A summary of the gradings achieved and panel feedback can be found in **Appendix 2**.

5.4. The Trust agrees with the grades provided except for the following:

5.4.1. Outcome 2A – The Trust believes this should be "Developing" rather than "Achieving". Whilst the Trust has a comprehensive support offer in relation to mental health, the Trust recognises that support for other conditions named within the outcomes is not to the same extent.

5.4.2. Outcomes 2B and 2C – The Trust believes these should be "Achieving" rather than "Developing". The staff survey has shown a trend in reductions of bullying and harassment over time and the

Trust has a dedicated improvement programme that is led by the Chief Executive Officer. It was felt that the depth of the programme and the outcomes produced were not adequately reflected in the scoring.

## 6. Recommended Priorities

6.1. Following analysis of the metrics and review of the progress made against the HIAs, five priorities have been identified that will facilitate further improvement. These priorities are detailed below and, where required, include recommendations for further action in addition to those currently planned (See **Appendix 1**).

6.2. **Developing our Data (Enabling Activity)** – A consistent communications campaign involving Trust leadership should be undertaken to demonstrate the importance of disclosing protected characteristics and create safety for people to disclose. The Trust should also seek to look at data beyond what is required from mandated reporting. This should include exploring data relating to recruitment processes beyond interview stage, as well as triangulating data from other sources in relation to access to non-mandatory training to enable further progress on increasing representation at senior levels.

6.3. **Talent Management and Career Progression (HIA2 & HIA3)** - The Trust has a People Plan commitment on “career progression and development pathways”. Expansion of the Leadership Development Programme would provide an opportunity for this, especially if the target audience was increased to target those at Band 6 who are looking to move into higher-banded roles. Ringfenced places on the programme should be utilised as a positive action approach to accelerate improvement.

6.4. **Presenteeism (HIA4)** – In addition to the focus on enabling rapid access to NHS services to address health inequalities in the workforce, The Trust should consider approaches to prevent presenteeism amongst disabled staff. This will involve building on the People Plan commitment to “deliver a wellbeing programme to reduce staff sickness, burnout, and presenteeism”, ensuring the focus is given to the needs of disabled staff in the development of this programme.

6.5. **Integration of IECs (HIA5)** – The Trust should build upon the work it is doing with IECs to enable them to feel like they belong. Most of the activity so far has focussed on supporting IECs themselves; we need to also develop the services where IECs work to ensure they are equipped to support their integration.

6.6. **Discrimination (HIA6)** – The in-year rise in discrimination faced by BME staff demonstrates a need to specific focus on this as part of the Trust's Eradication of Bullying and Harassment campaign. The planned implementation of Active Bystander training provides a great opportunity to equip people with the skills to challenge discrimination should they witness it. Examples of racial discrimination will be embedded in the workshops to help staff recognise it. The Trust should also consider how BME staff, and other protected characteristic groups, can be involved as part of the co-creation of action plans to ensure they meet the needs of those staff.

## 7. Conclusion

7.1. Analysis across the metrics shows improvement in some areas, such as bullying and harassment and pay gaps, however there are still gaps in experience between staff with different protected characteristics.

7.2. Five priority areas have been identified to facilitate progress, four of these are aligned to HIAs and one is an enabling priority. Where applicable, these priorities also link in with the Trust's People Plan to build upon that work and maximise resource and capacity.

## 8. Recommendations

8.1. The Trust Board is asked to:

- Note the progress made against the HIAs; and
- Note the WRES, WDES, and GPG metrics in the accompanying data pack, and
- Note the EDS Gradings in Appendix 2, and
- Commit to the recommended priorities for improvement.

## 9. Appendix 1: Progress against the High Impact Actions

9.1. The below table provides an overview of the current state, and planned activity, against each of the High Impact Actions (HIAs) of the NHS EDI Workforce Improvement Plan. Activity that will enable progress against the HIAs and supports the EDI agenda has also been included.

| High Impact Action | Progress Status | Planned Activity |
|---|---|---|
| HIA1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. | • Chief Officers have identified individual EDI Objectives since 2023.<br>• Better People Leaders Programme delivered to increase core EDI capability of senior leaders. | • Agreement of 2025 EDI Objectives, including for Non-Executive Directors.<br>• Communication of Board EDI Objectives.<br>Cascade learning from Better People Leaders Programme and incorporate key lessons into existing leadership training. |
| HIA2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. | • Launched inclusive recruitment training with a requirement that all recruitment panels must have someone who has undergone the training.<br>• Developed material on Career Pathways, with a dedicated intranet site outlining career pathways for different groups and signposting to suitable development opportunities.<br>• Leadership development<br>• Promoted apprenticeship uptake. | • Enhance the inclusive recruitment training programme.<br>• Reduce shortlisting criteria and standardise the process.<br>• Embed Career Pathways work and support managers through creating a central repository of training opportunities for their specialty. |
| HIA3: Develop and implement an improvement plan to eliminate pay gaps. | • Implemented a ‘comply or explain’ intervention in consultant recruitment to embed accountability for decision-making and mitigate bias. | • Embed pay gap reporting into Divisional EDI Dashboard to create local accountability and responsibility for improving pay gaps.<br>• Evaluate impact of the ‘comply or explain’ intervention.<br>• Establish a working group that will maintain consistent oversight on pay gaps with the Trust and accelerate further action to improve them. |

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| HIA4: Develop and implement an improvement plan to address health inequalities within the workforce. | • Progressed implementation of Reasonable Adjustments Policy.<br>• Reviewed success of Menopause Health and Wellbeing Policy.<br>• Increased provision of breastfeeding and expressing spaces. | • Embed the new Reasonable Adjustments Policy<br>• Implement Rapid Access to NHS Services for staff. |
| HIA5: Implement a comprehensive induction, onboarding and development programme for internationally recruited staff. | • Re-introduced the overall Trust induction for all staff.<br>• Updated Welcome Pack for IECs to contain a greater range of support information and ensure welcome packs for nursing and medical colleagues are aligned.<br>• Developed the IEC forum and delivered a range of presentations focussing on topics such as career development. | • Deliver the 'Stay and Thrive' programme to support the retention of IECs.<br>• Deliver pilot of Cultural Competency Training. |
| HIA6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. | • Refreshed the Eradication of Bullying and Harassment strategy following outcomes of an internal audit to strengthen the programme.<br>• Progressed delivery of the dedicated Eradication of Bullying and Harassment campaign which includes:<br>  • Conducting a gap analysis against the Sexual Safety Assurance Framework and developing a plan to address gaps.<br>  • Rolled out Level 1 sexual safety training.<br>  • Rollout of Phase 2 of the 'No Excuses' campaign focussing of sexual safety.<br>  • Delivery of Respectful Resolutions and Leading with Kindness training to staff.<br>  • Created, consulted, an implemented the Respect and Dignity at Work (including sexual safety) Procedure. | • Procure, deliver, and embed Active Bystander Training.<br>• Deliver on priorities against the Sexual Safety Assurance Framework including, rollout of level 2 and 3 Sexual Safety training and developing central oversight of sexual safety cases.<br>• Continue the 'No Excuses' campaign with a focus on equal opportunities.<br>• Work on co-created action plans for areas that need support the most.<br>• Promote the WiC platform and the role of the FTSU team. |
| Enabling Activity | • Commissioned an audit to review EDI maturity and developed actions based on the outcomes of that audit.<br>• Supported Divisions in the development of their Divisional EDI Action Plans to enable local ownership and improvement of EDI.<br>• Supported development of Staff Networks and delivered workshops on Network governance. | • Create a structured development plan for Staff Networks to enable advancement on the Staff Networks Maturity Framework.<br>• Review of Equality Impact Assessment Procedure. |

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| | • Implemented processes to ensure protected characteristic data is pulled from TRAC into ESR. | |

## 10. Appendix 2: Summary of Evidence and Rating Against EDS Outcomes

### Understanding EDS Ratings

10.1. During the grading process, graders score each outcome 0, 1, 2, or 3. These scores provide an outcome rating. To determine the overall Trust rating, outcome scores are totalled together.

10.2. The table below summarises the ratings, with a description of the rating and the corresponding scores required for those ratings for each outcome as well as the Trust overall.

| Rating | Description | Outcome Score | Overall Score |
|---|---|---|---|
| **Underdeveloped** | No or little activity taking place | 0 | Less than 8 |
| **Developing** | Minimal/basic activity taking place | 1 | Between 8 and 21 |
| **Achieving** | Required level of activity taking place | 2 | Between 22 and 32 |
| **Excelling** | Activity exceeds requirements | 3 | 33 |

10.3. Further details of the evidence required to achieve ratings for each outcome can be found in the EDS Ratings and Scorecard Guidance 2022.

**Oxford University Hospital NHS Foundation Trust EDS Ratings 2024-25**

10.4. The table below summarises the evidence presented, the rating achieved, and feedback received against each of the EDS Outcomes. For the rating, a breakdown of scores is also given to provide further context.

| EDS Outcomes | | Evidence Presented | Ratings | Feedback |
|---|---|---|---|---|
| **Domain 1:** Commissioned or Provided Services | | | | |
| **1A** | Patients (service users) have the required levels of access to the service. | • Access to language: Language Line, Face to face interpreters & Written patient information. British Sign Language introductory course offered in Renal, Transplant and Urology.<br>• Care in communities: Community Neurology Nursing Team hosts Remote Epilepsy Clinic in Brackley: Easier access to the Neurophysiology reception. Remote follow-up for neuromodulation patients.<br>• Facilitating safe surgery for patients who have religious beliefs that forbid blood transfusion in Renal, Transplant and Urology.<br>• Flexible provisions: Pharmacy service embedded within inpatient pathway and providing trailed information and approach to meet patient and family needs such as Hospital@Home Pharmacy team provides @home pharmacy care. | **Achieving**<br>0 – 0%<br>1 – 30%<br>2 – 45%<br>3 – 25% | • Strong demonstration of supporting disability inclusion practices<br>• Despite the volume of work, there is a clear improvement plan.<br>• Strong demonstration of supporting a culture that recognises language needs.<br>• Considered and informed approaches to the safe provision of services for certain protected groups. |
| **1B** | Individual patient's (service users) health needs are met. | • Educational videos for cancer patients produced with Thames Valley Cancer Alliance. These videos were produced to address the lack of capacity for oral education clinics and a way to educate cancer patients on several other aspects, including access to medications and the impact of medications. | **Achieving**<br>0 – 0%<br>1 – 15%<br>2 – 68%<br>3 – 18% | • Strong demonstration of supporting disability inclusion practices.<br>• Strong demonstration of supporting a culture that recognises varied language needs.<br>• The value of allies and volunteers such as Daleys (a Youth Worker) are underestimated and their role within the trust could be understood better. |

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| | | • Visual information leaflet for children explaining their neurophysiology test.<br>• Improved hearing support for patients with NF2.<br>• Access to Halal meals and supporting Ramadan fasting.<br>• Patient therapy dog visits to the ward<br>• Language accessibility: Language Line, Face-to-face interpreters & Written patient information. British Sign Language introductory course offered in Renal, Transplant and Urology<br>• Access to multi-faith Chaplaincy service for patients<br>• Young Adults programme – Daley – Transplant Games Improving accessibility & engagement from young people.<br>• Patient with Learning Disability: adjusted scheduling, liaison with Learning Disability Nurses, simplified patient education. | | • Used diverse approaches to gather impacts such as patient stories through the storytelling method.<br>• Despite the volume of work, there is a clear improvement plan. |
| **1C** | When patients (service users) use the service, they are free from harm. | • Looking at how we appropriately use formulas in calculating drug doses in transgender patients to avoid errors.<br>• Reduction in noise levels on the ward.<br>• Monitor and reporting of mixed sex breaches on NICU.<br>• Ensuring patients feel safe using our service by encouraging staff to wear pronoun badges on lanyards.<br>• Quality Improvement work ongoing to embed pharmacists in pre-op assessment. | **Achieving**<br><br>0 – 0%<br>1 – 20%<br>2 – 63%<br>3 – 17% | • Strong demonstration of supporting gender and sexual identity inclusion.<br>• Despite the volume of work, there is a clear plan for improvement. |

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| **1D** | Patients (service users) report positive experiences of the service. | Evidence provided from data collected through various channels such as:<br>• Health Watch Oxfordshire<br>• Care Feedback from patients, family and service users.<br>• Daisy Awards<br>• Regular monitoring mechanisms and checks. | **Achieving**<br><br>0 – 5%<br>1 – 30%<br>2 – 35%<br>3 – 30% | • More evidence around how +/- feedback is handled and reported on.<br>• Seek feedback actively for underserved groups. |
| **Domain 2:** Workforce Health and Wellbeing | | | | |
| **2A** | When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions. | • Trust People Plan and EDI Objectives.<br>• Staff Survey Data.<br>• Details of how sickness absence is monitored through monthly reporting and how data is used to support improvements.<br>• Information on the Trust's wellbeing offering to support management of conditions in the workplace including Occupational Health, Here for Health, and the Staff Support Service.<br>• Information on initiatives and policies to provide healthy work-life balance, and providing opportunities to exercise, including the Flexible and Agile Working Policies and outdoor gym equipment.<br>• Examples of initiatives to improve health literacy, including health and wellbeing roadshows and health assessment kiosks. | **Achieving**<br>***(Trust Grade: Developing)***<br><br>0 – 0%<br>1 – 0%<br>2 – 100%<br>3 – 0% | • Many sources of information provided highlight how many teams are delivering a wealth of health and well-being support.<br>• The staff support systems seem to be reaching people across the divide.<br>• Key policies such as the Menopause Policy are inclusive of minority groups.<br>• Graders noted that more could be done to increase the uptake of services and raise awareness.<br>• Evidence on how the Trust is managing COVID and related health challenges should be included in the evidence packs was suggested by graders. |
| **2B** | When at work, staff are free from abuse, harassment, bullying | • Trust People Plan and EDI Objectives.<br>• Staff Survey Data. | **Developing** | • Many policies are new or updated, so it is early to say how effective these are. Nonetheless, it would be helpful |

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| | and physical violence from any source. | • Policies on Respect and Dignity at Work and Managing Violence and Aggression Against Staff.<br>• Information on the Eradication of Bullying and Harassment campaign; including Kindness into Action and No Excuses.<br>• Details of support available to those who experience B&H.<br>• Staff stories on B&H that have been presented to Board. | ***(Trust Grade: Achieving)***<br>0 – 0%<br>1 – 60%<br>2 – 40%<br>3 – 0% | to better understand how these will be evaluated.<br>• Respect and Dignity at Work policy focuses on resolving issues together which in some cases is very appropriate.<br>• The grader's feedback saying that it will be helpful to have more balance in the policy around situations where feelings of fear and intimidation make reporting of bullying and harassment challenging. |
| **2C** | Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source. | • Trust People Plan and EDI Objectives.<br>• Staff Survey Data.<br>• Freedom to Speak Up Strategy and Policy.<br>• Details on Staff Networks and how they are resourced.<br>• Trust Equality Impact Assessment Procedure.<br>• Examples of how B&H is monitored and reported through Employee Relations Case Updates and WRES/WDES Reporting. | **Developing**<br>***(Trust Grade: Achieving)***<br>0 – 0%<br>1 – 60%<br>2 – 40%<br>3– 0% | • The outreach and promotion work of Freedom To Speak Up Guardians is encouraging with staff networks offering support, however, there is still some significant work to do on sexual safety and staff feeling able to report difficult experiences. In particular, the graders felt the Trust could do more to address the fear of reporting. |
| **2D** | Staff recommend the organisation as a place to work and receive treatment. | • Trust People Plan and EDI Objectives<br>• Staff Survey Data.<br>• Details of how sickness absence is monitored through monthly reporting and how data is used to support improvements.<br>• Details on how exit interviews are used to support improvements.<br>• Examples of using experiences of staff with protected characteristics to inform action including WRES/WDES/GPG reporting. | **Achieving**<br>0 – 0%<br>1 – 17%<br>2 – 67%<br>3 – 17% | • The EDI objectives align with local and national policies, such as the NHS People Plan, reflecting the needs of our patients and our people.<br>• Encouraging to see Divisions react to the staff survey results and take measured actions.<br>• The regular 'Time to Talk' sessions make staff feel heard, ensuring that the Trust is cooperating with staff towards possible changes. |

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| | | • Examples of working with partner organisations to improve staff experience, including Kindness into Action. | | • Some graders noted that it would help to see how the Trust uses sickness and absence data to retain staff.<br>• The staff retention plan and data from end-of-employment-exit interviews could be used to make further improvements. This will strengthen the culture of acting on feedback from staff, in turn, it will help the staff feel heard.<br>• It was well evidenced that the Trust collates and compares the experiences of BAME and Disabled Staff as part of reporting to the Trust board, supporting actions at a local level.<br>• Working with other organisations across the counties shows a collaborative approach to support staff. |
| **Domain 3:** Inclusive Leadership | | | | |
| **3A** | Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities. | • Trust Strategy, People Plan, and EDI Objectives.<br>• Details of EDI Steering Group.<br>• Details of Health Inequalities Steering Group.<br>• Examples of senior leadership engagement with EDI & HI, including engagement with International Women's Day, Black History Month, Oxford Pride and communications on various holidays and awareness days. | **Achieving**<br><br>0 – 0%<br>1 – 33%<br>2 – 33%<br>3 – 33% | • There is clear consideration of equality and health inequalities at the Board level and this filters into decision-making, including EDI objectives.<br>• The Trust also has a good feedback loop with the Staff Networks to enable input from people in the Trust with different experiences.<br>• Great support from Board sponsors was provided to land the AccessAble project. This was a collaboration between Staff Networks and the board sponsor along with the Patient |

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| | | | | Experience Team. The procured service will be a huge benefit for health inequalities, noted some graders.<br>• An area of improvement is having multiple representations for each Staff Network. |
| **3B** | Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed. | • Review of Board papers including specific papers on EDI & HI as well as excerpts from Integrated Performance reports that discuss EDI & HI.<br>• Quality Impact Assessment (QIA)Tool.<br>• Equality Impact Assessment (EIA) Tool. | **Developing**<br>0 – 0%<br>1 – 67%<br>2 – 33%<br>3 – 0% | • Although the Board/Committee papers do seem to include references to equality on specific review, it is not simple to demonstrate this at a glance. Graders noted that this could be improved by virtue of a tick box, or a proforma, similar to that used in policies for an equality impact assessment. |
| **3C** | Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients. | • Trust Strategy, People Plan, and EDI Objectives.<br>• Combined Equality Standards Reporting (WRES/WDES/GPG).<br>• EDS Reporting.<br>• Chief Officer EDI Objectives.<br>• EDI and Health Inequalities Dashboard.<br>• Divisional EDI Actions.<br>• PLACE Reporting.<br>• AIS Reporting.<br>• Examples of working with system partners to identify and action priorities including Kindness into Action.<br>• Menopause Health and Wellbeing Policy. | **Achieving**<br>0 – 0%<br>1 – 33%<br>2 – 67%<br>3 – 33% | • Resource and investment in raising the culture of inclusion can be seen but unclear from the evidence on the impact of this on the metrics.<br>• More information on changes observed in the information packs will help graders.<br>• It was felt that great progress was shown on this outcome, particularly with the Menopause Policy and its implementation.<br>• One grader noted that the PLACE reports give very mixed feedback with some disappointing results but encouraging to read the improvement plan for this. |

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| | | | | • Training for the Reasonable Adjustments flag is very welcome. |

# Combined Equality Standards Report 2025- Data Pack

This data pack includes the success measures against each of the High Impact Actions (HIAs) of the NHS England Workforce Equality, Diversity, and Inclusion (EDI) Improvement Plan.

This includes Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Gender Pay Gap (GPG) metrics aligned to each of the HIAs.

Where data items are part of reporting against WRES, WDES, or GPG, this has been identified in the title of the data item.

Data within this pack uses a snapshot date of 31st March 2025.

## Table of Contents



## High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

There are no success measures for this HIA.

## High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

*HIA2.1: **WRES 1** - Percentage of BME staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| **Non-Clinical** | **16.8%** | **17.8%** | **19.2%** | **21.2%** | **23.2%** | **2.0%** |
| Under Band 1 | 19.0% | 0.0% | 0.0% | 0.0% | 15.4% | 15.4% |
| Band 1 | 0.0% | 0.0% | 20.0% | 0.0% | 0.0% | 0.0% |
| Band 2 | 18.3% | 20.2% | 21.4% | 19.9% | 22.8% | 2.9% |
| Band 3 | 18.5% | 21.6% | 25.5% | 27.3% | 30.5% | 3.2% |
| Band 4 | 17.2% | 17.6% | 18.7% | 22.1% | 25.9% | 3.8% |
| Band 5 | 17.3% | 18.3% | 20.4% | 23.7% | 25.0% | 1.3% |
| Band 6 | 17.9% | 17.8% | 17.8% | 20.1% | 19.2% | -0.9% |
| Band 7 | 13.1% | 10.5% | 12.7% | 13.5% | 17.0% | 3.5% |
| Band 8a | 10.9% | 13.2% | 10.9% | 10.4% | 11.8% | 1.4% |
| Band 8b | 10.1% | 11.3% | 12.9% | 12.2% | 7.1% | -5.1% |
| Band 8c | 8.3% | 11.8% | 7.4% | 10.0% | 14.0% | 4.0% |
| Band 8d | 12.0% | 8.8% | 9.7% | 13.5% | 16.7% | 3.2% |
| Band 9 | 13.6% | 18.2% | 19.2% | 13.4% | 13.3% | -0.1% |
| VSM | 12.5% | 19.2% | 20.0% | 25.0% | 19.2% | -5.8% |
| **Clinical** | **27.3%** | **31.7%** | **34.0%** | **33.0%** | **37.1%** | **4.1%** |
| Under Band 1 | 0.0% | 16.7% | 0.0% | 0.0% | 40.0% | 40.0% |
| Band 1 | 0.0% | 0.0% | 0.0% | 50.0% | 0.0% | -50.0% |
| Band 2 | 31.6% | 37.6% | 44.2% | 44.0% | 56.4% | 12.4% |
| Band 3 | 33.9% | 32.4% | 29.4% | 31.6% | 38.9% | 7.3% |
| Band 4 | 23.8% | 26.3% | 26.4% | 23.7% | 29.8% | 6.1% |
| Band 5 | 39.6% | 50.7% | 55.1% | 47.1% | 50.1% | 2.9% |
| Band 6 | 23.6% | 27.2% | 30.0% | 33.6% | 37.1% | 3.5% |
| Band 7 | 14.7% | 14.8% | 15.8% | 16.7% | 17.7% | 1.0% |
| Band 8a | 10.8% | 11.7% | 12.4% | 13.2% | 15.5% | 2.3% |
| Band 8b | 4.9% | 6.7% | 10.2% | 8.5% | 11.5% | 3.0% |
| Band 8c | 3.8% | 5.3% | 4.8% | 6.1% | 9.0% | 2.9% |
| Band 8d | 11.1% | 10.0% | 22.2% | 14.3% | 11.1% | -3.2% |
| Band 9 | 0.0% | 0.0% | 0.0% | 9.1% | 9.1% | 0.0% |
| VSM | 50.0% | 50.0% | 50.0% | 50.0% | 50.0% | 0.0% |
| **Medical and Dental** | **31.3%** | **29.9%** | **32.7%** | **30.9%** | **33.5%** | **2.6%** |
| Consultants | 23.8% | 25.2% | 25.2% | 27.0% | 29.3% | 2.3% |
| Non-Consultant Career Grade | 31.3% | 28.6% | 42.3% | 33.3% | 32.5% | -0.9% |
| Trainee Grade | 37.3% | 33.9% | 35.7% | 32.5% | 36.9% | 4.4% |
| **Trust Total** | **25.5%** | **28.3%** | **30.5%** | **29.9%** | **33.7%** | **3.7%** |

*HIA2.2: **WRES 2** - Relative likelihood of BME staff being appointed from shortlisting.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Relative Likelihood | 1.55 | 1.71 | 1.80 | 1.77 | 1.01 | -0.76 |

*HIA2.3: **WRES 4** - Relative likelihood of BME staff accessing non-mandatory training and CPD.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Relative Likelihood | 0.93 | 0.73 | 0.77 | 0.99 | 0.96 | -0.03 |

*HIA2.5: **WRES 7** - Percentage BME staff compared to white staff believing that trust provides equal opportunities for career progression or promotion.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| White | 60.5% | 58.7% | 57.7% | 58.0% | 56.3% | -1.7% |
| BME | 51.6% | 48.3% | 49.8% | 55.4% | 51.5% | -3.9% |

*HIA2.6: **WDES 1** - Percentage of Disabled staff in AfC paybands or medical and dental subgroups and very senior managers.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| **Non-Clinical** | **4.0%** | **4.3%** | **5.0%** | **6.0%** | **6.7%** | **0.7%** |
| AfC 1-4 | 4.4% | 4.5% | 5.4% | 6.5% | 7.4% | 0.9% |
| AfC 5-7 | 4.4% | 4.1% | 4.6% | 5.2% | 5.8% | 0.6% |
| AfC 8a & 8b | 2.7% | 4.3% | 4.5% | 5.9% | 5.9% | 0.0% |
| AfC 8c - VSM | 2.7% | 3.0% | 3.2% | 4.3% | 4.8% | 0.5% |
| **Clinical** | **3.8%** | **3.8%** | **4.2%** | **4.3%** | **4.7%** | **0.4%** |
| AfC 1-4 | 4.1% | 3.9% | 4.7% | 3.8% | 4.6% | 0.8% |
| AfC 5-7 | 3.8% | 3.9% | 4.1% | 4.6% | 5.0% | 0.4% |
| AfC 8a & 8b | 1.9% | 2.1% | 3.7% | 3.1% | 3.1% | 0.0% |
| AfC 8c - VSM | 1.4% | 1.3% | 2.3% | 2.3% | 1.1% | -1.2% |
| **Medical and Dental** | **1.3%** | **1.2%** | **2.0%** | **1.6%** | **1.9%** | **0.3%** |
| Consultants | 0.7% | 0.7% | 0.6% | 1.2% | 1.5% | 0.2% |
| Non-Consultant Career Grade | 0.0% | 1.4% | 1.9% | 1.3% | 6.9% | 5.6% |
| Trainee Grade | 1.8% | 1.7% | 3.5% | 2.0% | 2.0% | 0.0% |
| **Trust Total** | **3.4%** | **3.5%** | **4.0%** | **4.3%** | **4.7%** | **0.5%** |

*HIA2.7: **WDES 2** - Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Relative Likelihood | 1.43 | 1.12 | 1.09 | 0.96 | 0.95 | -0.01 |

*HIA2.8: **WDES 5** - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 59.5% | 56.8% | 56.6% | 58.4% | 56.0% | -2.4% |
| Disabled | 50.0% | 51.8% | 50.2% | 51.6% | 48.2% | -3.4% |

*HIA2.9: **WRES 9** - Percentage difference between the organisation's Board voting membership and its overall workforce.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Board Voting Membership %BME | 17.7% | 22.2% | 21.1% | 21.1% | 21.1% | 0.0% |
| Difference from Overall Workforce | -7.9% | -6.1% | -9.4% | -8.8% | -12.6% | -3.8% |

*HIA2.10: **WDES 10** - Percentage difference between the organisation's Board voting membership and its overall workforce.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Board Voting Membership % Disabled | 12.5% | 11.1% | 21.1% | 21.1% | 15.8% | -5.3% |
| Difference from Overall Workforce | 9.1% | 7.7% | 17.0% | 17.0% | 11.1% | -5.9% |

## High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps.

*HIA3.1: **Gender Pay Gap** – Ordinary Pay Gap*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Mean Pay Gap | 25.0% | 29.4% | 28.7% | 25.5% | 24.2% | -1.3% |
| Median Pay Gap | 17.2% | 15.8% | 13.6% | 9.0% | 10.9% | 1.9% |

*HIA3.2: **Gender Pay Gap** – Bonus Pay Gap*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Mean Bonus Pay Gap | 42.8% | 57.5% | 47.2% | 51.9% | 11.3% | -40.6% |
| Median Bonus Pay Gap | 0.0% | 62.7% | 4.2% | 87.6% | -0.2% | -87.8% |

*HIA3.3: **Gender Pay Gap** – Percentage of men and women receiving bonuses.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Men | 13.6% | 13.9% | 10.7% | 4.0% | 2.8% | -1.2% |
| Women | 3.7% | 6.4% | 4.7% | 1.4% | 0.6% | -0.8% |

*HIA3.4: **Gender Pay Gap** – Percentage of women within each quartile of the Trust's pay structure.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Q1 | 77.8% | 75.7% | 74.3% | 73.8% | 70.9% | -2.9% |
| Q2 | 80.3% | 81.6% | 81.8% | 78.6% | 81.9% | 3.3% |
| Q3 | 81.7% | 78.3% | 77.9% | 79.6% | 77.0% | -2.6% |
| Q4 | 61.9% | 62.8% | 61.4% | 63.1% | 61.4% | -1.7% |

*Q1 is low and Q4 is high.

*HIA3.5: **Ethnicity Pay Gap** – Ordinary Pay Gap*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| Mean Pay Gap | 10.8% | 11.1% | 15.3% | 4.2% |
| Median Pay Gap | 17.2% | 11.0% | 21.7% | 10.7% |

*HIA3.6: **Ethnicity Pay Gap** – Bonus Pay Gap*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| Mean Pay Gap | 37.6% | 29.9% | -29.5% | -59.4% |
| Median Pay Gap | 67.7% | 87.5% | 19.4% | -68.1% |

*HIA3.7: **Ethnicity Pay Gap** – 2025 Ordinary Pay Gap Disaggregated; comparator "White British"*

| Ethnicity | White British | White Other | Black | Asian | Mixed | Other | Unknown |
|---|---|---|---|---|---|---|---|
| Mean Pay Gap | 0.0% | 1.6% | 31.1% | 14.8% | 11.2% | -6.2% | 13.4% |
| Median Pay Gap | 0.0% | 0.3% | 27.8% | 21.3% | 22.4% | 1.2% | 18.6% |

*HIA 3.8: **Intersectional Pay Gap** – 2025 Sex & Ethnicity Intersectional Pay Gap; comparator "White Men"*

| | White Men | White Women | BME Men | BME Women |
|---|---|---|---|---|
| Mean Pay Gap | 0.0% | 27.3% | 24.1% | 37.8% |
| Median Pay Gap | 0.0% | 18.3% | 31.8% | 32.8% |

*HIA3.9: **Disability Pay Gap** – Ordinary Pay Gap*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| Mean Pay Gap | 17.7% | 31.3% | 15.5% | -15.8% |
| Median Pay Gap | 11.9% | 16.6% | 12.5% | -4.1% |

*HIA3.10: **Disability Pay Gap** – Bonus Pay Gap*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| Mean Pay Gap | 66.3% | 48.3% | 33.8% | -14.5% |
| Median Pay Gap | 84.0% | 38.8% | 15.8% | -23.0% |

*HIA3.11: **Divisional Pay Gap Breakdown** – 2025 Ordinary Gender and Ethnicity Pay Gaps*

| | Mean Gender Pay Gap | Median Gender Pay Gap | Mean Ethnicity Pay Gap | Median Ethnicity Pay Gap |
|---|---|---|---|---|
| Corporate | 0.5% | -5.3% | 12.5% | 7.4% |
| CSS | 20.3% | 13.3% | 16.1% | 20.9% |
| MRC | 21.7% | 8.9% | 23.6% | 23.7% |
| NOTSSCAN | 29.1% | 24.6% | 9.5% | 18.4% |
| SUWON | -35.1% | -11.4% | 14.1% | 14.9% |

## High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.

*HIA4.1: **WDES 6** - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 18.3% | 19.8% | 16.8% | 16.5% | 13.6% | -2.9% |
| Disabled | 26.8% | 27.1% | 26.5% | 25.8% | 23.6% | -2.2% |

*HIA4.2: **WDES 8** - Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Response | 81.5% | 79.4% | 75.2% | 77.7% | 75.5% | -2.2% |

## High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

*HIA5.1: Percentage of staff saying that team members have a set of shared objectives.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 77.8% | 79.1% | 78.7% | -0.4% |
| Domestic | 72.1% | 73.5% | 77.2% | 3.7% |

*HIA5.2: Percentage of staff saying that team members understand each other's roles.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 74.0% | 73.4% | 69.9% | -3.5% |
| Domestic | 71.3% | 70.8% | 72.7% | 1.9% |

*HIA5.3: Percentage of staff saying that they enjoy working with colleagues in their team.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 79.0% | 73.7% | 71.5% | -2.2% |
| Domestic | 82.4% | 81.7% | 81.7% | 0.0% |

*HIA5.4: Percentage of staff saying that feel the organisation respects individual differences.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| International | 75.4% | 75.5% | 69.3% | -6.2% |
| Domestic | 69.7% | 71.0% | 71.6% | 0.6% |

*HIA5.5: Percentage of staff saying that they feel the organisation offers them challenging work.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 67.2% | 64.1% | 63.6% | -0.5% |
| Domestic | 73.0% | 73.8% | 72.0% | -1.8% |

*HIA5.6: Percentage of staff saying that there are opportunities to develop their career in the organisation.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 71.7% | 72.5% | 65.9% | -6.6% |
| Domestic | 55.7% | 54.2% | 57.0% | 2.8% |

*HIA5.7: Percentage of staff saying that they have opportunities to improve their knowledge and skills.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 81.2% | 81.8% | 78.3% | -3.5% |
| Domestic | 70.2% | 69.9% | 73.1% | 3.2% |

*HIA5.8: Percentage of staff saying that they feel supported to develop their potential.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 67.1% | 68.6% | 62.6% | -6.0% |
| Domestic | 53.8% | 54.4% | 58.0% | 3.6% |

*HIA5.9: Percentage of staff saying that they are able to access the right learning and development when they need to.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 70.2% | 72.9% | 69.1% | -3.8% |
| Domestic | 55.8% | 57.0% | 60.3% | 3.3% |

*HIA5.10: Percentage of staff saying that they have not experienced harassment, bullying, or abuse from managers in the last 12 months.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 91.1% | 90.6% | 90.5% | -0.1% |
| Domestic | 89.7% | 89.2% | 90.5% | 1.3% |

*HIA5.11: Percentage of staff saying that they have not experienced harassment, bullying, or abuse from other colleagues in the last 12 months.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 75.3% | 75.0% | 77.9% | 2.9% |
| Domestic | 82.2% | 81.1% | 82.6% | 1.5% |

*HIA5.12: Percentage of staff saying that they reported their last experience of harassment, bullying, or abuse.*

| | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|
| International | 49.3% | 55.3% | 55.1% | -0.2% |
| Domestic | 44.7% | 46.0% | 49.2% | 3.2% |

## High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

*HIA6.1: **WRES 3** - Relative likelihood of BME staff entering the formal disciplinary process compared to White staff.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Relative Likelihood | 0.79 | 1.03 | 1.18 | 0.89 | 1.17 | 0.28 |

*HIA6.2: **WRES 5** - Percentage of BME staff compared to white staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| White | 25.8% | 23.9% | 23.6% | 21.7% | 20.8% | -0.8% |
| BME | 24.7% | 23.5% | 26.7% | 25.0% | 24.5% | -0.4% |

*HIA6.3: **WRES 6** - Percentage of BME staff compared to white staff experiencing harassment, bullying or abuse from staff in last 12 months*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| White | 25.3% | 22.0% | 23.0% | 22.4% | 21.5% | -0.9% |
| BME | 28.1% | 25.6% | 27.1% | 24.8% | 23.4% | -1.4% |

*HIA6.4: **WRES 8** - Percentage of BME staff compared to white staff who have personally experienced discrimination at work from a manager/team leader or other colleague in the last 12 months*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| White | 5.9% | 6.6% | 7.5% | 7.6% | 7.3% | -0.4% |
| BME | 16.0% | 15.3% | 16.9% | 13.4% | 15.7% | 2.3% |

*HIA6.5: **WDES 3** - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Relative Likelihood | 2.24 | 1.15 | -* | 5.83 | 0.00 | -5.83 |

*No disabled staff were involved in formal capability processes in the 2023 reporting year and therefore no figure is given.

*HIA6.6: **WDES 4ai** - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Non-Disabled | 24.2% | 22.4% | 23.3% | 21.4% | 21.1% | -0.3% |
| Disabled | 31.5% | 29.4% | 29.5% | 27.7% | 26.3% | -1.4% |

*HIA6.7: **WDES 4aii** - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 10.2% | 8.6% | 9.1% | 8.5% | 8.3% | -0.3% |
| Disabled | 17.0% | 16.4% | 17.5% | 15.3% | 15.5% | 0.2% |

*HIA6.8: **WDES 4aiii** - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 19.6% | 25.3% | 17.9% | 17.6% | 16.6% | -1.0% |
| Disabled | 30.4% | 25.3% | 27.6% | 27.4% | 24.8% | -2.7% |

*HIA6.9: **WDES 4b** - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it*

| | 2021 | 2022 | 2023 | 2024 | 2024 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 42.0% | 45.0% | 48.2% | 50.4% | 48.8% | -1.6% |
| Disabled | 48.0% | 45.4% | 44.9% | 48.8% | 53.7% | 4.9% |

## Metrics not aligned to a HIA

*7.1: **WDES7** - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 51.9% | 45.4% | 45.6% | 50.1% | 46.8% | -3.3% |
| Disabled | 40.8% | 36.3% | 34.9% | 36.6% | 36.2% | -0.4% |

*7.2: **WDES9** - The staff engagement score for Disabled staff, compared to non-disabled staff*

| | 2021 | 2022 | 2023 | 2024 | 2025 | Difference |
|---|---|---|---|---|---|---|
| Non-Disabled | 7.3 | 7.1 | 7.1 | 7.2 | 7.1 | -0.1 |
| Disabled | 6.8 | 6.7 | 6.5 | 6.6 | 6.5 | -0.1 |

# 12. RESPONSIBLE OFFICER'S REVALIDATION ANNUAL REPORT

## REFERENCES

Only PDFs are attached

11 TB2025.79 24-25 Responsible Officer's Revalidation Annual Report v2.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: 10 September 2025**

**TB2025.79**

| | |
|---|---|
| **Title:** | **Responsible Officer's Annual Medical Appraisal and Revalidation Report 2024/25** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **Annual Reporting** |

| | |
|---|---|
| **Board Lead:** | **Chief Medical Officer** |
| **Author:** | **Nicki Sullivan, Medical Revalidation and Job Planning Manager; Dr Elaine Hill, Director of Medical Workforce / Deputy Chief Medical Officer** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance, Performance** |

## Executive Summary

1. This report is presented to the Trust Board for assurance that the statutory functions of the Responsible Officer are being appropriately and adequately discharged.

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## 2. Recommendations

The Trust Board is asked to

- Receive this report for information;
- Note that the report will be shared with the Tier 2 Responsible Officer at NHS England.
- Note the Statement of Compliance (Appendix 1) confirms that the Trust, as a Designated Body, is in compliance with the Regulations. This will be signed by the OUH Chief Executive as required by NHS England.
- Note the Statement of Compliance for Helen and Douglas House for which the Trust provides Responsible Officer Services (Appendix 2), confirms compliance with regulations. This will be signed by the Board of Helen and Douglas House as required by NHS England.

## Contents

# Responsible Officer's Annual Medical Appraisal and Revalidation Report 2024/25

## 1. Purpose

1.1. This report is presented to the Trust Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Trust Board on progress since the 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks.

## 2. Background

2.1. More information on the background to revalidation can be found via this link.

2.2. The last report was submitted to Trust Board for the year 2022/23 on 13th September 2023. This report covers the period 1st April 2023 – 31st March 2024.

## 3. Governance

3.1. The Responsible Officer for the period 1st April 2024 – 31st March 2025 was Professor Andrew Brent, Chief Medical Officer, appointed by the Trust Board on 9th October 2023 in line with statutory requirements. The Chief Medical Officer is supported by a team who managed 1963 doctors to complete the appraisal and revalidation processes during the reporting period.

3.2. Progress and compliance with the regulations is monitored by:

- Monthly compliance reports supplied to Divisional and Directorate Management and personal action plans for those whose appraisals are overdue.
- Submission of the Annual Organisational Audit to NHS England (appended to this report).
- Comprehensive dashboards within SARD to enable Divisional management to access and review their own data and interrogate this in a number of ways to inform Divisional strategies.
- A formal audit schedule for other activities such as the management of multi-source feedback.

3.3. The number of doctors with a prescribed connection to OUHFT has increased again from 1886 in the year 2023/24 to 1970 at the time of writing. The effect of bringing the medical bank in-house continues to increase the demand for appraisals with the shift towards less than full time working also contributing to the increase in the number of connections. The Trust is also responsible for appraising military doctors working at the hospital, and dental surgeons and doctors in training posts who do not hold a national training number.

3.4. During the reporting period the Trust continued to provide external Responsible Officer services for 1 local hospice and thus has responsibility for oversight of their governance processes in relation to medical appraisal and revalidation.

## 4. Policy and Guidance

4.1. The Medical Appraisal and Revalidation Policy is reviewed regularly. The most recent review was in September 2017. The policy is currently being updated and is going through the formal HR process of approval.

## 5. Environmental Factors

5.1. Current challenges:

5.1.1. Appraiser numbers have continued to remain a challenge due to retirement of appraisers and the other requirements of job plans.

5.1.2. This, combined with the ongoing uplift in the number of doctors needing to be appraised, means that there is a waiting list for assignment to an appraiser in some Divisions and limited capacity to accept honorary contract applications where a prescribed connection is needed.

5.1.3. Extensions to appraisal deadlines have needed to be given more regularly due to pressures of work. This is particularly true for some locally employed doctors who do not have time set aside for appraisal in their rotas.

5.1.4. There has been an increase in the number of doctors needing their recommendation date to be deferred. There are a number of factors including clinical pressures affecting their ability to prepare, limited or portfolio working which impacts their ability to collect required evidence, and periods of absence which also affect preparation.

# 6. Medical Appraisal

## Appraisal Performance Data

### 2023/24

| | | Number of Prescribed Connections | 1 Completed Appraisal | 1a Completed Appraisal (Optional) | 2 Approved incomplete or missed appraisal | 3 Unapproved incomplete or missed appraisal |
|---|---|---|---|---|---|---|
| 2.1.1 | **Consultants** (Permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work.) | 1219 | 1041 | 583 | 152 | 26 |
| 2.1.2 | **Staff grade, associate specialist, specialty doctor** (Permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff.) | 62 | 49 | 28 | 11 | 2 |
| 2.1.3 | **Doctors on Performers Lists** (For NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs.) | 0 | 0 | 0 | 0 | 0 |
| 2.1.4 | **Doctors with practising privileges** (This is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade.) | 6 | 3 | 1 | 0 | 3 |
| 2.1.5 | **Temporary or short-term contract holders** (Temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) | 3 | 2 | 1 | 0 | 1 |
| 2.1.6 | **Other doctors with a prescribed connection to this designated body** (Depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc.) | 594 | 482 | 336 | 75 | 37 |
| Unallocated | **Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD) | 2 | 0 | 0 | 0 | 2 |
| 2.1.7 | **Total** | **1886** | **1577** | **949** | **238** | **71** |

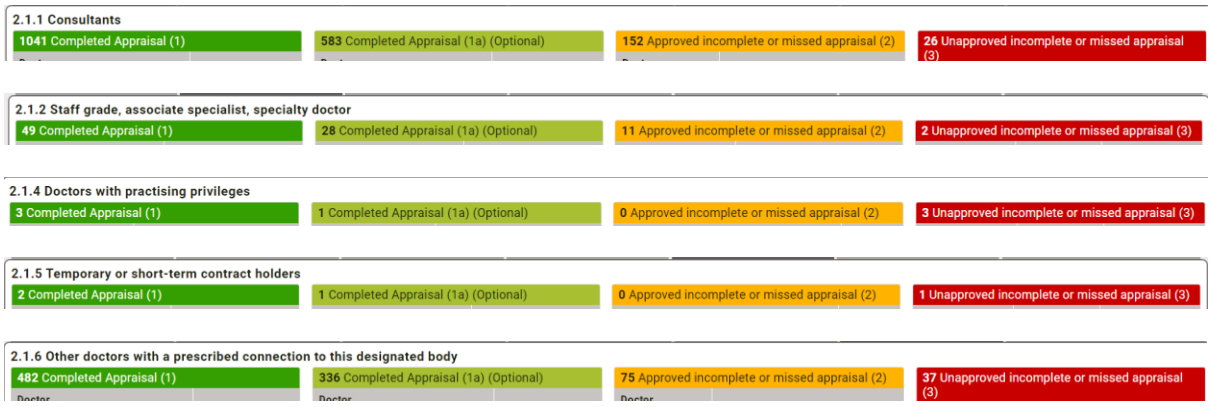
### 2024/25

| | | Number of Prescribed Connections | 1 Completed Appraisal | 1a Completed Appraisal (Optional) | 2 Approved incomplete or missed appraisal | 3 Unapproved incomplete or missed appraisal |
|---|---|---|---|---|---|---|
| 2.1.1 | **Consultants** (Permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work.) | 1233 | 1051 | 596 | 141 | 41 |
| 2.1.2 | **Staff grade, associate specialist, specialty doctor** (Permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff.) | 72 | 58 | 32 | 11 | 3 |
| 2.1.3 | **Doctors on Performers Lists** (For NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs.) | 0 | 0 | 0 | 0 | 0 |
| 2.1.4 | **Doctors with practising privileges** (This is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade.) | 9 | 6 | 5 | 0 | 3 |
| 2.1.5 | **Temporary or short-term contract holders** (Temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) | 5 | 3 | 3 | 1 | 1 |
| 2.1.6 | **Other doctors with a prescribed connection to this designated body** (Depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc.) | 642 | 497 | 298 | 104 | 41 |
| Unallocated | **Medics without an AOA medic group** (Medics that have not been allocated an AOA medic group on SARD) | 2 | 0 | 0 | 0 | 2 |
| 2.1.7 | **Total** | **1963** | **1615** | **934** | **257** | **91** |

Please see Appendix 1 for a summary of appraisal category classifications

## Appraisal Compliance by Staff Group

### 2023/2024

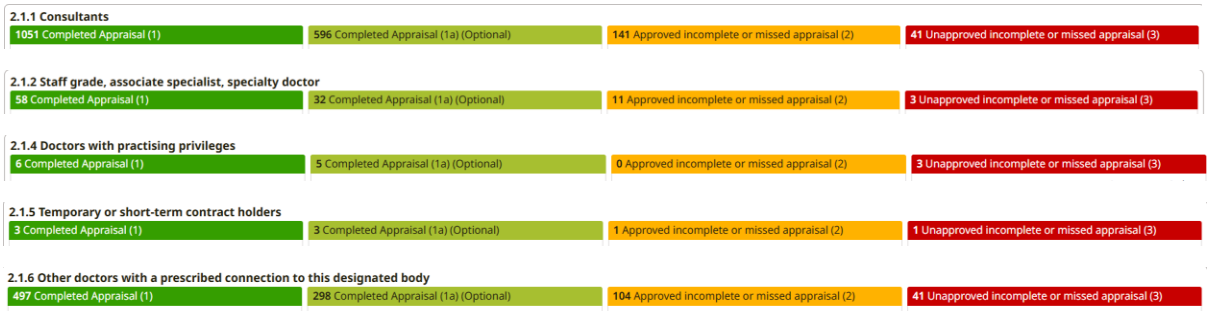



“Approved incomplete” includes appraisals missed for an acceptable reason eg: maternity leave or long term sick leave.

Unapproved incomplete relates to doctors whose appraisal has been missed without an acceptable reason being provided.

“Other” comprises all doctors who are not in the national training scheme and are not SAS or Consultant grades.

### 2024/2025




"Approved incomplete" includes appraisals missed for an acceptable reason eg: maternity leave or long term sick leave.

Unapproved incomplete relates to doctors whose appraisal has been missed without an acceptable reason being provided.

"Other" comprises all doctors who are not in the national training scheme and are not SAS or Consultant grades.

### Analysis of Results

6.1. The Trust's overall compliance rate for the period was 95.4% This compares to 96.2% in 2023/24.

6.2. Compliance amongst medical staff groups was relatively static compared with the previous year.

6.3. All of the 91 doctors with unapproved incomplete appraisals at 31 March 2024 have been contacted with personalised action plans to assist them to get back on track. At the time of writing this report:

- 6 appraisals have been completed
- 36 doctors with appraisals due have left the organisation
- 9 accounts were identified as Physician Associates who are currently exempted from these metrics
- 25 doctors have their appraisal meeting booked
- 14 appraisals remain outstanding with no action taken.

6.4. This raises the overall compliance rate to 98.0%.

### Audit of Missed Appraisals – Performance Management Framework

6.5. The Trust completes a summary of missed appraisals on a monthly basis with regular reports being submitted to Divisional Management for action.

6.6. Each summary reviews appraisals which are considered to be overdue for the period and follows up with the individuals concerned to ascertain the reasons for the delay. Where appropriate, action plans are developed for each doctor / appraiser to bring them back in line with their revalidation trajectory and to deal with any issues which have contributed to the delay.

6.7. A Performance Framework for Managing Medical Appraisals is employed. The key aims of the framework are to;

6.7.1. Ensure all doctors are treated equally in relation to appraisal compliance

6.7.2. Facilitate earlier intervention where it is ascertained a doctor needs support by reducing the time the doctor is able to remain non-compliant

6.7.3. Reduce “tacit acceptance” of non-compliance by escalating outliers more quickly and involving sources of support earlier.

6.8. Doctors whose appraisals are 90+ days overdue or have failed to comply with their action plan are also referred to their Divisional management for escalation to the CMO for consideration of disciplinary action. This has significantly reduced the number of doctors who remain non-compliant for appraisal for long periods of time and have allowed the team to give targeted support to doctors who are struggling. Interventions have included referrals to Occupational Health, personalised training, and IT / administration support to enable doctors to complete their appraisals in a timely manner and reduce the need for deferral at the point of revalidation.

**Appraisers**

6.9. There are currently 206 trained available appraisers to deliver circa 2025 appraisals (doctors attached to the OUH via a prescribed connection and those who are revalidated elsewhere but appraised by the OUH as part of a service level agreement). The 206 appraisers that are currently active can deliver a maximum capacity of 2244 appraisals assuming no long term leave is required. An increasing number of doctors leave and join each year with a significant percentage of each requiring an appraisal whilst employed. This takes the total number of projected appraisal spaces needed to c.2250 per annum which slightly exceeds current capacity.

6.10. The appraiser cohort has continued to see a number of resignations from appraiser posts over the past 12 months.

6.11. 22 appraisers were trained or retrained during the period to which this report pertains. These are included in the figures noted above.

6.12. Support for Appraisers is diverse and ranges from official events such as Appraiser Network Events (held 3 times a year) to individual feedback reports for appraisers and 1:1s with the Revalidation Manager and Director of Medical Workforce.

6.13. The Great Appraiser event was not held in 2024 due to lack of funding. Future iterations of this very popular conference are dependent on

financial support from outside the Trust which has not been possible to source and thus, at this time, there are no plans to hold future events.

6.14. The Revalidation Team actively support appraisers with challenging situations and provide bespoke assistance depending on the issue. Examples include advising on acceptable evidence for non-standard roles, assisting with non-compliant doctors and escalating more serious concerns that arise during the appraisal process to ensure a doctor receives the necessary support and intervention.

6.15. All of the above also supports the governance framework referred to earlier in this report.

**Medical Appraisal Quality Assurance**

**6.16.** A number of quality assurance mechanisms are in use in relation to medical appraisal;

- Each appraisal in a revalidation portfolio is checked for key items against the GMC's domains of Good Medical Practice and the Trust's local requirements. Discrepancies are notified to the doctor and, if necessary, an action plan prepared to rectify omissions to ensure a recommendation to revalidate can be made.
- For appraisers, attendance at OUH Appraiser Networks and the OUH/NHSE Appraiser Conference (where it is held) is recorded. Those not attending at least one development activity year are followed up as appropriate.
- All doctors submit feedback on their appraisal experience as the final step in the appraisal process. This not only allows personalised reports for appraisers to be generated but also enables the Revalidation Team to create an overview of how doctors perceive the process and thus to target resources and communications more effectively.
- A formal audit tool – ASPAT – is now available through SARD and a pilot of this tool has been undertaken.
- An Appraiser portal has been created within MS Teams to enable appraisers to offer peer support, ask questions and share best practice. This is moderated by the Revalidation Team.

**Access, Security and Confidentiality**

6.17. More information on access, security and confidentiality can be found via this link. This information has not changed since it was reported in 2017.

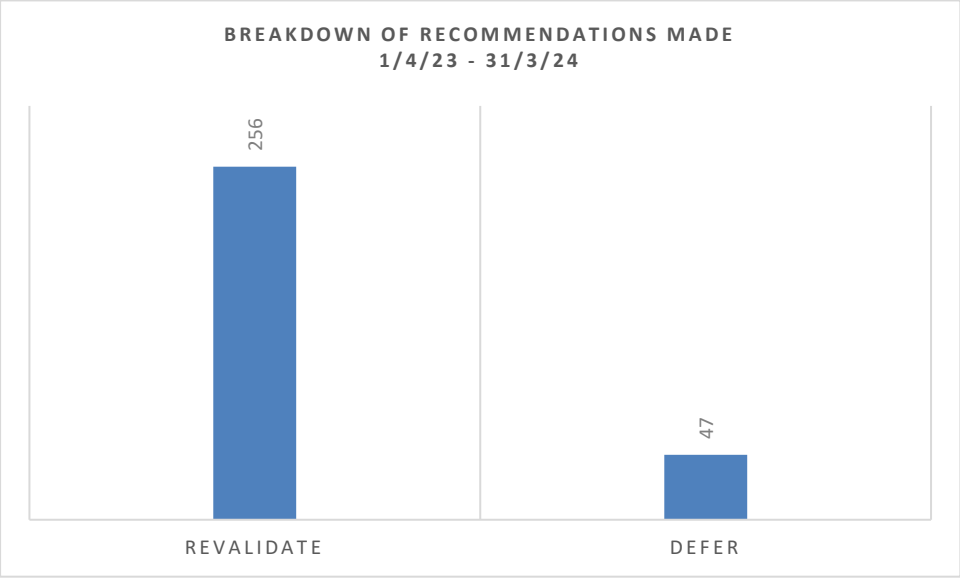
## 7. Medical Revalidation

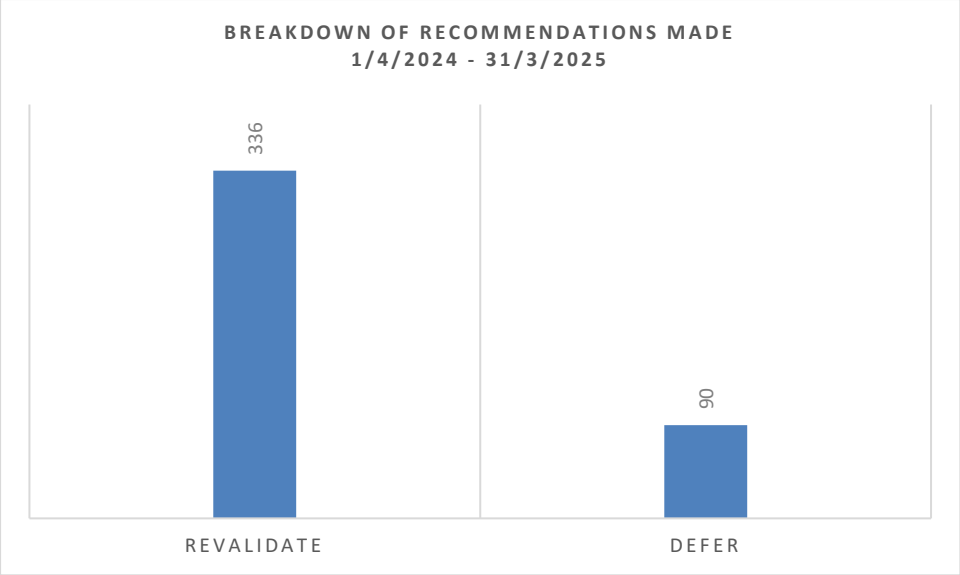
### Medical Revalidation Performance Data

7.1. During the period 1/4/24 – 31/3/25, 426 recommendations were made. This is an increase from the 303 made in the period 1/4/23 – 31/3/24

7.2. 1 recommendation was missed during the reporting period. This occurred due to a delay in the transfer of information from HR to the Revalidation Team meaning that the Trust were not aware of an imminent recommendation date for a new starter. It was not possible to increase the frequency of reports provided by HR therefore a new "self service" process via TRAC has been implemented by the Revalidation Team to avoid similar issues in future.

7.3. The following table shows the breakdown of recommendations made.






### Analysis of results

7.4. The overall deferral rate for the period was 21.1% which is up from 18.4% in 2023/24.

7.5. The main reasons for requesting a deferral (additional time to complete the requirements) were:

7.5.1. Inability to collect patient feedback

7.5.2. Delays to submission of the final appraisal mainly caused by clinical pressures.

7.5.3. Illness of both doctors and appraisers

### Recruitment and Engagement Background Checks

7.6. More information on recruitment and engagement background checks can be found via this link. This information has not changed since it was reported in 2017.

### Monitoring Performance, Responding to Concerns and Remediation

7.7. More information on monitoring performance, responding to concerns and remediation can be found via this link. This information has not changed since it was reported in 2017.

## 8. Risks and Issues

### Team Capacity

8.1. The administrative vacancy in the Revalidation Team was lost to cost saving measures during the reporting period. This means that nearly 2000 doctors are being supported for appraisal and revalidation and associated

tasks by 1 WTE Band 5 and approximately 0.3 WTE Band 8a (the Revalidation Manager is also responsible for a number of other outputs). This makes it one of the smallest teams in the country supporting one of the largest cohorts of prescribed connections. There is a risk that the team will not be able to continue to provide as much support and that there is no contingency in the case of unplanned leave and / or a vacancy arising.

8.2. In addition to the above the number of appraisals being delayed and recommendations being deferred are increasing due to clinical pressures across the Trust. This is increasing the already heavy workload for the team as it requires additional follow-up and support for appraisees and repeat recommendations being prepared in- year. There is a risk that the team will become overloaded and unable to keep up with the volume of recommendations required.

## 9. Action Plan

**Review of 2023 / 24 Action Plan**

| Objective | Actions | Expected Outcome | Outcome |
|---|---|---|---|
| Peer review of systems and processes | Carried forward from previous plan | Peer review completed. Recommendations shared. | Not undertaken due to changes at national level and lack of available guidance |
| Implement a number of processes to improve appraiser capacity | 12 PA cap on job plans temporarily removed for appraiser activity. Process for enabling honorary contract holders to appraise more in progress. Possibility of implementing a “pay per appraisal” system via the bank | The risk to the Trust of not being able to comply with its contractual obligations is mitigated. Doctors are appraised in a timely and supportive manner. Pressure on appraisers is reduced. | 12 PA cap lifted by 0.4SPA for 1 year. Process for recruiting honorary appraisers implemented but unsuccessful. Pay per appraisal process not adopted. Appraiser numbers currently equal to demand but no contingency. |
| Fully implement ASPAT | QA 10-20% of appraisal summaries and use data to inform a range of | More support for appraisers Higher quality summaries | Not undertaken. Team staffing levels have reduced and core business |

| | | | |
|---|---|---|---|
| | support materials and activities | Early intervention for appraisers requiring support | processes have had to be prioritised. |
| Review Appraisal Policy | Ensure all updates to statute, contract and local requirements are included and that the policy remains current and supportive. | Updated reference source to ensure all doctors are aware of their responsibilities and have the most up to date information available to support them. | In Progress – currently under review through the HR Policies and Procedures process |
| Implement Appraisal and Revalidation for Physician Associates | Ensure the Trust is compliant with GMC requirements for this group | Quality assured system for Physician Associates which mirrors the Medical Appraisal process | GMC update still awaited. Now due Dec 2025.<br>All Physician Associates now registered on SARD with individual access and support. |

**Proposed Action Plan for 2024/25**

| Objective | Actions | Expected Outcome | Outcome |
|---|---|---|---|
| Peer review of systems and processes | Carried forward from previous plan – national guidance dependant | Peer review completed. Recommendations shared. | |
| Fully implement ASPAT | Carried forward from last plan – team capacity dependant | More support for appraisers<br>Higher quality summaries<br>Early intervention for appraisers requiring support | |
| Implement Appraisal and Revalidation for Physician Associates | Carried forward from last plan – dependant on GMC guidance | Quality assured system for Physician Associates which mirrors the Medical Appraisal process | |
| Development of support framework for neurodiverse colleagues | Undertake R&D to understand difficulties faced by this group and issue advice and support materials in response. | Supports the EDI agenda.<br>Increased compliance and positive feedback achieved. | |

| | | | |
|---|---|---|---|
| Further automation of appraisal evidence | Investigate possibilities of SARD / ESR integration Implement import of Foundry documentation for Educational Supervision "revalidation" | Administrative preparation time for doctors minimised. New GMC requirements for Educational Supervisor's are met. | |

## 10. Recommendations

10.1. The Trust Board **is asked to**

- Receive this report for information;
- Note that the report will be shared with the Tier 2 Responsible Officer at NHS England.
- Note the Statement of Compliance (Appendix 1) confirms that the Trust, as a Designated Body, is in compliance with the Regulations. This will be signed by the OUH Chief Executive as required by NHS England.
- Note the Statement of Compliance for Helen and Douglas House for which the Trust provides Responsible Officer Services (Appendix 2), confirms compliance with regulations. This will be signed by the Board of Helen and Douglas House as required by NHS England.

## Appendix 1 – Appraisal Category Classifications

10.2. Category 1 is classed as

A *completed annual medical appraisal* is one where either:

a) All of the following three standards are met:
   i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*,
   ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting,
   iii. the entire process occurred between 1 April and 31 March.

Or

b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

10.3. Category 1a is classed as

i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*,
ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting,
iii. the entire process occurred between 1 April and 31 March.

# 13. HEALTH AND SAFETY ANNUAL REPORT

## REFERENCES

Only PDFs are attached

12 TB2025.80 Health and Safety Team Annual Report 2024  - 2025 v3.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.80**

| | |
|---|---|
| **Title:** | **Health and Safety team Annual Report 2024 - 2025** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **Annual health and safety reporting for assurance, performance and strategy.** |

| | |
|---|---|
| **Board Lead:** | **Chief Nursing Officer** |
| **Author:** | **Chris Green, Head of Health and Safety** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance, Performance, Strategy** |

## Executive Summary

1. A new health and safety strategy for 2026 – 2030 is being drafted with strategic objectives linked to the strategic pillars of People, Patient Care, Performance and Partnerships described in the Trust Strategic Framework.
2. The report confirms that all Health and Safety team objectives for 2024 - 25 were achieved and provided further details on specific items.
3. An external audit and internal review concluded that the Trust's Occupational Health and Safety Management System (OHSMS) is effective in providing a safe workplace and care environment.
4. Workplace inspections identified health and safety hazards associated with ageing buildings and infrastructure. Corrective actions have been given to local managers or relevant teams and risk mitigations implemented where required
5. Health and safety incidents have slightly increased (+206; +4.3%), mainly due to more reports of violence and aggression (+203; +10.25%) encouraged by the 'No Excuses' campaign. Other incident categories saw minor changes.
6. RIDDOR notifications increased (+21; +52%) due to a matching increase for incidents causing staff to be absent or unable to work for over 7 days. Causes have been identified and actions shared to prevent recurrence.
7. An annual fire safety statement outlines fire safety risks associated with physical defects within buildings and infrastructure and the current mitigations implemented by the Fire Safety Team to reduce these risks.

## Recommendations

8. The Trust Board is asked to note the content of this report.

## Contents

# Health and Safety team Annual Report 2024 - 2025

## 1. Purpose

1.1. This paper provides assurance for the effectiveness of the Trust's health and safety arrangements in meeting legal and other requirements. It provides information on health and safety performance and outlines future strategy.

## 2. Background

2.1. The Trust's Occupational Health and Safety Management System (OHSMS) meets ISO 45001: 2018 standards, recognized globally for occupational health and safety management. The Trust has been certified annually at the Churchill Hospital site since 2022, with processes implemented across all sites.

2.2. Aligning the OHSMS to ISO 45001 ensures compliance with health and safety laws. The standards require visible engagement and commitment from all management levels, especially senior leaders. This has helped develop effective Divisional Health and Safety Groups and the Health and Safety Committee, chaired by the Board Lead for Health and Safety, to provide regular assurance at the senior management level.

2.3. ISO 45001 and the Trust's OHSMS help identify significant health and safety risks and implement effective risk management processes.

2.4. Challenges include ageing buildings and infrastructure, and financial control targets. Current health and safety performance is reported in this context, and future strategy aims to support financial efficiencies.

## 3. Health and Safety Strategy and Team Objectives

3.1. The current H&S Strategy (2020 – 2025) is currently being reviewed and will be updated to cover 2026 – 2030. This new strategy will explore links to the Trust People Plan, the NHS 10-year plan and consider further integration with other business processes.

3.2. The revised H&S Strategy will aim to support the Trust's financial targets by incorporating opportunities for financial efficiencies. It will seek to commercialise certain H&S-related areas, for example training and first aid, initially to eliminate external provider costs and then to consider income generation.

3.3. The Health and Safety Committee was informed of the plans for the review of the strategy and asked for suggestions. Feedback will be considered in the strategic planning process.

3.4. The following draft strategic objectives are being considered subject to further consultation and approval:

- To reduce staff sickness and absence due to health and safety related incidents by 5% over the period of the strategy (note linked to theme 1 of the People Plan 2025-2028: Health, Wellbeing and Belonging for Our People)
- To reduce health and safety related patient falls by 5% over the period of the strategy (note linked to the Falls Reduction Programme)
- To increase compliance for health and safety requirements at all OUH main sites over the period of the strategy.
- To develop partnerships and collaboration within OUH, with other Trusts and organisations in other industries to monitor and assess our performance and support continual improvement in the health and safety management system over the period of the strategy.

3.5. All Health and Safety team objectives for 2024 - 25 were achieved as set out in table 1.

| Objective | Success criteria | Comments |
|---|---|---|
| Plan and implement a programme of workplace inspections across all OUH departments (3-year project) | Complete approx. 5 pw /15 per month. Target: May 24 – March 25 = Approx. 150 - 165 inspections completed Yr 1 (accounting for cancellations / leave etc.). | 160 inspections completed to March 31st 2025. |
| Plan and implement a programme of workplace inspections across all OUH satellite sites (3 yr project) | Complete approx. 1 pw /4 per month. Target: June 24 – March 25 = Approx. 30 - 40 inspections completed Yr 1 (accounting for cancellations / leave etc.). | 35 inspections completed to March 31st 2025. |
| Seek to exploit entrepreneurial opportunities to reduce H&S expenditure or generate income. | 1. Obtain accreditation to deliver IOSH Managing Safely course in house (cease to require external providers).<br>2. Obtain numbers and comments from Divisions to evaluate options for First Aid provision in house. | 1. IOSH training completed, and accreditation achieved. On track to deliver course in house from Q2 2025. Significant £ savings against external providers.<br>2. Quantitive data and comments from Divisions collected. Options to deliver in house contingent on financial resources (net cost saving after initial set up outlay) |
| H&S team to support Trust preparations to meet new Terrorism (Protection of Premises) Bill (also known as 'Martyn's Law). | Head of H&S forms a working group to review and implement new legislation once passed. | Working group with Emergency Planning Officer, Security Manager and Senior Operations Manager (Estates). Initial review of known requirements completed. Awaiting legislation to pass. |

| Objective | Success criteria | Comments |
|---|---|---|
| H&S team to support Clinical Divisions to meet 'SAFE' elements of CQC Single Assessment framework. | H&S team provide guidance for 'what good looks like' relating to H&S requirements of CQC SAF. | H&S team reviewed CQC SAF requirements relating to 'SAFE ENVIRONMENT' and developed a detailed guidance document for how H&S requirements can be met. Guidance issued to divisional H&S Group leads. |
| Seek to develop collaboration for H&S with other healthcare Trusts, including obtain and contribute to benchmarking data with Shelford, SWIOSH and BOB HS Network if possible. | OUH H&S team to contact former BOB H&S Group and to seek to form a Shelford H&S group.<br>OUH H&S team to host first meetings with BOB /Shelford. | H&S team successfully reinstated BOB H&S Group and hosted group meeting 2024. Quarterly meetings planned for 2025, benchmarking to be developed.<br>Shelford Group – all members contacted, 9 of 10 responded to OUH. Inaugural meeting planned for June 2025 to scope interest, areas for benchmarking and terms of reference. |
| H&S team to continue with an executive programme of site visits with revised focus on staff interaction and identification of themes. | A regular programme of Executive tours is implemented, led by Head / Dep Head of H&S team. | A programme of 13 Executive Tours was completed in the reporting period. Tours attended by Chief Officers or their representatives, and 1 tour by Non-Executive Director (Paul Dean). |
| Seek to support the development of local procurement processes to ensure local controls meet all relevant H&S legislation requirements. | Managers have access to suitable information about H&S requirements when purchasing equipment, particularly relating to needs for service, maintenance and statutory inspections and examination. | H&S team updated the Trust's OH&S Management System document to include information about procurement processes. Also provided a guidance document for managers detailing service, maintenance and inspection requirements. All guidance is available from the H&S team intranet site. |

Table 1: Health and Safety team objectives 2024- 25

3.6. Health and safety team objectives are developed and agreed with the Chief Nursing Officer for each year. The following H&S team annual objectives are under review for 2025-26 and subject to approval:

- Support reductions in work-related H&S incidents resulting in sickness/absence annually.
- Support reductions in civil claims related to high incidence/cost H&S incidents annually.
- Refine and redesign the Managing H&S course to reduce e-learning time and link more to intranet and ISO processes.
- Implement a programme of re-visits to monitor corrective actions by departments with high level of nonconformities.

- Deliver IOSH Managing Safely training in-house to selected managers and others with specific H&S responsibilities.

## 4. Assurance

4.1. The Trust recertified to the ISO 45001 Standard after a 5-day external audit in May 2024. The audit, conducted at the Churchill site, included departments across the Trust such as Estates and Facilities, Emergency Planning, PFI Contracts, Occupational Health, Clinical Engineering, and Assurance. It covered areas managed by OUH and the PFI, involving both clinical and administrative functions.

4.2. The auditor held meetings with the Head of Health and Safety, the Director of Regulatory Compliance and Assurance, and senior leaders from clinical divisions, department managers and staff. The audit identified six nonconformities, which were addressed during the remaining reporting period as shown in Table 1:

| Nonconformity | Corrective actions implemented to address |
|---|---|
| Develop and implement a process to offer statutory health assessments to night workers. | The Head of Occupational Health developed and implemented a process to meet statutory requirements. |
| Develop a process to improve compliance with the Trust's requirements for departments to complete a monthly workplace safety inspection. | A paper-based process was changed to electronic audit hosted on Ulysses Assurance Hub; enables automated recording and reporting for monitoring purposes. Reports provided by H&S team to Divisional H&S groups. |
| Develop a process to support management level monitoring of health and safety requirements (e.g. for completion of inspections and audits). | Annual H&S audit redesigned and hosted on Ulysses Assurance Hub. Reports provided by H&S team to Divisional H&S groups. A tracking template for risk assessments was also provided to Divisional H&S Groups. |
| Develop a non-patient incident investigation process similar to the robust process for patient incidents (based on the Patient Safety Incident and Reporting Framework (PSIRF) process). | A non-patient investigation process similar to the PSIRF patient process was developed by H&S team, approved by the Clinical Policy Group and incorporated to the Incident Reporting, Investigation and Learning Procedure. |
| Rectify one door in a Churchill Theatres (managed by PFI) to ensure a safety lock function operated correctly. | The PFI implemented a programme of upgrades to doors requiring work from minor repairs to full replacement. |
| Ensure the monitoring requirements of the Stress Management Policy are implemented. | The monitoring arrangements of the Stress Management Policy were reviewed and updated by Head of Occupational Health. New arrangements implemented. |

Table 2: 2024 ISO 45001 audit: nonconformities and corrective actions

4.3. The ISO 45001 Standards require an annual formal, independent, internal Management Review of the OHSMS. The Director of Regulatory

Compliance and Assurance (DRCA) completed reviews in November 2024, March 2025, and April 2025. The reviews noted:

- All actions set in November were completed or on track.
- The Trust is generally compliant with OHSMS requirements and health and safety legislation. Further work was identified and monitored locally.
- Audit compliance levels were improving. Divisional H&S meetings were attended by the DRCA, with divisions positively engaged.
- Many continual improvements were implemented, with additional areas identified for the 2026-2030 strategy.
- No further changes to the OHSMS were needed beyond identified actions and improvements. No new resource needs were identified.
- Two opportunities to improve OHSMS integration with other business processes were identified: these were to develop procurement processes to better account for health and safety requirements and to enhance PFI processes to address incidents and nonconformities promptly and manage risks effectively.

4.4. The Head of Health and Safety regularly meets with the Executive Lead for H&S (Chief Nursing Officer) or their deputy to provide updates and advice on health and safety matters, ensuring the Trust meets legal requirements. Additional assurance is provided to Non-Executive Directors and governors for specific health and safety queries.

4.5. The DRCA acts as Senior Responsible Officer for the ISO 45001 Management System and meets with the Head of Health and Safety approximately fortnightly to monitor objectives, actions, and processes. The DRCA supported continual improvement opportunities and strategy, advising on how H&S objectives might support Trust strategic plans and integration with other business processes.

4.6. In April 2025, the OUH H&S team were invited by Mid and South Essex NHS Foundation Trust (MES) to conduct a peer review of MES Trust's health and safety arrangements. The OUH team, consisting of Head and Deputy Head of Health and Safety and the DRCA. This was considered a positive opportunity for further collaboration with a Trust of a similar size seeking to adopt a similar journey to that taken by OUH over recent years. Both trusts identified that ageing buildings and infrastructure presented health and safety related hazards and both recognised similar financial challenges to prioritise remedial measures and maintenance. The OUH certification to the ISO 45001 Standard was one area of difference between the Trusts, overall there were similar processes in place albeit with different approaches for implementation due to organisational structures and staffing. The review enabled areas of shared learning that both OUH and

MES can reflect on and incorporate to future planning. OUH plans to maintain contact with MES to ensure ongoing mutual support and learning regarding our respective health and safety management systems.

## 5. Performance

5.1. Incident reporting rates across all categories remained fairly consistent, with a 4.3% increase in total numbers. The largest increase was in incidents of assault, aggression, and harassment, partly due to the ongoing 'No Excuses' campaign encouraging staff to report incidents, as shown in the table below:

| Incident type | Total 2023 - 2024 | Total 2024 - 2025 | Difference |
|---|---|---|---|
| Manual Handling | 128 | 134 | + 6 |
| Slips, Trips and Falls | 2203 | 2175 | -28 |
| Sharps, Needlestick and Splash | 464 | 489 | +25 |
| Assault, Aggression and Harassment | 1979 | 2182 | +203 |
| TOTAL | 4774 | 4980 | +206 |

Table 3: Incidents 2023/24 – 2024/25

5.2. The Trust's OHSMS effectively limits and reduces health and safety incidents despite the growing number of patient contacts. A detailed summary is in Appendix A.

5.3. RIDDOR notifications increased from 40 in 2023/24 to 61 in 2024/25, mainly due to incidents causing staff absences over 7 days. These incidents were mostly due to slips, falls involving water, and manual handling related to patient care and equipment use. Divisions were informed of these trends at recent meeting of the Health and Safety Committee and requested to review local actions to reduce recurrence. A breakdown of RIDDOR notifications is in Appendix B.

5.4. As noted in the objectives section, since May 2024, the Health and Safety team has completed approximately 160 departmental workplace inspections. The inspections aim to:

- Ensure compliance with trust and legal health and safety requirements.
- Help local managers identify and control workplace hazards.
- Review and ensure the quality of risk assessments.
- Provide reports with local management actions to address issues or nonconformities.

5.5. The top 5 areas of nonconformity are shown in Table 3. Actions were raised to report defects to relevant Helpdesks. Issues needing local management, like slips, trips, falls, and storage problems, were included in reports to department managers. The process for Portable Appliance Testing has been reviewed by the Operational Estates Electrical Tea. A schedule for a new inspection program at all main sites has been planned and is due to commence in Q1 2025 once arrangements for the appointed contractor have been approved.

| Question | No | Yes | NA |
|---|---|---|---|
| Are all fire doors in good condition / free of defects? | 58.3% | 40.5% | 1.2% |
| Were all areas free of slip and trip hazards, including floors and stairs. | 63.3% | 36.7% | |
| Is equipment in store rooms easily accessible and allow correct manual handling techniques? | 51.9% | 48.1% | |
| Were all portable appliances found to have been Portable Appliance Tested (PAT) and sticker still in date? | 91% | 6.4% | 2.6% |
| Are electrical cables well managed, undamaged and stored tidily? | 65.8% | 34.2% | |

Table 4: Top 5 nonconformities arising from departmental inspections

5.6. During the reporting period, the Trust developed and implemented two types of health and safety audits:

- Monthly workplace inspections completed by departments to ensure a safe work environment for staff and a safe care environment for patients and visitors
- A bi-monthly, six-part annual H&S audit measures compliance with trust and legal health and safety requirements.

5.7. The monthly workplace inspection was hosted on the Ulysses Assurance Hub module for the first time. This was initially mapped to approximately 540 locations. This has been subject to review and work to valid locations to departments is ongoing. This work will ensure accurate compliance reporting across the Trust.

5.8. Compliance with both audits is generally high for departments that have completed them, though overall compliance is around 50%, for the current list of locations / departments. Divisional health and safety groups have supported the audits well. Noncompliance is monitored and followed up by H&S team reports to Divisions with issues highlighted through internal communications and monthly Divisional H&S group meetings. Summaries of audit compliance are shown in Appendix C (monthly inspections) and Appendix D (annual audits).

## 6. Annual Fire Safety Statement

6.1. Health Technical Memorandum (HTM) 05-01 provides guidance intended to assist in determining the appropriate fire safety management system to be applied to healthcare organisations.

6.2. The Trust follows the guidance of HTM 05-01 and relevant legislation, other relevant guidance contained in other parts of the Firecode and advice and approval of external parties including from SOCOTEC, the Trust's appointed Authorising Engineers (AE) for fire; local authority building control and Oxfordshire Fire and Rescue Service.

6.3. HTM 05-01 recommends that an organisation should produce an annual statement of fire safety to provide a clear indication in respect of the status of fire safety management within the organisation and a statement of assurance that adequate fire safety measures are in place. An annual statement of fire safety for 2025 is shown in Appendix E.

## 7. Conclusion

7.1. The ISO 45001 standards provide an excellent framework for a robust Occupational Health and Safety Management System (OHSMS). The Trust uses various processes to ensure the OHSMS's effectiveness and to identify areas for improvement. Effective reporting routines exist from ward to Board, with Divisional H&S groups and the Health and Safety Committee increasingly contributing to this reporting.

7.2. Plans for a new health and safety strategy could further strengthen and integrate the OHSMS with other Trust plans, objectives, and business processes.

7.3. The annual fire safety statement confirms significant risks identified by fire risk assessment and describes the soft mitigations implemented to reduce these risks. The physical defects giving rise to fire safety risks require programmes of investment in fire precautions that are properly accounted for in the trust's annual business plan and reflected in the relevant Trust risk registers.

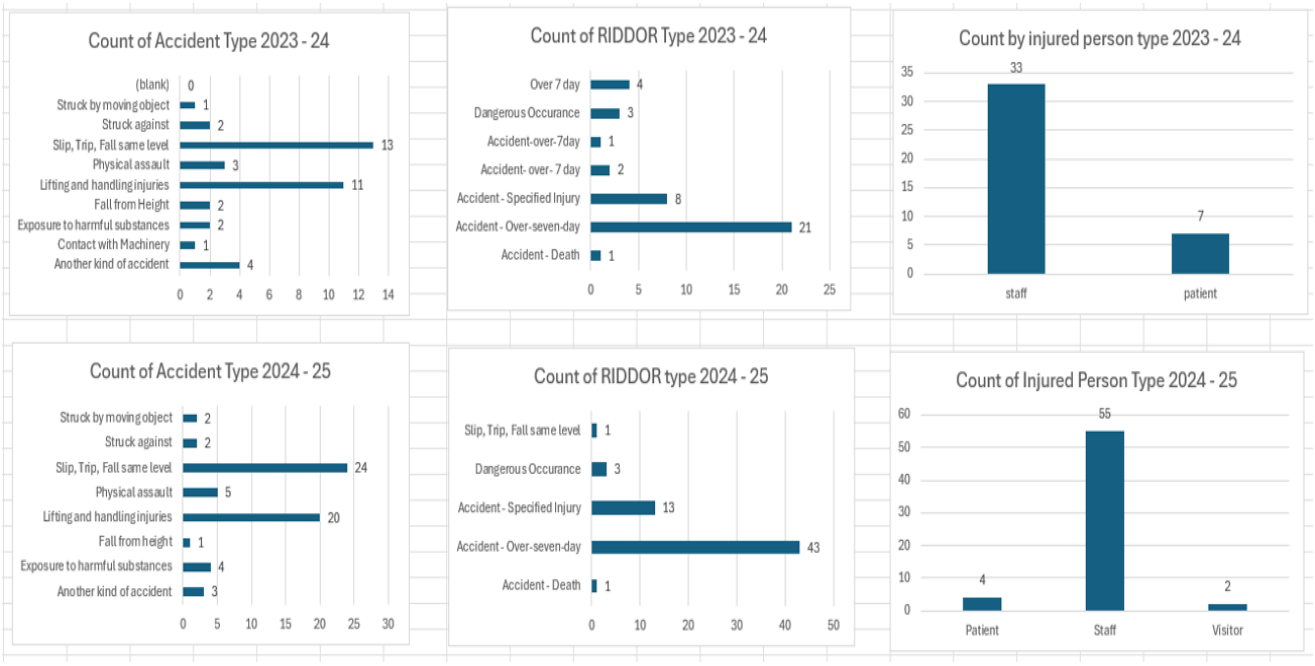
## 8. Recommendations

8.1. The Trust Board is asked to note the content of this report.

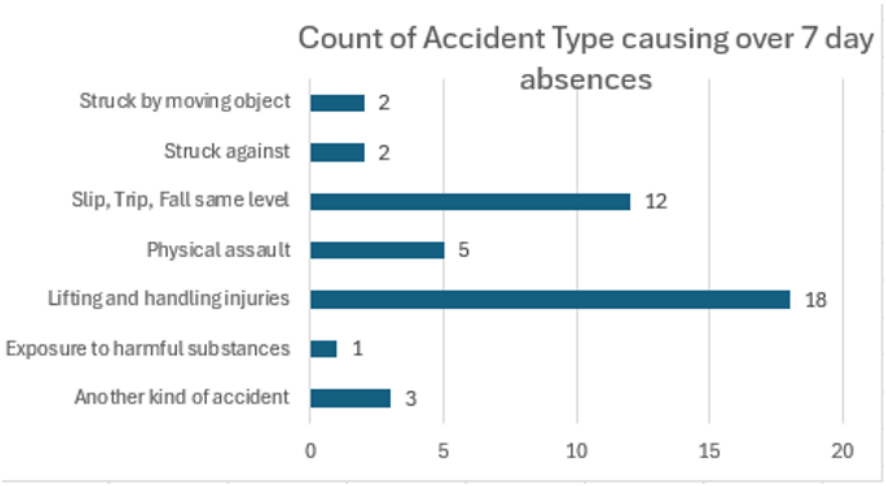
## Appendix A: Incident data 2023/24 – 2024/25

| | April 2023 to March 2024 | | | | | April 2024 to March 2025 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Incident category** | **Staff** | **Visitor** | **Contractors** | **Patient** | **Grand Total** | **Staff** | **Visitor** | **Contractors** | **Patient** | **Grand Total** | **Difference (Grand Totals)** | **diff %** |
| **Manual Handling** | **125** | **0** | **0** | **3** | **128** | **134** | **0** | **0** | **0** | **134** | **6** | 4.7 |
| No Harm | 22 | 0 | 0 | 3 | 25 | 12 | 0 | 0 | 0 | 12 | **-13** | -52.0 |
| Minor | 95 | 0 | 0 | 0 | 95 | 118 | 0 | 0 | 0 | 118 | **23** | 24.2 |
| Moderate | 8 | 0 | 0 | 0 | 8 | 4 | 0 | 0 | 0 | 4 | **-4** | -50.0 |
| Major | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0 |
| Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0 |
| Minor and above | 103 | 0 | 0 | 0 | 103 | 122 | 0 | 0 | 0 | 122 | **19** | 18.4 |
| **Slips Trips And Falls** | **110** | **24** | **1** | **2068** | **2203** | **112** | **33** | **1** | **2029** | **2175** | **-28** | -1.3 |
| No Harm | 32 | 11 | 0 | 1375 | 1418 | 28 | 16 | 0 | 1279 | 1323 | **-95** | -6.7 |
| Minor | 75 | 11 | 1 | 645 | 732 | 73 | 13 | 1 | 702 | 789 | **57** | 7.8 |
| Moderate | 3 | 2 | 0 | 32 | 37 | 11 | 4 | 0 | 36 | 51 | **14** | 37.8 |
| Major | 0 | 0 | 0 | 11 | 11 | 0 | 0 | 0 | 10 | 10 | **-1** | -9.1 |
| Death | 0 | 0 | 0 | 5 | 5 | 0 | 0 | 0 | 2 | 2 | **-3** | -60.0 |
| Minor and above | 78 | 13 | 1 | 693 | 785 | 84 | 17 | 1 | 750 | 852 | **67** | 8.5 |
| **Sharps Needlestick and Splash Incidents** | **436** | **3** | **1** | **24** | **464** | **467** | **0** | **3** | **19** | **489** | **25** | 5.4 |
| No Harm | 178 | 0 | 0 | 20 | 198 | 192 | 0 | 0 | 11 | 185 | **-13** | -6.6 |
| Minor | 258 | 3 | 1 | 3 | 265 | 275 | 0 | 3 | 8 | 246 | **-19** | -7.2 |
| Moderate | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | **-1** | -100.0 |
| Major | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0 |
| Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0 |
| Minor and above | 258 | 3 | 1 | 4 | 266 | 275 | 0 | 3 | 8 | 246 | **-20** | -7.5 |
| **Assault, Aggression & Harassment** | **1723** | **29** | **1** | **226** | **1979** | **1961** | **21** | **0** | **200** | **2182** | **203** | 10.3 |
| No Harm | 1008 | 18 | 1 | 144 | 1171 | 1084 | 14 | 0 | 114 | 1212 | **41** | 3.5 |
| Minor | 552 | 10 | 0 | 81 | 643 | 728 | 7 | 0 | 85 | 820 | **177** | 27.5 |
| Moderate | 163 | 1 | 0 | 1 | 165 | 149 | 0 | 0 | 1 | 150 | **-15** | -9.1 |
| Major | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0 |
| Death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0.0 |
| Minor and above | 715 | 11 | 0 | 82 | 808 | 877 | 7 | 0 | 86 | 970 | **162** | 20.0 |
| **Grand Total** | **2394** | **56** | **3** | **2321** | **4774** | **2674** | **54** | **4** | **2248** | **4980** | **206** | 4.3 |

## Appendix B: RIDDOR notification 2023 /24 comparison to 2024 / 25




### Breakdown of over 7-day absences for staff 2024/25



## Appendix C: Monthly workplace audits Oct 24 – March 25

**OUH - H&S Monthly Workplace Inspection - New Qs Added Report 01/10/2024 to 16/04/2025**

| | Yes | No | N/A | Total | % |
|---|---|---|---|---|---|
| Are all fire doors in good condition and free of defects? | 87 | 29 | 4 | 120 | 75.83% |
| Are fire extinguishers sited / located as per fire alarm zone plan? | 117 | 2 | - | 119 | 98.32% |
| Are all fire extinguishers serviceable? | 118 | 2 | - | 120 | 98.33% |
| Is there a fire alarm panel within or immediately outside your department? | 92 | 26 | - | 118 | 77.97% |
| - Is the Fire Alarm Panel clear of faults? | 84 | 7 | - | 91 | 92.31% |
| - Is the Fire Alarm Zone Plan located by the fire alarm panel? | 90 | 2 | - | 92 | 97.83% |
| - Is the Fire Alarm Zone Plan easy to read? | 86 | 6 | - | 92 | 93.48% |
| Are all fire safety equipment and emergency equipment easily accessible? | 119 | 0 | - | 119 | 100% |
| *Do you have oxygen / medical gas cylinders within your department? This will NOT affect your score* | 76 | 43 | - | 119 | |
| - Are oxygen/medical gas cylinders located as per the department's fire emergency plan? | 72 | 2 | - | 74 | 97.30% |
| - Are larger oxygen/medical gas cylinders on trolleys? | 65 | 11 | - | 76 | 85.53% |
| *Do you have any specialist evacuation aids in your department? This will NOT affect your score* | 7 | 113 | - | 120 | |
| - Are the specialist evacuation aids located as per the departmental Fire Emergency Plan | 6 | 0 | - | 6 | 100% |
| - Are all evacuation aids in a clean and serviceable condition? | 5 | 1 | - | 6 | 83.33% |
| Are evacuation routes free and clear for immediate use, including neighbouring departments where you may need to exit through. | 115 | 3 | - | 118 | 97.46% |
| Are the contents of the first aid kit / box complete and in date? | 92 | 4 | 20 | 116 | 96.55% |
| During the inspection walk round, were all areas inside and immediately outside of the department free of slip and trip hazards, including floors and stairs. (This includes corridors and access / egress areas to the department). | 111 | 4 | - | 115 | 96.52% |
| Are all areas uncluttered, with equipment and consumables stored appropriately. | 108 | 8 | - | 116 | 93.10% |
| Have all building defects (e.g. floors / floor covering, windows, doors, walls, sinks, taps, etc.) been reported to the relevant Estates Helpdesk? | 89 | 0 | 28 | 117 | 100% |
| *All previously reported building defects (e.g. doors, walls etc) been resolved within a timely manner? (please see Estates response guidance in tooltip)." This question does NOT affect score* | 64 | 28 | 25 | 117 | |
| Lighting is suitable for people to work and to move around safely and comfortably. | 116 | 1 | - | 117 | 99.15% |
| There is suitable natural ventilation (doors, windows etc.) and / or mechanical ventilation to provide a comfortable working environment? | 108 | 8 | - | 116 | 93.10% |
| Is the temperature comfortable for most people in the area? | 101 | 14 | 1 | 116 | 87.93% |
| Is all equipment in store rooms easily accessible and allow correct manual handling techniques? | 94 | 4 | 16 | 114 | 96.49% |
| Are low Risk COSHH items stored safely and only accessible by staff? | 93 | 0 | 20 | 113 | 100% |
| On inspection, are all other COSHH materials / substances i.e. those used in work activities / processes, stored securely? | 73 | 1 | 39 | 113 | 99.12% |
| On inspection, were suitable spill kits/materials readily available for use, where required. | 62 | 0 | 51 | 113 | 100% |
| On inspection, were all portable electrical appliances sampled found to have been Portable Appliance Tested (PAT) and the sticker was still in date. | 87 | 25 | 3 | 115 | 78.26% |
| Can you confirm that during the inspection there was no prohibited electrical equipment found in use I.E red element / bar heaters; block adapters | 100 | 3 | 12 | 115 | 97.39% |
| Can you confirm that during the inspection electrical extension leads were being used correctly? (Please see tooltip for this before responding) | 102 | 0 | 11 | 113 | 100% |
| Electrical cables are well managed, undamaged and stored tidily. | 111 | 3 | - | 114 | 97.37% |
| All work equipment observed during the inspection appeared to be in a safe condition for use? | 113 | 0 | - | 113 | 100% |
| All lifting equipment checked during the inspection was in date for statutory inspection? | 44 | 2 | 67 | 113 | 98.23% |
| Any gas cylinders noted during the inspection were safely stored and secured. | 69 | 0 | 45 | 114 | 100% |

**Continued below**…

| | | | | | |
|---|---|---|---|---|---|
| All work at height equipment (step ladders/foldable steps/ kick stools) seen during the inspection were visibly in good condition? | 88 | 0 | 26 | 114 | 100% |
| During the inspection all 'staff only' / 'restricted access' areas were found to be locked / secure to control access by unauthorised persons (e.g. by patients, visitors and contractors)? | 91 | 3 | 20 | 114 | 97.37% |
| Have all reoccurring issues / risks been escalated to the Divisional H&S Group for senior management line of sight and support? | 47 | 1 | 66 | 114 | 99.12% |
| *Have you completed any individual work related stress risk assessments this month?* | 28 | 86 | - | 114 | |
| *Has this area got any air outlets?* | 0 | 0 | - | 0 | |
| - Are piped air outlets appropriately capped? | 0 | 0 | - | 0 | 0% |
| | Yes | No | N/A | Total | % |
| *Does this area use Orange and Offensive waste disposal bins?* | 0 | 0 | - | 0 | |
| - Looking at up to 6 Offensive waste bins, has the correct waste been disposed of within each of these bins? (only answer Yes if ALL bins have the appropriate waste disposed of within them) | 0 | 0 | - | 0 | 0% |
| - Looking at up to 6 Orange waste bins, has the correct waste been disposed of within each of these bins? (only answer Yes if ALL bins have the appropriate waste disposed of within them) | 0 | 0 | - | 0 | 0% |
| **Total** | **0** | **0** | **-** | **0** | **0%** |

Note: Q's for piped air outlets and waste were new questions added for April 25 onwards and not included in data for 2024 – 25.

## Appendix D: Annual H&S Audit (Part 1 Dec 24 and Part 2 Feb 25)

**OUH - Health & Safety Audit (1/6)**

| | Yes | No | N/A | Total | % |
|---|---|---|---|---|---|
| **Section 3 - Use of Department** | Yes | No | N/A | Total | % |
| Are you aware of the most current H&S Policies, procedures and SOPs, including H&S Committee related P+Ps, as shown in the H&S Intranet site? | 238 | 1 | - | 239 | 99.58% |
| Is the department's General Workplace Risk Assessment complete and in date? | 215 | 24 | - | 239 | 89.96% |
| Has the department completed a departmental walk round inspection to meet the requirement for annual review of ligature risks in the department? | 162 | 25 | 52 | 239 | 89.54% |
| Has the department identified a specific area within the department where the risk of ligatures and anchor points have been removed or controlled as low as reasonably practicable (ALARP) | 93 | 31 | 115 | 239 | 87.03% |
| Has the department completed or updated a Ligature Risk Reduction Risk Assessment? Please upload a copy of this in the Evidence Section of the H&S topic | 99 | 46 | 94 | 239 | 80.75% |
| Has the department completed a baseline team Work Related Stress Risk Assessment within the last 12 months? | 129 | 110 | - | 239 | 53.97% |
| Are all other risk assessments required by the department complete and in date? | 209 | 30 | - | 239 | 87.45% |
| Have all health and safety related risk assessments been shared with staff so they are aware of hazards and controls needed to eliminate or reduce risks? | 217 | 22 | - | 239 | 90.79% |

**OUH - Health & Safety Audit (2 / 6) Report 01/02/2025 to 28/02/2025**

| **Before commencing this audit, please see H&S AUDIT** | Yes | No | N/A | Total | % |
|---|---|---|---|---|---|
| *Hospital Site:* | 0 | 0 | - | 0 | |
| **Use of Department** | Yes | No | N/A | Total | % |
| *What is the primary function of the department?* | 0 | 0 | - | 0 | |
| **First Aid** | Yes | No | N/A | Total | % |
| Has a First Aid needs assessment been conducted? | 180 | 36 | - | 216 | 83.33% |
| Does the department have sufficient numbers of First Aiders / Appointed Persons as per the First Aids Needs Assessment? (please see guidance in the tooltip). | 191 | 25 | - | 216 | 88.43% |
| Have those first aiders who need a First Aid at Work or Emergency First Aid at Work Certificate completed this training? | 61 | 10 | 144 | 215 | 95.35% |
| Is suitable First Aid equipment and eye-wash solution identified by the First Aid Needs Assessment readily available? | 193 | 22 | - | 215 | 89.77% |
| Are locations of First Aid boxes and eye wash stations clearly signposted? | 176 | 38 | - | 214 | 82.24% |
| Are first aiders and appointed persons known to all staff in the department? (This does not apply to clinical departments where there will be many qualified registered medical professionals). | 189 | 27 | - | 216 | 87.50% |
| **Welfare** | Yes | No | N/A | Total | % |
| Have suitable and sufficient sanitary conveniences and washing facilities been provided for staff? | 214 | 3 | - | 217 | 98.62% |
| Is there an adequate supply of drinking water available for staff? | 215 | 2 | - | 217 | 99.08% |
| Are suitable and sufficient rest facilities at readily accessible places available for staff? | 208 | 9 | - | 217 | 95.85% |
| Is there suitable and sufficient accommodation for the clothing of any person at work which is not worn during working hours? | 177 | 7 | 33 | 217 | 96.77% |
| Is there Suitable and sufficient accommodation for special clothing which is worn by any person at work but which is not taken home? | 103 | 8 | 106 | 217 | 96.31% |
| **Total** | **1907** | **187** | **283** | **2377** | **92.13%** |

## Appendix E: Fire Safety Compliance Statement

I confirm that for the period 1 April 2024 to 31 March 2025, all premises which the organisation owns, occupies or manages have had fire risk assessments undertaken in compliance with the Regulatory Reform (Fire Safety) Order 2005, and:

| | Fire safety statement | Statement response |
|---|---|---|
| 1. | There are no significant risks arising from the fire risk assessments. | There are some significant risks related to buildings and fire safety infrastructure. |
| 2. | The organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment. | At department level, a programme of soft mitigations has been developed and implemented by the Fire Safety Team. These mitigations include risk assessment at department level, training, including enhanced training in some areas, and amended evacuation strategies.<br>These 'soft mitigations' reduce the risk arising from the physical defects. |
| 3. | The organisation has identified significant risks, but does not have a programme of work to mitigate those significant risks. | There are soft mitigations in place to reduce risk as stated in section 2. At present, there is not a programme of work to eliminate physical defects managed by OUH Estates and Facilities (retained estate) e.g. fire dampers, fire doors, alarm systems and compartmentation. |
| 4. | Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. | Dates for any such programme will be aligned to the Estates back log maintenance plan and the Trust's business plans. |
| 5. | During the period covered by this statement, the organisation has not been subject to any enforcement action by the fire and rescue authority. | No formal enforcement action in this reporting period. |
| 6. | The organisation does not have any ongoing enforcement action pre-dating this Statement. | There is no ongoing enforcement action pre-dating this statement for the OUH managed areas (Retained Estate). The PFI management at the Churchill site (Ochre Solutions Ltd.) do have ongoing enforcement action pre-dating this statement, in the form of an Alterations Notice issued by Oxfordshire Fire and Rescue Service relating to external wall system (cladding). |
| 7. | The organisation achieves compliance with the Department of Health's fire safety policy by the application of Firecode or some other suitable method. | Yes. |
| | Head of Health and Safety: *Chris Green* | |
| | Fire Safety Manager: *Russell Adlam* | |

# 14. FREEDOM TO SPEAK UP POLICY

## REFERENCES

Only PDFs are attached

13 TB2025.81 Freedom to Speak Up Policy Cover Paper v1.1.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.81**

| | |
|---|---|
| **Title:** | **Freedom to Speak Up Policy** |

| | |
|---|---|
| **Status:** | **For Decision** |
| **History:** | **People and Communications Committee 11 August 2025** |
| | **Trust Management Executive 28 August 2025** |

| | |
|---|---|
| **Board Lead:** | **Chief People Officer** |
| **Author:** | **Lindley Nevers, Lead Freedom to Speak Up Guardian** |
| | **Susan Polywka, Freedom to Speak Up Project Manager** |
| | **Beverley Hoskin, Assistant Director of Workforce – Pay, Policy and Reward** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Policy** |

## Executive Summary

1. This paper presents the Freedom to Speak Up Policy for approval.
2. The updated Freedom to Speak Up Policy reflects the refresh of the Trust's Freedom to Speak Up (FTSU) service and incorporates national guidance on protecting staff who speak up from detriment, disadvantageous or demeaning treatment. WorkInConfidence, a third party platform that facilitates anonymous reporting, is introduced and clarification for staff on Raising a concern and on Signposting for formal employee concerns is also provided.
3. The policy makes reference to The National Guardian's Office - Freedom to Speak Up although, at the time of writing, publication of the Government's 10 Year Plan for the NHS (on Thursday 3 July, 2025), and of Dr Penny Dash's Review of patient safety across the health and care landscape - GOV.UK (on Monday 7 July), has signalled that the distinct role of a National Guardian for Freedom to Speak Up will no longer be required. No timeframe has yet been given for abolition of the role but once clarity is provided, the Chief People Officer will be responsible for ensuring that the policy is amended to reflect the new, alternative arrangements for external oversight of effective freedom to speak up functions within the Trust.
4. A more comprehensive breakdown of the updated policy can be found in the full document.

## Recommendations

5. The Trust Board is asked to approve the Freedom to Speak Up Policy.
6. The Trust Board is also asked to delegate authority to the People and Communications Committee to approve such updates that may be required to reflect changes in the mechanism for external oversight (once known), and to remove/amend terminology that consequently may be rendered obsolete.

# Freedom to Speak Up Policy

## 1. Purpose

1.1. This paper presents the Freedom to Speak Up Policy for approval.

## 2. Background

2.1. The current OUH FTSU Policy, approved by the Board in November 2022, is consistent with the national model policy published by NHS England in June 2022, which provides the minimum standard for local freedom to speak up policies across the NHS, so that those who work in the NHS know how to speak up and what will happen when they do. Adhering to the provisions and broader principles of the national model policy, the OUH FTSU Policy is designed to be inclusive and support resolution by managers wherever possible. (Refer to NHSE Model FTSU Policy ).

2.2. The OUH FTSU Policy presented here is the outcome of the 3-yearly review undertaken.

## 3. Freedom to Speak Up Policy

3.1. The updated Freedom to Speak Up Policy was circulated for consultation to staff side colleagues, staff network chairs (with a request to circulate the draft policy to their members), divisional management teams and HR colleagues between 20 May and 19 June 2025. A copy of the draft policy was also available in the 'Policy and Procedure Review' folder on the HR intranet site.

3.2. Following its review the key provisions of the policy, and its aims remain to ensure that all staff can speak up and that all matters raised as a concern are captured and considered appropriately.

3.3. The policy has been updated to reflect the refresh of the Trust's Freedom to Speak Up (FTSU) service, which includes the Chief People Officer as the Executive Lead, appointment of a new Deputy Lead Guardian and growth of the network of volunteer FTSU Champions.

3.4. The policy includes the introduction of WorkInConfidence, a third party platform that facilitates anonymous reporting, and sets out how to raise a concern anonymously via this independent platform.

3.5. Clarification for staff on Raising a concern and on Signposting for formal employee concerns is also included in the policy.

3.6. The policy also reflects developments nationally, including guidance on protecting staff who speak up from detriment, disadvantageous or demeaning treatment.

3.7. It is recognised that the Fit for the Future: 10 Year Health Plan for England identifies the National Guardian's work will align with other national staff voice functions, meaning the distinct role of the National Guardian will no longer be required. As and when further details of this change, and the timeline are known, the Freedom to Speak Up Policy will be updated accordingly.

3.8. The Chief People Officer will be responsible for ensuring that the policy is so updated, and it is recommended that authority to approve such updates to the Policy as may be required to reflect changes in the mechanism for external oversight (once known), and to remove/amend terminology that consequently may be rendered obsolete is delegated to People and Communications Committee by Trust Board.

3.9. There is a communication plan to support implementation of the updated OUH FTSU Policy, and the full policy is attached at Appendix 1.

## 4. Conclusion

4.1. The updates made to the Freedom to Speak Up Policy ensure it incorporate relevant national guidance, best practice and reflects current practices and processes.

## 5. Recommendations

5.1. The Trust Board is asked to approve the updated Freedom to Speak Up Policy.

5.2. The Trust Board is also asked to delegate authority to the People and Communications Committee to approve such updates that may be required to reflect changes in the mechanism for external oversight (once known), and to remove/amend terminology that consequently may be rendered obsolete.

## 6. Appendices

Appendix 1 – Freedom to Speak Up Policy

Oxford University Hospitals
NHS Foundation Trust

# Freedom to Speak Up Policy

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|---|---|
| **Category:** | Policy |
| **Summary:** | This document aims to outline the policy and procedure for employees and anyone working at the Trust to speak up to raise concerns (including concerns which may be considered as "whistleblowing") and to explain the protection given by the Public Interest Disclosure Act 1998. |
| **Equality Analysis undertaken/reviewed:** | May 2025 |
| **Valid From:** | |
| **Date of Next Review:** | Three years<br>Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid. |
| **Approval Date/ Via:** | |
| **Distribution:** | Trust-wide |
| **Related Documents:** | Complaints Policy<br>Counter Fraud Policies and Procedures<br>Conduct and Expected Behaviours Procedure (including Sexual Misconduct)<br>Incident Reporting, Investigation and Learning Procedure<br>Freedom to Speak Up - At a glance<br>Resolution (Grievance and Collective Disputes) Procedure<br>NHS England » The national speak up policy published June 2022<br>Respect and Dignity at Work Procedure (including Sexual Safety at Work)<br>Signposting – Employee Concerns<br>Managing Allegations against Staff and Persons in a Position of Trust Policy |
| **Author(s):** | Freedom to Speak Up Lead Guardian<br>Freedom to Speak Up Project Officer<br>HR Consultant |
| **Further Information:** | Freedom to Speak Up Lead Guardian<br>Freedom to Speak Up Deputy Lead Guardian<br>Freedom to Speak Up Champions |
| **This Document replaces:** | Freedom to Speak Up Policy v6.0 |

**Lead Director:** Chief People Officer

**Issue Date:**

## Contents

## Message from the Trust Chair and the Chief Executive Officer

To All Oxford University Hospitals NHS Foundation Trust Staff,

We are delighted to support and endorse this policy as we continue to work toward an open, transparent and responsive culture across the Trust. We appreciate that supporting staff who wish to raise concerns is a very important cultural change across the NHS and one we support wholeheartedly.

We encourage those of you with any concerns to speak up, and to access advice and support as necessary, as detailed in this document.

| | |
|---|---|
| Professor Sir Jonathan Montgomery | Simon Crowther |
| Chair | Interim Chief Executive Officer |

The content of this policy incorporates the provisions of the NHS England » The national speak up policy published June 2022.

# Introduction

1. Oxford University Hospitals NHS Foundation Trust (the "Trust") is committed to achieving the highest possible standards of service for the benefit of patients, employees, others working at Trust premises, service users and visitors. Where standards are not as would be expected, employees are expected to learn and make improvements to address issues.
2. The Trust is supportive of colleagues who have concerns over possible danger, risk, wrongdoing or malpractice and encourages all employees to act promptly and report their concern appropriately.
3. Any member of staff who identifies an issue has a duty to raise that matter appropriately so that it can be addressed, and improvements can be made.
4. Staff include anyone who works or has worked in the NHS or for an independent organisation including Retention of Employment (RoE) staff, bank and agency workers, temporary workers, students, volunteers, trainees, junior doctors, locums and governors.
5. All staff have the freedom to speak up about a genuine concern and should have confidence that their voice will be heard. No member of staff should suffer detrimental treatment or victimisation as a result of speaking up.
6. When a concern has been raised in good faith, the Trust must ensure it is addressed in line with the Trust values: excellence, compassion, respect, learning, delivery and improvement.
7. These Values are underpinned by Trust Behaviours. Following the Trust Values and Behaviours will enable concerns to be raised and addressed appropriately to the benefit of patients and employees.
8. Where a member of staff has a concern about their employment that only affects them, they should raise that concern through the Trust's Resolution (Grievance and Collective Disputes) Procedure.
9. Where a member of staff has a concern which affects not only them, but which they think does or could adversely affect patient care or adversely affect the working life of others within the Trust, there are many channels through which the concern can be raised. 'Signposting – Employee Concerns' provides further information about how different types of concerns can be raised and the process for resolving them.

# Policy Statement

## Speak Up – We Will Listen

10. The Trust welcomes speaking up and will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.
11. This policy is for all our people. The NHS People Promise commits to ensuring that "*we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words*".
12. We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up. **This policy is for all workers and we want to hear all our workers' concerns.**

13. The Lead Freedom to Speak Up [FTSU] Guardian meets regularly with the Trust Chair and provides regular (anonymised) feedback on concerns raised to them and to the Non-Executive and Executive Directors with lead responsibility for FTSU.

14. We want strongly to encourage all our people to complete the Speak Up online training that is available. The Listen Up online module is specifically aimed at leaders (after completion of Module 1) and the Follow Up module is for senior leaders to complete. You can find out more about what Freedom to Speak Up (FTSU) is in these videos.

### This Policy

15. This policy incorporates all the provisions of the updated national Freedom to Speak Up Policy which has been issued by NHS England/Improvement as a minimum standard to help normalise speaking up for the benefit of patients and workers. The **aim** of the policy is to ensure all matters raised are captured and considered appropriately.

### We want you to feel safe to speak up

16. By speaking up, staff may help the Trust to identify opportunities for improvement that we might not otherwise know about.

17. The Trust will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

18. Provided that a member of staff is acting honestly and in good faith, it does not matter if they are mistaken nor if upon explanation there transpires to be no grounds for concern.

19. No member of staff who speaks up in good faith to raise a concern should experience detriment, disadvantageous or demeaning treatment from colleagues, line managers or leaders as a result of the act of speaking up. (See further under paragraphs 25-30).

## Scope

### Who can raise concerns?

20. Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes Retention of Employment (RoE) staff, agency workers, temporary workers, students, volunteers, trainees, junior doctors, locum, bank and agency workers and governors.

21. If a patient or other member of the public wishes to raise a concern that should be handled under the Trust's Complaints Policy, overseen and administered by the Complaints Department.

## Aim

22. To promote a culture in which everyone has the freedom to speak up about any genuine concern.

23. To instil confidence that everyone's voice will be listened to, and follow-up action taken as appropriate.

24. To ensure all matters raised are captured and considered appropriately.

## Definitions

### Making a 'protected disclosure' (sometimes referred to as "whistleblowing")

25. If a member of staff makes a 'protected disclosure' as defined under the Public Interest Disclosure Act 1998, *amending the Employment Rights Act 1996* ["the 1998 Act"], it is unlawful to dismiss them or treat them detrimentally.

26. A "**disclosure qualifying for protection**" under the 1998 Act is a disclosure of information where the worker reasonably believes one or more of the following matters is happening, has taken place or is likely to happen in the future:

    26.1. a danger to the health and safety of any individual, or group of individuals, whether employees, patients or anyone else on Trust premises;

    26.2. a criminal offence;

    26.3. a breach of a legal obligation;

    26.4. a miscarriage of justice;

    26.5. a damage to the environment; or

    26.6. the deliberate attempt to conceal any of the above

    and where the individual reasonably believes that the disclosure is in the public interest.

27. The legislation is complex and to have grounds for lodging a claim under the 1998 Act, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from Protect or a legal representative.

## Protection from detriment, disadvantageous or demeaning treatment

28. Beyond the protection afforded by the **Public Interest Disclosure Act 1998**, whenever a member of staff speaks up in good faith to raise a concern, the Trust is committed to protecting them from experiencing detriment, disadvantageous or demeaning treatment [hereafter referred to as "detriment"] as a result of having spoken up.

29. Detriment can be experienced as a deliberate act or a failure to act or omission. Sometimes detriment can be subtle and not always easy to recognise. While these behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently.

30. Further reference may be made to Detriment Guidance issued by the National Guardian – Freedom to Speak Up (see further in **Appendix 5**).

### Abbreviations

31. The following abbreviations are used within this policy:

    31.1. **FTSU** – Freedom to Speak Up

## Responsibilities

32. The **Trust Board** has overall responsibility for ensuring that concerns raised in accordance with the Freedom to Speak Up Policy are dealt with appropriately within the Trust.

33. The **Senior Independent Director** is the designated **Non-Executive Director** at Step 3 of the procedure outlined at Appendix 2, to whom a concern may be escalated if it remains unresolved after exhausting all other internal channels. Details of the current Senior Independent Director are published on the FTSU intranet site.

34. The **Executive Director with lead responsibility** for the Freedom to Speak Up Policy is the **Chief People Officer**, whose details are published on the FTSU intranet site.

35. Details of the **Non-Executive Director with lead responsibility** for the Freedom to Speak Up Policy are published on the FTSU intranet site.

36. The **Freedom to Speak Up Guardians** are **not** responsible for undertaking investigations. Importantly, they are independent of the executive team, so as to be able to challenge senior members of staff, and report to the Board or externally as required, and they are responsible for:

    36.1. developing a range of mechanisms, in addition to established formal processes, which empower and encourage staff to speak up safely;

    36.2. ensuring the appropriate and confidential administration, recording, monitoring, analysis and reporting of concerns raised, including maintaining a central record of concerns raised with any of the FTSU Guardians, including:

        36.2.1. identification of concerns raised which meet the criteria for a 'disclosure qualifying for protection' under the Public Interest Disclosure Act 1998 ["the 1998 Act"]; and

        36.2.2. where a concern raised does meet the criteria for a 'disclosure qualifying for protection' under the 1998 Act, initiating an appropriate investigation and monitoring the preservation of protection afforded under the Act.

    36.3. acting as independent, impartial advisors and as the Trust experts on matters relating to raising concerns;

    36.4. developing and embedding a culture where staff feel confident and supported to raise a concern, and where appropriate signposting staff to the appropriate Trust policy/procedure/department to discuss an issue;

    36.5. overseeing initiation of an internal investigation process where required, ensuring investigations are properly undertaken, to focus on the issue that has been raised and achieve completion in a timely manner;

    36.6. ensuring that recommendations and lessons learnt arising from investigations are fully considered by the Trust and implemented where necessary;

    36.7. preparing regular raising concerns communications to staff, sharing non-confidential information and lessons learnt from concerns;

    36.8. maintaining a high level of visibility and ensuring that they spend the majority of working time making themselves available to all staff, providing expertise in developing a safe culture which supports and encourages staff to speak up, specifically providing support, guidance or advice to any member of staff who wishes to discuss or formally raise a concern, ensuring the individual raising the concern receives regular feedback on the progress and outcome of any associated investigations; and

    36.9. safeguarding the interests of the employee who legitimately raises a concern to ensure there are no repercussions for them either immediately or in the long term.

37. In addition to the Freedom to Speak Up Guardian responsibilities identified above, the **Freedom to Speak Up Lead Guardian** is also responsible for:

    37.1. working with the Chief Executive Officer and Board to help promote an open culture which is based on listening and learning, not blaming;

    37.2. meeting regularly with the Trust Chair, providing (anonymised) feedback to them and to the Non-Executive and Executive Directors with lead responsibility for FTSU; and

    37.3. producing and presenting the FTSU Annual Report to the Board, including assurance as to the extent to which this policy remains in alignment with best practice at the time, and making recommendations of any amendments required.

38. The volunteer **Freedom to Speak Up Champions** are responsible for:
    38.1. working closely with the Freedom to Speak Up Guardians;
    38.2. encouraging staff to speak up if they have a concern; and
    38.3. improving the experience of staff by providing an access point for information on the channels for addressing concerns raised.
39. All **Directors and Senior Managers** with whom a concern is raised or to whom a concern is referred are required to:
    39.1. offer to meet with the individual to discuss the concerns where appropriate and determine whether further investigation or review is required;
    39.2. consider whether the concern raised does or may meet the criteria for a 'disclosure qualifying for protection' under the Public Interest Disclosure Act 1998 (see paragraph 25) and notify a Freedom to Speak Up Guardian accordingly, via email to ftsu@ouh.nhs.uk;
    39.3. determine the process or procedure by which the concern should most appropriately be addressed, demonstrating the rationale for making that determination and communicating it clearly to the individual who has raised the concern;
    39.4. ensure that where further investigation into the concern and/or review of the issues raised is required this is undertaken in a timely fashion;
    39.5. ensure the Freedom to Speak Up Guardians receive regular updates on the progress of the investigation or review so that the central record of concerns can be updated;
    39.6. where appropriate, implement actions/recommendations resulting from the investigation or review in a timely manner and provide a report to the Freedom to Speak Up Guardian of completed actions/recommendations; and
    39.7. ensure that, where the person raising the concern is known (or where their identity is suspected), there is no victimisation of the complainant or suspected complainant.
40. All **members of staff**
    40.1. have a duty to raise concerns which impact on the treatment and care of patients and health and well-being of employees in accordance with this policy;
    40.2. must ensure that colleagues who have raised a concern are not victimised or otherwise suffer detriment for doing so; and
    40.3. if appropriate will be required to participate in any investigation or review.

## What can I speak up about?

41. You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.
42. If you have spoken up to raise a concern (or tried to do so), and feel that you have experienced detriment, disadvantageous or demeaning treatment as a result of speaking up (see paragraphs 25-30 above), then please do speak up about that.
43. Speaking up is about all of these things and it may therefore capture a range of issues, some of which may be appropriate for existing processes (for example, HR Policies and Procedures or The Patient Safety Incident Response Framework (PSIRF). As is

expressly stated in the national Freedom to Speak Up Policy, " It's fine" that issues raised may be brought up through different channels, and addressed through a range of processes. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

44. The choice of process by which a concern should be addressed will depend upon the nature of the issue to which the concern relates. The following is not an exhaustive list but provides some examples.

    44.1. For example, a concern about employment that affects not only the individual raising the concern (e.g. concern that a bullying culture prevails across a team or department) may be addressed under HR Policies and Procedures.

    44.2. A concern relating to sexual safety at work will be addressed under either the Respect and Dignity at Work Procedure (including Sexual Safety at Work) or the Conduct and Expected Behaviours Procedure (including Sexual Misconduct)

    44.3. Where a concern is raised about something that has been (or should be) reported as a patient safety incident, this will be investigated in accordance with The Patient Safety Incident Response Framework (PSIRF).

    44.4. Any concerns relating to safeguarding patients (children or vulnerable adults) will be handled in accordance with OUH Safeguarding Policies and Procedures and will - as necessary and where appropriate - follow the Trust's policy for managing allegations of harm by staff and persons in a position of trust.

    44.5. Where a concern is raised which challenges a management decision, e.g. that a proposed reconfiguration of a service may lead to unsafe working conditions, this should first be addressed within the management structure and in accordance with relevant procedures. If it cannot thus be satisfactorily resolved then it may be referred to the Trust Chair who will ultimately be the arbiter of whether further objective scrutiny should be undertaken and if so by what process.

    44.6. If a member of staff is unsure what is the most appropriate route, advice can and should be sought from a Freedom to Speak Up Guardian, an HR Consultant or a Respect and Dignity Ambassador. 'Signposting – Employee Concerns' also provides further information about how different types of concerns can be raised and the process for resolving them.

45. Where there are concerns about the fitness of a director or equivalent, reference should be made to the Trust's Fit and Proper Persons Policy and advice sought from the Chief People Officer or Director of Workforce.

46. All staff have the right and the duty to raise their concerns and staff who are healthcare professionals may also have a professional duty to report their concerns. If a member is in any doubt about a concern, they are asked to raise it.

47. Staff do not need to wait for proof. The Trust would like staff to raise any concerns at the earliest opportunity. It does not matter if they turn out to be mistaken. So long as the member of staff is genuinely troubled and there is no malicious intent, staff are encouraged to raise the concern.

## Who can I speak up to?

### Speaking up internally

48. Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. The Trust strives for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

49. However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you:

49.1. Senior manager, or director with responsibility for the subject matter you are speaking up about.

49.2. The Clinical Governance team on 01865 222566 or via an incident report form (where concerns relate to patient safety or wider quality).

49.3. Your Divisional Workforce Team or an HR Consultant, where concerns relate to any aspect of employment matters.

49.4. Where concerns relate to fraud these can be reported to the Trust's Local Counter Fraud team (also known as Anti-Crime Specialists).

49.5. Our Freedom to Speak Up Lead Guardian and team, whose details are published on the FTSU intranet site. They can support you to speak up if you feel unable to do so by other routes. They will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role on the FTSU staff intranet pages (and on the website of the National Guardian's Office).

49.6. You can also speak up by starting a conversation with any of the 'conversation recipients' designated on the **WorkInConfidence** platform (use registration code: **xxqqzz)**; an independently run platform that the Trust has introduced for raising a concern with a **complete guarantee of anonymity.** The designated 'conversation recipients' include the FTSU Guardians and the Trust's Safeguarding Lead (for any concern relating to sexual safety at work), as well as the Chief Executive Officer and the Chief People Officer.

49.7. You can also speak up to your Trade Union representative.

49.8. You can speak up to our senior lead executive responsible for Freedom to Speak Up [currently, the Chief People Officer, whose details are published on the FTSU intranet site] - they provide senior support for our speaking-up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.

49.9. You can speak up to our non-executive director responsible for Freedom to Speak Up [whose details are published on the FTSU intranet site]

## Escalating concerns internally

50. If you still have concerns after exhausting the options outlined in paragraphs 48 and 49 that feel appropriate to you, then the matter may be escalated further either *via* the senior executive lead for FTSU or the non-executive lead for FTSU or *via* the Senior Independent Director or Chief Executive Officer (see Step 3, Appendix 2).

## Speaking up externally

51. If you do not want to speak up to someone within the Trust, you can speak up externally to:

51.1. Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – more information about how the CQC handles concerns is available from their website;

51.2. NHS England for concerns about:

51.2.1. how the Trust is being run;

51.2.2. NHS procurement and patient choice;

51.2.3. the national tariff.

51.2.4. NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their

oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

51.3. Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

51.4. NHS Counter Fraud Agency for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

52. If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

53. Paragraphs 25 - 27 provide information about making a 'protected disclosure'.

## How should I speak up?

54. You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

55. You can make an appointment to have a **confidential chat** with your FTSU Guardian.

56. You can also raise a concern with a **complete guarantee of anonymity** using the external **WorkInConfidence** platform (use registration code: **xxqqzz)**.

### Confidentiality

57. The most important aspect of your speaking up is the information you can provide, not your identity.

58. You have a choice about how you speak up:

58.1. **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.

58.2. **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.

58.3. **Anonymously:** you do not want to reveal your identity to anyone. NB *This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.*

59. In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

## Advice and Support

60. Details of the support available to staff can be found on the FTSU staff intranet pages and your local Staff Networks can be a valuable source of support. The Raising a concern website provides guidance to staff on how to navigate the various routes and channels available for raising concerns and at 'Signposting – Employee Concerns' further information is provided about how different types of concerns can be raised and the process for resolving them.

61. Support may also be accessed through the Trust's Employee Assistance Programme.

62. Staff can also contact:

62.1. their Trade Union representative or

62.2. their professional body (such as the Nursing and Midwifery Council, General Medical Council or Health and Care Professions Council).

63. Other sources of support include:

63.1. NHS England

63.1.1. Support available for our NHS people.

63.1.2. Speaking Up Support Scheme.

63.2. Speak Up Direct provides free, independent, confidential advice on the speaking up process.

63.3. The charity Protect provides confidential and legal advice on speaking up.

63.4. The Trades Union Congress provides information on how to join a trade union.

63.5. The Law Society who may be able to provide signposting to other sources of advice and support.

63.6. The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

## What will the Trust do?

64. The matter you are speaking up about may be best considered under a specific existing policy, process or procedure; for example, the Trust's Respect and Dignity at Work Procedure (including Sexual Safety at Work) for dealing with a prevailing culture of bullying and harassment in a team or department. We will discuss with you how best the matter that you are speaking up about should be considered. If you speak up about something that does not fall into an HR or patient safety incident process, the Trust will ensure that the matter is still addressed.

### Investigation, review, resolution

65. The Trust supports its managers/supervisors to listen to issues raised and take action to resolve them wherever possible. In most cases, it is important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

66. Where an investigation or further review is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and appropriately trained. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

67. Where an investigation identifies any employment issues these will be addressed in line with the relevant Trust policy or procedure and in accordance with the just culture principles.

### Communicating with you

68. You will be treated with respect at all times and will be thanked for speaking up. Whoever you speak up to will discuss the issues with you to ensure that they understand exactly what you are worried about. If they propose to confer with anyone else then they will let you know, and they will check with you whether you are happy to reveal your identity to someone else. If it is decided to investigate or undertake further review, you will be told how long the investigation or review is expected to take, and how you will be kept up to date with its progress. Wherever possible, the full report of the investigation or review will be shared with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

### How the Trust learns from your speaking up

69. The Trust wants speaking up to improve the services it provides for patients and the environment staff work in. Where it identifies improvements that can be made, the Trust will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

### Board Oversight

70. The Board will receive an annual report providing a thematic overview of speaking up by our staff to the Trust's FTSU guardians.

## Failure to Comply

71. Where inappropriate behaviour or action, or failure of appropriate action, by an individual member of the workforce, has taken place in relation to any member(s) of staff speaking to raise concerns, this may be investigated and addressed using the Trust's Conduct and Expected Behaviours Procedure. External employers e.g. third-party contractors will be required to address such matters appropriately using their own internal procedures.

## National Guardian Freedom to Speak Up

72. Where NHS trusts and foundation trusts may have failed to follow good practice in the treatment of staff who speak up to raise concerns, the National Guardian can independently review how staff have been treated, working with some of the external bodies listed above to take action where needed.

## Training

73. There is no mandatory training associated with this policy but the following optional modules (which have been made available on the Trust's Learning Management System) will be promoted through the Divisional and Corporate management teams, with a particular emphasis on very strong encouragement for Senior leaders and managers to complete all 3 training modules (Speak Up, Listen Up, and Follow Up).

    73.1. Module 1 "Speak Up" (Speak Up) is available to all staff and covers:

    - What speaking up is and why it matters
    - How to speak up and confidentiality
    - Barriers to speaking up
    - The role of the guardian and the National Guardian's Office
    - Making a pledge.

    73.2. Module 2 "Listen Up" (Listen Up), is aimed at leaders (after completion of Module 1) and covers:

    - Fostering a speak up, listen up culture
    - Supporting speaking up and listening well
    - Perceptions of yourself and others and understanding conflicts of interest
    - Welcoming feedback as a gift.

    73.3. Module 3, "Follow Up" (Follow Up), is aimed at senior leaders including executive and non-executive directors, and governors. It should be undertaken after completion of Modules 1 and 2 and aims to promote a consistent and effective Freedom to Speak Up culture across the system which will enable workers to speak up and have confidence that they will be listened to and action will be taken.

73.4. All staff are encouraged to complete Module 1: *Speak Up* and senior leaders are strongly encouraged to complete all three modules, *Speak Up*, *Listen Up* and *Follow Up* to ensure they have a full understanding of the speaking up process.

74. Anyone appointed to undertake an investigation or review to address any concern raised may seek guidance from the Divisional HR Consultant or Freedom to Speak Up Lead Guardian.

## Monitoring Compliance

75. Uptake of the FSTU training modules will be monitored and reported in the FTSU Annual Report to the Board. Compliance with the policy will be monitored in the following ways. All reports will maintain confidentiality and will not report individual identifiable data.

| **Aspect of compliance or effectiveness being monitored** | **Monitoring method** | **Responsibility for monitoring (job title)** | **Frequency of monitoring** | **Group or Committee that will review the findings and monitor completion of any resulting action plan** |
|---|---|---|---|---|
| Confidential database managed by FtSU Lead Guardian and FtSU Deputy Lead Guardian (Operational Manager) | Review of concerns<br>Identification of themes<br>Learning from concerns raised | FTSU Lead Guardian | Quarterly | FTSU |
| Patient safety concerns | Review of concerns<br>Identification of themes<br>Learning from concerns raised | FTSU Lead Guardian | 6 monthly | TME<br>Clinical Governance Committee |
| Staff concerns | Review of concerns<br>Identification of themes<br>Learning from concerns raised | FTSU Lead Guardian | 6 monthly | TME<br>People and Communications Heads of Service<br>Quality Committee |
| Completion of data requests from the National Guardian office | Information submitted accurately and on time | FTSU Lead Guardian | Quarterly | National Guardian office |

76. In addition to the monitoring arrangements described above, the Trust may undertake additional monitoring of this procedure as a response to the identification of any gaps or as a result of the identification of risks, arising from the procedure, prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

- Commissioned audits and reviews
- Detailed data analysis
- Other focused studies

Results of this monitoring will be reported to the nominated Committee.

## Review

77. Feedback will be sought from workers about their experience of speaking up.

78. This policy and local process will be considered annually by the FTSU Lead Guardian, who will include in the FTSU Annual Report presented to the Board their recommendations for any amendments required to maintain alignment with best practice.

79. A full review of the effectiveness of this policy and local process will be undertaken at least every three years, with the outcome published and changes made as appropriate.

80. Until such time as the review is completed and the successor document approved by the Board this policy will remain valid.

## References


81. The Public Interest Disclosure Act 1998 (legislation.gov.uk), *amending the Employment Rights Act 1996*.

82. Enterprise and Regulatory Reform Act 2013.

83. Health Service Circular 1999/198 - The Public Interest Disclosure Act 1998: Whistleblowing in the NHS.

84. Department of Health and Social Care – The NHS Constitution for England (Updated 17 August 2023)

85. Freedom to Speak Up Report by Sir Robert Francis QC (2015)

86. NHS England » The national speak up policy published June 2022


## Equality Impact Assessment

87. As part of its development, this procedure and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, gender reassignment, marriage and civil partnership and pregnancy and maternity. The completed Equality Impact Assessment can be found in Appendix 5.

## Further Information

88. Further information can be found on the Trust's intranet site under Freedom to Speak Up and on the OUH website at: Raising a concern - Oxford University Hospitals, where staff can also refer to 'Signposting – Employee Concerns' for further information about how different types of concerns can be raised and the process for resolving them.

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| 20th August 2013 | Version 2 | Policy reviewed as planned. |
| | Version 3.1 | Policy reviewed in line with 3 year review period and following publication of the Freedom to speak up: raising concerns (whistleblowing) policy for the NHS by NHS Improvement and NHS England. |
| July 2019 | Version 3.2<br>Version 4.1 | Updated following meeting with FTSU Lead Guardian<br>Policy reviewed as planned |

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| August 2019 | Version 4.2 | Second review |
| August 2019 | Version 4.3 | Review of Equality Impact Assessment |
| August 2019 | Version 4.4 | Signed off Equality Impact Assessment |
| September 2019 | Version 5 | Updated following feedback received during consultation |
| May 2022 | Version 5.3 | Policy reviewed to take into account key findings of the OUH Freedom to Speak Up Review 2021, and recommendations made in KPMG's internal audit report (July 2021) to ensure full alignment with best practice |
| June 2022 | Version 5.13 | Revised policy reviewed to incorporate the NHS England » The national speak up policy published June 2022 |
| July 2022 | Version 5.14 | Draft revised policy supported by HR Policy Development Group |
| August 2022 | Version 5.16 | Draft updated following feedback received during consultation. |
| November 2022 | Version 6.0 | Policy formally approved by OUH Trust Board |
| March 2025 | Version 6.1 | Review of Policy undertaken ahead of 3 year anniversary. |
| May 2025 | Version 6.8 | Policy revised to reflect feedback from HR Heads of Service, and to include approval of updated Equality Impact Assessment |

# Appendix 1 – What will happen when I speak up?

### The Trust will:

- thank you for speaking up;
- help you identify the options for resolution;
- signpost you to health and wellbeing support;
- confirm what information you have provided consent to share; and
- support you with any further next steps and keep in touch with you.

### Steps towards resolution:

- engagement with relevant senior managers (where appropriate);
- referral to HR process;
- referral to patient safety process; and
- other appropriate steps - investigation, review, mediation etc.

### Outcomes:

- The outcomes will be shared with you wherever possible, along with learning and improvement identified.

### Escalation

- If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter further to the senior executive lead for FTSU or the non-executive lead for FTSU or to the Senior Independent Director or Chief Executive.
- Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body such as the CQC or NHS England.

## Appendix 2 – Speaking Up to Raise Concerns at Work

1. You do not need to have firm evidence before raising a concern in good faith, however, we do ask that you explain as fully as you can the information or circumstances that gave rise to your concern, including:

   1.1. dates, times and location of the matter of concern;

   1.2. if the concern is about another person, (e.g. an employee) their name, job title, employee group, employer;

   1.3. details of other employees who were present and may have observed the situation giving rise to your concern; and

   1.4. how you think the matter might best be resolved.

2. There are a number of different people and ways of raising your concern which are outlined in the three steps below, and others who you may wish to contact with specific concerns.

3. Once you have raised a concern, a meeting will be offered for you to discuss your concern as soon as possible and if necessary, to advise on the process by which an investigation or review may follow.

**Step One**

4. If you have concerns about issues at work, where the interests of others or the organisation are at risk, you should raise the matter first with your line manager or lead clinician or tutor (for students), where you feel able. This may be done verbally or in writing.

5. If you are a line manager with whom a concern has been raised, you should consider whether it meets the criteria of a "disclosure qualifying for protection" (see paragraphs 25-27 of the Policy) and notify one of the Freedom to Speak Up Guardians accordingly. In all cases, you should keep in mind that the Trust is committed to protecting anyone who speaks up in good faith to raise a concern from experiencing detriment, disadvantageous or demeaning treatment as a result of having spoken up. You should also refer to the guidance available in Appendices 3 and 5.

**Step Two**

6. If you wish to raise a concern but feel unable, for whatever reason, to do so with your line manager or lead clinician, paragraph 48 of the policy sets out other options in terms of who you can speak up to, depending on what feels most appropriate to you. The options include the Freedom to Speak Up Guardians via ftsu@ouh.nhs.uk or otherwise using full contact details provided in the FtSU staff intranet pages. Alternatively, you may raise a concern directly and anonymously with one of the 'conversation recipients' designated on the **WorkInConfidence** platform (use registration code: **xxqqzz**). The designated 'conversation recipients' include the FTSU Guardians and the Trust's Safeguarding Lead (for any concern relating to sexual safety at work), as well as the Chief Executive Officer and the Chief People Officer. Or you may wish to speak to your Trade Union Representative to discuss your concern.

7. The Freedom to Speak Up Guardians have been given special responsibility and training in dealing with concerns and will:

   7.1. treat your concern confidentially, unless otherwise agreed;

   7.2. ensure you receive timely support to progress your concern;

   7.3. escalate to the board any indications that you are being subjected to detriment for raising your concern so that appropriate steps may be taken;

   7.4. remind the Trust of the need to give you timely feedback on how your concern is being dealt with; and

7.5. ensure you have access to personal support to assist you, for example to manage any situations which may be stressful.

8. If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

**Step Three**

9. If you still have concerns after pursuing options outlined in Step 2 then, if you haven't already done so, you may contact:

9.1. Our senior lead executive responsible for Freedom to Speak Up [currently, the Chief People Officer, whose details are published on the FTSU intranet site]

9.2. Our non-executive director responsible for Freedom to Speak Up [whose details are published on the FTSU intranet site]

10. If you feel that you have exhausted the options that feel appropriate to you (options are outlined in paragraphs 43 and 44 of the policy), or you feel that the matter is so serious that you cannot discuss it with any of the above, please contact

10.1. Chief Executive Officer; or

10.2. The Senior Independent Director as identified amongst the OUH Trust Board Directors , whose contact details are provided on the FTSU staff intranet pages.

**Step 4**

11. You can raise concerns formally with external bodies (see paragraph 51 of the policy for details of external bodies) or with 'prescribed persons'.

## Appendix 3 - Guidance for Managers to Whom a Concern has been reported or referred

1. As a manager, employees may approach you directly to raise concerns or you may be approached about concerns that were first raised through other channels. In some cases, the concerns raised may relate to suspected malpractice or wrongdoing or may otherwise amount to "disclosures qualifying for protection" under the Public Interest Disclosure Act 1998 (legislation.gov.uk), *amending the Employment Rights Act 1996* ["the 1998 Act"] (see paragraphs 25-30 of the policy). Any such qualifying disclosures should be notified to one of the Freedom to Speak Up Guardians who will record the disclosure and monitor its investigation to ensure that the individual who has raised the concern is afforded the protection conferred by the 1998 Act.

2. . In all cases, you should keep in mind that the Trust is committed to protecting anyone who speaks up in good faith to raise a concern from experiencing detriment, disadvantageous or demeaning treatment as a result of having spoken up.

3. Below are some tips to help you deal with handling the situation whenever a concern has been raised. In all situations you should:

    3.1. Thank the employee for speaking to you and raising the matter.

    3.2. Take the employee's concerns seriously and where applicable, aim to meet with them as soon as possible.

    3.3. Recognise that raising a concern can be a difficult experience for employees and offer them appropriate support as they may be feeling nervous or stressed.

    3.4. Ensure that the concern is being reported and addressed under the correct policy or procedure.

    3.5. Inform the employee how you will progress their concern and discuss reasonable timeframes for feedback.

    3.6. Respect the confidentiality of the individual if they have requested this.

    3.7. Where there are serious grounds for concern, or where further information is required, then the matter should be investigated or reviewed as soon as possible and within the given timeframe of one month wherever possible.

    3.8. Consider whether further investigation or review is required and, if so, under what process or procedure any investigation or review should be pursued, bearing in mind also the need to adhere to process/procedure when determining whether to commission an investigation or review (e.g. the Trust's Conduct and Expected Behaviours Procedure (including Sexual Misconduct) specifies the pre-assessment process to be completed before commissioning an investigation). If the concern raises issues that are very serious or wide-reaching you should ensure an appropriate level of seniority for the Investigating Officer or Reviewer. It may be appropriate to ask a senior member of staff from another Division to ensure impartiality.

    3.9. Ask for help or advice from your own management structure or the HR Department.

    3.10. Take prompt action to resolve the concern or refer it on to the appropriate person for action.

    3.11. Inform the Freedom to Speak Up Lead Guardian by sending a copy of the relevant documentation.

    3.12. Keep the employee informed of progress.

    3.13. Monitor and review the situation.

3.14. Ensure appropriate feedback is given to the employee raising the concern, with due care not to infringe the rights or duties owed to other parties i.e. by having regard to confidentiality of other individuals.

3.15. Ensure employees reporting genuine concerns are not penalised, suffer retaliation or are subjected to any detriment as a result of raising concerns and advice should be sought from the HR Department where applicable.

3.16. Consider reporting to the Trust Board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed.

3.17. Provide a record of the concern raised and actions taken to address the concern to the Freedom to Speak Up Lead Guardian so that the central record of concerns raised under the Freedom to Speak Up Policy can be updated. A form is available for this purpose on the FTSU staff intranet pages.

# Appendix 4 - A Vision for Raising Concerns in the NHS[1]

## 1. Identifying that something might be wrong

I know that it is right to speak up.

My organisation is a supportive place to work.

I am regularly asked for my views.

I know how to raise concerns and have had training which explained what to do.

I know that I will not be bullied, victimised or harassed as a result of speaking up.

## 2. Raising a concern

My colleagues and managers are approachable and trained in how to receive concerns.

My organisation has a clear and positive procedure in place.

I know where to go for support and advice.

Concerns are taken seriously and clear records are kept.

Managers always explain what will happen and keep me informed.

## 3. Examining the facts

An independent, fair and objective investigation into the facts will take place promptly and without the purpose of finding someone to blame.

The investigation will be given the necessary resource and scope.

I am confident that any recommendations made will be based on the facts and designed primarily to promote safety and learning.

I will be kept informed of developments.

The process is kept separate from any disciplinary or performance management action.

## 4. Outcomes and feedback

Where there are lessons to be learned they will be identified and acted on.

I will be satisfied the outcome is fair and reasonable, even if I do not agree with it.

I will be told what was found out and what action is being taken.

A plan to monitor the situation will be put in place.

I feel confident that patients are safe and that my team remains a supportive place to work.

## 5. Reflecting and moving forward

I will be thanked for speaking up.

I will speak up again in future if the need arises.

I know that my concerns will be taken seriously and actioned as appropriate.

Lessons learnt will be shared and acted on by me and my colleagues.

I will advise and support others to speak up in future.

[1] Source: The review by Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*

## Appendix 5 – Protection from detriment, disadvantageous or demeaning treatment

1. As well as honouring the protection afforded by the Public Interest Disclosure Act 1998, (see paragraphs 25-27 of the Policy), the Trust is committed to protecting any member of staff who speaks up in good faith to raise a concern; specifically to protect them from experiencing detriment, disadvantageous or demeaning treatment [hereafter referred to as "detriment"] as a result of having spoken up.

2. Detriment Guidance has been issued by The National Guardian – Freedom to Speak Up, aimed at ensuring that those who have spoken up are supported, and to encourage trusts to do more to remove the barrier of fear of detriment that may prevent speaking up.

3. As is made clear in the Guidance, detriment can be experienced as a deliberate act or a failure to act or omission. Sometimes detriment can be subtle and not always easy to recognise. While these behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently.

4. The Guidance includes some examples of what may lead to an individual feeling that they have experienced detriment as a result of speaking up:

    - Experiencing poor behaviours not in line with the organisational values such as being ostracised, gaslighting, gossiping, incivility
    - Being given unfavourable shifts; repeated denial of overtime/bank shifts; being denied shifts in a certain area/department without good reason; changes to shifts at short notice with no apparent reason
    - Being repeatedly denied annual leave; failure on a regular basis to approve leave in reasonable time; or leave cancelled without good reason
    - Micro-managing; excessive scrutiny
    - Sudden and unexplained changes to work responsibilities, or not being given adequate support
    - Being moved from a team or inexplicable management of change without clear rationale
    - Being denied access to development opportunities, training or study leave without good reason
    - Being overlooked for promotion
    - Receiving a negative performance appraisal or disciplinary action.

5. **NB** A proven instance of any of the examples given will not in and of itself necessarily amount to proof of detriment (e.g. there may have been just cause for disciplinary action, or for a negative performance appraisal).

6. When someone speaks up and voices a fear of perceived detriment, FTSU Guardians will consider completing a detriment risk assessment, exploring:
    - History of individual speaking up
    - Nature of issue being spoken up about
    - Vulnerability of individual
    - Risk of identification
    - Risks relating to origin of individual's concerns
    - Previous raising of issue
    - Perspective of individual
    - Suggestions from the individual to help support or protect them
    - Action to take.

# Appendix 6 - Equality Impact Assessment

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | Existing Policy / Procedure |
| **Job title of staff member completing assessment** | Freedom to Speak Up Project Manager,<br>Freedom to Speak Up Guardian |
| **Name of policy / service / function:** | Freedom to Speak Up Policy |
| **Details about the policy / service / function** | This policy incorporates the 'standard integrated policy' first developed and published in June 2022 by NHS Improvement and NHS England in response to the review by Sir Robert Francis QC into whistleblowing in the NHS. It aims to:<br>• Set out the Trust's commitment to ensuring staff feel confident to speak up about any concerns they have relating to a risk, malpractice or wrongdoing that they believe is harming the service the Trust delivers to patients.<br>• Set out clear pathways for employees to raise concerns, making a range of multiple channels available so that there is equitable access for all.<br>• Provide information regarding sources of support for staff in relation to raising concerns.<br>Changes made as a result of reviewing the policy have only further strengthened equitable access, experience and outcomes for all staff in relation to their freedom to speak up. It has been in direct response to feedback from staff in the annual Staff Survey and at People Plan Listening Events that the Trust has introduced an independent 3rd party platform (WorkInConfidence) for the anonymous reporting of concerns. The revised policy also reflects a strengthened commitment to protect all staff from any detriment as a result of speaking up, in compliance with Detriment Guidance issued by the National Guardian's Office. |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | Yes |
| **Review Date** | Three years |
| **Date assessment completed** | May 2025 |
| **Signature of staff member completing assessment** | Susan Polywka<br>Rebekah Menon |
| **Signature of staff member approving assessment** |  |

## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**

- Staff

**Does the policy, service or function involve direct engagement with the target audience?**

Yes

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

### Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Gender Re-assignment** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | X | | The Trust is cognisant of the particular barriers to speaking up reported by Black and minority ethnic staff across the NHS (as reflected in responses received to the national NHS Staff Survey, and explored in research undertaken by the equalities charity **brap**[i] and Roger Kline OBE Difference Matters: The impact of ethnicity on speaking up as well as in the Too Hot To Handle report and the Response to Too Hot to Handle - National Guardian's Office) |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | It is recognised that FTSU Guardians have a particular role to break down barriers to speaking up that are interlinked with racism. As part of their role FTSU Guardians are focused on encouraging the Trust to remove the barriers which all workers face in speaking up – particularly Black and minoritised workers.<br><br>The mandatory annual refresher training delivered by the National Guardian's Office for FTSU Guardians - and a mandatory part of foundation training going forward - is focused on equity, diversity and belonging in order to give all FTSU Guardians an understanding of discrimination.<br><br>The barriers to speaking up having been explored in a detailed review and OUH trust-wide survey undertaken in 2021, the Trust continues to take into account feedback in each of the annual national NHS Staff Surveys and at OUH People Plan Listening Events<br><br>All NHS trusts are required to adhere to the national model policy for Freedom to Speak Up – the tenets of which are very much aimed at ensuring that everyone will have equitable access, experience and outcomes in relation to the freedom to speak up - and local adaptations have been made specifically to further lower barriers to speaking up for all.<br><br>Notably at OUH, this has included the launch of the WorkInConfidence anonymous reporting platform which is now available for use by all staff. |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | FTSU at OUH has been developed to enhance accessibility to advice and support for all members of staff. |
| **Disability** - disabled people and carers | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Age** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Sexual Orientation** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Religion or Belief** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Pregnancy and Maternity** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Marriage or Civil Partnership** | | | X | | The Policy sets out the process and options available to any member of staff who wishes to |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | X | | The Policy sets out the process and options available to any member of staff who wishes to raise a concern and sets out a clear process that should be followed and routes for escalation if concerns are not addressed. |

### Sources of information

Results of the NHS Staff Survey

Research undertaken by the equalities charity **brap** and Roger Kline OBE Difference Matters: The impact of ethnicity on speaking up which explored particular barriers to speaking up that have been reported by Black and minority ethnic staff across the NHS.

Too Hot to Handle? and Response to Too Hot to Handle - National Guardian's Office

Report on Key Findings of OUH FtSU Review 2021

OUH Freedom to Speak Up Survey 2021: Summary analysis of responses

KPMG Internal Audit Report on Freedom to Speak Up (July 2021) – providing 'significant assurance with minor improvement opportunities'.

### Consultation with protected groups

The following groups were targeted for staff engagement and participation in the OUH FTSU Review 2021 and during annual Speak Up Months in October of each year, and their feedback has been taken into account in revising the policy:

- Black Asian and Minority Ethnic (BAME) Staff Network
- LGBT Staff Network
- Disability & Accessibility Staff Network
- Women's Network
- Respect and Dignity Ambassadors

### Consultation with others

All staff had the opportunity to provide feedback during the OUH FTSU Review 2021, key findings of which were taken into account when first developing the OUH FTSU Policy in 2022 (aligning with the national model policy' first developed and published in June 2022 by NHS Improvement and NHS England in response to the review by Sir Robert Francis QC into whistleblowing in the NHS). Consultation also occurred with staff side colleagues during this time and all staff had the opportunity to comment on the draft policy as part of the consultation process. All staff will again have the opportunity to comment on the draft revised policy as part of the consultation process.

## 4. Summary stage

### Outcome Measures

The key benefits of this Policy are:

- To support every member of staff to speak up freely, and ensure staff feel safe and supported to speak up.
- To ensure no one suffers any victimisation as a result of speaking up.
- To ensure issues highlighted as a result of staff speaking up are dealt with appropriately and lessons learnt.

The Policy will be available to all staff online, in a format that is compliant with accessibility requirements, ensuring that it will be compatible with 'text to speech' facilities. Upon request, it can be made available in large print hard copy.

### Positive Impact

Through the raising of concerns about unsafe patient care; unsafe working conditions; inadequate induction or training of staff; lack of, or poor, responses to a reported patient safety incident there should be improved patient outcomes for diverse patient groups.

There may be a positive impact in particular for staff with protected characteristics if other policies/procedures have failed and the issue can be raised under this Policy (e.g. cases of a bullying culture across teams/departments).

An open and transparent culture will improve the work environment, including team dynamics, for all staff, including those with protected characteristics.

### Unjustifiable Adverse Effects

*List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.*

Data on the incidence of concerns raised by protected groups (which the Trust is required to submit as part of its data submission to the National Guardian's Office) will be kept under review to evaluate if there are any adverse effects.

### Justifiable Adverse Effects

*List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.*

None identified.

### Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| **Failure to disseminate knowledge and awareness of the Policy and process to be followed** | Introduction of new Policy to build on the OUH FTSU Review 2021<br>which was supported by a comprehensive internal communications and engagement plan, developed with support of the Director of Communications, to include a series of staff engagement events, liaison with Staff Networks, and a trust-wide online Freedom to | FtSU Lead Guardian<br>and<br>Exec Director Lead for FtSU | None | 12 months | |

| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| | Speak Up Survey 2021 | | | | |
| **Failure to ensure that all staff can have confidence and feel secure to raise concerns** | To implement comprehensive FtSU Action Plan, developed to address key findings of the OUH FTSU Review 2021 as well as recommendations made in Internal Audit Report on FtSU (July 2021), and any outstanding actions from implementation plan associated with OUH FtSU Strategy. | FtSU Lead Guardian<br>and<br>Exec Director Lead for FtSU | A revised operational model has been developed to support implementation of the FtSU Action Plan, funded via a release of funds from the Chief Finance Officer's and Chief Operating Officer's budgets with the remaining budget being released from a reprofile of the Chief Assurance Officer's budget. | 12 months | |

[i] brap | equality charity: transforming the way we think and do equality

# 15. INTEGRATED PERFORMANCE REPORT M4

## REFERENCES

Only PDFs are attached

14 TB2025.82 OUH Integrated Performance Report_M4 Board.pdf

Oxford University Hospitals
NHS Foundation Trust

# Integrated Performance Report

## M4 (July data)

**Accessible Information Standard notice**: We are committed to ensuring that everyone can access this document as part of the Accessible Information Standard. If you have any difficulty accessing the information in this report, please contact us.

# Table of Contents

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



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

The month 4 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the four strategic pillars: People, Patient Care, Performance and Partnerships, and key measures included within the NHS England Segmentation and Oversight Framework. Segmentation outcomes and performance are referenced within the assurance reports, where relevant, noting that the period of measurement can differ from the IPR. There are also differences in segmentation scoring based on national ranking and/or performance in relation to the annual plan. Segmentation indicators are identified within this report by the presence of a purple circle.

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

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

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

Lower staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our sickness absence rate showed rates lower than the National and Shelford averages, and the second lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets and exhibited improving Special Cause Variation (SCV).

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

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

Of the 117 indicators currently measured in the IPR, 26 are detailed further using standardised assurance templates. These indicators, which include those failing to meet performance standards or showing deteriorating SCV, are listed in summary on the following page and elaborated within the relevant domain in section 3 (Assurance reports).

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

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

Oxford University Hospitals NHS Foundation Trust

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

**Not achieving target**

**Special cause variation - deterioration**

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

**Common cause variation and missed target**

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

**Special cause variation - improving**

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

**Other***

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

**where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)*

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

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

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

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

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

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

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

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

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

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

Oxford University Hospitals NHS Foundation Trust

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

**Not achieving target**

**Special cause variation - deterioration**

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

**Common cause variation and missed target**

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

**Special cause variation - improving**

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

**Other***

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

**where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)*

The **sickness absence performance** (rolling 12 months) was 4.2% in July 2025, exhibiting common cause variation. The in-month sickness rate also displayed common cause variation at 4.1% for months 3 and 4. Divisions are reviewing the top 20 absences and working on action plans to reduce sickness absence. The focus is on areas with consistent absenteeism, and collaboration with Occupational Health. Managers are alerted about staff triggering absenteeism, and HR is promoting sickness absence management training. Monthly meetings with the Wellbeing lead are held to identify additional areas where support may be required.

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

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

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

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

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

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

# 2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

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

# 2. b) SPC indicator overview summary

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

## Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jul-2025

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

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

## Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jul-2025

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

# 2. b) SPC indicator overview summary

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

## Integrated Performance Report (SPC)

Operational Performance Summary: All

Latest Indicator Period: Jul-2025

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

## Integrated Performance Report (SPC)

Operational Performance Summary: All

Latest Indicator Period: Jul-2025

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

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

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

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

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

Latest Indicator Period: Jul-2025

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

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

Latest Indicator Period: Jul-2025

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

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

Latest Indicator Period: Jul-2025

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

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

Latest Indicator Period: Jul-2025

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

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

Latest Indicator Period: Jul-2025

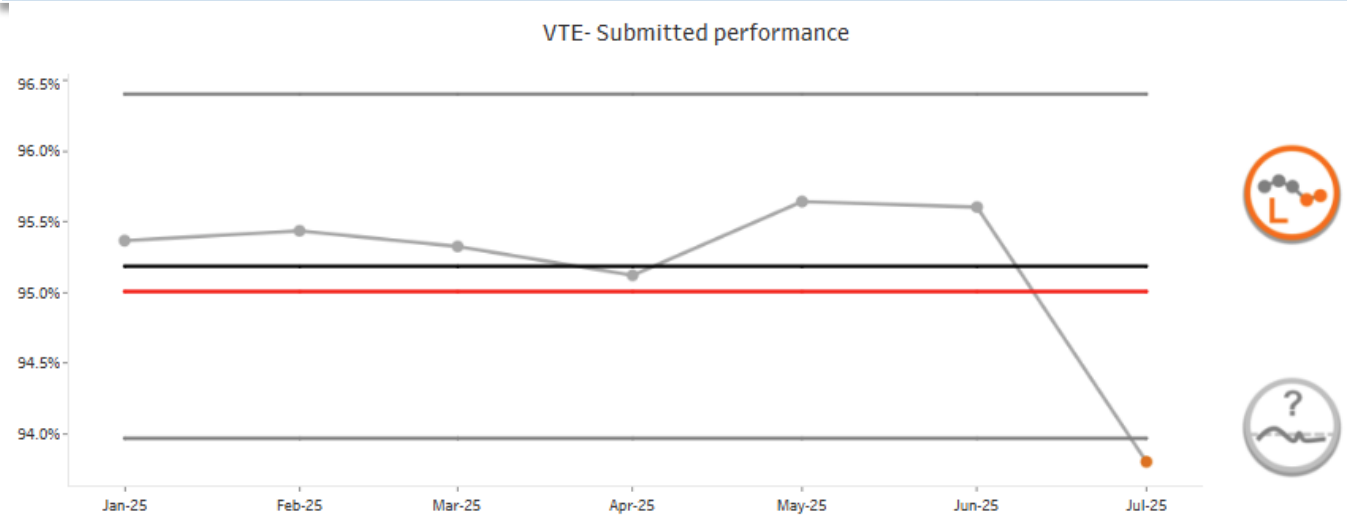
| Indicator Description | Period | Performance | Target | Met? | Mean | LCL | UCL |
|---|---|---|---|---|---|---|---|
| CQC overdue actions ('must do') | Jul-25 | 0 | 0 | | 0 | - | - |

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

# 03. Assurance reports

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






## Summary of challenges and risks

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

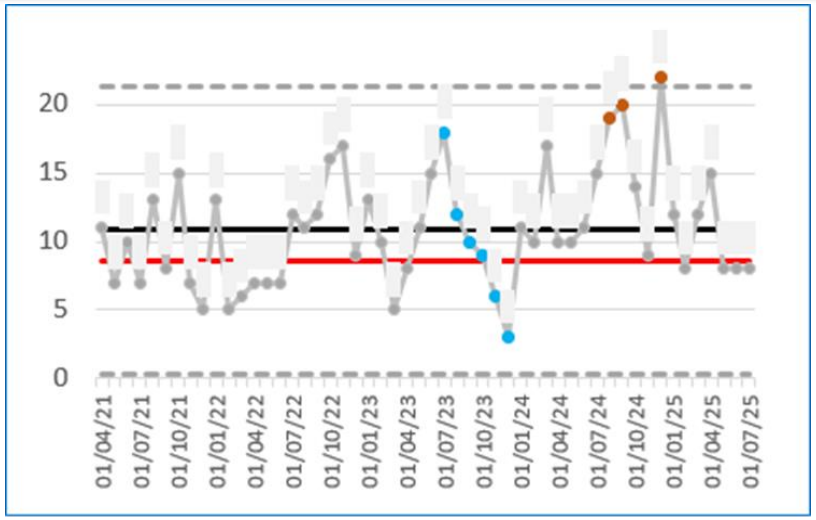
In July OUH compliance fell below the national target to 93.8% (a drop of 1.2%).

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

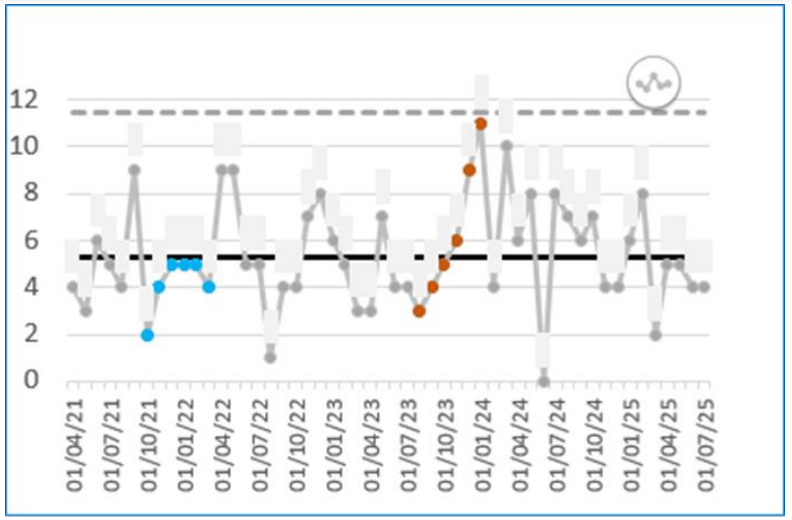
| Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality |
|---|---|---|---|
| **The issue has been discussed as a priority in the Clinical Governance Committee, and all Divisions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

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






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

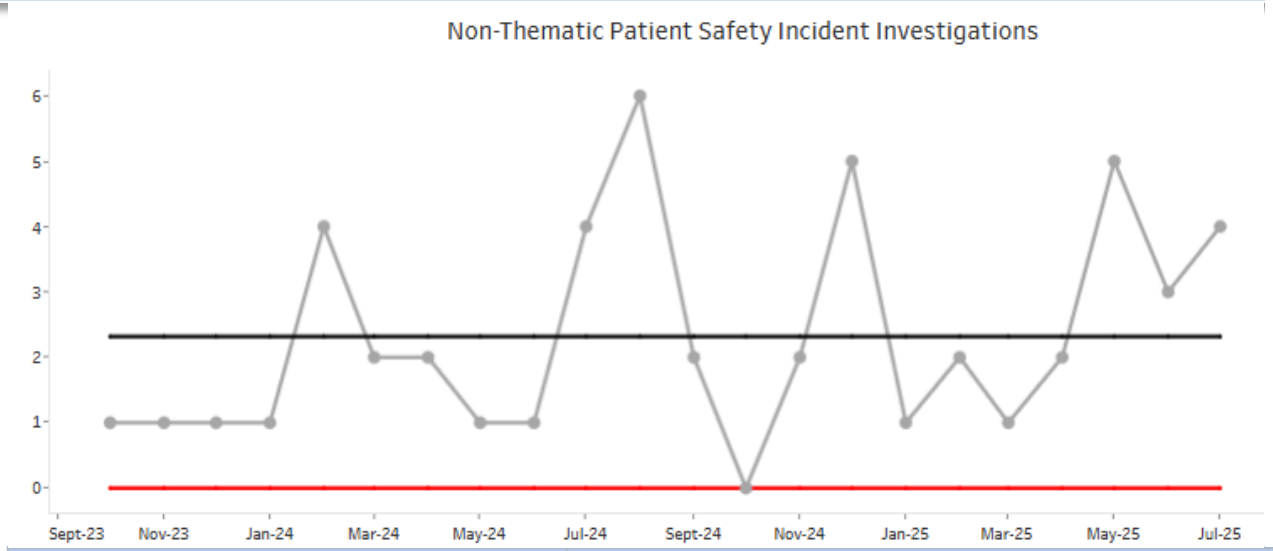


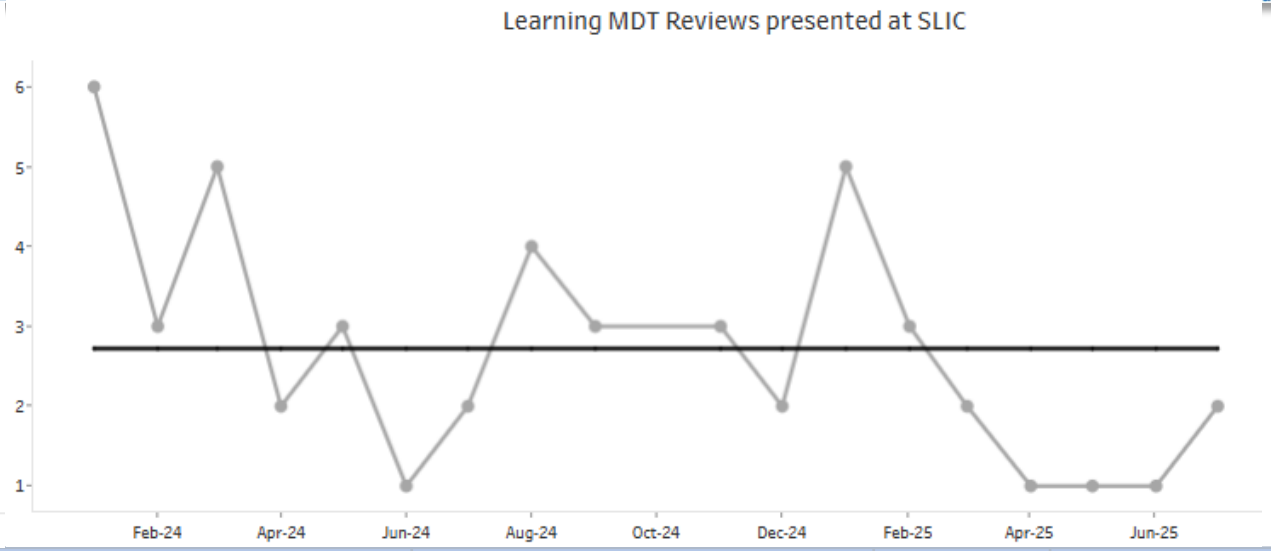

SPC MSSA HOHA and COHA Cases (April 2021- July 2025)

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

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

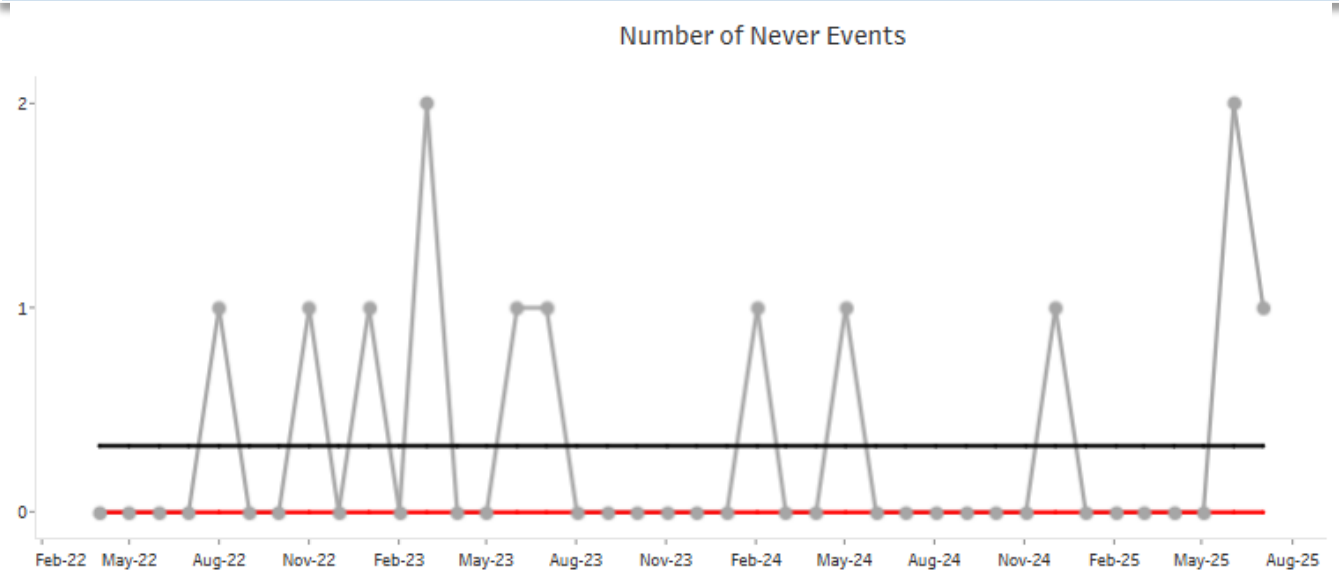





| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Four new non-thematic PSIIs were confirmed in July.<br>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

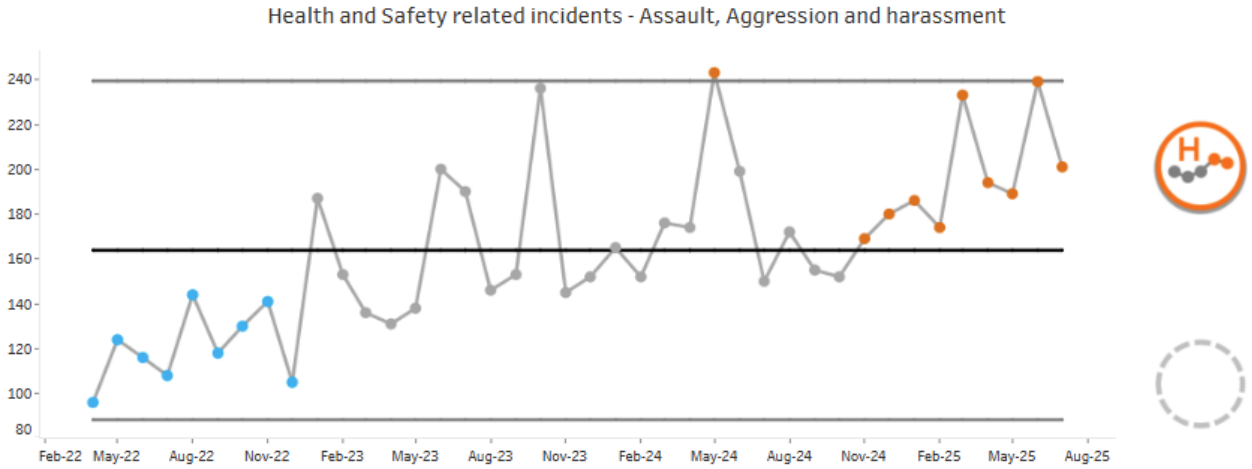
# 3. Assurance report: Quality, Safety and Patient Experience




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

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

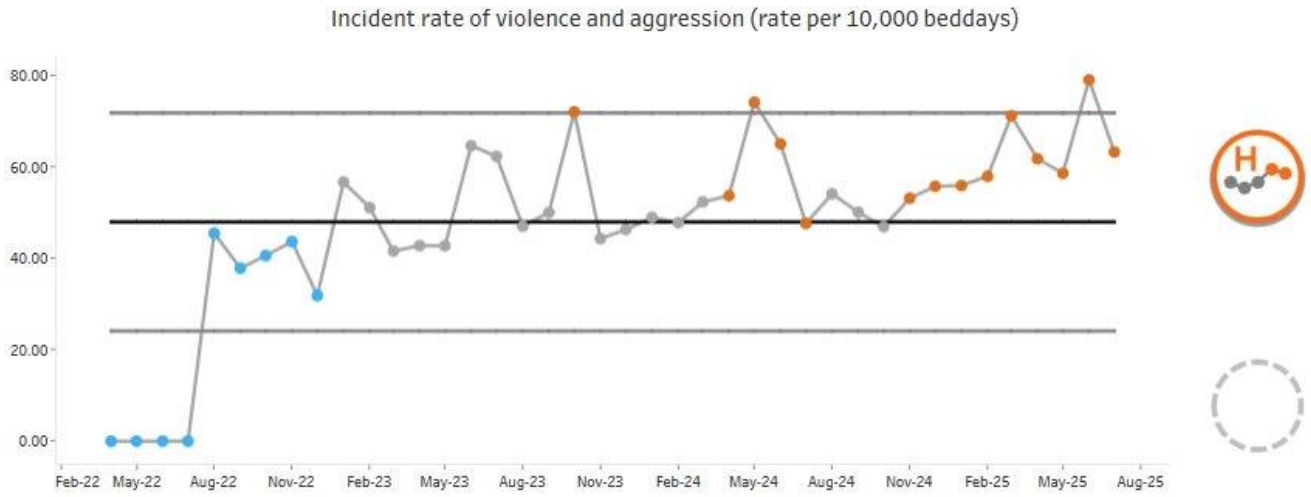





| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group | Risk Register | Data quality |
|---|---|---|---|---|
| There were 63 Health and Safety incidents relating to assault, aggression and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

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

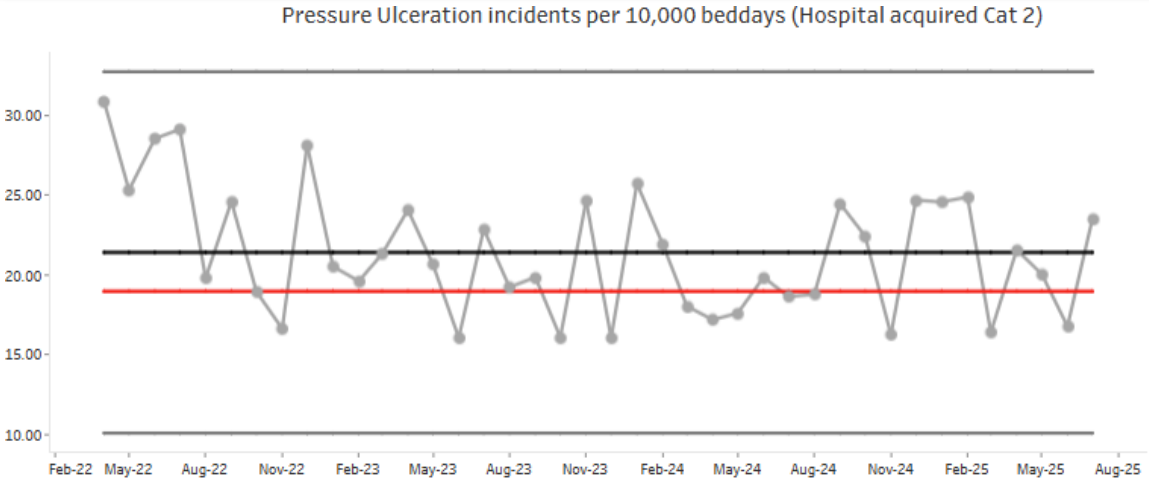


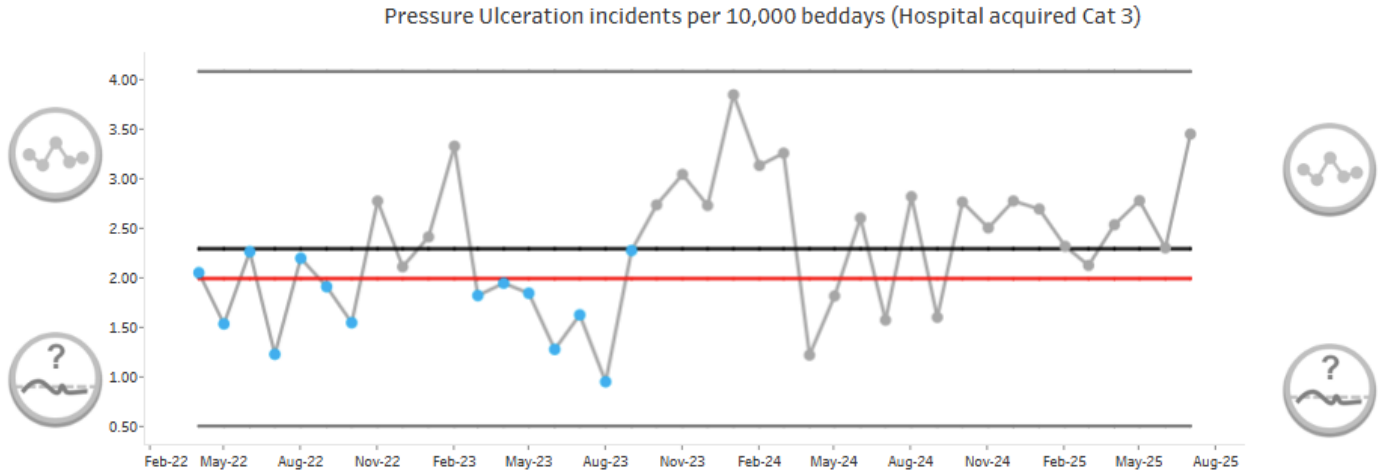



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group | Risk Register | Data quality |
|---|---|---|---|---|
| Continued from slide 2<br>Overall, the trend is most pronounced in high-throughput,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

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

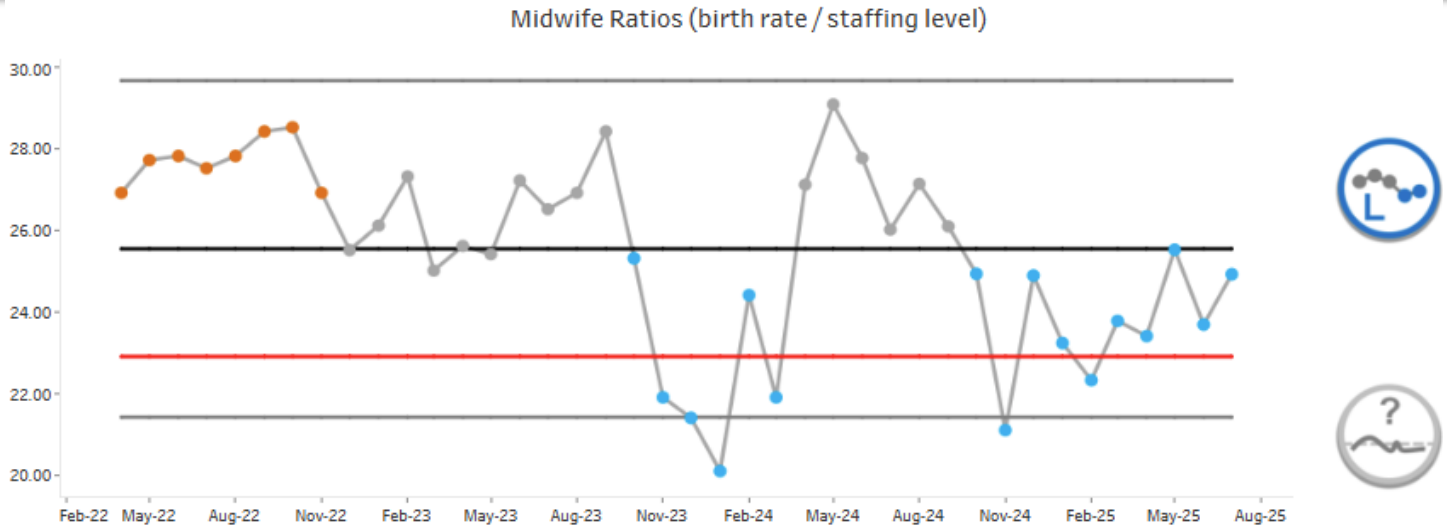





| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The Trust continues to demonstrate a proactive and data-informed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

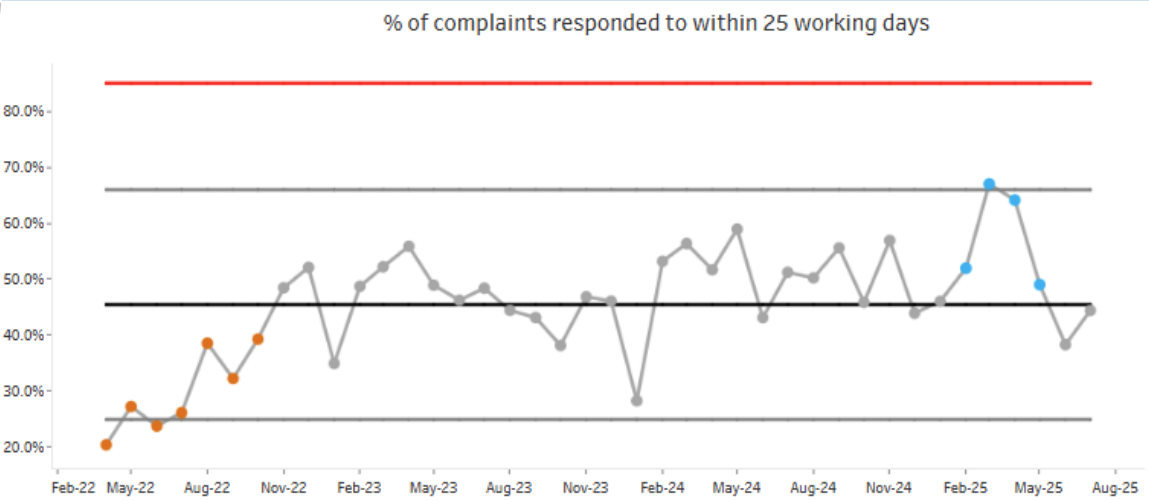
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*

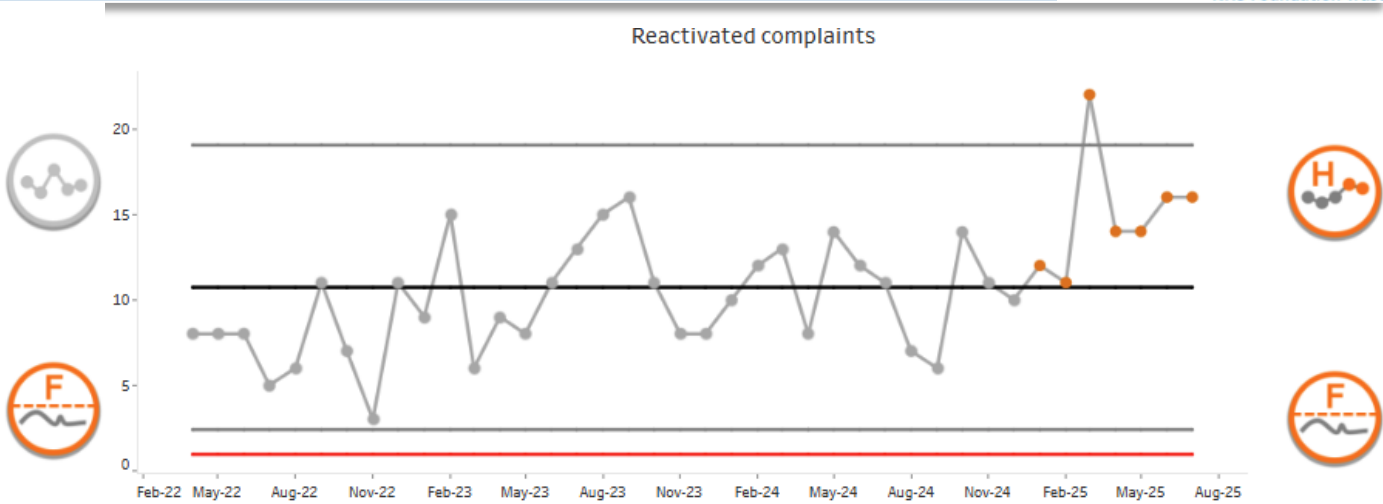



| Summary of challenges & risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance | Risk Register | Data quality |
|---|---|---|---|---|
| In July 607 mothers birthed at OUH, 9 more than the previous month<br><br>The midwife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

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



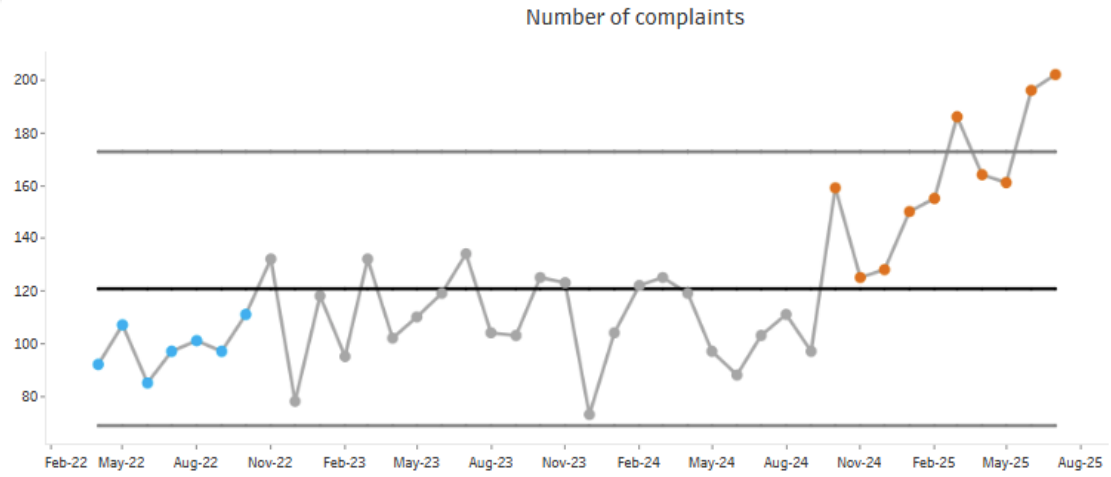


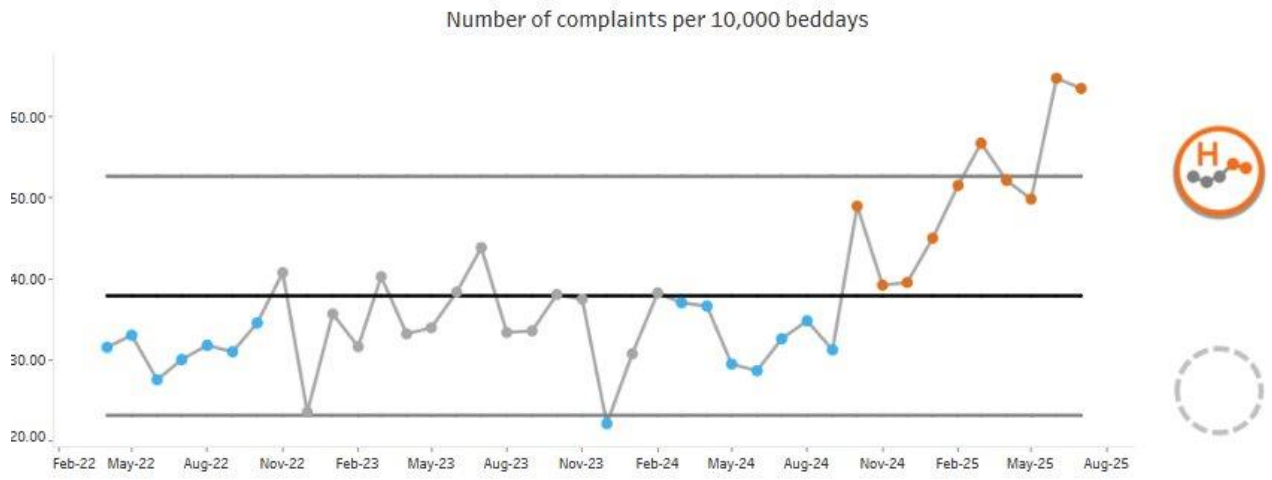




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| In July 2025, OUH received a total of 202 formal complaints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

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





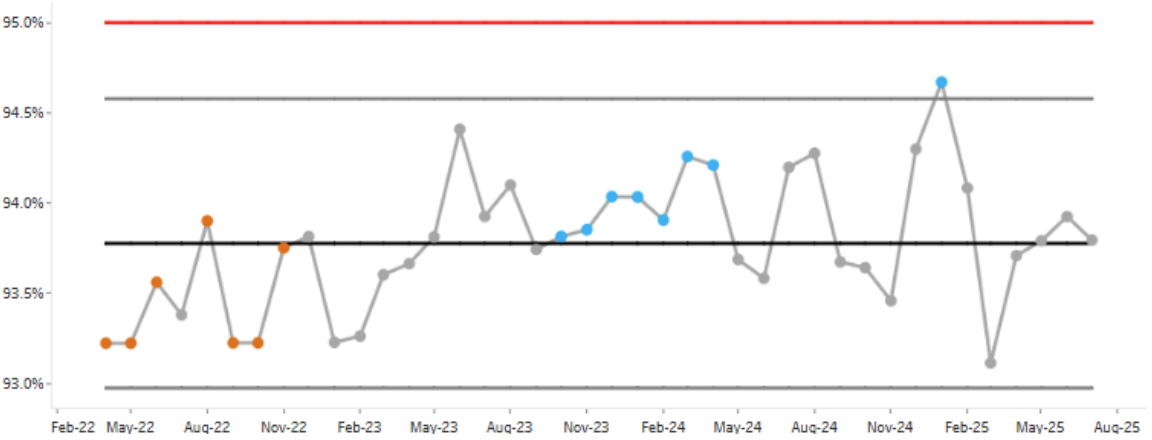




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Continuation of this trend in the volume of patient complaints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

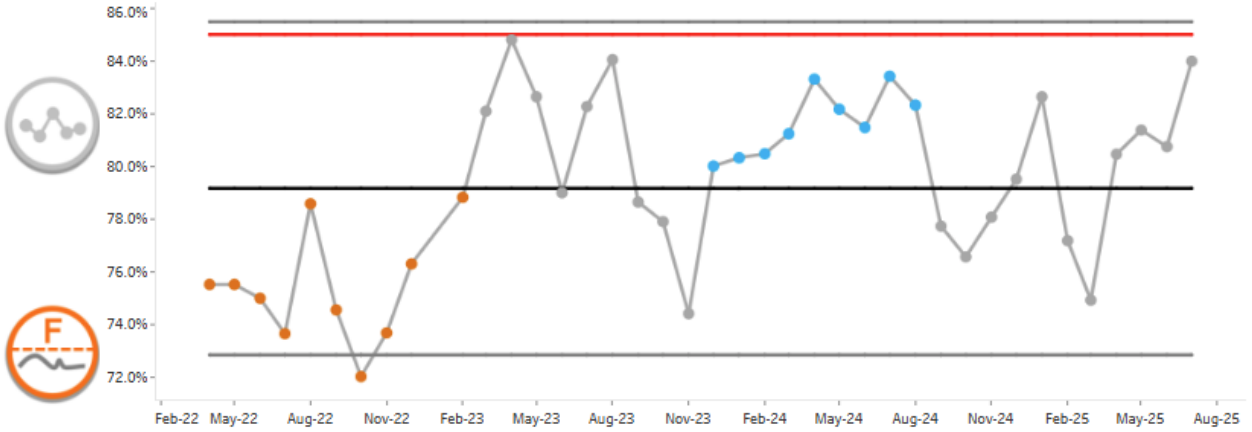
# 3. Assurance report: Quality, Safety and Patient Experience, *continued*



Friends & Family test % likely to recommend - OP




Friends & Family test % likely to recommend - ED




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

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

Oxford University Hospitals NHS Foundation Trust

## Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level. It is an NHSE requirement for this to be reviewed by Trust Boards each month. The NICE Safe Staffing guidelines inform the nurse-sensitive, paediatric, and maternity-sensitivity indicators summarised below.

Nursing and midwifery staffing is reviewed at a Trust level twice daily and was maintained at Level 2 (Amber) throughout July 2025. Paediatric Critical Care Unit (PCCU) declared level 3 one night shift. With support from the other Critical Care Units, PCCU was able to implement team nursing as mitigation to make the unit safe. The Trust-wide planned versus actual fill rates were 92.55% during the day and 97%% at night. Where fill rates were less than 90%, all shifts were reviewed, reported, and mitigated by a Matron or above at the safe staffing meeting, and shifts were not left at risk. The figures reflect that many wards across the trust are working with minimum, rather than, optimum staffing levels.

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

The staffing levels for nurses and midwives, as well as the nurse-sensitive indicators, are consistently reviewed and validated with divisional directors of nursing and deputy divisional directors of nursing. Each monthly review triangulates all relevant data in accordance with National Quality Board standards and assesses whether these nurse-sensitive harm indicators are directly related to staffing levels. The July review confirmed across all divisions that there were no instances of nurse-sensitive harm indicators directly linked to nursing or midwifery staffing levels. The HR data is being reviewed, as following the amendment to budgets, based on M11, the data is inaccurate. The division will work with HR and finance teams to ensure budgets are aligned with safe staffing requirement following the establishment reviews and CNO approval. It is hoped the data will be updated and accurate by September.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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



| July 2025 | Care Hours Per Patient Day | | | Census | Red Flags | | | | Nurse Sensitive Indicators | | | | HR | | | | | Rostering KPIs (14.7.25 - 10.8.25) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Budgeted Overall | Required Overall | Actual Overall | Census Compliance (%) | Open | Reviewed | Resolved | Raised in error | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | All reported Falls | Vacancy (%) | Turnover (%) | Sickness (%) | Maternity (%) | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% |
| **MRC** | | | | | | | | | | | | | | | | | | | | | |
| Ward 5A SSW | 8.88 | 8.47 | 8.1 | 94.62% | 11 | 7 | 5 | 3 | 1 | | 3 | 6 | 4.39% | 5.93% | 4.17% | 8.07% | 12.10% | Yes | 1.18% | 8.57 | 13.68% |
| Ward 5B SSW | 8.88 | 8.79 | 8.2 | 100.00% | 13 | - | 1 | - | 4 | | 4 | 5 | 4.55% | 10.18% | 3.24% | 0.00% | 4.55% | Yes | 2.84% | 8.57 | 15.84% |
| Cardiology Ward | 7.85 | 8.01 | 8.3 | 100.00% | 1 | 6 | 10 | 4 | 3 | | 0 | 5 | 10.29% | 12.84% | 7.26% | 0.00% | 12.31% | Yes | -1.93% | 8.29 | 14.17% |
| Cardiothoracic Ward (CTW) | 7.82 | 7.04 | 7.2 | 100.00% | 9 | - | - | - | 1 | | 0 | 0 | 3.18% | 0.73% | 3.37% | 2.25% | 5.36% | Yes | -0.94% | 7.86 | 13.01% |
| Complex Medicine Unit A | 8.94 | 11.02 | 8.1 | 97.85% | - | 7 | 1 | 2 | 0 | | 1 | 0 | 4.67% | 9.60% | 6.88% | 2.17% | 10.43% | No | 1.19% | 8.71 | 12.35% |
| Complex Medicine Unit B | 10.15 | 9.56 | 8.9 | 100.00% | - | 2 | - | 2 | 0 | | 4 | 4 | -3.97% | 8.35% | 4.84% | 2.29% | -0.13% | No | 2.63% | 8.71 | 15.38% |
| Complex Medicine Unit C | 8.75 | 10.42 | 7.9 | 100.00% | - | 1 | - | 2 | 2 | | 0 | 4 | 6.69% | 6.68% | 3.88% | 6.22% | 14.67% | No | -0.33% | 8.71 | 11.73% |
| Complex Medicine Unit D | 9.21 | 9.21 | 8.1 | 100.00% | - | 1 | 2 | 1 | 1 | | 2 | 1 | 7.88% | 19.91% | 6.80% | 0.00% | 9.29% | No | 1.39% | 8.71 | 14.27% |
| CTCCU | 21.10 | | 20.5 | | - | - | - | - | 9 | | 1 | 0 | 8.17% | 8.34% | 4.79% | 2.22% | 13.58% | Yes | -0.16% | 8.00 | 14.08% |
| Emergency Assessment Unit (EAU) | 9.23 | 8.63 | | 95.16% | 2 | - | - | - | 4 | | 0 | 6 | 5.11% | 11.55% | 6.16% | 1.17% | 7.63% | Yes | -0.14% | 9.00 | 18.37% |
| HH EAU | 9.77 | 7.25 | | 96.77% | - | - | - | - | 0 | | 0 | 6 | 5.14% | 7.31% | 5.61% | 1.16% | 7.59% | Yes | 2.50% | 8.57 | 14.03% |
| HH Emergency Department | 22.83 | | | | - | - | - | - | 3 | | 0 | 1 | 3.76% | 6.28% | 3.38% | 4.87% | 8.45% | Yes | -2.77% | 8.00 | 13.86% |
| JR Emergency Department | 19.84 | | | | - | - | - | - | 4 | | 0 | 4 | 13.65% | 14.85% | 4.59% | 3.30% | 16.98% | Yes | -0.39% | 8.86 | 12.23% |
| HH Juniper Ward | 8.07 | 11.44 | 8.2 | 100.00% | - | - | - | - | 0 | | 5 | 9 | 4.48% | 5.88% | 4.96% | 4.74% | 12.04% | Yes | -0.69% | 9.71 | 14.00% |
| HH Laburnum | 9.65 | 10.08 | 8.6 | 100.00% | - | - | - | - | 0 | | 0 | 8 | 0.57% | 7.34% | 6.67% | 4.58% | 6.86% | Yes | -0.36% | 9.29 | 15.36% |
| HH Oak (High Care Unit) | 10.58 | | 13.9 | 94.62% | 6 | - | 1 | - | 2 | | 5 | 3 | 0.52% | 4.68% | 6.14% | 15.29% | 15.72% | Yes | -0.58% | 9.71 | 13.40% |
| John Warin Ward | 10.21 | 10.59 | 9.7 | 100.00% | 2 | 5 | 7 | - | 1 | | 1 | 1 | 2.66% | 7.63% | 4.35% | 12.37% | 14.70% | Yes | -0.71% | 8.86 | 14.49% |
| OCE Rehabilitation Nursing (NOC) | 10.54 | 9.89 | 9.7 | 100.00% | 1 | - | 5 | 1 | 0 | | 0 | 3 | 1.98% | 12.27% | 4.99% | 1.61% | 4.35% | Yes | -1.06% | 8.43 | 16.45% |
| Osler Respiratory Unit | 14.45 | 8.52 | 12.2 | 100.00% | - | 2 | 4 | 1 | 5 | | 5 | 2 | -0.31% | 6.65% | 4.41% | 2.73% | 3.25% | Yes | -0.05% | 8.86 | 12.66% |
| Ward 5E/F | 11.01 | 9.52 | 10.5 | 100.00% | 10 | - | - | - | 0 | | 2 | 6 | -4.34% | 15.97% | 5.12% | 3.30% | 0.83% | Yes | -0.89% | 8.57 | 14.69% |
| Ward 7E Stroke Unit | 10.93 | 8.83 | 9.6 | 100.00% | 5 | - | - | - | 0 | | 1 | 5 | 0.37% | 10.88% | 4.68% | 2.05% | 2.41% | Yes | -3.11% | 8.00 | 14.63% |

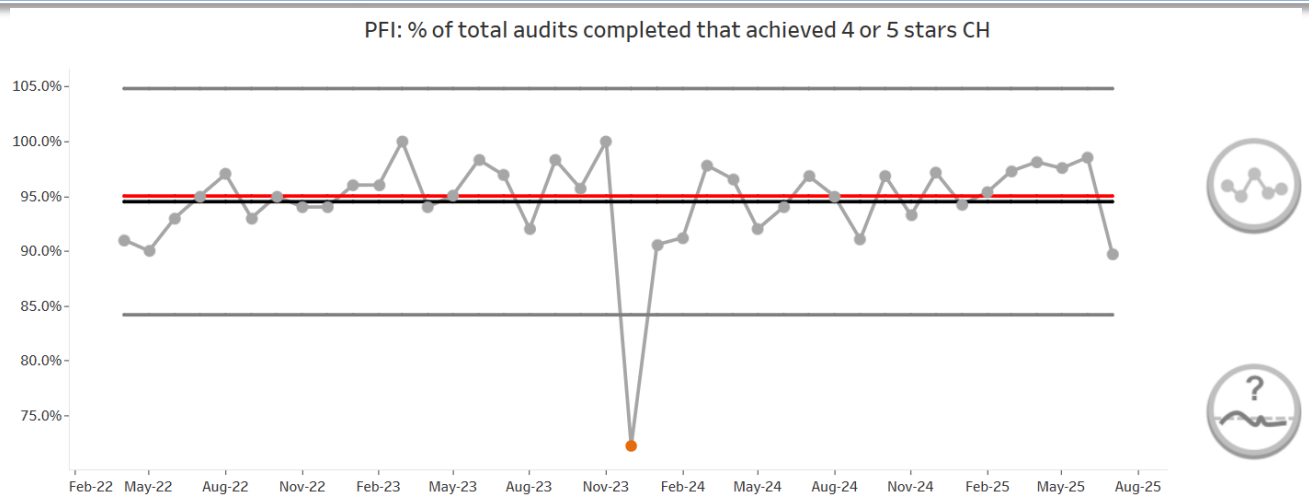
# 3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)



| July 2025 | Care Hours Per Patient Day | | | Census | Red Flags | | | | Nurse Sensitive Indicators | | | | HR | | | | | Rostering KPIs (14.7.25 - 10.8.25) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Budgeted Overall | Required Overall | Actual Overall | Census Compliance (%) | Open | Reviewed | Resolved | Raised in error | Medication Administration Error or Concerns | Extravasation Incidents | Pressure Ulcers Category 2,3&4 | All reported Falls | Vacancy (%) | Turnover (%) | Sickness (%) | Maternity (%) | Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%) | Roster manager approved for Payroll | Net Hours 2/-2% | 8 week lead time | Annual Leave 12-16% |
| **SUWON** | | | | | | | | | | | | | | | | | | | | | |
| Gastroenterology (7F) | 7.50 | 8.23 | 8.5 | 100.00% | - | 32 | 3 | - | 6 | | 1 | 4 | 13.81% | 12.52% | 6.78% | 4.98% | 18.11% | Yes | -3.07% | 7.86 | 15.32% |
| Gynaecology Ward - JR | 5.14 | 5.88 | 8.4 | 100.00% | 1 | - | - | - | 1 | | 0 | 3 | 0.38% | 9.98% | 5.80% | 2.74% | 3.11% | Yes | -1.10% | 8.57 | 14.05% |
| Haematology Ward | 7.64 | 8.36 | 9.2 | 100.00% | - | 3 | 3 | - | 5 | | 0 | 6 | 23.92% | 15.19% | 7.07% | 4.68% | 27.47% | Yes | 0.74% | 6.57 | 12.35% |
| Katharine House Ward | 9.21 | 8.85 | 10.3 | 100.00% | - | 5 | 2 | - | 2 | | 5 | 1 | 13.05% | 10.15% | 4.19% | 4.97% | 17.37% | No | 0.77% | 8.57 | 13.60% |
| Oncology Ward | 7.71 | 8.40 | 8.0 | 98.92% | - | - | 1 | - | 1 | | 4 | 7 | 8.53% | 5.84% | 3.72% | 3.10% | 11.37% | Yes | 0.89% | 9.00 | 14.26% |
| Renal Ward | 7.70 | 8.32 | 9.1 | 100.00% | - | 3 | 2 | - | 1 | | 2 | 1 | 13.42% | 16.96% | 3.21% | 10.76% | 22.73% | Yes | 0.66% | 7.29 | 12.97% |
| SEU D Side | 8.69 | 8.46 | 8.6 | 100.00% | - | - | - | 1 | 4 | | 2 | 2 | 16.34% | 4.60% | 4.77% | 4.58% | 20.18% | Yes | 0.18% | 8.57 | 12.38% |
| SEU E Side | 8.40 | 8.80 | 8.5 | 100.00% | - | - | - | - | 4 | | 1 | 1 | 21.64% | 9.55% | 6.41% | 0.00% | 21.64% | Yes | 0.44% | 8.57 | 12.10% |
| SEU F Side | 7.51 | 8.52 | 7.7 | 100.00% | 1 | - | - | 2 | 2 | | 1 | 2 | 18.19% | 0.00% | 3.18% | 0.00% | 18.19% | Yes | -2.34% | 8.57 | 16.05% |
| Sobell House - Inpatients | 8.02 | 8.53 | 8.3 | 100.00% | - | 13 | - | - | 5 | | 4 | 5 | 6.40% | 5.66% | 4.81% | 9.57% | 15.35% | Yes | -1.41% | 7.86 | 13.06% |
| Transplant Ward | 9.43 | 8.00 | 8.6 | 100.00% | 4 | 4 | - | - | 6 | | 0 | 0 | 13.01% | 5.18% | 6.85% | 0.00% | 13.01% | Yes | 1.86% | 8.86 | 10.68% |
| Upper GI Ward | 9.54 | 7.34 | 8.3 | 100.00% | 3 | - | - | - | 2 | | 3 | 4 | 2.34% | 2.60% | 5.44% | 13.45% | 15.48% | Yes | -7.89% | 9.29 | 14.71% |
| Urology Inpatients | 8.84 | 9.71 | 9.1 | 100.00% | - | 6 | - | 1 | 1 | | 3 | 0 | 18.39% | 3.53% | 4.88% | 0.00% | 18.39% | Yes | -2.64% | 6.43 | 13.32% |
| Wytham Ward | 7.63 | 7.29 | 7.5 | 100.00% | 1 | 9 | 2 | - | 4 | | 0 | 0 | -8.09% | 7.52% | 4.58% | 14.92% | 8.03% | Yes | -5.78% | 9.29 | 8.68% |
| MW Delivery Suite | 13.50 | | 18.1 | | 1 | - | 66 | - | | | | | | | | | | Yes | -2.81% | 7.00 | 10.68% |
| MW Level 5 | 5.66 | | 4.8 | | - | - | - | - | | | | | | | | | | Yes | 0.06% | 7.00 | 11.21% |
| MW Level 6 | 4.78 | | 7.2 | | - | - | - | - | | | | | | | | | | Yes | -2.28% | 7.00 | 15.64% |
| MW The Spires | 15.51 | | 19.0 | | 1 | - | - | - | | | | | | | | | | Yes | -2.13% | 7.00 | 13.08% |
| **CSS** | | | | | | | | | | | | | | | | | | | | | |
| JR ICU | 31.12 | | 25.6 | 100.00% | - | - | - | - | 20 | | 1 | 0 | 13.17% | 10.55% | 4.19% | 5.26% | 17.74% | Yes | -0.28% | 8.86 | 13.21% |

# 3. Assurance report: Estates, Facilities and PFI

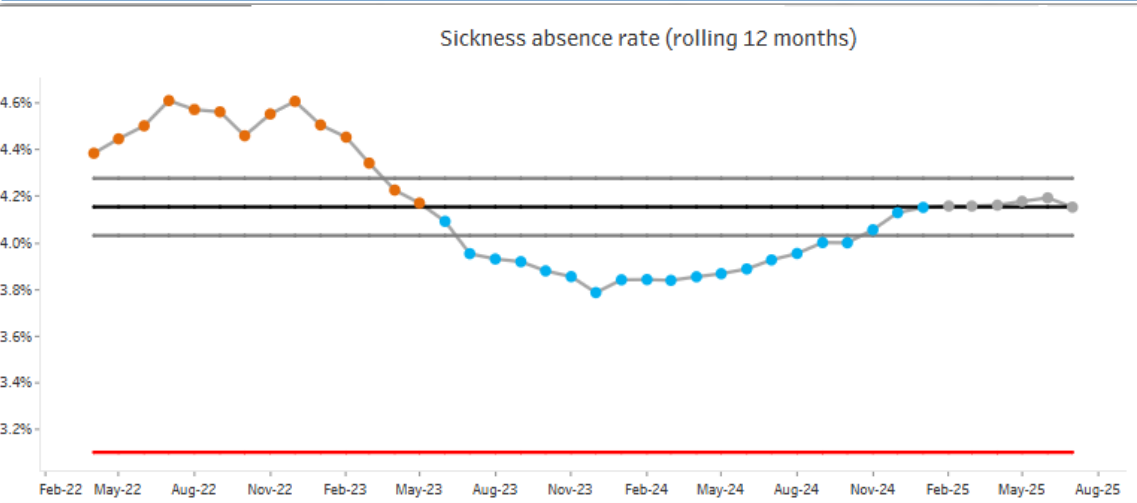


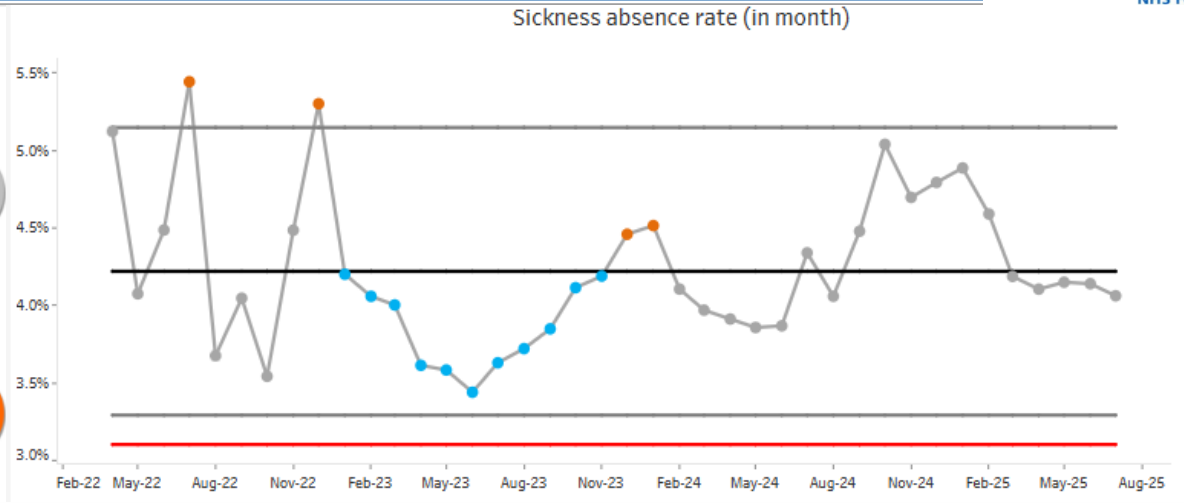



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group | Risk Register | Data quality |
|---|---|---|---|---|
| In July 2025, the combined PFI % cleaning score by site (average) for the Churchill was 95.21% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 89.66% which is below the 95% Trust target.<br><br>In total, at the Churchill, 58 audits were conducted, 6 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2025. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating.<br><br>It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating along with re training if required, review of cleaning equipment etc. | Unfortunately, G4S did not complete the planned number of audits at the Churchill in July 2025. 71 audits were scheduled and 58 completed. Audits not completed are quarterly audits and still in the quarterly period of July – Sept. The FR4 quarterly audits that have not been completed are still in the quarterly period of July – September so will be completed in August or September. Six of the 58 audits failed to achieve the set Trust target under domestic and clinical. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. There is no pattern or trend in the six departments that fell below 4* on the first audit. We continue to work closely with IPC, G4S and the ward/department leads and are completing additional audits with the management, increased supervision from G4S and clinical staff when areas are cleaned.<br><br>When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities.<br><br>The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how. | 1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at Churchill.<br><br>2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion.<br><br>3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC<br><br>4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports | BAF 4<br>CRR 1123 | Sufficient<br>*Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months* |

# 3. Assurance report: Growing Stronger Together





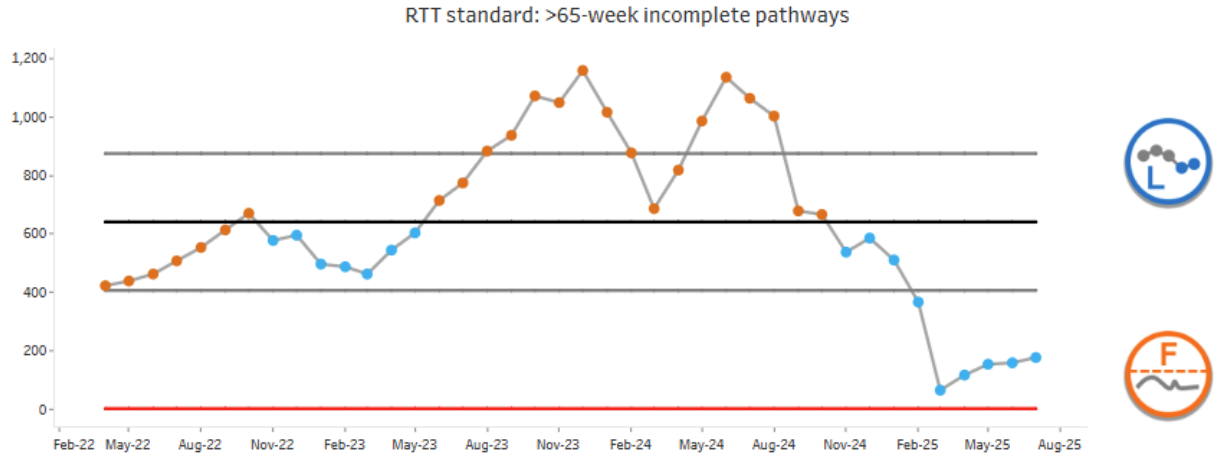

**Benchmarking: February 2025 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).**

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

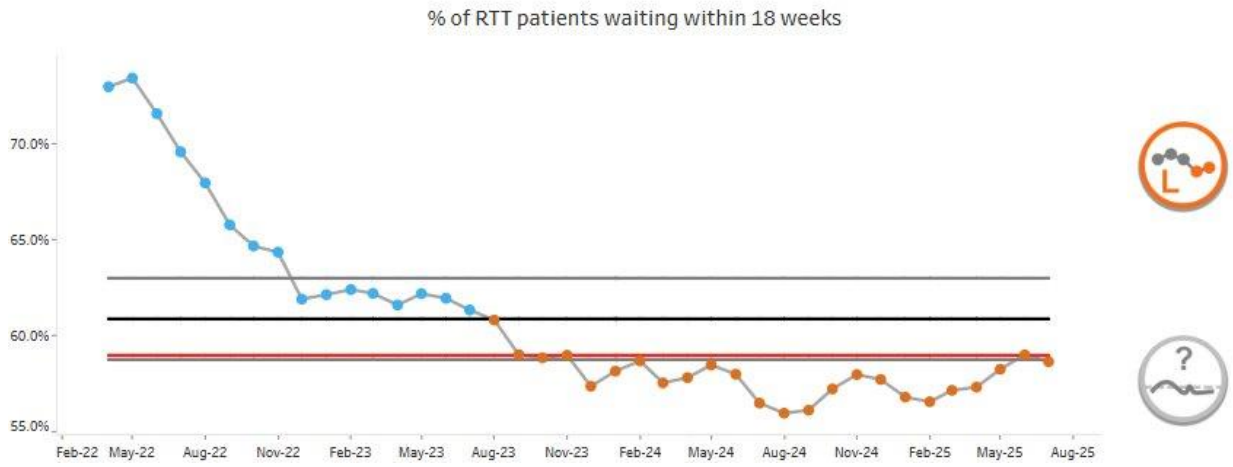
| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Sickness absence performance (rolling 12 months) was 4.2%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

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






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

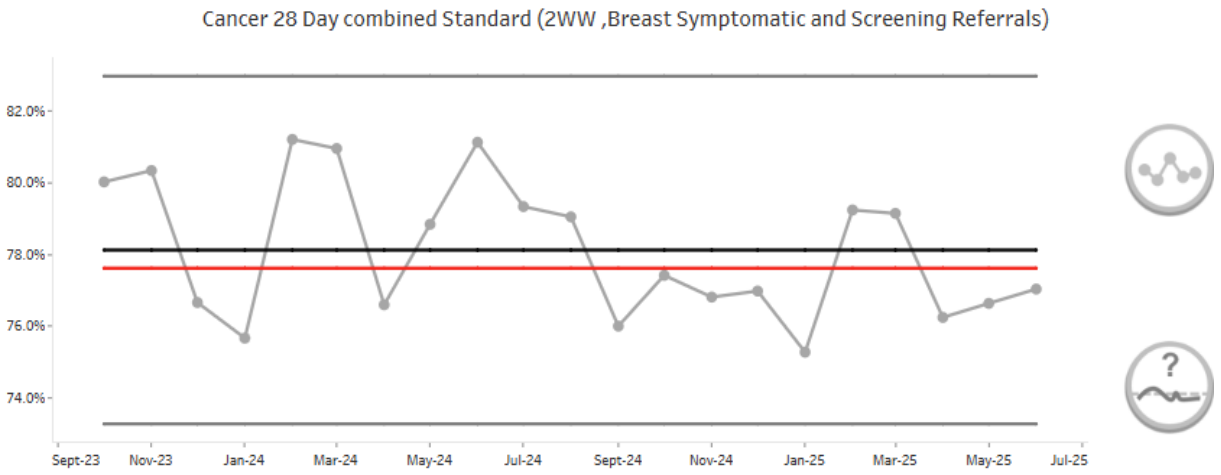



| Benchmarking >18-week %: April 2025 | | | | |
|---|---|---|---|---|
| OUH: 58.95% | National: 62.4% | Shelford: 61.2% | BHT: 58.01% | RBH: 79.92% |

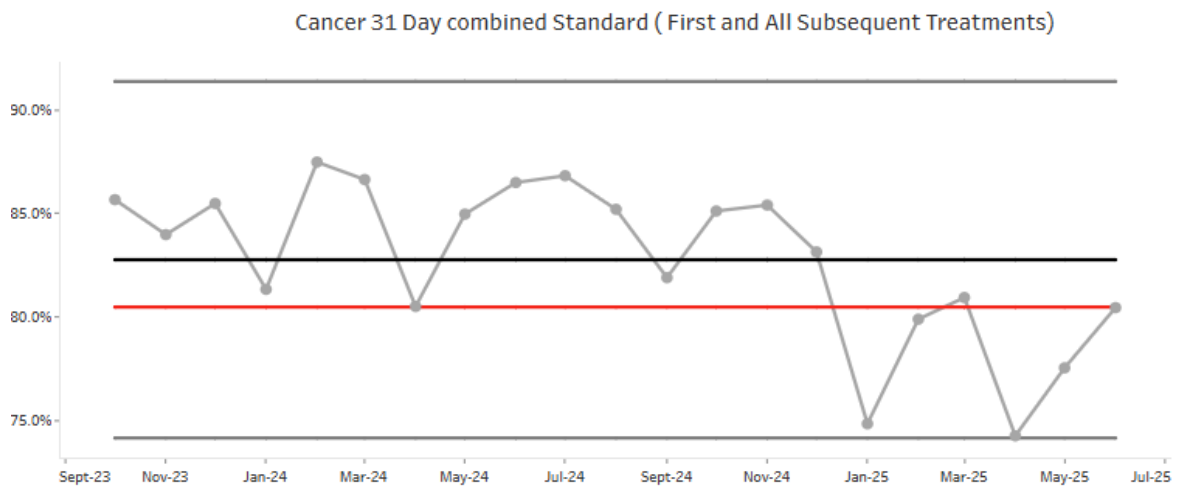
| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| The number of patients waiting more than 65 weeks to start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

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






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



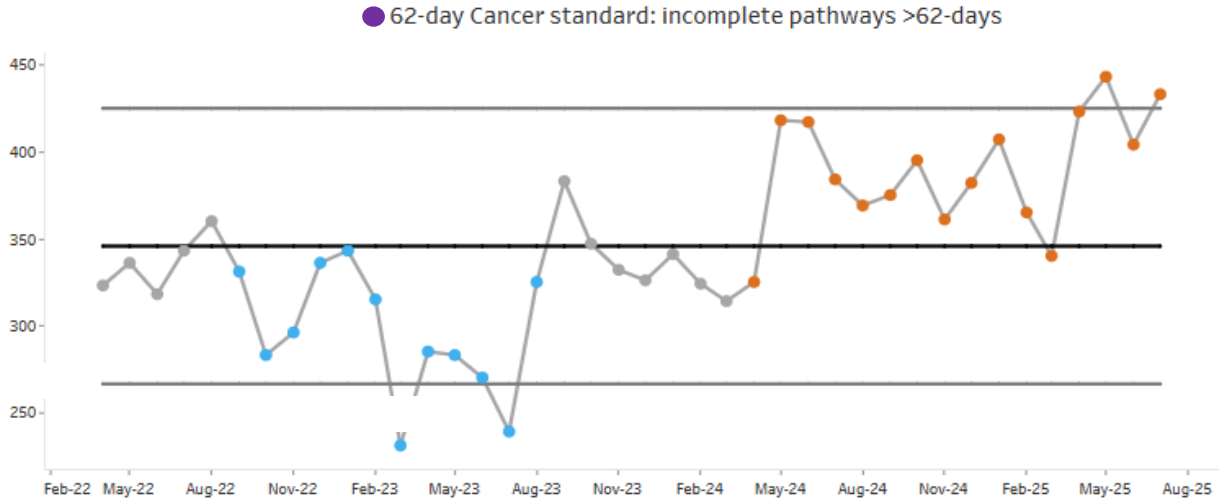

| Benchmarking: Cancer 31 Day Faster Diagnosis June 2025 | | | | |
|---|---|---|---|---|
| OUH: 80.4% | National: 94.4% | Shelford: 90.7% | BHT: 80.8% | RBH: 93.3% |

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data quality rating |
|---|---|---|---|---|
| Cancer performance against the 31 days Decision to Treat was 80.4% in June 2025 against an operational plan of 80.5% (0.01% variance) and below the national standard of 96.0%. Performance is reported one month in arrears due to the extended reporting period for this indicator.<br><br>All tumour sites apart from Children's, Haematology – Acute Leukaemia, UGI Oesophagus and Stomach, Urological Testicular are non-compliant for this standard in June.<br><br>OUH ranked 127th out of 134 Providers in June and 9th out of the 10 Shelford Group.<br><br>UGI – Hepatobiliary is nationally ranked bottom out of 119 Providers, Lung is nationally ranked 121st out of 122 and Lower GI is nationally ranked 120th out of 123. Urology Prostate is ranked 113th out of 120 Providers. | As per next slide. | As per next slide. | As per next slide. | As per next slide. |

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

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

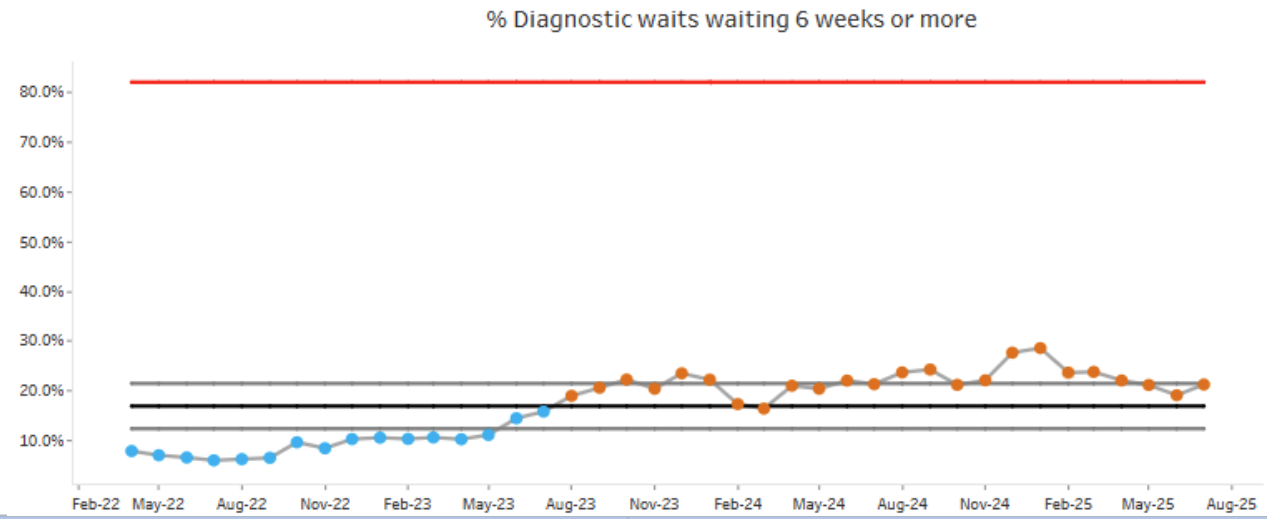



| Benchmarking: Cancer 62 Day All Routes (May 2025) |
|---|
| OUH: 61.80% |
| National: 69.8% |
| Shelford: 62.8% |
| BHT: 62.28% |
| RBH: 70.25% |

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

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

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

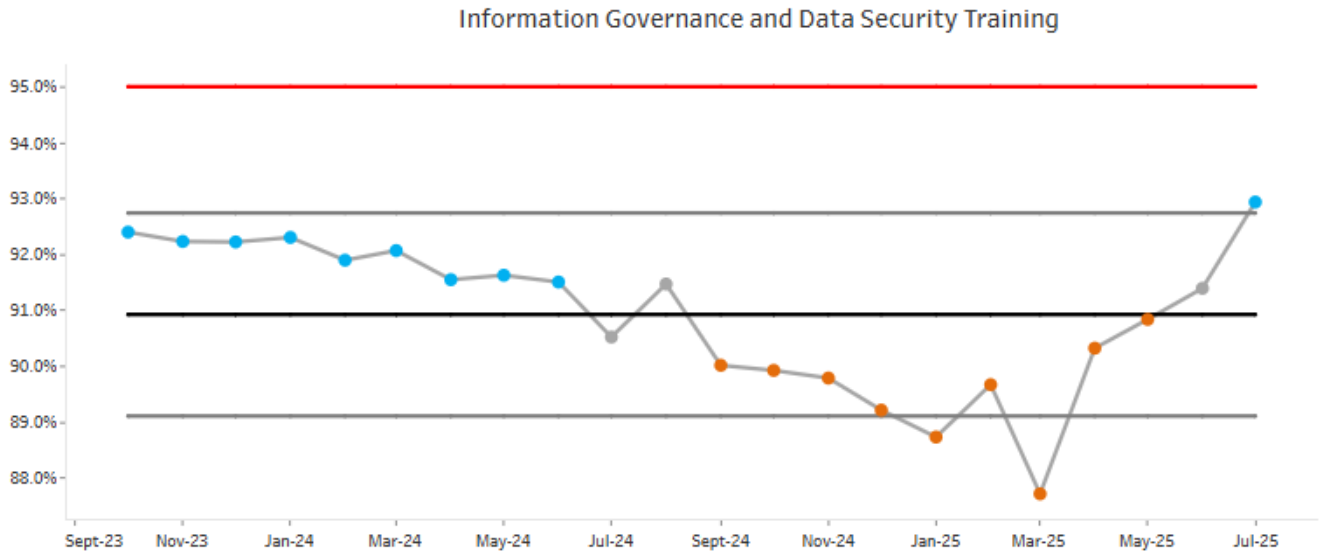



| Benchmarking: Cancer 31 Day All Stages (May 2025) |
|---|
| **OUH: 19.05% (OUH Internal Target 21.1%)** |
| **National:** 17.5% |
| **Shelford:** 18.2% |
| **BHT:** 23.82% |
| **RBH:** 10.31% |

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

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group | Risk Register | Data quality |
|---|---|---|---|---|
| The percentage of diagnostic waits over 6 weeks+ (DM01) was 21.2% in July. The indicator exhibited special cause variation due to performance being above the mean for more than six successive periods, as well as below the lower process control limit. The indicator however has achieved the plan of 18.0% in July.<br><br>**Audiology:**<br>• Demand above capacity since ENT pathway changes<br>• Clinical staffing gaps<br>• Capacity shortfall for children's audiology tests<br>**Endoscopy:**<br>• Capacity shortages to meet demand<br>• Lapsed Planned patients retriggering as a reportable<br>**Neurophysiology**:<br>• Capacity mismatch with demand.<br>**Ultrasound**:<br>• Difficulty recruiting to sonographer vacancies<br>• Increased demand<br>• Reduced sessions due to NHSP changes | **Audiology:**<br>• Extended insourcing for adult audiology<br>• Business case to reconfigure Community Paediatric and Acute Paediatric being prepared for submission to TME<br>• Filled several vacancies with start dates in May/June.<br>• Location identified at the Horton to install funded VRA Booth's<br>• Audiology is no longer on trajectory of delivering plan.<br><br>**Endoscopy:**<br>• Nurse endoscopist is now independently working since April.<br>• Delivery fund utilised and scheme fully allocated for additional capacity above baseline.<br>• Job plans reviewed introducing additional endoscopy list in place of outpatient clinic<br>• Clinical triage continued into 2025/26<br><br>**Neurophysiology**:<br>• Replacement of Insourcing supplier commenced 9th May<br>• Additional sessions considered where possible<br>• 4PA clinician returning from a sabbatical in June has resigned. PA's on hold as no longer in budget.<br><br>**Ultrasound: Most accelerated recovery of all modalities with 557 less breaches than last month**<br>• Additional capacity through insourcing agreed and monitoring closely<br>• Sessional tracker in place monitoring substantive gaps as well as NHSP uptake.<br>• Workforce plan developed with TME approved case for converting the ERF scheme to substantive posts. | Assurance meeting monitor all actions on a weekly basis<br><br>**Audiology:** Will not deliver plan due to Paediatrics by March. Expect to deliver during 2026/27.<br><br>**Endoscopy:** Agreement of additional capacity are being finalised to confirm delivery of plan<br><br>**Neurophysiology:** Will deliver plan by March.<br><br>**Ultrasound:** On plan to deliver | BAF 4<br><br>Link to CRR 1136 (Red) | Satisfactory<br><br>*Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance* |

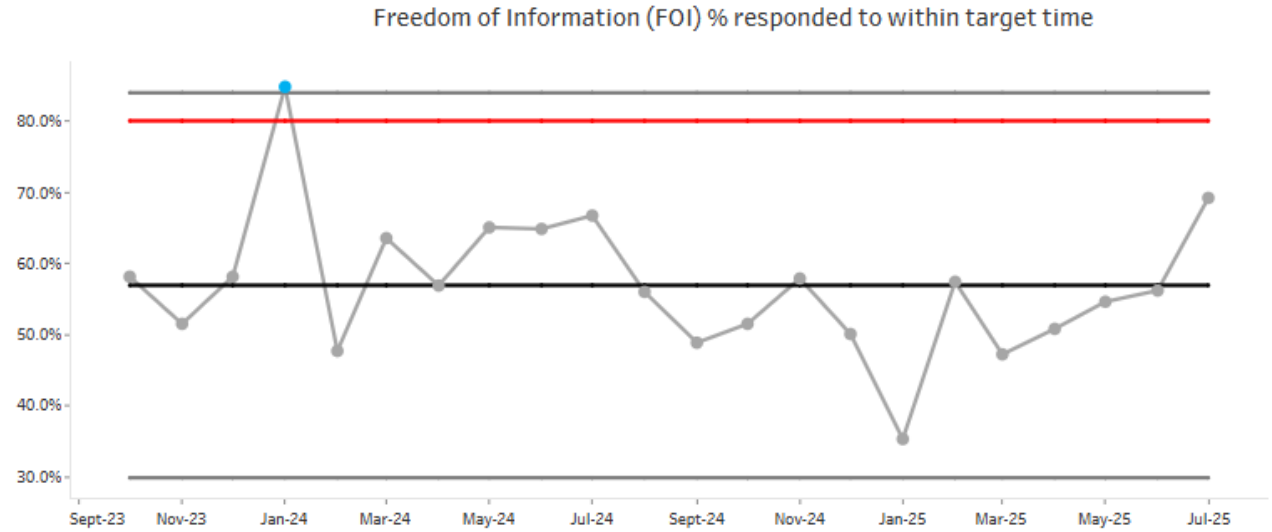
# 3. Assurance report: Corporate support services – Digital, *continued*




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

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

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




Historic case backlog:

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

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

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

## SPC Variation/Performance Icons

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

## SPC Assurance Icons

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

## OUH Data Quality indicator

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

Sufficient | Satisfactory | Inadequate

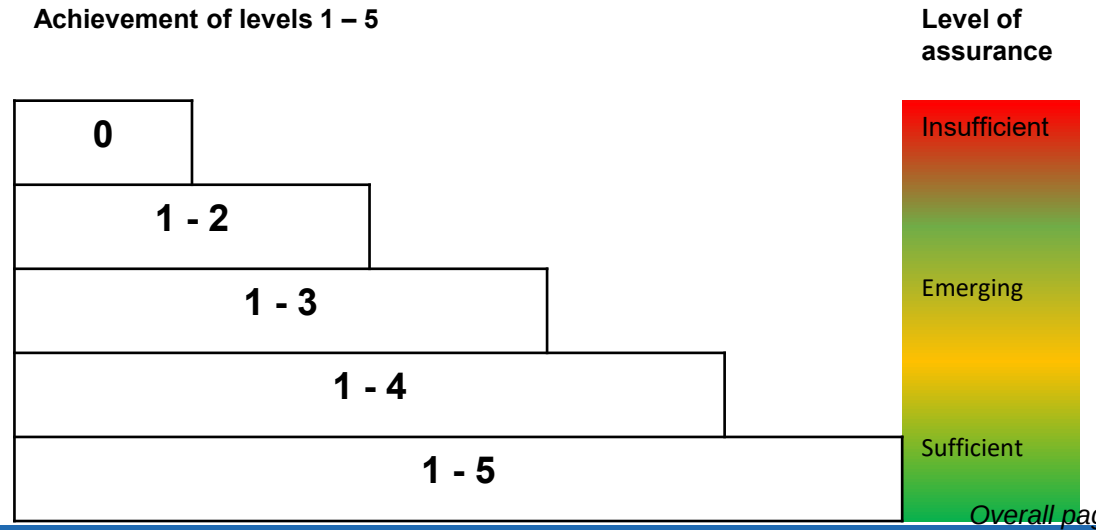
Oxford University Hospitals NHS Foundation Trust

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

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

## 2. Framework for levels of assurance:

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



# 16. FINANCE REPORT M4

## REFERENCES

Only PDFs are attached

15 TB2025.83 Finance Report M4 v1.pdf

## Finance, Procurement and Contracting

# Financial Performance Report:

# Month 4

Jason Dorsett: Chief Finance Officer

# Financial Performance Report

Oxford University Hospitals NHS Foundation Trust

## Integrated themes and issues from Month 4 (July 2025)

## Executive Summary

**Overall**

**Income and Expenditure (I&E)** was a £1.0m deficit in Month 4, which was £0.2m better than plan. The underlying deficit was estimated to be £5.8m, which was £1.8m worse than planned. This was driven by underlying income. Overall worked WTE (excluding R&D) increased by 28 WTE in July, with a 71 WTE increase in temporary bank staffing primarily due to industrial action.

This paper also reports on the underlying position which will be resubmitted to NHSE in September as part of preparation for the medium-term plan. A final one page update will be circulated prior to the meeting.

**Activity**

For 25/26 most elective activity will be paid variably, up to the plan value agreed with each commissioner. Variable income performance has been included this month based on Q1 activity data which shows a net overperformance for electives and diagnostics, this has increased income by £0.9m this month (£3.4m YTD). There is risk in recognising this if performance is not maintained or if commissioners implement an 'Activity Management Plan (AMP)'.

**Income**

**Commissioning income** (excluding passthrough) was £0.8m better than plan for Month 4, £0.8m of this was from elective and diagnostic activity (as noted above). Passthrough drugs and devices were £3.1m above plan in month, this is neutral to the bottom line as matched with expenditure.

**Other income** was £0.9m worse than plan in Month 4, this was driven by Education and Training income (£1.4m worse than plan).

**Private patients, overseas and RTA income** was £0.2m worse than plan in Month 4, due to Private Patient income which was £0.2m worse than plan.

**Headcount**

**Whole Time Equivalent** headcount (excluding R&D) in July increased by 28 WTE. The increase has been in bank staffing (71 WTE, including 26 on medical staff). Substantive staff reduced by 32 and agency staff reduced by 12. The Trust plan assumes a WTE reduction of 675 (575 substantive staff and 100 on temporary staffing) by M12 2025/26 to achieve the savings target.

**Pay Expenditure**

**Pay costs** are £0.5m better than plan in Month 4, this is driven by underspends on substantive staffing, most significantly on medical staff, £0.9m underspend in month, 103 WTE below plan).

**Non-Pay Expenditure**

**Non-pay costs** were £4.0m adverse to plan in Month 4, (£0.8m adverse to plan excluding the £3.1m passthrough variance and R&D £0.1m overspend). £1.4m is driven by shortfall against efficiency plans in month (excluding non-cash releasing schemes).

**Cash**

**Cash** was £13.5m at the end of July, £4.6m higher than the previous month and £9.9m higher than plan. This variance is predominantly due to slippage on capital cash outflows (which are £8.5m below plan) and the Trust continuing to defer more supplier payments than originally planned to manage the Trust's cash since there is currently no external cash support available. Any upsides in cash are being used to offset the need for external cash support.

**Conclusion**

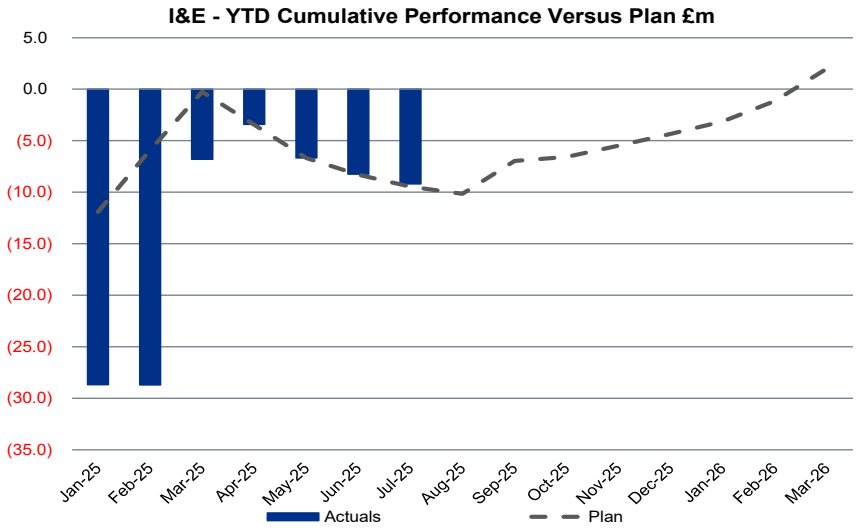
The Trust is slightly ahead of plan in month and year to date with a £9.2m deficit, this has been partly achieved through non-recurrent underspends although recurrent efficiency delivery has improved over the last two months.

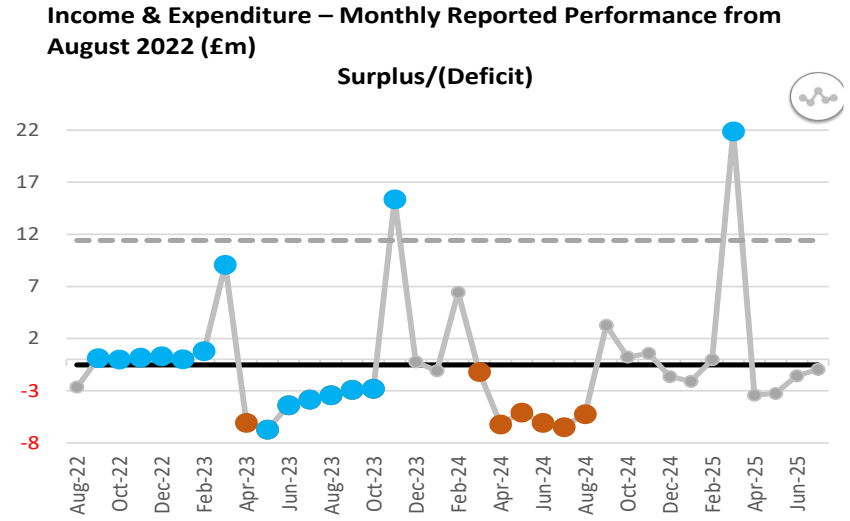
# Financial Performance Report

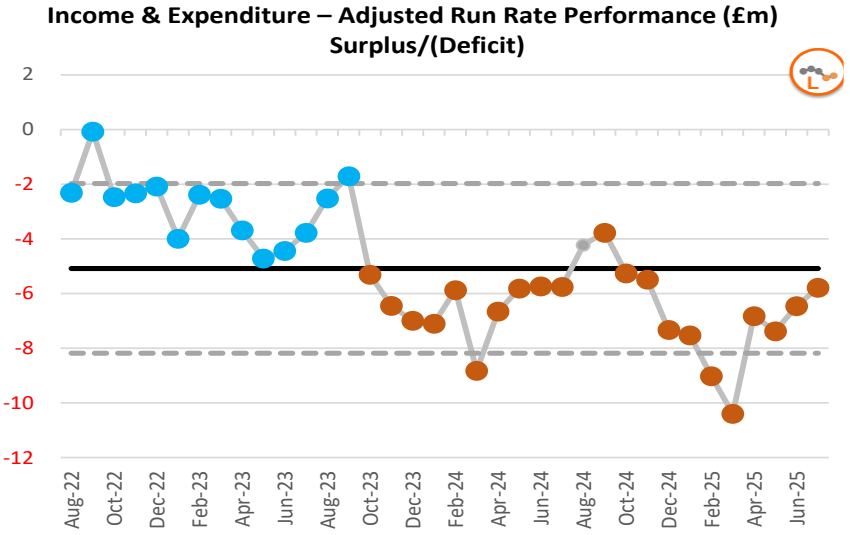
## Integrated themes and issues from Month 4 (July 2025)

Oxford University Hospitals NHS Foundation Trust

## Summary Charts



# Financial Performance Report

Oxford University Hospitals NHS Foundation Trust

## Integrated themes and issues from Month 4 (July 2025)

## Key Actions Arising from Month 4

**CIP**

The key action arising from the month 4 financial position remains the need to improve the delivery of the CIP programme. The YTD delivery is 80% of the planned level. Delivery of the full £99m plan is fundamental to the Trust meeting its financial plan. 100% of the CIP programme was identified by the end of June deadline. Work now must focus on de risking the plans and moving identified schemes from opportunities into fully developed schemes. At month 4 reporting 34% of identified schemes were classified as high risk.

**Budget Control Process**

As the clinical divisions remained off plan year to date at month 3, they were required to completed rectification plans to demonstrate how they will deliver the financial plan. The first submission of these plans on 18th July highlighted that no division has submitted a route to deliver a breakeven financial plan. Further confirm and challenge meetings will be held with the divisions and further financial controls may be considered. Until rectification plans are agreed:

- No new posts can go out to recruitment. Divisions will have to request exceptions with agreement required by the COO. Divisions will be required to document any divisional reviews of posts and outcomes as well as those that are put forward for approval.
- No discretionary non-clinical non pay. Exceptions can be requested from the COO and CFO
- No new business cases to BPG even if funded. Exceptions will need to be requested from the COO and CFO.

A series of options are under consideration by TME to ensure in year delivery of the financial plan. See private board paper.

**Contracts**

Income reporting is using actual contract values, or draft contract values where the contract has not been finalised.

TME is asked to note that:

- HCDD T&Cs are being finalised with BOB
- Progress with Spec comm is slower due to queries relating to activity plans, and difficulties in getting responses from non-SE Regional teams
- Contracts with Associate commissioners are aligned to plan

# Income and Expenditure: Overview – Reported Position

Oxford University Hospitals NHS Foundation Trust

Source: Budget in Finance Ledger.

| I & E Subjective | IN MONTH 4 | | | | YEAR TO DATE | | | | FULL YEAR |
|---|---|---|---|---|---|---|---|---|---|
| £m | Plan | Actual | Var | Var % | Plan | Actual | Var | Var % | Plan |
| **Income** | | | | | | | | | |
| Commissioning Income | 111.1 | 111.8 | 0.8 | 0.7% | 427.8 | 431.3 | 3.5 | 0.8% | 1,283.4 |
| Passthrough Drugs & Devices | 17.8 | 20.9 | 3.1 | 17.2% | 79.5 | 87.1 | 7.6 | 9.5% | 238.5 |
| Other Income | 15.4 | 14.6 | (0.9) | -5.7% | 61.4 | 61.6 | 0.3 | 0.4% | 188.9 |
| PP, Overseas and RTA Income | 1.7 | 1.4 | (0.2) | -14.0% | 7.4 | 5.4 | (2.0) | -27.1% | 20.1 |
| **Total Income** | 146.0 | 148.7 | 2.7 | 1.9% | 576.0 | 585.4 | 9.4 | 1.6% | 1,730.8 |
| **Pay** | | | | | | | | | |
| Consultants and Medics | (30.7) | (30.3) | 0.3 | 1.1% | (118.4) | (116.7) | 1.7 | 1.5% | (353.1) |
| Health Care Assistants & Support | (6.8) | (7.4) | (0.5) | -7.5% | (27.3) | (29.1) | (1.8) | -6.7% | (79.0) |
| Nurse and Midwives | (23.8) | (23.0) | 0.8 | 3.5% | (95.0) | (92.9) | 2.1 | 2.2% | (277.3) |
| Other Staff | (12.1) | (12.4) | (0.3) | -2.5% | (48.5) | (50.0) | (1.5) | -3.1% | (139.9) |
| Scientific, Therapeutic and Technical | (12.0) | (11.9) | 0.1 | 1.0% | (47.8) | (47.2) | 0.6 | 1.3% | (140.1) |
| **Total Pay** | (85.5) | (85.0) | 0.5 | 0.5% | (337.1) | (336.0) | 1.2 | 0.3% | (989.3) |
| **Non-Pay** | | | | | | | | | |
| Clinical negligence | (3.2) | (3.1) | 0.0 | 1.1% | (12.7) | (12.7) | 0.0 | 0.3% | (38.2) |
| Clinical Supplies & Services | (10.3) | (12.3) | (2.0) | -19.6% | (40.9) | (45.2) | (4.3) | -10.5% | (122.7) |
| Drugs & Devices | (24.5) | (27.6) | (3.2) | -13.0% | (98.0) | (106.5) | (8.5) | -8.6% | (294.1) |
| Passthrough Drugs & Devices | (17.8) | (20.9) | (3.1) | -17.2% | (79.5) | (87.1) | (7.6) | -9.5% | (238.5) |
| Drugs | (6.7) | (6.8) | (0.1) | -1.6% | (18.5) | (19.5) | (0.9) | -4.9% | (55.6) |
| General Supplies & Services | (0.5) | (0.6) | (0.0) | -7.8% | (2.2) | (2.2) | (0.0) | -0.1% | (6.4) |
| Internal Recharges | (0.0) | (0.0) | 0.0 | 100.0% | (0.1) | 0.0 | 0.1 | 100.0% | (0.3) |
| Premises & Fixed Plant | (10.8) | (9.0) | 1.8 | 16.8% | (42.5) | (39.3) | 3.2 | 7.5% | (124.5) |
| Other Expenditure | (4.1) | (4.8) | (0.7) | -16.0% | (18.9) | (21.1) | (2.2) | -11.8% | (52.0) |
| **Total Non-Pay** | (53.4) | (57.4) | (4.0) | -7.5% | (215.3) | (227.0) | (11.7) | -5.4% | (638.2) |
| **Operational EBITDA** | 7.1 | 6.3 | (0.8) | -11.7% | 23.6 | 22.4 | (1.2) | -5.0% | 103.3 |
| **Financing and Capital Charges (Excl Tech Adj)** | (8.3) | (7.2) | 1.0 | 12.7% | (33.0) | (31.6) | 1.5 | 4.4% | (101.3) |
| **Operational Surplus / (Deficit)** | (1.2) | (1.0) | 0.2 | 18.2% | (9.5) | (9.2) | 0.3 | 2.8% | 2.0 |

## Income

- Commissioning income, including passthrough, is £11.1m better than plan to date. £7.6m is due to passthrough drugs and devices (offset by increased expenditure), other commissioning income is £3.5m better than plan mainly due to recognising £3.4m of contract activity overperformance and £0.6m of additional income from other ICB contracts.
- Other income is £0.3m better than plan YTD. R&D income is £0.8m better than plan (£0.9m contribution from R&D YTD), this is offset by other areas of income being £0.5m below plan.
- Private patients, overseas and RTA income is £2.0m worse than plan to date, principally from private patient income (£1.7m), where the efficiencies are £1.0m below the target.

## Pay

- Pay is £1.2m better than plan to date (£1.5m better than plan excluding R&D). The variance is driven by delivery of recurrent pay efficiencies, especially bank staff and agency savings which are £1.9m better than plan.

## Non-Pay

- Non-pay is £11.7m worse than plan YTD, excluding the £7.6m adverse variance on passthrough and the R&D underspend of £0.5m, it was £4.6m worse than plan. The main driver of this variance is the non-pay savings delivery being £6.0m worse than plan YTD (excluding non-cash releasing efficiencies)

# Income and Expenditure: Divisional Positions

Source: Finance Ledger.

Oxford University Hospitals NHS Foundation Trust

| I&E Variance Analysis £ms | | | IN MONTH 4 Budget | IN MONTH 4 Actual | IN MONTH 4 Variance | IN MONTH 4 Var % | YEAR TO DATE Budget | YEAR TO DATE Actual | YEAR TO DATE Variance | YEAR TO DATE Var % | FULL YEAR Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Clinical** | | Income | £12.7 | £12.1 | (£0.7) | (5.3%) | £46.2 | £46.7 | £0.5 | 1.1% | £138.2 |
| | Clinical Support Services | Pay | (£15.2) | (£14.9) | £0.4 | 2.4% | (£58.3) | (£59.0) | (£0.7) | (1.2%) | (£171.8) |
| | | Non-Pay | (£4.8) | (£5.8) | (£1.0) | (20.5%) | (£19.8) | (£22.8) | (£3.0) | (15.1%) | (£58.1) |
| | **Total Clinical Support Services** | | **(£7.3)** | **(£8.6)** | **(£1.3)** | **(17.9%)** | **(£31.8)** | **(£35.0)** | **(£3.2)** | **(9.9%)** | **(£91.8)** |
| | | Income | £33.4 | £35.5 | £2.1 | 6.2% | £137.9 | £139.4 | £1.4 | 1.0% | £413.3 |
| | Medicine Rehabilitation and Cardiac | Pay | (£17.9) | (£18.2) | (£0.3) | (1.6%) | (£70.9) | (£71.7) | (£0.8) | (1.2%) | (£207.0) |
| | | Non-Pay | (£9.4) | (£10.1) | (£0.7) | (7.0%) | (£37.6) | (£39.8) | (£2.2) | (5.9%) | (£112.5) |
| | **Total Medicine Rehabilitation and Cardiac** | | **£6.1** | **£7.2** | **£1.1** | **18.8%** | **£29.4** | **£27.8** | **(£1.6)** | **(5.4%)** | **£93.8** |
| | | Income | £38.7 | £39.9 | £1.2 | 3.1% | £155.4 | £157.1 | £1.7 | 1.1% | £465.9 |
| | Neurosciences Orthopedics Trauma Specialist Surgery Childrens and Neonates | Pay | (£21.5) | (£21.1) | £0.4 | 1.8% | (£84.7) | (£83.5) | £1.2 | 1.4% | (£247.3) |
| | | Non-Pay | (£10.5) | (£11.4) | (£0.9) | (8.2%) | (£42.2) | (£46.7) | (£4.5) | (10.7%) | (£126.3) |
| | **Total Neurosciences Orthopedics Trauma Specialist Surgery Ch** | | **£6.6** | **£7.4** | **£0.7** | **11.0%** | **£28.5** | **£26.9** | **(£1.6)** | **(5.6%)** | **£92.3** |
| | | Income | £40.4 | £44.1 | £3.7 | 9.2% | £161.7 | £168.7 | £7.0 | 4.3% | £484.7 |
| | Surgery Women and Oncology | Pay | (£18.3) | (£19.0) | (£0.7) | (4.1%) | (£72.3) | (£73.8) | (£1.5) | (2.1%) | (£210.7) |
| | | Non-Pay | (£13.2) | (£15.0) | (£1.9) | (14.4%) | (£53.1) | (£59.2) | (£6.1) | (11.5%) | (£157.4) |
| | **Total Surgery Women and Oncology** | | **£9.0** | **£10.0** | **£1.1** | **12.0%** | **£36.4** | **£35.8** | **(£0.6)** | **(1.7%)** | **£116.6** |
| **Clinical Total** | | | **£14.3** | **£16.0** | **£1.6** | **11.4%** | **£62.5** | **£55.5** | **(£7.0)** | **(11.2%)** | **£210.9** |
| **Non-Clinical** | Corporate | Total | (£10.6) | (£10.9) | (£0.3) | (3.1%) | (£42.1) | (£42.5) | (£0.4) | (0.9%) | (£125.9) |
| | Education and Training | Total | £4.0 | £2.1 | (£1.8) | (46.2%) | £15.8 | £13.6 | (£2.2) | (14.0%) | £47.3 |
| | Estates | Total | (£12.4) | (£11.3) | £1.1 | 8.7% | (£48.9) | (£47.9) | £1.0 | 2.1% | (£146.5) |
| | Hosted Services | Total | £0.0 | £0.0 | £0.0 | 1997.8% | £0.0 | £0.0 | £0.0 | 709.6% | £0.0 |
| | Operational Services | Total | (£0.9) | (£0.9) | £0.0 | 4.0% | (£3.6) | (£3.5) | £0.1 | 3.3% | (£10.7) |
| | Research and Development | Total | £0.0 | £0.1 | £0.1 | | £0.0 | £0.9 | £0.9 | | (£0.0) |
| **Non-Clinical Total** | | | **(£19.9)** | **(£20.9)** | **(£1.0)** | **(4.8%)** | **(£78.9)** | **(£79.4)** | **(£0.5)** | **(0.7%)** | **(£235.7)** |
| **Technical** | Operating Expenses | Total | (£3.6) | (£3.1) | £0.6 | 15.8% | (£14.8) | (£14.7) | £0.1 | 0.7% | (£42.1) |
| | Trust Wide Services | Total | £8.1 | £7.0 | (£1.0) | (12.9%) | £21.8 | £29.5 | £7.7 | 35.2% | £68.9 |
| **Technical Total** | | | **£4.4** | **£4.0** | **(£0.5)** | **(10.5%)** | **£7.0** | **£14.7** | **£7.8** | **111.7%** | **£26.9** |
| **Control Total** | | | **(£1.2)** | **(£1.0)** | **£0.2** | **18.2%** | **(£9.5)** | **(£9.2)** | **£0.3** | **2.8%** | **£2.0** |

## Clinical Divisions

- Clinical divisions are £7.0m off plan year to date. CSS are the most significant at £3.2m adverse to plan, driven by a £3.4m efficiency shortfall, which is partially offset by increased activity and increased contract income. NOTSSCaN are £1.6m off plan, driven by a £1.6m efficiency shortfall. MRC are £1.6m off plan, driven by a £1.7m efficiency shortfall. SUWON are £0.6m off plan, driven by a £2.4m efficiency target shortfall, offset by favourable variances on income.

## Corporate, Opex, Trustwide Services

- Underspends in the central Trust wide budget (£7.7m YTD) are offsetting the Clinical Divisions overspends. A net £68.9m income budget remains in Trustwide services which is comprised of income not distributed to divisions. For example, the largest items are deficit support funding (£16.5m), depreciation growth funding (£11.1m), distance from target funding (£8m), system stretch funding (£8m), convergence funding (£5.9). There are small amounts held against business cases (e.g. surgical Hub business case - £3m for the year) and centrally held commissioning income.
- The Corporate division is £0.5m adverse to plan, driven by Education and Training in month (£1.8m off plan in month, predominantly due to £1.4m of funding for training posts being transferred into Clinical Divisions for the YTD, after receipt of the updated LDA schedule for the current financial year).

# Risks to the Financial Position

Oxford University Hospitals NHS Foundation Trust

| Risk | Link to CRR | Category | Likelihood | Value (£m) |
|---|---|---|---|---|
| Delivery of CIP programme | CRR 1153 Financial Plan - Cost Control Risk cause 2: Budgets set based on unrealistic assumptions | All | High | 32 |
| Divisional rectification plans | Divisional rectification plans not delivering | Non Pay and Non operating costs | Medium | 6 |
| Commissioners do not pay for overperformance (estimated value | CRR 1153 (Financial Plan - Cost Control) Risk cause 4: Demand for services above assumptions in the plan | Income | High | 4 |
| Cerner Pharmacy write-off and OCMR investment property accounting | CRR 1153 Financial Plan - Cost Control Risk cause 2: Budgets set based on unrealistic assumptions | Non Pay and Non Operating costs | Medium | 4 |
| Prior year aseptic costs not acrrued | CRR 1153 Financial Plan - Cost Control Risk cause 3: Inadequate controls in place over pay and non-pay costs | Non Pay and Non operating costs | High | 2 |
| Unfunded volume growth due to end of BOB local HCDD arrangement | CRR 1119 (Medium- to Long-Term Sustainability of Trust I&E Position) Risk cause 5: Move of some elements of funding to block versus activity-based funding | Income | High | 1 |
| **Total Risk identified at month 4** | | | | **49** |

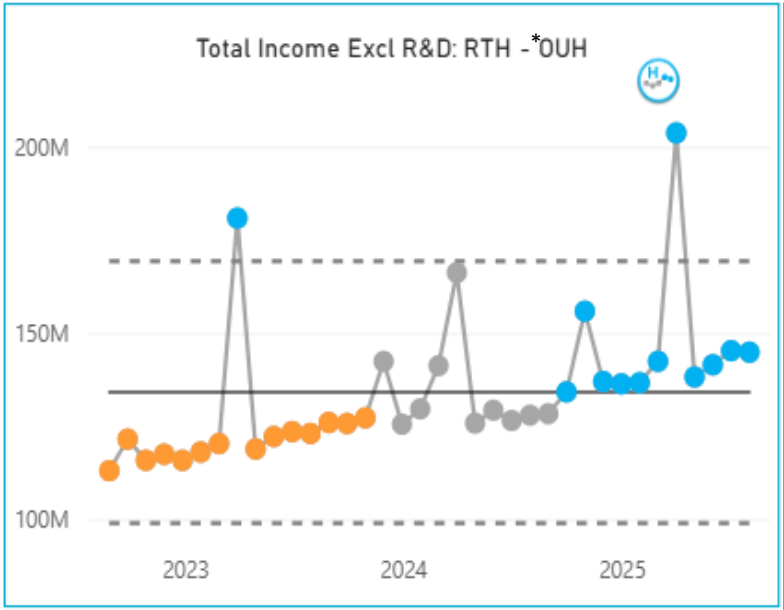
**NHSE is placing more significance on the risks declared in the monthly finance return. These are set out in the table above for assurance via TME to Board/IAC prior to carrying out a thorough review of the finance risks in the CRR.**

- There is currently £49m of risk identified to the financial forecast of £2m surplus as at month 4
- £32m of this risk related to the delivery of the efficiency programme and is calculated using an NHSE methodology based on the status of our identified schemes.
- The remaining £16m of risk has been identified based upon risk to payment of activity overperformance, changes to the BOB high-cost drugs and devices arrangement, risk relating to the delivery of divisions rectification plans and by some potential costs that were not known at the planning stage, but which may materialise in year.
- The risks have been linked to the Corporate Risk Register (CRR) and further work will be undertaken to ensure the triangulation of risk reporting.

# Income By Source

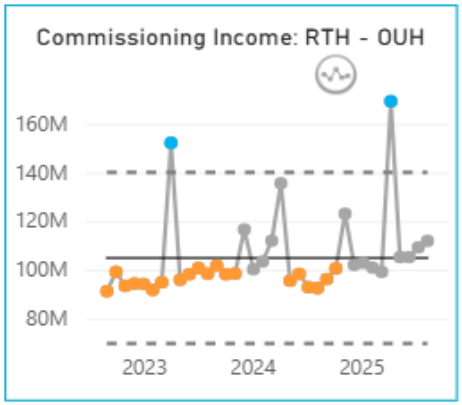
Source: Finance Ledger

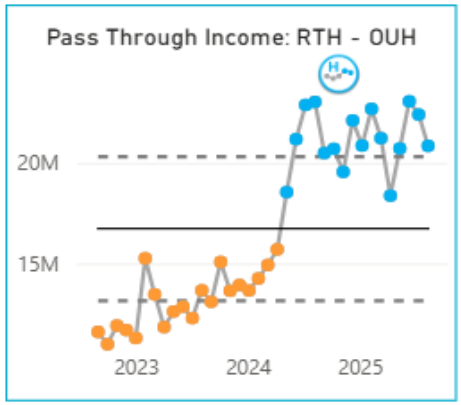
Oxford University Hospitals NHS Foundation Trust

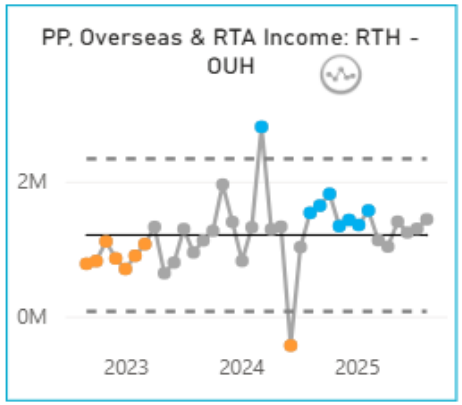


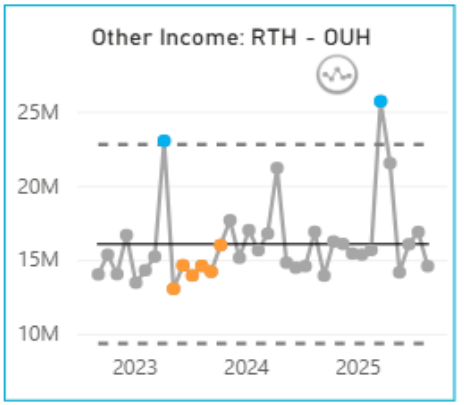

**July 2025 (Month 4) - Total in-month Income of £148.7m**

- Total income is £1.1m lower in July compared to June.
- Commissioning income is £1.1m higher in July. Passthrough income was £1.6m lower than the previous month and non-passthrough income was £2.7m higher in July due to additional Cost Uplift Factor (CUF) income being accrued for in relation to funding of the 2025/26 pay award. This is matched with additional pay inflation costs, so neutral to the I&E overall.
- VWA targets have been replaced for 2025/26 with Indicative Activity Plans (IAPs) with commissioners that enable us to achieve the RTT / performance targets we committed to in the plan. The IAPs are currently part of contract negotiations.
- Other income was £2.3m lower in July than June. £0.6m of this was due to R&D income and £0.9m from non-patient care income, with reductions across several areas.
- Private patient, overseas and RTA income increased in July by £0.1m. The increase was driven by RTA income, which was £0.3m higher this month and Private Patient income £0.1m higher than in June, offset by a £0.2m reduction in overseas income.




**SPC Trend Analysis**

Total Income has consistently increased over the last financial year, driven by commissioning income and passthrough income (also seen in the 'Commissioning Income' and 'Pass Through Income' charts above). This a result of the pay award funding as well as the recognition of additional non-recurrent commissioner funding in the second half of each financial year (including deficit support funding in 2024/25).

- Total Income (and Commissioning income) each year-end above were all significantly high because of additional pension contributions funding

# Income VWA performance (to M3)

Oxford University Hospitals NHS Foundation Trust

**Variable Elective Activity only: by Point of Delivery (POD)**

| POD | 2025-26 | | | |
|---|---|---|---|---|
| | M1-M3 Plan | M1-M3 Actual | M1-M3 Variance | M1-M3 % Variance |
| | £m | £m | £m | % |
| Day Case | 20.85 | 20.82 | (0.03) | -0.1% |
| Elective Inpatient | 26.41 | 26.44 | 0.02 | 0.1% |
| Elective Excess Beddays | 0.39 | 0.24 | (0.16) | -39.8% |
| Outpatient First Appts | 17.94 | 18.91 | 0.97 | 5.4% |
| Outpatient Procedures | 8.15 | 8.90 | 0.74 | 9.1% |
| Total | 73.74 | 75.30 | 1.56 | 2.1% |

**Variable Elective Activity only: by Commissioner**

| Commissioner | 2025-26 | | | |
|---|---|---|---|---|
| | M1-M3 Plan | M1-M3 Actual | M1-M3 Variance | M1-M3 % Variance |
| | £m | £m | £m | % |
| BOB ICB | 39.44 | 40.39 | 0.96 | 2.4% |
| NHSE Spec Comm | 27.24 | 27.61 | 0.37 | 1.4% |
| Other Commissioners | 7.07 | 7.29 | 0.22 | 3.2% |
| Total | 73.74 | 75.30 | 1.56 | 2.1% |

**Variable Elective Activity only: by Division**

| Division | 2025-26 | | | |
|---|---|---|---|---|
| | M1-M3 Plan | M1-M3 Actual | M1-M3 Variance | M1-M3 % Variance |
| | £m | £m | £m | % |
| NOTSSCAN | 35.15 | 35.31 | 0.16 | 0.5% |
| SUWON | 22.05 | 23.24 | 1.20 | 5.4% |
| MRC | 14.45 | 14.39 | (0.06) | -0.4% |
| CSS | 2.09 | 2.36 | 0.26 | 12.5% |
| Total | 73.74 | 75.30 | 1.56 | 2.1% |

*NB Actuals data taken from SLAM M3v4 2526, adjusted to exclude elective activity not included within the definition of the Variable Elective envelope.*

NHSE Spec Comm includes both

NHSE and Delegated Specialised Services contracts and activity plans not yet agreed. Activity performance is reported above using our internal SLAM plan. One key change to be applied is for NHSE's intention to monitor using SUS data, different to the SLAM based ICB contracts.

M3 shows a value overperformance of 2.1% on variable elective activity. This £1.56m YTD overperformance, if maintained, is in line with the Board approved level of risk on overperformance.

The overperformance mainly sits within the BOB ICB contract.

By POD:

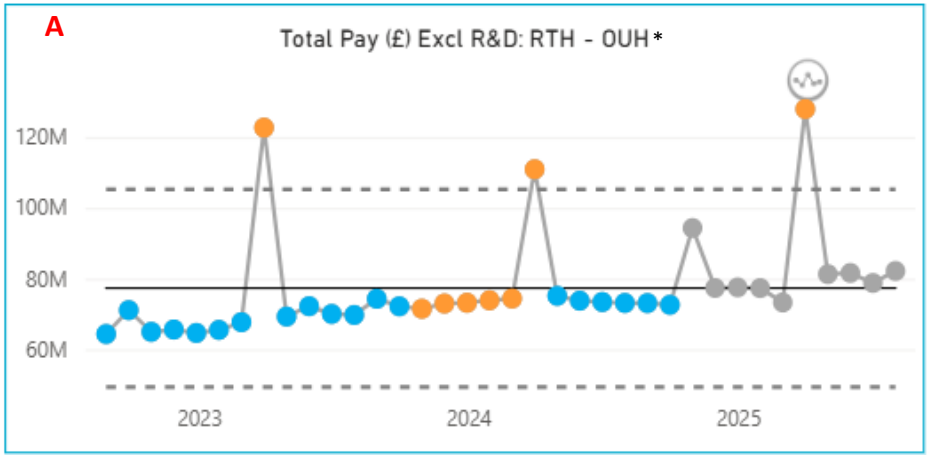
- Under performance on DC has reduced significantly since M2. Over performance in most directorates is being offset by under performance in is driven by Specialist Surgery (NOTTSCAN)(-£251k), Children (NOTTSCAN (-£126k), and Gynae (SUWON) (-£108k).
- EL performance has worsened between M2 and M3, driven by adverse variances in run rate in C&T Surg (+£61k M2 to -£53k M3), Children (+£129k to +£43k) and SpecSurg (-£16k to -£216k). These have been offset to an extent by improved positions for Neurosci (-£306k to -£231k) and Surg (SUWON) (-£49k to +£17k).
- The OPFA overperformance is largely down to overperformance within SUWON, specifically Onc & Haem (+£373k) and GET (+£108k); alongside T&O (NOTTSCAN) (+£135k). These have been offset to an extent by improved positions for
- The OPPROC overperformance is driven by NOTTSCAN (Ophthalmology +£211k) and SUWON (Renal +£366k).

# Pay: Run Rate Overview

Source: Finance Ledger, excluding R&D costs.



A

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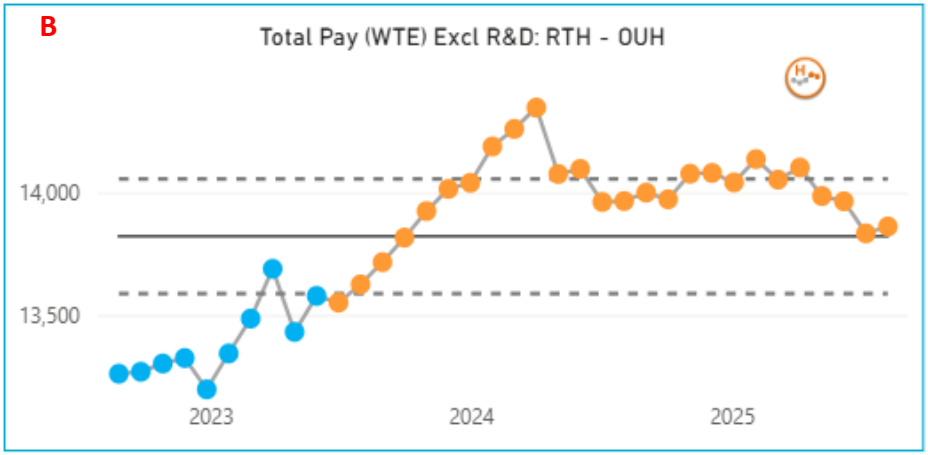



**July 2025 (Month 4)**

**£85.0m (£82.2m excl. R&D)**

**13,861 WTE (excl. R&D)**

- Total pay was £2.9m higher in July compared to June. Excluding R&D, pay costs were £3.4m higher in July than in June.
- Substantive staffing costs were £2.2m higher in July compared to June. Excluding R&D, substantive pay increased by £2.7m driven by a £2.6m accrual for four months worth of the additional pay award between the rate included in the planning guidance and the final award given (matched with additional income). The July position also includes £0.4m of additional pay costs to cover the resident doctor industrial action.
- Temporary staff in-month expenditure was £0.7m higher in July compared to June at £3.9m. The increase in the cost of temporary staffing was in Bank spend (agency costs remained at the same level), due to covering resident doctor strikes and the holiday period.
- Overall WTEs increased by 28 in July compared to June (excluding R&D), driven by a 71 WTE increase in bank staffing (Consultants and Medics 26 WTE, Nurses 19 WTE, Health Care Assistants 17 WTE). Substantive staff decreased by 32 WTE and agency staff decreased by 12 WTE. The Trust plan assumes a WTE reduction of 675 (575 substantive staff and 100 on temporary staffing) by M12 2025/26 to achieve the savings target.
- The Trust plan is based on the month 11 run rate of 2024/25.
- Note the Reading Room pack includes a reconciliation from ESR to the general ledger which provided assurance on data quality

**Trend Analysis**

- Pay spend continued its upward trend in Q4, albeit at a reduced rate, in part due to lower costs in February. Overall WTE has been stable and has been on a downward trend now for the last four months (with decreases in substantive, bank and agency staff since March). These are shown in Chart A and B above. Prior to this year, the previously increasing trend was driven by the annual pay awards, alongside other increases in pay relating to approved business cases, overall pay increase for Junior Doctors, open escalation beds and the use of temporary staffing to backfill sickness. Trend by staff group and type are shown in the additional detail provided in the Diligent Reading Room.

# Non-Pay Run Rate Overview

Is Performance Stable?

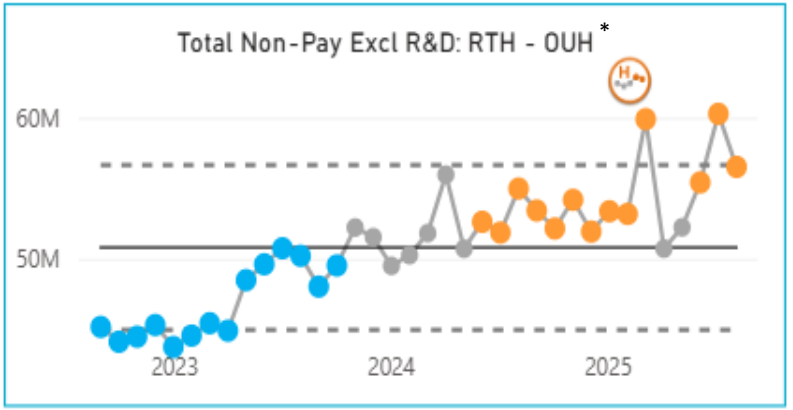
| Yes | Getting Worse | Getting Better |
|---|---|---|

Source: Finance Ledger, excluding R&D costs.

Oxford University Hospitals NHS Foundation Trust

**July 2025 (Month 4) – Total Non-Pay £57.4m (£56.5m excl. R&D)**

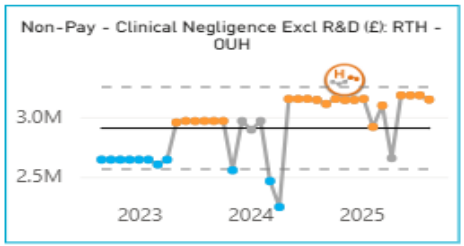
- Total non-pay is £3.7m lower in July than in June. Excluding R&D, non-pay costs are £3.8m lower than last month. Excluding passthrough costs that are £1.6m lower than in June, non-pay costs are £2.2m lower in July. Premises costs are £1.1m lower than last month due to a one-off benefit of £1.2m for an insurance rebate on the PFI contract.
- Underlying non-pay at £38.1m is £3.3m higher than the average for the 2024/25 financial year.
- Detailed analysis is underway to understand fully the drivers of the non pay position both against plan and the increasing run rate trend, which will be included in next month's report.

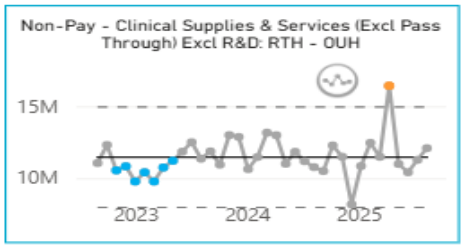


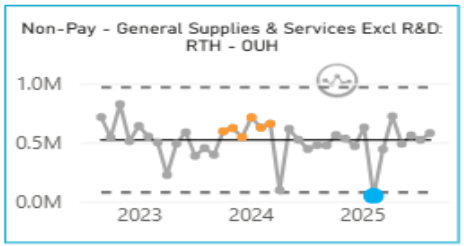

**SPC Trend Analysis**

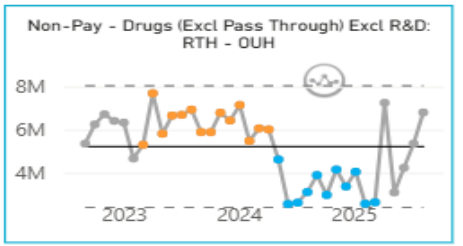
Non-pay expenditure has increased over the last two financial years and is an adverse special cause variation. This is driven by three principal factors.

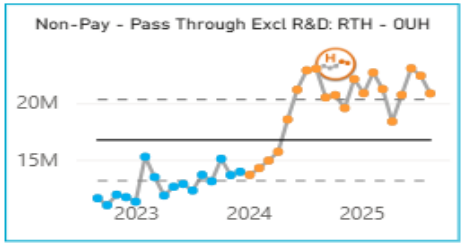
- Non-elective (NEL) activity has grown significantly over the last 12 months (along with ALOS), this growth is unfunded in the commissioner contracts (see Non-Elective Activity analysis in the reading room pack).
- Non-activity driven non-pay costs have been impacted by extra-inflationary increases; premises & fixed plant has seen an increase in PFI costs from high RPI uplifts over the last two years (in excess of that allowed for in the CUF). Energy prices increased 226% in 2023/24 driving up costs in this area.
- Passthrough drugs and devices costs grew significantly during 2024/25 (matched by income).
- Drugs (excluding passthrough) costs had reduced since re-categorising some pass-through items in 2023/24, however this financial year is showing an increasing cost trend in this area.

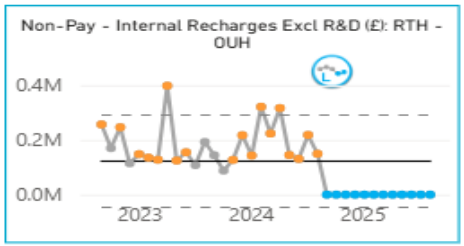


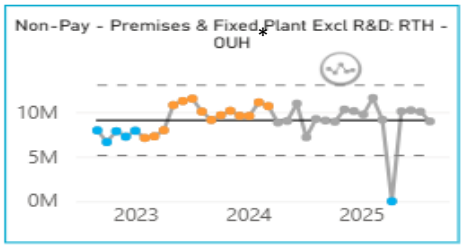



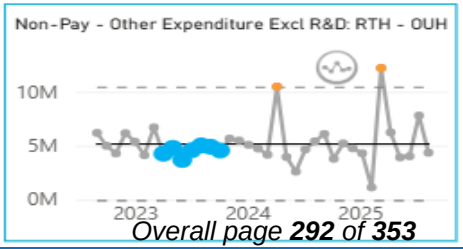



# Efficiency

Oxford University Hospitals NHS Foundation Trust

| Division | Plan 2025/26 (£m) | YTD Plan (£m) | Identified 2025/26 (£m) | Percentage Identified 2025/26 | Delivered YTD (£m) | Variance to Plan YTD (£m) | Percentage Delivered |
|---|---|---|---|---|---|---|---|
| CSS | 19.4 | 5.3 | 12.8 | 66% | 1.9 | -3.4 | 37% |
| MRC | 15.7 | 3.7 | 10.0 | 64% | 2.0 | -1.7 | 55% |
| NOTSSCAN | 21.6 | 5.2 | 16.6 | 77% | 3.6 | -1.6 | 69% |
| SUWON | 20.6 | 5.3 | 13.3 | 64% | 2.9 | -2.4 | 55% |
| Corporate | 8.1 | 2.3 | 21.5 | 265% | 1.9 | -0.4 | 83% |
| Education | 1.2 | 0.4 | 0.0 | 0% | 0.0 | -0.4 | 0% |
| Estates | 7.0 | 2.4 | 4.6 | 66% | 0.8 | -1.5 | 35% |
| Operational Services | 0.6 | 0.1 | 0.5 | 82% | 0.2 | 0.0 | 126% |
| Operating Expenses | 4.8 | 0.0 | 3.6 | 75% | 1.1 | 1.1 | 0% |
| Central | | | 23.9 | 0% | 5.2 | 5.2 | 0% |
| **TOTAL CASH RELEASING** | **99.0** | **24.7** | **106.7** | **108%** | **19.7** | **-5.0** | **80%** |
| **TOTAL NON-CASH RELEASING** | **0.0** | **0.0** | **13.7** | **0%** | **5.3** | **5.3** | **0%** |
| **TOTAL SAVINGS** | **99.0** | **24.7** | **120.4** | **122%** | **25.0** | **0.3** | **101%** |

## Progress to Date

108% (£106.7m) of the total £99.0m target has been identified. Receiving the deficit support funding from NHSE on a quarterly basis was conditional on the Trust's efficiency programme being fully identified by the end of Q1 and now, a new requirement has been added that efficiency plans must be fully developed by the end of Q2.

We are working with divisions to ensure their plans are fully developed. Divisions were issued with CIP checklists in June to be completed by each directorate. Progress so far has been unsatisfactory ((MRC 3/3, SUWON 2/6, CSS 0/5, NOTTSCaN 6/6, Corporate 4/9). Divisions are also submitting PIDs for specific schemes at the fortnightly Productivity Committee.

Total cash-releasing savings reported as delivered in Month 4 amounted to £19.7m against a target of £24.7m (80%). Clinical divisions are £9.1m worse than plan, corporate divisions and Estates are £1.2m worse than plan, offset by £5.2m of central savings. The Trust is still on plan even though only 80% of savings have been delivered, this will become more difficult to maintain if efficiency delivery does not continue to pick up.

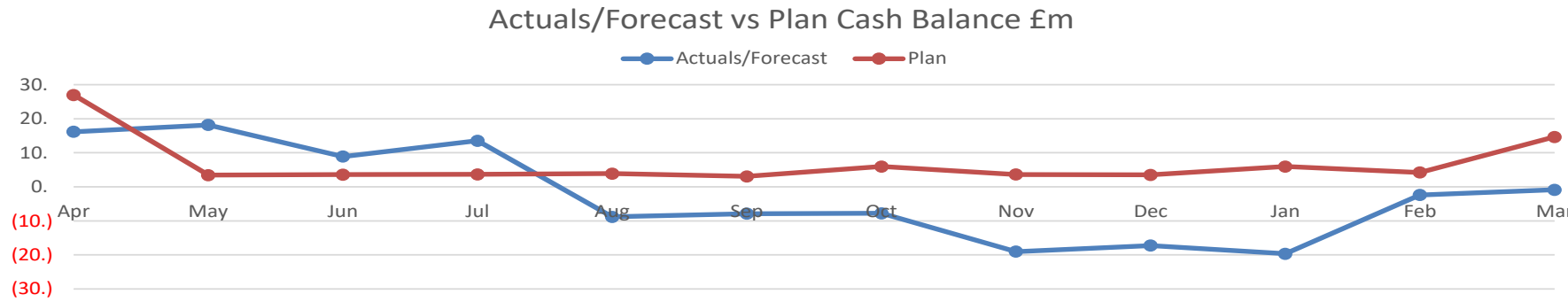
£5.3m of non-cash releasing savings were also reported at M4 to NHSE following changes in their data collection last month requiring this information in addition to cash-releasing schemes.

## Productivity

The Trust's Implied Productivity Growth compared to last year is +4.3%, which puts the trust 1.4% above the national average, and 0.8% above the average across the Trust's peer group. (Latest available data as at March 2025).

# Cash

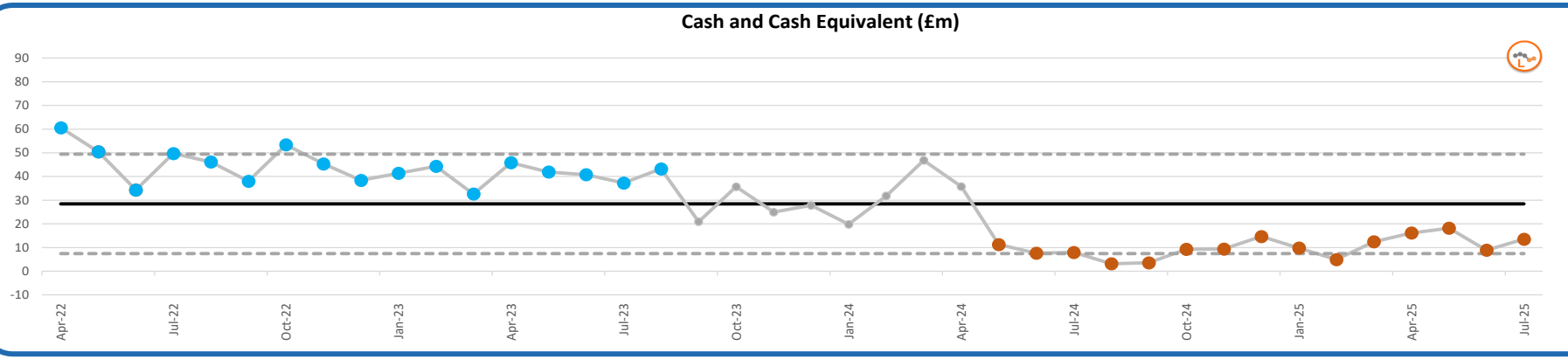





Cash is above plan at Month 4 by £9.9m.

- The Trust deferred more supplier payments than originally planned to manage the Trust's cash as there has been no external cash support available so far in 25/26
- Payroll costs have been higher than planned

Any upsides in cash, for example, additional income received related to 2024/25 activity, are being used to offset the need for external cash support. Ongoing actions through the Operational and Strategic Cash Committees are aiming to minimise the risk of cash issues and optimise any cash flows to the Trust's advantage.

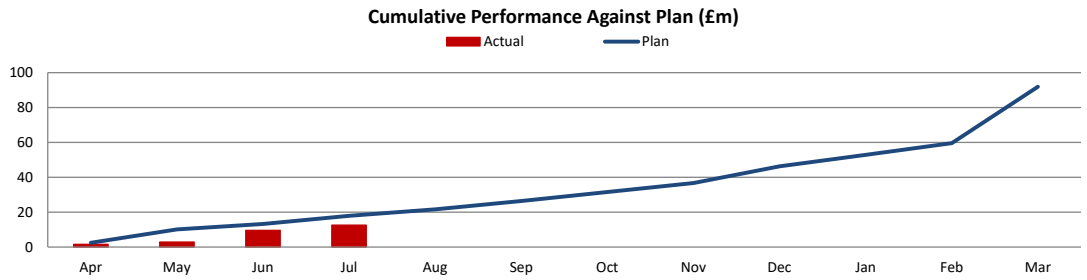


# Capital

Oxford University Hospitals NHS Foundation Trust

| £m | IN MONTH 4 Plan | Actual | Variance | YEAR TO DATE Plan | Actual | Variance | Full year Plan |
|---|---|---|---|---|---|---|---|
| Gross Capital Expenditure included in Capital Allocation | £0.8 | £0.1 | £0.7 | £2.9 | £1.8 | £1.1 | £16.3 |
| Less disposals/other deductions included in CDEL | £0.0 | £0.0 | £0.0 | (£1.5) | £0.0 | (£1.5) | (£14.8) |
| Purchase/(Sale) of Financial Assets | £0.0 | £0.0 | £0.0 | £0.0 | £0.0 | £0.0 | £0.0 |
| **Net Capital Expenditure included in Capital Allocation before IRFS 16** | **£0.8** | **£0.1** | **£0.7** | **£1.4** | **£1.8** | **(£0.4)** | **£1.5** |
| IFRS 16 - Right of Use assets/Lease accounting | £1.1 | £1.5 | (£0.4) | £6.3 | £6.0 | £0.3 | £32.6 |
| **Net Capital Expenditure included in Capital Allocation after IRFS 16** | **£1.9** | **£1.5** | **£0.3** | **£7.8** | **£7.8** | **(£0.1)** | **£34.0** |
| National Funding PDC | £1.3 | £0.1 | £1.2 | £2.5 | £0.2 | £2.2 | £23.1 |
| Residual interest (UK GAAP accounting for PFI life-cycling) | £0.5 | £0.5 | £0.0 | £1.9 | £1.9 | £0.0 | £5.6 |
| **Capital Departmental Expenditure Limit (CDEL)** | **£3.6** | **£2.1** | **£1.5** | **£12.1** | **£9.9** | **£2.2** | **£62.7** |
| Government grants | £0.1 | £0.3 | (£0.2) | £0.5 | £0.5 | £0.0 | £0.8 |
| Charitable and other donations | £0.1 | £0.1 | (£0.0) | £0.3 | £0.3 | £0.0 | £1.0 |
| IFRIC 12 - PFI life-cycling (less Residual Interest) | £0.9 | £0.5 | £0.4 | £3.5 | £1.8 | £1.7 | £12.7 |
| **Net Capital Expenditure** | **£4.7** | **£3.0** | **£1.7** | **£16.4** | **£12.5** | **£3.9** | **£77.1** |
| Add back sales, disposals, and other deductions | £0.0 | £0.0 | £0.0 | £1.5 | £0.0 | £1.5 | £14.8 |
| Gross Capital Expenditure | £4.7 | £3.0 | £1.7 | £17.9 | £12.5 | £5.4 | £91.9 |

| £m | IN MONTH 4 Plan | Actual | Variance | YEAR TO DATE Plan | Actual | Variance | Full year Plan |
|---|---|---|---|---|---|---|---|
| Replacement / compliance | £4.3 | £2.7 | £1.6 | £16.6 | £11.2 | £5.4 | £56.1 |
| Clinical strategy | £0.2 | (£0.1) | £0.3 | £0.8 | £0.9 | (£0.1) | £34.8 |
| People plan | £0.0 | (£0.0) | £0.0 | £0.0 | (£0.0) | £0.0 | £0.3 |
| Other | £0.1 | £0.3 | (£0.2) | £0.5 | £0.4 | £0.1 | £0.8 |
| Gross Capital Expenditure | £4.7 | £3.0 | £1.7 | £17.9 | £12.5 | £5.4 | £91.9 |




The Capital plan for 2025/6 is as submitted to NHSE on 30 April 2025.

The Gross Capital value from the plan is £91.94m, of which £34.01m is included within the Operating Capital allocation, which includes the impact of IFRS16 (leases).

The Operating Capital envelope comprises:

- £32.55m lease impacts on CDEL; £16.25m self-funded expenditure; less £14.80m planned disposals

Outside Operating Capital, the following provisions are included:

- £23.10m PDC-funded; £0.80m grants; £1.0m for charitable and other donations; £18.24m for PFI life-cycling, of which £7.14m is MES.

Gross CapEx to July was £12.52m, £5.42m (24%) below the submitted plan, overall.

Spend with the Operating Capital envelope was £7.81m, £0.05m (1%) over plan. However, this hides issues around complex accounting of the Ergea lease and disposals. Within this variance were:

- Impact of the treatment of the MRIN transfer has added £2.30m to the YTD position. The treatment of this transaction is subject to further review. This is in part offset by the deferred recognition of the PET CT lease element, anticipated in July at £1.05m.
- Other notable underspends due to profiling include: MEPG/MERRP £0.75m; SEC £0.33m; self-funded CIR £0.19m; other leases £0.20m. These are partly offset by an overspend on Digital of £0.44m due to staff capitalization relating to SDE.

Outside Operating Capital, PDC expenditure to date is behind £2.25m, as work has recently started following receipt of early funding MoUs. PFI MES replacements (radiology) is behind a straight-line plan by £1.66m.

# Appendix 1 – Other Supporting Analysis: Month 4 2025/26

# Underlying Position

Oxford University Hospitals NHS Foundation Trust

| Month 4 Year to Date (£ms) | | | | | |
|---|---|---|---|---|---|
| Plan | Underlying | R&D | Pass through | One-off | Reported |
| Income | 479.5 | 14.9 | 79.5 | 2.1 | 576.0 |
| Pay | (327.8) | (11.8) | 0.0 | 2.5 | (337.1) |
| Non pay | (140.2) | (3.1) | (79.5) | 7.4 | (215.3) |
| Non-Opex | (33.0) | 0.0 | 0.0 | 0.0 | (33.0) |
| Total Plan | (21.5) | 0.0 | 0.0 | 12.1 | (9.5) |
| Actuals | Underlying | R&D | Pass through | One-off | Reported |
| Income | 474.8 | 15.7 | 87.1 | 7.8 | 585.4 |
| Pay | (327.6) | (12.2) | 0.0 | 3.8 | (336.0) |
| Non pay | (141.0) | (2.6) | (87.1) | 3.7 | (227.0) |
| Non-Opex | (32.7) | 0.0 | 0.0 | 1.1 | (31.6) |
| Total Actuals | (26.4) | 0.9 | 0.0 | 16.4 | (9.2) |
| Variance | Underlying | R&D | Pass through | One-off | Reported |
| Income | (4.7) | 0.8 | 7.6 | 5.7 | 9.4 |
| Pay | 0.2 | (0.4) | 0.0 | 1.3 | 1.2 |
| Non pay | (0.8) | 0.5 | (7.6) | (3.8) | (11.7) |
| Non-Opex | 0.4 | 0.0 | 0.0 | 1.1 | 1.5 |
| Total Variance | (4.9) | 0.9 | 0.0 | 4.3 | 0.3 |

**R&D:**

- £0.9m underspend due to surpluses on commercial and non-commercial income. This was released from the Balance Sheet once it was clear deferred income was not needed to cover any further trial costs.
- Small mix change between pay and non-pay due to specific grants won and projects/trials delivered.

**Pass through:**

- Passthrough income and expenditure are above plan by £7.6m to date, net nil impact.
- The Trust is paid 3+ months in arrears for over-performance and after suppliers have been paid.
- On passthrough drugs and devices there are currently £16.1m of cash payments still due to the Trust (with £8.1m of this due from NHSE and £8.0m due from BOB ICB. Included in the BOB cash delay are £6.6m of payments due from last financial year). The Trust does not have an I&E exposure to over-performance.

**One-off:** The more significant non-recurrent items included in the reported financial position to date for this financial year include:

- Deficit support funding (£6.4m)
- Underspends on centrally held budget allocations (£5.4m)
- Gain on Disposals (£1.1m)
- PFI Insurance Benefit (£1.2m)

**NHSE data collection – for medium term plan**

- NHSE collected estimates of the underlying financial performance of the Trust as part of planning. OUH reported that it estimated it's underlying deficit to be £55.6m for 2025/26 (2024/25: £71.9m). The £2m planned deficit was adjusted for non-recurring efficiencies (£38.5m) and deficit support (£19.3m). NHSE's methodology required us to treat contractually non-recurrent income as recurrent. This is different to the methodology used abo
- Underspends on centrally held budget allocations (£5.4m)
- Gain on Disposals (£1.1m)
- PFI Insurance Benefit (£1.2m)

# Statement of Financial Position (SOFP)

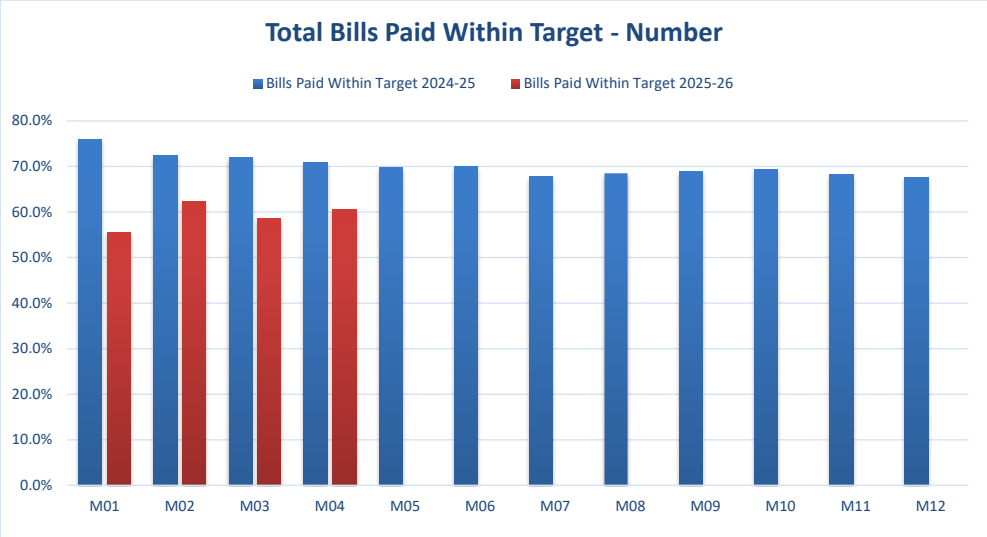
Oxford University Hospitals NHS Foundation Trust

| Statement of Financial Position 2024/25 | M12 2025 | In Month 4 2026 | In Mth PLAN | Variance to PLAN | Movement in month | Movement from year-end |
|---|---|---|---|---|---|---|
| **NON-CURRENT ASSETS:** | | | | | | |
| Property, Plant and Equipment | £769.2 | £762.1 | £779.6 | (£17.5) | (£1.9) | (£7.0) |
| Investments | £62.1 | £62.0 | £60.4 | £1.6 | £0.0 | (£0.1) |
| Trade and Other Receivables - non current | £14.0 | £13.7 | £9.1 | £4.6 | £0.1 | (£0.3) |
| **Total Non Current Assets** | **£845.2** | **£837.8** | **£849.1** | **(£11.3)** | **(£1.8)** | **(£7.4)** |
| **CURRENT ASSETS:** | | | | | | |
| Inventories | £32.9 | £31.4 | £34.3 | (£2.9) | (£0.3) | (£1.5) |
| Trade and Other Receivables - current | £93.1 | £116.3 | £81.6 | £34.7 | £17.4 | £23.2 |
| Cash | £12.5 | £13.5 | £3.6 | £9.9 | £4.6 | £1.1 |
| **Total Current Assets** | **£138.4** | **£161.3** | **£119.6** | **£41.7** | **£21.8** | **£0.7** |
| | | | | | | |
| **TOTAL ASSETS** | **£983.7** | **£999.1** | **£968.7** | **£30.4** | **£20.0** | **(£6.7)** |
| **CURRENT LIABILITIES** | | | | | | |
| Trade and Other Payables - current | (£197.6) | (£204.7) | (£170.7) | (£34.0) | (£7.9) | (£7.1) |
| Other Liabilities: Deferred Income - current | (£1.3) | (£15.8) | (£18.7) | £2.9 | (£12.4) | (£14.6) |
| Other Liabilities: - current | (£0.3) | (£0.3) | (£0.3) | (£0.0) | £0.0 | £0.0 |
| Provisions current | (£0.9) | (£0.8) | (£0.9) | £0.0 | £0.1 | £0.1 |
| Borrowings - current | (£8.1) | (£6.4) | (£24.0) | £17.6 | £2.3 | £1.7 |
| Loans - current | (£1.2) | (£1.2) | (£1.6) | £0.4 | (£0.0) | £0.0 |
| **Total Current Liabilities** | **(£209.4)** | **(£229.3)** | **(£216.2)** | **(£13.1)** | **(£18.0)** | **(£19.9)** |
| | | | | | | |
| **NET CURRENT ASSETS/(LIABILITIES)** | **(£71.0)** | **(£68.0)** | **(£96.6)** | **£28.6** | **£3.9** | **(£19.2)** |
| | | | | | | |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **£774.3** | **£769.8** | **£752.6** | **£17.2** | **£2.0** | **(£26.6)** |
| **NON-CURRENT LIABILITIES:** | | | | | | |
| Other Liabilities: Deferred Income - non current | (£2.3) | (£2.3) | (£2.5) | £0.2 | (£0.0) | £0.0 |
| Other Liabilities: - non current | (£3.6) | (£3.5) | (£3.4) | (£0.1) | £0.0 | £0.1 |
| Provisions - non current | (£6.4) | (£6.4) | (£6.2) | (£0.2) | £0.0 | £0.0 |
| Borrowings - non current | (£356.6) | (£359.4) | (£351.1) | (£8.3) | (£0.7) | (£2.8) |
| Loans - non current | (£17.8) | (£17.3) | (£17.4) | £0.1 | £0.0 | £0.5 |
| **Total Non-Current Liabilities** | **(£386.6)** | **(£388.9)** | **(£380.6)** | **(£8.3)** | **(£0.7)** | **(£2.3)** |
| | | | | | | |
| **S LESS LIABILITIES (Total Assets Employed)** | **£387.6** | **£380.9** | **£372.0** | **£8.9** | **£1.3** | **(£28.8)** |
| **TAXPAYERS EQUITY** | | | | | | |
| Public Dividend Capital | £355.0 | £357.4 | £357.5 | (£0.1) | £2.4 | £2.4 |
| Retained Earnings reserve | (£154.5) | (£160.0) | (£171.7) | £11.7 | (£0.2) | (£5.5) |
| Revaluation Reserve | £195.3 | £191.6 | £194.3 | (£2.7) | (£0.9) | (£3.6) |
| Other Reserves | £1.7 | £1.7 | £1.7 | £0.0 | £0.0 | £0.0 |
| FV Assets Reserve | (£9.9) | (£9.9) | (£9.8) | (£0.0) | £0.0 | £0.0 |
| **Total** | **£387.6** | **£380.9** | **£372.0** | **£8.9** | **£1.3** | **(£6.7)** |

## Balance Sheet

- PPE has reduced YTD due to additions being lower than depreciation and amortisation
- Trade and other receivables are higher than plan due to some new items being accrued at year-end that weren't known at the time the plan was produced
- Cash is above plan – see earlier slide
- Trade and other payables have increased largely due to deferral of payments since no external cash support was available
- Borrowings are lower in total (current and non-current taken together) than plan due to the Trust changing its policy on when to account for remeasurement of two of its largest PFI liability balances

# Working Capital




| | 2025 | 2026 | | | |
|---|---|---|---|---|---|
| | M12 | M01 | M02 | M03 | M04 |
| Debtor Days | 8.09 | 6.71 | 7.36 | 5.43 | 8.30 |
| Creditor Days | 52.33 | 43.32 | 45.32 | 38.65 | 43.70 |

## BPPC

- Performance of paying invoices within 30 days has dropped due to managing the Trust's cash position. The Trust is taking action to prioritise and cycle supplier payments as appropriate to maintain services and relationships.

## Debtor Days

- Debtor days have increased in M4 due to a timing issue where some new invoices being raised that have been received early in M5.

## Creditor Days

- Creditor days have increased in M4 due to the Trust deferring more supplier payments.

# Appendix 2 – Financial Control Update

# Financial Controls Update (previously presented to April IAC)

Oxford University Hospitals NHS Foundation Trust

| Activity | Outputs | Deadline | Update | RAG |
|---|---|---|---|---|
| 1. 2025/26 budget setting | • Budget setting approach paper approved by TME<br>• First iteration of budgets agreed and locked down prior to start of 25/26 FY | 27th March 2025 for first iteration of budgets | Complete<br>Budget setting paper to TME 26th June confirming approved business case funding devolved at month 3. | |
| 2. Implementation of budgetary controls | • Budgetary control policy developed and approved by TME<br>• Budgetary control expectations communicated to all Divisions and arrangement in place to monitor compliance | 27th March 2025 | Complete<br>Budget reconciliation in place.<br>£52.7m of funding distributed to divisions at month 3 and 155.34 WTE. | |
| 3. Standing Financial Instructions and Scheme of Delegated Authorities review | • Revised SFIs and SoDA developed, socialised with key stakeholders and approved by Audit Committee<br>• Where possible, delegated limits hard-coded into systems (e.g. Oracle)<br>• Revised documents shared on the intranet and promoted internally | 30th April 2025 | Complete<br>SFIs approved by May Board and SoDA approved by Board in June.<br>Launch of SFI's and SoDA on 1 July with communications out to organisation. | |
| 4. Divisional Finance operating model | • Review Divisional Finance operating model to ensure resilience and alignment of actions to the Trust financial plan and budget | 18th April 2025 | In progress. All testing complete except non-pay testing in one division.<br>Draft internal audit report due imminently. | |

# Financial Controls Update (previously presented to April IAC

Oxford University Hospitals NHS Foundation Trust

| Activity | Outputs | Deadline | Update | RAG |
|---|---|---|---|---|
| **5. Review and implementation of financial control best practice** | • Further review of HFMA Financial Sustainability Checklist and Grip and Control checklists undertaken<br>• A set of deliverable priorities arising from the review agreed, including lead owners and indicative milestones / deadlines | 31st July 2025 | Initial review of both checklists undertaken.<br>Paper at Productivity Committee discussed and agreed proposed priorities, timescales and owners.<br>Programme of work being mobilised (see private board paper) | |
| **6. Maximise 3rd line of defence assurance** | • Review of 25/26 Internal Audit plan to increase focus on control / align better to key financial and operational priorities | 30th April 2025 | Complete<br>Plan approved, audits started in Q1 for divisional finance control and stock control. | |
| **7. Budget holder training** | • Rolling Trustwide budget holder training programme to equip budget holders with skills and information to more effectively manage their budgets | Commenced March 2025 and ongoing | Programme up and running. Over 122 staff trained to date. Additional sessions are being laid on due to demand.<br>Variable attendance by division (CSS 44, SUWON 37, NOTSSCAN 15, MRC 10, Corporate 11, Other 5) | |
| **8. Monthly Performance Process** | • Review of monthly finance performance reporting<br>• Review of meeting structure and content of material presented to ensure good financial management.<br>• Detailed mitigation plans required for any areas off plan | 31st July 2025 | Paper went to IAC outlining potential options in August.<br>See private board paper | |

## 17. WINTER PREPAREDNESS PLAN TO INCLUDE: •?WINTER PLAN BOARD ASSURANCE STATEMENT

# 18. URGENT AND EMERGENCY CARE OXFORDSHIRE SYSTEM DASHBOARD

## REFERENCES

Only PDFs are attached

17 TB2025.85 Board UEC System dashboard paper - 10 September 2025.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.85**

| | |
|---|---|
| **Title:** | **Urgent and Emergency Care Oxfordshire System Dashboard** |
| **Status:** | **For Discussion** |
| **History:** | **N/A** |
| **Board Lead:** | **Chief Operating Officer** |
| **Author:** | **Lisa Glynn, Director of Clinical Services and Louise Johnson, Deputy Director of Urgent Care** |
| **Confidential:** | **No** |
| **Key Purpose:** | Assurance and Performance |

## Summary


- The Urgent and Emergency Care (UEC) Oxfordshire System Dashboard illustrates, in a consolidated format, the relative performance of 75 indicators relating to Urgent and Emergency Care across the areas of:
    - Admissions avoidance schemes
    - Ambulance arrivals and turnaround times
    - In-hospital performance
    - Discharges performance
    - Emergency Department (ED) performance

- The formatting of the report uses a heat map-based approach to highlight performance for each month relative to performance within the time series. For example, ED performance that is red will be at a level when it is lower than average, and green when above average, within the time period. The heat-map methodology, therefore, does not indicate whether any indicator is achieving target or at a level that meets expectations with respect to quality, efficiency or productivity. The purpose is to highlight visually how clusters of indicators change (improving or deteriorating) relative to other indicators. From this view the dashboard shows the relative importance of the following indicators on ED performance:

    - Referrals into the Urgent Community Response (UCR)
    - Minor Injuries Unit (MIU) and First Aid Units (FAU) referrals
    - Acute Same Day Emergency care (SDEC)
    - Community SDEC
    - Medically Optimised For Discharge (MOFD) total and Average Length of Stay (ALOS)
    - Total discharges from OUH Inpatient wards on pathway 0-3
    - Discharge to Assess (D2A) pathways

- The above list does not highlight statistical significance but may be used to direct further attention to some of the more detailed reports for each area within the accompanying productivity report, as well as other reports produced within the UEC system covering these areas.

- Information is now available for the Primary Care indicators and this is included. Additionally, further forms of analysis using this dashboard are being considered, including statistical significance tests for changes, as well as setting targets for each indicator.

- The report will be updated monthly and shared at the Oxfordshire UEC Board as well as in other performance forums. Following the meeting held in

October, it has been agreed that the dashboard will now form part of the UEC Sitrep pack presented and discussed at the Oxfordshire UEC Board.

- The System and partners will review in light of the winter plan the focus for key metrics as we approach this period for 2025/26.

**Current Status and Trends:**

- Emergency Department (ED) 4- and 12-hour performance (a key patient quality indicator) has sustained the significant improvement seen since April 2025 and improved further to reach 82.1% for 4-hour all types and 99.3% for 12-hour performance in July.
- OUH has exceeded its trajectory (positive) for average ambulance handover times with very minimal >60 minute and >30-minute handover delays. Further work to improve data quality in this area is required.
- The number of GP surgeries declaring 'red' on the Directory of Services has significantly increased.
- CARe (crisis care) team community pick-ups have increased over the last four months fully utilising their capacity for the appropriate patient group.
- Utilisation of admission avoidance pathways or alternatives to ED has been sustained at a higher-level March through to July across all providers.
- Although the overall number of patients delayed in OUH has remained broadly the same, this does represent a deterioration in occupied bed days since May and it has not achieved the lower levels that we would aspire to, for the time of year. Referrals into the Transfer of Care Hub are increasing month on month.
- There has however been a gradual reduction in the average length of stay of medically optimised patients over the last two years, with April seeing the lowest average days delay since recording this metric began. Therefore, there is a very high turnover of patients who are declared medically fit and who are being supported for discharge.
- Reablement outcomes are a concern which is influenced by increasing volume, increasing dependency and workforce factors. Focused work is underway in this area to overcome these challenges and consider alternatives and different ways of working.
- The number of patients discharged before midday remains low at 16.78% for June and 17.84% for July. This is an area of focus within the Discharge Quality Priority.

**Key Focus Areas:**

- Emphasis on addressing the root causes of increased ED attendances and improving admission or conveyance avoidance strategies.

- Further development of SPA, to include access to SCAS ‘stack’ for Category 3 and 4 calls.
- Additional review of a deterioration in occupied bed days for patients who do not have a criteria to reside.

## Recommendations

- The Integrated Assurance Committee is asked to:
    - Review the UEC Performance Dashboard and, noting that this will continue to be developed, and that this will be used to provide assurance on system performance in connection with other detailed reports produced or with accompanying narrative.
    - Note that the Oxfordshire UEC Board review the dashboard monthly as part of the system sitrep report & develop KPIs for Winter preparedness.

| System area | Indicator | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E Performance | A&E 4hr performance (all attendance types) | 68.5% | 69.1% | 63.7% | 61.7% | 57.9% | 59.8% | 63.7% | 65.0% | 72.2% | 71.4% | 74.9% | 74.0% | 78.7% | 76.1% | 73.1% | 69.0% | 68.8% | 66.7% | 72.7% | 70.8% | 68.4% | 75.5% | 75.8% | 80.0% | 82.1% |
| | A&E 4hr performance - Type 1 | 62.5% | 63.0% | 57.5% | 55.0% | 50.8% | 53.2% | 57.1% | 58.7% | 67.3% | 66.1% | 67.1% | 66.6% | 72.1% | 69.1% | 65.3% | 59.9% | 59.6% | 57.0% | 63.9% | 61.9% | 59.8% | 66.1% | 66.3% | 72.8% | 75.4% |
| | A&E 4hr performance - Paed's Type 1 | 75.9% | 79.9% | 72.0% | 64.0% | 56.5% | 62.5% | 66.0% | 70.0% | 70.2% | 74.4% | 74.4% | 74.8% | 80.8% | 81.5% | 74.9% | 69.0% | 62.1% | 63.7% | 74.2% | 74.8% | 71.9% | 76.9% | 75.9% | 79.9% | 84.2% |
| | A&E 4hr performance - Day (8am to 5pm) | 73.4% | 72.7% | 69.3% | 66.5% | 62.8% | 63.2% | 68.5% | 70.3% | 76.3% | 76.3% | 79.1% | 79.0% | 81.6% | 80.2% | 76.8% | 73.2% | 72.3% | 69.9% | 74.2% | 72.9% | 71.1% | 76.7% | 77.7% | 80.6% | 82.3% |
| | A&E 4hr performance - Night (5pm to 8am) | 55.3% | 57.3% | 49.3% | 47.4% | 42.1% | 47.3% | 49.4% | 50.6% | 61.2% | 58.9% | 58.8% | 57.7% | 65.3% | 60.9% | 56.5% | 49.9% | 49.7% | 47.6% | 56.2% | 53.3% | 50.9% | 57.8% | 57.8% | 66.8% | 70.5% |
| | A&E 4hr performance - Weekdays | 61.3% | 62.9% | 57.7% | 56.6% | 50.8% | 52.7% | 57.3% | 58.7% | 65.8% | 66.5% | 67.6% | 66.1% | 71.7% | 69.3% | 64.9% | 60.1% | 59.3% | 59.7% | 63.9% | 61.7% | 59.8% | 66.8% | 65.6% | 73.5% | 75.9% |
| | A&E 4hr performance - Weekends | 70.2% | 69.9% | 62.9% | 57.2% | 56.8% | 60.3% | 63.6% | 64.8% | 75.4% | 69.7% | 71.1% | 71.8% | 77.3% | 72.3% | 70.8% | 65.4% | 65.6% | 55.8% | 69.5% | 67.0% | 64.3% | 68.3% | 73.0% | 73.5% | 77.3% |
| | A&E 12hr performance (all attendance types) | 97.0% | 96.4% | 95.0% | 94.2% | 93.0% | 92.7% | 93.2% | 93.7% | 95.0% | 95.8% | 96.2% | 96.7% | 97.2% | 95.7% | 95.8% | 95.3% | 94.6% | 94.2% | 94.5% | 95.1% | 96.0% | 97.0% | 96.7% | 98.0% | 99.3% |
| | A&E 12hr trolley waits (DTA to admission) | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 1 |
| Primary care | GP: Number of face-to-face GP appointments (Oxfordshire) | 204,375 | 208,766 | 230,364 | 275,333 | 242,564 | 192,010 | 246,721 | 231,534 | 225,726 | 228,351 | 228,052 | 211,312 | 230,380 | 203,888 | 225,115 | 314,516 | 246,551 | 211,441 | 250,236 | 221,129 | 239,092 | 224,479 | 216,784 | 226,327 | |
| | GP: Number of telephone GP appointments (Oxfordshire) | 134,177 | 132,445 | 131,136 | 142,552 | 142,689 | 118,213 | 149,143 | 138,079 | 133,200 | 131,294 | 129,877 | 121,373 | 125,913 | 114,537 | 119,303 | 130,906 | 122,131 | 114,433 | 135,162 | 121,958 | 129,016 | 118,578 | 116,047 | 122,989 | |
| | GP: Total number of GP appointments (Oxfordshire) | 349,052 | 352,090 | 373,285 | 431,775 | 400,313 | 322,554 | 414,614 | 385,540 | 375,839 | 376,346 | 374,314 | 348,223 | 373,198 | 334,449 | 363,531 | 469,188 | 390,389 | 347,049 | 412,446 | 365,905 | 393,182 | 366,378 | 357,045 | 374,413 | |
| | GP: Number of GP hours at red DoS capacity status (Oxfordshire) | 0:00 | 0:00 | 0:00 | 0:00 | 11:46 | 39:39 | 18:41 | 40:53 | 13:01 | 9:23 | 2:57 | 19:49 | 86:02 | 398:58 | 601:01 | 793:24 | 1181:12 | 1423:47 | 1322:35 | 1292:12 | 1405:54 | 1546:22 | 1186:25 | 1134:43 | |
| Admission avoidance | Hospital @ Home - new admissions | 248 | 312 | 350 | 352 | 346 | 507 | 620 | 454 | 389 | 422 | 437 | 448 | 466 | 384 | 419 | 445 | 344 | 417 | 412 | 361 | 377 | 366 | 367 | 391 | 409 |
| | Hospital @ Home - beddays consumed | 1806 | 1768 | 1848 | 2519 | 2275 | 3577 | 3748 | 2802 | 2732 | 2251 | 2583 | 3450 | 2861 | 2834 | 2933 | 3040 | 2508 | 2605 | 2910 | 2706 | 2643 | 2364 | 2996 | 2496 | 2325 |
| | CARe (crisis care) team - Community pickups | 93 | 104 | 126 | 140 | 121 | 133 | 133 | 126 | 113 | 91 | 123 | 111 | 92 | 105 | 104 | 114 | 112 | 119 | 141 | 114 | 119 | 140 | 145 | 151 | 134 |
| | CARe (crisis care) team - Bed based pickups | 26 | 22 | 13 | 19 | 29 | 32 | 32 | 57 | 47 | 50 | 49 | 36 | 42 | 49 | 18 | 26 | 30 | 35 | 37 | 23 | 20 | 13 | 14 | 13 | 11 |
| | Community referrals accepted for reablement | 51 | 48 | 56 | 56 | 46 | 43 | 41 | 60 | 48 | 58 | 74 | 65 | 66 | 67 | 84 | 99 | 75 | 98 | 130 | 94 | 97 | 75 | 83 | 79 | 66 |
| | Referrals into Urgent Community Response | | | | | | | | | | | | | | | | | 627 | 681 | 716 | 665 | 839 | 890 | 1018 | 948 | 999 |
| | D2A pick ups from bed-based referrals (Home | | | | | | | | | | | | | 250 | 242 | 256 | 317 | 281 | 298 | 322 | 294 | 314 | 377 | 320 | 346 | 383 |
| | D2A pick ups from all teams (Home First) | | | | | | | 360 | 330 | 340 | 345 | 401 | 349 | 375 | 391 | 396 | 464 | 420 | 440 | 513 | 450 | 446 | 484 | 437 | 442 | 488 |
| | Fiennes UCC attendances | 1555 | 1501 | 1568 | 1659 | 1720 | 1628 | 1542 | 1419 | 1728 | 1896 | 1824 | 1501 | 1682 | 1421 | 1524 | 1964 | 1983 | 2043 | 2065 | 1807 | 1659 | 1734 | 1863 | 1640 | 1654 |
| | City UCC referrals | 840 | 750 | 1018 | 1305 | 1117 | 1139 | 1340 | 1337 | 1360 | 1229 | 1259 | 1335 | 1622 | 1230 | 1289 | 1683 | 1882 | 1588 | 1486 | 1340 | 1314 | 1345 | 1416 | 1366 | 1404 |
| | MIU and FAU referrals: Total | 4644 | 4523 | 4709 | 4500 | 4208 | 3672 | 3969 | 3973 | 4645 | 4389 | 5137 | 4407 | 4817 | 4647 | 4627 | 4517 | 4184 | 3726 | 3979 | 3733 | 4865 | 4753 | 5289 | 5239 | 5277 |
| | MIU referrals: Abingdon | 2111 | 2000 | 2181 | 2105 | 1912 | 1630 | 1784 | 1828 | 2067 | 1954 | 2278 | 1938 | 2180 | 1997 | 2115 | 2129 | 1936 | 1632 | 1787 | 1758 | 2190 | 2075 | 2319 | 2311 | 2315 |
| | MIU referrals: Henley | 968 | 938 | 875 | 969 | 870 | 743 | 830 | 748 | 958 | 894 | 1040 | 924 | 997 | 1024 | 967 | 903 | 827 | 797 | 792 | 701 | 1005 | 981 | 1093 | 1134 | 1108 |
| | MIU referrals: Witney | 1417 | 1469 | 1516 | 1325 | 1318 | 1229 | 1267 | 1288 | 1490 | 1395 | 1612 | 1375 | 1517 | 1458 | 1416 | 1341 | 1326 | 1187 | 1292 | 1180 | 1534 | 1539 | 1706 | 1627 | 1676 |
| | FAU referrals: Bicester | 148 | 116 | 137 | 101 | 108 | 70 | 88 | 109 | 130 | 146 | 207 | 170 | 123 | 168 | 129 | 144 | 95 | 110 | 108 | 94 | 136 | 158 | 171 | 167 | 178 |
| | Acute SDEC: total | 3030 | 3194 | 3286 | 3381 | 3364 | 3164 | 3418 | 3215 | 3336 | 3245 | 3520 | 3228 | 3388 | 3170 | 3293 | 3724 | 3232 | 3274 | 3454 | 3045 | 3511 | 3384 | 3270 | 3181 | 3221 |
| | Acute SDEC: H-WD Rowan AU | 414 | 416 | 448 | 444 | 452 | 419 | 470 | 452 | 493 | 496 | 548 | 472 | 516 | 449 | 470 | 578 | 512 | 485 | 522 | 493 | 531 | 507 | 482 | 471 | 456 |
| | Acute SDEC: J-WD AAU | 1455 | 1508 | 1610 | 1707 | 1765 | 1650 | 1739 | 1597 | 1656 | 1624 | 1712 | 1604 | 1618 | 1583 | 1603 | 1808 | 1559 | 1634 | 1671 | 1514 | 1666 | 1665 | 1666 | 1491 | 1482 |
| | Acute SDEC: J-WD SEU triage | 885 | 981 | 951 | 937 | 875 | 833 | 940 | 907 | 921 | 861 | 961 | 895 | 971 | 897 | 953 | 1011 | 895 | 885 | 968 | 780 | 986 | 940 | 902 | 983 | 1030 |
| | Acute SDEC: J-WD Child CDU | 276 | 289 | 277 | 293 | 272 | 262 | 269 | 259 | 266 | 264 | 299 | 257 | 283 | 241 | 267 | 327 | 266 | 270 | 293 | 258 | 328 | 272 | 220 | 236 | 253 |
| | Acute SDEC Specialty: C-WD OncHTriage | 209 | 233 | 220 | 232 | 240 | 220 | 246 | 206 | 212 | 192 | 208 | 213 | 232 | 235 | 199 | 233 | 229 | 228 | 237 | 215 | 233 | 239 | 212 | 192 | 221 |
| | Acute SDEC Specialty: C-WD UrolTriage | 214 | 217 | 252 | 240 | 226 | 193 | 226 | 189 | 215 | 211 | 229 | 205 | 237 | 277 | 203 | 233 | 256 | 239 | 265 | 246 | 280 | 272 | 247 | 247 | 231 |
| | Acute SDEC Specialty: C-WD GPRU | 79 | 76 | 98 | 85 | 78 | 88 | 87 | 87 | 85 | 103 | 76 | 89 | 84 | 99 | 78 | 81 | 110 | 93 | 97 | 88 | 82 | 108 | 102 | 88 | 91 |
| | Acute SDEC Specialty: J-WD Gyn Triage | 344 | 325 | 307 | 325 | 316 | 320 | 359 | 326 | 386 | 344 | 320 | 312 | 380 | 336 | 326 | 296 | 266 | 266 | 347 | 254 | 282 | 330 | 317 | 299 | 338 |
| | Acute SDEC Specialty: J-WD Maty AU | 408 | 396 | 370 | 453 | 355 | 371 | 366 | 374 | 392 | 357 | 400 | 371 | 369 | 353 | 388 | 431 | 378 | 422 | 414 | 384 | 431 | 355 | 371 | 362 | 412 |
| | Community SDEC: total | 218 | 255 | 252 | 272 | 274 | 259 | 311 | 323 | 286 | 303 | 217 | 263 | 277 | 234 | 237 | 289 | 328 | 328 | 311 | 253 | 313 | 302 | 318 | 319 | 349 |
| | Community SDEC: Abingdon EMU | 81 | 104 | 113 | 114 | 118 | 107 | 140 | 128 | 124 | 108 | 87 | 90 | 123 | 89 | 98 | 110 | 119 | 130 | 116 | 91 | 131 | 108 | 116 | 132 | 143 |
| | Community SDEC: Witney EMU | 84 | 98 | 80 | 95 | 86 | 97 | 103 | 122 | 109 | 128 | 87 | 107 | 97 | 51 | 84 | 101 | 140 | 131 | 124 | 102 | 124 | 115 | 144 | 121 | 144 |
| | Community SDEC: RACU | 53 | 53 | 59 | 63 | 70 | 55 | 68 | 73 | 53 | 67 | 43 | 66 | 57 | 94 | 55 | 78 | 69 | 67 | 71 | 60 | 58 | 79 | 58 | 66 | 62 |

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| System area | Indicator | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A&E Performance** | A&E 4hr performance (all attendance types) | **68.5%** | **69.1%** | **63.7%** | **61.7%** | **57.9%** | **59.8%** | **63.7%** | **65.0%** | **72.2%** | **71.4%** | **74.9%** | **74.0%** | **78.7%** | **76.1%** | **73.1%** | **69.0%** | **68.8%** | **66.7%** | **72.7%** | **70.8%** | **68.4%** | **75.5%** | **75.8%** | **80.0%** | **82.1%** |
| | A&E 4hr performance - Type 1 | 62.5% | 63.0% | 57.5% | 55.0% | 50.8% | 53.2% | 57.1% | 58.7% | 67.3% | 66.1% | 67.1% | 66.6% | 72.1% | 69.1% | 65.3% | 59.9% | 59.6% | 57.0% | 63.9% | 61.9% | 59.8% | 66.1% | 66.3% | 72.8% | 75.4% |
| | A&E 4hr performance - Paed's Type 1 | 75.9% | 79.9% | 72.0% | 64.0% | 56.5% | 62.5% | 66.0% | 70.0% | 70.2% | 74.4% | 74.4% | 74.8% | 80.8% | 81.5% | 74.9% | 69.0% | 62.1% | 63.7% | 74.2% | 74.8% | 71.9% | 76.9% | 75.9% | 79.9% | 84.2% |
| | A&E 4hr performance - Day (8am to 5pm) | 73.4% | 72.7% | 69.3% | 66.5% | 62.8% | 63.2% | 68.5% | 70.3% | 76.3% | 76.3% | 79.1% | 79.0% | 81.6% | 80.2% | 76.8% | 73.2% | 72.3% | 69.9% | 74.2% | 72.9% | 71.1% | 76.7% | 77.7% | 80.6% | 82.3% |
| | A&E 4hr performance - Night (5pm to 8am) | 55.3% | 57.3% | 49.3% | 47.4% | 42.1% | 47.3% | 49.4% | 50.6% | 61.2% | 58.9% | 58.8% | 57.7% | 65.3% | 60.9% | 56.5% | 49.9% | 49.7% | 47.6% | 56.2% | 53.3% | 50.9% | 57.8% | 57.8% | 66.8% | 70.5% |
| | A&E 4hr performance - Weekdays | 61.3% | 62.9% | 57.7% | 56.6% | 50.8% | 52.7% | 57.3% | 58.7% | 65.8% | 66.5% | 67.6% | 66.1% | 71.7% | 69.3% | 64.9% | 60.1% | 59.3% | 59.7% | 63.9% | 61.7% | 59.8% | 66.8% | 65.6% | 73.5% | 75.9% |
| | A&E 4hr performance - Weekends | 70.2% | 69.9% | 62.9% | 57.2% | 56.8% | 60.3% | 63.6% | 64.8% | 75.4% | 69.7% | 71.1% | 71.8% | 77.3% | 72.3% | 70.8% | 65.4% | 65.6% | 55.8% | 69.5% | 67.0% | 64.3% | 68.3% | 73.0% | 73.5% | 77.3% |
| | A&E 12hr performance (all attendance types) | 97.0% | 96.4% | 95.0% | 94.2% | 93.0% | 92.7% | 93.2% | 93.7% | 95.0% | 95.8% | 96.2% | 96.7% | 97.2% | 95.7% | 95.8% | 95.3% | 94.6% | 94.2% | 94.5% | 95.1% | 96.0% | 97.0% | 96.7% | 98.0% | 99.3% |
| | A&E 12hr trolley waits (DTA to admission) | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 1 |
| **Ambulance** | OUH Percentage of ambulances with turnaround time >30 minutes | 7.3% | 9.2% | 11.8% | 13.6% | 10.9% | 11.6% | 10.9% | 10.9% | 8.9% | 7.8% | 7.9% | 7.39% | 6.9% | 8.5% | 7.5% | 10.7% | 11.7% | 10.5% | 9.6% | 8.3% | 6.8% | 5.6% | 6.4% | 4.7% | |
| | OUH Percentage of ambulances with turnaround time >60 minutes | 0.5% | 0.8% | 0.7% | 1.9% | 1.1% | 1.4% | 1.0% | 1.3% | 0.7% | 0.4% | 0.8% | 0.81% | 0.5% | 0.8% | 0.5% | 1.1% | 1.3% | 0.8% | 0.5% | 0.5% | 0.8% | 0.2% | 0.5% | 0.2% | |
| | OUH average ambulance handover time (h:mm:ss) | 0:17:42 | 0:18:43 | 0:19:47 | 0:21:00 | 0:19:27 | 0:19:54 | 0:19:47 | 0:19:09 | 0:18:39 | 0:17:46 | 0:18:07 | 0:17:48 | 0:17:14 | 0:17:59 | 0:18:24 | 0:19:13 | 0:19:53 | 0:20:07 | 0:19:23 | 0:18:17 | 0:17:28 | 0:17:14 | 0:17:16 | 0:16:48 | |
| **In hospital** | OUH G&A bed occupancy | 93.0% | 93.5% | 94.7% | 95.1% | 96.5% | 94.9% | 95.7% | 95.5% | 95.7% | 95.2% | 92.7% | 93.1% | 93.95% | 92.52% | 93.39% | 94.10% | 94.68% | 93.83% | 94.95% | 95.11% | 94.00% | 93.48% | 92.45% | 90.90% | 92.42% |
| | OUH ALOS while Medically Fit for Discharge (MOFD) | 6.0 | 6.6 | 6.8 | 6.3 | 6.1 | 5.9 | 7.1 | 8.2 | 6.7 | 6.7 | 6.3 | 7.0 | 5.7 | 5.8 | 6.4 | 6.1 | 5.4 | 5.7 | 6.5 | 6.2 | 5.5 | 4.8 | 5.6 | 5.6 | 5.9 |
| | OUH Average number of MOFD patients per day | 87 | 87 | 79 | 83 | 96 | 104 | 120 | 125 | 95 | 98 | 96 | 91 | 87 | 90 | 92 | 99 | 90 | 113 | 121 | 99 | 90 | 90 | 104 | 106 | 105 |
| | Community Hospitals: Average number of MOFD patients per day | 10 | 16 | 13 | 14 | 20 | 12 | 14 | 23 | 27 | 28 | 27 | 21 | 29 | 29 | 28 | 23 | 21 | 23 | | | | 20 | 24 | 24 | 17 |
| **Discharge** | Percentage of patients discharged before 12:00 | 18.3% | 17.1% | 16.8% | 18.3% | 17.7% | 18.2% | 18.3% | 17.4% | 16.4% | 15.7% | 17.4% | 17.1% | 17.00% | 17.03% | 15.76% | 17.01% | 16.71% | 17.90% | 18.70% | 18.05% | 17.31% | 17.39% | 17.36% | 16.78% | 17.84% |
| | Percentage of patients discharged before 17:00 | 61.4% | 59.8% | 59.5% | 61.0% | 60.3% | 60.4% | 60.9% | 61.9% | 60.5% | 58.8% | 59.6% | 58.3% | 60.38% | 57.97% | 56.79% | 60.92% | 59.56% | 60.13% | 60.72% | 61.01% | 60.85% | 58.28% | 58.72% | 58.08% | 59.52% |
| | Total discharges from OUH inpatient wards: Pathway 0 | 4982 | 4962 | 5029 | 5003 | 5130 | 4930 | 4628 | 4260 | 4743 | 4425 | 4811 | 4726 | 4916 | 4839 | 4690 | 5048 | 5009 | 4666 | 4652 | 4131 | 4802 | 4707 | 4772 | 4782 | 4860 |
| | Total discharges from OUH inpatient wards: Pathway 1 | 272 | 262 | 238 | 286 | 328 | 298 | 333 | 237 | 293 | 273 | 278 | 254 | 259 | 291 | 246 | 299 | 267 | 265 | 314 | 252 | 297 | 303 | 303 | 294 | 308 |
| | Total discharges from OUH inpatient wards: Pathway 2 | 233 | 244 | 216 | 216 | 230 | 225 | 214 | 215 | 217 | 186 | 226 | 212 | 207 | 199 | 195 | 223 | 192 | 213 | 228 | 220 | 234 | 222 | 174 | 165 | 183 |
| | Total discharges from OUH inpatient wards: Pathway 3 | 177 | 160 | 142 | 156 | 155 | 159 | 166 | 169 | 168 | 174 | 138 | 123 | 108 | 95 | 130 | 123 | 97 | 84 | 29 | 32 | 28 | 34 | 31 | 51 | 54 |
| | Percentage of OUH patients aged 18+ discharged on pathway 0 or 1 | 90.1% | 90.7% | 91.5% | 91.1% | 91.0% | 90.7% | 90.7% | 90.4% | 90.8% | 91.1% | 91.4% | 92.0% | 92.90% | 93.30% | 92.03% | 92.36% | 93.51% | 92.48% | 92.67% | 92.81% | 93.55% | 93.05% | 93.45% | 93.20% | 92.62% |
| | % Reablement outcomes: Reablement independent | | | | | | | | | | | | | 73% | 71% | 71% | 74% | 80% | 72% | 76% | 71% | 77% | 67% | 76% | 74% | 73% |
| | % Reablement outcomes: Reablement reduced | | | | | | | | | | | | | 6% | 15% | 15% | 10% | 10% | 11% | 10% | 15% | 9% | 12% | 8% | 11% | 12% |
| | JR: Days at OPEL 1 | 12 | 13 | 5 | 7 | 0 | 3 | 0 | 3 | 2 | 10 | 7 | 10 | 11 | 8 | 3 | 2 | 2 | 3 | 3 | 3 | 4 | 5 | 3 | 16 | 11 |
| | JR: Days at OPEL 2 | 14 | 15 | 13 | 6 | 12 | 4 | 0 | 6 | 11 | 6 | 14 | 12 | 9 | 13 | 9 | 9 | 5 | 8 | 10 | 10 | 18 | 16 | 17 | 14 | 16 |
| | JR: Days at OPEL 3 | 5 | 3 | 10 | 17 | 16 | 21 | 21 | 20 | 18 | 14 | 10 | 8 | 11 | 10 | 18 | 20 | 23 | 20 | 18 | 15 | 9 | 9 | 11 | 0 | 4 |
| | JR: Days at OPEL 4 | 0 | 0 | 2 | 1 | 2 | 3 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | HH: Days at OPEL 1 | 12 | 15 | 11 | 8 | 2 | 4 | 6 | 12 | 13 | 10 | 24 | 24 | 24 | 28 | 24 | 22 | 19 | 9 | 14 | 16 | 19 | 20 | 24 | 30 | 29 |
| | HH: Days at OPEL 2 | 9 | 8 | 10 | 6 | 10 | 4 | 7 | 4 | 8 | 7 | 5 | 5 | 4 | 3 | 5 | 7 | 7 | 9 | 11 | 6 | 9 | 9 | 7 | 0 | 2 |
| | HH: Days at OPEL 3 | 10 | 8 | 9 | 15 | 15 | 19 | 9 | 13 | 10 | 13 | 2 | 1 | 3 | 0 | 1 | 2 | 4 | 13 | 5 | 6 | 3 | 1 | 0 | 0 | 0 |
| | HH: Days at OPEL 4 | 0 | 0 | 0 | 2 | 3 | 4 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |

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# 19. REGULAR REPORTING ITEMS

# 19.1 TRUST MANAGEMENT EXECUTIVE REPORT TO INCLUDE: O ENERGY POLICY O SAS DOCTOR PAY PROGRESSION

## REFERENCES

Only PDFs are attached

18a TB2025.86 Trust Management Executive Report.pdf

Oxford University Hospitals
NHS Foundation Trust

**Cover Sheet**

**Trust Board Meeting in Public: Wednesday 10 September 2025**

**TB2025.86**

| | |
|---|---|
| **Title:** | **Trust Management Executive Report** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **Regular Reporting** |

| | |
|---|---|
| **Board Lead:** | **Chief Executive Officer** |
| **Author:** | **Joan Adegoke, Corporate Governance Officer** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance** |

# Trust Management Executive Report

## 1. Purpose

1.1. The Trust Management Executive [TME] has been constituted by the Trust Board and is the executive decision-making committee of the Trust. As such, it provides a regular report to the Board on some of the main issues raised and discussed at its meetings.

1.2. Under its terms of reference, TME is responsible for providing the Board with assurance concerning all aspects of setting and delivering the strategic direction for the Trust, including associated clinical strategies; and to assure the Board that, where there are risks and issues that may jeopardise the Trust's ability to deliver its objectives, these are being managed in a controlled way through the Trust Management Executive Committee. This regular report aims to contribute to this purpose.

## 2. Background

2.1. Since the preparation of its last report to the Trust Board, the Trust Management Executive has met on the following dates:

- 10 July 2025
- 31 July 2025
- 14 August 2025
- 28 August 2025

## 3. Key Decisions

Internal Recruitment Proposal

3.1. TME approved the proposal for all Agenda for Change roles to be advertised internally for two weeks without exception, including expressions of interest before opening to external candidates if no suitable internal applicant is found.

3.2. The proposal reinforces the Trust's commitment to developing administrative and clinical staff, offering improved career progression, reducing recruitment costs, and improving retention.

Freedom of Information (FoI) Requests Backlog Resourcing

3.3. The Trust must comply with the Freedom of Information Act 2000, responding to requests within 20 working days unless exemptions apply. The Information Governance team coordinates responses, but timely input from staff is essential.

3.4. Due to rising request volumes, the Trust faces pressure in managing responses. Progress has been made by identifying key contacts across divisions, but further support is needed to clear the backlog.

3.5. TME approved a proposal to procure temporary resourcing via NHS Professionals (NHSP) to clear the backlog by 31 October.

## External Well-led Review Proposal

3.6. TME approved the commissioning of an external evaluation of Well-led Review of the Trust's leadership and governance in line with the relevant elements of the CQC Single Assessment Framework to begin in September. These reviews are a requirement under the Code of Governance and one has not recently been undertaken.

3.7. In line with guidance from the CQC and NHS England under the Single Assessment Framework, the review will focus on three key areas: shared direction and culture; capable, compassionate and inclusive leadership; and learning, improvement and innovation.

## Combined Equality Standards Report 2025

3.8. TME was presented with the Combined Equality Standards Report, outlining progress on WRES, WDES, and Gender Pay Gap metrics. Key improvements include increased BAME representation in senior clinical roles, a reduced gender pay gap, and Chief Officers adopting individual EDI objectives with five priority actions agreed:

- Encourage disclosure of protected characteristic data
- Support career progression for underrepresented groups
- Improve wellbeing for disabled staff
- Strengthen integration of internationally educated colleagues
- Address racial discrimination through co-produced solutions

3.9. TME endorsed the actions and recommended the report for Board approval.

## NHS Staff Survey 2025 Approach

3.10. TME received a proposed approach to the NHS Staff Survey, opening on 22 September. As in previous years, all staff would be given protected time and a suitable environment to complete the survey, with local teams responsible for delivery.

3.11. Most staff would receive the survey electronically via IQVIA, the independent provider. Alternative formats, such as paper copies, would be available for staff with limited email access.

3.12. TME endorsed the approach and committed to promoting survey participation across the Trust. The survey's value in capturing honest staff feedback was emphasised and with reassurance that responses were fully anonymous and confidential.

Winter Preparedness Plan 2025/26

3.13. TME received the 2025/26 Winter Preparedness Plan ahead of Trust Board approval. The plan prioritises patient safety and flow, with close collaboration across Oxfordshire's health and care system.

3.14. Key measures included opening additional winter beds, streamlining hospital processes, reducing length of stay, and supporting staff wellbeing such as through the flu vaccination programme.

3.15. The Winter Plan aligned with the national Urgent and Emergency Care Plan 2025–26, targeting improved ED performance, reduced ambulance handover delays, and shorter patient waiting times.

3.16. TME supported the plan and recommended it for Board approval.

Surgical Elective Centre (SEC) Terms of Reference

3.17. TME received an update on governance arrangements for the Surgical Elective Centre Programme, including updated Terms of Reference (ToR**)** for the Programme Board and new ToR for the Risk Management Group and Steering Group.

3.18. TME recommended the inclusion of senior clinical leadership and a patient engagement mechanism in the Programme Board and it was agreed that membership would be reviewed by Chief Officers.

3.19. The current ToR were approved, with a revised version to be brought to a future meeting.

## 4. Other Activity Undertaken by TME

Strengthening R&D Governance, Performance and Support

4.1. TME received a proposal to strengthen R&D governance by establishing a formal Trust R&D Committee, replacing the informal COVID-era structure, and creating Research Delivery Groups (RDGs) to report into it. This followed recommendations from a recent internal audit and aimed to improve oversight and performance.

4.2. TME noted the need to strengthen Trust R&D governance and improve study setup and recruitment KPIs and approved the establishment of a new R&D Committee and Research Delivery Groups, along with their respective terms of reference.

AccessAble Project Update

4.3. AccessAble helps people with disabilities access NHS sites confidently by providing detailed, non-judgmental accessibility guides. The Trust, supported by Oxford Hospitals Charity, was creating these guides for its hospitals, aligning with equality duties and improving patient experience.

4.4. Site surveys at Horton and Nuffield were completed, and draft Access Guides have been reviewed. Once live, AccessAble would support a launch event and training. Post-launch, guidance documents would be provided to help improve accessibility.

4.5. TME received the update and the next steps for further review by patient safety partners.

Swipe Access Update

4.6. TME was briefed on ongoing swipe access issues affecting Churchill, Horton General, and JR sites and recognised the collaborative efforts of teams across Digital, Estates, Operations, and clinical areas to address these, highlighting this as a strong example of the One Team, One OUH approach.

Health and Safety Annual Report 2024-25

4.7. TME received this report showing that incident reporting remained stable, with a 4.3% increase in 2024-25, mainly due to increased reports of staff assault and harassment, driven by the No Excuses Campaign.

4.8. TME welcomed this as a sign of a positive reporting culture and reaffirmed support for staff affected by violence and aggression

4.9. A new Health and Safety Strategy (2026–30) was in development, aligned with the OUH People Plan and the NHS 10-Year Plan.

Capital Schemes Update

4.10. TME continued to receive updates on a range of capital schemes to enhance both patient care and staff experience.

4.11. Progress continued on the Surgical Elective Centre (SEC) at the JR. Modular units were being delivered**,** with installation underway. The project remained on track, with seven new operating theatres scheduled for phased completion by March 2026.

## 5. Policy

Space Policy Update

5.1. TME approved an updated Space Policy**,** introducing an electronic request system (E-form) and clearer processes for space management, including

business case requirements for additional costs and compliance with regulatory standards.

5.2. Members emphasised the need for a strategic approach to space utilisation**,** noting capacity gaps across divisions and the importance of coordination.

5.3. Future work on space optimisation would align with the Clinical Service Review and the Trust's Estate Strategy to support long-term planning.

Overtime and Additional Hours Procedure

5.4. This was a new procedure requiring all overtime to be pre-authorised, with defined approval levels and a preference for using bank staff where possible. It also clarified the use and payment of TOIL (time off in lieu), aiming to improve oversight and planning. A communications plan would be developed to support consistent implementation.

5.5. TME approved the Overtime and Additional Hours Procedure.

SAS Doctors Pay Progression Policy

5.6. TME endorsed the SAS Doctors Pay Progression policy which outlined the requirements and process for pay progression for SAS doctors employed under the Trust's 2021 terms and conditions (Specialist or Specialty Doctor) prior to submission to the Trust Board.

Freedom to Speak Up (FTSU) Policy

5.7. TME considered and supported an updated FTSU policy reflecting national guidance, stronger protections, new reporting tools, and clearer processes prior to submission to the Trust Board.

5.8. Training uptake monitoring was requested to be added to future reports.

## 6. Regular Reporting

6.1. In addition, TME reviewed the following regular reports:

- Integrated Performance Report (this is now received by TME prior to presentation to the Trust Board and Integrated Assurance Committee);
- Capital Schemes: TME continues to receive updates on a range of capital schemes across the Trust;
- Finance Report: TME continues to receive financial performance updates;
- People Performance Report: TME receives and discusses monthly updates of the key KPIs regarding HR metrics;
- Clinical Governance Committee Report (including supporting and approving an updated Quality Strategy);

- Divisional Performance Reviews;
- Corporate Performance Reviews;
- Business Planning Pipeline Report;
- Procurement Pipeline Report; and
- Summary Impact of TME Business (which allows TME members to more easily track the combined financial impact of decisions taken.)

## 7. Key Risks

7.1. **Risks associated with the financial performance:** TME recognised the risks in relation to the delivery of the financial plan for 2025/26. **(BAF Strategic Risk 3.1 & 3.2)**

7.2. **Risks associated with workforce:** TME maintained continued oversight on ensuring the provision of staff to ensure that services were provided safely and efficiently across the Trust and to maintain staff wellbeing in the light of operational pressures. **(BAF Strategic Risk 1)**

7.3. **Risks to operational performance:** TME noted the risks to operational performance and the delivery of key performance indicators that were included in its plan for 2025/26. **(BAF Strategic Risk 2)**

## 8. Recommendations

8.1. The Trust Board is asked to

- **note** the regular report to the Board from TME's meetings held on 10 July, 31 July, 14 August and 28 August 2025;
- **approve** the Energy Policy; and
- **approve** the SAS Doctors Pay Progression Policy.

# Oxford University Hospitals NHS Foundation Trust - Energy Policy

This Energy Policy outlines Oxford University Hospitals NHS Foundation Trust's (OUH) commitment to systematic energy management and continual improvement in energy performance. The previous policy from 2007 has been updated and revised to align with the requirements of ISO 50001:2018 Energy Management System, ensuring a robust framework for our energy and carbon management efforts.

## Purpose and Scope

OUH is dedicated to providing outstanding patient care, and integral to this purpose is our commitment to responsible environmental stewardship. This Energy Policy articulates OUH's dedication to systematically managing energy consumption, enhancing energy performance, reducing carbon emissions, and contributing to national sustainability targets, including NHS England's ambition for Net Zero for its direct emissions by 2040 and for all emissions by 2045.

This policy applies to all buildings, facilities, operations, and activities under the direct control of OUH, encompassing all hospital sites, administrative buildings, and associated services. It applies to all staff, and contractors working on the Trust's behalf.

## Our Commitment

OUH is committed to the continual improvement of our energy performance and the effectiveness of our Energy Management System (EnMS). To achieve this, we commit to:

- Providing a clear framework for setting, reviewing, reporting and achieving measurable energy objectives and energy targets that drive continual improvement in our energy performance.
- Guaranteeing the availability of necessary information and resources required to achieve our established energy objectives and energy targets, including appropriate training and technology.
- Fully complying with all applicable legal requirements and other requirements related to energy efficiency, energy use, and energy consumption.
- Actively promoting and supporting the procurement of energy-efficient products and services that significantly impact our energy performance, ensuring energy efficiency and carbon emissions are key considerations in acquisition.
- Ensuring that design activities for new, modified, or renovated facilities, equipment, and processes proactively consider and support improvements in energy performance.

This Policy is communicated throughout the organisation to all staff and contractors and made available to interested parties, as needed. It will also be reviewed periodically as part of the Management Review or sooner, if required, by operational changes, legal updates, or performance needs.

While the Chief Executive holds overall responsibility, the policy's successful implementation is a collaborative effort involving the Estates and Facilities Management teams, the Sustainability and Carbon Team, all managers, and individual staff members across OUH.

**Insert Signature here upon approval**

Chief Executive

Oxford University Hospitals
NHS Foundation Trust

# Specialist and Specialty (SAS) Doctor Pay Progression Policy

| | |
|---|---|
| **Category:** | Policy |
| **Summary:** | This policy implements the 2021 amendments to pay progression arrangements for SAS Doctors as set out in the Terms and Conditions of Service Speciality Doctors – England (2021) and the Terms and Conditions of Service Specialist – England (2021) and sets out the process to be followed when a SAS Doctor reaches a pay point or threshold. |
| **Equality Impact Assessment undertaken:** | February 2025 |
| **Valid From:** | |
| **Date of Next Review:** | 3 years<br>Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid. |
| **Approval Via/Date:** | |
| **Distribution:** | Trust wide |
| **Related Documents:** | Conduct and Expected Behaviours Procedure<br>Core Skills Policy<br>Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure<br>Job Planning Policy<br>Medical Revalidation and Appraisal Policy<br>New and Expectant Parent Leave Procedure |
| **Author(s):** | Assistant Director of Workforce – Resourcing<br>Medical HR Manager |
| **Further Information:** | Divisional Workforce Teams<br>SAS 2021 pay progression system guidance \| NHS Employers<br>SAS pay progression<br>SAS-contract-reform-implementation-guidance_0.pdf<br>Terms and Conditions of Service Speciality Doctors – England (2021)<br>Terms and Conditions of Service Specialist – England (2021) |
| **This Document replaces:** | New policy |

**Lead Director:** Chief Medical Officer

**Issue Date:**

## Contents

## Introduction

1. Specialty Doctors, Specialists and Associate Specialists (collectively referred to as SAS doctors hereafter) are a vital and growing part of the medical workforce.
2. The SAS contract reform in 2021, the restoration of a senior SAS role, and the associated national documents (see Toolkit and NHS employers guidance) offers an opportunity to re-evaluate what it means to be a SAS doctor at our organisation.
3. The new progression system for SAS doctors on the 2021 contract is intended to enhance and strengthen existing processes, underlining the employer and doctors' mutual obligations. There is an expectation that certain standards must be met, and the new system will help ensure that all SAS doctors have the appropriate knowledge and skills they need to carry out their roles.
4. This policy sets out the pay progression arrangements for all SAS doctors employed under the Terms and Conditions of Service Speciality Doctors – England (2021) and the Terms and Conditions of Service Specialist – England (2021) at Oxford University Hospitals NHS Foundation Trust ("the Trust").
5. All doctors appointed into new SAS posts at the Trust are appointed as specialist or specialty doctors on the appropriate 2021 Terms and Conditions.

## Policy Statement

6. It is the policy of the Trust that pay progression for SAS doctors to a pay point that results in an increase in salary is conditional upon meeting the required pay progression criteria.
7. It will be the norm for SAS doctors to achieve pay progression and the intention is not to prevent doctors who are achieving the expected standards from moving through the pay scale. Pay progression may only be deferred where the doctor has not met the required pay progression criteria (see the Pay Progression Criteria section below).
8. The policy should be read in conjunction with the Terms and Conditions of Service Speciality Doctors – England (2021) and the Terms and Conditions of Service Specialist – England (2021)

## Scope

9. This policy applies to all employees under the Trust that are employed under the Terms and Conditions of Service Speciality Doctors – England (2021) and the Terms and Conditions of Service Specialist – England (2021), including locums. It does not apply to honorary and observer contract holders, contractors, workers hired on a self-employed basis, or temporary staff engaged via the Bank.
10. For the avoidance of doubt, this policy does not apply to doctors employed under the Terms and Conditions – Associate Specialist (England) 2008 or the Terms and Conditions of Service – Speciality Doctor (England) 2008.

## Aim

11. The purpose of this policy is to ensure:
    - 11.1. all decisions regarding pay progression are made consistently, fairly and transparently;
    - 11.2. that all SAS doctors and their clinical managers are aware of and understand the criteria that will be taken into account when determining pay progression; and
    - 11.3. that all SAS doctors and their clinical managers are aware of and understand the process that will be followed and their responsibilities within that process.

## Definitions

12. The terms in use in this document are defined as follows:

    12.1. A **pay point** is a pay value within a grade expressed in terms of years of experience. The pay structure describes the minimum length of service on a pay point required before a doctor becomes eligible to move to the next pay point.

        12.1.1. The **Specialist** grade is made up of three points and doctors will be expected to spend a minimum of three years on each pay point and evidence the criteria set out in paragraph 35 before moving to the next pay point.

        12.1.2. The **Speciality** grade is made up of five pay points and doctors will be expected to spend a minimum of three years on each pay point and evidence the criteria set out in paragraph 36 before moving to the next pay point. To progress to the top pay point (also referred to as progression through the higher threshold) there are additional pay progression criteria which must be met.

    12.2. A **pay progression review meeting** is the meeting held between a SAS doctor and their clinical manager to discuss if the SAS Doctor has met the pay progression criteria.

## Responsibilities

13. The **Chief Medical Officer** has overall responsibility for the pay progression process and for ensuring fairness and consistency in the process. They are responsible for:

    13.1. ensuring the policy is applied equitably across the Trust and that the minimum clinical standards defined within the policy are met;

    13.2. liaising with the clinical manager and/or SAS doctor, where advised by the Director of Medical Workforce that the timescales set out in this policy have not been achieved;

    13.3. promoting the development of Specialty and Specialist Doctors within the Trust; and

    13.4. approving the annual report (composed by the Director of Medical Workforce/Deputy Chief Medical Officer see paragraph 14.4) to the Trust Management Executive and Joint Local Negotiating Committee.

14. The **Director of Medical Workforce/Deputy Chief Medical Officer** is responsible for:

    14.1. ensuring the policy is applied equitably across the Trust and that the standards defined within the policy are met;

    14.2. liaising with the clinical manager and/or SAS doctor, where it escalated to them that the timescales set out in this policy are at risk of not being achieved;

    14.3. escalating to the Chief Medical Officer where the timescales set out in this policy have not been achieved, following their liaison with the clinical manager and/or the SAS doctor; and

    14.4. compiling an annual report including anonymised pay progression outcomes for all eligible SAS doctors by protected characteristics; and the number of mediation requests and appeals submitted in relation to a decision that the pay progression criteria have not been met.

15. The **Clinical Manager** (who will ordinarily be the Clinical Lead) is responsible for:

    15.1. arranging the pay progression review meeting within the timescales set out in this policy and confirming the date of the meeting (and if the meeting is re-arranged, the new date) to the Medical HR Advisory Team;

15.2. deciding each year that a pay threshold occurs whether the SAS doctor has met the pay progression criteria, documenting this on the Pay Progression Review Meeting Record and submitting the signed record to the Medical HR Advisory Team to action, copied to the SAS doctor for their records; and

15.3. identifying and discussing with the SAS doctor any problems affecting the likelihood of pay progression as they emerge, to allow time for possible solutions to be found.

16. The **SAS Doctor** is responsible for:

16.1. ensuring they are familiar with this policy and the pay progression criteria;

16.2. preparing information ahead of the pay progression review meeting to enable them to confirm that they have met the pay progression criteria, including completing and submitting the Pay Progression Self Declaration. Where not all pay progression criteria have been met, clarifying the reason(s) for this and if they were beyond their control.

16.3. engaging in the process and supporting the Clinical Manager in arranging the pay progression review meeting within the timescales set out in this policy; and

16.4. identifying and discussing with their Clinical Manager any problems affecting the likelihood of pay progression as they emerge, to allow time for possible solutions to be found.

17. The **HR Records Team** are responsible for processing all authorised Pay Progression Review Meeting Records and ensuring the record is uploaded to the SAS doctor's electronic personal record.

18. The **Workforce Information Team** are responsible for providing a monthly report to the Medical HR Advisory Team and relevant Divisional Workforce Team to confirm the SAS doctors due for pay progression within the next nine months.

19. The **Medical HR Advisory Team** is responsible for:

19.1. contacting the relevant clinical manager and SAS doctor by six months before the pay progression date, informing them of the doctor due for pay progression, providing them with a copy of this policy and the supporting documentation;

19.2. maintaining a record of pay progression review meeting dates provided by the clinical manager and monitoring submission of the completed and signed Pay Progression Review Meeting Records;

19.3. once received, ensuring the authorised Pay Progression Review Meeting Record is processed with sufficient time to enable pay progression to be effective from the SAS doctor's pay progression date;

19.4. where the clinical manager is unresponsive or the pay progression review meeting does not go ahead as anticipated, escalating the matter to the relevant Divisional Head of Workforce to raise with the Clinical Lead and Clinical Director; and

19.5. where a doctor holds a contract of employment with another NHS organisation and/or University in addition to the Trust, copying the outcome of their pay review to the relevant HR department.

20. The **Divisional Head of Workforce** is responsible for:

20.1. providing advice and guidance on pay progression in accordance with this Policy;

20.2. ensuring clinical managers are aware of their responsibilities regarding pay progression;

20.3. following notification by the Medical HR Advisory Team that a Clinical Manager is unresponsive or that the pay progression review meeting has not gone ahead as anticipated, raising this with the relevant Clinical Lead and Clinical Director; and

20.4. where the timescales set out in this policy are at risk of not being achieved, escalating the matter to the Director of Medical Workforce/Deputy Chief Medical Officer for intervention.

21. The **Clinical Director** is responsible for addressing any instances of non-compliance with this policy or the timescales set out in the policy with the relevant clinical manager and/or SAS doctor.

## Pay Progression

22. The pay progression process set out in this policy, along with the pay progression criteria, applies to any SAS doctor employed on 2021 Terms and Conditions (either Specialist or Speciality Doctor) who is due to progress to the next pay point which results in an increase in salary.

23. A progression process will be conducted between the SAS doctor and their clinical manager (normally their Clinical Lead) so that progression is achieved where the clinical manager is satisfied that the pay progression requirements have been met.

### Pay Progression Date

24. The **pay progression date** is the anniversary of the date the doctor first commenced employment in the speciality doctor or specialist grade.

24.1. For doctors appointed to the Terms and Conditions of Service Specialist – England (2021) from the existing national contracts for associate specialists, the pay progression date will be their existing incremental date.

24.2. For doctors appointed to the Terms and Conditions of Service Speciality Doctors – England (2021) from the existing national speciality doctor contract, the pay progression date will be their existing incremental date.

25. When changing roles within the same grade, whether at the same or different employer, the pay progression date remains unchanged provided there is no break in continuous service.

26. The new pay structure describes the minimum length of service on a pay point required before a doctor becomes eligible, provided the pay progression standards are met, to move to the next pay point.

### Pay Progression Criteria

27. The expectation is that all SAS doctors will meet the pay progression criteria and will therefore be able to progress on their pay progression date. Managers and doctors will be expected to identify problems affecting the likelihood of pay progression as they emerge to allow time for possible solutions to be found. The medical appraisal process should ensure that the required standards are understood, and additional support identified in good time.

28. The Trust's Core Skills Policy sets out the core skills requirements for all staff within the Trust. Details of and compliance with required core skills are recorded in the SAS doctor's individual record in the Trust's Learning Management System.

29. For the purposes of determining if the pay progression criteria have been met any formal warnings issued under the Sickness Absence Management Procedure are excluded.

30. Progression cannot be withheld due to financial or other non-performance related issues.

31. A 'disciplinary sanction' refers to sanctions in relation to conduct only, and excludes warnings applied in relation to absence due to ill health. It refers to formal disciplinary sanctions such as formal warnings issued under the Trust's Conduct and Expected Behaviours Procedure (which should be read in conjunction with the Trust's Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental

Practitioners Procedure). It does not include investigations, informal warnings, counselling or other informal activities.

32. If a disciplinary sanction is in place at the time of the pay progression date and is subsequently repealed, for example as a result of a successful appeal, the pay progression will be backdated to the pay progression date if all other requirements have been met.

33. A 'capability process' will be as set out in the Trust's Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure which applies Part 4 of Maintaining High Professional Standards (MHPS). 'Process' means that there has been an outcome following an investigation which places the employee in a formal capability process. Investigations, informal stages and processes for dealing with absence due to ill health are all excluded from this pay progression standard.

34. If a capability process is in place at the time of the pay progression date and is subsequently repealed, for example as a result of a successful appeal, the pay progression will be backdated to the pay progression date if all other requirements have been met

## Specialist

### Standard Pay Progression

35. Standard pay progression will require the specialist doctor having:

35.1. participated satisfactorily in the job planning process on a yearly basis (i.e. have a job plan fully approved for the current year and signed by all parties, or have a job plan for the current year in formal mediation, in accordance with the Job Planning Policy):

35.1.1. made every effort to meet the time and service commitments in their job plan and participated in the annual job plan review;

35.1.2. met the work related personal objectives in the job plan (or the appraisal where personal objectives are agreed as part of the appraisal process as opposed to the job planning process), or where this is not achieved for reasons beyond the specialist doctor's control, made every reasonable effort to do so;

35.1.3. worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives;

35.2. participated satisfactorily in the medical appraisal process on a yearly basis in accordance with the GMC's requirements set out in 'Good Medical Practice' where the outcomes are in line with organisational standards and objectives (i.e. the appraisal has been completed for the current year and signed off by all parties, or a letter has been issued by the Responsible Officer certifying that the missed appraisal is justified or excusable, in accordance with the Medical Revalidation and Appraisal Policy);

35.3. undertaken anonymous colleague and patient multi-source feedback (MSF) exercises since appointment/last progression and demonstrated learning from these results. This learning will be considered as having been completed where the doctor has articulated learning points from the exercise and can demonstrate their delivery;

35.4. performed a full audit cycle into a chosen aspect of their personal clinical practice and demonstrated any learning identified is being addressed. The audit will be chosen by the doctor and must be agreed with the Clinical Director as part of the job planning process;

35.5. demonstrated the ability to deliver learning to others by completion of either clinical supervisor or educational supervisor training and supervision; and/or delivery of a

minimum of one educational lecture/workshop relevant to area of practice to clinicians;

35.6. demonstrated yearly completion of the Trust's mandatory training (within the Trust this is referred to as core skills), or where this is not achieved for reasons beyond their control, made every reasonable effort to do so;

35.7. no formal capability process in place; and

35.8. no disciplinary sanction live on their record.

## Speciality

### Standard Pay Progression

36. Standard pay progression will require the speciality doctor having:

36.1. participated satisfactorily in the job planning process on a yearly basis (i.e. have a job plan fully approved for the current year and signed by all parties, or have a job plan for the current year in formal mediation, in accordance with the Job Planning Policy):

36.1.1. made every effort to meet the time and service commitments in their job plan and participated in the annual job plan review;

36.1.2. met the work related personal objectives in the job plan (or the appraisal where personal objectives are agreed as part of the appraisal process as opposed to the job planning process), or where this is not achieved for reasons beyond the doctor's control, made every reasonable effort to do so;

36.1.3. worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives;

36.2. participated satisfactorily in the medical appraisal process on a yearly basis in accordance with the GMC's requirements set out in 'Good Medical Practice' where the outcomes are in line with organisational standards and objectives (i.e. the appraisal has been completed for the current year and signed off by all parties, or a letter has been issued by the Responsible Officer certifying that the missed appraisal is justified or excusable, in accordance with the Medical Revalidation and Appraisal Policy);

36.3. demonstrated yearly completion of the Trust's mandatory training (within the Trust this is referred to as core skills), or where this is not achieved for reasons beyond their control, made every reasonable effort to do so;

36.4. no formal capability process in place; and

36.5. no disciplinary sanction live on their record.

### Higher Threshold

37. The criteria for passing through the higher threshold (to the top pay point) recognises the higher level of skills, experience and responsibility of those doctors working at that level. Doctors will pass through the higher threshold if they have met the criteria set out below:

37.1. the standard pay progression criteria in paragraph 36 and its associated sub-paragraphs have been met;

37.2. the doctor has demonstrated an increasing ability to take decisions and carry responsibility without direct supervision; and

37.3. the doctor has provided evidence to demonstrate their contribution to a wider role, for example, meaningful participation in or contribution to one or more of the following relevant domains:

37.3.1. management or leadership;

37.3.2. service development and modernisation;

37.3.3. teaching and training (of others);

37.3.4. committee work;

37.3.5. representative work;

37.3.6. quality improvement and/or innovation;

37.3.7. research; or

37.3.8. audit.

37.3.9. This list is not exhaustive but is intended to give an indication of the types of evidence of contributing to a wider role that a doctor could provide.

38. In making a judgement about whether a doctor has met the requirements for the higher threshold, there will not be an expectation that the doctor will be able to provide evidence in all wider areas of contribution listed and an overall picture will be considered.

39. The aim should be that doctors will acquire the skills and experience to allow them to meet the criteria for passing through the higher threshold, with appropriate support and development through job plan review, appraisal and Supporting Professional Activities.

## Pay Progression Process

40. The clinical manager will receive notification six months before a doctor's next pay progression date and must initiate a pay progression review meeting with the doctor. A minimum of one months' notice of the meeting will be given and the meeting should take place no later than two months prior to the SAS Doctor's next pay progression date. This allows sufficient time for the necessary payroll paperwork to be completed and actioned to apply the new pay values on time.

41. In advance of the meeting, the SAS doctor must complete a Pay Progression Self Declaration and forward this to their Clinical Manager no later than one week prior to the pay progression review meeting.

42. It is not necessary to schedule appraisals and job plan reviews to coincide with pay progression dates.

43. The purpose of the pay progression review meeting is to review whether the requirements for progression have been met. The meeting will draw on the most recent medical appraisal and job plan review and consider the pay progression criteria applicable to the doctor's grade (see the relevant Pay Progression Criteria section above).

44. There may be occasions where the pay progression criteria have not all been met, but there are mitigating factors. In these circumstances the Clinical Manager must consider whether the mitigating factors justify confirming pay progression or not. Advice should be sought from the appropriate Divisional Workforce Team or Medical HR Advisory Team as necessary.

45. The Pay Progression Review Meeting Record will document this process and should be signed by the clinical manager and SAS doctor before being submitted to Medical HR Advisory Team.

46. If it is determined that the pay progression criteria have not been met please refer to the Deferral of Pay Progression section for further information on the process to follow.

47. Where a doctor holds a contract of employment with another NHS organisation or the University in addition to the Trust, the outcome of their pay review meeting will be copied to the relevant HR department.

## Deferral of Pay Progression

48. It is expected that the doctor will achieve the required standards at the point of their pay progression date. Doctors should not be penalised if any element of the progression criteria have not been met for reasons beyond their control. Therefore, if the doctor has been prevented by any action or inaction on the part of the Trust from satisfying any element of the progression criteria, they will not be prevented from moving to the next pay point.

49. In situations where the required pay progression criteria have not been met, and there are no mitigating factors sufficient to justify this, it is expected that an individual's pay progression will be delayed for one year, subject to the arrangements outlined in paragraphs 51 and 52 below.

50. The clinical manager must use the pay progression review meeting to discuss the criteria that have not been met and review any previous discussions about these, consider any mitigating factors, and record their decision on the Pay Progression Review Meeting Record. The Record should be signed by the Clinical Manager and SAS doctor before being submitted to the Medical HR Advisory Team copied to the doctor.

51. The clinical manager should discuss and seek to agree a plan with the doctor for any remedial action needed to ensure that the required criteria for pay progression are met the following year, including a timescale, and how any training and support needs will be met. The doctor must take all necessary steps to meet the requirements, and the clinical manager must provide the necessary support.

52. A review meeting will be arranged with the SAS doctor, by their clinical manager no later than two months prior to the one-year anniversary of the pay progression date where a criterion or criteria had not been met. A minimum of one months' notice of the meeting will be provided. Provided that the SAS doctor has met the criteria in the intervening year, they will receive that pay point from that one-year anniversary date.

### Pay Progression and interaction with periods of absence

53. If a doctor is absent from work for reasons such as parental leave or sickness when pay progression is due, the principle of equal and fair treatment should be followed so that no detriment is suffered as a result.

54. In the case of planned long-term paid absence such as maternity, adoption or shared parental leave the pay progression review can be conducted early if this is reasonable and practical, allowing the pay progression to be applied on the SAS Doctor's pay progression date in their absence. If a pay progression review cannot be conducted prior to the pay progression date, pay progression should be automatically applied in the individual's absence from the pay progression date.

55. If there was a live disciplinary sanction in place at the point the member of staff went on leave which will still be live at the pay progression date, the 'Deferral of Pay Progression' process should be followed.

56. If there was an active formal capability process underway at the point the member of staff went on leave, the 'Deferral of Pay Progression' process should be followed.

## Appeals

57. A SAS Doctor has the right of appeal against a decision that they have not met the required pay progression criteria in respect of a given year. A mediation procedure and appeals procedure are set out in Appendix 2.

## Moving Employers

58. A SAS doctor's pay progression date will remain the same and move with them to the new employer.

59. If a doctor moves to a new employer shortly before pay progression is due, the new employer will be expected to carry out the review required, within three months of the date that the doctor begins work for the new employer.

60. If progression is granted, pay shall be backdated to the pay progression date. If such a review is not undertaken by the new employer within three months following the date of employment the provisions of paragraph 48 will apply.

## Training

61. There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual's training needs will be defined within their annual appraisal or job plan.

## Monitoring Compliance

62. Compliance with the policy will be monitored in the following ways:

| **Aspect of compliance or effectiveness being monitored** | **Monitoring method** | **Responsibility for monitoring (job title)** | **Frequency of monitoring** | **Group or Committee that will review the findings and monitor completion of any resulting action plan** |
|---|---|---|---|---|
| Number of mediation requests and appeals submitted in relation to a decision that pay progression has not been met. | Report | Director of Medical Workforce/Deputy Chief Medical Officer | Annual | Trust Management Executive |
| Anonymised pay outcomes for all eligible SAS doctors by protected characteristics. | Report | Director of Medical Workforce/Deputy Chief Medical Officer | Annual | Trust Management Executive and JLNC |



63. In addition to the monitoring arrangements described above, the Trust may undertake monitoring of this policy as a response to identification of any gaps or as a result of the identification of risks arising from the policy prompted by incident review, external reviews, or other sources of information and advice. This monitoring could include:

    63.1. commissioned audits and reviews;

    63.2. detailed data analysis; and/or

    63.3. other focused studies.

    63.4. Results of this monitoring will be reported to the nominated Committee.

## Review

64. This policy will be reviewed in three years, as set out in the Developing and Managing Policies and Procedural Documents Policy. It may need revising before this date, particularly if national guidance or local arrangements change.

65. Until such time as the review is completed and the successor document approved by the relevant committee this policy will remain valid.

## References

SAS 2021 pay progression system guidance | NHS Employers

SAS pay progression

Terms and Conditions of Service Speciality Doctors – England (2021)

Terms and Conditions of Service Specialist – England (2021)

## Equality Impact Assessment

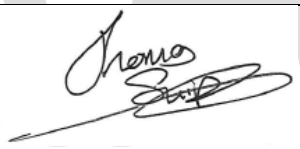
66. As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible, remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief. No detriment was identified. The completed Equality Impact Assessment can be found at **Appendix 1**.

## Document History

| Date of revision | Version number | Reason for review or update |
|---|---|---|
| September 2024 | 0.1 | New policy |
| | | |
| | | |

# Appendix 1 - Equality Impact Assessment

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | New Policy / Procedure |
| **Job title of staff member completing assessment** | Assistant Director of Workforce – Resourcing |
| **Name of policy / service / function:** | Specialist and Specialty (SAS) Doctor Pay Progression Policy |
| **Details about the policy / service / function** | This policy implements the 2021 amendments to pay progression arrangements for SAS Doctors as set out in the Terms and Conditions of Service Speciality Doctors – England (2021) and the Terms and Conditions of Service Specialist – England (2021) and sets out the process to be followed when a SAS Doctor reaches a pay point or threshold. |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | Yes |
| **Review Date** | 3 years |
| **Date assessment completed** | February 2025 |
| **Signature of staff member completing assessment** | Summer Lovegrove |
| **Signature of staff member approving assessment** |  |



## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**

- Staff

**Does the policy, service or function involve direct engagement with the target audience?**

Yes - *continue with full equality impact assessment*

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

## Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex** | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions – and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Gender Re-assignment** | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | reaching a pay threshold.<br><br>With regards to pay progression criteria not being met if the doctor has either a formal disciplinary sanction under the Conduct and Expected Behaviours Procedure (which should be read in conjunction with the Trust's Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure) or is in a formal capability process as set out in the Trust's Handling Concerns Relating to Conduct, Capability or Ill Health of Medical and Dental Practitioners Procedure, both of these procedures have been equality impact assessed separately and work has been undertaken to ensure equitable outcomes under these procedures. |
| **Disability** - disabled people and carers | | | X | | The policy sets out the steps to be followed if the member of staff is absent from work on a long term basis when a pay threshold is due to ensure the member of staff suffers no detriment as a result of their absence.<br><br>Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Age** | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Sexual Orientation** | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Religion or Belief** | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Pregnancy and Maternity** | X | | | | The policy sets out the steps to be followed if a member of staff is on maternity leave (or adoption or shared parental leave) at the time a pay threshold is due to ensure the member of staff suffers no detriment as a result of their absence. The pay progression criteria are as detailed in the Terms and Conditions –and will be applied consistently to all SAS doctors reaching a pay threshold. |
| **Marriage or Civil Partnership** | | | X | | Pay progression review meeting outcomes will be monitored by protected characteristic and the anonymised data shared with the relevant committee(s). The pay progression criteria are as detailed in the Terms and Conditions –and will |

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| | | | | | be applied consistently to all SAS doctors reaching a pay threshold. |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | | | |

### Sources of information

- SAS 2021 pay progression system guidance | NHS Employers
- SAS pay progression

### Consultation with protected groups

| Group | Summary of consultation |
|---|---|
| | |

### Consultation with others

Senior stakeholders and representatives of those in scope of this policy will have the opportunity to comment on the draft policy in advance of its approval by the Trust Board.

## 4. Summary stage

### Outcome Measures

Through implementation of this policy it is anticipated the following will be achieved:

- Transparent pay progression process for SAS Doctors who have reached a pay threshold,
- Process applied consistently across the Trust to all eligible SAS doctors; and
- Pay progression process is aligned with nationally agreed Terms and Conditions of Service Speciality Doctors – England (2021) and Terms and Conditions of Service Specialist – England (2021)

For staff who will be absent at the time of their pay threshold guidance is included on pay progression.

If at the time the pay threshold is due the SAS doctors does not meet the criteria for pay progression, they able to explain the reason(s) why the criteria have not been met, and if these are out of their control.

The policy also allows a doctor to request mediation or submit a formal appeal against a decision to defer pay progression which will allow the decision to be reviewed on up to two separate occasions by an independent third party/panel.

### Positive Impact

Pay progression will only occur when the SAS doctors has reached a pay threshold and can demonstrate they have met the pay progression criteria.

### Unjustifiable Adverse Effects

N/A

### Justifiable Adverse Effects

N/A

## Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

| Identified risk | Recommended actions | Lead | Resource implications | Review date | Completion date |
|---|---|---|---|---|---|
| | | | | | |

# Appendix 2 – Mediation and Appeals

1. Where it has not been possible to agree a job plan (including job plan reviews and interim reviews) or a doctor disputes a decision that they have not met the required criteria for a pay progression in respect of a given year, a mediation procedure and an appeal procedure are available.

2. Where a doctor is employed by more than one NHS organisation, mediation and appeals will be undertaken by the organisation where the issue arises.

## Mediation

3. The doctor may refer the matter to the Chief Medical Officer. The purpose of the referral will be to reach agreement if at all possible. The process will be that:

   3.1. The doctor makes the referral in writing within 10 working days of the disagreement arising;

   3.2. the doctor will set out the nature of the disagreement and their position or view on the matter including any supporting evidence. This should be provided in writing and normally within 15 working days of the referral being submitted;

   3.3. the process should be open and transparent, and any submissions should be shared no less than five working days in advance of the mediation meeting with all involved parties;

   3.4. the clinical manager responsible for the job plan review, or (as the case may be) for making the recommendation as to whether the criteria for pay progression have been met, will set out the employing organisation's position or view on the matter. This should be provided in writing and normally within 15 working days of the referral being received;

   3.5. the Chief Medical Officer or their nominated deputy will convene a meeting, normally within 20 working days of receipt of the referral, with the doctor and the responsible clinical manager to discuss the disagreement and to hear their views;

   3.6. if agreement is not reached at this meeting, then within 10 working days the Chief Medical Officer or their nominated deputy will decide the matter and shall notify the doctor and the responsible clinical manager of that decision or recommendation in writing;

   3.7. if the doctor is not satisfied with the outcome, they may lodge a formal appeal in accordance with paragraph 5 below.

## Formal Appeal

4. A formal appeal panel will be convened only where it has not been possible to resolve the disagreement using the mediation process. A formal appeal will be heard by a panel under the procedure set out below.

5. An appeal shall be lodged by the doctor in writing to the Chief Executive Officer as soon as possible, and in any event, within 10 working days of receipt by the doctor of the decision.

6. The appeal should set out the points in dispute and the reasons for the appeal. The Chief Executive Officer will, on receipt of a written appeal, convene an appeal panel to meet within six calendar weeks of the appeal.

7. The membership of the panel will be:

   7.1. A Chair, being a Non-executive Director/Independent Member, or other independent member (for example, a governor);

7.2. A second panel member nominated by the appellant doctor; preferably from within the same grade at an equivalent or more senior level; and

7.3. An Executive Director or nominated deputy from the appellant's employing organisation.

No member of the panel should have previously been involved in the dispute.

8. The parties to the dispute will submit their written statements of case to the appeal panel and to the other party no less than five working days before the appeal hearing. The appeal panel will hear oral submissions on the day of the hearing. Following the provision of the written statements neither party shall introduce new (previously undisclosed) written information to the panel. A representative from the employing organisation will present its case first.

9. The doctor may present their own case in person, or be assisted by a work colleague or trade union or professional organisation representative, but legal representatives acting in a professional capacity are not permitted.

10. Where the doctor, the employer or the panel requires it, the appeals panel may hear expert advice on matters specific to a speciality or to the subject of the appeal.

11. It is expected that the appeal hearing will last no more than one day.

12. The decision of the panel will be binding on both the doctor and the employing organisation. The decision shall be recorded in writing and provided to both parties no later than 15 working days from the date of the appeal hearing.

13. The decision of the panel will be implemented in full as soon as is practicable and normally within 20 working days.

14. No disputed element of the job plan will be implemented unless and until it is confirmed by the outcome of the appeals process and where appropriate a revised job plan is issued.

15. Where a decision has been made that alters the job plan and therefore the salary of the appellant doctor, the following will apply:

15.1. A decision which increases the salary or pay which the appellant doctor will receive will have effect from the date on which the doctor first referred the matter to mediation

15.2. A decision which reduces salary or pay will have effect from a date after the revised job plan is offered to the doctor following the decision of the panel at either the mediation meeting or the appeals hearing (subject to any local period of notice).

## 19.2 INTEGRATED ASSURANCE COMMITTEE REPORT

### REFERENCES

Only PDFs are attached

18b TB2025.87 Integrated Assurance Committee Report.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

## Trust Board Meeting in Public: Wednesday 10 September 2025

**TB2025.87**

| | |
|---|---|
| **Title:** | **Integrated Assurance Committee Report** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **Regular Reporting** |

| | |
|---|---|
| **Board Lead:** | **Committee Chair** |
| **Author:** | **Neil Scotchmer, Head of Corporate Governance** |
| **Confidential:** | **No** |
| **Key Purpose:** | Assurance |

# Integrated Assurance Committee Report

## 1. Purpose

1.1. As a Committee of the Trust Board, the Integrated Assurance Committee provides a regular report to the Board on the main issues raised and discussed at its meetings.

1.2. Since the last report to the Board held in public, the Integrated Assurance Committee has met on 13 August 2025.

1.3. Under its terms of reference, the Integrated Assurance Committee is responsible for reporting to the Board items discussed, actions agreed and issues to be referred to the Board, indicating the extent to which the Committee was able to take assurance from the evidence provided and where additional information was required.

## 2. Key Areas of Discussion

### Corporate Risk Register (CRR) and Emerging Risks

2.1. A review of the Corporate Risk Register takes place at the start of each meeting. This allows members to seek assurance on specific risks and to provide a baseline for Committee discussion.

2.2. The Committee discussed workforce risks and agreed that the risk description and scoring for the current risk entry on headcount reduction should be refined for clarity and emphasis.

2.3. The Committee considered in particular risks associated with the delivery of clinical trials and noted that an improvement was needed in recruiting to time and target to avoid risks to commercial research income and the top-slicing of infrastructure funding.

2.4. The actions being taken to strengthen governance, improve processes, and review the Joint Research Office (JRO) with the University of Oxford for better integration and responsiveness were described. It was agreed that further assurance would be brought to the Committee regarding these issues.

### Patient Care

2.5. The Committee reviewed the Maternity Performance Dashboard. It noted an improvement in Venous Thromboembolism (VTE) risk assessment compliance, which was over 90%, following the work of a multidisciplinary task and finish group. The ongoing commitment to improving patient experience was stressed, with positive feedback rates of between 80–88% and a focus on addressing inequalities and accessibility through data analysis. An update was provided on efforts to improve telephone and in-person triage. Improvements in post-partum

haemorrhage (PPH) and third-degree tear figures were commended. The Committee discussed patient safety incidents and the Trust's reporting culture and suggested that some of the language in the dashboard might be simplified for clarity to assist with staff and public engagement in future reporting.

2.6. The Committee reviewed an Involvement and Engagement Strategy and Plan which aimed to rebuild trust in its Maternity services following concerns raised. Key objectives included acknowledging harm, delivering sincere apologies, ensuring safe and compassionate engagement, and rebuilding trust through transparency. An independent facilitator was to be appointed, and support resources would be provided to ensure emotionally safe forums for both staff and families. The engagement work would require a financial investment and there would be a need to reprioritise strategic expenditure. The Committee endorsed the engagement workstreams and the monitoring and evaluation framework.

2.7. An overview of harm reduction efforts across the Trust was provided to the Committee, focusing on Hospital-Acquired Pressure Ulcers (HAPUs) and inpatient falls. It synthesised three years of performance data, clinical audit findings, and quality improvement initiatives to inform assurance. The review identified challenges, evaluated the impact of interventions, and proposed recommendations to strengthen governance, accountability, and patient safety outcomes. The Committee saw evidence that work on falls prevention was proving effective with a year-on-year decline. Data on HAPUs was less clear and a new assessment tool was to be implemented with the benchmarks reviewed.

**Annual Workforce Plan Profiling**

2.8. The Committee received an update on plans for workforce reduction, establishment controls, and vacancy control. It recognised that progress had been made towards the target of achieving a financially sustainable workforce but that a gap still remained. Plans to close this gap were outlined to the Committee.

2.9. Assurance was provided regarding the vacancy control processes which were now fully embedded, with strengthened governance, mandatory rota reviews, revised pay panel approvals.

2.10. The need to target reductions appropriately to ensure that critical posts were preserved and that opportunities associated with additional income were not lost. However, it was also recognised that projected increases in workforce later in the year needed to be reviewed.

2.11. Divisions also provided updates on their individual workforce plans to the Committee.

2.12. The need to ensure that decisions were aligned with strategic priorities and operational needs was highlighted and regular updates were to be provided to the Committee and Board.

**Integrated Performance Report**

2.13. The Committee received its regular report based on key metrics in relation to operational performance, quality, workforce, finance and digital and also had access to a link to the new Core Metrics Dashboard for which a detailed walkthrough was provided at a subsequent deep dive.

2.14. Discussion focussed in particular on an overview of current performance against the core cancer standards.

**Financial Reporting**

2.15. The Committee was updated on the financial position at M3 which showed that the Trust was on plan and in a stronger position than at the same point in the previous year. A challenge was noted in relation to non-pay spend and further analysis was underway to identify the main drivers. The need also to continue to maintain robust controls on workforce numbers was recognised.

2.16. It was noted that underdelivery of divisional efficiency targets was being balanced by non-recurrent savings. The Committee considered the approach to taking corrective action to address this at an earlier stage than in previous years. Divisions were being asked to prepare rectification plans and a package of possible actions was to be prepared for consideration by the Board.

2.17. An updated cash forecast was also provided to the Committee and noted an improvement in the August position and that the outlook for September and October now appeared positive.

**FOI Backlog Remediation Plan**

2.18. The Committee received an updated on work to address the Freedom of Information request backlog which had been significantly reduced after a review of historic requests. The remaining backlog was being cleared with additional temporary staff and new policies were being implemented to manage ongoing FOI requests.

**Oxfordshire Place-Based Partnership Update**

2.19. The Acting Chief Executive updated the Committee on changes to the Oxfordshire Place Based Partnership Board since August 2024 and the current context for the Oxfordshire Place Based Partnership Board.

**Guardian of Safe Working Report**

2.20. The quarterly report on Safe Working Hours from the independent guardian was received with aim of providing context and assurance around safe working hours

for OUH resident doctors. The Committee noted that a deep dive on resident doctor experience had been scheduled for the October meeting. The desirability of a holistic approach to consider workforce data, rostering information and the resident doctor experience was highlighted.

**Industrial Action**

2.21. The Committee was provided with an overview of the impact of recent industrial action by resident doctors, noting that a lessons learned exercise was being undertaken. It heard that the organisation had managed the impact relatively well, maintaining service safety and patient care and with reduced cancellation of activities compared with previous industrial action though with the full impact on activity and finances to be confirmed.

**Other Reporting**

2.22. The following regular reports were received by the Committee:

- A quarterly update on progress on Quality Priorities;
- A summary of the July 2025 meeting of the Trust's Delivery Committee;
- A summary of M2 Divisional Performance Reviews; and
- The Patient Safety Incident Response Framework Report for the period May and June 2025.

## 3. Recommendations

3.1. The Trust Board is asked to:

- **note** the Integrated Assurance Committee's report to the Board from its meeting held on 13 August 2025.

# 19.3 CONSULTANT APPOINTMENTS AND SEALING OF DOCUMENTS

## REFERENCES

Only PDFs are attached

18c TB2025.88 Consultant Appointments Signing and Sealing Report.pdf

Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

## Trust Board Meeting in Public: Wednesday 10 September 2025

## TB2025.88

| | |
|---|---|
| **Title:** | **Consultant Appointments and Signing of Documents** |

| | |
|---|---|
| **Status:** | **For Information** |
| **History:** | **This is a regular report to the Board** |

| | |
|---|---|
| **Board Lead:** | **Acting Chief Executive Officer** |
| **Author:** | **Laura Lauer, Deputy Head of Corporate Governance** |
| **Confidential:** | **No** |
| **Key Purpose:** | **Assurance** |

# Consultant Appointments and Signing of Documents

## 1. Advisory Appointments Committee Appointments

1.1. The Board is asked to note that Advisory Appointments Committees, under delegated authority of the Chief Executive, have appointed the following Medical Consultants:

| Date | Chaired by | Name | Specialty/ Department | Mentor Name |
|---|---|---|---|---|
| 27/07/2025 | Claire Feehily | Ruth Ting | Palliative Medicine | Tim Harrison |
| 27/07/2025 | Claire Feehily | Fiona Lindsay | Palliative Medicine | Mary Miller |
| 27/07/2025 | Claire Feehily | Keaton Jones | HPB Surgery | Mike Silva |
| 04/08/2025 | Joy Warmington | Olga Tatarinova | Haemostasis | Beth Psaila |
| 04/08/2025 | Joy Warmington | Nervine Elmeshad | Ophthalmology | Manoj Parulekar |
| 04/08/2025 | Joy Warmington | Sanil Shah | Ophthalmology | Manoj Parulekar |
| 15/08/2025 | Katie Kapernaros | Louise Bovijn | Dermatology | John Reed |
| 15/08/2025 | Katie Kapernaros | Christopher Phillips | Dermatology | Charlie Archer |
| 22/08/2025 | Katie Kapernaros | Claire Sethu | Plastic Surgery | Alex Ramsden and Sarah Tucker |
| 22/08/2025 | Katie Kapernaros | Mohammed Zeeshan Zameer | Medical Oncology | Elizabeth Smyth |

## 2. Signing and Sealing of Documents

2.1. Documents which are a necessary step in legal proceedings on behalf of the Trust should also, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any executive / non-executive director. The signing of such documents will also be reported to the Board.

2.2. This table below reports to the Board on documents to which the Trust seal has been applied.

| Date | Description of document | Name of Director/s signing |
|---|---|---|
| 18/07/2025 | Underlease of Part of the Fourth Floor, Great Western Hospital, Marlborough Road, Swindon SN3 6BB<br>(1) Great Western Hospitals NHS Foundation Trust<br>(2) Oxford University Hospitals NHS Foundation Trust | Felicity Taylor-Drewe and Yvonne Christley |
| 18/07/2025 | Leas of Ground Floor Premises at Rose Hill Community Centre, Oxford<br>(1) Oxford City Council<br>(2) Oxford University Hospitals NHS Foundation Trust | Felicity Taylor-Drewe and Yvonne Christley |

## 3. Recommendations

3.1. The Trust Board is asked to note the Medical Consultant appointments made by Advisory Appointment Committees under delegated authority and to note the signings that have been undertaken in line with the Trust's Standing Orders since the last report to the Trust Board at its meeting on Wednesday 9 July 2025.

## 20. ANY OTHER BUSINESS

## 21. DATE OF NEXT MEETING WEDNESDAY 12 NOVEMBER 2025