Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M3 (June data)

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Segmentation dashboard: selected indicators

		Segmentation performance (*nationally reported position - Q4 25/26*)					Latest performance (*monthly internal data*)			
Domain	**Indicator**	**Performance**	**Segmentation national ranking**	**NOF score**	**Segmentation measurement period**	**Segmentation reporting data inclusion date**	**Latest monthly performance**	**Latest monthly performance target (operational plan)**	**Latest monthly performance vs plan**	**Period of latest monthly performance**
Operational Performance	1. Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	82.08	13/123 (low is good)	1.00	Rolling 3-month	March 2026	77.9	83.8	Non compliant	June 2026
	2. Percentage of patients treated for cancer within 62 days of referral	60.09	108/118 (low is good)	3.76	Rolling 12-month	March 2026	63.5	61.2	Compliant	May 2026
	3. Percentage of patients waiting over 52 weeks	1.80	103/130 (low is good)	3.10	End of period	March 2026		1.9	Compliant	June 2026
	5. Summary Hospital Level Mortality Indicator			2.00	Rolling 12-month	December 2025	88.0	100.0	Compliant	February 2026
Quality Performance	6. Variance year-to-date to financial plan	0.27	56/134 (low is good)	1.00	Year to date	March 2026	296.3	0.0	Compliant	May 2026
Financial Performance	7. Planned surplus/deficit score	-1.02	57/134 (low is good)	3.00	Annual plan	March 2026				

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

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 3 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 internal Power BI dashboard is included for selected Segmentation Indicators (on page 3).

Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals (Cancer, UEC, standard work, QI learning hub). Safeguarding training compliance for adults and children (L1-L3) were achieved. We achieved key measures related to patient safety and care experience, including fewer pressure ulcer incidents per 1,000 bed days for hospital acquired categories 2, and 4 (but not category 3). We recorded fewer c-diff cases vs the monthly threshold and VTE assessments were better than the national target. Our mortality indicators (SHMI and HSMR - excluding hospices) were below 100, indicating fewer deaths than expected.

Achieving workforce metrics including, staff sickness rates, vacancies, and turnover contributes to better patient care and reduced costs from temporary staffing. Our sickness absence rate was worse than threshold for the month and rolling 12-month position, and the monthly position. Rates remain better than National and Shelford averages. Turnover rates performed better than targets but the vacancy rate did not meet the performance target. Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. We did not meet the non-medical appraisals target since the new appraisal cycle has commenced. We met targets for core skills training demonstrating commitment to staff development and achieved our time to hire standard.

Performance against the operating plan trajectory for A&E in month 3 was non-compliant (below plan) for all types and for type 1 performance within 4 hours (above plan). Performance was also non-compliant for the % of patients waiting over 12 hours (both A&E – all types and 12-hour performance are Segmentation indicators).OUH 4-hour performance was 2nd best in the region in this period. In month 3, the % of pathways over 52 weeks (segmentation indicator), met the operating plan trajectory, but the number of patients over 52-weeks did not by 154 patient pathways the deviation to plan narrowed from 0.69 percentage points last month to 0.60 percentage points in M3. The percentage of patients within 18 weeks for first OP attendances also did not meet the operating plan (67.5% vs 68.1%), but similarly the deviation to plan narrowed (improved). Performance in month 2 met the operating plan target for the Faster Diagnosis Standard and the 62-day Cancer Standard (segmentation indicators) .Focus continues to reduce the number of patients over 62 days waiting and to reduce the total patient waiting list (PTL). NB. Cancer performance is reported one month in arrears. Diagnostic performance (% within 6 weeks) was below the operating plan in month 3. Total diagnostic activity was 33,941 and worse than (below) the operating plan by 3,226. Modalities with lower activity compared to the average run rate in M3 included MRI, Urodynamics and Colonoscopy. There is further validation planned in a staged way across the summer period that is being addressed.

The plan in month 3 was for a £3.9m deficit. the Trust achieved a £1.8m deficit which is favourable to plan by £2.1m. The underlying deficit at month 3 is £9.1m. The following are the key headlines for the 2026/27 CIP programme in month 3: Planned target: £7.3m, Achievement: £6.4m, Adverse Variance: £0.9m.

- The Trust planned £4.6m recurrent savings but only reported £1.9m.
- Budget WTE are 14,346 for month 3 with worked WTE at 13,978 overall showing vacancies of 368 WTE. This delivered divisional non-recurrent CIP. Bank use decreased to 606 WTE.
- Non-pay is overspent by £3.6m (excluding pass-through). The driving variances are in HIOTV and R&D of £1.9m (offset by income) and £2.3m adverse in Trust reserves (driven by £1.7m shortfall on non-recurrent CIP). Offsets in PFI and energy reduced the overspend.
- Cash was £7.2m at month 3 which was £3.6m above plan. Cash is now close to plan after the completion of the year end creditor unwinding, with a slightly higher June balance due to in-year 26/27 capital spend being behind plan, this is timing and not a permanent difference. The cash plan for 2026/27 suggests that the pressure on cash will return, now the timing issues have unwound from 2025/26.
- The rate of CIP identification and delivery will need to improve rapidly in ALL divisions to avoid further spending control.

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. Development indicators for the IPR currently include MRSA screening.

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 ('Must Do')
- Externally Reportable ICO Incidents
- Vacancy Rate
- Sickness Absence Rate (Rolling 12 months)
- Pressure Ulceration Incidents per 1,000 beds (Cat 3)
- Number of Complaints
- Number of Complaints per 10,000 bed days
- % of Complaints Responded to Within 25 Days

Common cause variation and missed target

- Information Governance Training
- Freedom of Information (FOI) % Responded in Time
- Data Subject Access Requests (DSAR)
- Priority 1 Incidents
- Non-Medical Appraisals
- Sickness Absence Rate (In Month)
- MRSA Cases: HOHA+COHA
- Number of Never Events
- % Patients with Sepsis Attending ED Receiving Timely Antibiotics in Accordance with NICE
- Neonatal Deaths per 1,000 Total Live Births
- Midwife Ratios (Birth rate/staffing level)
- Reactivated Complaints
- FFT % Likely to Recommend – OP, IP, and ED
- ED 4hr Performance – All and Type 1
- Proportion of Type 1 Attendances Spending More than 12 hours in ED
- No of Corridor Care Patient in IP wards at 8am
- No of Corridor Care Patient in ED > 45min
- Cancer 31-Day and 62-Day Combined Standard
- Number of Patients Put Onto a PIFU

Special cause variation - improving

- % of RTT Patients waiting for a first appointment
- % of RTT Patients Waiting Within 18 weeks
- RTT Standard: >65-week Incomplete Pathways

Other*

** (where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation).*

***E. coli* bacteraemia:** Current performance shows 10 cases in June, slightly down year-on-year but reflecting a marginal deterioration in Oversight Framework position. Improvement highlights limited modifiable drivers in secondary care, with urinary infections reducing but hepatobiliary infections increasing, prompting deeper review of potential links with procedure waiting times.

MSSA and MRSA bacteraemia: Current performance shows seven MSSA cases in June, improved year-on-year, and two MRSA cases, with the overall MRSA Oversight Framework position continuing to improve. MSSA and MRSA bacteraemia: Improvement activity focuses on IV-line assessment and documentation, urology screening and decolonisation learning, refresher teaching, and inclusion of multi-site MRSA screening compliance in divisional reporting. MSSA and MRSA bacteraemia

C. difficile infection: Current performance shows continuing improvement year-on-year and maintaining the strongest possible Oversight Framework score. Improvement activity includes antimicrobial stewardship, rollout of enhanced environmental cleaning, ICNet implementation, and Power BI options to restore AMS reporting.

ED Sepsis: Current performance shows 79% compliance with timely IV antibiotic administration in June, below the 90% standard, with delays affecting three of 14 sepsis patients. ED sepsis and antibiotic timeliness: Improvement activity focuses on difficult IV access, communication between prescribing and nursing teams, corridor care impacts, and review of the ED sepsis screening tool following audit findings that 20% of triggers were low risk. ED sepsis and antibiotic timeliness.

Never Event: Current performance confirms one June PSII relating to wrong-site ophthalmology treatment, with no harm reported. Never Event: Improvement activity includes revised WHO checklist practice, "STOP, pause & review" prompts, reinforced positive patient identification, patient-facing reminders, 100% weekly PPID audit compliance, improved LocSSIP, and further human factors training. Never Event: Immediate actions were completed in May, with any further investigation actions to be managed via Ulysses and overseen by Patient Safety and Divisional governance teams.

Pressure Ulcers; Hospital acquired Category 3 incidents were reported, linked to higher activity and increased clinical complexity; No Category 4 incidents were reported; Oversight remains through the Harm Free Assurance Forum with escalation to Clinical Governance Committee; Harm reviews are being undertaken in areas with sustained challenges, supported by a comprehensive Pressure Ulcer Prevention and Management QIP.

Complaints Performance; The Trust received 261 formal complaints in June, reflecting sustained high demand and continued pressure on the 25-day KPI; Median response time was held at 29 days, unchanged from May, despite increased activity; Closure volumes improved with 228 complaints closed, a 14% increase on May, indicating capacity is keeping pace with demand; Reopened complaints increased to 26 cases (9.9%), mainly for further information or meetings with clinical staff; Escalation at 40 and 60 days through PEEC provides direct oversight of long-running cases.

Friends and Family Tests; FFT response volume increased to 12,629 responses in June with an overall response rate of 18.5% and sustained positive sentiment at 93.02%; Recommendation rates remained strong in Outpatients (93.7%) and Inpatients (94.9%), with lower performance in ED (81.3%); Positive themes continue to focus on staff attitude, admission and implementation of care, while negative themes include car parking, cancelled admissions/procedures and discharge; Divisional accountability is reinforced through bi-monthly PEEC updates.

Maternity Safe Staffing; Maternity activity increased with a midwife-to-birth ratio of 1:24.24; Safe staffing was maintained with no reported failures in 1:1 care in labour and the Delivery Suite Coordinator supernumerary on every shift; Establishment remains aligned to Birthrate Plus, with total establishment at 344.45 WTE, though unavailability and MSW vacancies remain key pressures.

Neonatal Mortality; Neonatal mortality increased in Q1 2026, but small numbers mean short-term variation should be interpreted with caution; A rapid review found no common care-related factors or concerning trends, with deaths largely associated with unrelated congenital abnormalities and extreme prematurity

Sickness absence remains above target at 4.2%, though aligned with peer benchmarks; key drivers remain mental health, musculoskeletal and respiratory conditions. Actions focus on strengthened divisional reporting, targeted support in high-absence areas, Occupational Health and wellbeing input, improved return-to-work processes, and manager training.

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Oxford University Hospitals NHS Foundation Trust

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Non-medical appraisal compliance has improved to 62.8%, with further progress expected as the appraisal window continues; latest completion is 74.92%, ahead of 58.52% at the same point last year. Actions centre on communications, leadership oversight, webinars and training, targeted divisional support, and monitoring through governance routes.

Urgent & Emergency Care / Patient Flow: Performance deteriorated in June due to sustained demand, with ED attendances 2.4% higher year-on-year and periods of intense arrivals over 3–4 days related to the heat. Pressures were compounded by medical sickness, discharge lounge/transport constraints, delayed Pathways 1–3 discharges. Actions include the UEC deep dive, Call Before Convey options, pharmacy review, and a Horton "Perfect Week"; assurance via TWUCG and PLACE/system support. A formal escalation to system partners has been sent with a request for clear actions to address the non-compliant Medically Optimised for discharge patients. A Full Capacity Protocol and surge planning is in development to address periods of sustained pressure. In addition, formal preparation for Winter / Seasonal planning is being developed to submit to Trust Board by 31 August. Learning from the heatwave periods will be included in our seasonal plan. Work with system partners for Winter plan responsibilities will be led by the Integrated Commissioning Board (ICB).

ED 12-Hour Waits: June improved, but >12-hour waits remained around 3% (335 patients), with attendances 2.4% higher year-on-year. Pressures relate to JR bed flow, acuity, patients not meeting criteria to reside, and delayed transfers to inpatient beds. Actions include UEC deep dive learning, SCAS conveyance avoidance, Horton Perfect Week in September, and ongoing adult social care/provider capacity work.

RTT 18 Weeks: Performance was 62.48% against a 63.12% plan, with the waiting list at 90,587. Performance shows sustained improvement but remains below plan by 0.68%, with focus shifting to longest waiters. Actions include clinical, admin & patient validation, outpatient and theatre improvement programmes, Patient Initiated Follow Up (PFIU) rollout, insourcing in ENT/OMFS/Gynaecology, and elective capacity expansion through the Surgical Elective Centre.

RTT 65 Weeks: There were 47 pathways >65 weeks, against the ambition of nil, although >104-week waits remain nil and >78-week waits were down to 2. Recovery actions focus on outpatient activity across the Summer; a focus on ENT insourcing/validation, Gynaecology additional capacity and pathway redesign, OMFS activity expansion, and specialty-level delivery action plans overseen through weekly Check & Challenge, Elective Delivery Group and Divisional Performance Reviews.

Cancer 62-Day Pathways: Performance met plan at 63.5% against an 61.2% plan, though we note that we are significantly below national and Shelford comparators. Actions include, NHS E support and review on guidance; radiotherapy (GIRFT review September); review of Patient Tracking List Management; MDT demand and capacity review, tumour-site workshops, 100-day plans, and Cancer Improvement Group oversight.

Diagnostics 6-Week Waits: Diagnostics performance was 21.03% waiting over 6 weeks against a 19.5% plan. Actions focus on over-delivery across modalities, validation of longest waiters, and targeted recovery in Endoscopy, Neurophysiology, Audiology and Non-Obstetric Ultrasound, including insourcing, workforce stabilisation, estates work and Delivery Fund schemes; assurance via weekly Check & Challenge and Elective Delivery Group.

Discharge Ready Date / Flow: Performance deteriorated due to increased Pathway 1–3 discharge complexity, D2A capacity challenges, reduced Short Stay Hub Beds and out-of-county delays. Despite this, Oxfordshire remains one of the strongest South-East systems for patients not meeting National Criteria to Reside. Actions include ward-level reviews, escalation routes, SSHB trajectory tracking, and QI work.

Freedom of Information was 72% in M3, below the 80% target, with 28 valid cases received and 16 closed on time. Performance was affected by vacancies, sickness, e-Case onboarding and complex overdue cases; recovery actions include recruited maternity cover, targeted escalation support and improved divisional onboarding. **Data Subject Access Request** performance remains challenged, with 551 of 794 requests closed on time and medical records SARs the main pressure area. Backlog reduction continues by embedded e-Case processes and ongoing monitoring.

Information Governance and Data Security Training compliance was 90.9% in M3, with no divisions meeting the 95% target and Corporate, NOTSSCAN, R&D and Education below visibility of non-compliant staff and targeted reporting, supported by the appraisal cycle; performance is overseen by the Digital Oversight Committee.

Priority 1 Incidents related to VDI connectivity/login issues caused degraded availability when multiple session hosts became unregistered; the issue was resolved by 08:30 on 22/06/2026.

2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

	Common cause variation	Special cause variation - improving	Special cause variation - deterioration	Other (where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)
Quality, Safety and Patient Experience	Not achieving target • MRSA Cases: HOHA + COHA • Number of Never Events • % patients with Sepsis receiving timely antibiotics in accordance with NICE • Neonatal Deaths per 1,000 live births • Midwife Ratios • Reactivated Complaints • FFT % Likely to recommend OP, IP, and ED	H • C-Diff Cases: HOHA+COHA and per 10,000 bed days • FFT % Likely to recommend ED	L Not achieving target • CQC Overdue Actions • % of complaints responded to within 25 working days • Pressure Ulceration Cat 3 H Not achieving target • Number of complaints per 10,000 bed days • Number of complaints	No SPC Not achieving threshold
Growing Stronger Together	Not achieving target • Non-Medical Appraisals • Sickness and absence rate (in month)	L Not Achieving target	H Not achieving target • Vacancy Rate • Sickness and absence rate (Rolling 12 Months) • Non-Medical Appraisals	
Operational performance	Not achieving target • ED 4hr Performance – All and Type 1 • No of Corridor Care Patients in Past 24hrs in ED >45min • No Of Corridor Care Patient in IP Wards at 8am • Proportion of Type 1 Attendances Spending more than 12hrs in ED • Cancer 31-, and 62-Day Combined Standard	L Not Achieving target • % of RTT Patients Waiting within 18 weeks • % of RTT of patients waiting for a first appointment • RTT Standard: >65-Week Incomplete Pathways	L Not achieving target H Not achieving target	
Corporate Support Services	Not achieving target • Freedom of Information (FOI) % Responded to Within Target Time • Information) Governance and Data Security Training compliance • Data Subject Access Requests • Efficiency Delivery £'000 • BPPC £% • BPPC Volume % • Year to date financial performance Surplus/ Deficit £'000	H Not achieving target • Year to date financial performance Surplus/ Deficit £'000	L Not achieving target • BPPC £ % • BPPC Volume % • In-month financial performance Surplus/ Deficit £'000 • Externally Reportable ICO Incidents	No SPC Not achieving threshold

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience

No specified section

Data updated on: 09/06/2026 12:08:12

SPC Chart | Show SPC legend

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
18.00	MRSA Cases: HOHA+COHA Per 10,000 Beddays	✗	Yes	Jun-26	0.66	0.46	0.00	1.63	0.00		
19.00	MRSA Cases: HOHA+COHA	✗	Yes	Jun-26	2	1	0	3	0		
20.00	C-Diff Cases: HOHA+COHA Per 10,000 Beddays		Yes	Jun-26	2.63	3.42		6.60	0.24		
21.00	C-Diff Cases: HOHA+COHA	✓	Yes	Jun-26	8	11	10	21	1		
22.00	E. Coli Cases: HOHA+COHA Per 10,000 Beddays		Yes	Jun-26	2.96	5.54		9.58	1.49		
23.00	E. Coli Cases: HOHA+COHA		Yes	Jun-26	10	18		31	5		
24.00	MSSA Cases: HOHA+COHA		Yes	Jun-26	7	6		13	0		
25.00	Number Of Never Events	✗	No	Jun-26	1	0	0	1	-0		
26.00	Non-Thematic Patient Safety Incident Investigations		No	Jun-26	2	2		7	-3		
27.00	PSII Overdue Actions		Yes	Jun-26	18	30		52	9		
28.00	VTE- Submitted Performance	✓	Yes	May-26	96.4%	95.3%	95.0%	95.9%	94.6%		
29.00	% Of Emergency Admissions 65yrs + Receiving Cognitive Screen		Yes	Jun-26	71.8%	64.8%		71.9%	57.7%		
30.00	% Patients With Sepsis Attending ED Receiving Timely Antibiotics In Accordance With NICE Guidelines	✗	Yes	Jun-26	78.6%	86.1%	90.0%	110.5%	61.7%		
31.00	CAS Alerts Breaching Deadlines At End Of Month And/Or Closed During Month Beyond Deadline	✓	No	Jun-26	0	0	0				
32.00	Medication Incidents Causing Moderate Harm, Major Harm Or Death As Reported On Ulysses		Yes	Jun-26	2	3		7	-1		
33.00	HSMR Excluding Hospices	✓	No	Mar-26	93.0	91.8	100.0	94.2	89.3		
34.00	Summary Hospital-Level Mortality Indicator	✓	No	Feb-26	88.0	79.0	100.0	80.3	77.6		
35.00	Neonatal Deaths Per 1,000 Total Live Births	✗	Yes	Jun-26	3.36	3.10	3.20	7.30	-1.10		
36.00	Stillbirths Per 1,000 Total Live Births	✓	Yes	Jun-26	1.68	2.89	4.00	6.96	-1.18		
37.00	National Patient Safety Alerts Not Completed By Deadline		No	Jun-26	0	0					
39.00	Number Of Active Clinical Research Studies Hosted		Yes	Feb-26	1471	1428		1457	1400		
40.00	Number Of Active Clinical Research Studies (Commercial)		Yes	Feb-26	408	398		413	383		
41.00	Number Of Active Clinical Research Studies (Non Commercial)		Yes	Feb-26	1063	1030		1048	1012		
42.00	Number Of Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Jun-26	52.94	45.53		58.91	32.16		
43.00	Number Of Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Jun-26	45.71	39.15		52.30	25.99		
44.00	Number Of Non-Patient Incidents With Moderate Harm Or Above Per 10,000 Beddays		Yes	Jun-26	7.23	6.39		12.86	-0.09		
45.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 2)	✓	Yes	Jun-26	1.48	1.96	1.90	2.85	1.07		
46.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 3)	✗	Yes	Jun-26	0.43	0.25	0.20	0.42	0.09		
47.00	Pressure Ulceration Incidents Per 1,000 Beddays (Hospital Acquired Cat 4)	✓	Yes	Jun-26	0.00	0.01	0.00	0.01	0.01		
48.00	Pressure Ulceration Incidents Per 1,000 Beddays (Present On Admission Cat 1+)		Yes	Jun-26	9.60	9.74		12.52	6.95		
49.00	Patient Falls (Moderate And Above) As Reported On Ulysses		Yes	Jun-26	4	4		9	-2		
50.00	Patient Falls (Moderate And Above) As Reported On Ulysses Per 1,000 Beddays		Yes	Jun-26	0.13	0.12		0.30	-0.06		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
51.00	Health And Safety Related Incidents - Assault, Aggression And Harassment		Yes	Jun-26	245	190		267	112		
52.00	Adult Safeguarding Activity		Yes	Jun-26	1873	1544		2111	977		
53.00	Children's Safeguarding Activity		Yes	Jun-26	499	493		730	255		
54.00	Adult Safeguarding Activity And Children's Safeguarding Activity		Yes	Jun-26	2372	2036		2738	1334		
55.00	Safeguarding (Children) Training Compliance L1 - L3	✓	Yes	Jun-26	91.3%	90.6%	90.0%	92.6%	88.5%		
56.00	Safeguarding (Adults) Training Compliance L1 - L3	✓	Yes	Jun-26	92.6%	91.9%	90.0%	94.1%	89.6%		
57.00	Total Deliveries In Month	-	Yes	Jun-26	585	597	625	694	501		
58.00	Babies Born		Yes	Jun-26	593	608		706	509		
59.00	Maternity Bookings (Planned + Unplanned)	-	Yes	Jun-26	583	679	750	826	533		
60.00	Inductions Of Labour From IView		Yes	Jun-26	119	121		170	71		
61.00	Midwife Ratios (Birth Rate / Staffing Level)	✗	Yes	Jun-26	24.2	24.0	22.9	28.4	19.6		
62.00	Number Of Learning MDT Reviews Instigated		Yes	Jun-26	2	2		5	-2		
63.00	Percentage Of Learning MDT Reviews Within 42 Days		Yes	May-26	0.0%	53.6%		181.9%	-74.7%		
64.00	After Action Review (AAR)		No	Jun-26	11	14		24	4		
65.00	Percentage Of AAR's Within 14 Days		Yes	Jun-26	33.3%	27.9%		65.4%	-9.6%		
66.00	Number Of Complaints		Yes	Jun-26	263	178		237	119		
67.00	Number Of Complaints Per 10,000 Beddays		Yes	Jun-26	86.48	56.95		78.04	35.86		
68.00	Reactivated Complaints	✗	Yes	Jun-26	26	15	1	27	3		
69.00	% Of Complaints Responded To Within 25 Working Days	✗	Yes	Jun-26	27.3%	41.6%	85.0%	62.1%	21.1%		
70.00	Number Of RIDDORs	✓	Yes	Jun-26	4	5	5	11	0		
71.00	Friends & Family Test % Likely To Recommend - IP	✗	Yes	Jun-26	94.9%	94.8%	95.0%	96.5%	93.2%		
72.00	Friends & Family Test % Likely To Recommend - OP	✗	Yes	Jun-26	93.7%	93.8%	95.0%	94.9%	92.8%		
73.00	Friends & Family Test % Likely To Recommend - ED	✗	Yes	Jun-26	81.3%	81.5%	85.0%	87.0%	76.1%		
74.00	FFT Maternity % Positive (Births)	✓	Yes	Jun-26	100.0%	84.7%	90.0%	103.8%	65.5%		
75.00	Inpatient FFT (Response Rate)		Yes	Jun-26	15.8%	20.8%		24.2%	17.5%		
76.00	Outpatient FFT (Response Rate)		Yes	Jun-26	7.7%	9.3%		10.2%	8.5%		
77.00	ED FFT (Response Rate)		Yes	Jun-26	11.4%	15.3%		17.9%	12.8%		
78.00	Maternity FFT (Response Rate; Births)		Yes	Jun-26	1.8%	2.9%		8.4%	-2.6%		
79.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars JR	✓	Yes	Jun-26	97.4%	94.8%	95.0%	100.2%	89.5%		
80.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars CH	✓	Yes	Jun-26	98.6%	96.2%	95.0%	103.7%	88.7%		
81.00	PFI: % Of Total Audits Completed That Achieved 4 Or 5 Stars NOC	✓	Yes	Jun-26	100.0%	95.8%	95.0%	106.2%	85.3%		
82.00	Incident Rate Of Violence And Aggression (Rate Per 10,000 Beddays)		Yes	Jun-26	80.57	60.37		87.52	33.21		
83.00	Trust Level: CHPPD Vs Budget		Yes	Jun-26	46.3	15.0		43.6	-13.7		
84.00	Trust Level: CHPPD Vs Required		Yes	Jun-26	3.4	-0.6		19.5	-20.7		

Integrated Performance Report (SPC)

Data updated on: 17/06/2026 13:02:54

Operational Performance

No specified section

SPC Chart | Show SPC legend

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
85.0	Proportion Of Ambulance Arrivals Delayed Over 30 Minutes		Yes	May-26	4.7%	6.8%		9.6%	4.0%		
86.0	Proportion Of Ambulance Arrivals Delayed Over 60 Minutes		Yes	May-26	0.3%	0.5%		1.4%	-0.4%		
87.0	ED 4Hr Perfromance - All	✗	Yes	Jun-26	77.9%	76.1%	83.8%	82.1%	70.0%		
88.0	Mean Ambulance Handover Time In Seconds For All Handovers At Trust Level	✓	Yes	May-26	1032	1059	1180	1147	971		
89.0	ED 4Hr Perfromance - Type 1	✗	Yes	Jun-26	70.8%	68.2%	77.2%	75.7%	60.6%		
90.0	No Of Corridor Care Patients In IP Wards At 8am	✗	Yes	Jun-26	20	10	0	32	-13		
91.0	No Of Corridor Care Patients In Past 24 Hours In ED > 45mins Avg Per Day	✗	Yes	Jun-26	7.2	6.5	0.0	10.1	2.9		
92.0	Proportion Of Type 1 Attendances Spending More Than 12 Hours In An Emergency Department	✗	Yes	Jun-26	2.3%	3.1%	1.8%	5.2%	1.0%		
93.0	Proportion Of Patients Discharged From Hospital To Their Usual Place Of Residence		Yes	Jun-26	95.8%	95.6%		96.0%	95.2%		
94.0	% Of RTT Patients Waiting For A First Appointment	✗	Yes	Jun-26	67.5%	66.7%	68.1%	68.4%	65.0%		
95.0	% Of RTT Patients Waiting Within 18 Weeks	✗	Yes	Jun-26	62.5%	58.9%	63.1%	60.3%	57.5%		
96.0	% Of RTT Patients Waiting Over 52 Weeks	✓	Yes	Jun-26	1.9%	2.6%	1.9%	2.9%	2.3%		
97.0	RTT Standard: >52-Week Incomplete Pathways	✗	Yes	Jun-26	1714	2685	1560	3042	2327		
98.0	RTT Standard: >65-Week Incomplete Pathways	✗	Yes	Jun-26	58	292	0	397	186		
99.0	RTT Number Of Incomplete Pathways	-	Yes	Jun-26	90587	87908	80427	90413	85403		
100.0	RTT Number Of Incomplete Pathways (<18 Weeks)	✓	Yes	Jun-26	56601	52258	51977	53714	50802		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
101.0	% Of RTT Patients Waiting Over 52 Weeks For Community Services		Yes	Jun-26	3.6%	3.0%		4.3%	1.7%		
102.0	Cancer 28 Day Combined Standard (2WW ,Breast Symptomatic And Screening Referrals)	✓	Yes	May-26	85.3%	79.1%	80.0%	84.7%	73.4%		
103.0	Cancer 31 Day Combined Standard (First And All Subsequent Treatments)	✗	Yes	May-26	79.8%	79.5%	81.0%	88.2%	70.8%		
104.0	Cancer 62 Day Combined Standard (2WW, Consultant Upgrade And Screening)	✓	Yes	May-26	63.5%	60.3%	61.2%	70.5%	50.2%		
105.0	62-Day Cancer Standard: Incomplete Pathways >62-Days		Yes	Jun-26	289	365		434	297		
106.0	% Diagnostic Waits Waiting 6 Weeks Or More	✗	Yes	Jun-26	21.0%	22.7%	20.0%	27.6%	17.8%		
107.0	Diagnostic Activity Vs 2019/20		Yes	Jun-26	138.2%	134.9%		146.1%	123.6%		
108.0	Total Outpatient Attendances (SUS)	-	Yes	May-26	105361	111757	117191	134949	88565		
109.0	Bed Utilisation General & Acute	✗	Yes	Jun-26	90.2%	93.1%	90.7%	96.5%	89.6%		
110.0	Average Non Elective LOS Trust Level For IPR (Average So Cannot Aggregate Up)	✗	Yes	May-26	6.6	6.8	6.3	7.6	6.0		
111.0	Number Of Non-Discharged Patients Put Onto A PIFU	✗	Yes	Jun-26	1390	978	5860	1197	760		
112.0	Cancelled Operations Within 24hrs (Non-Clinical Reasons)		Yes	Jun-26	0.4%	0.3%		0.5%	0.1%		
113.0	Cancellations Not Re-Booked Within 28 Days		Yes	Jun-26	5.6%	13.6%		39.2%	-12.0%		
114.0	Elective DC Spells - SUS	-	Yes	May-26	6615	6789	7200	8352	5226		
115.0	Elective IP Spells - SUS	-	Yes	May-26	1577	1503	1591	1860	1147		
116.0	Average Delay (Exclude Zero Delay) Of Discharges	✓	Yes	May-26	5.8	5.7	6.2	6.9	4.5		
117.0	Percentage Of Patients Discharged On Discharge Ready Date	✗	Yes	May-26	87.3%	87.9%	90.3%	89.6%	86.2%		

Integrated Performance Report (SPC)

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Data updated on: 16/06/2026 12:08:22

SPC Chart | Show SPC legend

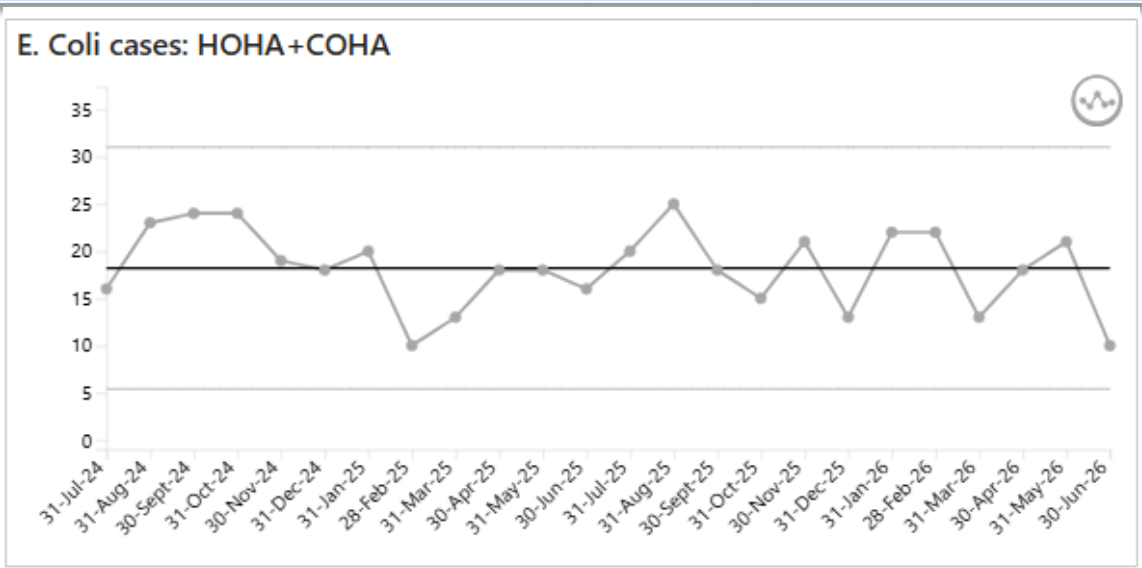
Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
[illegible].0	Vacancy Rate	✗	Yes	Jun-26	7.8%	6.0%	7.7%	7.1%	4.9%		
[illegible]1.0	Turnover Rate	✓	Yes	Jun-26	7.8%	9.0%	12.0%	9.3%	8.6%		
12.0	Turnover Rate With No Exclusions		Yes	Jun-26	9.7%	10.7%		11.2%	10.3%		
[illegible]3.0	Sickness Absence Rate (Rolling 12 Months)	✗	Yes	Jun-26	4.2%	4.1%	3.1%	4.2%	4.1%		
14.0	Non Medical Appraisals	✗	Yes	Jun-26	62.8%	77.7%	85.0%	97.0%	58.3%		
15.0	Sickness Absence Rate (In Month)	✗	Yes	Jun-26	4.3%	4.4%	3.1%	5.1%	3.8%		
16.0	Core Skills Training Compliance	✓	Yes	Jun-26	92.9%	92.0%	85.0%	92.9%	91.1%		
17.0	Time To Hire (Average Days)	✓	Yes	Jun-26	43.8	45.2	53.0	54.9	35.6		

Ref	Indicator Description	Met Target?	SPC	Latest Date	Value	Mean	Target	UCL	LCL	Variation	Assurance
3.0	Information Governance And Data Security Training	✗	Yes	Jun-26	90.9%	90.5%	95.0%	92.1%	89.0%		
4.0	Data Security & Protection Breaches		Yes	Jun-26	24	29		47	10		
5.0	Externally Reportable ICO Incidents	✗	No	Jun-26	1	0	0	1	-0		
6.0	All IG Reported Incidents		Yes	Jun-26	27	31		48	13		
9.0	Priority 1 Incidents	✗	No	Jun-26	1	1	0	3	-2		
118.0	Adjusted In-Month Financial Performance Surplus/Deficit £'000		Yes	Jun-26	-9060.8	-7211.8		-3531.1	-10892.6		
119.0	BPPC £ %	✗	Yes	Jun-26	57.4%	62.0%	95.0%	66.2%	57.8%		
120.0	BPPC Volume %	✗	Yes	Jun-26	36.9%	37.5%	95.0%	41.3%	33.7%		
121.0	Cash £'000	✓	Yes	Jun-26	7185	22612	3605	42561	2664		
122.0	Efficiency Delivery £'000	✗	Yes	Jun-26	6394.0	7093.7	7308.1	14224.7	-37.3		
123.0	In-Month Financial Performance Surplus/Deficit £'000	✓	Yes	Jun-26	-1819.1	84.4	-3910.0	5557.3	-5388.4		
124.0	In-Month ICS CDEL Capital Expenditure	-	Yes	Jun-26	1590.0	7624.9	5046.1	19111.4	-3861.5		
125.0	Year-To-Date Financial Performance Surplus/Deficit £'000	✓	Yes	Jun-26	-15496.7	-13054.5	-15793.0	-6895.9	-19213.2		

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

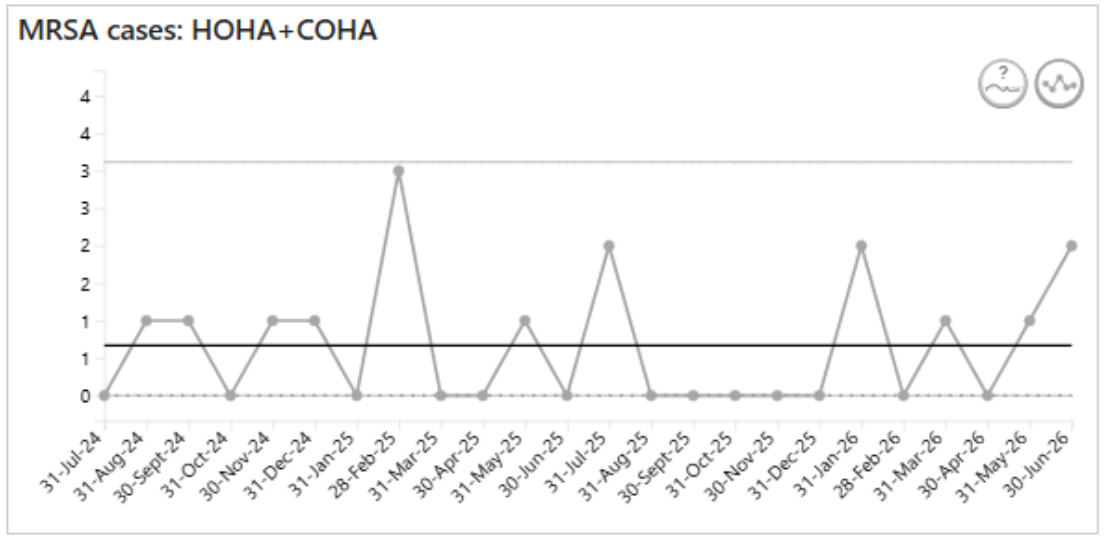
03. Assurance reports

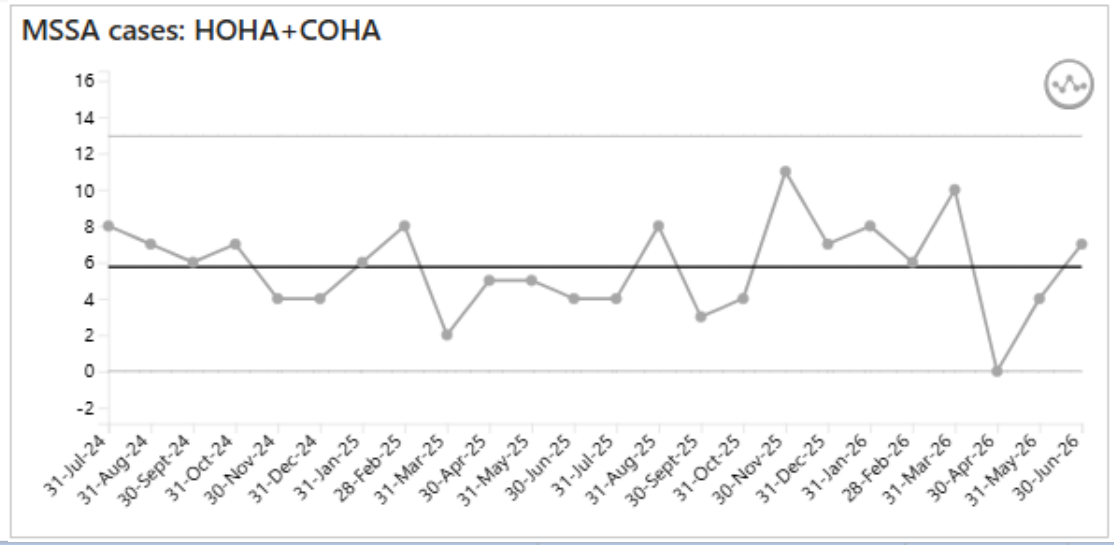
3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***E. coli* bacteraemia**: There were 10 cases of *E. coli* reported in June (5 HOHA and 5 COHA). Numbers so far this year are now slightly down on last year (by 3 cases). The number of *E. coli* bacteraemia cases assigned to OUH between April 2025 and March 2026 gave the Trust a score of 3.42 in the NHS Oversight Framework Acute Trust league table, which represents a slight deterioration. We have not received annual infection thresholds from NHS England for 2026/7 yet.	***E. coli* bacteraemia:** Apart from good catheter management, there are no clear themes or interventions to reduce the rate of *E. coli* bloodstream infections in secondary care, and catheters are not currently a significant theme in our cases. The number of infections associated with urine has dropped over recent months, but this has been offset by a rise in hepatobiliary infections. A deeper look into these cases is planned, to understand if there is any connection with waiting times for hepatobiliary procedures.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

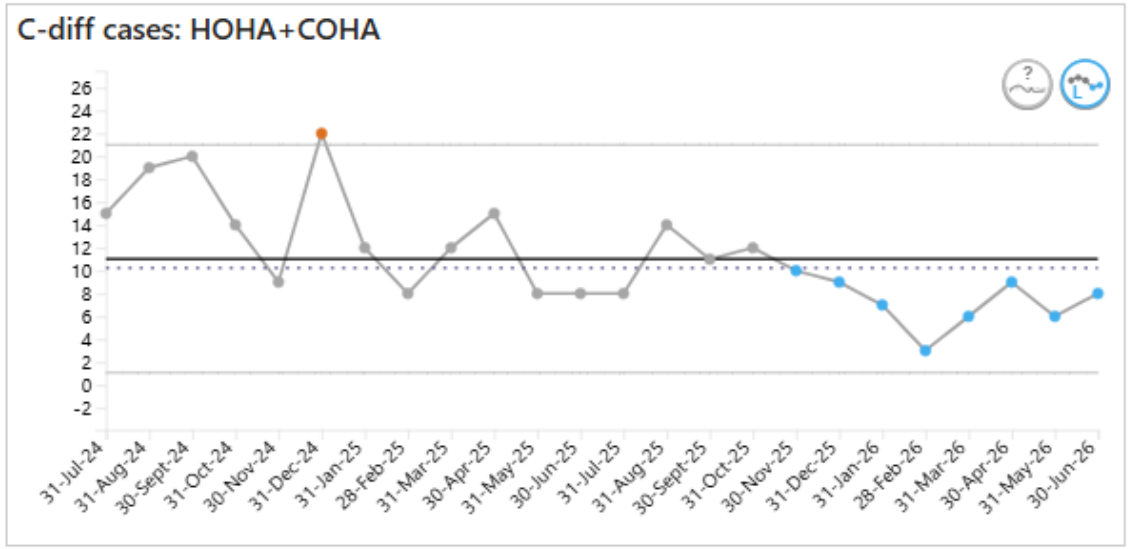
3. Assurance report: Quality, Safety and Patient Experience

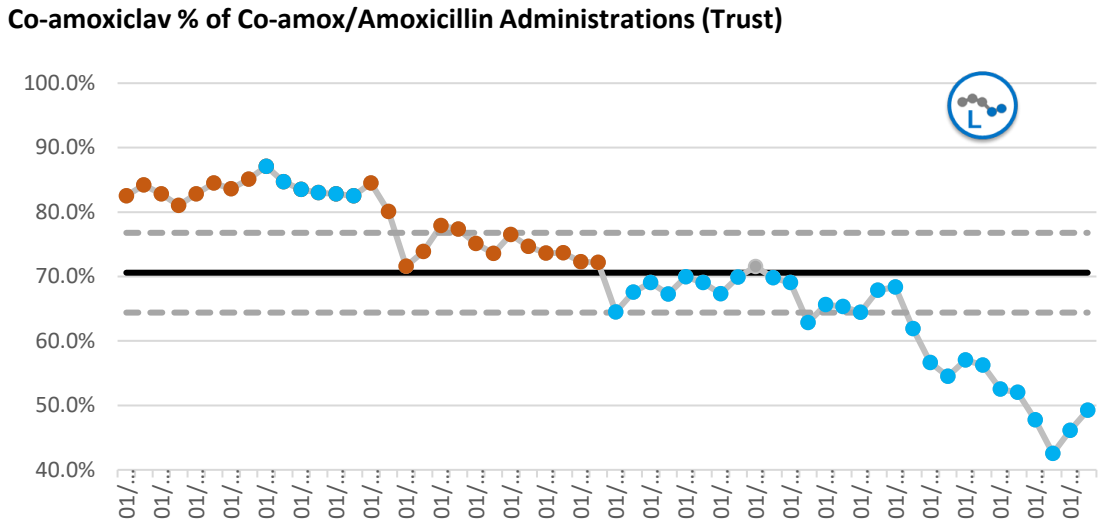




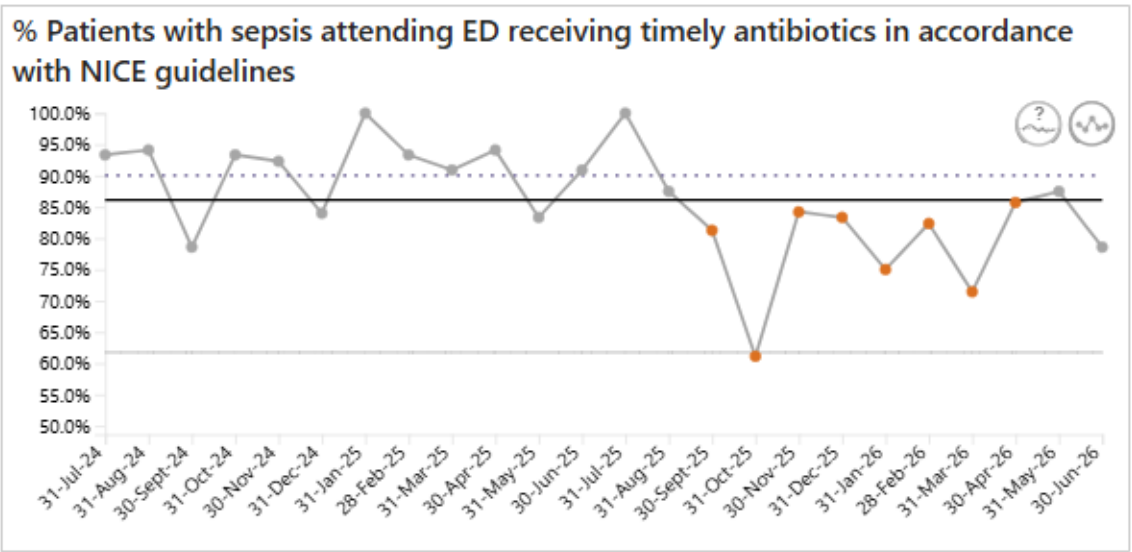
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MSSA bacteraemia: There were seven cases of healthcare associated MSSA bacteraemia in June. We have seen three fewer cases than by the same time last year. **MRSA Bacteraemia:** There were two cases of MRSA bacteraemia in June, one HOHA and one COHA. The number of MRSA bacteraemia cases assigned to OUH between April 2025 and March 2026 (six cases) gave the Trust a score of 3.32 in the NHS Oversight Framework Acute Trust league table, improved from Q3's score of 3.44, which itself was an improvement on Q2 (3.74).	The IPC team continue to support wards with action plans on improving the assessment and documentation of IV lines. There were no cases associated with intravenous cannulas this month, however there were three MSSA cases associated with PICC lines. The HOHA MRSA case was found to be an unavoidable deterioration of an infection present on admission. The COHA MRSA case investigation found learning relating to screening and decolonisation prior to a urology procedure. Refresher teaching on this is planned. The case from May has now been investigated jointly with the private hospital where the patient had received care. All learning related to the patient's care at the private hospital. The new MRSA screening process with multi-site swabbing to improve the sensitivity of detection of MRSA colonisation has now been in place for several months, thus screening compliance will now be included in divisional performance reporting. A lookback found a statistically significant increase in MRSA detection rates since the new process began (1.02% positive with a single site screen, 1.38% positive with a multi-site screen, $p < 0.01$).	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

3. Assurance report: Quality, Safety and Patient Experience

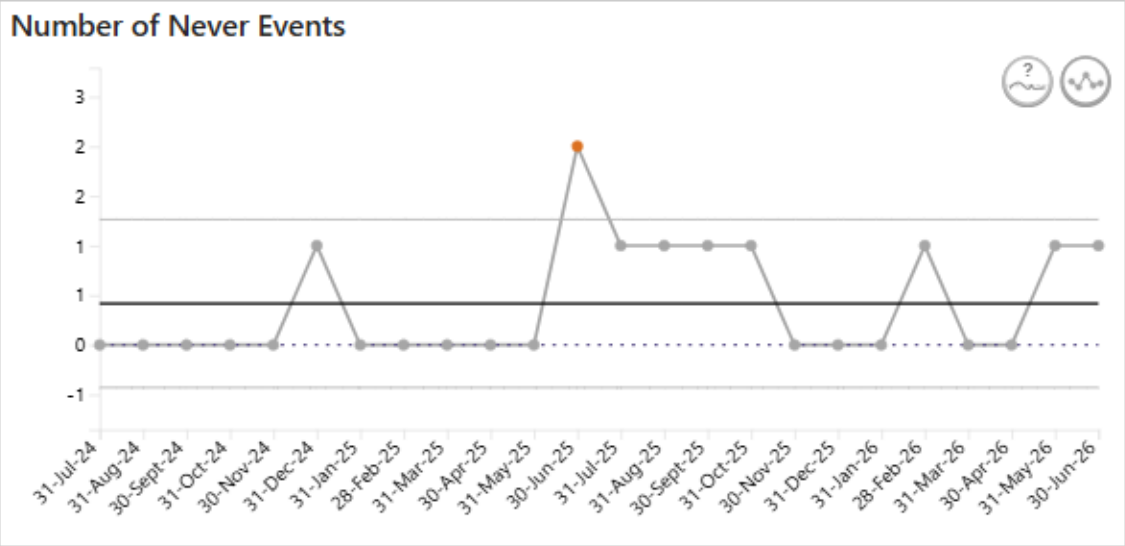




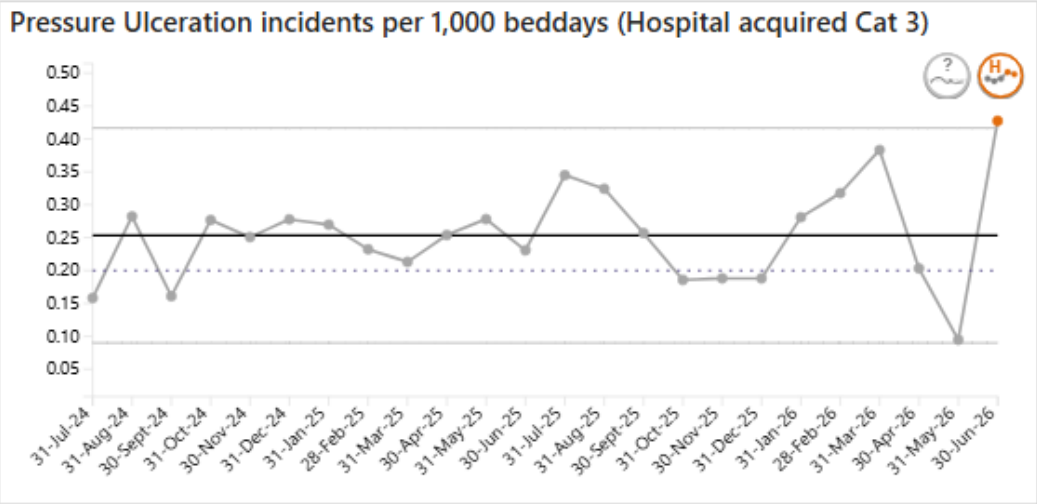
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***C. difficile* infection:** OUH reported eight healthcare-associated *C. difficile* cases (six HOHA and two COHA) in June, meaning we have seen seven fewer cases than by the same time last year. Our latest quarterly position in the NHS Oversight Framework Acute Trust league table shows a score of 1.00 (the lowest/best possible score) as we met our threshold for 2025/6. **IPC surveillance:** While the lack of a comprehensive surveillance system remains high on the Trust risk register, work on the installation and integration of ICNet has begun, with multiple workstreams convened to drive this. The go-live is planned to be mid-December. **AMS data:** Currently unable to update antimicrobial stewardship (AMS) graphs and dashboards as the Tableau platform on which it was hosted was withdrawn.	***C. difficile* infection:** A continued focus on good antimicrobial stewardship will be required to maintain our significantly improved *C. difficile* position. Additionally, we are continuing to roll out a combined cleaning and disinfection product for environmental cleaning which should provide ongoing background efficacy against *C. diff* spores and may thus have an impact on case numbers. **IPC surveillance**: Implementation of Phase 1 of ICNet to take place over next 6 months, followed by 2nd phase (integration of surgical data to support SSI surveillance) in 2027. **AMS data:** The Data and Analytics team are supporting a solution to provide some options to re-instate AMS data availability using Power BI.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
ED Delays in Antibiotic Administration – June 2026 In June 2026, **11 of 14 (79%) sepsis patients** received timely intravenous antibiotics in line with NICE guidance. 3 patients experienced delays in antibiotic administration, resulting in performance falling below the **90% compliance standard**. The delays have been reviewed to identify contributory factors and opportunities for improvement.	**Key Challenges Identified** Clinical review of the delayed cases identified the following contributory factors: • **Difficult intravenous (IV) access**, resulting in delays to antibiotic administration. • **Delay between antibiotic prescribing and administration**, despite timely medical review, suggesting potential communication issues between the prescribing clinician and the nursing team. • **Corridor care**, which contributed to delays in the initial clinical assessment and timely initiation of treatment.	**Sepsis Screening Tool Review** A recent audit of 100 patients who triggered the ED sepsis screening tool identified that 20% were classified as low risk. We are reviewing the screening tool with the aim of refining it to improve prioritisation of high-risk patients and facilitate more timely clinical review and treatment.	N/A	

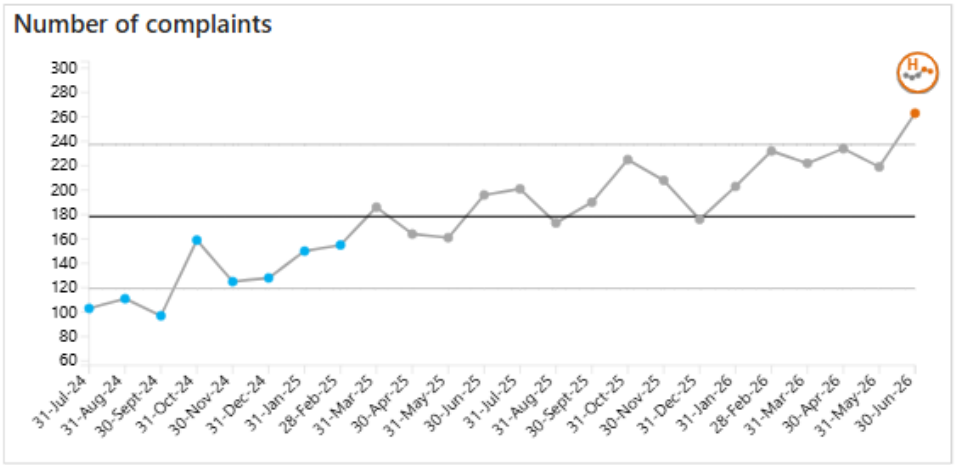


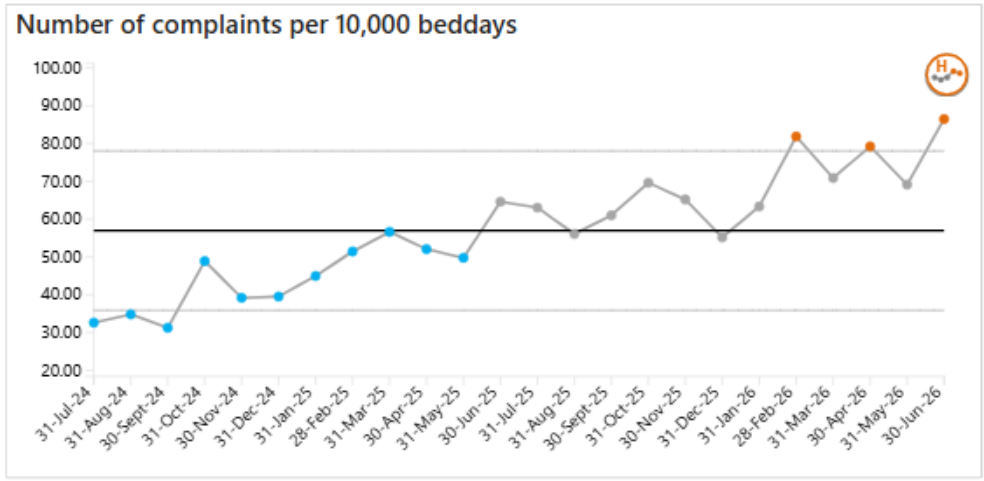
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
One Never Event was confirmed as a PSII in June, 2627-004. This concerned an ophthalmology patient who attended clinic and mistakenly received a left-eye intravitreal injection intended for a different patient (Wrong Site Surgery). This incident did not result in any harm.	The main immediate action undertaken to address the risk of recurrence was to change practice so that the entirety of the injection WHO checklist is completed in the injection room, where previously sign-in was completed by the clinical support worker checking vision outside of the injection room. “STOP, pause & review” notice added to all surgical packs to remind the injection team to undertake positive patient identification (PPID). Reinforcement of PPID to all Ophthalmology clinical teams via various routes, and patients are now also advised to expect PPID to be done via posters and handouts. Weekly PPID audits confirm 100% compliance. The injection LocSSIP has been developed and improved by SSPIG.. Human factors training has been delivered to some injection staff with more to follow. Further bespoke training also commissioned from OxSTAR.	Immediate actions were all completed in May, when the incident occurred. 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.		



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust continues to demonstrate a proactive and data-informed approach to the prevention and management of pressure ulcers. In June 2026, the data indicate a decrease in Hospital Acquired Category 2 pressure ulcer incidents from 49 in May to 37 in June, which is a decrease of 12. There were 11 Hospital Acquired Category 3 in June, and this is attributable to higher Trust activity and the increasing clinical complexity of the patient population. Please note that the data cut-off is the 5th working day of the month.. There were no reported incidents of Hospital Acquired Category 4 pressure ulcers.	Oversight is maintained through the Harm Free Assurance Forum, with escalation to the Clinical Governance Committee. In depth harm reviews will be undertaken in areas with consistent challenges in delivering a sustained reduction. A comprehensive Pressure Ulcer Prevention and Management Harm-Free Quality Improvement Plan (QIP) has been created to integrate lessons from pressure ulcer incidents, promoting shared learning and driving systemic improvement. Data reporting to be reviewed by the TV team. Oversight is active and effective. The reduction in Category 2 incidents follows targeted improvement work, every Category 3 incident is subject to a structured harm review, and delivery of the QIP is tested monthly 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*

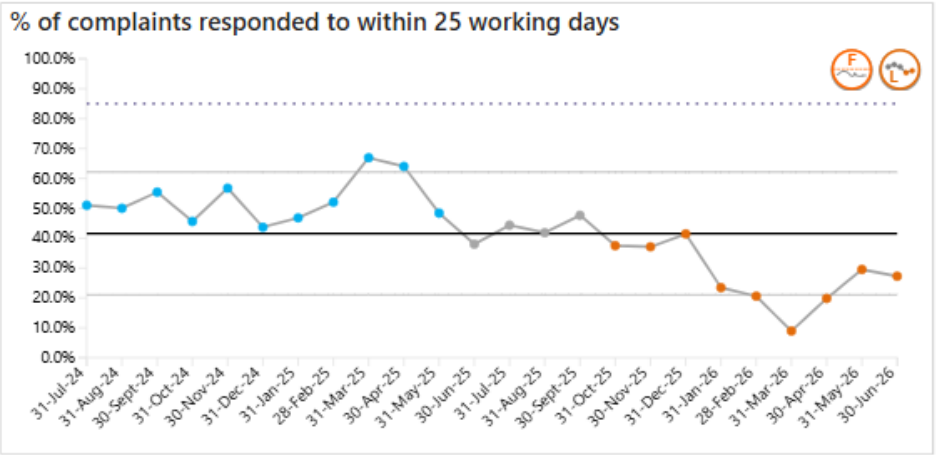
3. Assurance report: Quality, Safety and Patient Experience, *continued*

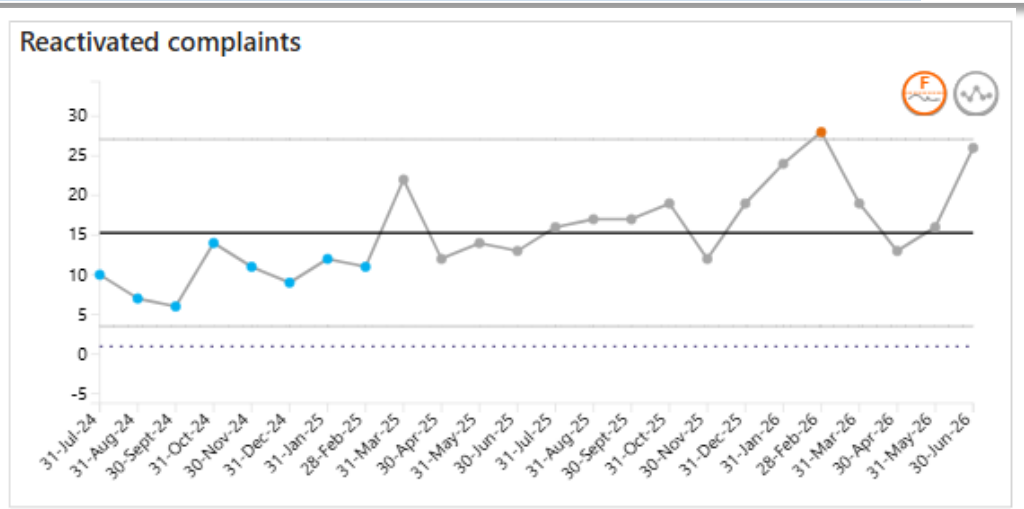




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In June the Trust received 261 formal complaints. This is an increase of 18% in the number of formal complaints received in May (n=221). This continues the trend of a sustained increase in underlying demand, which is both a local and national issue, with similar trends reported across the NHS. Further reporting of the national picture is expected to be published by NHS England in October 2026. The growing complexity of complaints, alongside rising demands on investigating staff, has continued to affect delivery of the 25-working day target. The two-year median response time is 32.27 days. The June median was 29 days, an improvement on the longer-term position.	The top five complaint categories remained consistent with previous months: Communications (n=58/22.2%), Clinical Treatment (n=57/21.8%), Appointments (n=35/13.4%), Values and Behaviours (n=23/8%) and Admission & Discharge (n=14/5.3%). Neurosciences (n=31), Emergency Medicine (n=30), Trauma and Orthopaedics (n=29) and Gynaecology (n=28) received the highest numbers of new complaints in June. Targeted meetings with each of these areas, involving the CNO and CMO teams, provide direct executive oversight and are driving continued progress. The review and sign off process for complaint responses has been strengthened. The Chief Nursing Officer now requires assurance that every issue raised has been fully addressed, and that learning from each investigation is demonstrated, before a response is signed off. No response is released without this evidence. The impact of the strengthened process on the number of reopened complaints is being measured and will be reported.	Actions are ongoing and reviewed weekly, with oversight through the Patient Experience and Engagement Committee (PEEC) and Delivery Committee oversight. The risks are recognised and actively managed through process improvement and strengthened governance, with continued focus on delivering sustained compliance with the 25-day KPI.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

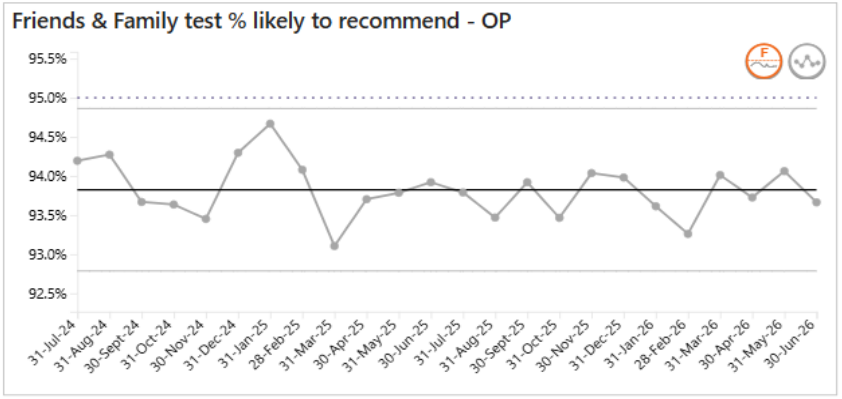
3. Assurance report: Quality, Safety and Patient Experience, *continued*

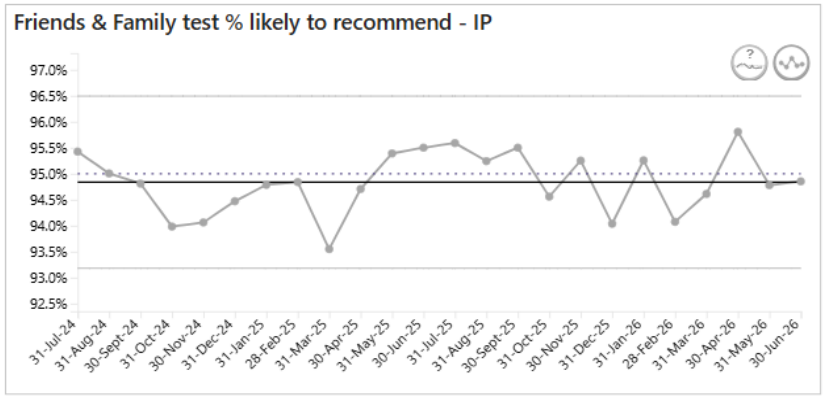


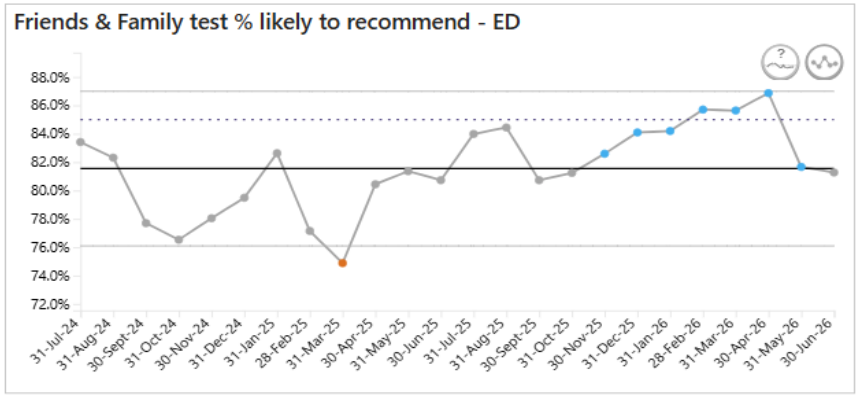


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The Trust received 261 formal complaints in June 2026, consistent with the higher level of demand seen in recent months. This sustained increase remains the principal challenge to meeting the 25-day KPI.	The Trust held its median response time at 29 days in June 2026, unchanged from May, despite the continued rise in demand. 228 complaints were finalised and closed in June, compared with 200 in May. This is a 14% increase in closures and demonstrates that capacity is keeping pace with demand. 26 complaints (9.9%) were reopened in June. The predominant reasons were requests for further information and the opportunity to meet with the relevant clinical staff. Of these, 11 related to NOTSSCAN, 8 to SUWON, 5 to MRC, 1 to Corporate Services and 1 to CSS. Reopened cases are tracked by division so that themes can be identified and addressed through the strengthened sign off process. Performance is improving under sustained demand. Every complaint unresolved at 40 days, and again at 60 days, is escalated to PEEC, giving direct committee oversight of every long running case.	Ongoing, reviewed weekly. New escalation triggers have been introduced with Divisions required to discuss complaints that are not resolved at 40 days and again at 60 days at PEEC. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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

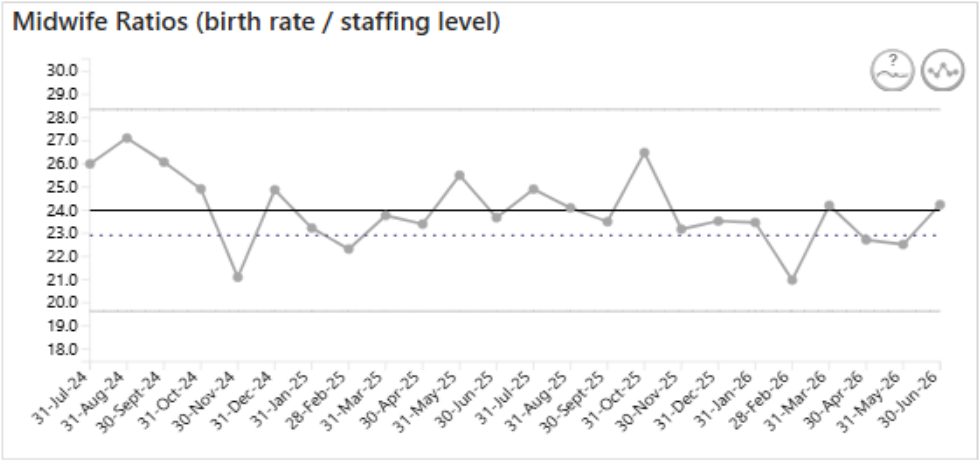




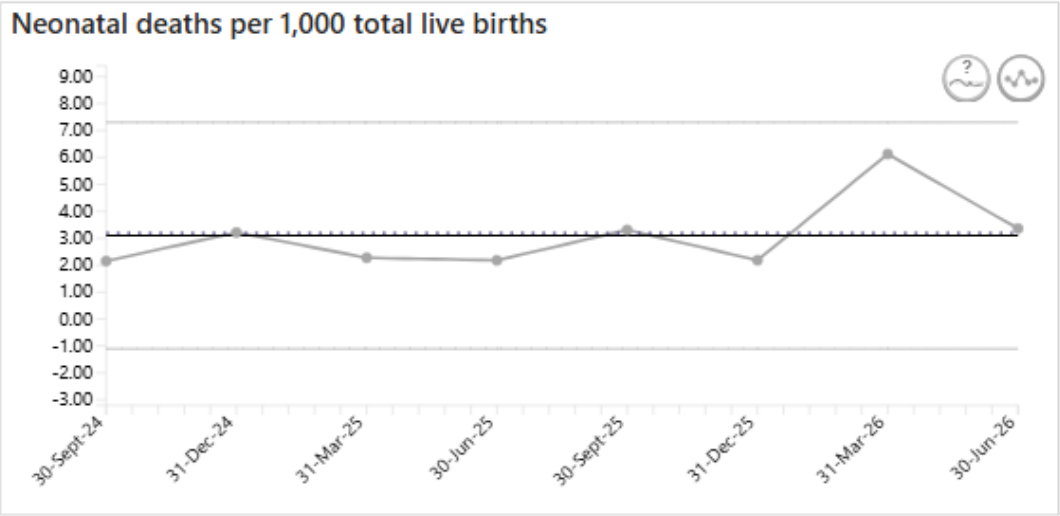


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses made up 9,090 of all responses received in June 2026, with a recommendation rate of 93.7% 2. ED responses made up 1,057 of all responses in June, with a recommendation rate of 81.3% 3. Inpatient responses made up 2,623 of all responses in June, with a recommendation rate of 94.9% 4. Overall, the Trust received 12,629 responses – a response rate of 18.5%. 93.02% responses were positive. 5. The top positive themes were staff attitude, admission and implementation of care. The top negative themes were car parking, cancelled admissions and procedures and discharge.	Each division presents an update on patient experience, including FFT data and themes, to the Patient Experience and Engagement Committee bi-monthly. This gives every division clear accountability for its patient experience performance. The recently endorsed Patient Experience and Engagement Plan sets the improvement priorities. Early actions include promoting online collection methods to improve response rates and introducing a new Patient Experience Survey. Delivery of the Plan is overseen by PEEC. Patient experience data is reviewed at every level of the organisation, from ward to committee. The 93% positive response rate has been sustained, and the top negative themes of car parking, cancelled admissions and procedures, and discharge are being addressed through the 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*

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
Births: 631 women birthed their babies in June, an increase of 44 on May. **Midwife-to-birth ratio:** 1:24.24 for June. The ratio reflects a stable birth and staffing model with sustained fill rates; the movement in June is explained by the higher number of births. **Safe staffing incidents:** There were no reported incidents of 1:1 care in labour not being provided, and the Delivery Suite coordinator remained supernumerary on every shift. **Workforce establishment:** The midwifery establishment is aligned to Birthrate Plus (332.45 WTE), with an additional 23 WTE uplift for maternity leave, giving a total establishment of 344.45 WTE. **Unavailability:** Total unavailability averaged –36.88 WTE across June, incorporating true vacancy, sickness, non-medical absence and supernumerary midwives. Mental health remains the highest cause of absence and is being actively addressed through staff wellbeing support. **Maternity Support Workers:** Vacancies remain high at –13.5 WTE, with unavailability of –24.77 WTE. Mental health and surgery were the highest causes of absence. **Mitigation:** Increased use of on-call hours across the service correlated with 100% fill rates, alongside stable and improving unavailability. NHSP use was increased to strengthen the MAU staffing model. All gaps were mitigated and no safe staffing incidents resulted.	**Strengthened safe staffing infrastructure:** Supported by the corporate safe staffing team, the service is implementing full use of the Birthrate Plus acuity tool across all inpatient areas. This gives real time visibility of staffing against acuity, strengthens operational responsiveness, and aligns maternity with Trust wide safe staffing processes. **Enhanced community and hospital resilience:** Additional community night on-calls are now consistently rostered alongside hospital on-call arrangements. This provides flexibility across all settings and was a direct contributor to the 100% fill rates achieved in June.	The workforce plan monitors on an ongoing basis: recruitment, including divisional approval to proactively recruit into maternity leave; and staff retention strategies. Weekly monitoring is in place for: one to one care in labour; the supernumerary status of the Delivery Suite Coordinator; the accuracy of safe staffing fill rates; community on-call hours required; and community-based births. Any exception is escalated and mitigated in real time. The Birthrate Plus assessment is complete and the final report has been received. Its findings will inform the next stage of establishment planning. A business plan will be submitted to the Business Planning Group and reported to Board. Safe staffing was maintained on every shift in June, evidenced through the weekly monitoring set out above.	BAF 4 CRR 1145	*Satisfactory Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*



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

Small numbers can create significant variation. Neonatal mortality is typically low (around 25–35 deaths per year), so increases over a short period, such as a single quarter, can appear significant and should be interpreted with caution.
 	
Strong PMRT processes provide assurance. All neonatal deaths are reviewed through the multidisciplinary PMRT process, ensuring care is assessed consistently and that learning is identified, shared and acted upon.
 	
Q1 2026 increase investigated promptly. The neonatal team recognised the higher number of deaths during the first quarter of 2026 and undertook a rapid review. No common care-related factors or concerning trends were identified. The increase was attributable to a higher than expected number of deaths associated with a range of unrelated congenital abnormalities. Although the service would typically expect around 10 deaths across a full year, a similar number occurred within the first three months of 2026.
 	
The increase was identified early, investigated thoroughly, and continues to be monitored closely through established governance and PMRT processes.
	All neonatal deaths are reviewed through the Perinatal Mortality Review Tool (PMRT) process, including detailed multidisciplinary discussion at neonatal mortality review meetings with external representation. This provides robust scrutiny of care and supports shared learning.
	
	A review of the 13 deaths identified:
	• One death occurred after 28 days of life and is therefore not classified as a neonatal death; the cause was a congenital abnormality.
	• Of the 12 neonatal deaths (less than 28 days of life), one baby was born outside Oxford and died from a congenital abnormality.
	• Of the 11 babies born in Oxford:
	  • Seven died due to congenital abnormalities.
	  • Three were born at 22–23 weeks' gestation and died following extreme prematurity; two received planned comfort-focused care and died in the delivery suite.
	  • One baby born at 26 weeks' gestation died from severe pulmonary hypoplasia and pulmonary hypertension secondary to preterm premature rupture of membranes.
	All cases reviewed through PMRT were graded either **A** (no care issues identified) or **B** (care issues identified but not affecting the outcome). No cases were graded **C** or **D**, indicating that no care-related factors were identified that may have, or were likely to have, contributed to the deaths.
		Mortality data is closely monitored on an ongoing basis, with trends in care issues actively identified and acted upon.
		Findings from every review are reported through the multidisciplinary neonatal mortality review meeting, which includes external representation, and are escalated through perinatal governance. This provides independent challenge as well as internal scrutiny.
			No	

Summary of challenges and risks

Trust-wide nursing and midwifery staffing remained at Level 2 (Amber) throughout June. On one day shift, Paediatric Critical Care Unit (PCCU), and on three day shifts, JR Emergency Department (ED), declared level 3, however, PCCU was mitigated with team nursing, support provided by the adult units, and ED was regularly reviewed by senior staff. Planned versus actual fill rates of 94.7% (day) and 99.15% (night), providing assurance that staffing levels were maintained safely. Where fill rates fell below 90%, all shifts were reviewed and mitigated at Matron level or above, with no shifts left at risk. Monthly triangulation of staffing metrics and nurse-sensitive indicators confirmed no harm directly attributable to staffing across all divisions. This demonstrates effective operational grip, supported by twice-daily Trust-level reviews and clear accountability arrangements.

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

Staffing metrics for nurses and midwives, including nurse-sensitive indicators, are consistently reviewed and validated with Directors of Nursing (DN) and Deputy Divisional Director of Nursing (DDN). Each monthly review triangulates all relevant data in accordance with National Quality Board standards and assesses whether these nurse/midwifery-sensitive harm indicators are directly related to staffing levels. The June review confirmed across all divisions, there were no instances of nurse/midwifery-sensitive harm indicators directly linked to nursing or midwifery staffing levels. The HR data for May report was not available at the time of review. It has now been reviewed, with no concerns raised. HR data for June is unavailable, therefore a review of this, will take place in the July report.

SUWON – No harms were related to staffing. All red flags have now been reviewed. One roster was late being published due to unplanned absence of the ward manager, the next roster is back on track. Some wards had slightly low annual leave, however, no concerns raised and will be reviewed each month moving forward to ensure leave is booked effectively. Three wards were not approved for payroll. This has been addressed with the new Deputy Matron for Katharine House Hospice, and existing Matrons for Gastroenterology and Wytham to ensure cover has been planned for future months.

MRC – No harms were related to staffing. Three wards had open flags, but DN has confirmed, these have now been reviewed. One ward was late publishing the roster, an oversight by the Matron, however, the roster publication is back on track for the next roster. One ward had slightly low annual leave; however, this has been raised with the ward manager, who has given assurance that leave for the team has been booked effectively across the year.

NOTSSCAN – No harms related to staffing. Review and closure of red flags continues to improve, however, two children's wards, had unreviewed red flags. The DN is addressing this with the relevant Matron. Net hours outside of the 2% KPI on Neurosurgery Green ward relate to student hours, rather than substantive hours. Some wards had slightly low annual leave, however, no concerns have been raised and will be reviewed each month moving forward to ensure leave is booked effectively.

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

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

Maternity – One birth experienced a change in place of planned birth due to staffing. As a result, the patient experience was not optimum, but no harm came to mother or baby. Red flags raised were all reviewed. Roster KPI's were almost achieved. Roster publication was only a day late, and two wards had slightly low annual leave, however, this is closely monitored by the Deputy Head of Midwifery, who has no concerns.

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

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

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

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

Sickness: This is a rolling twelve-month figure and is reported in the same manner as Trust Board sickness data. The figures presented reflect both registered and unregistered staff.
Maternity: This is taken on the last day of a particular month (aligned to all Trust reporting) and reflects those on maternity/adoption leave on that day. The FTE absent on this day is then divided by the total FTE for this cohort. The figures presented reflect both registered and unregistered staff.

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

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 data for May was reviewed for this report, as June data was unavailable. June data will be reviewed next month, with any issues being reported in the July 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 and assurance that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing at Trust level triangulated with other Trust level metrics allows the Board to see where there are increased capacity and acuity, (required) versus budget.	N	***Sufficient*** Information reported at required level. Staff appropriately trained and quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse workforce team monthly.

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

Oxford University Hospitals NHS Foundation Trust

June 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 18.5.26- 14.6.26				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	7.93	9.42	9.7	100.00%	1				3	1	0	0	2.92%	22.26%	3.05%	13.18%	15.72%	Yes	0.69%	8.86	13.64%	18	3	1	1	2	0
HH Childrens Ward	6.29	9.59	15.1	100.00%		6			1	0	0	0	7.20%	12.18%	5.70%	15.18%	21.29%	Yes	-0.56%	8.29	11.75%	28	8	0	0	1	0
Kamrans Ward	7.65	10.68	8.7	100.00%		34			0	0	0	0	6.80%	0.00%	2.00%	13.10%	22.80%	Yes	1.06%	9.00	13.29%	7	0	0	0	0	0
Melanies Ward	7.53	11.50	10.9	100.00%		2	1		2	0	0	0	-23.53%	4.46%	5.45%	13.28%	2.59%	Yes	-1.36%	8.86	14.47%	8	1	0	0	1	0
Robins Ward	8.22	9.39	9.8	82.22%	12		1		3	2	0	0	7.99%	20.17%	3.97%	10.18%	26.72%	Yes	-0.64%	8.86	13.28%	23	4	0	1	0	0
Tom's Ward	7.63	9.57	8.7	100.00%					2	0	0	0	0.22%	1.67%	4.99%	0.00%	4.98%	Yes	-0.08%	8.86	12.77%	14	6	0	1	0	0
Neonatal Unit	19.92		16.7						8	5	0	0	15.40%	5.17%	6.85%	5.97%	28.04%	Yes	-0.87%	8.57	12.85%	2	0	0	0	0	0
Paediatric Critical Care	27.58		26.7						14	5	1	0	-15.29%	4.56%	5.47%	5.04%	8.76%	Yes	1.28%	8.43	12.54%	0	0	0	0	0	0
BIU	5.99	7.05	8.0	100.00%			11		0		1	1	-9.78%	0.00%	2.15%	12.58%	10.99%	Yes	0.96%	9.29	13.98%	22	6	2	0	0	0
HDU/Recovery (NOC)	4.82		9.9						0		0	0	18.70%	20.72%	10.15%	0.00%	30.34%	Yes	-2.30%	8.43	16.28%	0	0	0	0	0	0
Head and Neck Blenheim Ward	6.54	7.37	8.3	100.00%					0		2	4	9.44%	0.00%	2.90%	0.00%	9.44%	Yes	-0.78%	8.14	11.45%	20	1	0	0	0	0
HH F Ward	7.02	8.91	7.4	100.00%					0		1	0	-1.19%	3.88%	4.13%	0.00%	3.14%	Yes	-2.74%	8.86	14.76%	10	3	0	0	0	0
Major Trauma Ward 2A	9.63	11.03	10.8	98.89%					2		3	1	15.11%	5.13%	2.77%	11.28%	24.68%	Yes	-1.82%	7.86	12.88%	8	6	2	0	0	1
Neurology - Purple Ward	7.62	10.43	8.1	100.00%			4		5		0	5	12.76%	0.00%	4.97%	0.00%	21.84%	Yes	1.23%	7.71	12.53%	8	1	0	0	0	0
Neurosurgery Blue Ward	8.51	11.03	9.1	100.00%		4	5		1		0	3	11.51%	10.66%	5.69%	5.97%	21.65%	Yes	2.17%	7.71	11.89%	9	2	1	0	0	0
Neurosurgery Green/IU Ward	9.59	10.34	9.6	100.00%			2		1		1	1	22.41%	14.45%	5.36%	0.00%	35.52%	Yes	3.03%	8.29	13.56%	4	0	0	0	1	0
Neurosurgery Red/HC Ward	10.93	12.16	11.7	100.00%		3	3		2		0	4	-8.80%	4.56%	5.04%	8.52%	8.99%	Yes	0.70%	8.43	14.06%	4	0	0	0	0	0
Specialist Surgery I/P Ward	6.90	7.25	7.9	100.00%		1	1		2		2	4	1.48%	3.80%	4.38%	3.61%	15.57%	Yes	0.43%	8.14	12.45%	18	1	0	1	0	0
Trauma Ward 3A	9.19	9.43	9.4	96.67%		2	1	2	0		0	6	3.62%	5.18%	5.49%	5.10%	21.38%	Yes	-0.39%	7.86	12.79%	7	1	2	0	1	0
Ward 6A - JR	7.03	6.87	7.4	100.00%		1	6		1		0	6	9.83%	0.00%	3.82%	12.27%	20.89%	Yes	1.10%	8.71	13.45%	20	1	1	0	0	0
Ward E (NOC)	5.30	7.05	8.0	100.00%		1			3		0	1	-27.43%	0.00%	5.48%	22.39%	8.61%	Yes	2.95%	9.29	11.74%	52	9	0	0	0	0
Ward F (NOC)	5.80	8.05	8.3	93.33%		1			0		1	3	3.30%	28.24%	8.25%	7.76%	10.81%	Yes	-0.09%	8.29	14.36%	2	0	0	0	0	0
WW Neuro ICU	27.96		29.2						2		1	0	4.65%	7.41%	5.18%	11.48%	23.03%	Yes	-0.91%	8.29	13.20%	0	0	0	0	0	0

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

Oxford University Hospitals NHS Foundation Trust

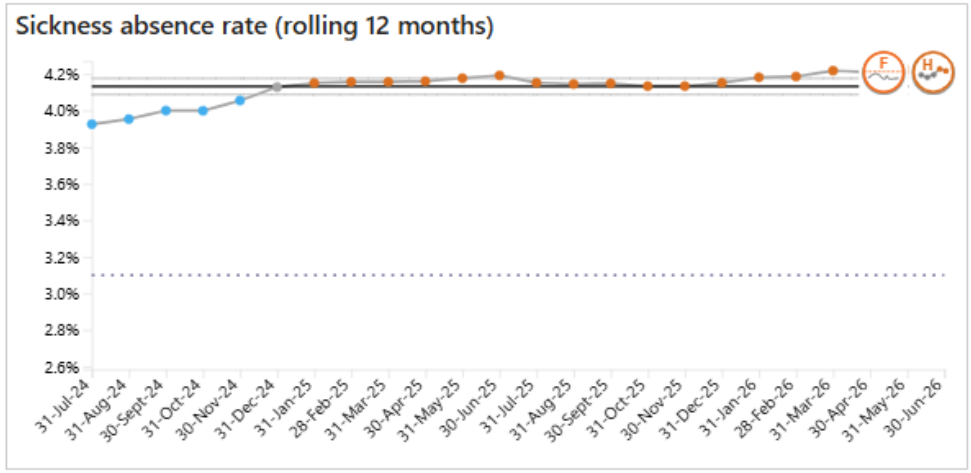
June 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 18.5.26- 14.6.26				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in 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
MRC																											
Ward 5A SSW	8.36	8.19	8.5	100.00%		11		2	0		7	1	18.04%	0.00%	4.63%	0.00%	23.45%	Yes	-0.73%	9.43	11.51%	18	4	0	0	0	0
Ward 5B SSW	8.36	9.59	9.1	100.00%		13	1	1	2		0	6	19.91%	0.00%	3.67%	0.00%	30.74%	Yes	0.68%	9.43	11.68%	0	0	0	0	0	0
Cardiology Ward	8.24	7.31	8.8	100.00%		14	3		3		0	4	7.19%	5.44%	5.31%	13.60%	22.33%	Yes	-0.61%	8.29	11.11%	12	2	0	0	0	0
Cardiothoracic Ward (CTW)	7.43	6.56	6.8	92.22%	2		1		2		0	4	-0.05%	5.00%	4.14%	10.00%	14.96%	Yes	1.37%	8.57	7.41%	14	2	0	0	1	0
Complex Medicine Unit A	8.94	10.31	8.2	91.11%		3	2	1	1		0	3	2.63%	7.22%	8.48%	0.00%	15.56%	Yes	0.84%	8.71	11.60%	1	3	0	0	0	0
Complex Medicine Unit B	9.48	9.96	8.8	100.00%					1		1	1	2.73%	7.79%	4.83%	7.79%	17.88%	Yes	0.71%	8.71	13.41%	0	0	0	0	0	0
Complex Medicine Unit C	8.21	10.52	8.4	100.00%			2		0		0	3	3.87%	13.10%	2.81%	0.00%	10.19%	Yes	-0.89%	8.71	10.72%	22	2	1	0	0	0
Complex Medicine Unit D	8.63	8.47	8.6	98.89%		1			0		1	5	18.43%	4.15%	4.22%	0.00%	24.75%	Yes	0.78%	8.71	14.41%	0	0	0	0	0	0
CTCCU	21.59		24.0						4		3	0	17.24%	15.68%	4.39%	9.89%	31.69%	Yes	-0.35%	7.57	12.68%	1	0	0	0	0	0
Emergency Assessment Unit (EAU)	8.89	8.52		91.11%	2				5		0	5	2.03%	15.90%	6.67%	5.52%	12.85%	Yes	-2.25%	8.43	13.98%						
JR Emergency Department	19.84								5		0	4	22.78%	15.44%	3.94%	0.00%	35.09%	Yes	1.92%	8.43	13.08%	0	0	0	0	0	0
HH EAU	9.20	7.11		94.44%					3		1	2	-3.41%	0.00%	8.77%	2.44%	16.79%	Yes	-0.20%	8.57	14.92%	0	0	0	0	0	0
HH Emergency Department	23.16								0		0	1	-7.90%	6.89%	3.70%	14.33%	10.14%	Yes	1.11%	8.57	12.97%	0	0	0	0	0	0
HH Juniper Ward	7.46	9.6	7.9	84.44%					0		3	8	-3.68%	0.00%	6.24%	4.65%	5.58%	Yes	1.63%	6.29	14.25%	0	0	0	0	0	0
HH Laburnum	8.00	9.46	8.4	100.00%		1			1		3	2	-6.93%	0.00%	5.03%	0.00%	3.90%	Yes	-0.73%	8.71	15.22%	1	0	0	1	0	0
HH Oak (High Care Unit)	10.78		10.4	100.00%		6	1	2	3		2	0	-17.58%	6.26%	5.73%	12.89%	12.12%	Yes	2.28%	8.57	13.37%	4	1	0	0	0	0
John Warin Ward	10.06	10.74	10.5	100.00%	1	2	1		0		1	0	-7.78%	6.36%	3.37%	7.03%	-0.20%	Yes	-1.89%	7.86	11.77%	13	5	1	0	0	0
OCE Rehabilitation Nursing (NOC)	10.21	10.26	9.5	100.00%			4	1	0		1	0	-7.23%	0.00%	4.47%	6.49%	6.68%	Yes	-2.96%	9.29	15.05%	2	0	0	2	0	0
Osler Respiratory Unit	11.98	9.02	12.1	100.00%		1	3		0		1	3	3.03%	4.32%	3.82%	4.88%	12.50%	Yes	-1.20%	7.86	13.33%	9	0	0	9	0	0
Ward 5E/F	9.58	10.09	10.7	100.00%		15	6	2	5		1	4	24.24%	8.83%	4.27%	6.25%	33.71%	Yes	-1.24%	9.43	11.89%	7	3	0	7	0	0
Ward 7E Stroke Unit	9.20	10.21	9.2	100.00%		1	21		2		1	3	14.02%	10.43%	6.03%	5.51%	36.36%	Yes	0.81%	7.86	11.50%	17	1	0	0	0	0

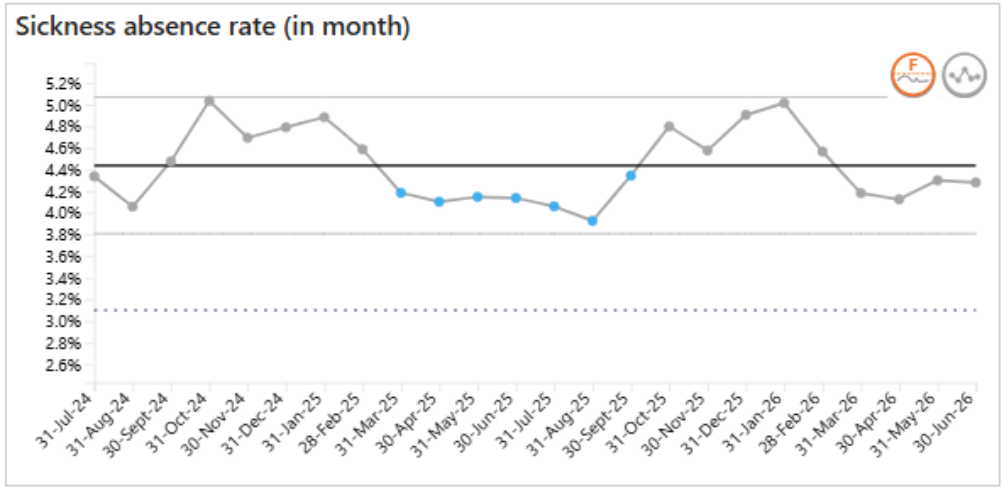
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

Oxford University Hospitals NHS Foundation Trust

June 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 18.5.26- 14.6.26				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	8.34	8.6	100.00%	3	28		2	5		2	4	15.79%	6.24%	4.18%	12.50%	42.11%	No	0.00%	8.86	10.41%	10	3	1	0	0	0
Gynaecology Ward - JR	5.02	5.35	8.8	98.89%					2		0	1	8.43%	12.89%	6.06%	0.00%	14.35%	Yes	-0.22%	9.29	12.76%	24	1	0	0	0	0
Haematology Ward	7.90	8.80	9.6	100.00%		14	4	3	4		0	3	2.59%	8.35%	7.07%	8.36%	14.80%	Yes	1.90%	5.29	11.70%	4	3	0	0	0	0
Katharine House Ward	9.70	7.65	9.0	100.00%		4	2	1	3		2	3	42.20%	11.39%	8.52%	0.00%	42.20%	No	-0.47%	8.86	9.56%	0	0	0	0	0	0
Oncology Ward	7.68	7.66	7.7	98.89%		2	4		3		2	2	-6.74%	0.00%	3.92%	11.08%	17.30%	Yes	-0.16%	8.86	14.20%	0	0	0	0	0	0
Renal Ward	7.60	8.32	8.7	100.00%		8			0		0	3	32.05%	9.98%	5.47%	0.00%	32.05%	Yes	-0.14%	7.71	16.31%	7	1	0	0	0	0
SEU D Side	7.70	7.65	7.7	100.00%					4		2	2	11.65%	0.00%	5.33%	0.00%	16.90%	Yes	0.18%	8.86	15.42%	24	5	0	0	0	0
SEU E Side	7.66	8.82	8.6	100.00%	1		3		0		1	2	17.44%	27.47%	7.51%	6.91%	23.14%	Yes	-1.42%	8.86	12.46%	10	1	0	1	0	0
SEU F Side	6.94	8.56	7.7	100.00%			4		3		1	2	13.77%	4.62%	5.21%	0.00%	13.77%	Yes	-0.29%	8.86	10.21%	25	5	1	0	1	0
Sobell House - Inpatients	7.75	8.75	8.6	100.00%			1		2		3	6	24.11%	28.39%	7.08%	7.86%	36.04%	Yes	2.18%	8.86	16.00%						
Transplant Ward	8.80	7.36	9.2	100.00%	1	7		2	0		0	1	41.60%	22.94%	5.20%	0.00%	53.70%	Yes	-1.75%	9.57	14.41%	24	8	0	0	0	0
Upper GI Ward	9.44	6.91	6.5	97.78%					1		0	1	13.01%	8.66%	5.01%	4.46%	21.73%	Yes	-0.16%	8.43	10.64%	10	2	0	0	0	0
Urology Inpatients	8.32	8.30	11.0	100.00%	1	13	1		1		0	2	0.34%	7.33%	3.49%	6.83%	20.76%	Yes	-0.23%	8.86	18.24%	49	9	1	0	0	0
Wytham Ward	6.82	7.31	6.7	95.56%			2		2		0	0	14.97%	0.00%	9.05%	0.00%	16.75%	No	-1.36%	8.43	10.24%	13	3	1	0	0	0
MW Intrapartum Team	14.58		16.6				44						-15.66%	9.56%	5.60%	5.46%	14.90%	Yes	-1.37%	7.43	11.07%						
MW Level 5	5.40		4.1					1					-63.06%	14.31%	5.71%	5.42%	-36.54%	Yes	0.55%	7.43	14.59%						
MW Level 6	4.60		8.5															Yes	-0.64%	7.43	14.94%						
MW Level 7 (Bereavement)	-		5.9				1											Yes	1.17%	7.43	9.33%						
CSS																											
OCC/CICU	26.60		31.2	100.00%	-	-	-	-	12		1	0	13.61%	15.50%	5.07%	2.27%	22.95%	Yes	-1.36%	8.29	8.88%						

3. Assurance report: Growing Stronger Together



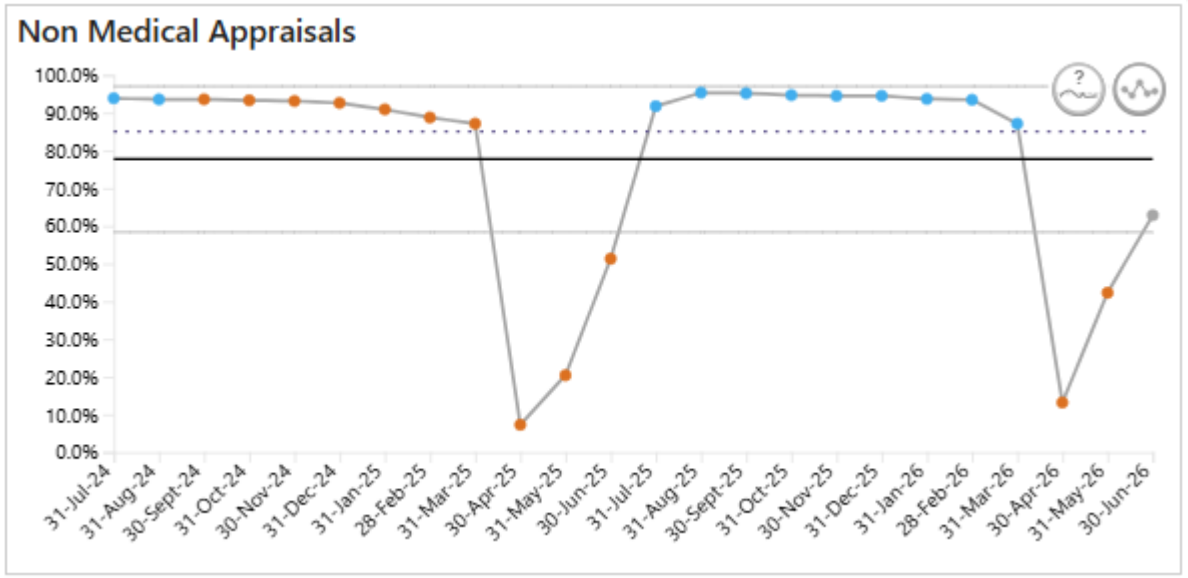


Benchmarking: March 2026 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.03% **National: 5.21%** **Shelford: 4.64%** Buckinghamshire Healthcare NHS Trust: 4.03% Royal Berkshire NHS Foundation Trust: 3.44% Oxford Health: 4.64% South Central Ambulance Service: 6.43%

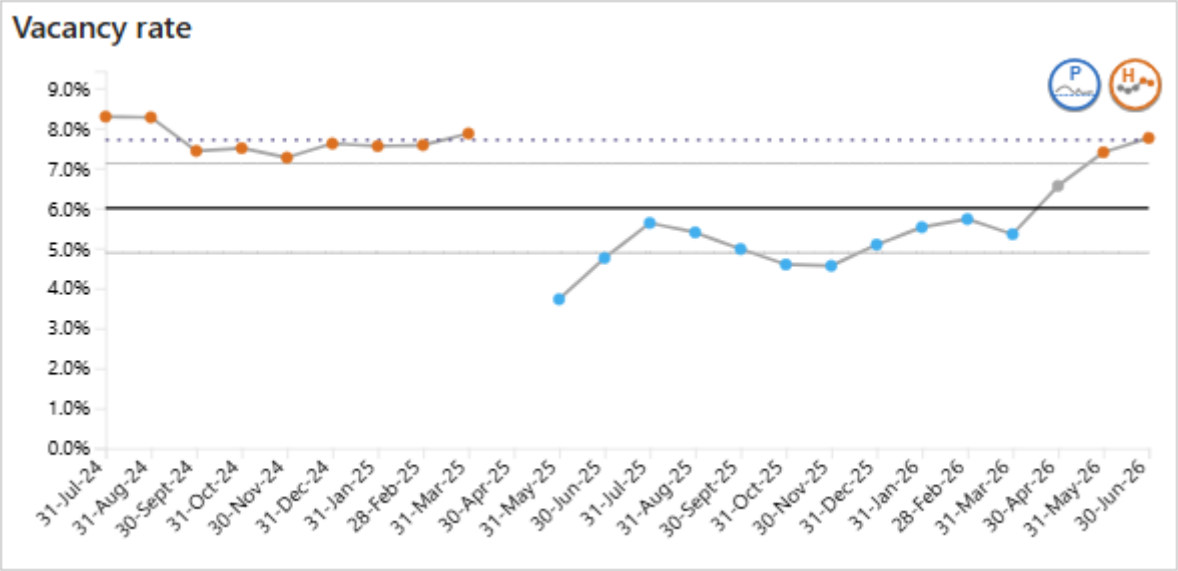
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality rating
Rolling sickness absence is 4.2% (monthly rate 4.3%), unchanged from the previous month and remaining above the Trust target of 3.1%. Variation persists across divisions, with SUWON and NOTSSCaN recording the highest absence rates (4.4%), while CSS reports the lowest (4.0%). The top 5 key reasons for sickness continue to be :- 1. Mental, Behavioural or Neurodevelopmental 2. Musculoskeletal or Connective Tissue 3. Respiratory system 4. Digestive system 5. Injury, Poisoning or External causes Long-term sickness top 5 reasons:- 1. Mental, Behavioural or Neurodevelopmental 2. Musculoskeletal or Connective Tissue 3. Injury, Poisoning or External causes 4. Not elsewhere classified 5. Neoplasms	• Divisions receive a monthly report outlining the top 10 reasons for sickness absence. These reports are used to inform targeted action plans, with a particular focus on Cost Service Units (CSUs) reporting higher-than-average absence levels. • 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 through updated documentation and enhanced guidance to support more meaningful and effective RTW conversations. Local workshops remain in place to build management capability, supported by ongoing Occupational Health engagement through regular monthly meetings to proactively identify and address emerging themes. • 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, HR Governance, Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1616 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in the previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

3. Assurance report: Growing Stronger Together



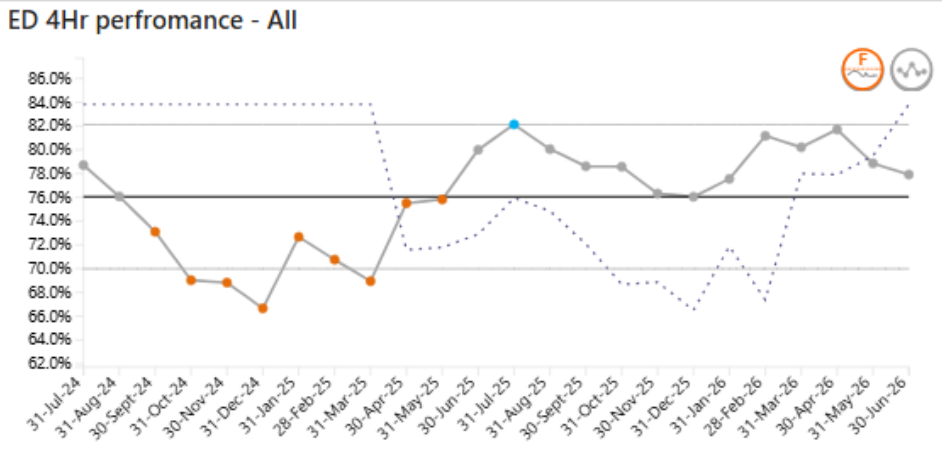
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M3 Non-medical appraisal compliance increased significantly to 62.8%, a 20.5 percentage point improvement from Month 2. Colleagues in the Divisional Workforce receive weekly reports detailing progress and the names of compliant and non-compliant staff. Compliance is expected to increase as the Trust is currently within the appraisal window, with further improvement anticipated as activity accelerates following the commencement of the new appraisal cycle.	• We offer a full range of communication, resource, and leadership support for managers and appraisees. • The Chief Officers have provided updates and a call for action at team briefings and senior leadership team briefings. • The culture and leadership team are delivering twice-weekly webinars on how best to prepare for an appraisal, and to date, over 950 people have attended. These sessions are also supported by online training for appraisers and appraisees. As at 10th July 2026, 74.92% of appraisals have been completed; this exceeds the 58.52% completion rate at the same point in 2025. • There is targeted support being provided within the divisions for areas where in the staff survey, it was raised that the quality of appraisal could be improved. • There are regular divisional communications being sent, encouraging all managers and staff to book and prepare for their appraisals. • Advice is being provided on how to conduct an appraisal for staff who have different career aspirations and that everyone should have an appraisal conversation. • Appraisal compliance is being monitored at divisional performance reviews. • The Divisional Workforce Team and divisional SLT's are reviewing appraisal compliance progress at directorate performance reviews to ensure appraisals are being booked and held.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 2331 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

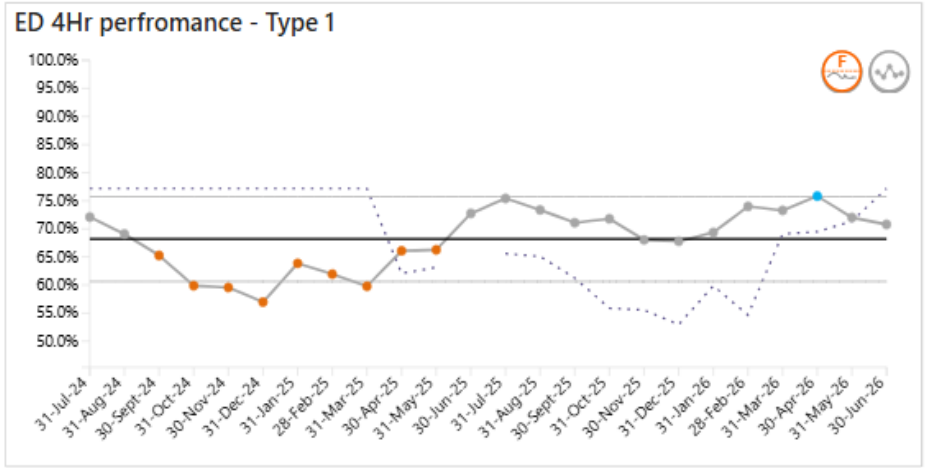
3. Assurance report: Growing Stronger Together



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 increased to 7.8% for M3, up from 7.4% in Month 2, and is now marginally above the 7.7% KPI. Divisional variation remains evident, with NOTSSCaN reporting the highest vacancy rate (9.0%) and MRC the lowest (6.2%), remaining below target. The upward trend suggests continuing recruitment challenges in some services.	• Targeted recruitment campaigns continue in specialities and services experiencing the highest vacancy levels. • Recruitment pipeline reviews are undertaken regularly to identify and address delays in filling posts • Divisions are implementing local recruitment and retention plans focused on hard-to-recruit roles • Workforce teams continue to support managers to maximise recruitment activity and improve candidate conversion rates • Apprenticeship pathways and career development opportunities are being utilised to strengthen workforce supply. • Vacancy performance is monitored through divisional workforce reviews and escalation processes 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, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 2331 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

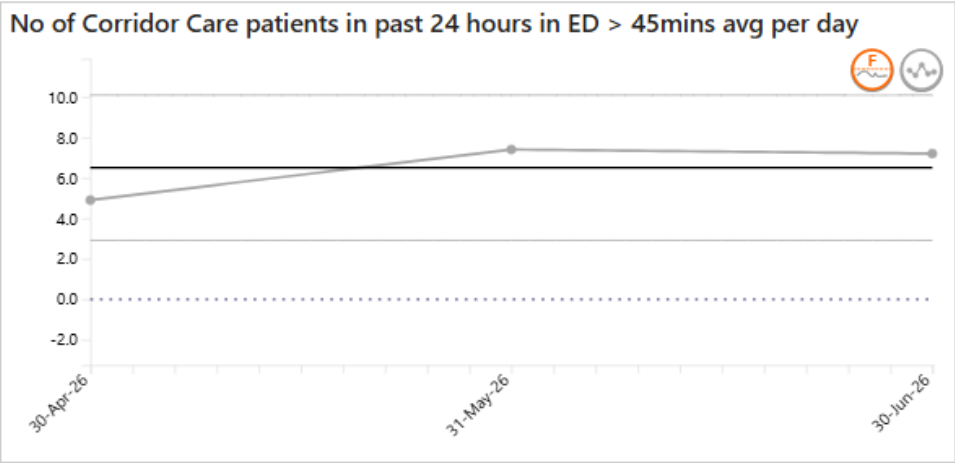
3. Assurance report: Operational Performance





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 performance deteriorated in June due to sustained increases in demand and significant operational pressures. Emergency Department attendances increased by 2.4% year-on-year, with the greatest impact arising from 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. At times, congestion limited the ability to rapidly assess and progress patients, resulting in delays and reduced flow through the departments. Periods of increased arrival intensity were sustained over 3–4 days, making recovery more challenging, particularly at the Horton General Hospital, where pressures persisted and impacted the ability to return to expected performance levels. Operational resilience was further impacted by increased medical workforce sickness absence, ongoing challenges with Discharge Lounge capacity and patient transport, and delays to the Level 1 redevelopment programme. Patient flow continued to be constrained by rising numbers of delayed discharges across Pathways 1–3, including cross-border operational delays affecting Horton General Hospital beds. Additional pressures included downstream bed availability affecting the children admitted pathway and pharmacy service changes impacting AMR wards, increasing the risk of discharge delays and reduced patient flow.	• Deep Dive UEC performance in May/June 26 completed. • Analysis of patient cohort underway – increase in under 50's walk-ins. • Options to increase utilisation of Call before Convey being explored. • Full Capacity Protocol – Via Trust Wide Urgent Care Group. • Medical Sickness absence review underway. • Overnight Transport delays and lack of 24-hour discharge lounge being explored. • High volumes of attendance compounded by SEU/Medical "take" in ED. SEU Improvement Group. • Times of peak attendance requires corresponding surge plan – improvement focus on admitted pathway required. Surge Plan in development. • Streaming of increased volume of primary care patients impacted by lack of downstream capacity. • A 'Perfect Week' is planned for the Horton site – September • Work underway to review pharmacy provision with CSS Division.	• Full Capacity Protocol Implementation • PLACE level Surge plan for MOFD >80 • All Assessment areas respond to surge and according escalations. • TWUCG Actions – Surge Plan. • Options in open Discharge Lounge overnight. • PLACE leadership support is required to strengthen the System Surge response during periods of high acuity and increased delays in step-down pathways. • Assess gaps in Model Discharge pathway – minimum standards.	N/A

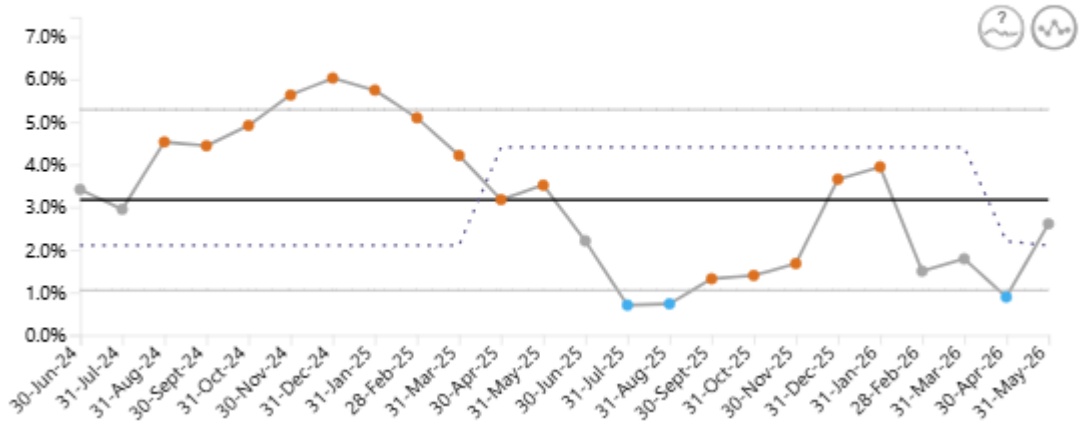
3. Assurance report: Operational Performance, *continued*



Corridor patients >45 mins: Average per day				
	March	**April**	**May**	**June**
Trust	**12.5**	**10.3**	**15.3**	**14.4**
JR	8.1	8.8	14.1	12.5
HH	4.4	1.5	1.1	2.0

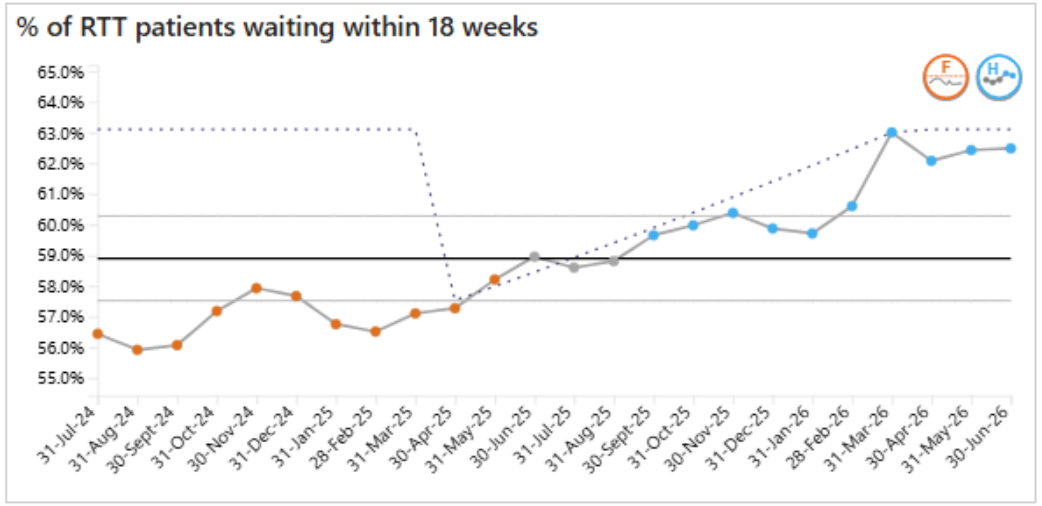
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
When the emergency and assessment units become congested, to maintain flow at the front door and ensure timely ambulance 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 will place 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. Inline with increasing pressures experienced in the JR ED, corridor care deteriorated in May with some improvement in June. 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 in the last two weeks.	**** Corridor Care Taskforce initiated May 2026 **** 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 focuses on the Emergency Department, while the other focuses on non-ED clinical areas. ○ The taskforce groups comprise representatives from all Divisions, key areas where corridor care has been significant, and the Corporate Division, ensuring that quality improvement (QI) methodology and data are used to inform decision-making and measure progress. ○ The taskforce groups meet weekly to ensure actions and key priorities are progressing at pace. ○ The groups work collaboratively to review outstanding actions, monitor progress, and will be updating the Full Capacity Protocol to support improved patient flow across the organisation. ○ Actions in place and underway relating to digital, data quality, communication, QI process and governance. ○ National GIRFT seminars attended to gain insight into the current national picture and incorporate emerging learning across OUH ○ A self assessment against the GIRFT Corridor Care Improvement Guide is being undertaken in July and will form the basis of the improvement work when the two groups merge with wider stakeholders joining from across the system and Trust in August.	TWUCG - September	ED – 2375 SEU - 3460	

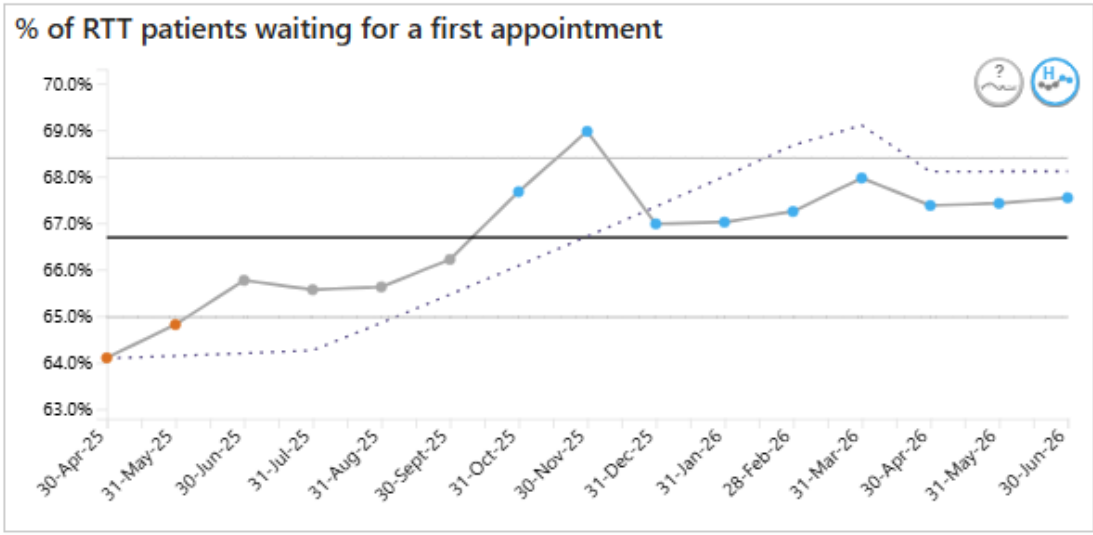
Proportion of Type 1 attendances spending more than 12 hours in an emergency department



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The proportion of patients with a length of stay greater than 12 hours improved in June. However, whilst this exceeded our submitted plan OUH is on a par with the same period last year and is just above the target at 3% which represents 335 patients. Attendances were the largest contributory factor with a 5.7% increased compared to the same month last year. Bed flow out of the ED has been a challenge at the JR whilst we attempt to overcome an increased number of patient not meeting the criteria to reside and an increase in acuity resulted in delayed transfer to inpatient beds.	• A 'deep dive' into May's UEC performance overall is underway with learning and action shared internally and with system partners. • Conveyance avoidance and strategies to support crews to utilise alternative pathways is a key area of focus. Collaborative work with SCAS is planned to support this with representation in the JR ED • A 'perfect week' is planned for the Horton in September, of which conveyance avoidance will be a significant area of focus. • Improvements and developments are ongoing within adult social care and provider capacity and staffing with limited impact to date on overall non criteria to reside figures.	TWUCG July TWUCG July TWUCG July Ox UCDG July	N/A	

3. Assurance report: Operational Performance, *continued*



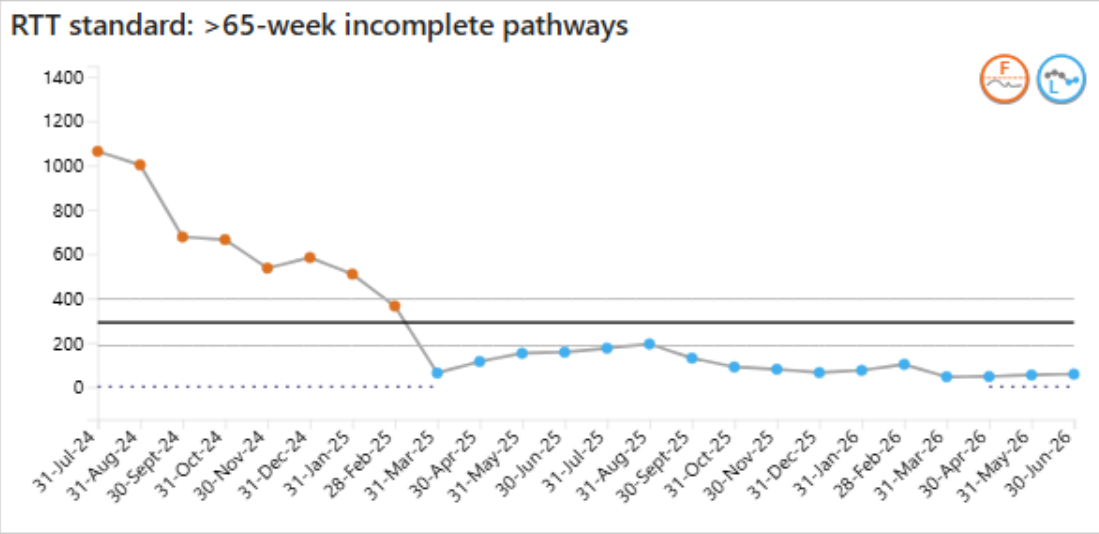


Benchmarking: RTT Patients Waiting 18 Weeks or Less May 2026 NOF Score of 3.18

OUH: 62.43% National: 66.07% Shelford: 67.48% BHT: 62.11% RBH: 83.09%

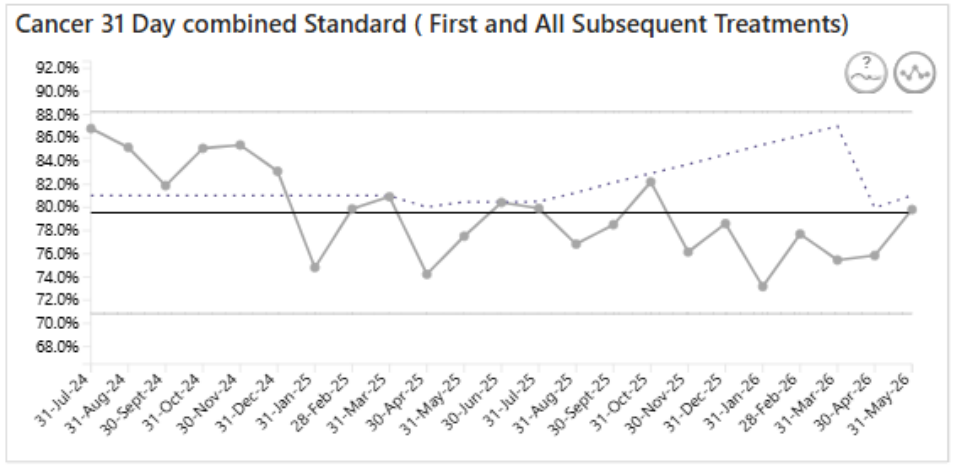
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting less than 18 weeks as a proportion of the total waiting list was 62.48% at the end of June against an operational plan of 63.12%. Performance exhibited special cause of improvement due to more than six consecutive periods of performance above the mean. Total incomplete RTT pathway waiting list size was 90,587 for June with *67.54% of patients awaiting a first appointment below 18-weeks. *using the weekly NWL submission officially however when using the monthly return, performance was 68.37%	The Trust is below plan by 0.64% for patients waiting within 18 weeks as at the end of June. 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, we acknowledge this to be the main contributing factor for an increased waiting list size against plan for June. Patient engagement exercises are in place though require phasing due to administrative impact. Exploring opportunities for digital solutions. An Outpatient Improvement Programme and a Theatres Improvement Programme are in place. Digital outcome form roll-out all specialties continues, 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 onwards in ENT, OMFS, and Gynaecology. Additional elective capacity through the Surgical Elective Centre (L1) operational plan assumed July this is now October and L2 is subject to revenue requirements and Board & ICB approval.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

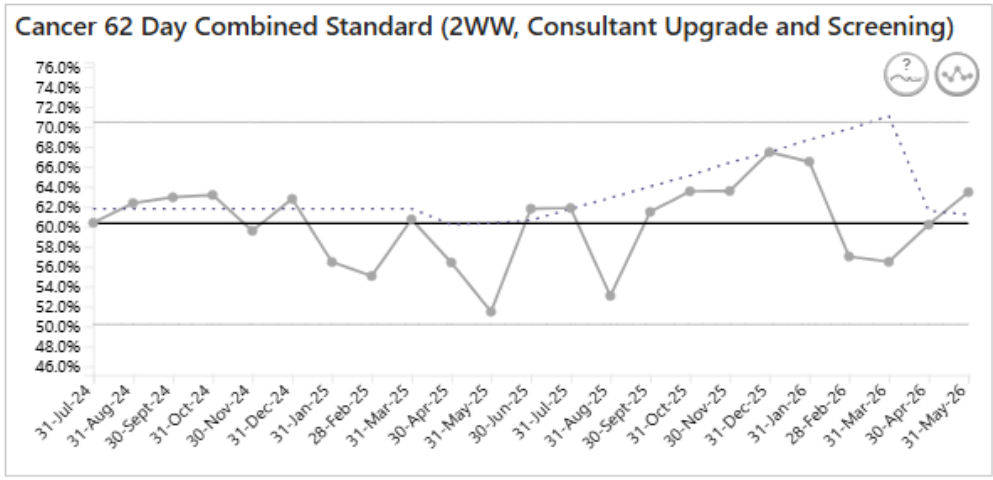
3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 65 weeks to start consultant-led treatment was 47 at the end of April. Performance exhibited a positive special cause of variation due to exceeding below the lower control limit. We remain committed to eliminating patients waiting over 65 weeks but did not deliver this for April. **Focus remains on longest wait patients:** **>104 weeks - nil** incomplete pathways reported. **>78 weeks - 2** incomplete pathways reported. One has been treated in early May, and one has a transient illness therefore rescheduled in early June. **>65 weeks – 47** incomplete pathways reported which is a increase from the previous month by 1 pathway. Focus remains in place to deliver nil pathways. Other less challenged services have moved to recovering **52-week backlog and 18-week performance.**	**ENT services**: Audiology insourcing in place to support with backlog recovery. Insourced ENT clinics continues. All new appointments in the 52-week cohort have been scheduled. Additional senor level validation being undertaken. The addition of administrative time to support this has been welcomed. This service will be reviewing their next interventions following the peer review that took place in March 2026 with NHSE (at our request). **Gynaecology services:** Additional theatre slots scheduled, insourcing focusing on outpatients. Locum specifically assigned to focus on delivering 40-weeks in outpatients for endometriosis. Undergoing clinical pathway redesign to take effect in M4. This remains a challenged speciality and is likely to remain so for a period of time, there is no mutual aid supported. **Oral-Maxillio Facial services:** Additional activity underway. Share of septorhinoplasty cases between appointed consultant and senior specialist. A few **other specialities** who have a small number off breaches each contributing - specialities have been asked to address each month as this is not acceptable. **Delivery Action Plan**: Live and populated against specialty level trajectories – introducing new framework for tracking deliverables in conjunction with weekly check and challenge meetings. We are working to focus on the patients waiting over a year (52 ww cohort).	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

3. Assurance report: Operational Performance, *continued*

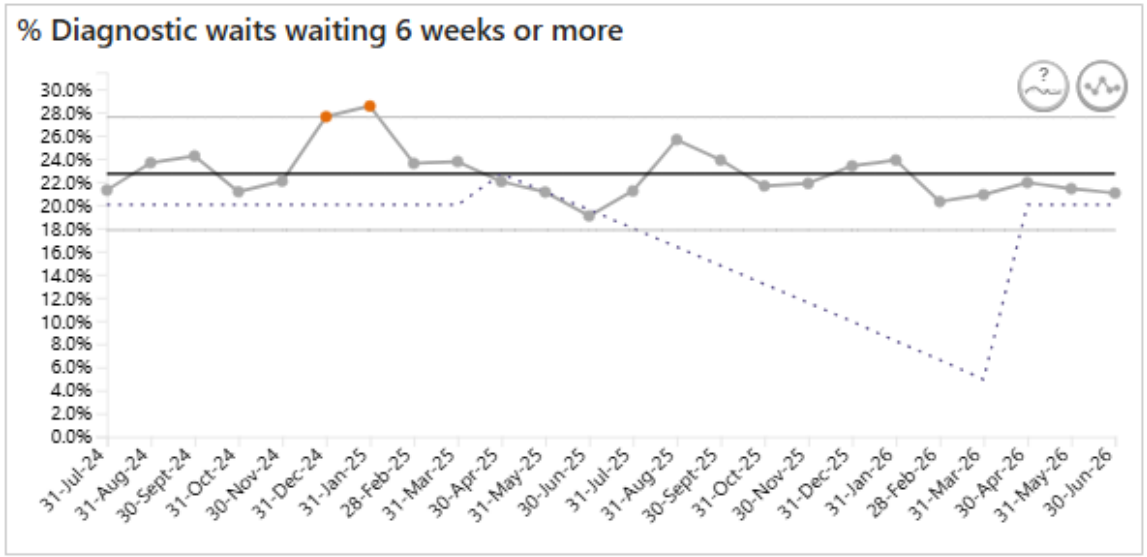




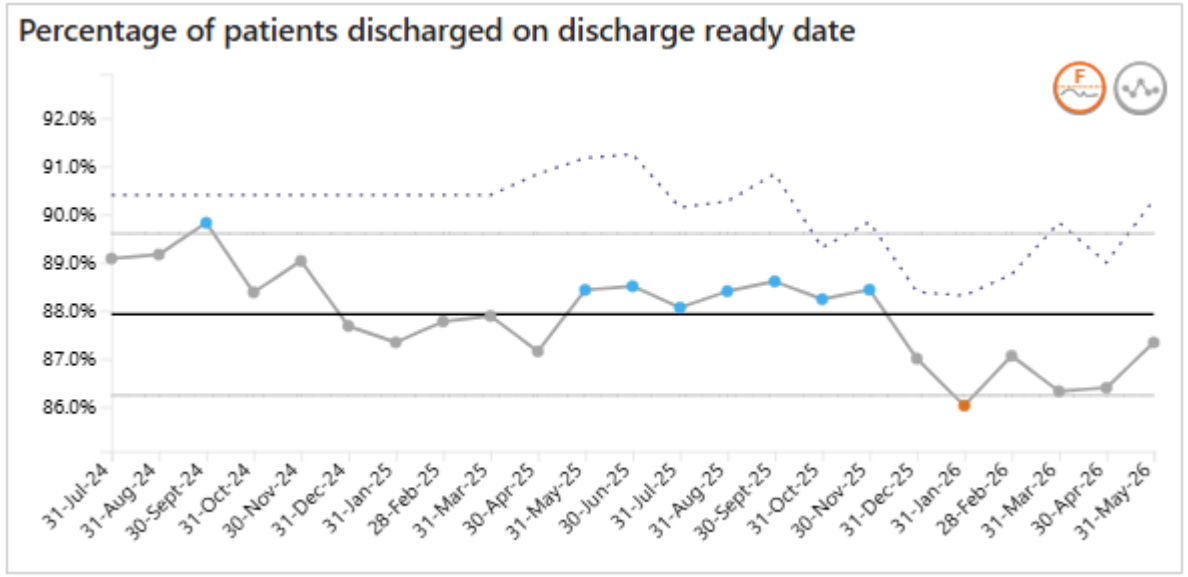
Benchmarking: Cancer 31 Day All Stages May 2026				
OUH: 79.8%	National: 95%	Shelford: 91.2%	BHT: 87.9%	RBH: 92.9%

Benchmarking: Cancer – Patients Treated Within 62 of Referral May 2026				
OUH: 63.5%	National: 70.08%	Shelford: 68.27%	BHT: 63.23%	RBH: 77.16%

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 met plan at 63.5% - this is not acceptable for our patients against national standard. We have support as requested from NHS E to enable delivery against plan to continue to support March 26 delivery 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. Kick off meeting held 15th June with Cancer Management and QI teams, due to be presented to all MDT leads **Brain Workshop (June 2026):** Scheduled for Thursday 18th June to drive sustainable improvements to become in the top quartile nationally for FDS and treat all patients within 62-days. **Cohort 4 (March 2026):** 3-Tumour sites workshop held 20th March for Bladder, NSS and SACT. 100-day plans agreed for Bladder and NSS with SACT taking a strategic approach for longer term gains. Day 100 updates for these areas scheduled to be reviewed at Cancer Improvement Group on 26th June 2026. **Cohort 3 (Nov 2025): 3-Tumour Site Workshop held on 26th November** focussing on UGI and Renal with a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. Day 100 plans took take place at cancer strategy group on 27th March 2026. Initiatives to be continued locally with divisional oversight **Cohort 2 (Aug 2025):** focussing on LGI with updates following Day-100 presented on 19th December. Urology also locally undertaken and presented in the same forum for governance and support. Ongoing actions to continue at local level with the ability to escalate to Cancer Improvement Group every month by exception.	Cancer Improvement Group – June 2026	N/A	

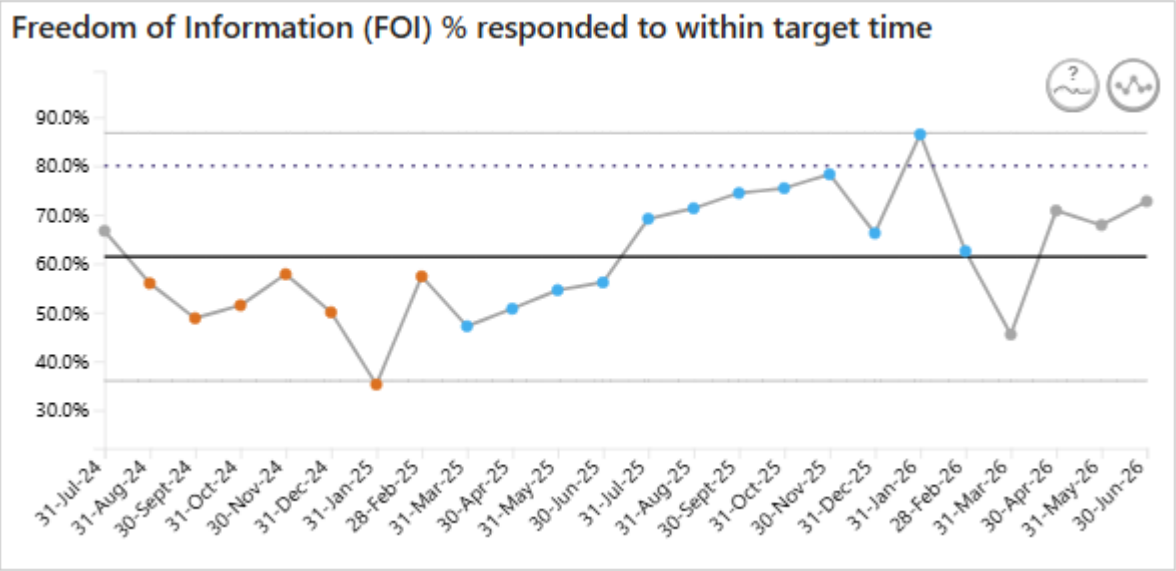


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The number of patients waiting more than 6 weeks as a proportion of the total waiting list was 21.03% at the end of June against an operational plan of 19.5%. Performance exhibited common cause of variation.	All modalities have been asked to over deliver where possible to support "total" delivery. Focus has remained on the under 17-year-old cohort as well as total waiting list. Specialities are reviewing the "longest waiting" patients to determine if clinical and administrative validation could be applied. The teams are working to the end of September to complete this work based on the administrative capacity across all Elective pathways. **Endoscopy** Oversight of list utilisation and ensure maximum opportunity is delivered and maintained. Plan to undertake Patient Engagement to obtain list of patients willing to be scheduled at very short notice. Additional capital for newer scopes (with efficiency) have been delivered in March. Improved focus on validation, with particular focus on 13-week long waits and completing Root Cause Analysis targeting admin improvements, booking discipline and patient engagement. **Neurophysiology** Stabilisation of workforce by supporting return to full staffing (e.g. phased return staff) Accelerating recruitment pipeline where gaps remain whilst maximising existing capacity including expansion of insourcing Clinical pathway reviewed to assess whether all referrals require neurophysiology testing and explore alternative appropriate pathways **Audiology** Delivery Fund scheme to insource capacity and is delivering an additional 500 units of activity per month. Estates work underway at the Horton for a dedicated facility. Brackley booth delivered. CDC activity commenced. Validation plan in place with newly recruited band 6 to deliver the agreed changes. **Non-obstetric Ultrasound** Delivery Fund scheme has supported sufficient capacity to tackle demand. Performing above plan, which is offsetting some of the other modalities under performance	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews	N/A	



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The percentage of patients NOT discharged on their Discharge Ready Date reflects the increased proportion of patients who have been discharged on Pathways 1-3 from inpatient beds. The Discharge To Assess (D2A) pathway encountered new challenges with capacity in Q1 this year with the National changes to recruitment. More providers have been onboarded and the situation is resolving. The reduction of Short Stay Hub Beds (SSHB) has resulted in long delays for some patients on Pathway 2. In addition, the complexity of discharges across all pathways has increased over time. This correlates with deterioration shown in the above chart. However, despite this the Oxfordshire system performs well with consistently the lowest percentage of patients not meeting the National Criteria to Reside in the South-East Region.	• Ward areas with the lowest percentage of patients discharged on their discharge ready date have been reviewed; they have seen an increase in very long delayed patients due to a small number of unique cases. • The broader root cause is being addressed with system partners with movement from very large community packages to SSHB with a clear focus on trajectories for length of stay for this bed base which is being tracked monthly via the Urgent and Emergency Care (UEC) sit rep. • Out of County Delays and escalation pathway, involving COO at an earlier stage. • Quality Improvement Project on reducing cancelled discharges. The group met the target ahead of the deadline and have achieved further improvement exceeding the target. An end of project report has been produced with some PDSA's moving to 'business as usual' and recommendations for further improvements. • New Extended Length of Stay improvement cycles to reduce the number of extended length of stay patients occupying open beds.	January 2026 – complete Oxfordshire system Urgent Care Delivery Group - ongoing Ongoing TWUCG & Oxfordshire system Urgent Care Delivery Group March 2026 - complete June 2026	N/A	

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

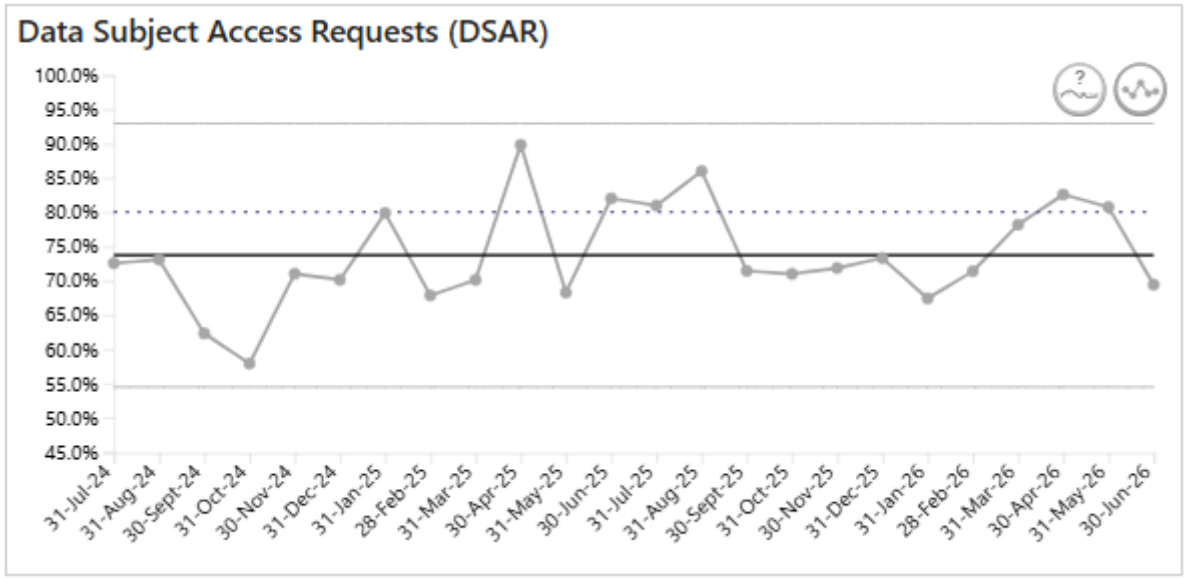


Breakdown of open FOI cases by area

Clinical Support Services		10
Maternity		8
Chief People Officer		6
SuWOn		5
Data and Analytics		5
Estates and Facilities		5
Information Technology		3
Legal Services		2
Workforce		2
Procurement		2
Secure Data Environment		2
Patient Experience		1
Research and Development		1
Chief Operating Officer		1
Digital		1

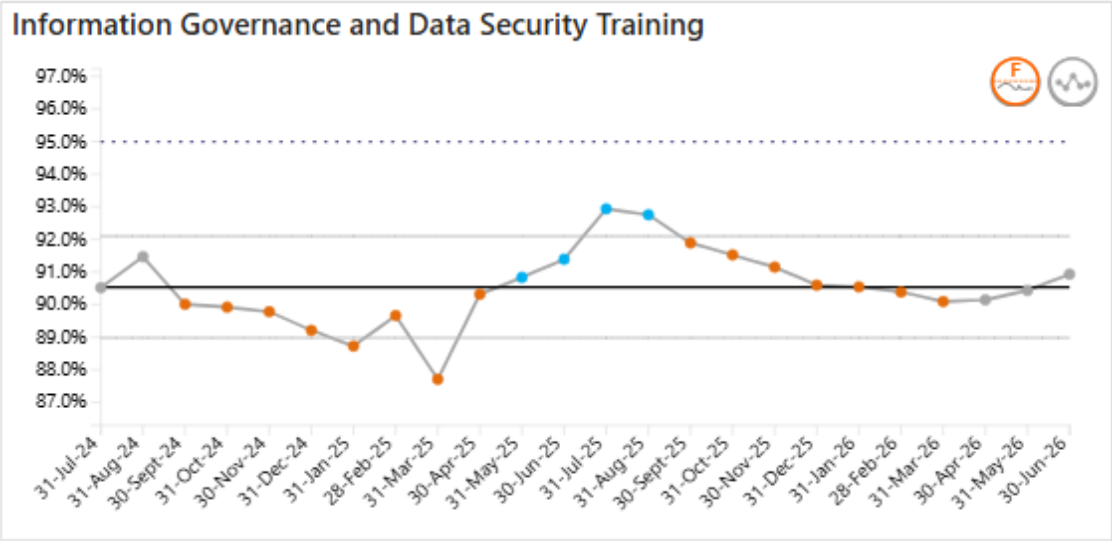
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M3 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 72%. 28 valid cases were received in M3 – a similar figure to M1 and M2. 16 of these cases were closed on time – in total 28 cases were closed as efforts to close complex overdue cases continue. Staff sickness, vacancies and activities to onboard divisions to the new e-Case FOI management system had a significant impact on the central IG/FOI function in M3.	Maternity cover for the vacancy in the IG team has been recruited and starts 3rd August. Feedback from divisional and departmental colleagues who had their e-Case onboarding has been positive, and feedback has been passed to the developers to facilitate further improvement. This will enable enhanced local management and escalation of complex cases and cases at risk of breaching.	Updates provided to Digital Oversight Committee and Delivery Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Corporate support services – 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 M3 the Trust received 794 SAR requests, of which 551 were closed on time. This drop is due to the medical records SAR team concentrating on closing their oldest cases to remove the backlog before the Trust reports again to the ICO on the 31st July. As a result, 46 of the 266 medical SAR requests were closed on time. A total of 703 medical SARs were closed, reducing the backlog by 657. There are now 184 overdue cases, from a peak of 808. Occupational Health closed 88% of their cases on time PACS closed 100%.	E-Case is now well embedded and updated processes to reflect the Data Use and Access Act are in place and realising benefits – at the current rate of closure the system will reach equilibrium in September. The Amos Report may trigger an increase in requests for maternity notes in the coming months; this is being monitored using the e-Case classification features.	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*

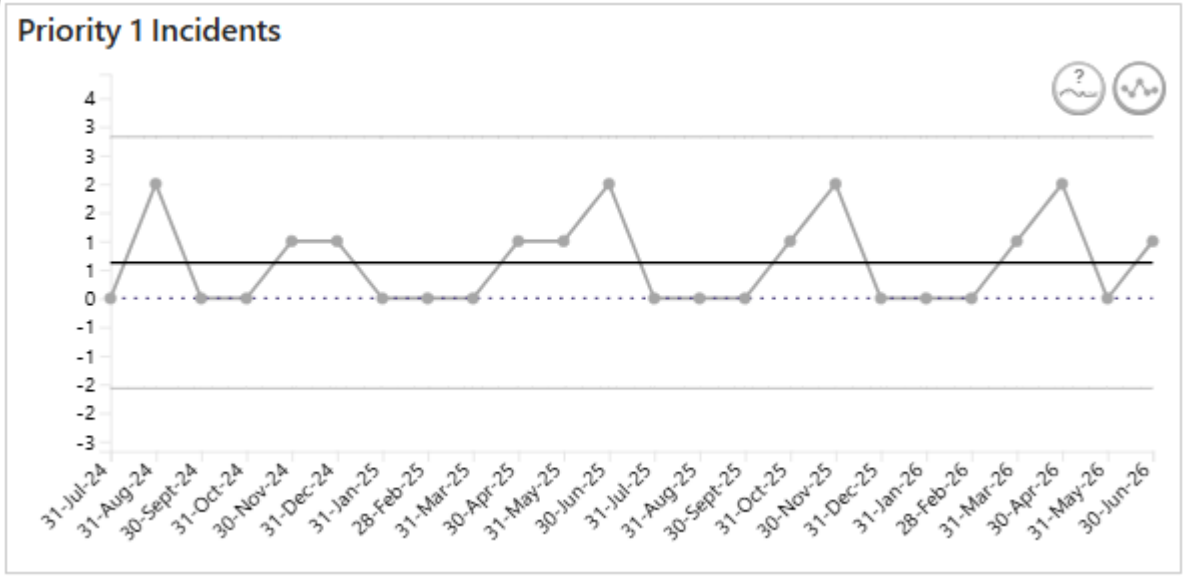
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
Education and Training	67	22	67.2%
Research and Development	163	29	82.2%
Hosted Services DIV	47	6	87.2%
NOTSSCAN	3478	434	87.5%
Corporate	1154	116	89.9%
MRC	3265	322	90.1%
Surgery Women and Oncology	3359	321	90.4%
Estates	180	16	91.1%
Clinical Support Services	2333	197	91.6%
Operational Services	209	16	92.3%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 90.9% in M3. No divisions are achieving 95% and this month's performance exhibits common cause variation. Corporate, NOTSSCAN, R&D and Education are below 90%	1485 staff are currently non-compliant. Compliance rates are cyclical and increase during the appraisal window, which is open so an increase over the next few months is expected. 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.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
INC0384555 / PRB0040818 – 21/06/2026 – VDI Connectivity / Login Issues Staff experienced issues accessing Citrix Virtual Desktop Infrastructure (VDI) when a large number of session hosts (most of the environment) became unregistered, resulting in staff being unable to log in and a degraded service availability. Digital confirmed that all affected servers required restarting, and initial analysis indicated the incident coincided with a scheduled update which had already reduced availability of the solution.	The issue was fully resolved at 08:30 on 22/06/2026, following the successful restart of all impacted servers and confirmation that the VDI environment was operating normally. Response times to the challenges were also reviewed within the context of standing operating procedures for responses for the teams that responded overnight on-call.	N/a – already resolved through technical remediation and staff training.	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