Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Review

M7 (October 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 7 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the NHS England Segmentation and Oversight Framework. The 2026/27 NHS Oversight Framework has been reviewed to incorporate the ICB Operating Model and priorities of the 10-Year Health Plan. The integration of Segmentation outcomes and performance is referenced within the assurance reports, where relevant, noting that the period of measurement can differ from the IPR measures. There are also differences in segmentation scoring based on national ranking and/or performance in relation to the annual plan. Segmentation indicators are identified within this report by the presence of a purple circle and the Public View NHS Oversight Framework dashboard is included (on pages 7 to 9).

Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals (Cancer, UEC, standard work, QI learning hub). We achieved key measures related to patient safety and care experience, including fewer pressure ulcer incidents per 1,000 bed days for hospital acquired category 2 (but not category 3 or 4) and our mortality indicators (SHMI and HSMR - excluding hospices) were below 100, indicating fewer deaths than expected. Safeguarding training compliance for adults and children (L1-L3) were achieved and VTE assessments. There were zero cases of MRSA and C-Diff cases were below the monthly threshold. Patients with Sepsis receiving antibiotics within ED in accordance with NICE guidelines also met the performance standard in month 7.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. We met the non-medical appraisals target as well as targets for core skills training, demonstrating commitment to staff development. We also achieved our time to hire standard. Workforce metrics including, staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our sickness absence rate was worse than threshold for the month and rolling 12-month position, and both indicators exhibited deteriorating Special Cause Variation (SCV). Rates remain better than National and Shelford averages. Turnover rates performed better than the Trust target and exhibited improving SCV. The vacancy rate met the performance target but exhibited deteriorating SCV.

Performance against the operating plan trajectory for A&E waits within 4 hours was non-compliant (below plan) in month 7 for all types (80.1% vs 82.7%) and for type 1 attendances (74.2% vs 76.5%). Performance did not meet the operating plan trajectory for the % of patients waiting over 12 hours (2.9% vs 1.6%). Both A&E all types and 12-hour performance are Segmentation indicators but measured relatively on national performance rather than against the operational plan. In month 7, the submission deadline was extended for RTT indicators and at the time of the submission of this report, the final position was not available. A verbal update will be provided on the month 7 performance. Performance in month 6 did not meet the operating plan target for the Faster Diagnosis Standard (77.0% vs 80.0%) and the 62-day Cancer Standard (56.8% vs 63.2%), both of which are Segmentation indicators. NB. Cancer performance is reported one month in arrears. Diagnostic performance for the DM01, which is a Segmentation indicator, met the operating plan trajectory in month 6 for the % of patients over six weeks (16.9% vs 19.0%).

Service Level Activity Monitoring (SLAM),was 1.52% higher than the income plan YTD to month 7 for the variable elective component and 0.07% below plan overall when the fixed component is included, which incorporates outpatient follow ups. Within the variable elective plan, day-case and inpatient income was above plan (2.38% and 1.73%, respectively) along with outpatient procedures (+6.86%), but outpatient first attendances were below plan (-2.54%).

The Trust has reported a £2.2m deficit in month 7 which is £2.1m adverse the route map value of £0.1m deficit. Against the original Trust plan of £1.1m there is an adverse variance of £3.3m. There are three drivers for the non-delivery in month; costs not being adequately controlled across the cost base, CIP delivery being less than required and temporary staffing spend increasing in month. This has been partially mitigated by several one-off items including the mid-year valuation.

Year to date, the Trust is £7.6m adverse to the original annual plan and £2.1m adverse to the route map. The forecast outturn therefore continues to assume the delivery of a breakeven position for 2026/27 as reflected in the plan and the route map.

The following are the key headlines for the 2026/27 CIP programme in month 7: Planned target: £11.6m, Achievement: £8.8m, Adverse Variance: £2.8m. Recurrent CIP is £4.3m below plan driven by recurrent pay CIP shortfall to plan of £5.6m (including £2.9m shortfall on the strategic central CIP) with an increase in target of £0.6m in month that is unachieved. This is partly offset by income CIP £1.7m above plan.

- Budget WTE are 14,292 for month 7 with worked WTE at 14,253 overall (139 more than month 6) showing vacancies of 38 WTE. Bank use increased to 721 WTE.
- Non-pay (excluding passthrough items) is £2.4m worse than plan, driven by a £2.2m adverse on other expenditure, primarily from an adverse variance of £1.7m on the centrally held non-recurrent CIP target and SDE costs £0.5m (offset by income). This was partly offset by a further non-recurrent Estates PFI water deduction of £0.4m.
- Cash is £16.5m at month 7, which is £13.3m below plan. This is due to higher payments to suppliers. The cash forecast has been updated to partly reflect current trends and shows a year-end balance of £6m. This is dependent on delivery of cash releasing savings in Q3 and Q4.

Indicators identified for assurance reporting are detailed further using standardised assurance templates. Criteria for assurance reporting includes indicators failing to meet performance standards or showing deteriorating SCV. The process also considers indicators without targets and those not flagging SCV in assurance reporting. Assurance reporting includes updates to Tiering requirements for Elective, Cancer, and Urgent and Emergency Care. The data quality ratings of the assurance templates range from 'satisfactory' to 'sufficient', as defined in section 4.

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

- CQC Overdue Actions
- % of Subject Access Requests Responded
- Vacancy Rate
- Sickness Absence rate
- Number of Incidents with Moderate Harm or Above per 10,000 bed days
- Number of Non-Patient Incidents per 10,000 Beddays
- Pressure Ulceration per 1,000 Beddays (Hospital Acquired Cat 3 and Cat 4)
- Number of complaints
- Number of Complaints per 1,000 Beddays
- % of Complaints Responded to Within 25 Working Days
- Friends and Family Test – ED
- % of RTT Patients Waiting over 52 weeks for community services

Common cause variation and missed target

- Priority 1 Incidents
- Reactivated Complaints
- Friends & Family Test % Likely to Recommend – OP
- PFI: % Of Total Audits Completed that Achieved 4 or 5 Stars NOC
- Proportion of Type 1 Attendances Spending More Than 12 hours in ED
- Cancer 28 and 62 Combined standard
- Cancer 31 Day Combined Standard
- Information Governance Training

Special cause variation - improving

- Friends & Family Test % Likely to Recommend – OP
- ED 4hr Performance – All and Type 1
- Core Skills Training Compliance

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).*

Urgent and emergency care: Four-hour performance improved slightly to 80.08% in October but remained below plan, while 12-hour total length-of-stay performance deteriorated to 97.08%. Increased walk-in demand drove pressure, with John Radcliffe type 1 attendances 12.8% higher than October 2025. Actions include patient-cohort analysis, Perfect Week reviews and Home First improvements, alongside winter mitigations for delays to the Level 1 redevelopment.

Corridor care: ED corridor-care episodes remained broadly static, predominantly at the John Radcliffe, although total corridor-care hours fell by 24% between June and September. SEU reported no episodes after 24 June. The combined Corridor Care Taskforce meets fortnightly, with 82% compliance against the GIRFT improvement guide and workstreams covering discharge lounges, ED streaming, the Full Hospital Protocol and healthcare-professional referrals to SCAS, targeting completion in December.

Cancer 62-day performance: Performance reached 56.8% in September against a 63.2% operational plan and the 85% national standard, with pathway numbers 3% above the annual average. Dermatology contributed to the deterioration, although the service reported recovery in November through insourcing and prioritising cancer patients. Weekly Cancer Delivery Action Group meetings track tumour-site recovery priorities, supported by MDT efficiency reviews, quality-improvement work and specific backlog and breach targets for March delivery.

Referral to treatment: At the end of September, 63.9% of patients had waited less than 18 weeks, meeting the operational plan and exhibiting improving Special Cause Variation following more than six consecutive periods above the mean. Recovery work prioritises the longest waits through pathway validation, outpatient and theatre improvements, and additional insourcing. The Surgical Elective Centre opening has moved from July to 9 December, with progress overseen through weekly Check and Challenge meetings and divisional performance reviews.

MSSA and MRSA bacteraemia: There were four healthcare-associated MSSA bacteraemia cases in October, bringing the cumulative position to two fewer cases than at the same time last year. Two cases involved peripheral cannulas, with reviews identifying gaps in documentation and monitoring that clinical teams have received for learning, while failure to remove cannulas no longer in use will be escalated through PSEC. There were no MRSA bacteraemia cases in October, leaving the cumulative total at seven, one fewer than at the same time last year.

E. coli bacteraemia: There were 19 E. coli bacteraemia cases reported in October bringing the cumulative position to five fewer cases than at the same time last year. Despite this improvement, performance remained 28 cases above trajectory against the annual threshold of 165, with a latest NHS Oversight Framework score of 3. Good catheter management remains a focus, supported by a trial of new catheter packs.

C. difficile infection: Performance continued to improve, with current infection rates remaining below threshold and the Trust achieving the required 70% target for use of 'Access' antibiotics, which the report identifies as the most likely driver of improvement.

Patient safety incidents: October recorded 202 incidents against a seven-month mean of 151, comprising 161 patient incidents and 41 staff incidents, although the increase in patient safety incidents remained within common cause variation. The largest increases involved assault, aggression and harassment, maternity, and surgical incidents. Reviews identified no unusual maternity trends, and four surgical cases received additional Clinical Governance and Deputy Chief Medical Officer review without further learning responses.

Never Events: One Never Event involving a retained swab following colposcopy entered a Patient Safety Incident Investigation in October, one month after completion of a previous retained-swab investigation whose action plan remained incomplete. The new investigation will build on the earlier findings, with interim measures including an updated LocSSIP, faster scanning of count sheets and strengthened colposcopy nurse staffing. Further work includes aligning consumables across the JR and Horton, moving to packs of five swabs and exploring tracking and counting solutions, with investigation actions managed through Ulysses under Patient Safety Team and divisional governance oversight.

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CQC inspection actions: Work continues against the 14-action plan following the June 2026 John Radcliffe Hospital maternity inspection, with environmental and fire safety work remaining the principal outstanding area. The update confirms completion of the previously overdue action, while the environmental and fire safety survey is substantially complete and remedial work is progressing. Fire door replacement will commence before Christmas 2026, although the wider programme remains dependent on Building Safety Regulator approvals and coordination with clinical services. Assurance continues through the Evidence Review Group and fortnightly Chief Executive meetings, with newborn care inspection progress due for review on 30 November ahead of a CQC engagement meeting in February 2027.

Hospital-acquired pressure ulcers: The Trust reported 15 Category 3 hospital-acquired pressure ulcers in October, equivalent to 0.44 per 1,000 bed days, alongside one Category 4 incident, the first since October 2025. Preliminary learning identified increased patient acuity and workforce pressures as potential contributors, while a comprehensive review of the Category 4 incident continues. Prevention audit compliance reached 92.35%, exceeding the 90% target, and Category 2 incidents fell by 12% compared with October 2025. Priorities include reviewing incidents for common themes, targeted harm reviews and Matron-led assurance rounds, supported by the revised prevention policy, staff education and monthly audits, alongside a proposed PressureAI pilot and early exploration of eKare.

Complaints: The Trust received 250 formal complaints in October, remaining above the process mean and sustaining pressure on divisional and Corporate complaints capacity. Approximately 36% of complaints met the 25-working-day standard against an 85% target, with timeliness continuing to exhibit deteriorating Special Cause Variation (SCV). Reopened complaints decreased during October, while their proportion has remained broadly stable as overall complaint volumes have increased over the past two years. Communications and Clinical Treatment accounted for 42% of complaints, with Acute Medicine and Rehabilitation recording the highest directorate volume at 32. Divisional and service reviews continue to identify recurring themes and improve initial response quality, supported by weekly Chief Nursing Officer divisional meetings and oversight through the Patient Experience and Engagement Committee.

FFT (OP and ED): October Friends and Family Test positive scores were 94.5% for outpatients and 75% for ED, below their respective 95% and 85% targets. Outpatients received 127 responses, while ED received only four responses from 9,330 eligible attendances, substantially limiting conclusions about overall ED patient experience. Response volumes remained low following the provider transition because SMS invitations remain paused while the Trust finalises Business Rules, including safeguarding requirements, and appropriate exclusions. The priorities include restoring SMS invitations, improving feedback collection and embedding the Patient Experience Survey.

RIDDOR incidents: The Trust reported eight incidents to the Health and Safety Executive in October, with five falling outside notification deadlines because of delayed Ulysses reporting and investigations affected by unreported sickness absence. Incidents comprised three lifting and handling injuries, two staff slips, trips and falls, and three needlestick injuries involving blood-borne virus exposure. Reviews identified no common themes among the manual handling incidents, and referrals to the back care team will confirm appropriate risk assessments and safe working practices. Divisional health and safety leads have reviewed the remaining incidents, with Occupational Health follow-up for blood-borne virus exposure due for confirmation by the end of December and monthly monitoring of reporting timeliness continuing.

Sickness absence: Rolling sickness absence increased to 4.4%, with a monthly rate of 5.3%, remaining above the Trust target of 3.1%. NOTSSCaN and SUWON recorded the highest rolling rates at 4.7%, while mental health and musculoskeletal conditions featured among the leading causes of absence. Divisional engagement continues to embed the new absence management system, alongside Occupational Health support and tailored interventions for colleagues experiencing long-term sickness.

Vacancy rate: The Trust vacancy rate improved to 7.3% in Month 7, down from 7.5% in Month 6 and below the 7.7% target. Most divisions reported improvements, with MRC retaining the lowest rate at 6%, although bank usage remains a focus. Targeted recruitment campaigns and divisional support sessions continue to address hard-to-fill roles and improve time to hire.

1. OUH NOF dashboard

Oxford University Hospitals NHS Foundation Trust

Overview of dashboard

The OUH NHS Oversight Framework is shown in the Public View dashboard. The dashboards presents the latest available information submitted and therefore can be used to forecast the likely Segment Position and therefore provides early visibility of likely NOF outcomes. This can support executive decision-making, strengthen Board assurance, highlight emerging performance risks and improve the quality of Integrated Performance Reporting.

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

Summary of performance Q1

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

Access to services: Quartile score 3

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

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

Effectiveness and experience of care: Quartile score 4

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

- % of patients readmitted within 30 days of discharge 4/ rank 97 * ***this metric is under further investigation as includes those patients on ambulatory pathways (SEU pathway)***
- % of acute patients making a supported quit attempt with an in-house tobacco dependence treatment service. 4/ (no national rank due to banding classifications) ****this is being reviewed as we did not submit the data***

Patient Safety: Quartile score 2

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

Finance, Productivity and innovation: Quartile score 2

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

People: Quartile score 1

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

Experience of care (new): Quartile score 2

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

1. NOF dashboard – Public View

Oxford University Hospitals NHS Foundation Trust

Access to services

Access to Services

9 Scoring KPIs Mean Score: 2.31

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Cancer - Patients treated within 62 of referral QTD	Q2 26/27	80.00%	**62.36%**			3.71
Cancer - Urgent referrals diagnosis within 4 weeks QTD	Q2 26/27	80.0%	80.8%			1.00
Community Services - Patients waiting less than 18 weeks	Sep 26	78.00%	**40.43%**			3.44
Community Services - Patients waiting over 52 weeks	Sep 26	-	4.34%			3.16
Diagnostics - 6 Week Standard	Sep 26	-	19.00%			2.66
ED - Attendances managed within 4 hours - Acute trust footprint QTD	Q2 26/27	82.00%	82.40%			1.00
ED - Attendances over 12 hours in department QTD	Q2 26/27	-	2.1%			1.30
RTT - Patients waiting 18 weeks or less	Sep 26	-	63.85%			3.10
RTT - Patients waiting over 52 weeks	Sep 26	0.00%	**1.93%**			3.46

9 NOF Metrics

Experience of Care and Effectiveness of Care

Experience of Care

2 Scoring KPIs Mean Score: 2.19

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
CQC inpatient survey satisfaction rate	2026	-	4.0			2.00
Staff Survey - Advocacy sub-score	2025	-	6.79			2.02

2 NOF Metrics

Effectiveness of Care

3 Scoring KPIs Mean Score: 2.43

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Delayed inductions rate	Q2 26/27	-	6.9			1.28
Patients readmitted within 30 days of discharge	2025	-	15.4%		Non-Linear Spread	4.00
Summary Hospital Mortality Indicator	Jun 26	-	0.90		Non-Linear Spread	2.00

3 NOF Metrics

1. NOF dashboard – Public View

Oxford University Hospitals NHS Foundation Trust

Patient safety

Patient Safety

5 Scoring KPIs Mean Score: 2.20

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Clinical audit outlier score	Q1 26/27	-	1			1.00
Number of MRSA bacteraemia cases	Jul 26	0	6			3.37
Rate of C-Difficile	Jul 26	-	2.00		Non-Linear Spread	2.00
Rate of E-Coli bacteraemia	Jul 26	-	3.00			3.00
Staff Survey - Raising Concerns sub-score	2025	-	6.31			2.64

5 NOF Metrics

Population Health, Prevention and Reducing Inequality

Population health, prevention and reducing inequality

1 Scoring KPIs Mean Score: 4.00

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Inpatients seen by an tobacco treatment services who commence a quit attempt	Q1 26/27	0.10%	0.00%		Non-Linear Spread	4.00

1 NOF Metrics

1. NOF dashboard – Public View

Oxford University Hospitals NHS Foundation Trust

People

People

6 Scoring KPIs Mean Score: 1.76

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Frontline healthcare workers to receive a flu vaccination	Q4 25/26	-	52.0%			2.06
NETS - Overall Experience subscore	2025	-	77.18			2.22
NHS staff standards sub-score	2026	-	7.64			1.81
Sickness Absence Rate QTD	Q2 26/27	-	4.43%			1.34
Staff Survey - Engagement Theme Score	2025	-	6.85			2.14
Temporary staffing cost relative band	Q1 26/27	-	1			1.00

6 NOF Metrics

Finance, productivity and innovation

Finance, Productivity and Innovation

6 Scoring KPIs Mean Score: 2.35

Key Performance Indicator	Period	Target		SPC	Segment Position	Score
Clinical trials set up within 90 days	Q1 26/27	95.00%	21.74%		Non-Linear Spread	4.00
Data Quality Maturity Index (DQMI)	Jul 26	-	92.3			2.85
Finance - Combined finance score	Q1 26/27	-	1			1.00
Finance - Planned surplus/deficit	Q1 26/27	0.00%	0.00%			1.00
Finance - Variance year-to-date to financial plan	Q1 26/27	0.00%	0.07%			1.00
Productivity - Relative difference in costs	Q4 24/25	-	99.6%			2.35

6 NOF Metrics

Integrated Performance Report (SPC)

NHSE Segmentation Indicator

Safety, Effectiveness, and Patient Experience

No specified section

Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
1	CQC Overdue Actions	No	Aug-26	1	0	0	0	0		
21	MRSA Cases: HOHA+COHA Per 10,000 Beddays	Yes	Aug-26	0.32	1.65	0.48	0.00	0.00		
22	MRSA Cases: HOHA+COHA	Yes	Oct-26	0	3	1	0	0		
23	C-Diff Cases: HOHA+COHA Per 10,000 Beddays	Yes	Oct-26	1.88	5.77	2.91		0.05		
24	C-Diff Cases: HOHA+COHA	Yes	Oct-26	6	19	9	9	0		
25	E. Coli Cases: HOHA+COHA Per 10,000 Beddays	Yes	Oct-26	5.64	9.33	5.42		1.51		
26	E. Coli Cases: HOHA+COHA	Yes	Oct-26	19	30	18	14	5		
27	MSSA Cases: HOHA+COHA	Yes	Oct-26	4	12	5		0		
28	Number Of Never Events	No	Oct-26	1	2	0	0	-1		
29	Non-Thematic Patient Safety Incident Investigations	No	Oct-26	4	6	2		-3		
30	PSII Overdue Actions	Yes	Oct-26	11	49	28		7		
31	VTE- Submitted Performance	Yes	Sep-26	95.8%	96.2%	95.5%	95.0%	94.7%		
32	% Of Emergency Admissions 65yrs + Receiving Cognitive Screen	Yes	Oct-26	74.2%	74.6%	67.3%		59.9%		
33	% Patients With Sepsis Attending ED Receiving Timely Antibiotics In Accordance With NICE Guidelines	Yes	Oct-26	91.7%	109.8%	84.5%	90.0%	59.2%		
34	CAS Alerts Breaching Deadlines At End Of Month And/Or Closed During Month Beyond Deadline	No	Oct-26	0	0	0	0	0		
35	Medication Incidents Causing Moderate Harm, Major Harm Or Death As Reported On Ulysses	Yes	Oct-26	6	9	3		-3		
36	HSMR Excluding Hospices	No	Jul-26	92.6	95.4	93.0	100.0	90.6		
37	Summary Hospital-Level Mortality Indicator	No	Jun-26	90.0	91.2	89.5	100.0	87.9		
38	Neonatal Deaths Per 1,000 Total Live Births	Yes	Sep-26	3.88	7.36	3.31	3.20	-0.75		
39	Stillbirths Per 1,000 Total Live Births	Yes	Sep-26	2.76	7.27	2.96	4.00	-1.35		
40	National Patient Safety Alerts Not Completed By Deadline	No	Oct-26	0	0	0		0		
42	Number Of Active Clinical Research Studies Hosted	Yes	Oct-26	1623	1482	1443		1403		
43	Number Of Active Clinical Research Studies (Commercial)	Yes	Oct-26	481	419	403		386		
44	Number Of Active Clinical Research Studies (Non Commercial)	Yes	Oct-26	1142	1064	1040		1016		
45	Number Of Incidents With Moderate Harm Or Above Per 10,000 Beddays	Yes	Oct-26	64.51	59.84	46.43		33.02		

Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
45	Number Of Incidents With Moderate Harm Or Above Per 10,000 Beddays	Yes	Oct-26	64.51	59.84	46.43		33.02		
46	Number Of Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays	Yes	Oct-26	51.36	53.34	39.63		25.93		
47	Number Of Non-Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays	Yes	Oct-26	13.15	12.23	6.80		1.36		
48	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 2)	Yes	Oct-26	1.75	2.67	1.83	1.90	1.00		
49	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 3)	Yes	Oct-26	0.44	0.42	0.26	0.20	0.10		
50	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 4)	Yes	Oct-26	0.03	0.00	0.00	0.00	0.00		
51	Pressure Ulceration Incidents Per 1,000 Beddays (Present On Admission Cat 1+)	Yes	Oct-26	8.24	11.97	9.62		7.27		
52	Total Number Of Patient Falls Per 1,000 Bed Days	Yes	Oct-26	4.95	5.89	4.76		3.63		
53	Patient Falls (Moderate And Above) As Reported On Ulysses	Yes	Oct-26	4	10	4		-2		
54	Patient Falls (Moderate And Above) As Reported On Ulysses Per 1,000 Beddays	Yes	Oct-26	0.13	0.31	0.13		-0.06		
55	Health And Safety Related Incidents - Assault, Aggression And Harassment	Yes	Oct-26	201	275	198		121		
56	Adult Safeguarding Activity	Yes	Oct-26	1728	2224	1596		968		
57	Children's Safeguarding Activity	Yes	Oct-26	797	771	508		246		
58	Adult Safeguarding Activity And Children's Safeguarding Activity	Yes	Oct-26	2525	2881	2104		1327		
59	Safeguarding (Children) Training Compliance L1 - L3	Yes	Oct-26	90.0%	92.3%	90.4%	90.0%	88.4%		
60	Safeguarding (Adults) Training Compliance L1 - L3	Yes	Oct-26	91.0%	93.8%	91.9%	90.0%	89.9%		
61	Total Deliveries In Month	Yes	Oct-26	659	693	597	625	501		
62	Babies Born	Yes	Oct-26	679	707	608		508		
63	Maternity Bookings (Planned + Unplanned)	Yes	Oct-26	645	811	670	750	529		
64	Inductions Of Labour From IView	Yes	Oct-26	150	170	124		78		
65	Midwife Ratios (Birth Rate / Staffing Level)	Yes	Oct-26	25.8	27.7	23.6	22.9	19.6		
66	Number Of Learning MDT Reviews Instigated	Yes	Oct-26	2	5	2		-1		
67	Percentage Of Learning MDT Reviews Within 42 Days	Yes	Oct-26	0.0%	176.8%	50.3%		-76.1%		
68	After Action Review (AAR)	No	Oct-26	14	22	14		6		
69	Percentage Of AAR's Within 30 Days	Yes	Oct-26	75.0%	112.1%	73.5%		34.8%		

Integrated Performance Report (SPC)

No specified domain
No specified section

Data updated on: 19/11/2

SPC Chart | Show SPC legend

Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
70	Number Of Complaints	Yes	Oct-26	253	256	199		142	H	
71	Number Of Complaints Per 1,000 Beddays	Yes	Oct-26	7.92	8.60	6.37		4.15	H	
72	Reactivated Complaints	Yes	Oct-26	24	31	17	1	4		F
73	% Of Complaints Responded To Within 25 Working Days	Yes	Oct-26	36.1%	57.3%	37.8%	85.0%	18.3%	L	F
74	Number Of RIDDORs	Yes	Oct-26	8	13	6	5	-1		?
75	Friends & Family Test % Likely To Recommend - IP	Yes	Oct-26	97.8%	96.7%	94.8%	95.0%	92.9%	H	?
76	Friends & Family Test % Likely To Recommend - OP	Yes	Oct-26	94.5%	95.0%	93.9%	95.0%	92.8%		F
77	Friends & Family Test % Likely To Recommend - ED	Yes	Oct-26	75.0%	85.7%	80.6%	85.0%	75.5%	L	?
78	FFT Maternity % Positive (Births)	Yes	Oct-26	83.3%	108.3%	90.8%	90.0%	73.4%		?
79	Inpatient FFT (Response Rate)	Yes	Oct-26	4.2%	23.2%	18.2%		13.3%	L	
80	Outpatient FFT (Response Rate)	Yes	Oct-26	0.1%	9.8%	8.4%		7.1%	L	
81	ED FFT (Response Rate)	Yes	Oct-26	0.0%	17.5%	13.7%		9.9%	L	
82	Maternity FFT (Response Rate; Births)	Yes	Oct-26	1.4%	9.2%	3.1%		-2.9%		
83	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars JR	Yes	Oct-26	99.6%	100.6%	95.3%	95.0%	89.9%		?
84	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars CH	Yes	Oct-26	100.0%	104.3%	96.5%	95.0%	88.6%		?
85	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars NOC	Yes	Oct-26	93.2%	104.2%	96.7%	95.0%	89.1%		?
86	Incident Rate Of Violence And Aggression (Rate Per 10,000 Beddays)	Yes	Oct-26	62.94	91.41	63.29		35.18		
87	Trust Level: CHPPD Vs Budget	Yes	Oct-26	47.4	43.6	19.9		-3.7		
88	Trust Level: CHPPD Vs Required	Yes	Oct-26	4.8	19.8	-0.5		-20.8		

Integrated Performance Report (SPC)

NHSE Segmentation Indicator

Operational Performance

Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
89	Proportion Of Ambulance Arrivals Delayed Over 30 Minutes	Yes	Sep-26	5.7%	8.5%	6.2%		3.9%		
90	Proportion Of Ambulance Arrivals Delayed Over 60 Minutes	Yes	Sep-26	0.2%	1.2%	0.4%		-0.4%		
[illegible]	ED 4Hr Perfromance - All	Yes	Oct-26	80.1%	82.5%	77.0%	82.7%	71.4%		
92	Mean Ambulance Handover Time In Seconds For All Handovers At Trust Level	Yes	Sep-26	1033	1123	1046	1180	969		
93	ED 4Hr Perfromance - Type 1	Yes	Oct-26	74.2%	76.3%	69.4%	76.5%	62.5%		
94	No Of Corridor Care Patients In IP Wards At 8am	Yes	Oct-26	0	22	5	0	-12		
95	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day, All Sites	Yes	Oct-26	20.4	26.2	15.2		4.2		
96	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day, Horton Site	Yes	Oct-26	2.0	3.2	1.4		-0.5		
97	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day, John Radcliffe Site	Yes	Oct-26	18.4	24.7	13.8		2.9		
[illegible]	Proportion Of Type 1 Attendances Spending More Than 12 Hours In An Emergency Department	Yes	Oct-26	2.9%	4.9%	2.8%	1.6%	0.7%		
99	Proportion Of Patients Discharged From Hospital To Their Usual Place Of Residence	Yes	Oct-26	95.9%	96.1%	95.7%		95.2%		
[illegible]	% Of RTT Patients Waiting For A First Appointment	Yes	Oct-26	70.1%	68.9%	67.0%	69.0%	65.1%		
[illegible]	% Of RTT Patients Waiting Within 18 Weeks	Yes	Sep-26	63.9%	61.2%	59.8%	63.9%	58.5%		
[illegible]	% Of RTT Patients Waiting Over 52 Weeks	Yes	Sep-26	1.9%	2.8%	2.5%	1.8%	2.1%		
103	RTT Standard: >52-Week Incomplete Pathways	Yes	Sep-26	1731	2689	2345	1447	2001		
105	RTT Number Of Incomplete Pathways	Yes	Sep-26	89488	90245	88082	79500	85918		
106	RTT Number Of Incomplete Pathways (<18 Weeks)	Yes	Sep-26	57140	54434	52938	51977	51443		
[illegible]	% Of RTT Patients Waiting Over 52 Weeks For Community Services	Yes	Oct-26	5.8%	4.9%	3.4%		1.8%		
108	Cancer 28 Day Combined Standard (2WW ,Breast Symptomatic And Screening Referrals)	Yes	Sep-26	77.0%	85.9%	79.6%	80.0%	73.4%		
109	Cancer 31 Day Combined Standard (First And All Subsequent Treatments)	Yes	Sep-26	71.1%	87.5%	78.0%	83.0%	68.6%		

Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
109	Cancer 31 Day Combined Standard (First And All Subsequent Treatments)	Yes	Sep-26	71.1%	87.5%	78.0%	83.0%	68.6%		
[illegible]	Cancer 62 Day Combined Standard (2WW, Consultant Upgrade And Screening)	Yes	Sep-26	56.8%	71.9%	60.6%	63.2%	49.2%		
111	62-Day Cancer Standard: Incomplete Pathways >62-Days	Yes	Oct-26	349	427	356		285		
[illegible]	% Diagnostic Waits Waiting 6 Weeks Or More	Yes	Oct-26	16.9%	27.0%	22.2%	19.0%	17.4%		
113	Diagnostic Activity Vs 2019/20	Yes	Oct-26	134.9%	151.9%	137.1%		122.3%		
114	Total Outpatient Attendances (SUS)	Yes	Sep-26	116283	136099	111574	117191	87049		
115	Bed Utilisation General & Acute	Yes	Oct-26	91.9%	95.9%	92.7%	94.5%	89.4%		
116	Average Non Elective LOS Trust Level For IPR (Average So Cannot Aggregate Up)	Yes	Sep-26	6.6	7.6	6.8	6.3	6.0		
117	Number Of Non-Discharged Patients Put Onto A PIFU	Yes	Oct-26	2001	1358	1095	5860	833		
118	Cancelled Operations Within 24hrs (Non-Clinical Reasons)	Yes	Sep-26	0.3%	0.5%	0.3%		0.1%		
119	Cancellations Not Re-Booked Within 28 Days	Yes	Sep-26	3.2%	40.4%	13.9%		-12.7%		
120	Elective DC Spells - SUS	Yes	Sep-26	7232	8430	6816	7200	5203		
121	Elective IP Spells - SUS	Yes	Sep-26	1547	1854	1510	1591	1165		
122	Average Delay (Exclude Zero Delay) Of Discharges	Yes	Sep-26	6.2	6.9	5.7	6.2	4.6		
123	Percentage Of Patients Discharged On Discharge Ready Date	Yes	Sep-26	88.9%	89.4%	87.8%	90.5%	86.2%		

Integrated Performance Report (SPC)

NHSE Segmentation Indicator

Workforce

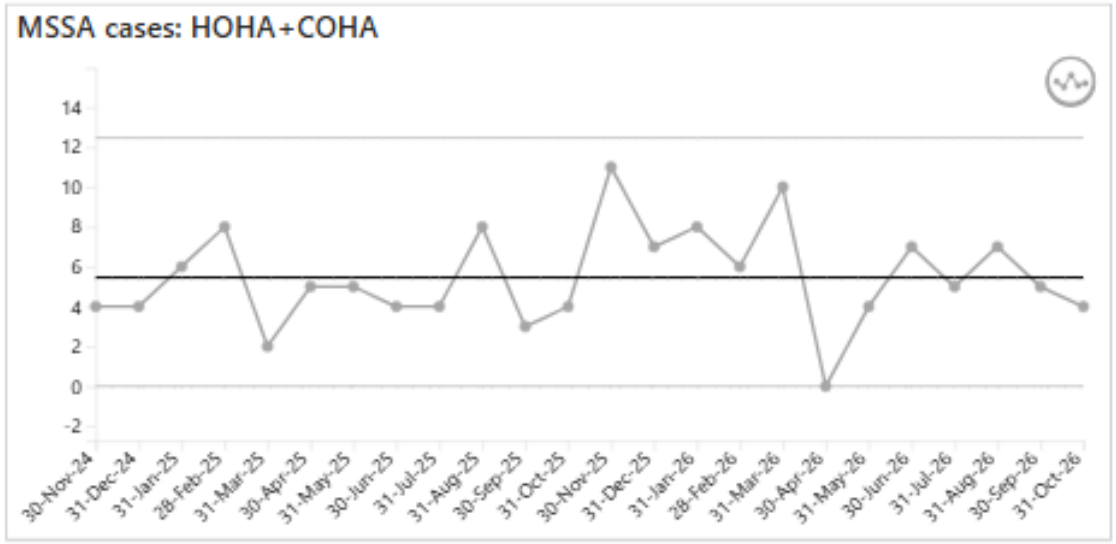
Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
13	Vacancy Rate	Yes	Oct-26	7.3%	7.3%	6.2%	7.7%	5.2%		
14	Turnover Rate	Yes	Oct-26	7.5%	8.9%	8.6%	12.0%	8.3%		
15	Turnover Rate With No Exclusions	Yes	Oct-26	9.2%	10.8%	10.4%		10.1%		
16	Sickness Absence Rate (Rolling 12 Months)	Yes	Oct-26	4.4%	4.2%	4.2%	3.1%	4.1%		
17	Non Medical Appraisals	Yes	Oct-26	90.9%	100.6%	77.4%	85.0%	54.1%		
18	Sickness Absence Rate (In Month)	Yes	Oct-26	5.3%	5.0%	4.5%	3.1%	4.0%		
19	Core Skills Training Compliance	Yes	Oct-26	92.0%	93.2%	92.1%	85.0%	91.0%		
20	Time To Hire (Average Days)	Yes	Oct-26	45.2	56.9	45.2	53.0	33.5		

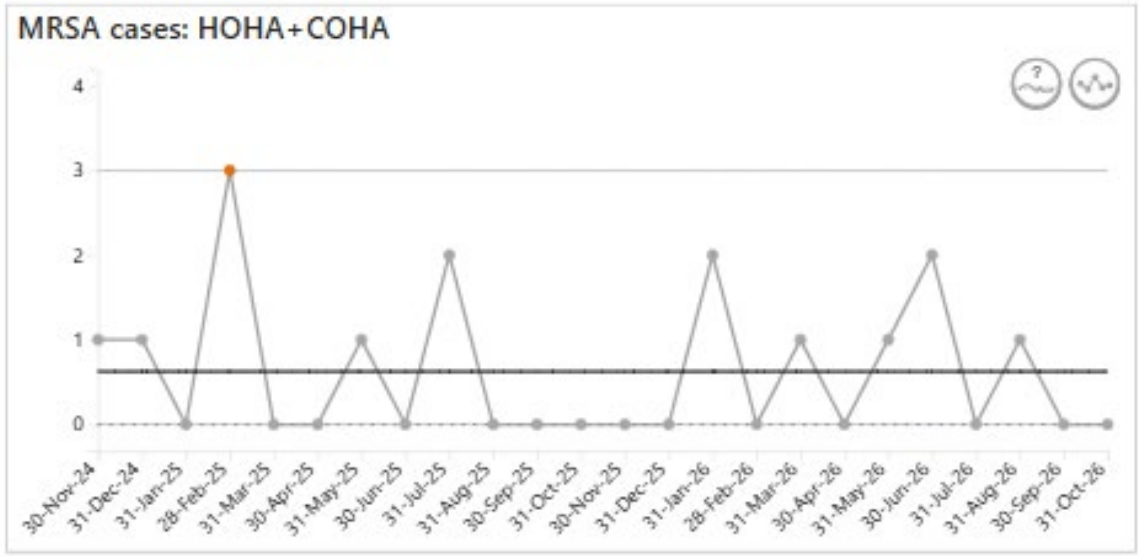
Assurance, legal services, digital and finance

Ref	Indicator Description	SPC	Latest Date	Value	UCL	Mean	Target	LCL	Variation	Assurance
2	Legal Services: Number Of Claims	Yes	Oct-26	36	38	22		7		
3	Information Governance And Data Security Training	Yes	Oct-26	89.2%	92.1%	90.6%	95.0%	89.0%		
4	Data Security & Protection Breaches	Yes	Oct-26	33	47	29		11		
5	Externally Reportable ICO Incidents	No	Oct-26	0	1	0	0	0		
6	All IG Reported Incidents	Yes	Oct-26	35	48	31		13		
8	Freedom Of Information (FOI) % Responded To Within Target Time	Yes	Oct-26	37.5%	86.9%	57.9%	80.0%	28.8%		
10	% Of Subject Access Requests Responded Within Target	Yes	Oct-26	50.3%	89.5%	71.1%	80.0%	52.7%		
12	Priority 1 Incidents	No	Oct-26	0	2	1	0	-1		
124	Adjusted In-Month Financial Performance Surplus/Deficit £'000	Yes	Oct-26	-10001.1	-4227.6	-7999.6		-11771.6		
125	BPPC £ %	Yes	Oct-26	62.9%	65.1%	60.7%	95.0%	56.3%		
126	BPPC Volume %	Yes	Oct-26	37.7%	40.0%	36.1%	95.0%	32.1%		
127	Cash £'000	Yes	Oct-26	16513	47748	23504	29852	-741		
128	Efficiency Delivery £'000	Yes	Oct-26	8839.0	13115.3	7420.3	11624.1	1725.4		
129	In-Month Financial Performance Surplus/Deficit £'000	Yes	Oct-26	-2209.5	4800.5	-54.0	1060.0	-4908.5		
130	In-Month ICS CDEL Capital Expenditure	Yes	Oct-26	13736.9	20297.3	8197.4	2869.1	-3902.5		
131	Year-To-Date Financial Performance Surplus/Deficit £'000	Yes	Oct-26	-26997.6	-6280.1	-12714.6	-19378.9	-19149.1		

03. Assurance reports

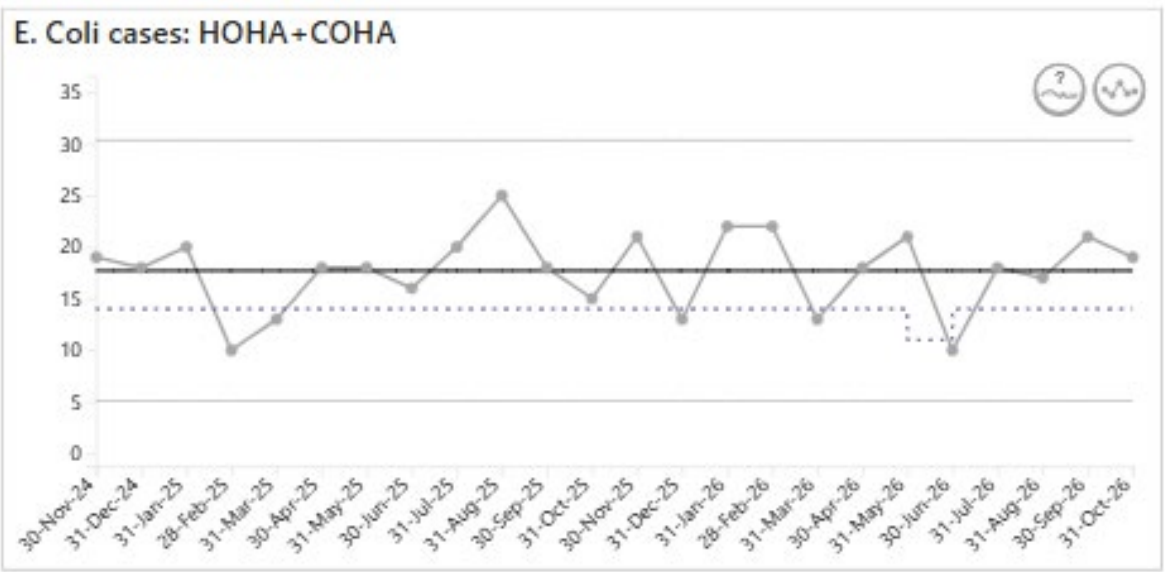
3. Assurance report: Quality, Safety and Patient Experience

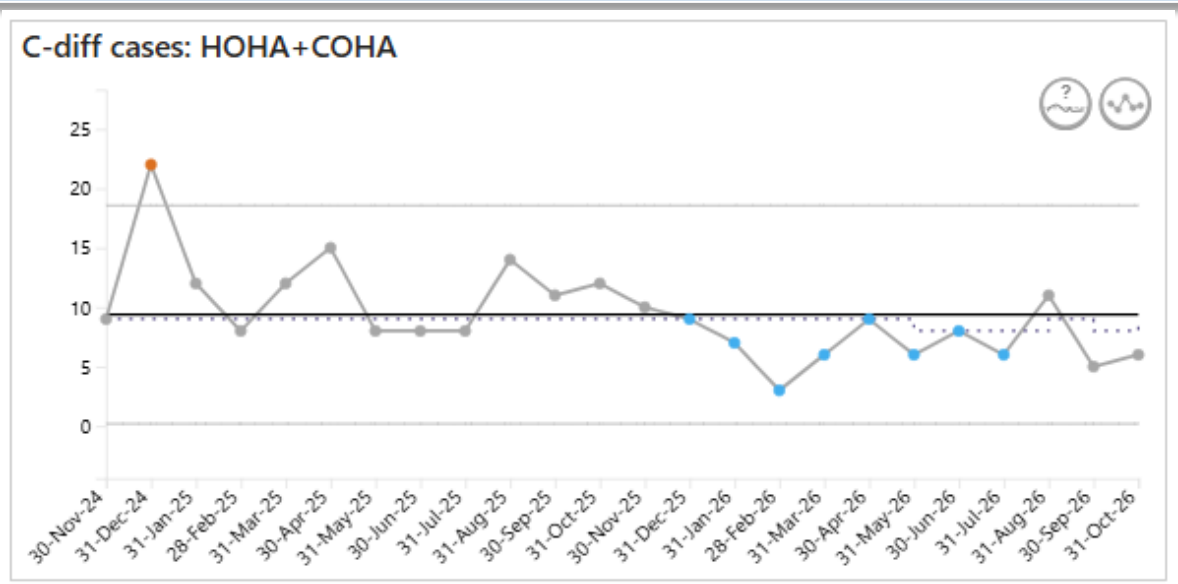




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MSSA bacteraemia: There were four cases of healthcare associated MSSA bacteraemia in October. We have seen two fewer cases compared to the same time last year. **MRSA Bacteraemia:** There were no MRSA bacteraemia cases in October. We remain one case below the same time last year (currently seven cases). The number of MRSA bacteraemia cases assigned to OUH between July 2025 and June 2026 (eight cases) gave the Trust a score of 3.6 in the NHS Oversight Framework Acute Trust league table.	Two MSSA cases were associated with intravascular lines – both peripheral cannulas. Gaps in documentation and monitoring of lines were identified and have been shared with the clinical teams. An issue with cannulas are not being removed when no longer in use was identified, and this will be escalated through PSEC.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

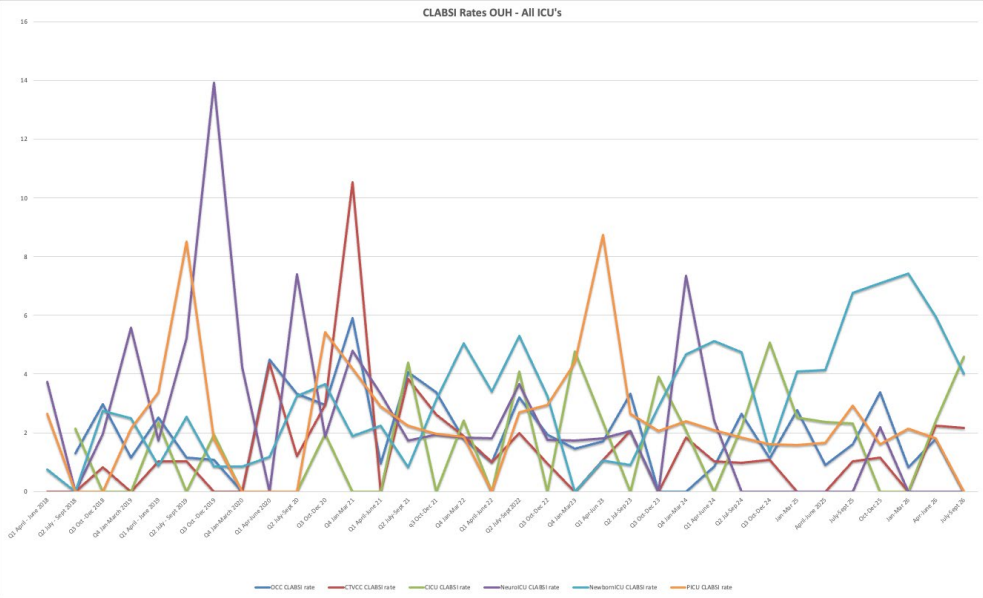
3. Assurance report: Quality, Safety and Patient Experience





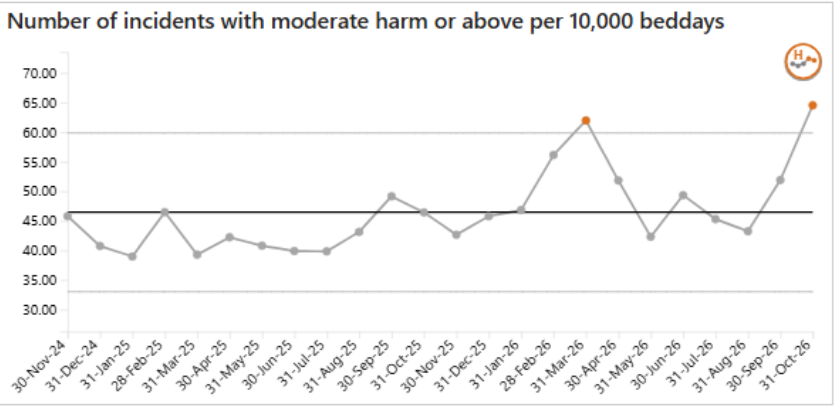
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***E. coli* bacteraemia**: There were 19 cases of *E. coli* reported in October (9 HOHA and 10 COHA). There have been five cases fewer than by the same time last year. Our latest quarterly position in the NHS Oversight Framework Acute Trust league table shows a score of 3. The OUH *E. coli* threshold from the NHS England Standard Contract for 2026/7 is set at 165 cases which is unchanged from last year when our case count was 220. We are 28 cases above the trajectory for this threshold. ***C. difficile*:** In line with the requirement in UK's *5-year action plan for antimicrobial resistance 2024 to 2029*, the Trust has improved its use of 'Access' antibiotics and has reached the required 70% target. This is the most likely driver for our continued improvements in C. difficile rates, where we are maintaining below threshold rates. The number of *C. difficile* cases assigned to OUH between July 2025 and June 2026 has given the Trust a score of 2 in the NHS Oversight Framework dashboard as our sampling rates are not considered 'high' despite us exceeding our target threshold.	***E. coli* bacteraemia:** Apart from good catheter management, there are no clear themes or interventions to reduce the rate of *E. coli* bloodstream infections in secondary care. The number of cases with a urinary tract focus in October was slightly lower than previous months. Work at the Horton to trial new catheter packs may reduce these numbers further. A deeper look into an increase in hepatobiliary infection cases found no connection with waiting times for hepatobiliary procedures.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

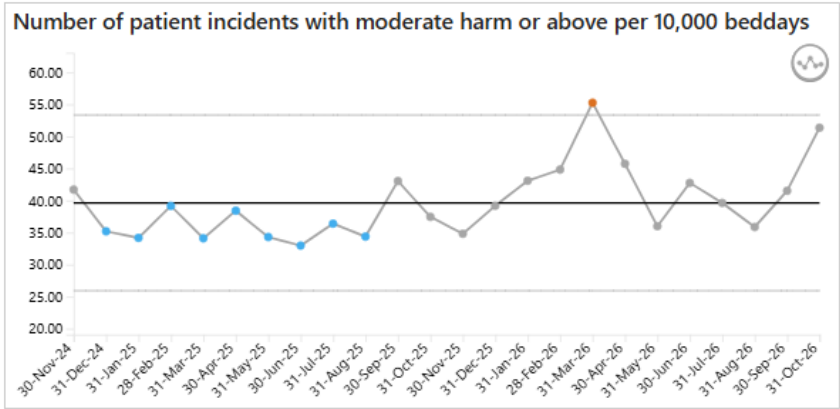
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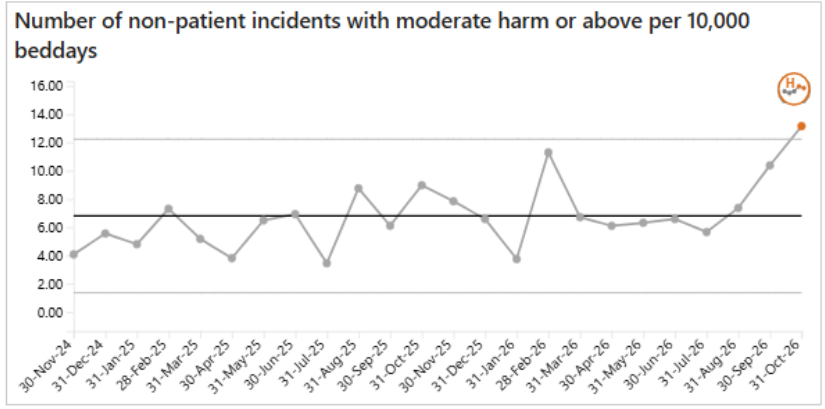


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
Central line associated blood stream infection (CLABSI) rates in Intensive care: Regular data collection to ascertain CLABSI rates across all 6 of the Trust's intensive care areas continues. Following implementation of an action plan to reduce CLABSI on newborn ICU (turquoise line), rates are now reducing. Rates in the Churchill ICU (green line) fluctuate due to low numbers of patients compared with the other ICUs and there are no concerns. Half of the ICU areas had no CLABSI events to report in Q2. **Safe ventilation management:** Inadequate ventilation to the incubator cleaning room in the neonatal unit has been partially rectified with further work required. Two cases of aspergillus infection in neonates in August may have been associated with this issue, although given the ubiquitous occurrence of Aspergillus spores in the environment this is difficult to prove.	**Safe ventilation management:** Meetings to track progress on outstanding actions continue.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

3. Assurance report: Quality, Safety and Patient Experience

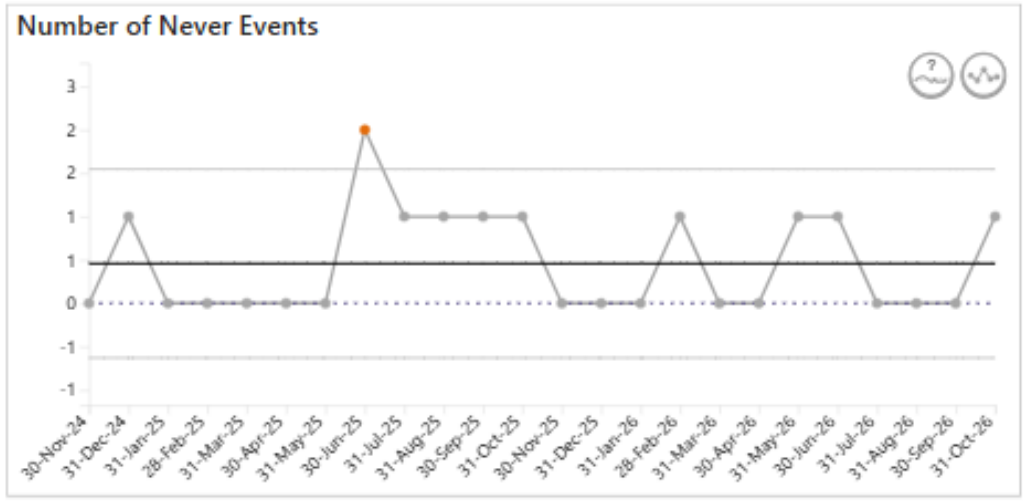






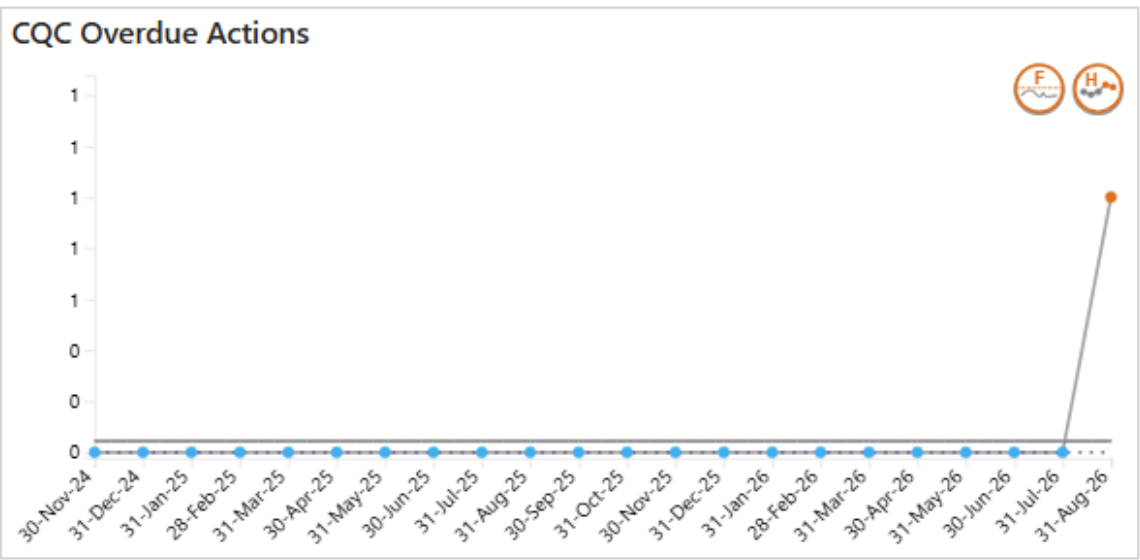
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
Overview October incident data has been compared to that of the previous 6 months and is high at 202 incidents against a 7-month mean of 151. The excess is roughly split between Patient incidents (161 against a mean of 127) and Staff incidents (41 against a mean of 22). The rise in patient safety incidents showed common cause variation. Trends 7 Cause Groups saw their highest 7-month total in October, accounting for the excess. The 3 most significant were: **Assault, Aggression & Harassment** (33, mean 18). 26 of these covered assaults on staff, verbal or physical. These took place over 9 departments, but the most common was Emergency Department (ED) and the JR with 10 incidents. **Maternity** (50, mean 38). No unusual trends have been identified. 35 of the incidents cover 3rd/4th-degree tears and post-partum haemorrhages. These are individually reviewed by Maternity to ensure there are no learning opportunities. **Surgical** (32, mean 22). The rise was primarily down to the sub-group for unplanned returns to theatre (RTT) beyond 48 hours. These were spread across 5 Specialties, with Spinal (10) and Acute & Endocrine Surgery (7) the most frequent.	All Moderate+ incidents are discussed the next working day at the Patient Safety Response meeting to identify the next steps to confirm whether there is potential learning from an incident. **Assault, Aggression & Harassment** All such incidents are managed by Health & Safety, with discussion at PSR of how to support the staff affected, and whether Safeguarding should assist in managing the patient. In addition, there is a weekly oversight meeting for violence and aggression concerns in ED. **Maternity** There is a dedicated questionnaire on Ulysses for the maternal tear and haemorrhage incidents, and the Perinatal Risk Coordinators inform Patient Safety Team (PST) if concerns about the incidents or their trend are identified through this process, which has not been the case with those reported in October. **Surgical** In addition to discussion at PSR, 4 cases were further reviewed by Clinical Governance and Deputy Chief Medical Officer (DCMO). There is a dedicated questionnaire on Ulysses for RTT incidents, which allows any concerns to be raised about the incident or related trends, and no further learning responses have been undertaken.	A list of incidents is reviewed each week between PST and DCMO, including a subset of the Moderate+ Patient incidents, plus any others that are identified by PST, Divisional governance teams, or subject matter experts. At a weekly meeting progress is discussed, including confirmation of formal learning responses, such as PSIIs. Assurance relating to incident management goes to CGC bimonthly.		

3. Assurance report: Quality, Safety and Patient Experience



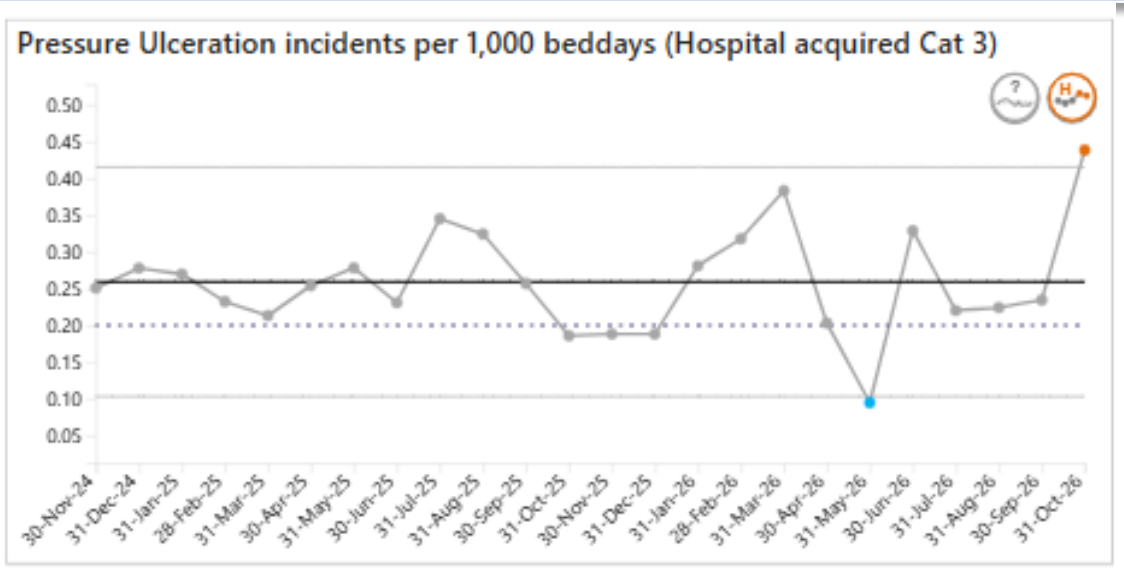
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
One Never Event was confirmed as a PSII in October, 2627-010. This concerned a retained swab that was found during a vaginal examination when the patient presented to another provider following a previous colposcopy at OUH (Never Event category 3: Retained foreign object post procedure).	This incident took place one month after the completion of a previous retained-swab Never Event investigation. The action plan from the previous investigation had not yet been completed. A PSII has been commenced, which will build on the last PSII. Actions taken in the interim include: • The LocSSIP has been updated • Scanning of count sheets is being expedited to strengthen documentation • Nurse staffing for colposcopy has been strengthened • Alignment of consumables used at the JR and Horton is underway • Moving to using 5 swab packages (rather than bulk containers currently used) • Explored swab tracking/counting solution: interim systems-based solution while longer term solution explored.	The investigation team has been identified and the timeframe agreed. Any actions identified through the current investigation will have their own future timetables, which will be managed via Ulysses, with oversight by the Patient Safety Team and the Divisional governance staff.		

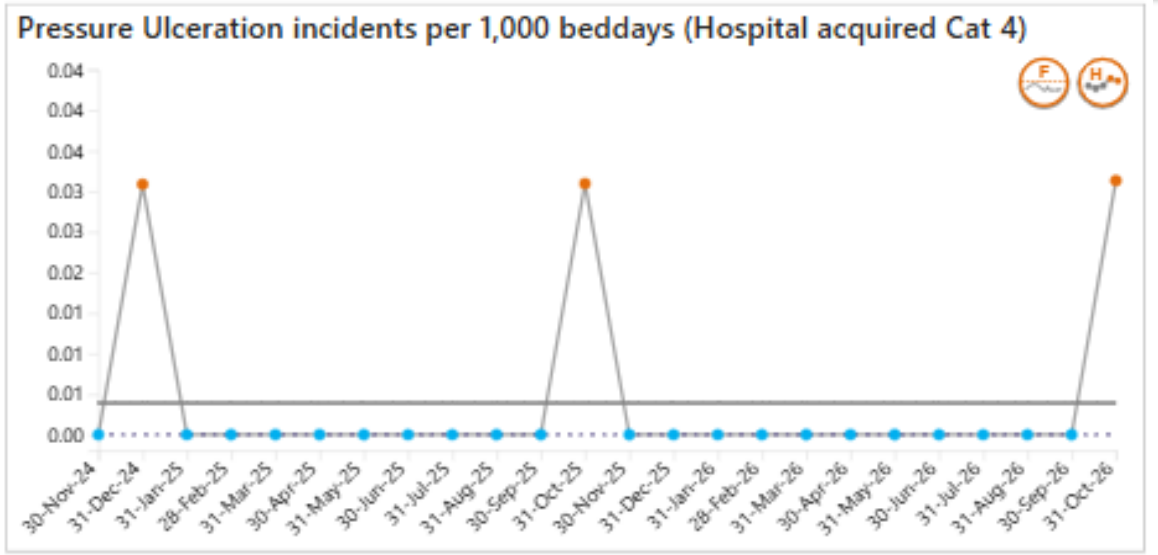
3. Assurance report: Quality, Safety and Patient Experience



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
There were 14 actions associated with the June 2026 CQC JRH maternity inspection report action plan. Of those actions 5 have been completed, 8 are in progress and on-track with one overdue. Assurance monitoring for progress and sustainability is undertaken via Evidence Review Group. Since the last report, the action that was reported as overdue has been completed. The current outstanding action (number 4) relates to the substantially completed environmental and fire safety survey Phase 2 and we move to the remedial work identified. Phase 3 planning and implementation for delivery of an associated improvement plan optimising patient flow, evacuation routes and access, with zoning, screens and appropriate care spaces to protect privacy is being progressed. Fire door replacement will commence before Christmas 2026. Progress with actions associated with the JRH Newborn Care Inspection will be received by Evidence Review Group on 30 November 2026. CQC inspectors have requested an update on progress with the actions at the Quarterly Engagement meeting in February 2027 (date tbc).	The Women's Centre Fire Safety Board is in place, to address any emerging concerns, performance and forecast issues, facilitated by the Deputy Chief Estates and Facilities Officer and an external Project Manager. There is a bi-weekly Chief Executive Stand up meetings to track Women's Centre Fire Safety related actions, complemented by monthly meetings undertaken with the Oxfordshire Fire and Rescue service. The wider remedial programme remains subject to Building Safety Regulator approvals and coordination with clinical services	Monthly Evidence Review Group and bi-weekly Chief Executive Stand up meeting to track Women's Centre Fire Safety related actions	Risk numbers 1329 1330 and 2221	*Reviewed via Evidence Review group*

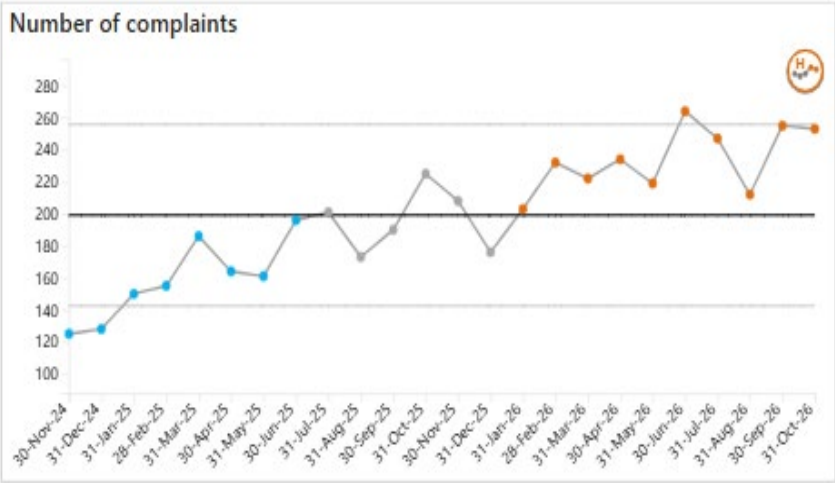
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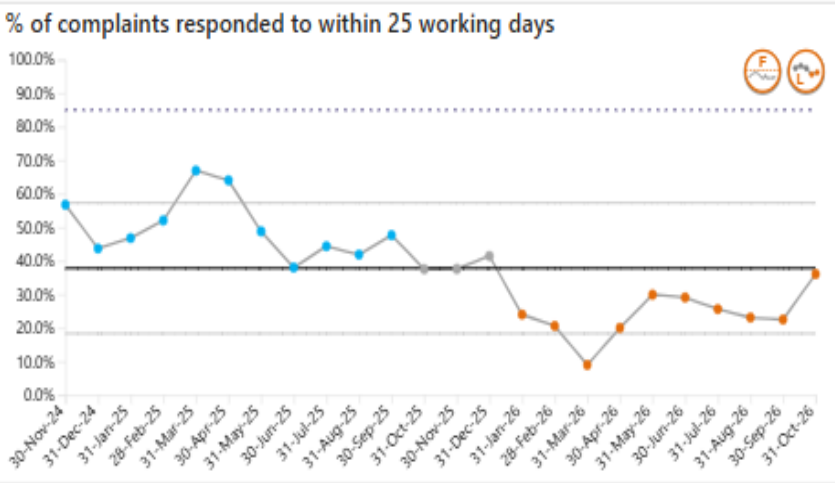


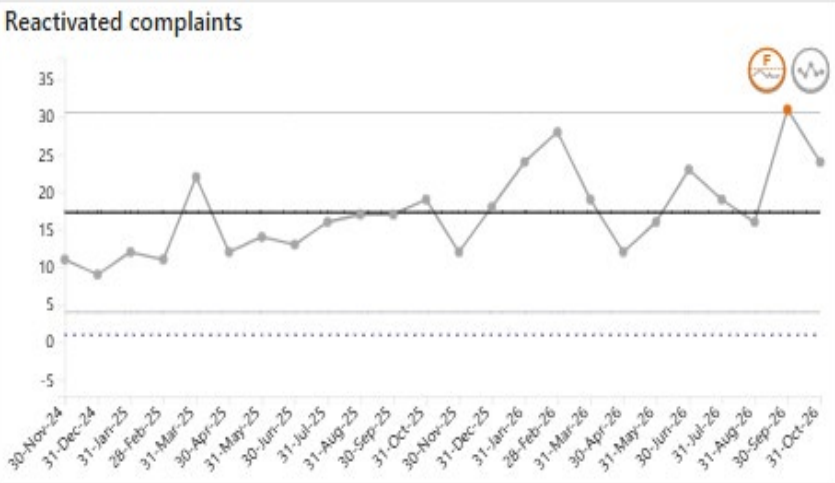


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
In October 2026 there were 15 hospital-acquired Category 3 pressure ulcers, a rate of 0.44 per 1,000 bed days. Preliminary learning points to increased patient acuity as a potential contributory factor, including complex needs and limited tolerance of repositioning. One hospital-acquired Category 4 pressure ulcer was reported, the first since October 2025. This was a Category 3 ulcer that deteriorated in a patient receiving end of life care at Sobell House hospice, where care is directed by comfort and the wishes of the patient and family. The Harm Free Assurance Forum reviewed the case and acknowledged significant clinical and patient-related factors. It is considered an isolated event and not an indication of a deteriorating trend.	Each Category 3 incident is reviewed at the Harm Free Assurance Forum, with divisional accountability for actions. The Tissue Viability Team is completing a thematic review of October's incidents and will report to the Forum. Areas with recurring incidents are subject to targeted harm reviews, Matron-led assurance rounds and divisional action plans, focused on consistent preventative practice, device-related injury and shared learning. For the Category 4 case, the deterioration was considered likely unavoidable, but learning was identified on the consistency of mental capacity assessments, documenting family involvement in care decisions, and managing pressure area care where treatment or repositioning is declined. This has been shared with the clinical team and will be tested through Matron-led assurance rounds. Wider assurance is provided by prevention audit compliance of 92.35% against a 90% target and the October safe staffing review, which found no nurse-sensitive harm directly linked to staffing levels. Oversight continues through the Harm Free Assurance Forum	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*

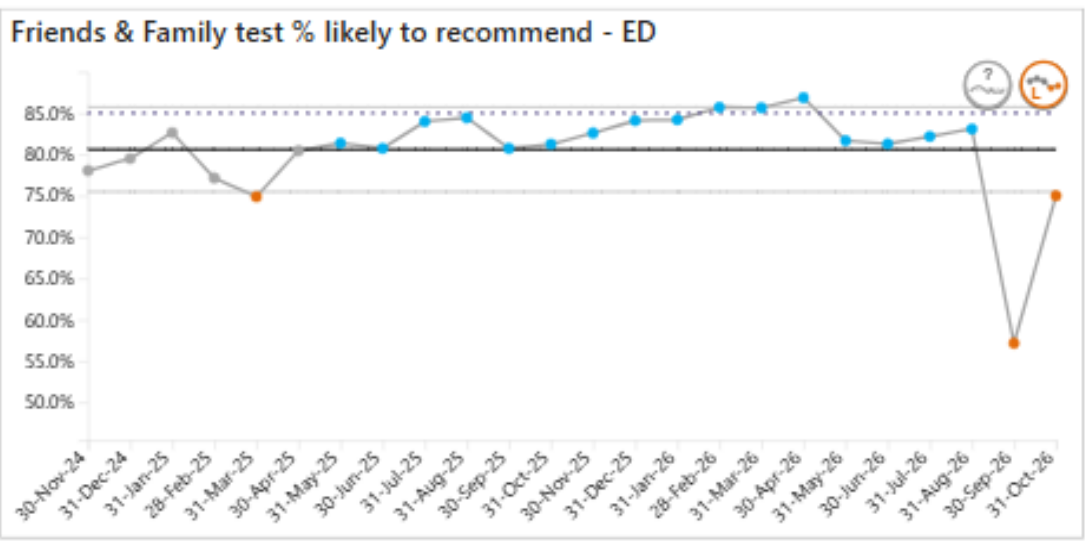
3. Assurance report: Quality, Safety and Patient Experience, *continued*

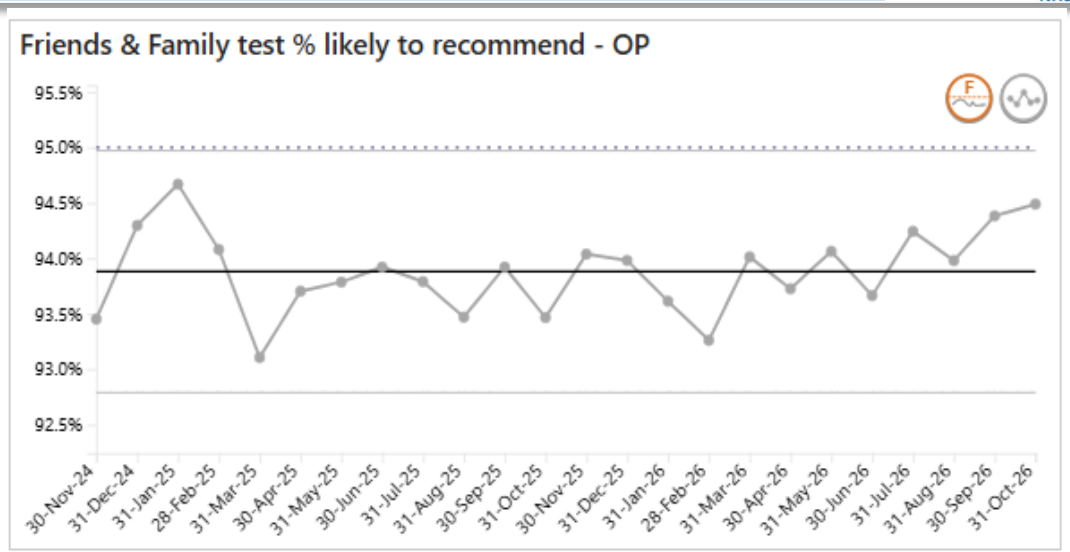




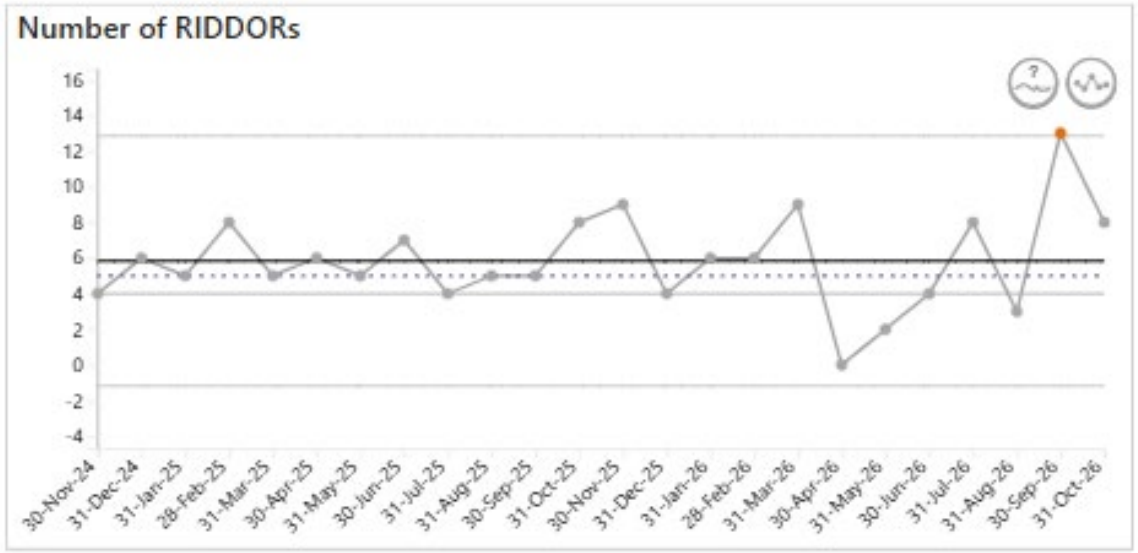


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust received 250 formal complaints in October, remaining above the process mean and continuing the higher levels of activity seen throughout 2026. Complaint volumes therefore remain a key operational pressure, with sustained demand continuing to place pressure on divisional and Corporate complaints capacity. Reopened complaints have risen broadly in line with the growth in complaints over the past two years, and the proportion reopened has remained stable. October saw a decrease in the number of reopened complaints received. Reopened complaints continue to be reviewed by division and service so that recurring themes can be identified, including whether further clarity, completeness or quality within initial complaint responses could reduce subsequent correspondence and reactivation.	Reopened complaints in October were concentrated across three Divisions: Surgery, Women's and Oncology (SUWON) with 7 cases, Medicine, Rehabilitation and Cardiac (MRC) with 7 cases, and Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonates (NOTSSCaN) with 11 cases. The higher number within NOTSSCaN will continue to be monitored to identify any recurring themes or areas requiring further action. In October, the five highest complaint category types were Communications, with 57 complaints; Clinical Treatment, with 48; Appointments, with 28; and Admissions and Discharge and Patient Care, with 23 complaints each. Communications and Clinical Treatment together accounted for 42% of all formal complaints received during the month. At directorate level, the highest complaint volumes were recorded within Acute Medicine and Rehabilitation, with 32 complaints; Gynaecology, with 25; Trauma and Orthopaedics, with 24; and Children's and Neurosciences, with 21 complaints each. These areas will continue to be monitored to identify recurring themes and any opportunities for focused learning and improvement.	CNO divisional meetings held weekly. Oversight through the Patient Experience and Engagement Committee (PEEC) and Delivery Committee. Complaints Policy and escalation guideline to PEEC for approval. Median response time reported monthly in this report.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*





Summary of challenges and risks	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
• FFT response rates remained lower during October 2026 following the transition to a new provider. This reduction was anticipated, as SMS invitations remain temporarily paused while the Trust finalises its agreed Business Rules. • In October 2026, Emergency Department (ED) services received 4 FFT responses from 9,330 eligible attendances: 1 from Horton General Hospital and 3 from John Radcliffe Hospital. Two respondents rated their experience as very good, one as good and one as very poor. The very small number of responses limits the conclusions that can be drawn about overall ED patient experience. • In October 2026, outpatient services received 127 FFT responses: 112 very good, 8 good, 2 neither good nor poor, 3 poor and 2 very poor, with no 'don't know' responses. Overall, 94.5% of responses were positive (very good or good). Of the 127 responses, 55 were collected through paper/postcard forms after appointments and 72 through online surveys after appointments; none were received through SMS or other collection methods.	• The Trust is finalising the SMS Business Rules, including appropriate exclusions, to support a consistent approach across services and ensure appropriate safeguarding and data protection measures are in place. Response rates are expected to improve once SMS invitations resume and become established. • The Patient Experience Team is manually uploading outstanding paper forms for inclusion in subsequent reporting. The reduction in responses and the reasons for this have been communicated through the national return. • The new provider's dashboard will enable clinical divisions to access and analyse their own feedback. • Divisions continue to provide updates to the Patient Experience and Engagement Committee every two months, including FFT data and themes. • Promoting feedback collection methods, improving response rates and embedding the new Patient Experience Survey remain early priorities under the recently endorsed Patient Experience and Engagement Plan.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Engagement Committee [PEEC] and the Trust Governors Patient Experience and Membership Committee (PEMQ).	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*



Summary of challenges and risks	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 October, the Trust reported 8 incidents to the HSE under RIDDOR. This is above the upper process limit, indicating special cause variation. Five of the eight reports were made outside the HSE notification period. This was because of delays in reporting on Ulysses and delayed investigations because of not reporting sickness absence. By type: lifting and handling injuries 3; staff slips, trips and falls 2; needlestick injury with BBV exposure 3	Timely reporting: divisional health and safety groups briefed on HSE deadlines, and compliance monitored monthly. Manual handling (3): all reviewed, with no common themes. Referred to the back care team to confirm risk assessments and safe systems of work were in place and followed. Slips, trips and falls (2) and needlestick (3): reviewed by the divisional health and safety leads. Occupational Health follow up for the BBV exposure will be confirmed by the end of December.	All actions to be completed by the end October and reported to the Health and Safety Committee. Assaults are also reported to the Violence Prevention and Reduction Group. Timeliness of reporting will be tracked monthly in this report.	BAF 4	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months

Summary of challenges and risks

Trust-wide nursing and midwifery staffing remained at Level 2 (Amber) throughout October. Planned versus actual fill rates of 94.55% (day) and 98.65% (night), providing assurance that staffing levels were maintained safely. When fill rates fell below 90%, all shifts were reviewed and mitigated at Matron level or above, and no shifts were left at risk. Monthly triangulation of staffing metrics and nurse-sensitive indicators confirmed no harm directly attributable to staffing across all divisions. This demonstrates effective operational grip, supported by twice-daily Trust-level reviews and clear accountability arrangements.

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

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

SUWON – The division saw one category 4 pressure ulcer reported during October. This was reviewed at Harm Free. It was found that all preventative measures were in place, but additional learning has been shared with the team. All staffing red flags have now been reviewed and actioned. Rostering KPI's were achieved for payroll and net hours. One directorate was late in roster publication which has been addressed with the Matron by the DDN. Some areas were low for annual leave, but assurance given that staff are on track to use effectively.

MRC – CMU-A & CMU-B wards had fill rates of less than 90%. The establishment for these wards is 4 nurses per day shift, however, the 4th nurse on most days was redeployed to other wards. This did make the wards short, but not unsafe, as the Matron had oversight and review, with ward managers and clinical educators supporting. HH EAU had a total of 10 falls recorded throughout this month. All have been reviewed, with the department having focused actions. JR EAU also had 10 recorded falls, however, 4 related to independent patients who had not been assessed as falls risk. All falls have been reviewed, resulting in no or minor harm. All staffing red flags have been reviewed. The roster KPI's were largely met. One directorate was just under the lead time of 8 weeks but was published within a few hours of the cut off time.

NOTSSCAN – An overall fill rate of over 90% was achieved across the division. There were some wards with less than 90% fill rate for unregistered staff, however, shifts were kept safe with support of ward managers, educators and unregistered staff from theatres. All red flags have been reviewed. 6A had multiple falls recorded. All have been reviewed, no theme found. The Children's directorate had several medication errors reported. Upon review, it was found that several related to teams outside of the children's wards. These issues have been addressed directly with the relevant teams .

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

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

Maternity – The variance between the actual CHPPD comparative to the budget is reflective of the additional midwife shifts created above budgeted template to staff the level 7 postnatal ward and provide 24/7 bereavement care.
Staffing red flags raised were all reviewed. Roster KPI's were almost achieved. The rosters missed the publication time but were published late on the cut off day. Annual leave for this roster period was low, however the DDN explained this was normal for this time of year with new graduates being added to the rosters.

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

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

Unavailability
All areas that experienced unavailability of workforce, due to vacancies, maternity leave, or long-term sickness (according to HR data), were mitigated to maintain safe staffing levels. This was achieved through the support of Ward Managers and Clinical Educators, as well as the use of temporary workforce solutions, including NHSP, Agency staff, and Flexible Pool shifts for Maternity. All relevant metrics, such as rostering efficiencies, professional judgement, patient acuity, enhanced care observation requirements, skill mix, bed availability, and RN-to-patient ratios, are reviewed each shift to ensure safe and efficient staffing levels are maintained.

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

Key:
Grey squares on the dashboard indicate where an indicator is either not relevant or not collected for the ward area.

For HR Data:
Turnover: This reflects the number of leavers divided by the average staff in post for both registered and unregistered Nursing staff. Leavers are based on a rolling 12 months, and do not include fixed term assignments or redundancies.

Sickness: This is a rolling twelve-month figure and is reported in the same manner as Trust Board sickness data. The figures presented reflect both registered and unregistered staff.

Maternity: This is taken on the last day of a particular month (aligned to all Trust reporting) and reflects those on maternity/adoption leave on that day. The FTE absent on this day is then divided by the total FTE for this cohort. The figures presented reflect both registered and unregistered staff.

HR Vacancy: For the designated areas this figure is the establishment (Budget FTE) minus the contracted FTE in post as at the last day of the month. The vacancy figure is then divided by the establishment. The figures presented reflect both registered and unregistered staff.

HR Vacancy adjusted: As per "HR Vacancy" ; with additional adjustment for staff on long term sick, career break, maternity leave, suspend no pay/with pay, external secondment. Data taken on last day of the month and reflects both registered and unregistered staff.

Please note that all data is taken at the last day of the month. This is how data is reported internally to Board and externally to national submissions. This ensures consistent reporting and assurance that the data is being taken at the same point each month for accurate comparisons to be made. The August data was not available at the time the report was reviewed. Any concerns relating to the data will be included with the September report. .

Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
The Trust has commenced developing actions tailored to improving roster efficiency and effectiveness in nursing and midwifery. This work will ensure a balanced skill mix during each shift. Assurance of ongoing oversight that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing at Trust level triangulated with other Trust level metrics allows the Board to see where there are increased capacity and acuity, (required) versus budget.	N	***Sufficient*** Information reported at required level. Staff appropriately trained and quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse workforce team monthly.

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

Oxford University Hospitals NHS Foundation Trust

October 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 5.10.2026-1.11.26				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
NOTSSCaN																											
Bellhouse / Drayson Ward	7.94	9.01	10.0	100.00 %			1		6	3	0	0	2.92%	15.32%	1.81%	13.18%	21.09%	Yes	-2.71%	8.29	13.62%	0	1	0	0	0	0
HH Childrens Ward	6.28	9.10	16.7	98.92 %		3			1	0	0	0	-6.89%	10.86%	5.72%	13.18%	7.20%	Yes	-0.75%	8.43	13.58%	0	0	0	0	0	0
Kamrans Ward	7.65	11.52	11.8	100.00 %		27		1	5	0	0	0	0.60%	0.00%	5.00%	12.30%	28.90%	Yes	2.02%	8.29	11.11%	0	0	0	0	0	0
Melanies Ward	7.53	10.16	9.8	100.00 %					1	0	0	0	-13.82%	2.03%	3.29%	14.42%	5.57%	Yes	-0.48%	8.57	11.99%	0	0	0	0	0	0
Robins Ward	8.23	9.17	11.2	100.00 %		2	6		4	1	0	0	-10.74%	10.45%	3.74%	16.91%	7.99%	Yes	-0.64%	8.29	10.52%	0	0	0	0	0	0
Tom's Ward	7.63	9.66	8.9	98.92 %					5	3	0	0	20.48%	10.90%	3.26%	0.00%	28.82%	Yes	0.04%	7.86	15.16%	0	0	0	0	0	0
Neonatal Unit	19.92		14.5						4	2	0	0	6.39%	6.98%	8.46%	5.39%	21.84%	Yes	-2.55%	9.29	14.19%	1	0	0	0	0	0
Paediatric Critical Care	27.58		32.2						11	1	1	0	-31.24%	2.54%	6.28%	2.66%	-5.41%	Yes	1.04%	6.57	12.33%	0	0	0	0	0	0
BIU	5.99	7.54	7.4	100.00 %		1	17		1		3	2	-13.31%	3.17%	4.81%	15.30%	10.99%	Yes	-0.75%	7.43	13.25%	0	0	0	0	0	0
HDU/Recovery (NOC)	4.82		8.3						2		0	0	18.70%	13.37%	10.46%	7.16%	30.34%	Yes	-0.39%	9.14	15.30%	0	0	0	0	0	0
Head and Neck Blenheim Ward	6.54	7.32	8.9	100.00 %					0		0	0	9.44%	0.00%	4.25%	0.00%	9.44%	Yes	-0.38%	8.86	14.07%	46	6	0	0	0	0
HH F Ward	7.02	8.27	7.2	100.00 %					2		2	0	3.83%	3.97%	3.26%	0.00%	8.54%	Yes	-3.47%	8.29	14.80%	18	4	0	0	0	0
Major Trauma Ward 2A	8.64	9.23	9.1	96.77 %		1	3	2	1		3	0	7.45%	0.00%	2.92%	10.34%	29.15%	Yes	-0.09%	8.86	12.22%	1	0	0	0	0	0
Neurology - Purple Ward	7.62	8.92	7.6	100.00 %					4		0	8	21.84%	10.97%	3.92%	0.00%	39.99%	Yes	2.88%	8.86	12.24%	24	3	0	0	0	0
Neurosurgery Blue Ward	8.47	9.46	8.9	100.00 %			7		1		0	3	11.51%	10.95%	8.46%	5.97%	26.93%	Yes	1.64%	8.86	11.53%	15	3	0	0	0	0
Neurosurgery Green/IU Ward	9.59	10.19	9.8	100.00 %			3		0		1	2	9.31%	14.45%	7.22%	0.00%	9.31%	Yes	1.05%	8.86	14.51%	7	1	0	0	0	0
Neurosurgery Red/HC Ward	10.93	12.29	11.7	100.00 %		1	8		4		1	1	1.33%	4.58%	6.48%	0.00%	5.59%	Yes	-0.66%	8.86	15.15%	2	0	0	0	0	0
Specialist Surgery I/P Ward	6.90	7.66	7.7	100.00 %					6		1	1	5.04%	7.46%	5.76%	7.49%	15.71%	Yes	0.91%	7.71	12.21%	3	0	0	0	0	0
Trauma Ward 3A	8.68	9.96	9.3	97.85 %		4	2	1	1		2	1	-1.36%	9.94%	6.06%	3.13%	20.48%	Yes	-0.63%	8.43	14.79%	0	0	0	0	0	0
Ward 6A - JR	7.03	6.53	7.2	100.00 %		4	5		2		1	6	9.83%	0.00%	3.70%	18.80%	32.67%	Yes	0.46%	8.57	14.01%	0	0	0	0	0	0
Ward E (NOC)	5.30	7.21	7.3	100.00 %		2	2		1		2	4	-27.43%	0.00%	5.98%	16.50%	8.11%	Yes	1.05%	7.86	13.37%	27	3	1	0	0	0
Ward F (NOC)	5.80	7.92	7.9	100.00 %			2		0		0	0	10.81%	31.68%	5.84%	0.00%	10.81%	Yes	-0.34%	7.86	13.40%	0	0	0	0	0	0
WW Neuro ICU	27.97		25.6				1		7		3	0	3.63%	7.34%	4.75%	11.46%	27.22%	Yes	-0.18%	8.86	11.58%	0	0	0	0	0	0

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

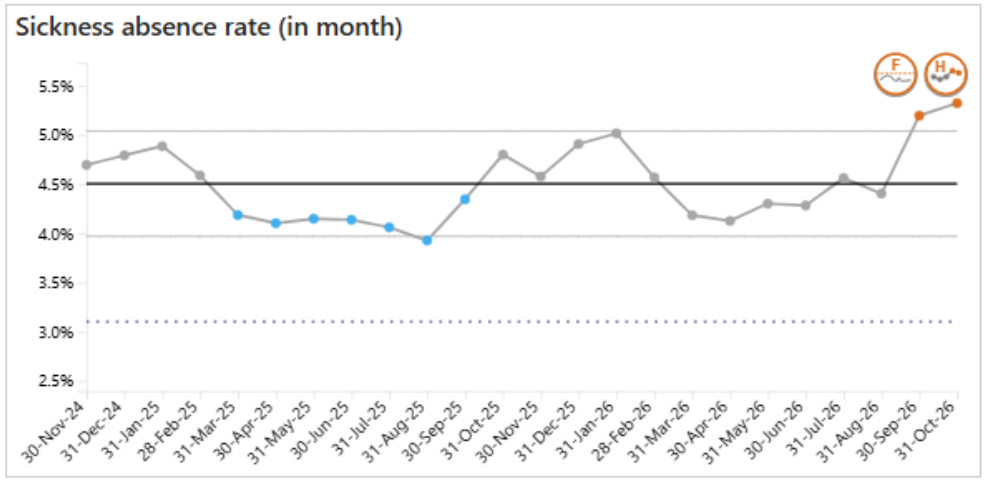
Oxford University Hospitals NHS Foundation Trust

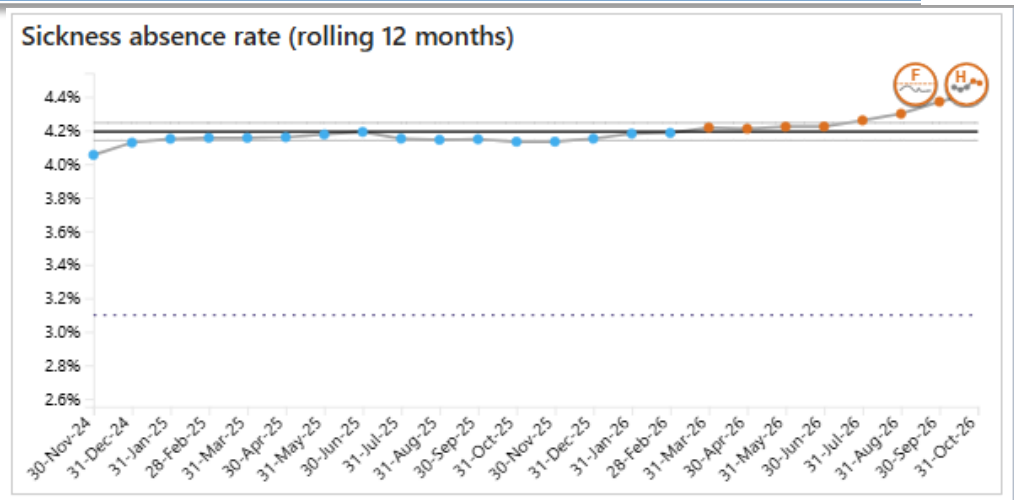
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Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
MRC																											
Ward 5A SSW	8.36	8.15	8.4	100.00 %		21	2	1	3		2	2	27.78%	6.98%	3.46%	0.00%	33.19%	Yes	-0.30%	8.43	14.64%	2	0	0	0	0	0
Ward 5B SSW	8.36	8.45	8.2	100.00 %		17		2	1		1	4	29.70%	6.00%	2.90%	0.00%	35.10%	Yes	-0.70%	8.43	12.74%	17	2	0	0	0	0
Cardiology Ward	8.24	7.93	8.6	100.00 %		11	2	2	9		2	4	-1.40%	5.14%	4.39%	4.98%	11.22%	Yes	-1.60%	8.57	11.41%	2	0	0	0	0	0
Cardiothoracic Ward (CTW)	7.43	6.20	6.8	98.92 %		9	1		1		0	2	-0.05%	0.00%	3.27%	5.00%	24.96%	Yes	1.32%	8.71	12.34%	0	0	0	0	0	0
Complex Medicine Unit A	8.94	9.41	8.4	100.00 %		7	3	2	0		1	4	17.07%	7.75%	6.42%	0.00%	17.07%	Yes	1.73%	8.43	13.38%	1	0	0	0	0	0
Complex Medicine Unit B	9.48	10.36	8.8	100.00 %		4	3		0		1	3	2.73%	7.50%	6.21%	15.58%	33.03%	Yes	1.58%	8.43	14.73%	8	1	0	0	0	0
Complex Medicine Unit C	8.21	9.90	8.0	100.00 %		6	1	6	1		1	3	9.68%	6.99%	3.00%	6.99%	20.03%	Yes	1.66%	8.43	13.13%	13	5	1	0	0	0
Complex Medicine Unit D	8.63	8.20	8.3	100.00 %		2	1		2		6	4	5.81%	4.15%	4.35%	6.70%	18.43%	Yes	-0.90%	8.43	12.10%	4	1	1	0	0	0
CTCCU	21.59		24.5						3		0	0	19.65%	14.26%	6.50%	4.99%	27.67%	Yes	-0.51%	8.00	13.59%	1	0	0	0	0	0
Emergency Assessment Unit (EAU)	8.72	9.07		98.33%			6		4		2	10	15.55%	8.79%	7.30%	6.41%	34.49%	Yes	0.42%	8.43	12.68%						
JR Emergency Department	18.33						4		3		0	6	19.45%	16.88%	4.52%	0.86%	31.98%	Yes	3.43%	8.29	13.04%	0	0	0	0	0	0
HH EAU	9.20	7.47		100.00%		9	2	2	2		1	10	-0.88%	2.50%	7.51%	5.01%	14.26%	Yes	-1.22%	7.86	11.91%	0	0	0	0	0	0
HH Emergency Department	87.10								3		0	2	-14.24%	9.10%	5.27%	15.79%	15.69%	Yes	0.14%	7.86	14.90%	0	0	0	0	0	0
HH Juniper Ward	7.46	9.48	7.9	100.00 %		1			1		6	10	1.14%	0.00%	6.93%	4.88%	10.79%	Yes	1.29%	8.71	14.23%	4	2	0	4	0	0
HH Laburnum	8.00	9.51	8.0	100.00 %		1	1		1		3	1	3.90%	0.00%	4.64%	0.00%	7.21%	Yes	-0.48%	7.86	14.82%	23	5	3	23	1	0
HH Oak (High Care Unit)	10.78		10.7	100.00 %		9	1		2		0	0	-2.42%	6.44%	9.50%	0.00%	5.15%	Yes	1.57%	8.71	15.43%	12	0	0	1	0	0
John Warin Ward	10.06	11.28	9.7	100.00 %		8			0		0	2	7.37%	21.86%	5.25%	8.18%	14.95%	Yes	-2.40%	8.29	14.10%	3	0	0	0	0	0
OCE Rehabilitation Nursing (NOC)	10.21	9.47	9.9	100.00 %					2		1	2	-5.84%	0.00%	6.79%	6.57%	13.77%	Yes	-2.96%	9.29	15.05%	4	5	0	4	0	0
Osler Respiratory Unit	11.98	9.42	11.4	100.00 %		4	2		1		0	3	4.48%	4.72%	4.70%	0.00%	13.95%	Yes	0.56%	8.29	12.61%	0	0	0	0	0	0
Ward 5E/F	9.58	9.71	10.3	98.92 %		27	5	7	2		2	5	24.24%	15.55%	5.31%	12.50%	47.92%	Yes	0.96%	8.43	14.22%	0	0	0	0	0	0
Ward 7E Stroke Unit	9.20	9.85	8.8	100.00 %			5		1		3	4	14.02%	9.91%	10.04%	5.51%	42.05%	Yes	0.56%	7.86	9.59%	0	0	0	0	0	0

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

October 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 5.10.2026-1.11.26				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/- 2%	8 week lead time	Annual Leave 12-16%	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
SUWON																											
Gastroenterology (7F)	7.95	8.82	8.1	100.00 %		19	3	4	3		2	0	15.79%	12.50%	6.59%	6.25%	36.84%	Yes	2.53%	8.86	13.49%	13	1	0	0	0	0
Gynaecology Ward - JR	5.02	5.40	7.8	100.00 %					1		0	1	2.51%	0.00%	5.55%	0.00%	12.61%	Yes	-0.72%	9.29	12.31%	24	2	0	0	0	0
Haematology Ward	7.56	8.04	9.4	100.00 %		18			5		1	4	17.30%	12.04%	4.39%	4.92%	41.72%	Yes	-0.06%	6.71	12.12%	0	0	0	0	0	0
Katharine House Ward	9.70	7.80	9.6	100.00 %		26			4		2	0	29.82%	0.00%	5.61%	0.00%	29.82%	Yes	-0.05%	7.86	12.04%	12	0	0	1	0	0
Oncology Ward	7.68	7.77	7.3	97.85 %		3	4		2		3	3	9.16%	4.30%	2.52%	13.44%	25.44%	Yes	0.20%	4.71	14.64%	1	0	0	0	0	0
Renal Ward	7.60	9.11	9.6	100.00 %		6			0		0	3	24.91%	0.00%	3.92%	0.00%	32.05%	Yes	1.13%	8.43	11.42%	0	0	0	0	0	0
SEU D Side	7.70	7.46	7.7	100.00 %		1			2		1	0	11.65%	0.00%	5.32%	0.00%	22.16%	Yes	0.25%	9.29	10.84%	19	2	0	0	2	0
SEU E Side	7.66	8.66	8.3	100.00 %		1			4		0	0	8.23%	5.54%	6.91%	0.00%	31.05%	Yes	-0.86%	9.29	15.67%	1	0	0	0	0	0
SEU F Side	6.94	8.07	7.5	100.00 %		1			1		0	2	8.23%	4.16%	3.62%	0.00%	8.23%	Yes	0.41%	9.29	11.67%	48	10	1	0	0	0
Sobell House - Inpatients	7.75	9.44	9.1	97.85 %		16			3		3	5	14.56%	24.87%	8.73%	0.00%	38.42%	Yes	-0.34%	3.57	12.97%						
Transplant Ward	8.80	8.00	7.8	100.00 %		22			2		0	1	37.89%	17.55%	5.37%	0.00%	43.94%	Yes	-1.66%	7.71	12.61%	18	7	0	0	0	0
Upper GI Ward	9.44	8.04	8.1	100.00 %		21		1	4		3	2	8.16%	9.23%	3.43%	4.22%	19.73%	Yes	0.47%	9.43	12.50%	22	2	0	0	0	0
Urology Inpatients	8.32	8.21	8.5	100.00 %		10			1		0	0	7.15%	7.61%	4.20%	0.00%	27.57%	Yes	-0.35%	9.86	17.27%	182	19	2	1	0	0
Wytham Ward	6.82	7.32	6.7	100.00 %		1			2		0	1	9.40%	0.00%	7.06%	0.00%	14.97%	Yes	0.17%	9.43	16.15%	0	0	0	0	0	0
MW Intrapartum Team	14.58		13.8			1	18						0.00%	26.16%	8.15%	0.00%	16.67%	Yes	-1.64%	7.71	10.50%						
MW Level 5	5.40		3.8				1											Yes	-0.46%	7.71	13.16%						
MW Level 6	4.60		6.0				8	1					-43.53%	11.41%	7.37%	6.16%	-17.01%	Yes	-1.12%	7.71	11.70%						
MW Level 7 (Bereavement)	-		5.8															Yes	-1.31%	7.71	10.71%						
CSS																											
OCC/CICU	26.60		33.3	100.00 %					9		1	1	13.14%	11.90%	5.90%	6.46%	28.28%	Yes	-0.67%	8.42	13.98%						

3. Assurance report: Growing Stronger Together



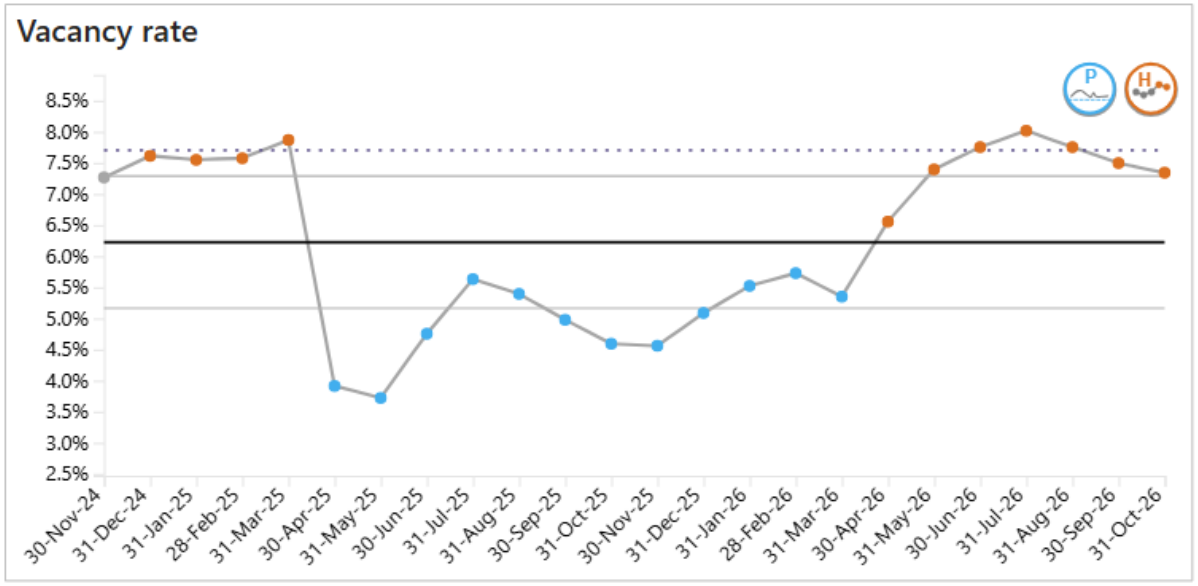


Benchmarking: July 2026 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.43% **National: 5.61%** **Shelford: 4.85%** Buckinghamshire Healthcare NHS Trust: 4.32% Royal Berkshire NHS Foundation Trust: 3.14% Oxford Health: 5.19% South Central Ambulance Service: 7.09%

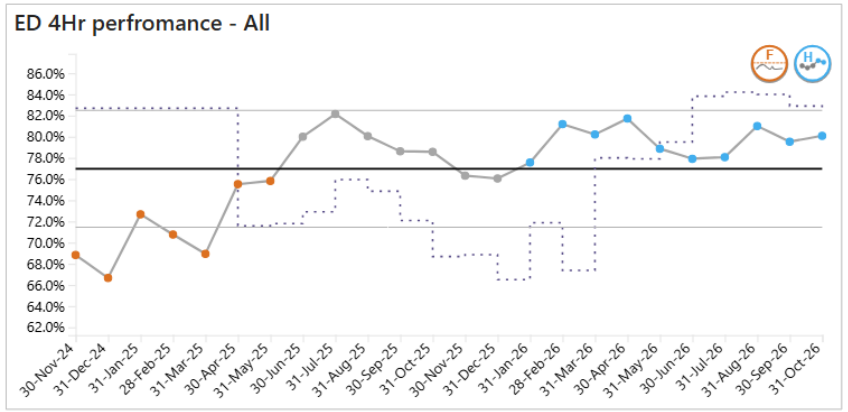
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality rating
Rolling sickness absence is 4.4% (monthly rate 5.3%), increased from the previous month and remaining above the Trust target of 3.1%. Variation persists across divisions, with NOTSSCaN and SUWON recording the highest absence rate (4.7%), MRC 4.4%, CORP (4.2%) and the lowest CSS at 3.9% Long-term sickness top 5 reasons:- 1. S10 Anxiety/stress/depression/other psychiatric illnesses 2. S11 Back Problems 3. S12 Other musculoskeletal problems 4. S13 Cold, Cough, Flu - Influenza 5. S15 Chest & respiratory problems Short-term sickness top 5 reasons:- 1. S10 Anxiety/stress/depression/other psychiatric illnesses 2. S11 Back Problems 3. S12 Other musculoskeletal problems 4. S13 Cold, Cough, Flu - Influenza 5. S14 Asthma	• Further dedicated work is underway to support with the embedding of the new absence management system and there are divisional engagement sessions underway. • Work continues in partnership with Occupational Health to support both managers and staff in understanding and addressing the key drivers of absence. A priority area remains providing tailored interventions for colleagues experiencing long-term sickness absence, with the aim of enabling a safe and sustainable return to work. • Managers receive absence trigger notifications and are provided with guidance to support effective case management. HR continues to promote line manager training to strengthen capability and confidence in managing sickness absence consistently and proactively. • Return-to-Work (RTW) processes have been streamlined and enhanced guidance is available to support more meaningful and effective RTW conversations. • Training has been created and is available for supporting employees with pregnancy related absences. • In addition, regular meetings with the Wellbeing Lead help identify further opportunities for support, while work continues to standardise sickness absence reason categories to improve consistency, reporting quality, and analysis across the organisation.	Governance - TME via IPR and People Committee. People Governance, Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1616 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in the previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

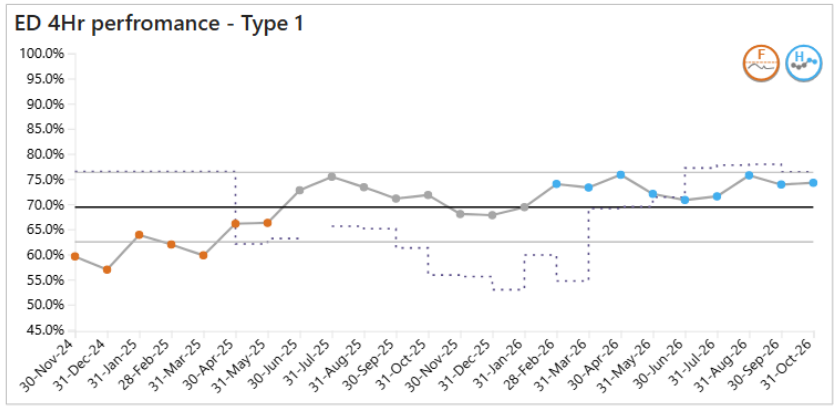
3. Assurance report: Growing Stronger Together

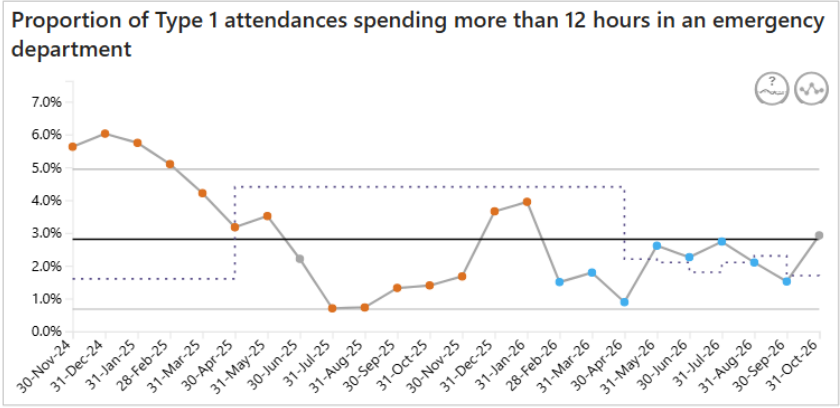


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust vacancy rate has improved to 7.3% in Month 7, down from 7.5% in Month 6, and is now below the Trust KPI of 7.7%. Improvement has been seen across most divisions, with NOTSSCaN reducing from 8.4% to 8% and SUWON & CORP reducing by 0.2%. MRC continues to report the lowest vacancy rate at 6%, remaining below target. While vacancy performance has improved overall, we are still seeing a volume of bank usage which continues to be a focus.	• The Talent and Attraction team are working closely with directorate managers on targeted recruitment campaigns for hard to fill specialities. . • The recruitment team are offering sessions with divisional teams to support recruitment queries to assist with improving the time to hire KPI. • Divisions are implementing local recruitment and retention plans focused on hard-to-recruit roles • The internal first recruitment approach has supported career progression for staff and assists with retention. • Apprenticeship pathways and career development opportunities are being utilised to strengthen workforce supply. • Vacancy performance is monitored through divisional workforce reviews and at directorate performance reviews. There are escalation processes in place where vacancy levels present operational risks. • Ongoing focus is being maintained on retention initiatives to reduce turnover and minimise future vacancy growth.	Governance - TME via IPR, People Governance Monthly meeting & Divisional meetings . People Committee quarterly All actions are ongoing	BAF 1 BAF 2 CRR 2331 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

3. Assurance report: Operational Performance





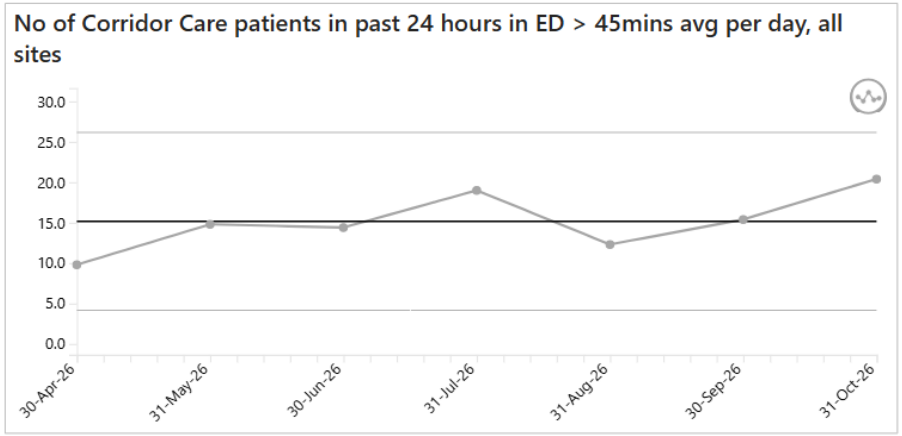


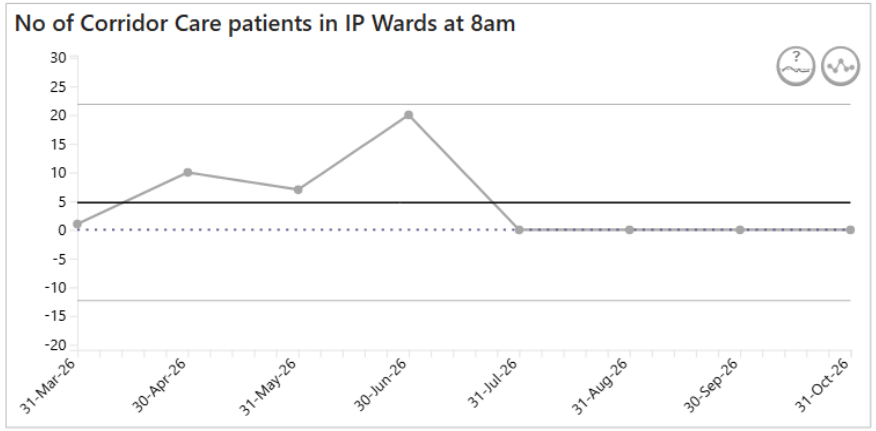
Benchmarking: ED – Attendances within 4 hours (all) October 2026					NOF Score (Q2)
OUH: 80.08%	Nat'l: 73.39%	Shelford: 72.50%	BHT: 78.28%	RBH: 75.08%	1.00

Benchmarking: ED – Attendances within 4 hours (type-1) October 2026				
OUH: 74.2%	National: 59.4%	Shelford: 55.6%	BHT: 69.8%	RBH: 63.9%

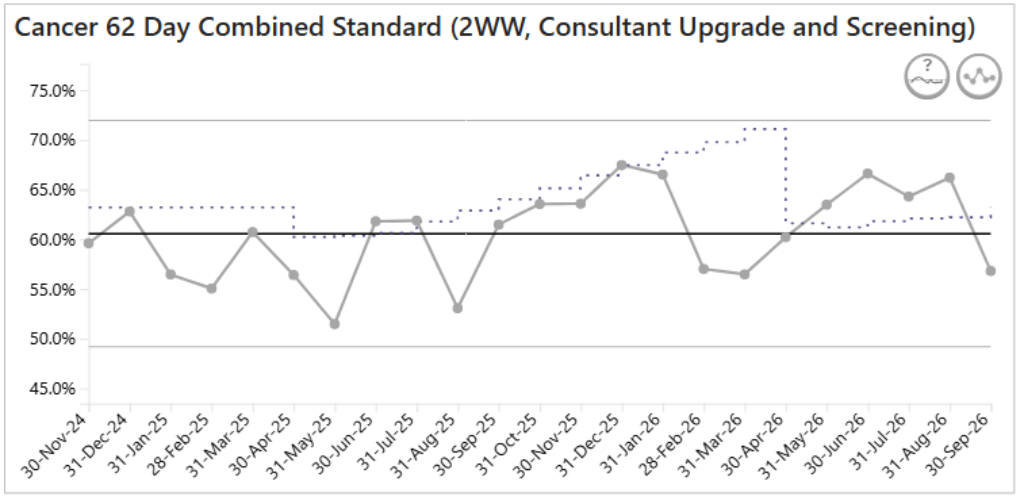
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register
Urgent and emergency care 4-hour performance improved slightly to 80.08% in October however remained adverse to plan. Emergency Department 12-hour total length of stay performed at 97.08% for October. This is a noted deterioration from the previous month and adverse to plan. The primary challenge affecting performance was a significant increase in attendances; October saw the highest type 1 attendance figures for the last 12 months and were above the previous high in September 2026. Type 1 attendances at the JRH ere 12.8% higher than October 2025 and the main contributor to the overall increase, although there was also an increase at the HH. Year to date Emergency Department (ED) type 1 activity is up by 6.1% at the John Radcliffe Hospital (JRH) and 5.2% at the Horton when compared to the same period last year. It should be noted that the type 1 growth in June to October has been very high at 7.4%, 5.5%, 6.6% and 15.4% and 12.8% compared to the same months in the previous year at the JRH. YTD, attendances for all types (type 1, 2 and 3) were 3.9% higher than last year (April to October). Growth has been from non-ambulance arrivals with periods of high arrival intensity, where large numbers of patients presented within short timeframes. These concentrated surges in demand increased departmental occupancy, reduced available operational capacity, and created challenges in maintaining timely assessment, treatment, and patient flow. Ambulance conveyances are reducing and exceeding trajectory and there has been a sustained reduction in average handover times with a decrease of 2.30 mins over the year.	• A 'Deep Dive' into urgent care performance in May/June 26 has been completed. Analysis of patient cohort underway noting an increase in under 50's walk-ins. Action 1 – A 'Perfect Week' for the Horton site has been completed week commencing 14 September. Findings have been reviewed with a small number of cost neutral schemes being developed. Action 2 – A 'Perfect Week' is planned in December for Children's Emergency Department – awaiting date Action 3 – 'Home First Deep Dive' completed 2 October interrogating the increased dependency of delayed patients. Actions identified across Social Care, ambulance conveyances, Nursing homes and End of Life pathway • Level 1 UEC redevelopment to expand Emergency Assessment Unit (EAU) and Extended Emergency Medicine Ambulatory Care (EEMAC) capacity and improved flow models in addition to a UTC merger with Oxford Health NHS Trust to improve capacity and access. This redevelopment is running behind plan, with mitigations being developed to support winter.	TWUCG TWUCG - November UCDG - November Level 1 Redevelopment Programme Board – Q4	

3. Assurance report: Operational Performance, *continued*



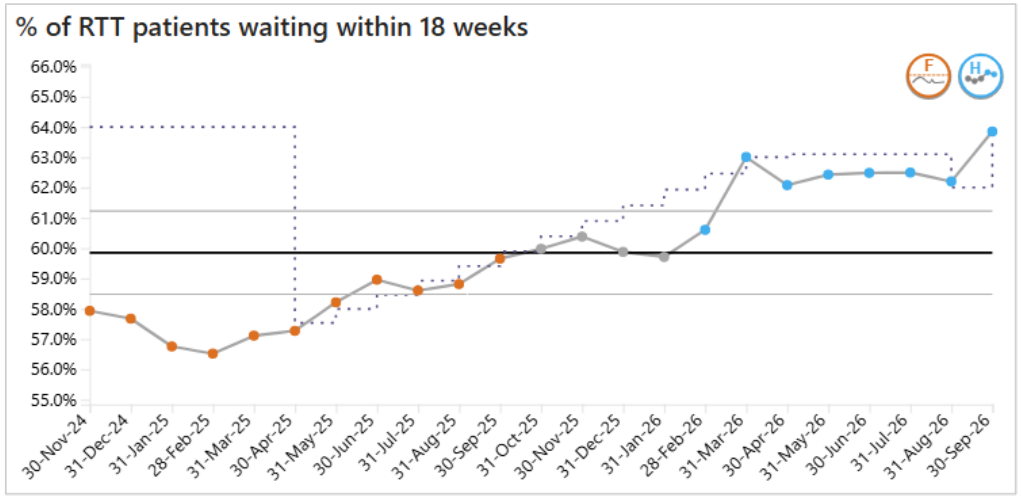


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
When the emergency and assessment units become congested, to maintain flow at the front door and ensure timely ambulance handover, patients are placed in the corridor. Within ward areas, to facilitate early morning flow out of the Emergency Department, patients who are for discharge are sat out in a suitable space. This can be in the corridor if the Discharge Lounge is not used, or alternative day room if not available on the wards. In addition, the Surgical Emergency Unit (SEU), to support ED historically placed patients in the corridor to support flow. Providing care to our patients in corridors is far below the standard of care that we aspire for our patients and is below the expectations of the public. As well as patient and staff experience implications, there is also clinical risk to our patients. Despite the ongoing urgent and emergency care pressures, the average number of patients cared for in an ED corridor has remained static and predominantly at JR. The Horton has very minimal episodes of corridor care and is related to space restrictions and estate. There have been no episodes of ward corridor care since April outside of SEU. Early signs shows good improvement however in SEU with no episodes since 24 June. Whilst individual reportable instances of ED corridor care remain static, the total hours of corridor care has seen a reduction of 24% comparing June to September. It is also important to note that the average ambulance handover time has reduced by 2minutes 30seconds in the year to date demonstrating OUH's prioritisation and partnership working.	In line with national guidance, OUH has taken the following steps to prioritise the reduction of corridor care across all clinical areas: ○ Established two Corridor Care Taskforce Groups, led by the Deputy Director of Urgent and Emergency Care. One taskforce group focused on the Emergency Department, while the other focuses on Ward areas. Improvements to escalation, process, governance and data quality were achieved. ○ A new combined Corridor Care taskforce was then established in August with representatives from all Divisions, key areas where corridor care has been significant, and the Corporate Division, and continue to ensure that quality improvement (QI) methodology and data are used to inform decision-making and measure progress. ○ The taskforce meets fortnightly to ensure actions and key priorities are progressing at pace. ○ A self assessment against the GIRFT Corridor Care Improvement Guide has been undertaken in August in which we are now 82% compliant and forms the basis of the improvement work. ○ Four priority work streams have been identified following this review:- Discharge Lounge, ED Streaming, Full Hospital Protocol and Healthcare Professional referrals to SCAS. ○ National GIRFT seminars attended to gain insight into the current national picture and incorporate emerging learning across OUH. ○ Ward Managers forum attended in November to share messaging and emphasize importance of bed declaration and acceptance from emergency and assessment areas.	Alternate TWUCG meetings update with completion of workstreams planned for December 2026	ED – 2375 SEU - 3460	



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
Cancer performance for 62 days Decision to Treat was 56.8% in September 2026 against an operational plan of 63.2% and below the national standard of 85.0%. Though the number on pathway was 3% above yearly average. Performance is reported two months in arrears due to the extended reporting period for this indicator.	**MDT Streamline:** Demand and Capacity toolkit developed by an external supplier to review every Tumour Site MDT to identify inefficiencies and recommend lean working for optimal utilisation. Tumour site liaison and meetings being held along with Cancer Management and Quality Improvement teams. MDT standard operating policy supported at Delivery Group, COO to authorise implementation. **Weekly Cancer Delivery Action Group:** CDAG meeting held every week with 3/4 tumour sites at a time, tracking progress of top 3 priorities selected by the group. Key Recovery Actions based on Key Lines Of Enquiry evidenced by analytic reports. Cancer day held 19/11 by tumour site, using Quality Improvement methodology and support data driven decisions with next steps to support end of March delivery. Quality improvement tumour sites in place. Radiotherapy GIRFT review – requested and held 12 November, early feedback received with some areas for improvement. Causal factor for decline in previous on- plan performance was Dermatology. This service has now recovered, with insourcing and cancellation of routine patients to support cancer patients. This recovery was in month November. This is not the route for delivery of March position, every tumor site has specific targets for backlog and breach numbers.	Cancer Strategy & Improvement Group – October 2026 Delivery Committee – December 2026 Quality and Performance Committee – December 2026	1111	

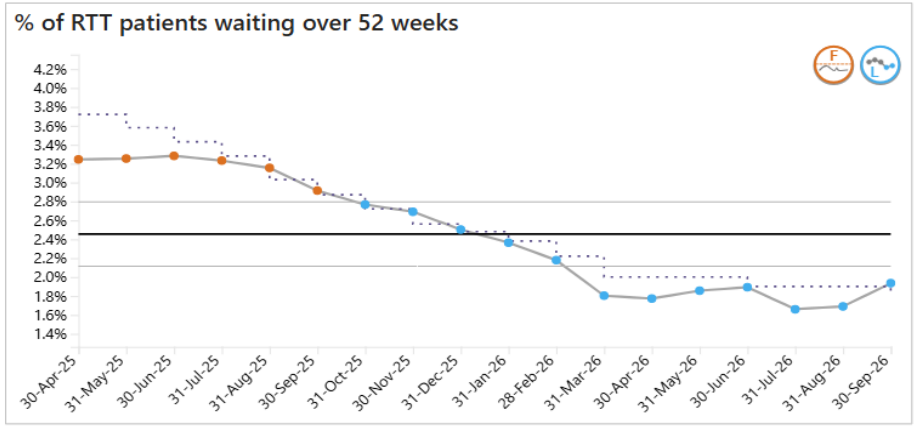
3. Assurance report: Operational Performance, *continued*

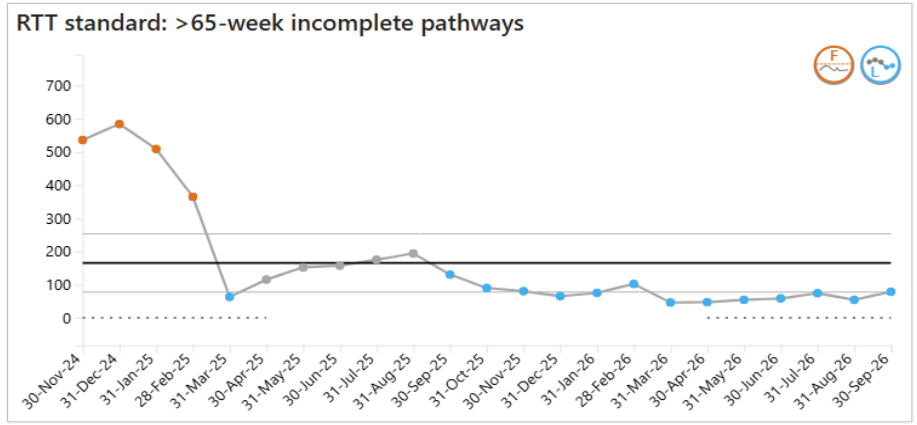


Benchmarking: RTT – Patients Waiting 18 weeks or less August 2026					NOF Score (Q2)
OUH: 63.85%	National: 66.12%	Shelford: 67.32%	BHT: 64.19%	RBH: 82.68%	3.10

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting less than 18 weeks as a proportion of the total waiting list was 63.9% at the end of September against an operational plan of 63.9%. Performance exhibited special cause of improvement due to more than six consecutive periods of performance above the mean. Total incomplete RTT pathway waiting list size was 89,488 for August with 70.1% of patients awaiting a first appointment below 18-weeks.	Performance for RTT is on plan. The key focus is on treating patients with the longest waits across all specialties. The Trust has shown improvement in the last six months. Validation continues – utilisation of resources for administrative validation to scrutinise pathways above 18-weeks. With focus moving away from total waiting list to instead the longest waiting patients. An Outpatient Improvement Programme and a Theatres Improvement Programme are in place, three main aims. Digital outcome form roll-out all specialties continues with vast majority in place (lead time to fully conclude tbc), supporting clinicians to place eligible patients on a Patient Initiated Follow-Up (PIFU), creating capacity for patients clinically required to be seen and potential to converting follow-up slots to new slots thus driving productivity opportunities. Additional Insourcing solutions are planned from August/September onwards in ENT, OMFS, and Dermatology. With Urology planned from early January. Additional elective capacity through the Surgical Elective Centre (Level 1) operational plan assumed July; this is now 9/12 go live. Activity for Day Case and Elective remains (slightly) above plan.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews Delivery Committee – November 2026	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

3. Assurance report: Operational Performance, *continued*

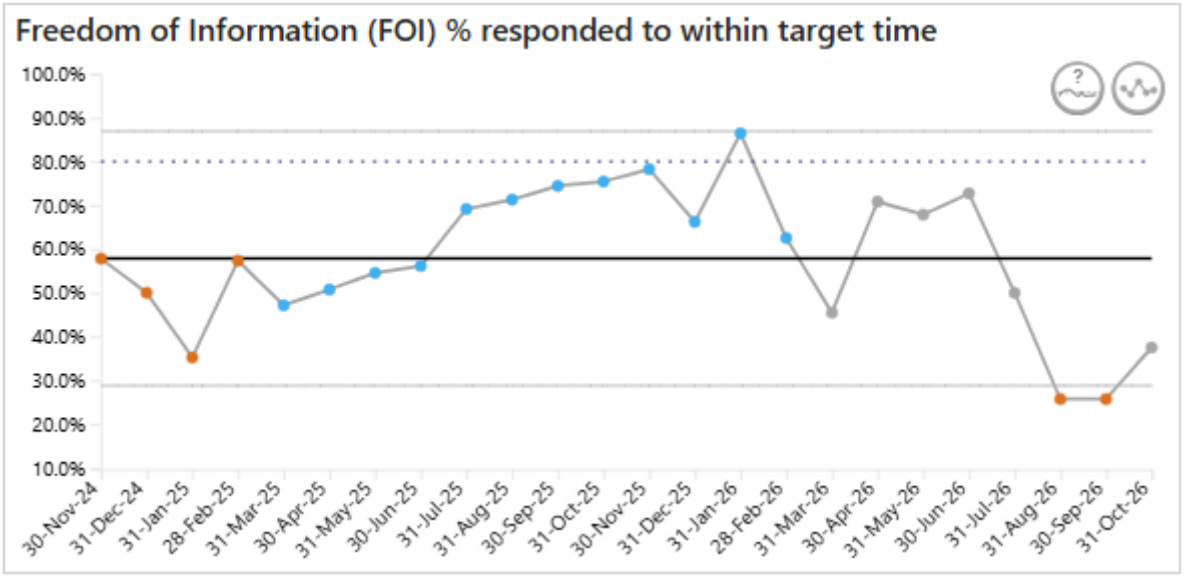


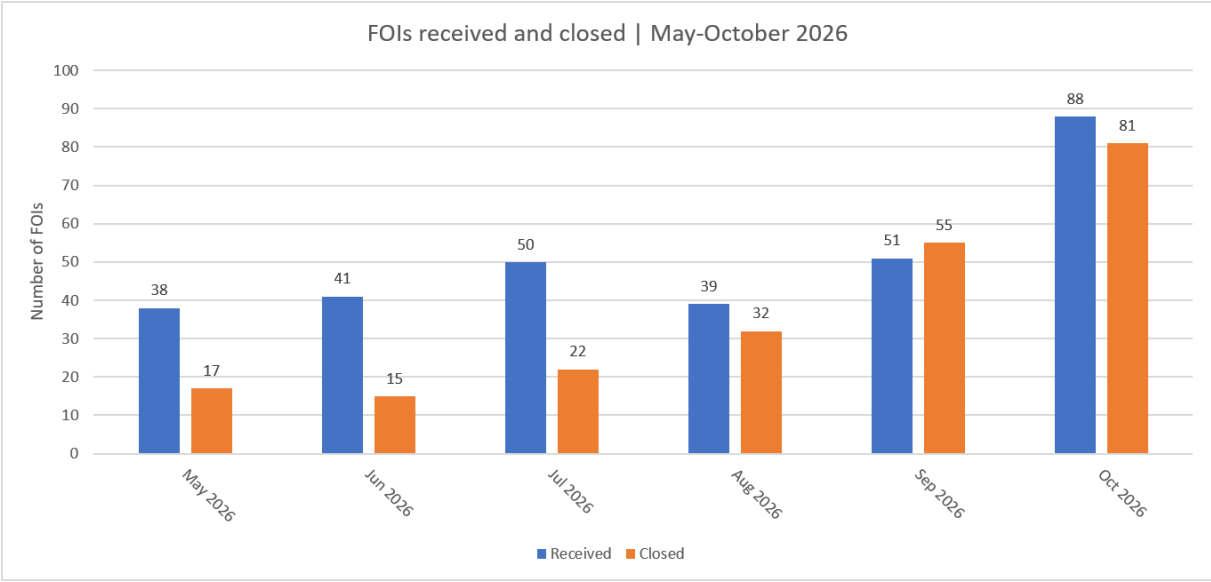


Benchmarking: RTT – Patients Waiting over 52 Weeks September 2026					NOF Score
OUH: 1.69%	National: 1.02%	Shelford: 0.99%	BHT: 0.11%	RBH: 0.05%	3.46

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality rating
The number of patients waiting more than 65 weeks to start consultant-led treatment was 78 at the end of September. Performance exhibited a positive special cause of variation due to exceeding below the lower control limit. We remain committed to eliminating patients waiting over 65 weeks but did not deliver this for August. **Focus remains on longest wait patients:** **>65 weeks – 78** incomplete pathways reported which is a increase from the previous month (54) by 24 pathways. Focus remains in place to deliver nil pathways. Other less challenged services have moved to recovering **52-week backlog and 18-week performance.**	**Focus has been on no patient waiting over a year by March 2027. Every speciality and Clinical Director has received their local position with regards to 1st Outpatients, diagnostic and elective patients. Divisional teams have been supported to reduce outstanding letters, outcomes and conclude patient pathways.** **Delivery Action Plan**: Live and populated against specialty level trajectories – introducing new framework for tracking deliverables in conjunction with weekly check and challenge meetings **Gynaecology services:** Insourcing focusing on outpatients stopped in September. Plans in final stages for insourcing outpatient Hysteroscopy with view to commence in December, and PEP work to commence shortly to support this. This remains a challenged speciality and Endometriosis is likely to remain so for a period of time, there is no mutual aid supported, this has been escalated to the regional COO. **Ophthalmology:** Theatre capacity for cataract surgery will continue to be supported at the Cherwell, alongside two additional theatre lists every weekend at the West Wing. Patients who are unable to undergo surgery at weekends remain a key risk to capacity and delivery. Ophthalmology is also progressing through Phase 2 of the SEC, which is expected to have a further positive impact on surgical capacity. This remains in place. **ENT inc Paeds services**: Enhanced senior-level validation is ongoing to support waiting list management including Audiology. Insourced ENT clinics continue to deliver additional capacity, with the service demonstrating a steady reduction in its backlog. Subspecialty consultant theatre capacity pressures are expected to be alleviated following the opening of the SEC, currently scheduled for early December. Performance continues to improve. **Urology-** The arrangement with Manor Hospital will remain in place until December, with theatre slots allocated to non-complex stone and benign prostate procedures. This will help optimise theatre capacity at OUH, enabling more complex procedures to be undertaken.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

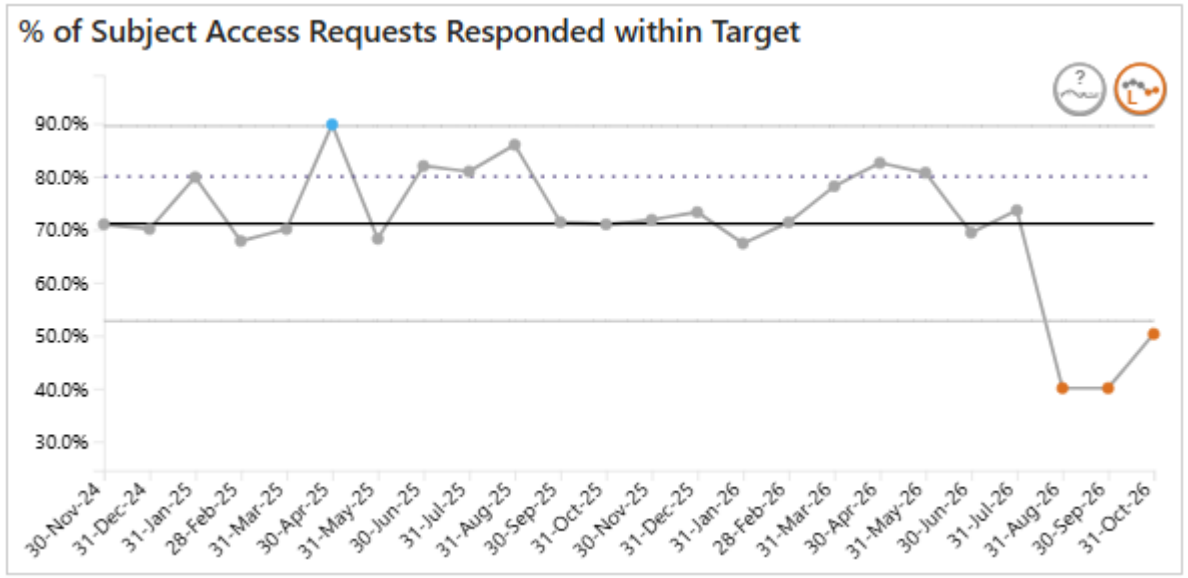
3. Assurance report: Corporate support services – Legal Services, *continued*

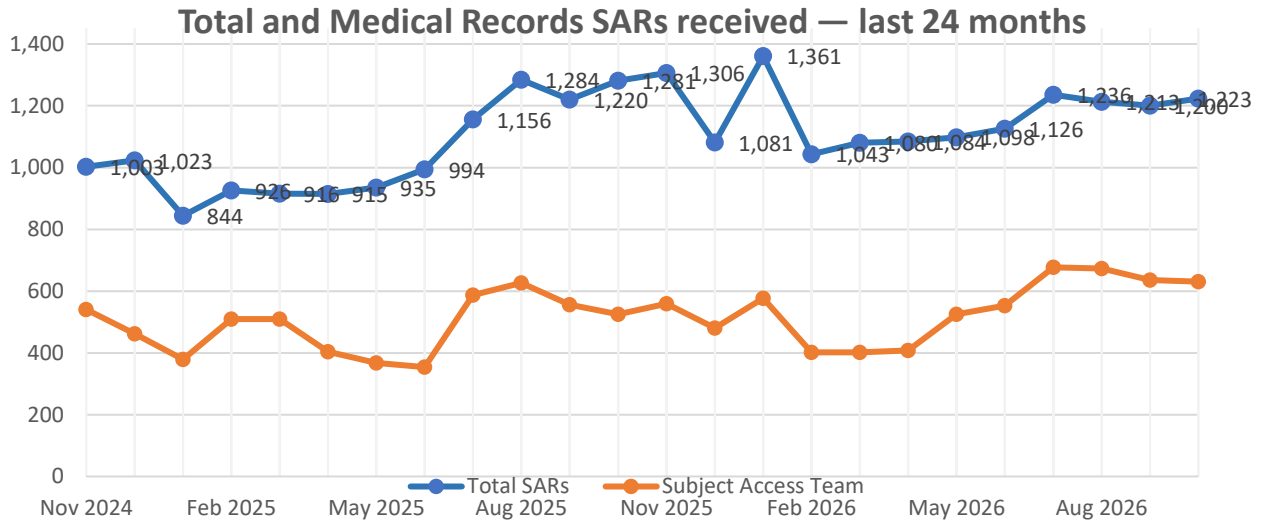




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M7 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 37.5%. This is because older, backlog cases are being prioritised. Case throughput has increased significantly since M4. 88 new cases were received in M7 (up from 50 in M6), of which 33 were closed on time (up from 13 in M6) – in total 81 cases were closed as efforts to close complex overdue cases continue. This is a 200% increase in the total number that was closed in M5. The rise in the use of AI LLMs is increasing the complexity of requests received, as requests are frequently imprecise or make incorrect assumptions that the requester is unable to expand on usefully when asked for a clarification.	An updated round of refresher training for divisional FOI SMEs/main contacts is currently underway, to reinforce current practice and train new staff. An automated report is now sent to divisional leadership and chief officers highlighting current open cases. This has highlighted some historic data quality issues which have been resolved and has been a valuable exercise. The ICO have issued guidance on dealing with AI requests, but the feedback to them has been that it needs to be much more robust – we are awaiting their response to this.	Updates provided to Digital Oversight Committee and Delivery Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

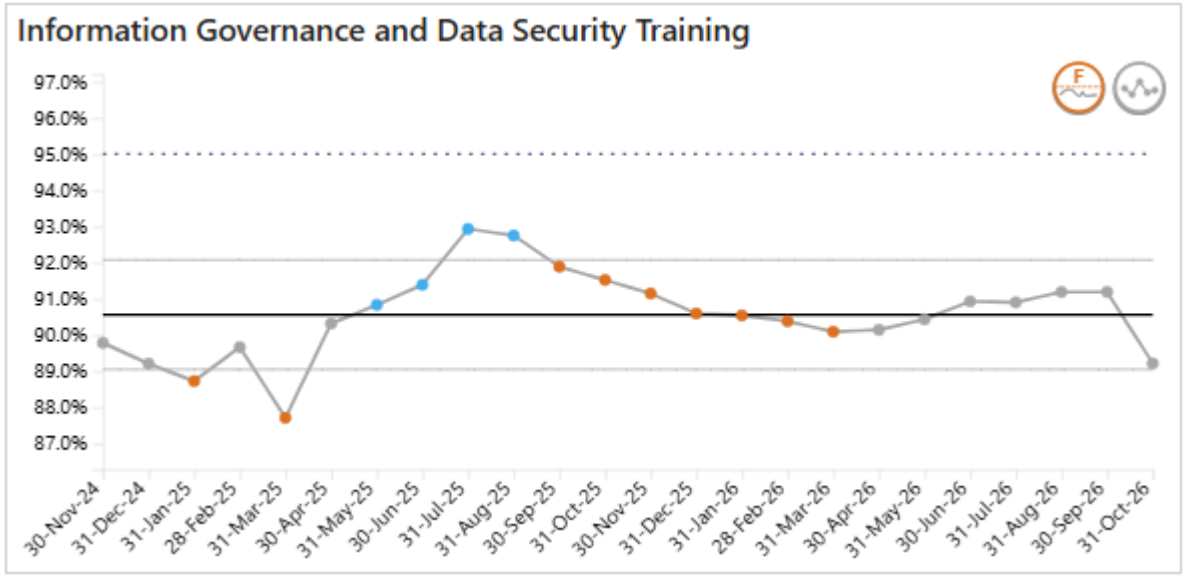
3. Assurance report: Corporate support services – Legal Services, *continued*





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In M7, the Trust received 1,223 SAR requests, similar to M6's 1200, and closed 572 on time. As a result overdue cases increased to 927. This figure was 808 overdue in M1 and as low as 103 in M4. Medical SARs closed: 455 of 631 received Occupational Health closed 96% of their 235 cases on time PACS closed 92% of their 357 on time. Both teams closed 100% of the cases that they received in M7.	E-Case is now well embedded and updated processes to reflect the Data Use and Access Act are in place and realising benefits. However a 60% surge in the volume of requests between M1-M3 and M5-M7, has exceeded the capacity of the available 3.6WTE resource. Recruitment of 4 WTE Band 4 staff for 9 months has been approved by Chief Officers Pay Panel and is underway. It has been identified that requests that include paper maternity records run 40% slower than requests that only cover electronic records, so the “paper free” digitisation project has brought forward the start date of maternity records scanning from Q1 2027 to December 2026.	Updates provided to Digital Oversight Committee and Delivery Committee	BAF6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Division	Employees Total Number	Heads Outstanding	% Completed
Operational Services	204	12	94.1%
Corporate	1192	121	89.8%
SuWON	3399	378	88.9%
Estates	166	19	88.6%
MRC	3324	414	87.5%
Clinical Support Services	2375	304	87.2%
NOTSSCAN	3499	459	86.9%
Research and Development	166	26	84.3%
Hosted Services DIV	48	8	83.3%
Operating Expenses	11	4	63.6%
Education and Training	74	41	44.6%

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 89.1% in M7, a drop of 2.1% from M6. This is a significant drop, the reporting data has been re-checked and is correct. The increase in training compliance usually seen during the annual appraisal window was particularly small this year, suggesting that managers are signing off appraisals even though this training has not been completed. No divisions are achieving 95% and this month's performance exhibits common cause variation. All areas except Operational Services are below 90%	1786 staff are currently non-compliant, an increase of 314 on M6. All divisional governance teams have visibility of their staff training levels and can access reports which name non-compliant individuals to help them manage the situation. Cyber awareness and IG communications activity is being re-energised as part of the new OUH Cyber Security Strategy – a Christmas campaign that will draw attention to this training is being delivered in December.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

4. Assurance framework model a) *SPC key to icons (NHS England methodology and summary)*

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

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

Sufficient | *Satisfactory* | *Inadequate*

Oxford University Hospitals NHS Foundation Trust

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales	Risk Register (Y/N)	Data quality rating
This section should describe the reason why the indicator has been identified for an assurance report and interpret the performance with respect to the Statistical Process Control chart, if appropriate. 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

