Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M12 (March data)

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 12 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 Partn*erships.* Within our key priorities for our people and financial performance, we set a plan to reduce temporary staffing by 700 by the end of Q2. The plan was set in agreement with the Integrated Care Board (ICB) and NHSE. By the end of Month 12 (March) £24.1m has been saved on temporary staffing against a £35m target. The WTE reduction for this achieved at M12 was 360 WTE against a plan of 700 WTE and a forecast of 350 WTE. The potential effect on patient care is carefully evaluated by Pay Panels led by Chief Officers and incorporate Quality Impact Assessments (QIAs).

We achieved key measures related to patient safety and care experience, including the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI), which show fewer patient deaths than expected. We also met targets in VTE Risk Assessments which support high quality patient care, NICE guidelines for timely antibiotics in ED, and did not record any Never Events.

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 both adults and children (L1-L3) was achieved.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In January, we met targets for non-medical appraisals and core skills training, demonstrating commitment to staff development. 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 12-month rolling sickness absence rate was lower than the National and Shelford averages, and the third lowest within the Integrated Care System (ICS). Turnover rates also performed better than targets and exhibited improving SCV. The Vacancy rate was better than the performance threshold but exhibited deteriorating SCV. This was expected because of the recruitment pause. An exception process for essential posts is in place and is regularly reviewed.

The Cancer Faster Diagnosis standard measures the percentage of patients diagnosed or who have cancer ruled out within 28 days of being referred. It is an important indicator to show that patients receive a diagnosis as soon as possible, which can improve clinical outcomes, or provide peace of mind when cancer can be ruled out. Performance was 79.2% and better than the national target and our operational target of 77.0%.

Income and Expenditure (I&E) was a £6.8m deficit to Month 12, £6.5m worse than plan but in line with the reforecast deficit, of £9.3m, adjusted by a further £2.5m for additional income received. The underlying deficit was £76.95m and the underlying deficit for the month was £1.4m worse than last month, at £10.4m. This was driven by underlying pay (a £1.1m increase in month). Overall worked WTE (excluding R&D) increased by 49 WTE in March, however substantive worked WTE decreased by 14.

Cash was £12.5m at the end of March, £7.6m higher than the previous month. The forecast is indicating the cash position into quarter 1 of 2025/26 is at risk with the Trust actively managing converting debtors to cash and prioritising staff and supplier payments as far as possible. This has become increasingly challenging and the 2025/26 cash plan demonstrates that external support will be required during the year. The Trust delivered the year end position through significant one-off benefits. The underlying deficit reached totals £76.95m for the year.

Of the 107 indicators currently measured in the IPR, 35 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

- Medication incidents causing harm
- Number of complaints
- Reactivated complaints
- ED FFT and Maternity FFT
- PFI: % cleaning score by site (average) NOC
- FFT's likely to recommend: IP
- Time to Hire
- Vacancy Rate
- RTT standard: >52-week incomplete pathways
- % Diagnostic waits under 6 weeks
- 62-day Cancer standard: incomplete pathway >62 days
- Information Governance and Data Security training

Common cause variation and missed target

- C. Diff Cases: HOHA + COHA
- Stillbirths per 1,000 live births
- Pressure ulceration per 10,000 bed days (Cat 3)
- Midwife ratios
- FFT's likely to recommend: OP and ED
- Sickness and absence rate (in month)
- Cancer 31-day combined Standard
- Cancer 62-day combined Standard
- Proportion of patients spending more than 12hrs in ED
- ED 4hr Performance – Type 1 and ALL
- Data Subject Access Requests (DSAR)
- Freedom of Information (FOI) % responded within target

Special cause variation – improving

- % of complaints responded to within 25 working days
- RTT standard: >65-week and >78-week incomplete pathways
- RTT patients > 78 weeks and > 65 weeks
- % Outpatient firsts and follow-up attendances (procedures)

Other*

- Non-Thematic Patient Safety Incident Investigations

**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)*

Healthcare-associated infection (HSC): In March 2025, there were increases in C. difficile and MSSA cases, while MRSA cases remained stable. Challenges include staffing issues and antibiotic use. Actions to address these issues include recruitment of a substantive Lead Nurse/Manager and decolonisation procedures .

Non-Thematic Patient Safety Incident Investigations: A new patient safety incident investigation was confirmed in March and 57% of actions were overdue. Actions to address risks include completing investigations, reducing meeting times, and training more staff.

Medication Incidents Causing Harm: There was a peak triggering SCV in medication incidents causing harm in March, particularly related to Foslevodopa-foscarbidopa. The service is not currently able to support the increased activity required to deliver this treatment. Actions include a service review (as requested by the Business Planning Group) and a business case to support the administration.

Complaints Performance: The Trust responded to 67% of complaints within target time in March, an improvement of 23 percentage points since December 2024. This improvement is in the context of a growing number of complaints received. Actions to improve complains response times include reviewing performance weekly and examining complaints through the Power BI Complaints dashboard and the breach report.

Friends & Family Test (FFT): The overall Trust performance for March was 91.6%. The main negative themes were waiting list, discharge, and ED waiting times. Actions to address these include improving survey question ratings, continuous monitoring of FFT data, creating a maternity-specific FFT poster, and discussions around FFT data.

Pressure Ulceration: Reports on pressure ulcer incidents per 10,000 beddays show a common cause variation. Under Divisional oversight, clinical areas are reviewing incidents using the PSIRF approach to improve care planning and delivery. Early indicators suggest a 20% reduction in reported Hospital Acquired Pressure Ulcers (HAPUs) for 2024/25 compared to 2023/24.

Stillbirths: There were 5 deaths for each 1,000 live births in March 2025, above the threshold of 4. All cases have undergone initial review and no immediate learning and/or safety concerns have been identified. None of the deaths met the criteria for Maternity and Newborn Safety Investigation (MNSI).

Midwife Ratios: There was 23.8 births per midwife in March 2025, above the target of 22.9. Actions to address risks include a robust recruitment and retention plan, uplift and retention strategies, optimizing rostering, and reducing NHS spend.

PFI Score: At the NOC site, the combined PFI cleaning score was 95.6%, with 90% of audits achieving 4 or 5 stars. The actions being taken are addressing failed audits, improving reporting, and collaborating with Infection Prevention and Control (IPC) and ward/department leads. The Trust PFI management team oversees these plans, with progress monitored by domestic supervisors.

Sickness Rate: In March, the sickness absence rate remained at 4.2%, primarily due to a reduction in flu-like symptoms. The team has implemented several actions to address sickness absence, including focusing on top CSUs, collaborative work with Occupational Health, targeted support for managers, and ongoing reviews of sickness absence management training content.

Time to Hire: The average time to hire new staff has increased to 57 days, primarily due to a recruitment pause. The team is aiding divisions with proper vacancy procedures, supporting divisional activities, and reviewing hiring data. Actions include meetings with recruitment leads, streamlining workflows, and rolling out a new escalation process to support recruitment coordinators.

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Oxford University Hospitals NHS Foundation Trust

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Emergency Department Performance: The ED 4-hour performance for all types was 68.45% in March for the Trust overall. Type 1 performance was 59.8%. Challenges include increased ambulance conveyance rates and high ED attendances. Actions to address these issues include recruitment drives, process visualization, and enhanced training.

12-Hour Emergency Department Stays: The proportion of patients staying over 12 hours in the ED was 3.5% in March, above the target. Bed occupancy overall remains high at 95%, with the JR at 97.7% and the Horton at 88.3%. The proportion of patients with delayed discharges was at its lowest in March at 7.3%. The Trust has made consistent improvements in reducing bed occupancy since December. Plans for additional minimal impact on planned care are in place and a new Board Round Policy published to support patient flow.

Diagnostic Waits: The percentage of diagnostic waits over six weeks was 23.8% in March. Challenges include capacity shortages in audiology, endoscopy, neurophysiology, and ultrasound. Actions to address these issues include recruiting additional clinicians, implementing clinical triage, and exploring solutions with another supplier

RTT Wait for 52-Week and 65-Week Incomplete Pathways: The number of patients waiting more than 52 weeks for consultant-led treatment was 2,711 of which 63 are over 65 weeks at the end of March and exhibited deteriorating special cause variation. Challenges include capacity issues in ENT, Urology, and Orthopaedics. Actions taken are insourcing capacity, mutual aid, and patient engagement validation.

RTT Standard of >78-Week Incomplete Pathways: Teams are working to reduce the longest waiting patients on the waiting list. Challenges include capacity issues and system-wide plans. Actions to address these issues include load balancing across BOB and monitoring through Tier 1 meetings.

Cancer Care Performance: Cancer performance against the 62-day combined standard was 55.0% in February 2025, below the performance target of 70%. Challenges include complex patients, capacity issues, late inter-provider transfers, and patient reasons. Actions taken include the relaunch of the Cancer Improvement Programme and targeted improvements in various cancer pathways.

Outpatient Activity: The percentage of first new outpatient and follow-up outpatient appointments with procedures was 44.9% in March. Challenges include delayed completion of outcome forms and the possibility of procedures being carried out in theatres instead of outpatient settings. Actions to address these issues include evaluating individual specialties to optimize procedures and implementing new programs like the Further Faster Programme cohort 3 and Clinic e-Outcome Form piloting in Orthopaedics.

Freedom of Information (FOI) Performance: FOI performance against the 80% target remained below 57%, with 70 valid cases out of 44 closed on time. Actions include meetings with the IG team, an Improvement Plan, an escalation process, benchmarking with other trusts, and staff education.

Data Subject Access Requests (DSAR): DSAR performance improved slightly, with a recent trend of 70%. The Subject Access Team consistently meets monthly case targets despite high clinical pressures.

Digital Training Compliance: Compliance rates for DSPT and IG training vary across divisions. Some divisions are close to full compliance, while others have significant non-compliant staff

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 • C. Diff Cases: HOHA + COHA • Stillbirths per 1,000 live births • Pressure ulceration incidents per 10,000 bed days (Cat 3) • Midwife ratios • FFT's likely to recommend: OP and ED	Not achieving target • % of complaints responded to within 25 working days	Not achieving target • FFT % positive IP • Inpatient FFT response • ED FFT and Maternity FFT • PFI: % cleaning score by site (average) NOC • FFT's likely to recommend: IP Not achieving target • Medication incidents causing harm • Number of complaints • Reactivated complaints	No target • Adult safeguarding activity • Adult& Children safeguarding activity No SPC Not achieving threshold • Non-thematic Patient Safety Incident Investigations
Growing Stronger Together	Not achieving target • Sickness and absence rate (in month) • Sickness and absence rate (rolling 12 months)		Not achieving target • Time to Hire (average days) • Vacancy Rate	
Operational performance	Not achieving target • Cancer 62-day combined Standard (2ww, Consultant upgrade and Screening) • Cancer 31-day combined Standard (First and all Subsequent Treatments) • ED 4-hour performance (type-1) • ED 4-hour performance All • Proportion of patients spending more than 12 hrs in ED	Not achieving target • % Outpatient activity: first (all) and follow-up procedures Not Achieving target • RTT patients > 78 weeks • RTT patients > 65 weeks	Not achieving target Not achieving target • % Diagnostic waits under 6 weeks • RTT standard: >52-week incomplete pathways • 62-day Cancer Standard: >62 days	
Corporate Support Services	Not achieving target • Data Subject Access Requests (DSAR) • Freedom of Information % responded to within target time	Not achieving target • Efficiency Delivery £'000 • In-month financial performance Surplus/Deficit £'000 • Elective recovery funding (ERF) value-weighted activity % in month	Not achieving target • Information Governance and Data Security Training • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % • Cash £'000 • Year-to-date financial performance surplus/Deficit £'000	No SPC Not achieving threshold

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Quality, Safety and Patient Experience Summary: All
Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Mar-25	0.0	-	-	0.2	-0.5	0.8
MRSA cases: HOHA+COHA	Mar-25	0	0		1	-1	3
C-diff cases: HOHA+COHA per 10,000 beddays	Mar-25	3.7	-	-	3.6	0.3	6.8
C-diff cases: HOHA+COHA	Mar-25	12	10	No	12	1	22
MSSA cases: HOHA+COHA	Mar-25	2	-	-	6	-1	12
Number of Never Events	Mar-25	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Mar-25	1	0	No	2	-	-
VTE- Submitted performance	Mar-25	98.3%	95.0%		98.0%	97.6%	98.4%
% of emergency admissions 65yrs + receiving cognitive screen	Mar-25	65.6%	-	-	57.9%	50.2%	65.6%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Feb-25	93.3%	90.0%		90.6%	-	-
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Mar-25	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Mar-25	11	-	-	2	-2	7
Hospital Standardised Mortality ratio	Mar-25	99.3	100.0		93.4	-	-
Summary Hospital-level Mortality Indicator	Mar-25	90.0	100.0		92.0	-	-
Neonatal deaths per 1,000 total live births	Mar-25	2.3	3.2		3.3	-1.4	8.0
Stillbirths per 1,000 total Live births	Mar-25	5.1	4.0	No	4.0	0.5	7.4
National Patient Safety Alerts not completed by deadline	Mar-25	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Mar-25	0.0	-	-	0.0	0.0	0.0
Number of active clinical research studies hosted	Mar-25	2829	-	-	1422	1275	1569
Number of active clinical research studies (commercial)	Mar-25	781	-	-	381	336	426
Number of active clinical research studies (non commercial)	Mar-25	2048	-	-	1041	937	1145
Number of incidents with moderate harm or above per 10,000 beddays	Mar-25	43.8	-	-	42.2	26.3	58.2
Number of patient incidents with moderate harm or above per 10,000 beddays	Mar-25	38.7	-	-	37.8	21.5	54.1
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Mar-25	5.2	-	-	4.4	-2.2	11.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Mar-25	16.4	19.0		21.5	10.2	32.8
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Mar-25	2.4	2.0	No	2.2	0.5	4.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Mar-25	0.0	0.0		0.1	-0.2	0.4
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Mar-25	103.5	-	-	98.8	71.3	126.2
Patient falls (moderate and above) as reported on Ulysses	Mar-25	3	-	-	4	-2	11
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Mar-25	0.9	-	-	1.3	-0.8	3.4

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: Mar-2025

Health and Safety related incidents - Assault, Aggression and harassment	Mar-25	232	-	-	159	85	233
Adult safeguarding activity	Mar-25	1451	-	-	942	629	1255
Children's safeguarding activity	Mar-25	898	-	-	627	326	929
Adult safeguarding activity and Children's safeguarding activity	Mar-25	2349	-	-	1569	1072	2067
Safeguarding (Children) training compliance L1 - L3	Mar-25	90.0%	90.0%		88.4%	83.3%	93.4%
Safeguarding (Adults) training compliance L1 - L3	Mar-25	90.0%	90.0%		41.1%	32.4%	49.8%
Total Deliveries in month	Mar-25	605	625	-	614	541	687
Babies born	Mar-25	616	-	-	623	551	695
Maternity Bookings (planned + unplanned)	Mar-25	670	750	-	706	543	868
Inductions of labour from iView	Mar-25	145	-	-	141	104	177
Midwife Ratios (birth rate / staffing level)	Mar-25	23.8	22.9	No	25.7	21.5	29.8
Learning MDT Reviews presented at SLIC	Mar-25	2	-	-	3	-	-
After Action Review (AAR)	Mar-25	17	-	-	14	-	-
Number of complaints	Mar-25	186	-	-	114	61	167
Number of complaints per 10,000 beddays	Mar-25	56.6	-	-	35.7	21.1	50.3
Reactivated complaints	Mar-25	22	1	No	10	2	19
% of complaints responded to within 25 working days	Mar-25	67.2%	85.0%	No	44.8%	24.5%	65.1%
Number of RIDDORs	Mar-25	5	5		5	0	9
Friends & Family test % likely to recommend - IP	Mar-25	93.5%	95.0%	No	95.0%	93.7%	96.3%
Friends & Family test % likely to recommend - OP	Mar-25	93.1%	95.0%	No	93.8%	92.9%	94.6%
Friends & Family test % likely to recommend - ED	Mar-25	74.9%	85.0%	No	78.9%	72.6%	85.1%
FFT maternity % positive (births)	Mar-25	92.3%	90.0%		69.8%	41.5%	98.0%
Inpatient FFT (Response Rate)	Mar-25	21.7%	-	-	24.7%	21.3%	28.2%
Outpatient FFT (response rate)	Mar-25	10.0%	-	-	8.1%	6.1%	10.0%
ED FFT (Response Rate)	Mar-25	15.6%	-	-	22.8%	17.7%	27.9%
Maternity FFT (response rate; births)	Mar-25	2.7%	-	-	8.9%	1.3%	16.4%
PFI: % of total audits completed that achieved 4 or 5 stars JR	Mar-25	96.0%	95.0%		93.2%	83.8%	102.6%
PFI: % of total audits completed that achieved 4 or 5 stars CH	Mar-25	97.3%	95.0%		94.3%	83.7%	105.0%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	Mar-25	90.0%	95.0%	No	96.2%	89.3%	103.1%
Incident rate of violence and aggression (rate per 10,000 beddays)	Mar-25	70.6	-	-	49.7	28.8	70.7
Trust level: CHPPD vs budget	Mar-25	-1.4	-	-	-18.4	-69.0	32.2
Trust level: CHPPD vs required	Mar-25	-9.5	-	-	-6.6	-26.2	13.1

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

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Mar-25	-10395.0	-	-	-4712.2	-7578.1	-1846.3
BPPC £ %	Mar-25	67.6%	95.0%	No	83.3%	77.4%	89.2%
BPPC Volume %	Mar-25	45.7%	95.0%	No	68.9%	62.3%	75.6%
Cash £'000	Mar-25	12456	14354	No	30022	8139	51906
Efficiency delivery £'000	Mar-25	9692.6	14201.0	No	5839.5	-448.7	12127.7
Elective recovery funding (ERF) value-weighted activity % In month	Feb-25	103.9%	107.0%	No	101.9%	91.4%	112.3%
In-month financial performance Surplus/Deficit £'000	Mar-25	21896.7	5013.6		-485.0	-11649.0	10679.1
In-month ICS CDEL capital expenditure	Mar-25	28839.9	3535.0	-	3477.0	-6100.0	13054.0
Year-to-date financial performance Surplus/Deficit £'000	Mar-25	-6795.8	-8100.0		-15382.5	-25625.0	-5140.1

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)
Operational Performance Summary: All

Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Patients whose operations cancelled for non-clinical reasons nc offered another binding date within 28 days	Mar-25	14.3%	-	-	12.6%	-13.5%	38.7%
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	Mar-25	0.2%	-	-	0.4%	0.2%	0.6%
Proportion of ambulance arrivals delayed over 30 minutes	Feb-25	8.3%	-	-	9.2%	4.9%	13.4%
Proportion of ambulance arrivals delayed over 60 minutes	Feb-25	0.5%	-	-	1.0%	-0.1%	2.1%
ED 4Hr perfromance - All	Mar-25	68.4%	78.0%	No	66.7%	58.5%	74.8%
ED 4Hr perfromance - Type 1	Mar-25	59.8%	73.6%	No	59.8%	50.9%	68.8%
Proportion of patients spending more than 12 hours in an emergency department	Mar-25	3.6%	2.0%	No	4.8%	2.6%	7.0%
Proportion of patients discharged from hospital to their usual place of residence	Mar-25	95.6%	-	-	95.1%	94.3%	96.0%
% Diagnostic waits waiting 6 weeks or more	Mar-25	23.7%	5.0%	No	16.4%	11.9%	21.0%
RTT standard: >52-week incomplete pathways	Mar-25	2711	-	-	2745	2385	3104
RTT standard: >65-week incomplete pathways	Mar-25	63	0	No	694	441	946
RTT standard: >78-week incomplete pathways	Mar-25	15	0	No	131	59	203
RTT standard: >104-week incomplete pathways	Mar-25	0	0		7	0	13
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Feb-25	55.0%	70.0%	No	62.1%	55.4%	68.8%
62-day Cancer standard: incomplete pathways >62-days	Mar-25	340	-	-	337	261	412
62-day Cancer standard: incomplete pathways >104-days	Mar-25	102	-	-	107	76	138
Inpatient Daycase activity vs 2019/20	Mar-25	93.5%	-	-	92.0%	78.1%	105.9%
Inpatient Elective activity vs 2019/20	Mar-25	92.6%	-	-	86.9%	64.8%	109.0%
Outpatient First Attendance activity vs 2019/20	Mar-25	107.3%	-	-	107.4%	87.1%	127.8%
Outpatient Follow Up Attendance activity vs 2019/20	Mar-25	129.2%	-	-	120.1%	99.7%	140.4%
Diagnostic activity vs 2019/20	Mar-25	139.4%	-	-	123.5%	111.3%	135.7%
Cancer First Treatments vs 2019/20	Mar-25	124.0%	-	-	126.1%	90.5%	161.7%
Bed Utilisation General & Acute	Mar-25	95.1%	-	-	95.2%	92.0%	98.4%
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Feb-25	79.2%	77.0%		78.3%	72.9%	83.8%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Feb-25	79.9%	96.0%	No	83.8%	75.3%	92.3%
% outpatient activity: first (all) and follow-up (procedures)	Mar-25	44.9%	46.0%	No	43.0%	41.3%	44.7%

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

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Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Mar-25	-10395.0	-	-	-4712.2	-7578.1	-1846.3
BPPC £ %	Mar-25	67.6%	95.0%	No	83.3%	77.4%	89.2%
BPPC Volume %	Mar-25	45.7%	95.0%	No	68.9%	62.3%	75.6%
Cash £'000	Mar-25	12456	14354	No	30022	8139	51906
Efficiency delivery £'000	Mar-25	9692.6	14201.0	No	5839.5	-448.7	12127.7
Elective recovery funding (ERF) value-weighted activity % In month	Feb-25	103.9%	107.0%	No	101.9%	91.4%	112.3%
In-month financial performance Surplus/Deficit £'000	Mar-25	21896.7	5013.6		-485.0	-11649.0	10679.1
In-month ICS CDEL capital expenditure	Mar-25	28839.9	3535.0	-	3477.0	-6100.0	13054.0
Year-to-date financial performance Surplus/Deficit £'000	Mar-25	-6795.8	-8100.0		-15382.5	-25625.0	-5140.1

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

Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Mar-25	87.7%	95.0%	No	90.8%	89.4%	92.2%
Data Security & Protection Breaches	Mar-25	32	-	-	27	9	45
Externally reportable ICO incidents	Mar-25	0	0		0	-	-
All IG reported incidents	Mar-25	32	-	-	29	13	45
Freedom of Information (FOI) % responded to within target tim	Feb-25	57.4%	80.0%	No	57.3%	27.1%	87.4%
Data Subject Access Requests (DSAR)	Mar-25	70.1%	80.0%	No	69.2%	52.2%	86.1%
Priority 1 Incidents	Mar-25	0	0		1	-	-

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

Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Mar-25	20	-	-	19	4	33

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

Latest Indicator Period: Mar-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Mar-25	20	-	-	19	4	33

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.

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

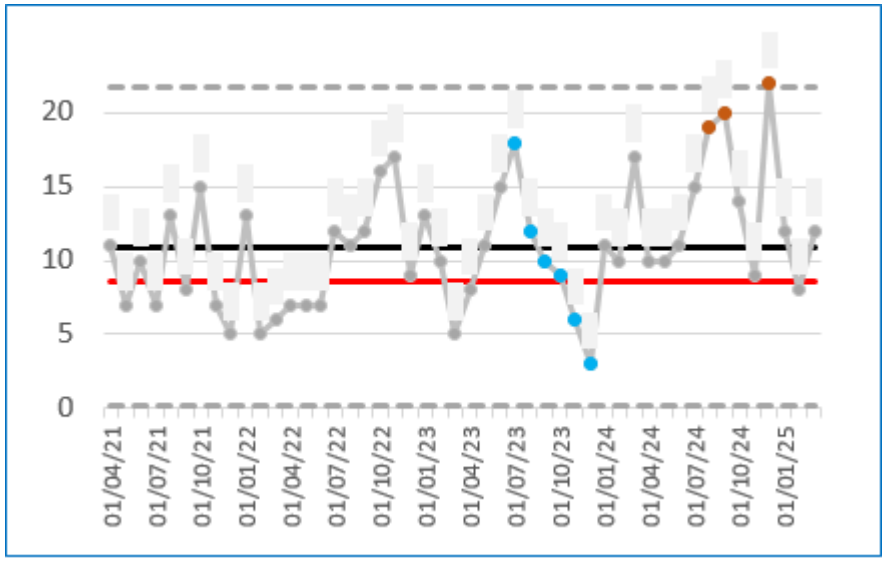
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

Sufficient	Satisfactory	Inadequate

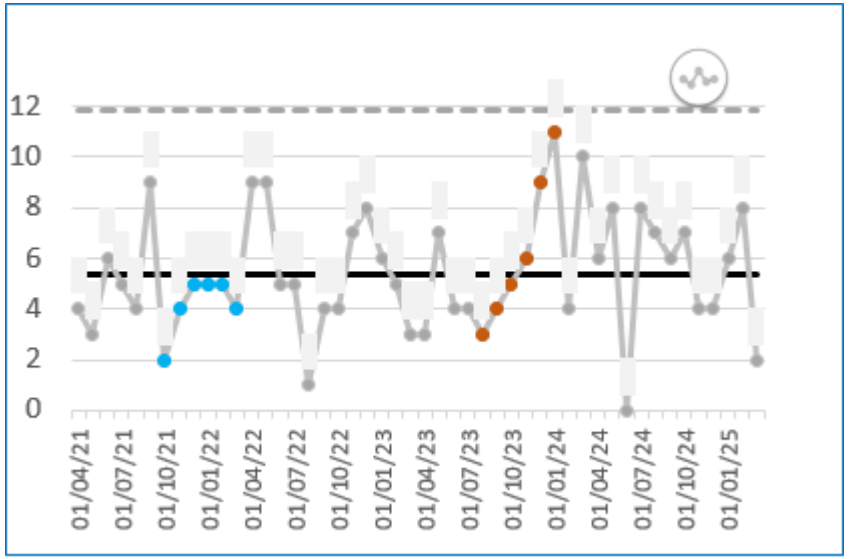
03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience

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

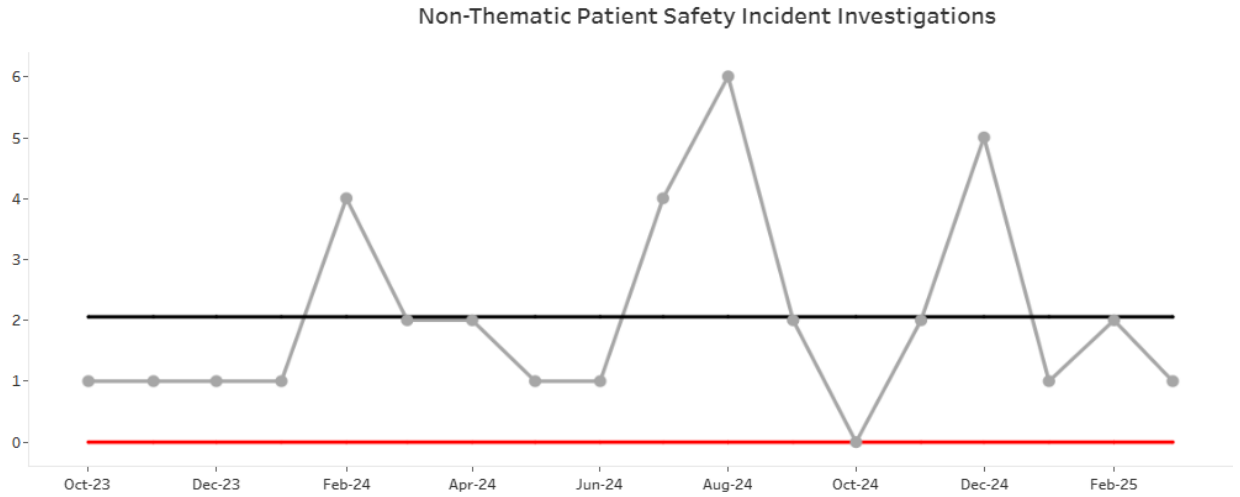


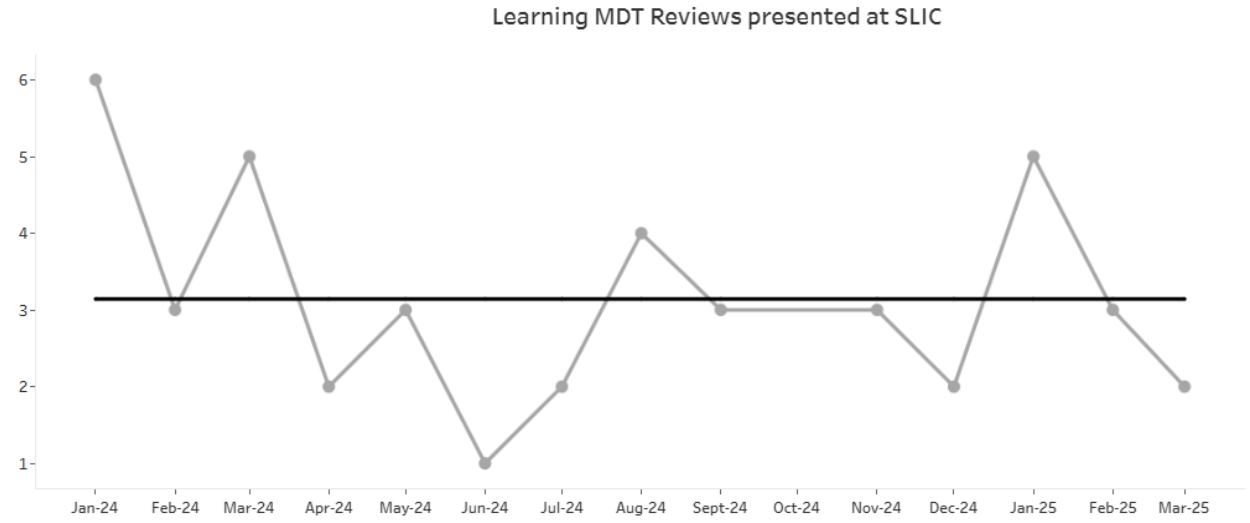
SPC MSSA HOHA and COHA Cases (April 2021-March 2025)



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 - There were no cases of MRSA bacteraemia reported in March. The total number of cases for 24/25 is 11 which is an increase of 5 cases from 23/24. A rise in MRSA bacteraemia has also been observed in community onset cases across the ICB. There is currently no clear explanation. **MSSA** - There were 2 HOHA cases and 0 COHA cases of MSSA bacteraemia reported in March. The total number of healthcare associated cases of MSSA in 2024/25 was 66 which is a reduction of 4 cases from 2023/34. **C. difficile** – There were 5 HOHA and 7 COHA reported cases for March. The total number of cases for 2024/25 is 164 which is above the contract threshold (123). This is an increase of 34 cases from 23/24. The OUH trend is in the context of a national increase in *C. difficile* incidence of 38% since 2019/2020 of hospital onset cases. **Staffing** – An interim IPC Lead /Manager is in place. The substantive IPC Lead/Manager role has gone back out to advert after the first round of recruitment failed to appoint a suitable candidate.	The antimicrobial stewardship programme continues to report a decline in use of antibiotics most likely to predispose to C. difficile infection. This is mainly driven by changes in Trust antimicrobial guidelines. A programme of decolonisation prior to elective insertion of central venous access has been implemented as part of a package of care to reduce central line associated blood stream infection (CLABSI) with MSSA. Recruitment of a substantive Lead Nurse/Manager is an urgent priority to support the IPC team. An MRSA screening audit has been completed and analysis of the results is in progress.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

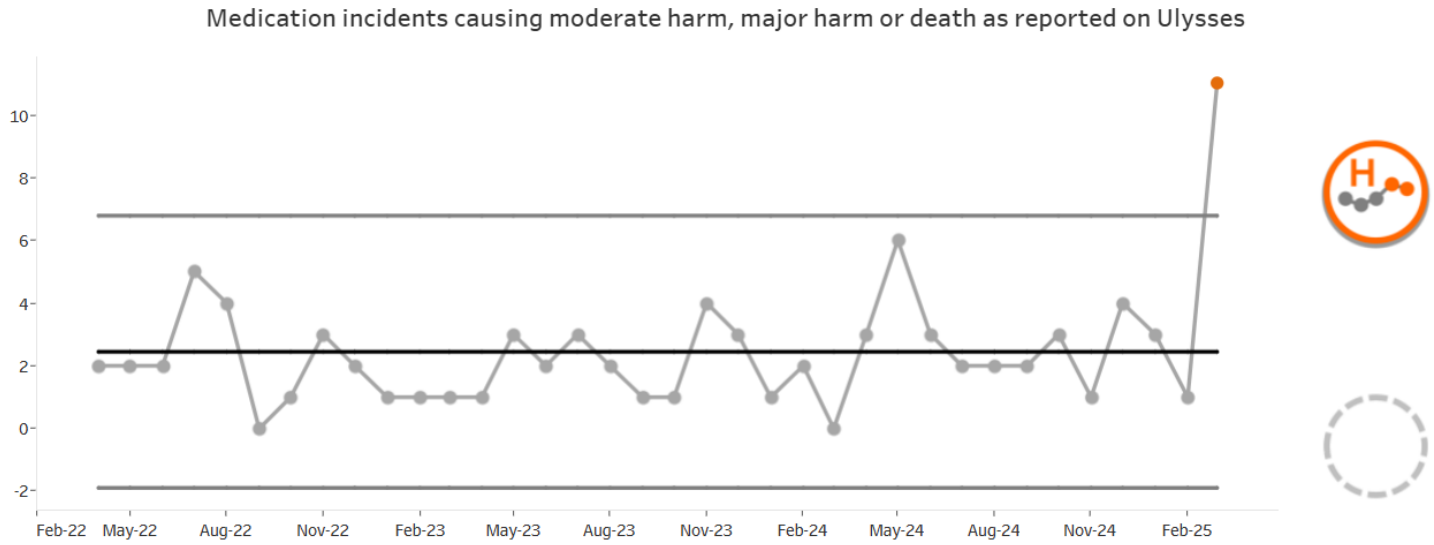
3. Assurance report: Quality, Safety and Patient Experience, *continued*



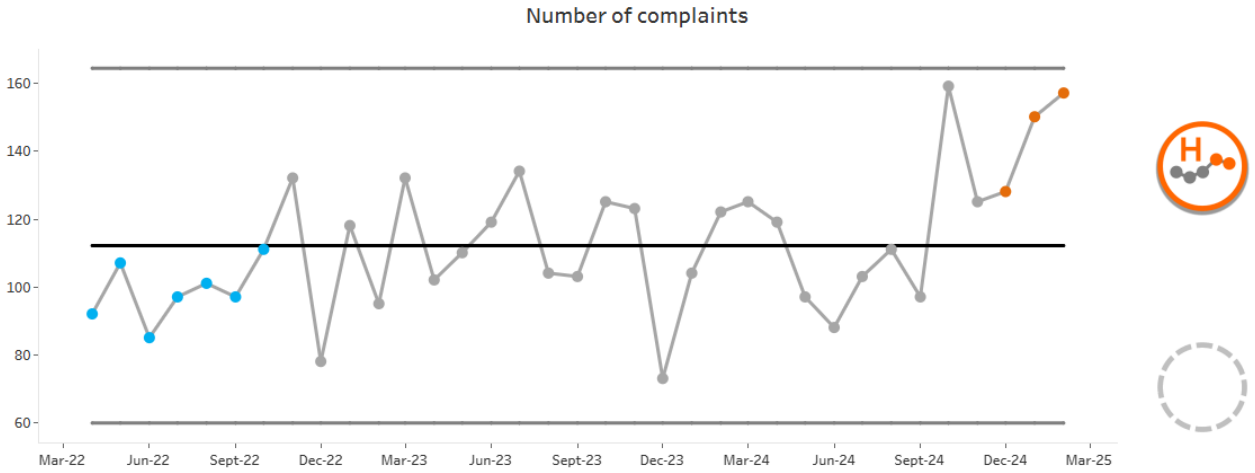


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
One new patient safety incident investigation (PSII) was confirmed in March 2025 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile). It concerned a baby who experienced sustained low blood sugar after delivery Individual PSIIs are incidents that warrant an extensive system-based review (more than a learning multidisciplinary team review (LMDTR)). The learning and improvement will be shared once the PSII has concluded. The specific timeline for PSIIs is set by the service in conjunction with the patient and/or family and confirmed at the weekly Safety Learning & Improvement Conversation (SLIC).	A total of 37 non-thematic PSIIs have been confirmed since OUH moved to the PSIRF framework in October 2023, of which 16 have been fully completed and a final report created. Actions are underway to improve patient safety based on learning from these investigations. PSIIs are one of a range of learning responses which can be applied to individual incidents or a cluster of similar incidents. Other learning responses include after action reviews (AARs) and LMDTR. LMDTRs have a target of 42 calendar days from the reporting of the incident to holding the meeting. The median time to complete LMDTR meetings was 47.5 calendar days in March 2025. 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 22 calendar days in March 2025. More staff are being trained in conducting learning responses with the aim of reducing the time to LMDTR and AAR meetings. Targets and adherence will be monitored at the PSIRF Improvement Group.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. 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 April 2024 a total of 57 actions were overdue.	BAF 4 CRR 1122	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Quality, Safety and Patient Experience



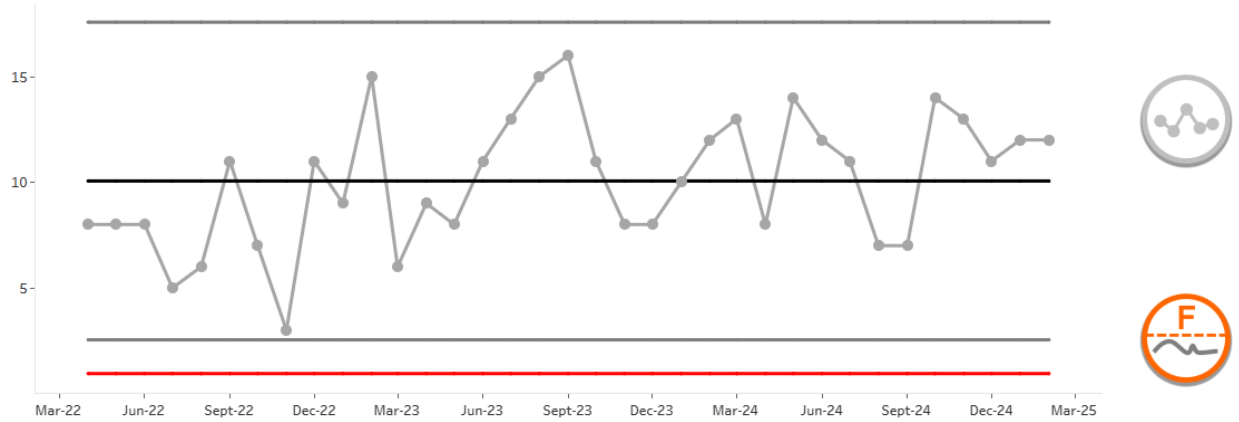
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
The rise in incidents is driven by 8 incidents relating to Foslevodopa-foscarbidopa Foslevodopa-foscarbidopa was recommended as a treatment option by NICE (TA934) in November 2023 for patients with advanced Parkinson's with motor symptoms. However, although the drug costs are pass-through, the clinical service is not currently able to support the increased activity required to deliver this treatment without additional resource to cover the multi-disciplinary clinical input required for drug initiation and follow up. The drug is therefore not yet being provided. The moderate harm reflects worsening of Parkinsonian symptoms in the absence of this treatment for patients in whom it is indicated clinically. A business case to support administration of Foslevodopa-foscarbidopahas been presented the Business Planning Group which has requested an overall service review in the context of this and several other business cases in Neurosciences. The remaining 5 moderate harm incidents are within the normal limits for medication incidents reported as moderate within the Trust. They are all under review by the clinical teams and one has already been downgraded to minor harm following review. They will be followed up at Medicines Safety Committee as per usual processes.	Service review as requested by BPG, noting that a solution is required as soon as possible to address non-compliance with this NICE-TA.	The Medicines Management and Therapeutics Committee will oversee implementation once resources have been identified to support drug initiation and follow up.		



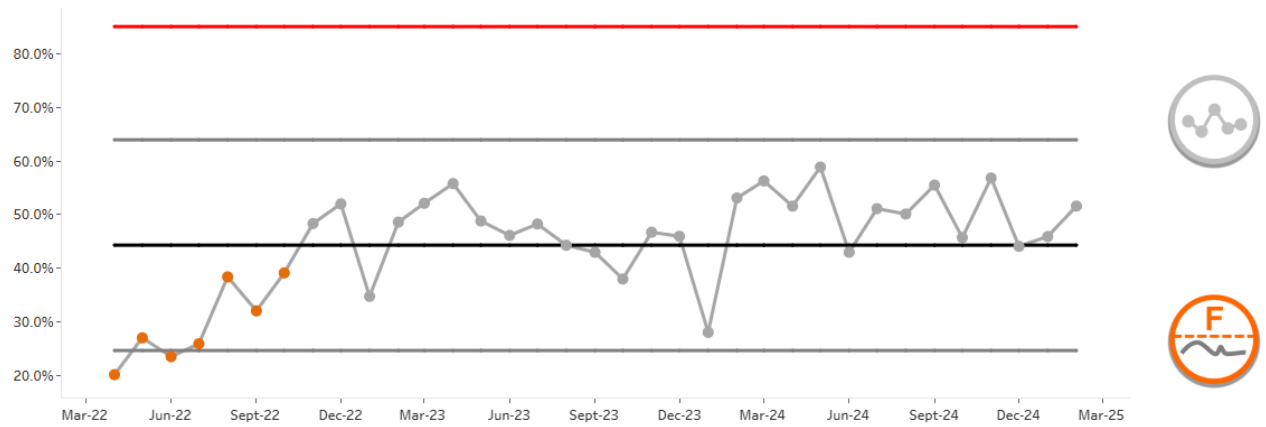
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The rise in complaints is reflective of concerns about long waiting times.	The rise in complaints across the four clinical divisions is reflective of patients concerns about long waiting times and access to treatment and care rather than a decline in quality of care. The top five areas of concern across the Trust raised by complainants in March were Communication with patient, Appointment Delay (inc. Length of Wait), Appointment Cancellations, Attitude of Medical Staff and Delay or Failure in Treatment or Procedure. The availability of the detailed thematic data in the Power BI Complaints dashboard enables the divisions to examine the reasons for their complaints and their performance in meeting the 25-day completion target.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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

Reactivated complaints

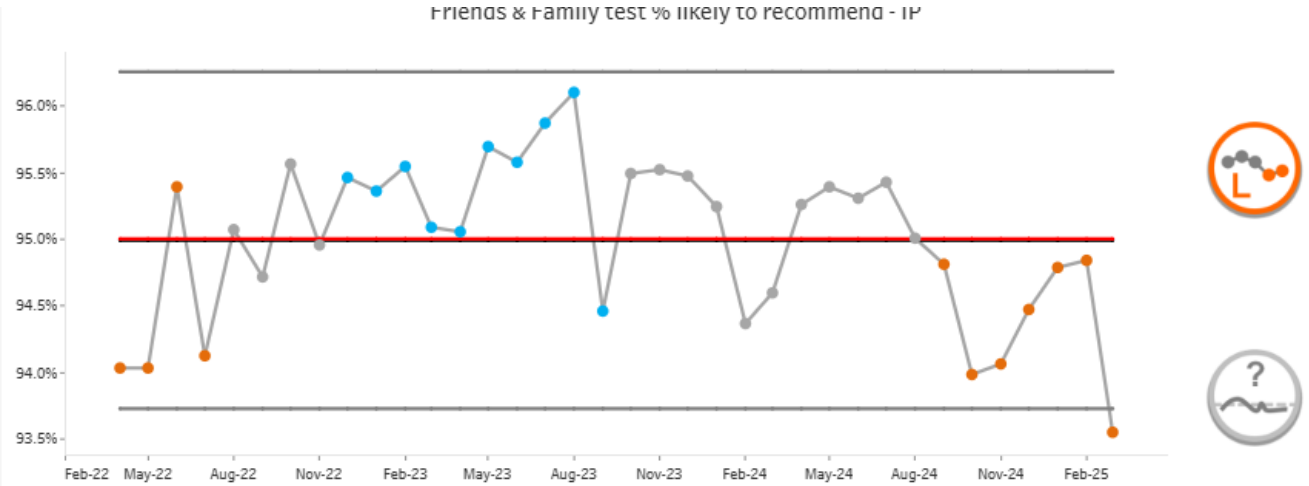


% of complaints responded to within 25 working days



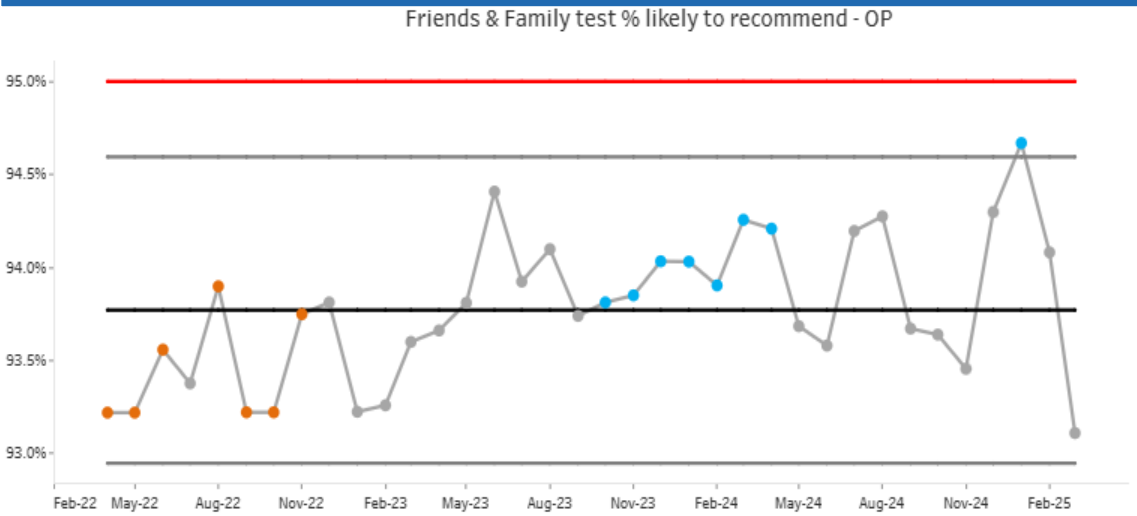
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In March 2025, 67% of complaints were responded to within 25 days, although below the target of 85% this is an improvement of 15% from the previous month.	The Trust continued to improve performance in closing complaints within 25 days, achieving 67% in March 2025 which although an increase from 44% on 31 December 2024, remains below the Trust target of 85%. The weekly breach report detailing the number of open complaints over a 25-day period is consistently shared and discussed with senior leaders across Divisions. This ensures their engagement in resolving response times and provides them with the necessary resources and support. Additionally, the breach report now illustrates the number of complaints held at each stage of the process, by Division, allowing focus on the previously noted bottlenecks of cross divisional complaints, medical engagement, clinical operational priorities and staff absence. Further reports are being developed, including a 'pre-breach' report, which shows Divisions all open cases at the investigation stage on days 7-13 (with the first draft expected to be returned on day 14). This report is designed to help Divisions identify which cases are on target for completion and which may benefit from additional support to complete the first draft on time. Weekly meetings continue to be held with the Complaints Team and Divisional Directors of Nursing, to escalate complaints cases about to breach, with each case given an identified way forward to bring the case to closure as quickly and appropriately as possible. Divisions also benefit from a weekly report that highlights the cases that are currently below 25 working days in the process, to ensure Divisions are aware and work to ensuring these cases do not breach. There were 19 reopened complaints during the month which represented 10% of complaints received with 56% of reopened complaints closed within 25 days. The reasons for reopening included the welcomed request for a meeting to discuss the response, the concern that a complaint was not fully addressed or request for a reinvestigation. From April the complaints outcome data will be reviewed to track the number of changed outcomes because of reopened complaints.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

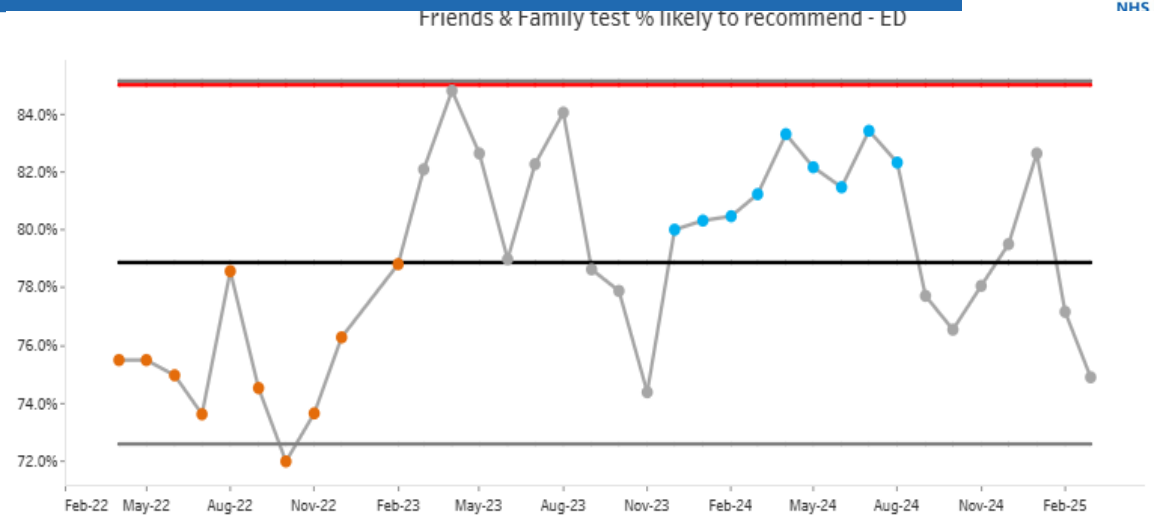
3. Assurance report: Quality, Safety and Patient Experience, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. The overall Trust performance for FFT for March '25 is 91.64% positive when analysing 15,524 responses. This is a total response rate for the Trust of 18.6%. The Trust overall positive rating for March was 91.64%, which has dropped from 92.68% in February. 2. Inpatient response numbers were 1370, and the approval rate for IP has dropped from 94.8% to 93.5% 3. The top positive themes during March for Inpatients was staff attitude, clinical treatment and admission. The top negative themes were waiting list, discharge and waiting time.	1. An area of focus as part of the CQC inpatient survey 2023 [IP] is to improve ratings for the question 'During your hospital stay, were you given the opportunity to give your views on the quality of your care?' This is to be discussed at the IP survey Improvement and Action meeting to determine what action can be taken and will be followed up in the Patient Experience and Family Carer forum. NB: This question has been removed for the 2024 survey and therefore will not be comparable. 2. The Trust's inpatient FFT response rates contribute consistently to over 50% of the overall ICB results. The Trust's inpatient response rates of between 2,700 to 4,000 per month also perform well in comparison with the national inpatient FFT as the Trust consistently places in the top 5-11 out of 152 Trusts.		BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

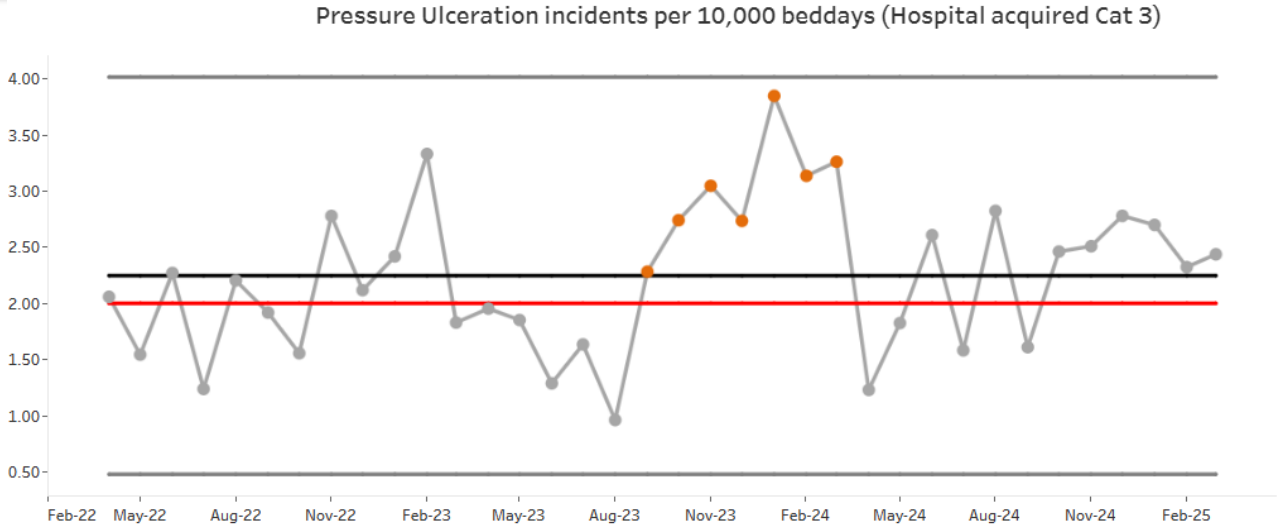
3. Assurance report: Quality, Safety and Patient Experience, *continued*



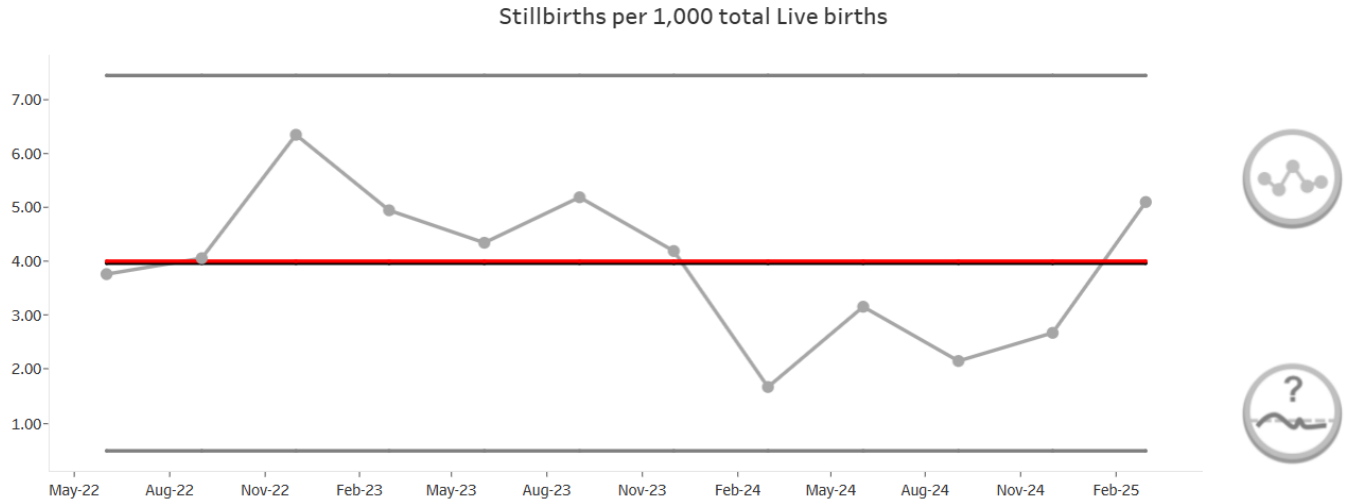


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses accounted for 10,603 of the total responses received and had a positive response rate of 93.16%. The approval rate has dropped from 94.1% in February to 93.16% in March. 2. The top positive themes during March for outpatients was staff attitude, implementation of care, and clinical treatment. The top negative themes were waiting list, cancelled admissions and procedures and catering. 3. ED response numbers were 1402, with a positive response rate of 74.82%. The approval rate has dropped from 77.1% in February to 74.82% in March. 4. The top positive themes during March for ED was staff attitude, implementation of care, and admission. The top negative themes were discharge, car parking and clinical treatment	1. A thematic analysis of patient feedback from complaints, Healthwatch and FFT is underway relating to waiting times to understand how the Trust can more effectively keep in touch with patients whilst they are waiting for an appointment or procedure. 2. Discussions around a dashboard for FFT have progressed and this is now being developed by the performance team. 3. A Maternity specific FFT poster has been created, along with A5 flyers to promote the survey and encourage completion. These have been shared within the community locations and are being handed out. For one week in March, the PE team supported FFT collection in person within maternity services. March saw 75 responses, and 172 responses have been received to date so the trajectory is positive. A Maternity SPC chart will be added. 4. Each division presents an update on patient experience, including FFT data and themes at the PE forum monthly. The drop in recommend rates will be discussed at the next meeting in May.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Family Carer Forum, and the Trust Governors Patient Experience and Membership Committee (PEMQ).	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

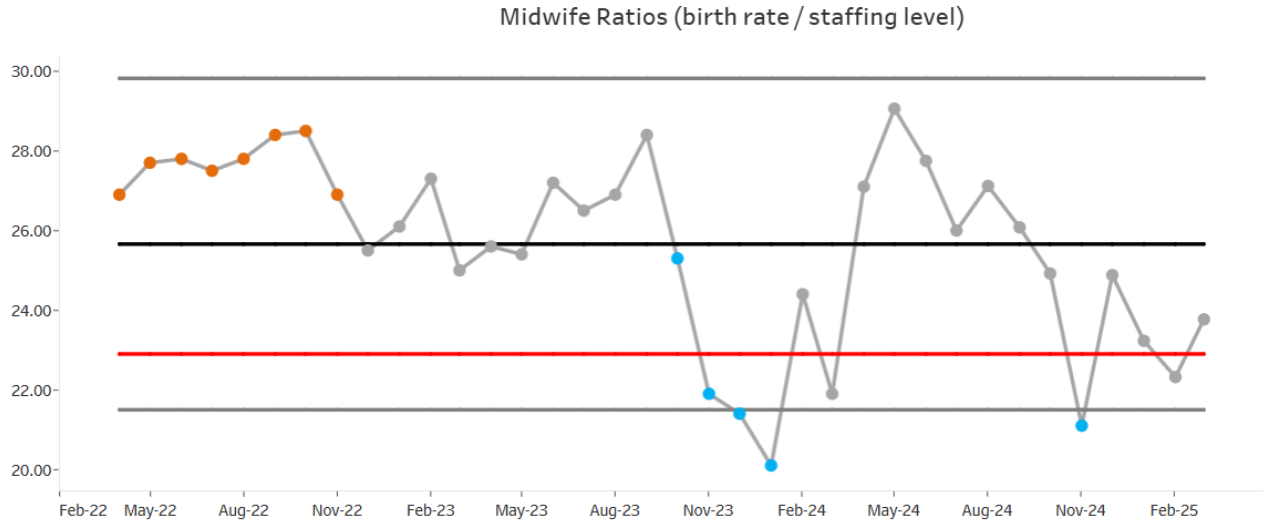


Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
HAPU Category 3: In March, 9 incidents of category 3 HAPUs were reported. It is noted that there was a significant reduction in reported HAPU Category 2 from 78 in February to 65 in March.	Under divisional oversight, clinical areas are reviewing all incidents using the PSIRF approach to identify lessons learned and develop remedial action plans. The emphasis remains on ongoing improvement in care planning and delivery. Early indicators for the year suggests a reduction in reported Hospital Acquired Pressure Ulcers (HAPUs) in 2024/25, building on the progress from 2023/24. Validation will be undertaken to confirm this before formally reporting the end-of-year position and reduction percentage.	Thematic learning from all HAPU incidents continue to be presented and shared at Clinical Governance Committee.	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, .*



Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
Stillbirth shows special cause concerning variation	Of the 5 cases reported in March, 2 were tertiary referrals of babies <26 weeks gestation. In addition a baby born at 20+6 weeks gestation had a known fetal abnormality. Sadly, there were 2 cases of Intrauterine Death at later gestations. All cases have undergone initial review and no immediate learning and/or safety concerns have been identified and none met the criteria for Maternity and Newborn Safety Investigation (MNSI). Every case will be reviewed using the Perinatal Mortality Review Tool with multidisciplinary and parental involvement.	Every case is reviewed robustly through the National Perinatal Mortality Review Tool alongside any additional appropriate investigation.	*N/A*	*N/A*

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 March there were 620 mothers birthed which is an increase from 524 in February. There were 734 scheduled bookings undertaken which an increase of 89 from the previous month. 204 caesarean sections were performed in March which is 33.3% of mothers birthed. There is an upward trend in women choosing to book an ELCS as an alternative to having an IOL. The midwife to birth ratio in March was 1:23.8. There were no occasions in March where 1:1 care could not be given in established in labour and no occasions when the Delivery Suite coordinator was not supernumerary.	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. Daily staffing meetings continue to ensure safe staffing across the service and enable tactical mitigations and trigger escalation as needed. Maternity safe staffing % fill rates improvement plan underway with weekly review of accuracy of planned V's actual fill rates – in collaboration with Trust Safe Staffing team. Further controls for NHSP authorisation now implemented for agreement at Matron level and above only. Additional community night on-calls are now consistently rostered. Cross service review commissioned of all short and long term sickness management and return to work processes to assure alignment to new absence policy.	Ongoing workforce plan to monitor: ➢ Recruitment to birthrate plus uplift, ➢ Staff retention strategies ➢ Reduction of NHSP spend. Positive trajectory towards full recruitment by June 2025. Weekly monitoring of: ➢ Accuracy of Safe Staffing fill rates ➢ Community on-call hours required ➢ Community based births	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: 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 coloured sections on the dashboard assist with the review, and any indicator not meeting the target is indicated in red. 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 March 2025. Paediatric Critical Care Unit (PCCU) declared level 3 on five days shifts and three night shifts. With support from the other Critical Care Units, PCCU was able to implement team nursing as mitigation to make the unit safe. JR-ED declared level 3 on one late shift. The shift was carefully monitored and reviewed every two hours. The Trust-wide planned versus actual fill rates were 86.65% during the day and 92.2% 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 March review confirmed across all divisions that there were no instances of nurse-sensitive harm indicators directly linked to nursing or midwifery staffing levels.

SUWON – Rostering KPI's were excellent in March. Some areas with low annual leave but not concerning as this was the last month in the leave year, with all leave used. SEU-F net hours relate to a student, not substantive hours. Transplant ward also has a net hours difference outside of the KPI, which will be reviewed and corrected. Overall, the fill rates were very good for the division, reflected in the required and actual CHPPD aligned for most wards.

Maternity – CHPPD and % staffing fill rates difficult to capture individual areas due to the dynamic movement of midwives to maintain safe staffing, however some dedicated work has commenced to improve accuracy in reporting lead by the Deputy CNO. Actions from this work include benchmarking to see whether reporting maternity as one service instead of individual locations is more representative data.
Vacancies and overall vacancy has been removed from reporting as the finance ledger is inaccurate against ESR data since Birth rate Plus was approved. As the ledger has not yet been updated, it appears the directorate are over recruited. This will be reported again when the alignment exercise is completed, after 1st April.
The Roster lead time remains a focus to improve; this will be supported with the Check &Confirm meetings going forward.

MRC – The rostering KPI's for the division are extremely good. One ward missed manager approval for payroll, which was an oversight. Overall, the review of red flags is much improved. Two areas slipped; however, this was due to a change of ward manager for one ward, and sickness in another. Both these areas will be addressed and expect to be back on track next month. Wards continue to work mainly on minimum levels rather than fully staffed, accounting for the difference between required and actual CHPPD, but assurance given that shifts were safe and nurse sensitive indicator reporting was not directly related to staffing concerns.

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

NOTSSCAN – Roster efficiencies and KPI adherence are being closely monitored by the DDN, supported well with the check and confirm meetings. Two children's wards appear over recruited however, the division believe this relates to initial recruitment to one ward. The DDN continues to review with HR and recruitment. Red flags are more consistently reviewed, with an exception this month on Neurology. This is being addressed by the DDN. For most wards the actual CHPPD are lower than required, but more aligned to budgeted staffing. Although most wards have not been fully staffed, assurance given by DDN that they have been at a minimum safe level. Medication incidents in Paediatric Critical Care (13) and the Neonatal Unit (10) are attributed to nurse administration errors. Each incident has been reviewed by the DDoN, who confirmed at formal sign-off that appropriate actions and interventions have been implemented. Additionally, on Neuro Purple Ward, 6 reported falls were related to one patient. Medication and falls incidents have been deemed not directly related to staffing concerns by the DDN.

CSS – JR ICU – CHPPD, budget and roster were all reviewed. Budgeted CHPPD were higher than actual, as not all beds were required to be staffed. Throughout March, most patients were cared for on one level. All areas were safely staffed in March, utilising temporary workforce when appropriate, with good overall fill rates.

Nurse Sensitive Indicators Directly Impacted by Staffing Levels

The divisional directors of nursing have reviewed and approved the staffing levels for March. They confirmed that insufficient or unsafe staffing did not directly impact nurse-sensitive indicators, and thus, no exception reporting is required for this month

Critical Care Recruitment

During M12, our Critical Care pipeline remained static yet robust, with 39 conditional offers in place across all critical care areas, including internal promotions. In March, two start dates were booked, and active efforts are underway to secure additional start dates for the remainder of the pipeline. There is a promising number of starts confirmed for April.
Moreover, ongoing work continues to develop a dedicated microsite to attract candidates to Critical Care in Oxford. This initiative is anticipated to significantly bolster our future recruitment efforts. Vacancy requests have commenced with submission from all Critical Care areas, ensuring that recruitment has resumed following the Trust-wide recruitment pause.
We have also undertaken focused work on band 5 over recruitment to support the band 6 gap within Paediatric Critical Care, which continues to present a challenge. This work is ongoing, and we remain committed to addressing staffing needs effectively.

Vacancies above 15%

All areas with a vacancy rate above 15% continue to be reviewed to ensure that there continues to be effective approaches to recruitment in place for those areas.

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)

Oxford University Hospitals NHS Foundation Trust

March 2025	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	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%	% Extremely likely or likely
NOTSSCaN																		
Bellhouse / Drayson Ward	8.95	9.40	8.4	79.57%	6	3	1	0	16.6%	23.0%	2.7%	1.9%	18.1%	Yes	-3.5%	9.6	14.2%	87.9%
HH Childrens Ward	9.54	9.12	12.2	97.85%	0	0	0	1	13.5%	4.0%	4.7%	8.7%	21.0%	Yes	-0.8%	9.4	15.2%	92.0%
Kamrans Ward	7.67	12.42	10.2	100.00%	1	0	0	0	-5.8%	3.9%	1.1%	2.3%	-3.3%	Yes	1.5%	9.4	13.7%	100.0%
Melanies Ward	9.74	11.83	10.9	100.00%	0	0	0	0	-10.3%	12.4%	4.0%	3.8%	1.4%	Yes	-2.1%	9.4	13.3%	85.7%
Robins Ward	10.68	10.05	9.1	94.62%	3	0	0	0	8.3%	16.5%	6.2%	6.7%	26.6%	Yes	1.2%	9.4	12.4%	83.7%
Tom's Ward	8.05	9.67	7.2	100.00%	4	1	0	0	-8.6%	0.0%	2.3%	3.9%	-4.3%	Yes	1.2%	9.4	15.1%	96.3%
Neonatal Unit	19.92		15.7		10	1	0	0	13.9%	8.9%	6.5%	3.7%	18.7%	Yes	-3.2%	9.0	14.9%	
Paediatric Critical Care	27.60		27.1		13	2	2	0	-2.3%	7.3%	4.5%	8.7%	8.0%	Yes	-0.6%	8.7	16.5%	
BIU	6.05	5.83	6.6	100.00%	1		0	5	7.0%	6.4%	3.9%	2.7%	9.5%	Yes	3.2%	9.6	11.2%	
HDU/Recovery (NOC)	9.04		21.0		0		0	0	17.9%	11.3%	7.3%	4.7%	29.5%	No	0.5%	7.9	15.7%	
Head and Neck Blenheim Ward	7.29	8.05	8.1	100.00%	2		0	0	15.8%	0.0%	5.0%	0.0%	17.6%	Yes	-2.0%	9.1	14.8%	100.0%
HH F Ward	7.39	8.48	7.8	100.00%	0		1	1	7.8%	10.2%	5.6%	2.3%	11.4%	Yes	-1.6%	9.7	14.0%	100.0%
Major Trauma Ward 2A	9.13	9.79	10.2	100.00%	3		2	4	5.2%	7.2%	4.6%	0.0%	5.2%	Yes	2.4%	8.1	14.0%	88.9%
Neurology - Purple Ward	8.96	11.70	10.1	100.00%	0		0	13	-4.5%	3.0%	5.1%	2.8%	1.2%	Yes	3.8%	9.6	11.9%	100.0%
Neurosurgery Blue Ward	8.93	10.41	9.3	100.00%	0		0	2	12.9%	7.0%	3.9%	2.2%	14.9%	Yes	2.2%	8.4	13.0%	90.0%
Neurosurgery Green/IU Ward	12.51	9.92	9.8	100.00%	0		1	1	12.2%	3.2%	3.9%	0.0%	12.2%	Yes	2.5%	8.3	15.9%	
Neurosurgery Red/HC Ward	12.82	12.73	11.8	100.00%	1		1	3	-3.5%	10.4%	4.2%	1.6%	0.6%	Yes	-0.3%	8.7	14.0%	
Specialist Surgery I/P Ward	7.28	7.65	8.6	100.00%	1		0	4	10.9%	7.6%	3.2%	6.1%	16.4%	Yes	1.3%	9.4	15.1%	85.7%
Trauma Ward 3A	9.13	9.61	9.4	94.62%	2		3	5	7.6%	8.5%	6.8%	2.0%	10.6%	Yes	2.7%	8.1	14.8%	100.0%
Ward 6A - JR	7.52	7.39	7.5	100.00%	2		1	4	13.0%	11.6%	3.1%	6.7%	18.9%	Yes	-4.3%	9.1	17.0%	96.6%
Ward E (NOC)	6.30	6.59	9.2	97.85%	2		0	0	13.7%	6.3%	7.1%	2.8%	19.8%	Yes	2.0%	9.3	11.8%	93.5%
Ward F (NOC)	6.65	7.20	7.3	100.00%	2		0	2	6.0%	2.9%	4.5%	2.8%	8.6%	Yes	0.6%	9.6	13.7%	100.0%
WW Neuro ICU	27.88		28.9		9		0	0	5.8%	5.9%	4.6%	2.0%	10.5%	Yes	-1.6%	9.0	14.0%	

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

Oxford University Hospitals NHS Foundation Trust

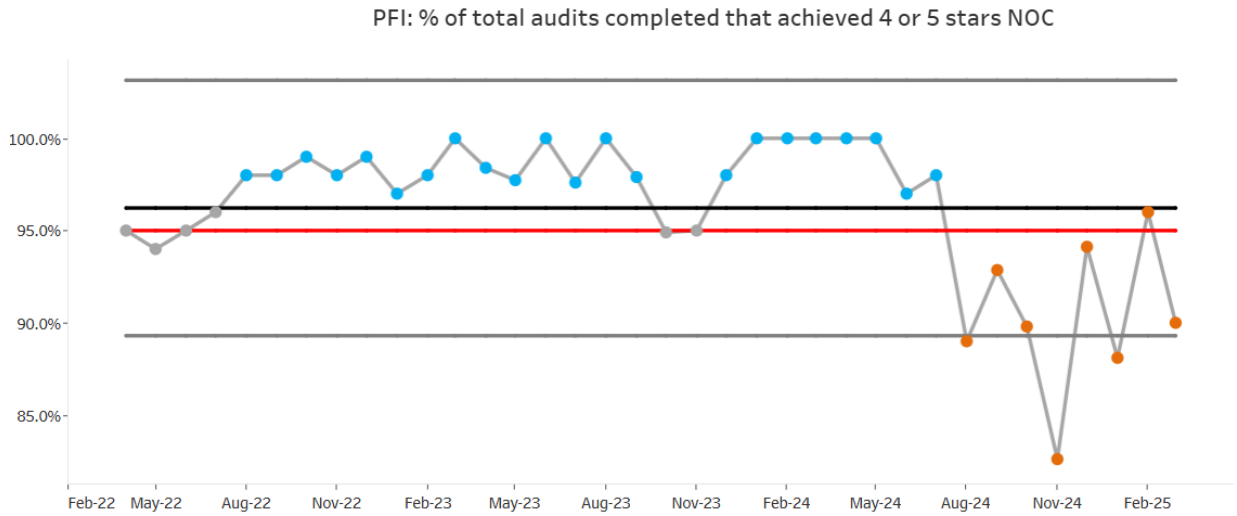
March 2025	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	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%	% Extremely likely or likely
MRC																		
Ward 5A SSW	8.8	9.2	8.3	100.0%	2		2	8	5.7%	4.2%	4.6%	8.6%	15.8%	Yes	-0.4%	9.0	12.7%	
Ward 5B SSW	8.9	8.9	8.3	100.0%	0		2	5	3.5%	10.6%	3.6%	4.0%	7.4%	Yes	0.4%	9.0	13.0%	100.0%
Cardiology Ward	7.9	7.5	6.8	100.0%	5		0	6	11.1%	17.5%	5.6%	0.0%	13.5%	Yes	-1.4%	9.4	15.6%	100.0%
Cardiothoracic Ward (CTW)	7.8	8.1	6.5	100.0%	0		0	1	11.9%	2.5%	3.4%	4.7%	16.0%	Yes	-1.3%	9.6	18.4%	66.7%
Complex Medicine Unit A	8.9	12.0	10.1	100.0%	0		1	9	-4.3%	9.7%	5.6%	2.1%	-0.6%	Yes	-0.5%	9.0	14.9%	100.0%
Complex Medicine Unit B	10.2	11.4	9.1	100.0%	0		0	4	-3.0%	10.6%	4.1%	4.6%	1.7%	Yes	1.5%	9.0	13.5%	100.0%
Complex Medicine Unit C	8.8	9.9	8.3	100.0%	1		0	3	7.4%	8.9%	3.8%	1.5%	13.0%	Yes	-1.0%	9.0	13.0%	96.8%
Complex Medicine Unit D	9.5	8.8	8.3	98.9%	1		2	0	9.7%	16.0%	7.9%	0.0%	11.8%	Yes	0.4%	9.0	14.9%	
CTCCU	21.1		20.7		3		1	0	11.0%	9.0%	4.3%	4.5%	19.9%	Yes	-0.6%	9.7	16.4%	
Emergency Assessment Unit (EAU)	9.2	8.3		100.0%	1		0	5	8.6%	9.3%	6.3%	2.3%	13.9%	Yes	0.7%	8.4	12.3%	
HH EAU	9.8	7.4		86.7%	1		0	6	5.9%	5.0%	5.5%	2.5%	10.6%	Yes	-0.7%	9.0	13.0%	
HH Emergency Department	22.8				2		0	2	3.2%	9.3%	3.5%	3.6%	6.7%	Yes	-2.0%	9.0	13.2%	81.7%
JR Emergency Department	18.2				9		0	8	18.5%	15.3%	4.4%	4.3%	23.9%	Yes	-1.2%	9.6	13.8%	71.3%
HH Juniper Ward	8.1	10.0	8.0	100.0%	0		3	4	0.2%	5.1%	4.5%	0.0%	2.9%	Yes	-2.5%	9.0	12.8%	50.0%
HH Laburnum	9.7	9.0	8.7	100.0%	0		3	9	1.4%	5.7%	7.7%	3.4%	6.5%	Yes	1.8%	9.0	15.1%	57.1%
HH Oak (High Care Unit)	10.1		11.5	94.6%	1		5	1	-4.2%	2.1%	7.0%	9.9%	7.7%	Yes	-3.3%	9.0	14.3%	
John Warin Ward	10.3	11.3	9.8	100.0%	1		0	4	-3.2%	3.9%	3.6%	9.1%	6.2%	Yes	-1.0%	8.7	15.3%	83.3%
OCE Rehabilitation Nursing (NOC)	10.6	10.8	9.6	100.0%	1		0	1	-5.2%	5.0%	5.7%	1.9%	-2.5%	No	-0.4%	8.3	15.8%	
Osler Respiratory Unit	14.5	10.3	11.7	100.0%	1		1	2	8.6%	9.8%	5.3%	2.8%	15.1%	Yes	-1.1%	8.7	14.1%	52.8%
Ward 5E/F	11.1	8.5	10.2	98.9%	1		3	10	9.3%	18.5%	5.5%	1.7%	14.0%	Yes	-1.4%	9.0	15.6%	50.0%
Ward 7E Stroke Unit	10.9	10.5	8.8	100.0%	0		2	8	-6.2%	14.2%	4.9%	4.3%	-0.1%	Yes	0.6%	8.3	15.9%	95.5%

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

Oxford University Hospitals NHS Foundation Trust

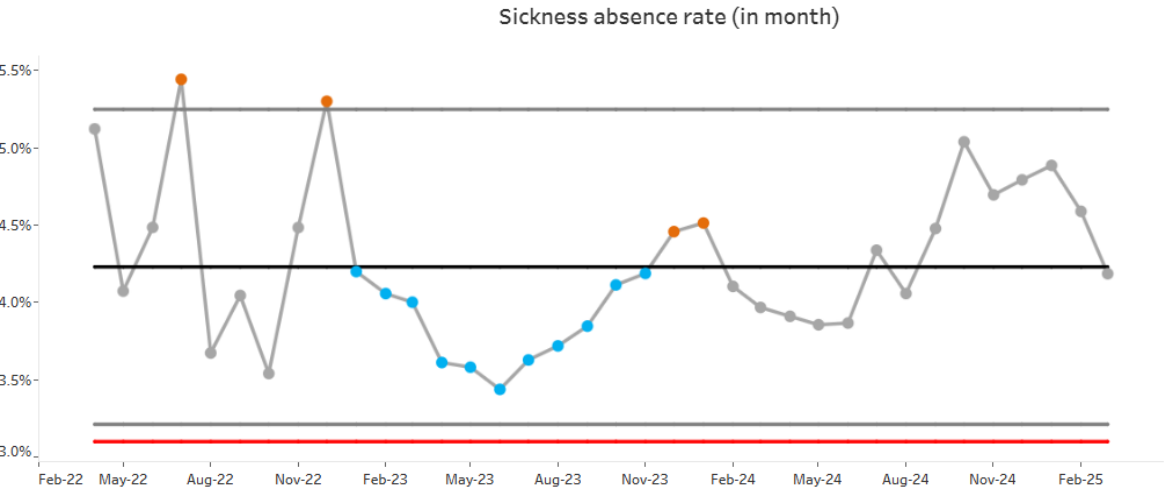
March 2025	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	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%	% Extremely likely or likely
SUWON																		
Gastroenterology (7F)	7.5	7.66	7.53378	95.7%	0		0	2	6.7%	7.9%	5.8%	7.6%	18.8%	Yes	-2.8%	9.7	13.6%	92.9%
Gynaecology Ward - JR	5.69	5.53	7.53027	100.0%	2		0	0	17.9%	9.9%	5.9%	5.8%	25.6%	Yes	-0.4%	9.3	13.7%	92.3%
Haematology Ward	7.68	7.27	8.55682	96.8%	7		0	2	23.3%	14.3%	6.1%	2.6%	27.4%	Yes	-3.0%	9.0	14.2%	80.0%
Katharine House Ward	9.22	9.7	10.0513	100.0%	2		4	4	13.2%	2.9%	5.0%	12.1%	27.0%	Yes	-0.5%	8.9	10.2%	
Oncology Ward	8.67	7.98	7.65683	97.9%	5		1	3	18.7%	8.1%	3.3%	3.6%	21.7%	Yes	-1.5%	5.7	14.4%	100.0%
Renal Ward	9.26	8.62	9.42493	100.0%	0		1	2	6.8%	10.6%	4.7%	9.7%	22.8%	Yes	1.6%	9.4	18.0%	75.0%
SEU D Side	8.69	8.04	8.56528	100.0%	2		2	5	23.2%	4.6%	4.9%	2.3%	25.0%	Yes	-0.7%	9.3	14.4%	94.7%
SEU E Side	8.35	8.12	8.93974	100.0%	2		0	1	19.0%	6.4%	4.7%	0.0%	21.1%	Yes	-0.3%	9.3	9.4%	98.0%
SEU F Side	7.52	7.96	8.24736	100.0%	0		1	0	29.4%	10.5%	3.1%	0.0%	29.4%	Yes	-10.7%	9.3	14.5%	82.4%
Sobell House - Inpatients	8.66	7.9	8.12508	97.9%	0		6	6	27.1%	10.7%	5.5%	7.8%	32.8%	Yes	-1.4%	8.9	16.8%	
Transplant Ward	9.43	8.02	8.22411	100.0%	2		0	3	22.1%	8.3%	6.0%	0.0%	24.7%	Yes	-4.6%	9.6	12.8%	91.7%
Upper GI Ward	9.53	8.12	8.79166	100.0%	5		2	3	12.2%	2.6%	5.4%	12.9%	23.6%	Yes	-0.9%	9.0	12.3%	100.0%
Urology Inpatients	8.74	7.56	8.89994	93.6%	1		2	1	20.9%	0.0%	3.8%	6.5%	32.9%	Yes	-1.1%	9.7	13.9%	100.0%
Wytham Ward	7.63	7.02	7.35357	100.0%	0		2	0	6.4%	3.2%	4.5%	17.5%	27.3%	Yes	0.3%	8.9	9.7%	96.9%
MW Delivery Suite	15.17		21.0984											Yes	-3.2%	6.0	13.5%	
MW Level 5	6.64		5.47654											Yes	-0.7%	6.0	13.9%	
MW Level 6	4.48		7.89334											Yes	-0.7%	5.9	12.9%	
CSS																		
JR ICU	31.13		27.1	100.0%	6		1	1	10.2%	7.0%	5.0%	7.2%	18.4%	Yes	-0.4%	8.9	16.0%	

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 March 2025, the combined PFI % cleaning score by site (average) for the NOC was 95.60% 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 90.00% which is below the 95% Trust target. But an improvement on last month. In total, at the NOC, 40 audits were conducted, 4 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2025. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating along with re training if required, review of cleaning equipment etc.	G4S completed the planned number of audits at the NOC in March 2025, and 4 of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. We are seeing a continued clinical and domestic failures in theatres 1-6 however we are seeing a slow improvement. We continue to work closely with IPC, G4S and the ward/department leads and are completing additional audits with the management, increased supervision from G4S and clinical staff when areas are cleaned. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at JR. 2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Growing Stronger Together

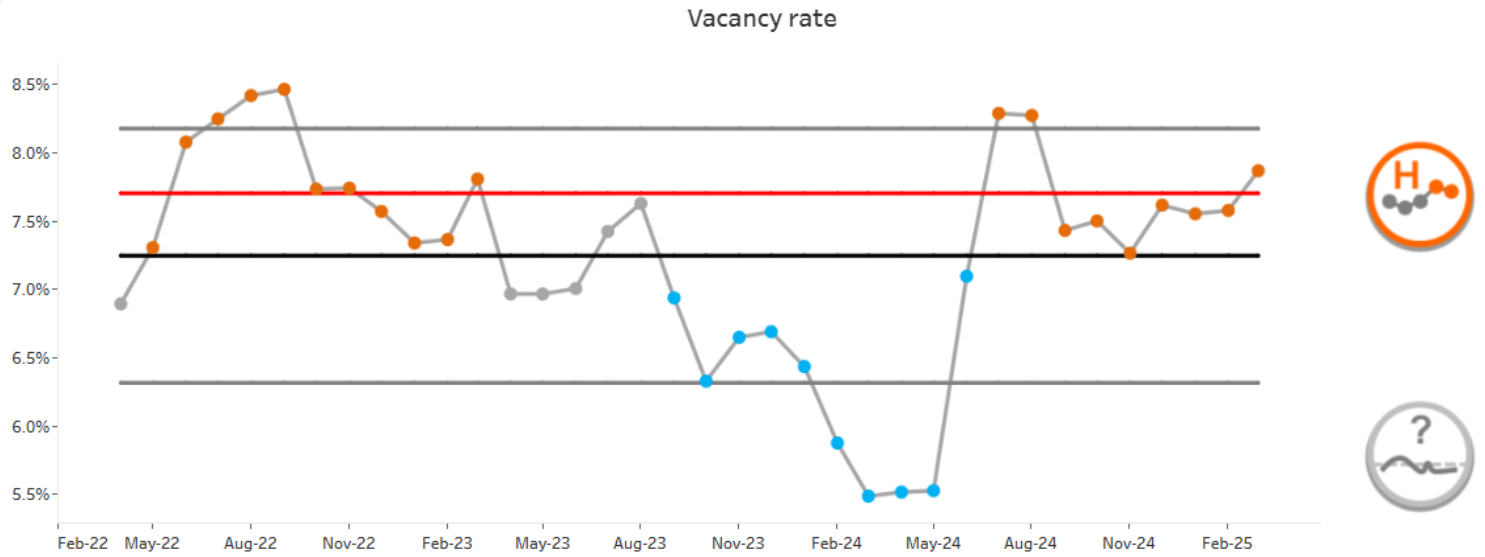


Benchmarking: October 24 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.99% **National: 5.49%** **Shelford: 5%** Buckinghamshire Healthcare NHS Trust: 4.5% Royal Berkshire NHS Foundation Trust: 4.3% Oxford Health: 4.9% South Central Ambulance Service: 6.7%

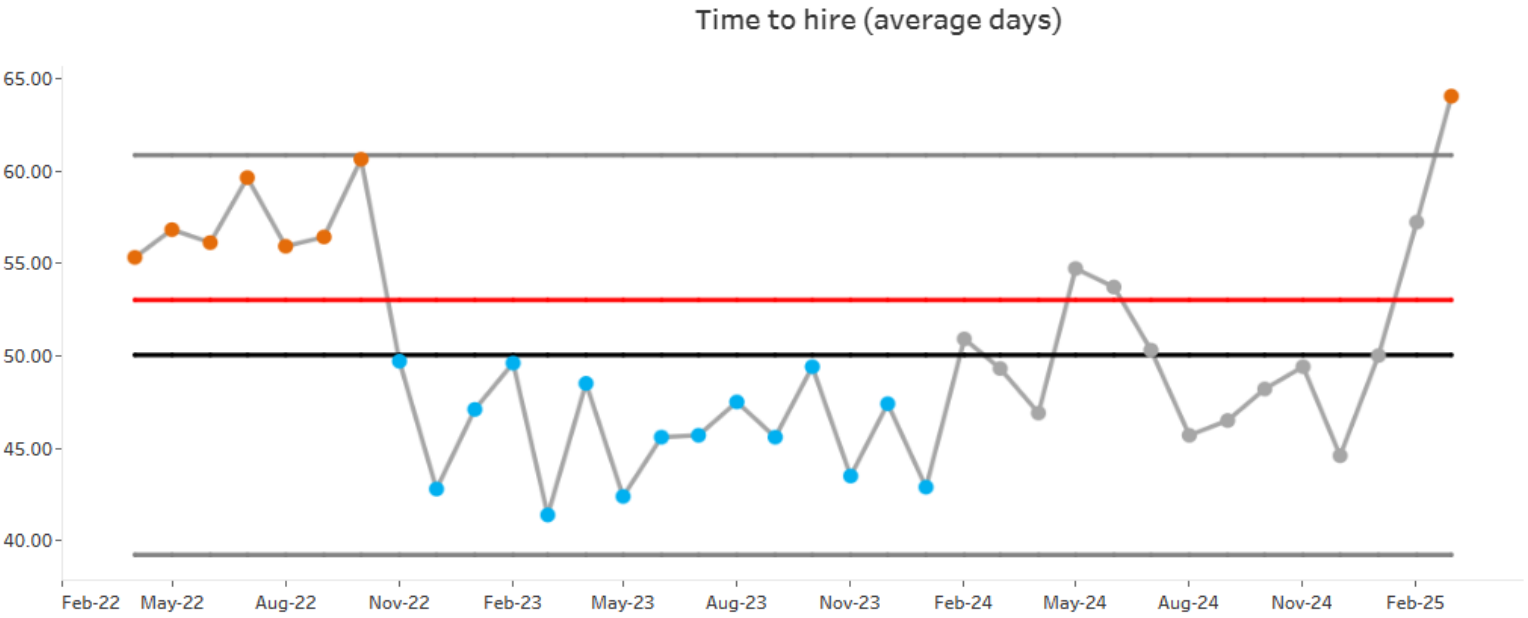
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.2% in March 25. The in month sickness has reduced in part due to a reduction in Flu. The expectation is that this will decrease furter.	• There is a focus on the top CSUs who have a consistent absence. • Collaborative work with Occupational Health to support managers and staff with a review on the top three absence reasons. • A call to action on long term sickness making sure that staff are supported to successfully return to work. • Alerting managers on staff who have triggered, signposting them to support and coaching them through the sickness absence process • HR pro-actively promoting the sickness absence management training to support managers with applying the new procedure. • HR is working closely with managers to ensure RTW's are completed. • Sickness absence workshops continuing to support managers • Continuation of support from OH colleagues at monthly meetings to unblock issues and support with proactive actions • Monthly meetings with Wellbeing lead in place to identify areas where additional support may be needed.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1616 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Growing Stronger Together



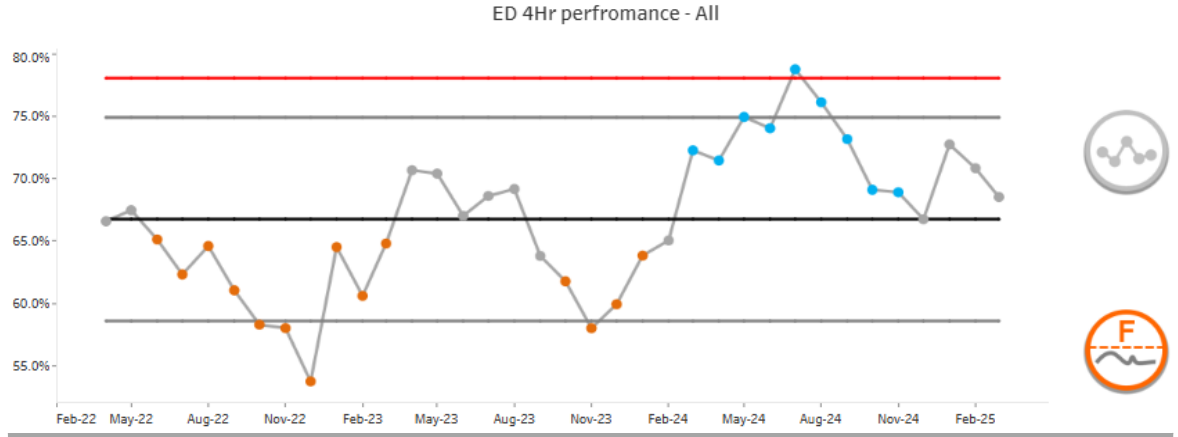
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Increase in vacancies expected following recruitment pause.				

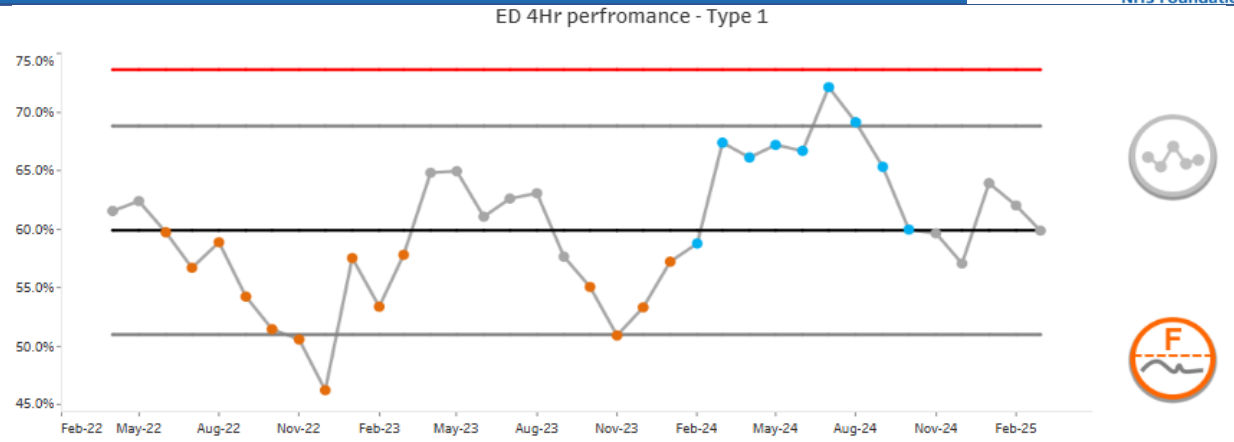
3. Assurance report: Growing Stronger Together



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The time to hire has risen to 57 days, primarily due to a recruitment pause. This pause caused several positions to be held for 30 days before being closed or moved back or offers being re-engaged once a vacancy has gone through the authorisaton process. This in turn is lengthening the recruitment process	• The recruitment team is aiding Divisions with proper vacancy procedures, including centralised nursing and administration processes. • Meetings with each Recruitment Lead are ongoing to support Divisional activities and streamline workflows. • Recruitment colleagues are reviewing time to hire data on a bi-weekly basis with senior leaders in the team to support in finding resolutions within individual recruitment processes • A new escalation process is being rolled out to support Recruitment Coordinators with the process. • The onboarding business case is progressing, with sections launching in June/July 2025 to help achieve approved hiring times.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 3 CRR 2595 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Operational Performance



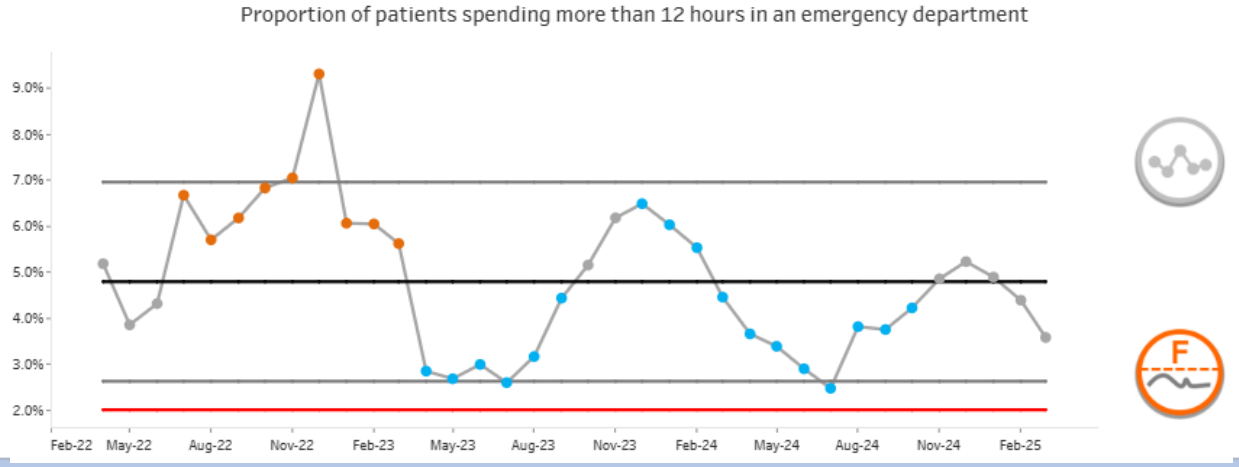


Benchmarking: ED (All types): January 25				
OUH: 70.76%	**National: 72.27%**	**Shelford: 71.78%**	BHT: 78.18%	RBH: 72.27%

ICS key			
BHT	Buckinghamshire Healthcare NHS Trust	**RBH**	Royal Berkshire NHS Foundation Trust

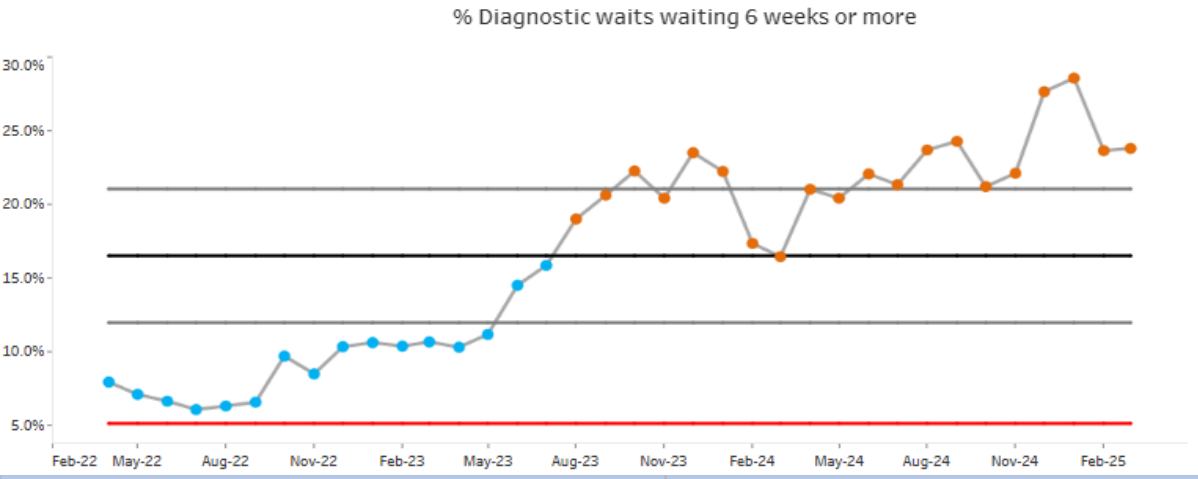
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
The Emergency Department 4hr performance for all types was 68.45% in March for the Trust overall. Type 1 performance was 59.8% for the Trust overall. Breach performance by site was 62.38% for all types and 53.81% for Type 1 at the John Radcliffe Hospital (JR), and 81.55% for all types and 74.22% for Type 1 at the Horton Hospital in March. Average daily attendances to ED remained high across all areas with March seeing the second highest monthly attendances for the last three years. Ambulance conveyance rates have steadily increased month on month over winter. Admission avoidance and the utilisation of alternative pathways via SPA is still emerging and requires further focus and targeted work with system partners to maximise this opportunity. 'Wait to be seen' continues to be the most significant breach reason on both sites for admitted and non-admitted patients accounting for 69% of all breaches. Most significantly, for non-admitted breaches this accounts for 79% of patients breaching four-hours in department. The Observation and Review Unit continues to have a positive impact on patient experience, currently accommodating approximately 35 patients per day, with peaks of up to 50. During March ORU saw 1146 patients supporting 3.5% less Type 1 4hr breaches. Phase 4 of the ORU QI project will introduce a dedicated doctor to provide earlier assessment and treatment, enhancing efficiency and utilisation. Full utilisation will be realised once posts are fully recruited to for the Senior Decision Maker and nursing staff.	**Senior Medical Decision Maker (Consultant) in the JR ED in the overnight period.** The team continue to recruit to the full complement (with attrition) this expected to be complete by June 2025. Quantified benefit realisation is being visualised in dashboard format to enable greater productivities where possible. Through Vacancy Control Process, posts have been approved and out to advert to support agile further recruitment. 4 nights continued to be covered in Q1, with continued phased approach to 7/7 implementation. The **Urgent and Emergency Care Quality Improvement Programme 2024/25** has been in place during the year. Five key priorities were agreed, with the Senior Decision Maker and Rapid Assessment & Treatment / Childrens Urgent Care Pathway priorities having commenced in October. Both of these workstreams are progressing well, with a number of PDSA cycles having been undertaken in the Decision Maker and Rapid Assessment workstream. During Q1 25/26, roll-out of this model will be undertaken and embedded. Agreement to align with the UCC for reporting purposes is also underway. The Urgent and Emergency Care Quality Improvement Programme is under review for 2025/26 following feedback and considering of emerging guidance for 2025/26. These will be reviewed for approval at future Trust Wide Urgent Care Group forums Phase 4 of the ORU QI project will introduce a dedicated doctor to provide earlier assessment and treatment, enhancing efficiency and utilisation.	Recruitment approach underway through 2025/26 completed in June2025. TWUCG Quarter 1 25/26	BAF 4 CRR 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns	Action timescales and assurance group	Risk Register	Data quality rating
The proportion of patients with a length of stay of more than 12 hours in the Emergency Department was 3.5% (610 patients, 38 less than previous month) in March. Whilst there has been an improvement month on month since December, this is above the target and sustaining previous positive performance has been more challenging. The Horton Hospital has made consistent improvements decreasing from 4% in December to 2.9% in January to 2.1% in February and 1.1% in March and is now meeting the target for patients residing in ED for more than 12 hours (50 patients). The JR position has improved month on month since November 2024 with 4.3% of patients residing in ED for more than 12 hours (560 patients). Bed occupancy overall remains high at 95%. The JR has increased from the previous month at 97.74% and the Horton has decreased significantly to 88.25%. The planned additional funded winter beds were open in December and January for both adults and children's beds at the JR. The Winter Super Surge Ward was not required, and staffing was stood down. No additional beds were required at the Horton. All winter beds are now closed and wards have return to normal funded capacity. SDEC capacity has remained protected throughout the year. There has been minimal impact to planned care owing to increasing urgent and emergency care pressures. The proportion of patients whose discharge was delayed was at its lowest point of the year in March with just 7.3% of patients delayed. This equates to 2936 bed days lost in March and a daily average of 95 patients delayed per day. As seen in February, this is an improvement on the same period last year where March 2024 saw 3231 acute bed days lost, daily average of 104 patients delayed and 9.2% of patients delayed. The average number of days delayed in March 2024 was 6.6 compared to 5.5 in March this year. This has been made possible through further system improvement work and the Discharge to Assess (D2A) pathway. The patients with the longest delays were Oxfordshire patients waiting for pathway 3 or out of county delays. The average days delayed for Pathway 3 has been increasing with 14.6 days being the average days delay in March. Whilst D2A is now embedded and there are minimal delays for Oxfordshire residents on this pathway, delays for Pathway 3 and housing related discharge delays continue to be an area of concern for patients in all Oxfordshire bed bases. Associated with the increase in ED attendances, is the medical and social complexity of patients and the impact of D2A where there is a significant increase in care package size and support required for a person to return home. Delays for non-generic pathway 2 beds are becoming an increasing concern and driving an increasing length of delay on this pathway at 6.1 days in March. In contrast, generic patients are transferred in under 24hrs. OUH is holding its position as the best performing Shelford Trust for patients with a stay over 21 days.	• The **live bed state** programme launched in Q3 23/24 with phase 1 successfully implemented across the Trust during Q4. Work continues to finalise plans for phase 2 which was due to launch in Q4 2024/25. • Plans for 12hr total length of stay improvement work in early stages • New **Board Round Policy** relaunched successfully across all adult inpatient areas (44 wards), including Hospices. Trust wide roll-out is underway through the Quality Improvement (QI) Standard Work Programme.	<u>Trust Wide Urgent Care Group</u> January 2025 – not on track due to delays with Cerner. Now resolved. Timescales to be amended once confirmation of Digital work plan confirmed for 2025/26. Q1/2 2025/26 Q3/Q4 2024/25 – on track Adoption in Children's planned for Q1 2025/26	BAF 4 Link to 1133 (Red)	Sufficient *SOP's are in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

3. Assurance report: Operational Performance, *continued*



H

F

Benchmarking: January 25 DM01	
OUH	28.51%
National	16.51%
Shelford	26.98%
ICS	BHT: 30.06% RBH: 13.37%

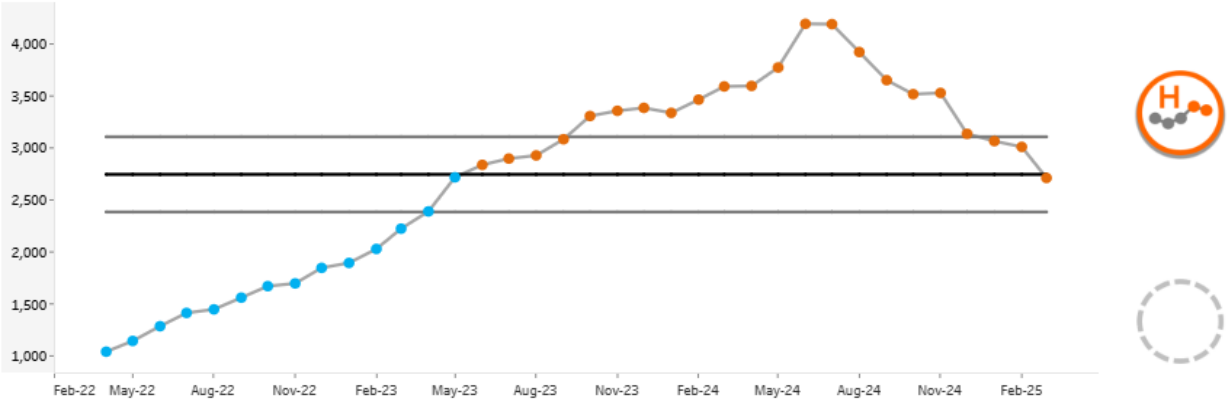
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of diagnostic waits over 6 weeks+ (DM01) was 23.8% in March. The indicator exhibited special cause variation due to performance being below the mean for more than six successive periods, as well as below the lower process control limit. The indicator has consistently not achieved the target of 95.0%. **Audiology:** • Demand above capacity since ENT pathway changes • Clinical staffing gaps • Capacity shortfall for children's audiology tests **Endoscopy:** • Capacity shortages to meet demand • Lapsed Planned patients retriggering as a DM01 reportable **Neurophysiology**: • Capacity mismatch with demand. Insource supplier in place **Ultrasound**: • Difficulty recruiting to sonographer vacancies • Increased demand in gynae pathways. • Reduced sessions due to NHSP changes	**Audiology:** • Northamptonshire referrals are no longer sent to OUH • Insourced capacity commenced in November • Recruitment of clinicians to maintain core capacity levels • Audiology is on a steady trajectory of recovery into 2025/26; however, Children's Audiology continues to experience demand / capacity shortfall. Options for additional support are being explored. **Endoscopy:** • Nurse endoscopist is now independently working from April. • Delivery fund utilised and scheme fully allocated. TVCA funding continuing to support some additional activity. • Review of Clinical Fellow job plans to introduce additional endoscopy capacity, including at HGH • Introduction of clinical triage from February where the pilot has found a discharge rate of 24%, this requires resource allocation from 1st April 2025. **Neurophysiology**: • Another supplier in place in March • Additional sessions undertaken through March. • Clinician returning from a sabbatical in June and will undertake 4PAs each week. **Ultrasound:** • Additional capacity funded through TVCA in Q4 supported performance. • Sessional tracker in place monitoring substantive gaps as well as NHSP uptake. • Workforce plan developed in conjunction with TME approved case for converting the ERF scheme to substantive posts.	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Expected to start recovering from Feb 2025. **Endoscopy:** Expected to start recovering by March 2025 **Neurophysiology:** Expected to recovering from March 2025 **Ultrasound:** Improvement trajectory in development	BAF 4 Link to CRR 1136 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

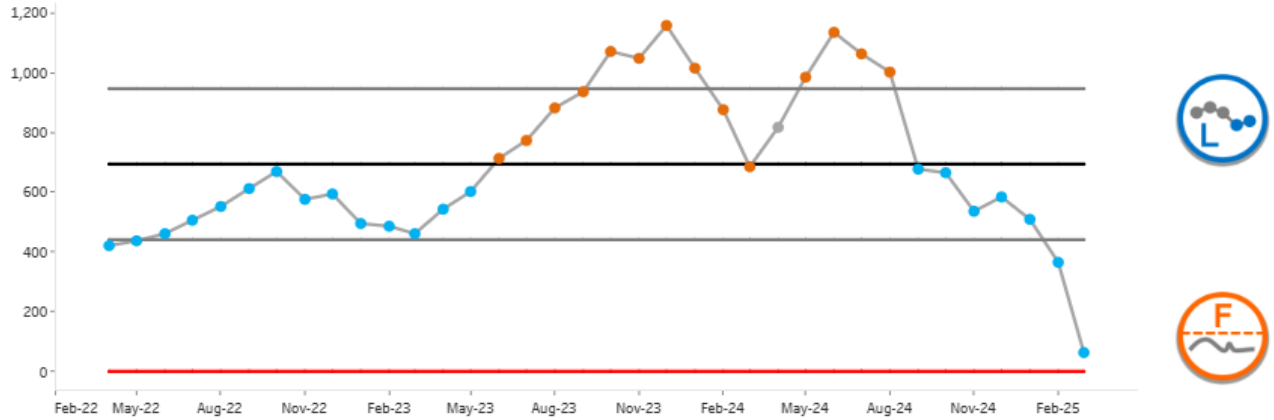
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

RTT standard: >52-week incomplete pathways



RTT standard: >65-week incomplete pathways

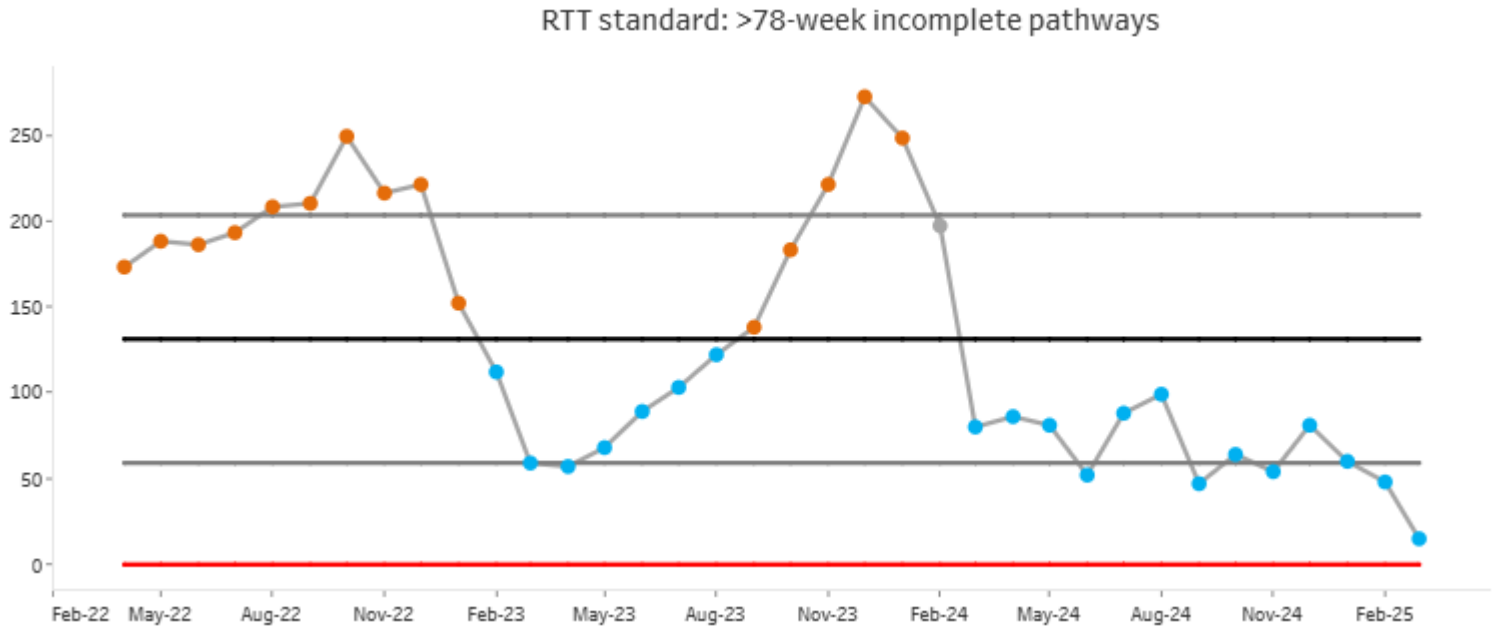


Benchmarking: January 25				
OUH: 3,061	National: 1,072	Shelford: 2,242	BHT: 1,072	RBH: 36

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 or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 2,711 at the end of March. Performance exhibited special cause variation due to >six consecutive periods of performance above the mean and exceeding the upper process control limit. **104 weeks** - **nil** incomplete pathway reported **78 weeks** - **15** incomplete pathways reported. 6 were complex, 6 capacity, 2 spinal adults and 1 patient choice **65 weeks – 63** incomplete pathways reported which is a decrease from the previous month of 302 pathways and better than our forecast trajectory. Focus remains in place to deliver nil pathways beyond 65-weeks. Services will be moving to recovering **52-week backlog in 2025/26.**	• **ENT services** insourcing capacity for Audiology is contributing to backlog recovery, increased paediatric day case capacity mitigating longer waits, insourcing ENT clinics remains in place. Mutual aid via Acute Provider Collaborative for Nose and Throat conditions offered, however minimal impact as backlog support required is for Ear procedures. • **Urology services** (TULA) in place and additional gynae lists identified for repurposing to urology. Insourcing of MEDCARE commenced in February focusing on outpatients and diagnostics. Mutual aid via Acute Provider Collaborative for HOLEP procedures offered however not all patients willing to transfer. • **Orthopaedic services** Weekend lists continued and recovering well. • **Non-admitted pathways** milestone management approach to be adopted enabling focus on increasing scheduled appointments in H1 to either clock stop or convert to follow-up or admission during H2 for service at risk of breaching 52-weeks or 18-weeks where there is no 52-week challenge. • **Patient Engagement Validation** launched for H1 2025/26 undated 1st appointments (4,539). Response rate was 85% (3,851) of which, 42% wish to remain at OUH (1,905), 33% willing to travel within BOB (1,477), 5% wish to be removed as treated elsewhere (247) and 5% wish to be removed as symptoms improved (222). In line with LMC approved process, following 3 mediums of communication attempts over 40-days, 15% have been discharged (688). If all patients were transferred to another provider, we could see up to a 58% attrition to the RTT PTL for those awaiting a 1st appointment. • **Recovery Action Plan** is live and populated against specialty level trajectories for delivery of the forecast	All actions are being reviewed and addressed via weekly Assurance meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*

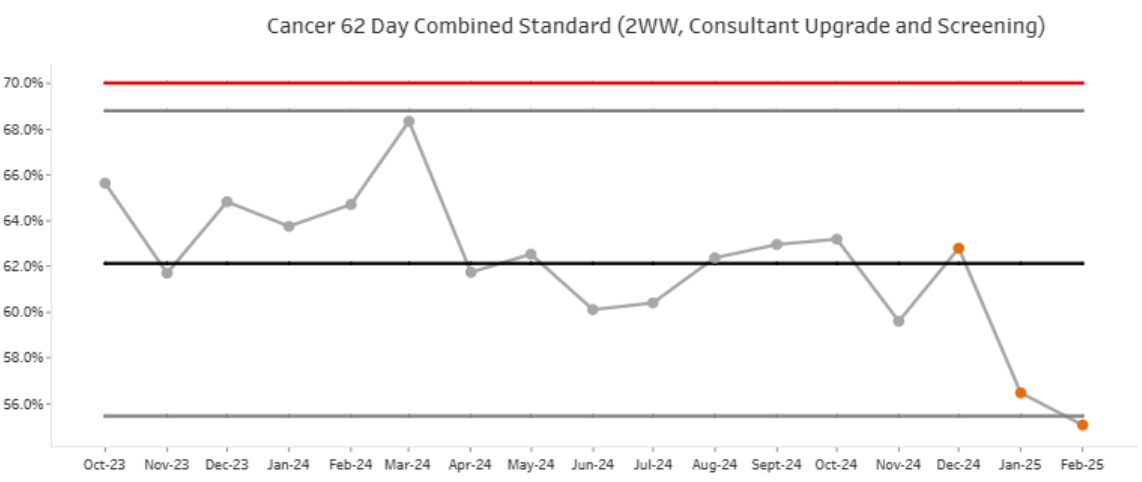


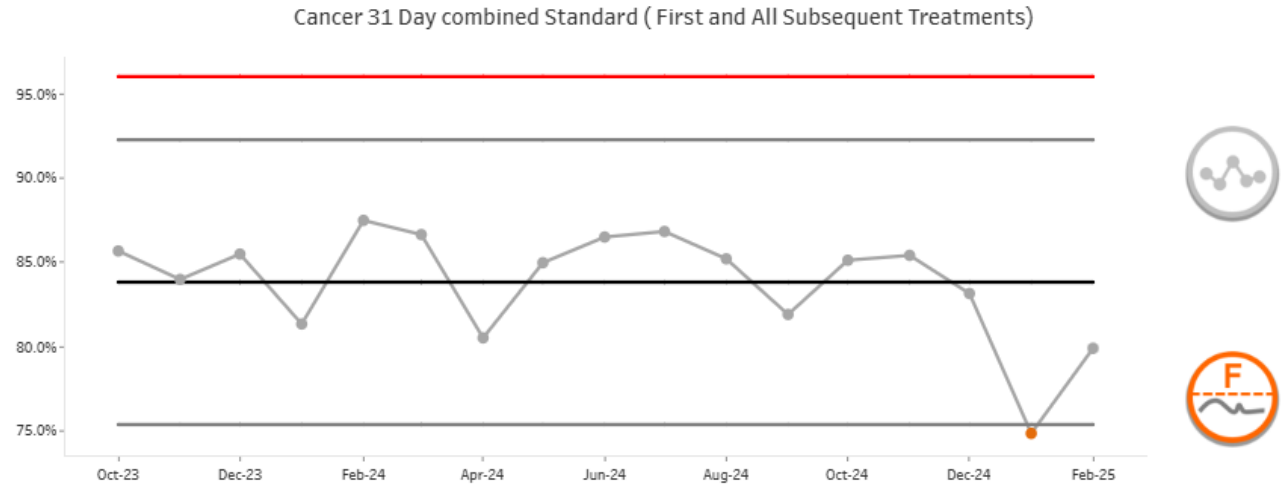
Benchmarking >78-weeks: January 2025	
OUH	60
National	16 (avg.)
Shelford	7 (avg.)
ICS	BHT: 0 RBH: 0

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 or committee	Risk Register	Data quality rating
As stated on previous slide	• Teams are working to reduce the longest waiting patients on the waiting list a full action plan is in place and is monitored through our Tier 1 meeting with BOB & regional colleagues. This includes a number of system wide plans, to include load balancing across BOB.	As stated on previous slide	As stated on previous slide	As stated on previous slide

3. Assurance report: Operational Performance, *continued*



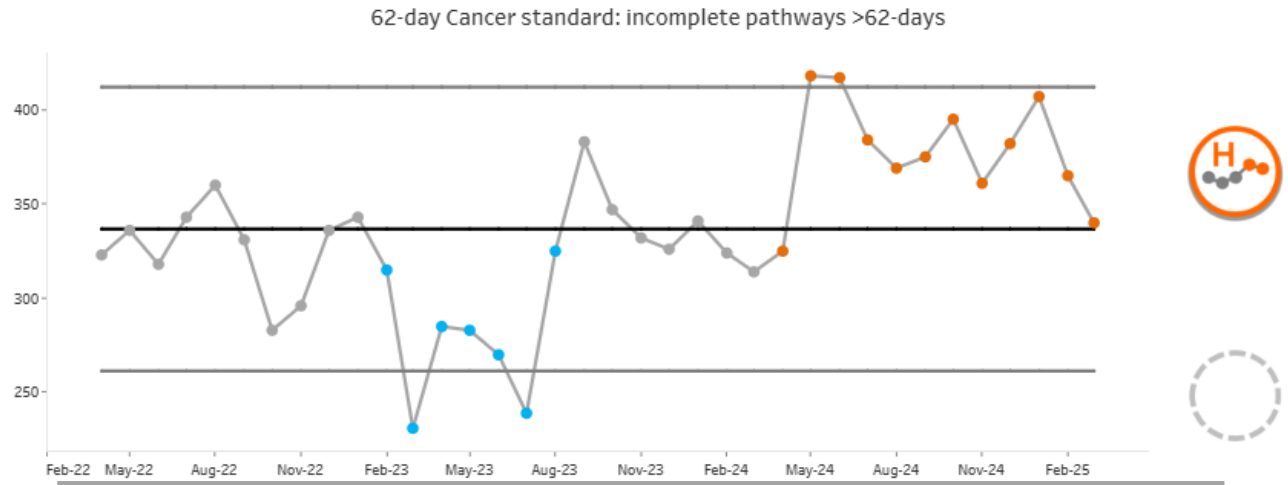


Benchmarking: January 25				
OUH: 57.92%	**National: 63.50%**	**Shelford: 59.44%**	BHT: 45.19%	RBH: 69.41%

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 or committee	Risk Register	Data quality rating
Cancer performance against the 62 days combined standard was 55.0% in February 2025, and below the performance target of 70%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Children's, Other, Skin, Urology Penile and Prostate are non-compliant for this standard in February. **Challenges identified:** • Complex tertiary level patients (8%) • Capacity for surgery, diagnostics and oncology (79%) • Late inter provider transfers (9%) • Patient reasons (2%) **>62-day incomplete PTL** census 23rd Apr 2025 is 409 patients and 10.9% as a proportion of the PTL.	**The Cancer Improvement Programme will be relaunched to combine Quality Improvement (QI) and Strategy to ensure aligned focus on clinically led strategy and operational delivery using QI techniques.** Both focus on 28-day Faster Diagnosis Standard (FDS) and other key standards. **Workshop scheduled** for Lung, Gynae and H&N on Friday 16th May with a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. **Performance of >62-day PTL vs plan –** recovery includes cross-cutting elements: • Incomplete and late Inter-Provider Transfer review and escalation to referring Providers • Surgical capacity through theatre reallocation • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication • Pathway mapping of tumour sites against Best Practice Timed Pathways **Waiting List Census 23/04/2025:** **Urology** remains the highest deficit to plan for >62-days (142 actual vs 42 plan) predominantly due to the increase in referrals linked to public figure awareness. TVCA funding used until end of March, mitigating further backlog impact **Head & Neck** – Demand has risen with this service. TVCA funding used until the end of March, mitigating backlog increase. **Gynaecology** – New consultant started in January providing additional hysteroscopy and operating sessions. Demand remains high for the service, with pre-hysteroscopy clinic have some impact.. **Lung -** Additional bronchoscopy capacity identified and in place. Trial commenced of one list per month in TH20 repurposing a Vascular list, business case for 4th Thoracic surgeon in development	Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024 186 patients over 62 days on the Combined Patient Tracking List to deliver 6% ask. Above trajectory (186) with 409 patients (10.9% vs 6% target) Full baseline review by tumour site against best practice standards to be undertaken in May this will be used to identify key areas to address which may require further actions following deep dives.	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

3. Assurance report: Operational Performance, *continued*

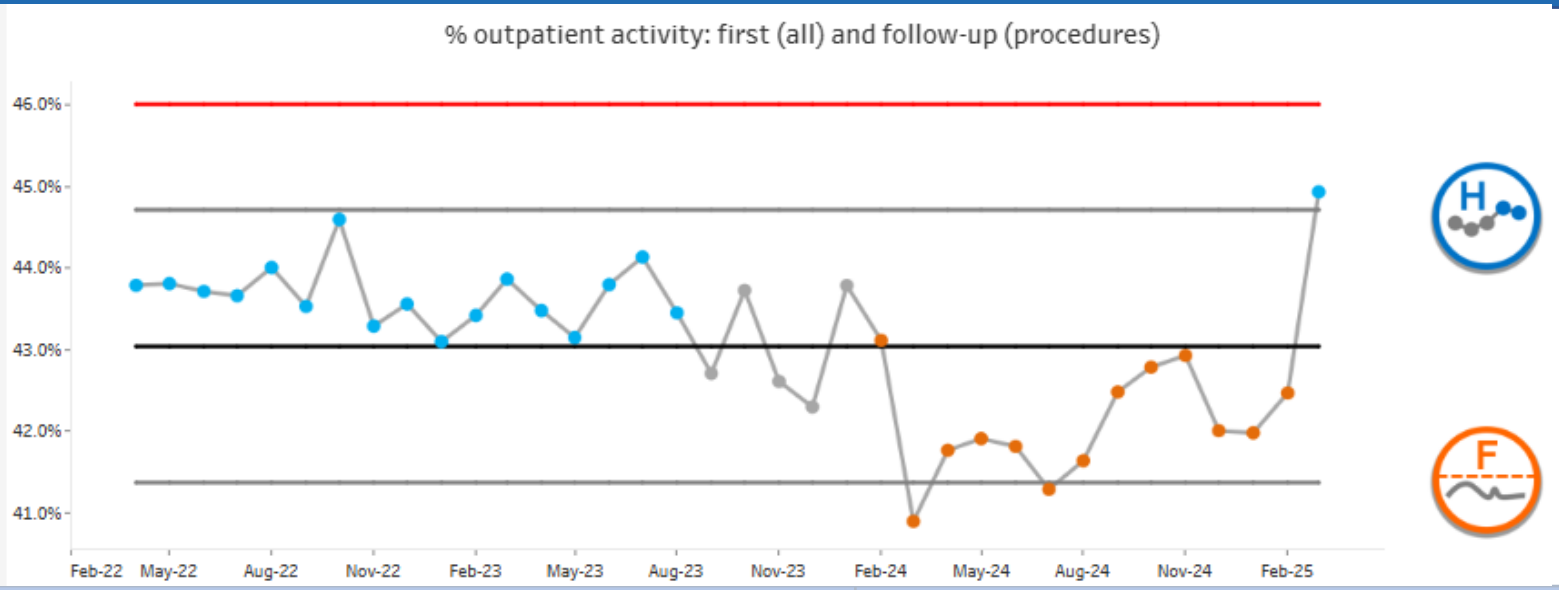


Benchmarking: January 25				
OUH: 57.92%	**National: 63.50%**	**Shelford: 59.44%**	BHT: 45.19%	RBH: 69.41%

ICS key			
BHT	Buckinghamshire Healthcare NHS Trust	**RBH**	Royal Berkshire NHS Foundation Trust

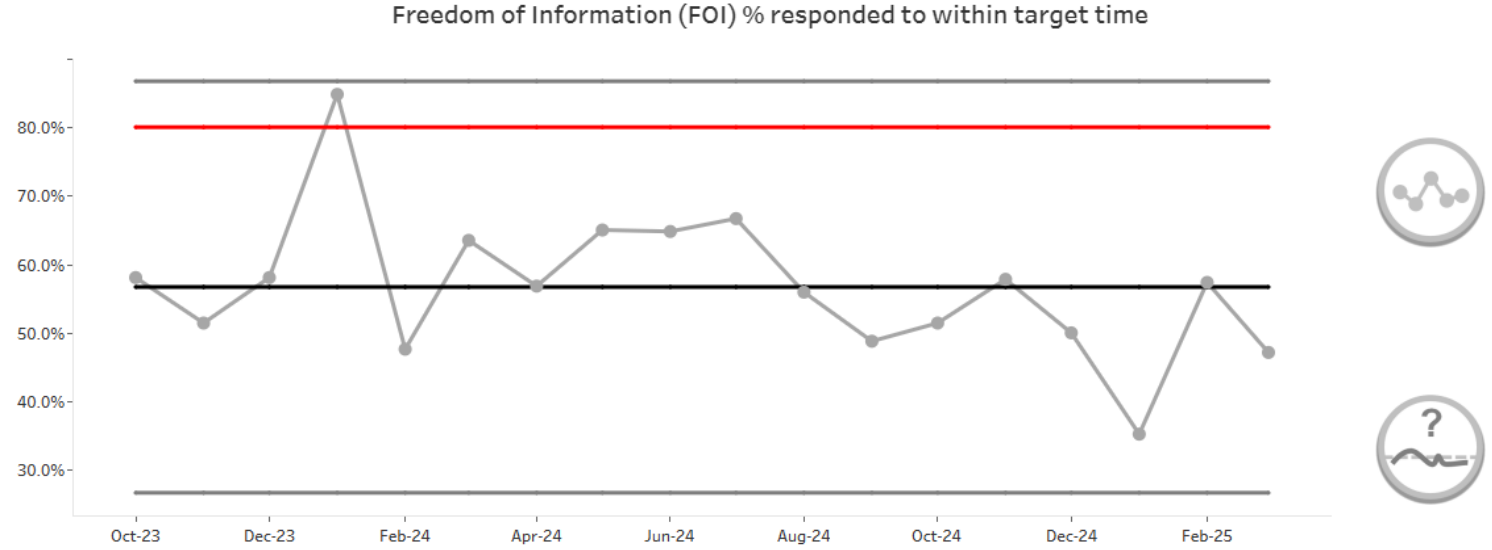
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
As per previous slide	As per previous slide	As per previous slide	As per previous slide	As per previous slide

3. Assurance report: Operational Performance, *continued*



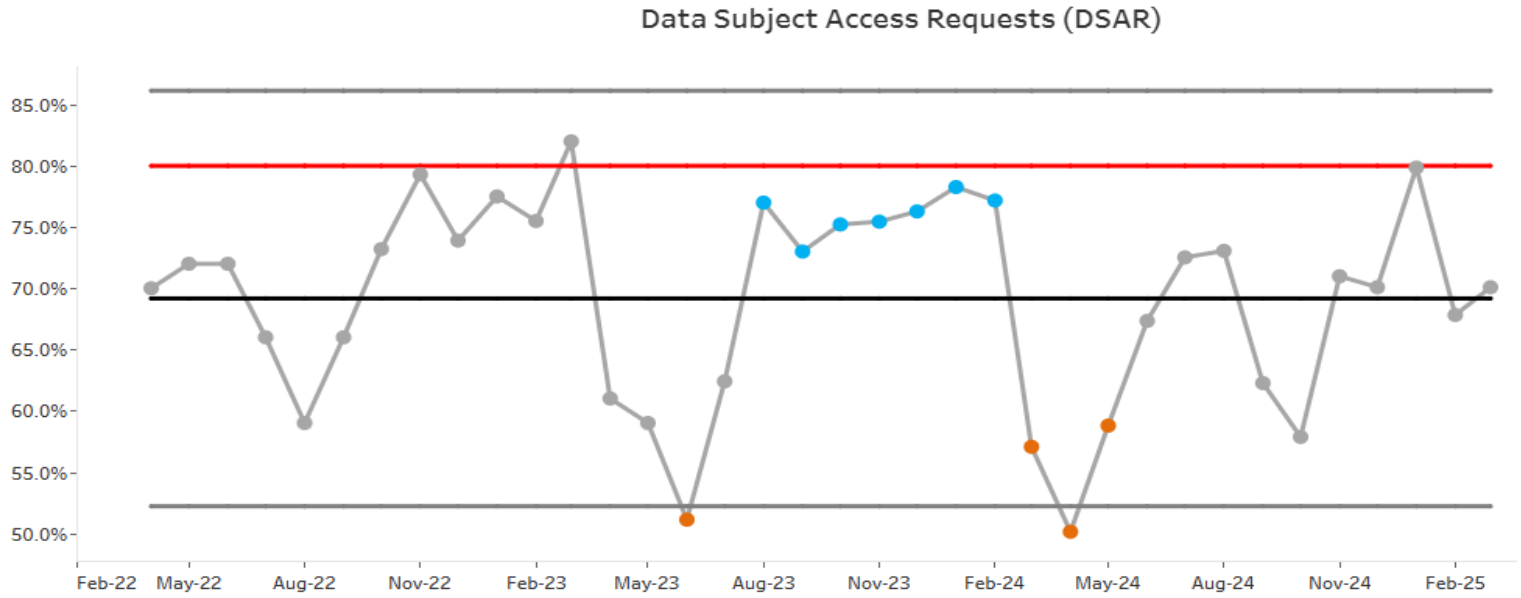
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of first new outpatient and follow-up outpatient appointments with procedures was 44.9% in March. The indicator exhibited special cause improving variation due to performance being above the higher process control limit. The indicator has consistently not achieved the target of 46.0%. Delayed completion of outcome forms to identify procedures in recent months under-reports performance Possibility of some procedures being carried out in theatres instead of an outpatient setting. *the most recent month's position may increase due to the completion of processing outpatient procedure coding.	Evaluation of individual specialties to optimise outpatient procedure activity by reviewing daycase procedures for conversion to an outpatient setting, releasing theatre capacity as well as modelling a one-stop services in outpatients, thus reducing follow-up activity. Using Model hospital GIRFT procedure specific analysis. The Further Faster Programme cohort 3 in association with GIRFT to support this performance metric. Several specialty level working groups in place undertaking evaluation and improvement work under this Programme. Clinic e-Outcome Form piloting in Orthopaedics to improve capture of procedure codes as well as several other benefits. Project Board reporting to Outpatient Improvement Group thus Productivity Committee. External audit supplier, IQVIA analysed missed opportunity for procedure coding by benchmarking specialty level activity. This programme of work is overseen by the Productivity Committee.	OPSG – May 2025	BAF 4 Link to CRR 1135 (Amber)	

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M12 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 57% and exhibited common cause variation. 70 valid cases were received in M12, of which 44 have been closed, 33 of which were closed on time The Trust is facing significant challenges in managing FOI requests, prompting the Information Commissioner's Office (ICO) to issue an Enforcement Notice requiring OUH to respond with a plan by 14th May and implement that action plan by 31st October 2025. There are 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.	An action plan is being developed to be submitted to the ICO to meet the 14th May deadline. The action plan will incorporate learnings from a review of FOI processes being undertaken in partnership with the Trust's Data Protection Officer, and the ICO. This has been expanded to include colleagues from the Quality Improvement team and stakeholders from across the Trust. Responsibility for compliance will also be managed across all areas of organisation. The IG team are attending a series of meetings with the FOI system supplier to work through data quality issues since the move to the new platform. An Improvement Plan has been presented to the Board which incorporate the following: **Escalation Process:** The improved management data will enable an improved escalation process for "stuck" cases. Chief officers will be presented with a list of cases in their areas in this situation **Resourcing:** A temporary increase or diversion of Trust resources to close the overdue cases and increase the monthly response rate to one in equilibrium with the rate at which cases are received will likely be necessary. **Staff Education:** an email detailing FOI responsibilities has been sent to all staff – a follow up in more detail will be sent to FOI stakeholders.	Action plan submitted to ICO: 14th May 2025 Completion of all actions: 31st October 2025 A QI project to examine the FOI process and awareness amongst staff and stakeholders is under way Assurance reviewed at Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

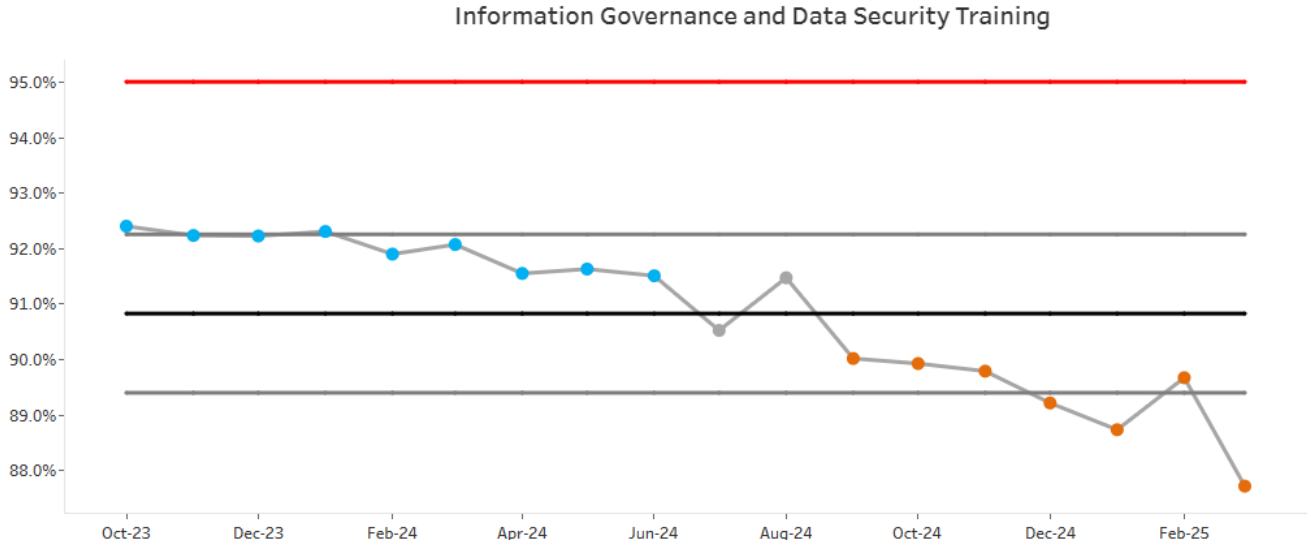
3. Assurance report: Corporate support services - Digital, *continued*



	Number of requests received from 1st - 31st March	Number of requests received from 1st - 31st March (in column B) closed within one calendar month	Percentage of requests received from 1st - 31st March (in column B) closed within one calendar month
Occupational Health	178	164	92%
PACS Team	224	199	89%
Subject Access Team	510	277	54%
Information Governance	4	2	50%
Total	916	642	70%

Summary of incident	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
M12 DSAR performance as a percentage has improved slightly, but as the Subject Access Team continue to receive an elevated number of cases in recent months.	PACS' performance varies depending on clinical pressures. Their seconded staff member has returned to the team. Performance was good this month due to reduced clinical demand. The Subject Access team consistently close 250-300 cases on time per month but receive 430-540 cases. They have received over 500 in M11 and M12	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3646	478	86.9%
Medicine Rehabilitation and Cardiac	3348	376	88.8%
Surgery Women and Oncology	3317	353	89.4%
Clinical Support Services	2406	228	90.5%
Corporate	1013	99	90.2%
Operational Services	220	16	92.7%
Estates	194	26	86.6%
Research and Development	160	22	86.2%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 90% in M12 – this is a recovery towards the target of 95%. With the change in calculation method, a breakdown per Division is now available and included at the top of this slide. No Divisions are currently achieving the 95% target. Satisfactory IG training completions rates are a requirement to pass DSPT – the current situation would not put us in a position to pass the training and awareness section.	Current situation to be presented at DOC on 06/05/2025 to follow up actions with Divisional Directors and senior Digital staff. 1598 staff are currently non-compliant – they (and their managers) are being contacted individually outside of the MyLearningHub platform to encourage them to complete it. Current training levels were noted as a low risk in the recent DSPT audit	Actions and performance are overseen by the Digital Oversight Committee DSPT Audit has been completed and report submitted to Audit Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

4. Development indicators

Chief Officer	Domain	Reporting section	Indicator type	Indicator	Comments
COO	Operational Performance	Elective access	National	Cancer: % patients diagnosed at stages 1 and 2	Further information due on the calculation method of this indicator within the National Planning Guidance
COO	Operational Performance	Elective Access	National	SDEC: % of Same Day Activity	

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

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

2. Framework for levels of assurance:

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