Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M6 (September data)

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 6 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the four strategic pillars: People, Patient Care, Performance and Partnerships, and key measures included within the NHS England Segmentation and Oversight Framework. Segmentation outcomes and performance are referenced within the assurance reports, where relevant, noting that the period of measurement can differ from the IPR 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, within Appendix 1, the internal PowerBI dashboard is included for selected Segmentation Indicators.

We achieved key measures related to patient safety and care experience, including MRSA cases (zero) and our mortality indicators (SHMI and HSMR - excluding hospices) were below 100, indicating fewer deaths than expected. Our Friends and Family Test (FFT) percentage positive scores achieved the performance target in inpatient areas, though not in outpatient and ED. Pressure ulceration indicators were achieved for hospital acquired category 4 incidents but were above the threshold for category 2 and 3 incidents.

Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals. Safeguarding training compliance for adults (L1-L3) was achieved.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In month 6, we met targets for core skills training, and non-medical appraisals demonstrating commitment to staff development. Our time to hire standard was also achieved. Core skills training exhibited improving SCV and process assurance for consistently meeting the target.

Lower staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our sickness absence rate showed rates lower than the National and Shelford averages, and the third lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets and exhibited improving Special Cause Variation (SCV).

Performance against the operating plan trajectory for A&E was compliant for A&E performance (all types and type 1 within 4 hours) and compliant for the % of patients waiting over 12 hours (both Segmentation indicators). Operating plan trajectories were off plan in month 6 for RTT % within 18 weeks (all pathways) and the % of pathways over 52 weeks, which are Segmentation indicators. The percentage of patients within 18 weeks for first OP attendances met the operating plan along with the number of patients on the RTT waiting list. Performance in month 6 was worse than the operating plan trajectories for Cancer waits within 62-days (Segmentation indicator), Cancer 31-days, but ahead of plan for the Faster Diagnosis Standard (diagnosis within 28-days), which is a Segmentation indicator. NB. Cancer performance is reported one month in arrears. Diagnostic performance (% within 6 weeks) was below the operating plan in month 6.

Income and Expenditure (I&E) was a £3.2m in-month surplus at the end of Month 6 (September), which was on plan. The plan included a £11m cash-releasing savings requirement in Month 6 (September). Total cash-releasing savings reported as delivered YTD amounted to £36.9m against a target of £43.2m (85%). Of the cash releasing delivered YTD, 48% (£17.6m) are recurrent savings, against the plan assumption of 61%. Cash was £32.2m at the end of Month 6 (September), £14.2m lower than the previous month but £29.1m higher than plan. Capital expenditure is £8.6m lower than plan at month 6.

Of the 117 indicators currently measured in the IPR, 24 are detailed further using standardised assurance templates. These indicators, which include those failing to meet performance standards or showing deteriorating SCV, are listed in summary on the following page and elaborated within the relevant domain in section 3 (Assurance reports).

The Trust Management Executive review process also considers indicators without targets and those not flagging SCV in assurance reporting. Assurance reporting includes updates to Tiering requirements for Elective, Cancer, and Urgent and Emergency Care. The data quality ratings of the assurance templates range from 'satisfactory' to 'sufficient', as defined on page 11.

1. Executive summary: *Part 2 – performance challenges*

Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- % of RTT patients waiting within 18 weeks
- Cancer 31 Day Combined Standard
- % Diagnostic waiting 6 weeks or more
- Number of non-discharged patients onto PIFU
- VTE-Submitted Performance
- Reactivated complaints

Common cause variation and missed target

- RTT number of incomplete pathways <18 weeks
- Cancer 62 Day Combined Standard
- Pressure ulceration per 10,000 bed days (Cat 2)
- Pressure ulceration per 10,000 bed days (Cat 3)
- C-diff cases: HOHA + COHA
- E-Coli cases: HOHA + COHA
- % of patient with sepsis attending ED received timely antibiotics according to NICE guidelines
- % of complaints responded to in 25 working days
- FFT % likely to recommend OP, and ED
- PFI: % cleaning score by site (average) CH and JR
- Sickness and absence rate (rolling and in month)

Special cause variation - improving

- Midwife ratios (birth rate/staffing level)
- Information Governance and Data Security Training
- Freedom of Information (FOI) % responded in target
- RTT patients > 65 weeks
- RTT patients > 52 weeks

Other*

- Average Non elective LOS
- Average delay of discharges (exclude zero delay)
- Number of Never Events

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

In month 6, **VTE (Venous Thromboembolism) compliance** fell below the national target of 95% to 94.2%, exhibiting deteriorating Special Cause Variation (SCV). Actions include monthly monitoring, submission of improvement plans, and targeted support from divisional leadership.

Clostridium difficile cases are currently 21 fewer than this time last year. The team has successfully recruited a substantive IPC lead nurse/manager, who began in October, and assurance has been provided through the IPC report to PSEC via HIPCC. E. coli bacteraemia cases remain above trajectory, with ongoing thematic analysis and targeted interventions.

One new **non-thematic PSII (Patient Safety Incident Investigation)** was confirmed in month 6—a Never Event involving wrong-site laser eye surgery. Learning from this incident will be shared after investigations conclude. Actions to improve PSII timeliness and learning dissemination include standardising investigation timeframes, monthly governance reviews, and cross-divisional learning, with progress monitored by the PSIRF Improvement.

The **Never Event** involved a patient receiving laser surgery to the unintended eye. Immediate actions taken include capping injection lists, reinforcing WHO TIME OUT and skin marking procedures, urgent communication to leadership, and reviewing the injection SOP. Investigations are underway and being coordinated with a similar recent incident to ensure thorough learning and improvement.

In month 6, 13/16 (81.3%) of **patients with sepsis attending ED received timely antibiotics** in accordance with NICE guidelines (NG51). Delays in timely antibiotic administration for sepsis were linked to late prescriptions, after-hours patient presentations without specialist support, and communication gaps between clinicians and nurses. These issues were noted to significantly impact compliance in a small data set. Ongoing audits, clinical governance reporting, and targeted teaching are in place to address these concerns and improve practice.

Hospital Acquired Category 2 and Category 3 pressure ulcer incidents decreased in September 2025, with Category 2 incidents falling from 80 to 63 and Category 3 incidents remaining stable at 8. Oversight continues via the Harm Free Assurance Forum, with escalation to the Clinical Governance Committee, and harm reviews are planned for persistently challenged areas. Compliance with prevention audits remains high at 93.3%, and a comprehensive Quality Improvement Plan has been implemented to support shared learning and systemic improvement. Data reporting processes are also under review.

The **midwife to birth ratio** was 1:23.5, above the Target. The workforce plan focuses on aligning recruitment with birth rates, supporting staff retention, and reducing NHSP spending, aiming for full recruitment by November 2025. Weekly reviews track safe staffing, community on-call hours, community births, and NHSP expenditures to ensure progress and accuracy.

The percentage of **complaints responded to within 25 working days** did not meet the target, and the number of complaints and reactivated complaints exhibited ongoing special cause variation. Actions include regular circulation of a weekly report on open complaints and compliance with time targets, to help divisions manage cases effectively. Weekly meetings with DDN's enable escalation of overdue complaints, and ongoing work aims to analyse bottlenecks and identify further process improvements.

Friends & Family Test (FFT) recommend rates remained high for outpatients (93.9%) and inpatients (95.5%), with positive themes including staff attitude and care. The ED recommend rate decreased to 80.7%. Maternity FFT response rates improved, but data collection remains challenging due to the transition to BadgerNet, with new methods being piloted to improve response rates.

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Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

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In September 2025, the **CH achieved a combined PFI** cleaning score of 94.5%. Out of 72 scheduled audits, 4 initially did not meet the 4-star Trust target—all were rectified. There is no defined trend for failed audits, and continuous improvement is supported by collaborative action plans and regular monitoring. The **JR achieved** a cleaning score of 961.1%. Out of 242 scheduled audits, 21 initially did not meet the 4-star Trust target—all of which were subsequently rectified.

Sickness absence performance (rolling 12 months) was 4.1% in September, with a rise in the monthly rate to 4.3% as flu season approaches. HR and Occupational Health are working together to address consistent absenteeism by supporting managers and staff, prioritising long-term sickness, and ensuring staff receive guidance to return to work. Proactive training, ongoing workshops, and regular meetings with Wellbeing leads are in place to strengthen sickness absence management and support, while work continues to clarify naming conventions for absence reasons.

The percentage of **RTT patients waiting within 18 weeks** in September did not meet the operational target, with 59.7% achieved against a plan of 59.9%. Validation Sprint initiatives and prioritisation of cancer services contributed to changes in the waiting list size. Actions include pathway validation, early adoption of Patient Initiated Follow-Up to optimise appointment slots, and increased capacity through targeted funds and digital tools. Weekly “Check & Challenge” meetings and the EPM support ongoing improvements.

For **RTT patients waiting over 52 weeks**, performance met the September operating plan, with 2,487 patients compared to a target of 2,494. Focus remains on reducing the longest waits, with no incomplete pathways over 104 weeks and a reduction in 65-week breaches. Actions include insourcing for key specialties, patient engagement validation, and a live recovery action plan. Progress is monitored through weekly assurance meetings.

Cancer 31-day and 62-day performance was below both the operational plan and national standard. Key actions include improving Inter-Provider Transfer review and escalation pending TVCA policy, reallocating theatres to increasing surgical capacity, advancing patient engagement through personalised care, developing SOPs for benign patients awaiting communication, and mapping tumour pathways to align with best practice standards.

Compliance with Data Security and Protection Training (DSPT) was 92% in month 6. No divisions achieved the 95% target, and the overall trend this month was a general decrease. R&D and NOTSSCAN divisions remain below 90%, while Operational Services exceed the target at 96.2%. Currently, 1,304 staff are non-compliant. Divisional governance teams have access to detailed compliance reports to help manage non-compliance, and oversight is provided by the Digital Oversight Committee.

Freedom of Information (FOI) performance remains below the 80% target, with a response rate of 74.4% in month 6. The Trust received an Enforcement Notice from the Information Commissioner’s Office, requiring a response plan by 14 May and implementation by 31 October 2025. All outstanding FOI cases (where responses were still requested) have now been closed. A new FOI management system is being procured, with staff training underway for a November go-live. The new process has streamlined case distribution, reducing contacts from over 180 to 19, and recruitment of temporary resources to address the backlog is ongoing.

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 • % of complaints responded to within 25 working days • FFT % Likely to recommend – OP • PFI: % cleaning score by site JR & CH • Pressure ulceration per 10,000 bed days (Cat 3) and (Cat 2) • C-diff cases: HOHA+COHA • % patients with Sepsis receiving timely antibiotics in accordance with NICE • Neonatal deaths per 1,000 live births • Midwife ratios (birth rate/staffing level)	H • FFT % Likely to recommend –ED	L Not achieving target • VTE Submitted Performance H Not achieving target • Number of complaints per 10,000 bed days • Reactivated complaints • Number of complaints	No SPC Not achieving threshold • Number of Never Events • Non-Thematic Patient Safety Incidents
Growing Stronger Together	Not achieving target • Sickness and absence rate (in month) • Sickness and absence rate (rolling 12 months)			
Operational performance	Not achieving target • RTT number of incomplete pathways (<18 weeks) • Number of RTT pathways over 52 weeks • 62-day Cancer Standard: >62 days	L Not Achieving target • RTT patients > 65 weeks • % of RTT patients waiting over 52 weeks	L Not achieving target • % of RTT patients waiting within 18 weeks • Cancer 31-day combined Standard (First and all Subsequent Treatments) • Non discharge patients on PIFU H Not achieving target • % Diagnostic waits under 6 weeks	
Corporate Support Services	Not achieving target • Efficiency Delivery £'000 • In-month financial performance Surplus/Deficit £'000	H Not achieving target • Information Governance and Data Security Training compliance • Year-to-date financial performance surplus/Deficit £'000 • Freedom of Information % responded to within target time	L Not achieving target • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % • Cash £'000	No SPC Not achieving threshold

2. b) SPC indicator overview summary

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Sept-25	0.0	-	-	0.2	-0.5	0.8
MRSA cases: HOHA+COHA	Sept-25	0	0		1	-2	3
C-diff cases: HOHA+COHA per 10,000 beddays	Sept-25	3.5	-	-	3.5	0.3	6.7
C-diff cases: HOHA+COHA	Sept-25	11	10	No	11	1	21
E. Coli cases: HOHA+COHA per 10,000 beddays	Sept-25	5.5	-	-	5.2	0.8	9.6
E. Coli cases: HOHA+COHA	Sept-25	18			17	3	31
MSSA cases: HOHA+COHA	Sept-25	3	-	-	6	-1	12
Number of Never Events	Sept-25	1	0	No	0	-	-
Non-Thematic Patient Safety Incident Investigations	Sept-25	1	0	No	2	-	-
Number of PSII Open Actions	Sept-25	14	-	-	36	-	-
VTE- Submitted performance	Sept-25	94.2%	95.0%	No	95.2%	94.4%	95.9%
% of emergency admissions 65yrs + receiving cognitive screen	Sept-25	67.1%	-	-	58.8%	50.9%	66.7%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Sept-25	81.3%	90.0%	No	90.3%	69.9%	110.7%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Sept-25	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Sept-25	6	-	-	3	-3	8
HSMR Excluding Hospices	Jul-25	92.8	100.0		85.7	-	-
Summary Hospital-level Mortality Indicator	Jun-25	90.3	100.0		91.9	-	-
Neonatal deaths per 1,000 total live births	Sept-25	3.3	3.2	No	3.2	-1.0	7.5
Stillbirths per 1,000 total Live births	Sept-25	3.3	4.0		3.7	-0.2	7.7
National Patient Safety Alerts not completed by deadline	Sept-25	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Sept-25	0.0	-	-	0.0	0.0	0.0
Number of active clinical research studies hosted	Sept-25	1420	-	-	1420	1190	1650
Number of active clinical research studies (commercial)	Sept-25	387	-	-	382	314	450
Number of active clinical research studies (non commercial)	Sept-25	1033	-	-	1038	874	1202
Number of incidents with moderate harm or above per 10,000 beddays	Sept-25	52.0	-	-	42.1	27.2	57.0
Number of patient incidents with moderate harm or above per 10,000 beddays	Sept-25	46.6	-	-	37.5	21.5	53.4
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Sept-25	5.5	-	-	4.6	-2.1	11.3
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Sept-25	20.2	19.0	No	21.5	10.1	32.9
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Sept-25	2.6	2.0	No	2.3	0.6	4.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Sept-25	0.0	0.0		0.1	-0.2	0.3
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Sept-25	97.3	-	-	99.5	72.0	127.0

NB. Indicators with a zero in the current month's performance and no SPC icons are not currently available and will follow.

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Patient falls (moderate and above) as reported on Ulysses	Sept-25	6	-	-	4	-2	10
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Sept-25	1.9	-	-	1.3	-0.7	3.3
Health and Safety related incidents - Assault, Aggression and harassment	Sept-25	149	-	-	164	89	240
Adult safeguarding activity	Sept-25	1882	-	-	1054	701	1407
Children's safeguarding activity	Sept-25	425	-	-	600	296	904
Adult safeguarding activity and Children's safeguarding activity	Sept-25	2307	-	-	1654	1141	2167
Safeguarding (Children) training compliance L1 - L3	Sept-25	91.3%	90.0%		88.7%	84.1%	93.4%
Safeguarding (Adults) training compliance L1 - L3	Sept-25	92.8%	90.0%		48.5%	41.0%	56.1%
Total Deliveries in month	Sept-25	620	625	-	612	538	686
Babies born	Sept-25	626	-	-	621	547	695
Maternity Bookings (planned + unplanned)	Sept-25	672	750	-	701	542	859
Inductions of labour from iView	Sept-25	132	-	-	138	97	179
Midwife Ratios (birth rate / staffing level)	Aug-25	24.1	22.9	No	25.5	21.4	29.6
Number of Learning MDT Reviews instigated	Sept-25	4	-	-	3	-	-
Percentage of Learning MDT Reviews within 42 days	Sept-25	0.0%	-	-	38.3%	-	-
After Action Review (AAR)	Sept-25	12	-	-	16	-	-
Percentage of AAR's within 14 days	Sept-25	54.5%	-	-	27.5%	-	-
Number of complaints	Sept-25	190	-	-	124	71	176
Number of complaints per 10,000 beddays	Sept-25	61.0	-	-	38.9	24.1	53.6
Reactivated complaints	Sept-25	19	1	No	11	3	19
% of complaints responded to within 25 working days	Sept-25	47.3%	85.0%	No	45.2%	25.0%	65.4%
Number of RIDDORs	Sept-25	5	5		5	1	9
Friends & Family test % likely to recommend - IP	Sept-25	95.5%	95.0%		95.0%	93.8%	96.3%
Friends & Family test % likely to recommend - OP	Sept-25	93.9%	95.0%	No	93.8%	93.0%	94.6%
Friends & Family test % likely to recommend - ED	Sept-25	80.7%	85.0%	No	79.3%	73.0%	85.6%
FFT maternity % positive (births)	Sept-25	93.8%	90.0%		73.0%	47.2%	98.9%
Inpatient FFT (Response Rate)	Sept-25	20.1%	-	-	24.1%	20.8%	27.4%
Outpatient FFT (response rate)	Sept-25	9.9%	-	-	8.4%	6.7%	10.1%
ED FFT (Response Rate)	Sept-25	15.8%	-	-	21.8%	17.3%	26.4%
Maternity FFT (response rate; births)	Sept-25	3.4%	-	-	8.3%	0.9%	15.6%
PFI: % of total audits completed that achieved 4 or 5 stars JR	Sept-25	91.1%	95.0%	No	93.1%	84.0%	102.2%
PFI: % of total audits completed that achieved 4 or 5 stars CH	Sept-25	94.5%	95.0%	No	94.5%	84.1%	105.0%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	Sept-25	96.0%	95.0%		96.5%	88.7%	104.2%
Incident rate of violence and aggression (rate per 10,000 beddays)	Sept-25	47.9	-	-	48.2	24.3	72.1
Trust level: CHPPD vs budget	Sept-25	6.9	-	-	-13.5	-59.9	32.8

2. b) SPC indicator overview summary

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)

Operational Performance Summary: All

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Aug-25	5.0%	-	-	8.6%	4.6%	12.6%
Proportion of ambulance arrivals delayed over 60 minutes	Aug-25	0.2%	-	-	0.9%	-0.2%	2.0%
ED 4Hr perfromance - All	Sept-25	78.6%	72.1%		68.5%	60.5%	76.4%
ED 4Hr perfromance - Type 1	Sept-25	71.1%	61.3%		61.4%	52.5%	70.3%
Proportion of Type 1 attendances spending more than 12 hours in an emergency department	Sept-25	1.3%	4.4%		5.1%	2.7%	7.5%
Proportion of patients discharged from hospital to their usual place of residence	Sept-25	95.8%	-	-	95.2%	94.5%	96.0%
% of RTT patients waiting for a first appointment	Sept-25	66.2%	65.5%		65.3%	64.0%	66.7%
% of RTT patients waiting within 18 weeks	Sept-25	59.7%	59.9%	No	60.7%	58.7%	62.8%
% of RTT patients waiting over 52 weeks	Sept-25	2.9%	2.9%	No	3.2%	3.0%	3.4%
RTT standard: >52-week incomplete pathways	Sept-25	2487	2494		2747	2402	3091
RTT standard: >65-week incomplete pathways	Sept-25	130	0	No	617	388	845
RTT number of incomplete pathways	Sept-25	85367	86784	-	79667	76894	82441
RTT number of incomplete pathways (<18 weeks)	Sept-25	50922	51977	No	50860	49820	51899
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Aug-25	79.5%	78.1%		78.3%	73.0%	83.6%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Aug-25	76.8%	81.3%	No	82.4%	74.1%	90.6%
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Aug-25	53.1%	62.9%	No	60.9%	51.9%	69.9%
62-day Cancer standard: incomplete pathways >62-days	Sept-25	374	-	-	347	268	426
% Diagnostic waits waiting 6 weeks or more	Sept-25	23.9%	85.2%		17.2%	12.5%	22.0%
Diagnostic activity vs 2019/20	Sept-25	140.4%	-	-	125.6%	114.1%	137.0%
Total outpatient attendances - EM32in the 25/26 plan	Aug-25	101629	106537	-	111481	91475	131486

Integrated Performance Report (SPC)

Operational Performance Summary: All

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Bed Utilisation General & Acute	Sept-25	93.4%	93.0%		94.8%	91.5%	98.1%
Average Non elective LOS Trust level for IPR (average so cannot aggregate up)	Aug-25	6.5	6.4	No	6.6	-	-
Number of non-discharged patients put onto a PIFU	Sept-25	906	1594	No	1161	327	1994
Cancelled operations within 24hrs (non-clinical reasons)	Aug-25	0.2%	-	-	0.4%	0.2%	0.6%
Cancellations not re-booked within 28 days	Aug-25	11.1%	-	-	12.8%	-11.0%	36.7%
Elective DC spells - SUS	Aug-25	6487	6545	-	6794	5650	7938
Elective IP spells - SUS	Aug-25	1388	1447	-	1496	1208	1785
Average delay (exclude zero delay) of discharges Trust level for IPR (average so cannot aggregate up)- EB46 in the 25/26 plan	Aug-25	6.7	6.1	No	7.5	-	-
Percentage of patients discharged on discharge ready date - EB45 in the 25/26 plan	Aug-25	95.8%	90.3%		95.8%	95.5%	96.2%

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

NHSE Segmentation Indicator

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Growing Stronger Together Summary: All

Latest Indicator Period: Aug-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Turnover rate with no exclusions	Aug-25	11.2%	-	-	11.5%	11.0%	11.9%
Vacancy rate	Aug-25	5.4%	7.7%		6.8%	4.7%	8.8%
Turnover rate	Aug-25	9.0%	12.0%		10.8%	10.4%	11.1%
Sickness absence rate (rolling 12 months)	Aug-25	4.1%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	Aug-25	95.3%	85.0%		76.6%	40.4%	112.9%
Sickness absence rate (in month)	Aug-25	3.9%	3.1%	No	4.2%	3.3%	5.1%
Core skills training compliance	Aug-25	93.0%	85.0%		90.6%	88.7%	92.4%
Time to hire (average days)	Aug-25	45.6	53.0		49.2	37.1	61.2

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Sept-25	-6959.7	-	-	-5075.6	-8053.8	-2097.3
BPPC £ %	Sept-25	58.5%	95.0%	No	79.9%	73.1%	86.7%
BPPC Volume %	Sept-25	28.5%	95.0%	No	63.8%	55.9%	71.7%
Cash £'000	Sept-25	32168	3066		28955	5948	51962
Efficiency delivery £'000	Sept-25	10180.0	10961.0	No	6009.7	-763.3	12782.8
Elective recovery funding (ERF) value-weighted activity % In month	Mar-25	101.9%	-	-	102.1%	91.6%	112.5%
In-month financial performance Surplus/Deficit £'000	Sept-25	3181.0	3180.0		-575.1	-12176.7	11026.5
In-month ICS CDEL capital expenditure	Sept-25	1692.1	3807.5	-	3274.0	-7506.6	14054.5
Year-to-date financial performance Surplus/Deficit £'000	Sept-25	-6696.5	-6968.0		-14235.4	-23822.7	-4648.0

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

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Sept-25	91.9%	95.0%	No	91.0%	89.3%	92.8%
Data Security & Protection Breaches	Sept-25	30	-	-	28	8	47
Externally reportable ICO incidents	Sept-25	0	0		0	-	-
All IG reported incidents	Sept-25	33	-	-	30	12	47
Freedom of Information (FOI) % responded to within target tim	Sept-25	74.4%	80.0%	No	58.2%	32.9%	83.5%
Data Subject Access Requests (DSAR)	Sept-25	71.4%	80.0%	No	70.7%	51.3%	90.1%
Priority 1 Incidents	Sept-25	0	0		1	-	-

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

Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Sept-25	21	-	-	20	4	35

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

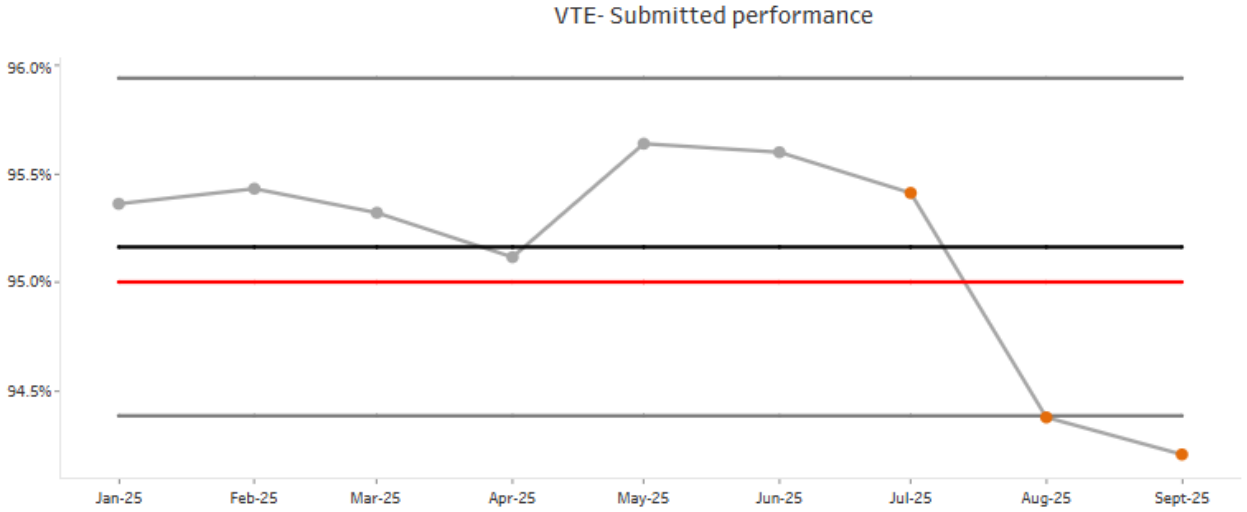
Latest Indicator Period: Sept-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Sept-25	0	0		0	-	-

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

03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks

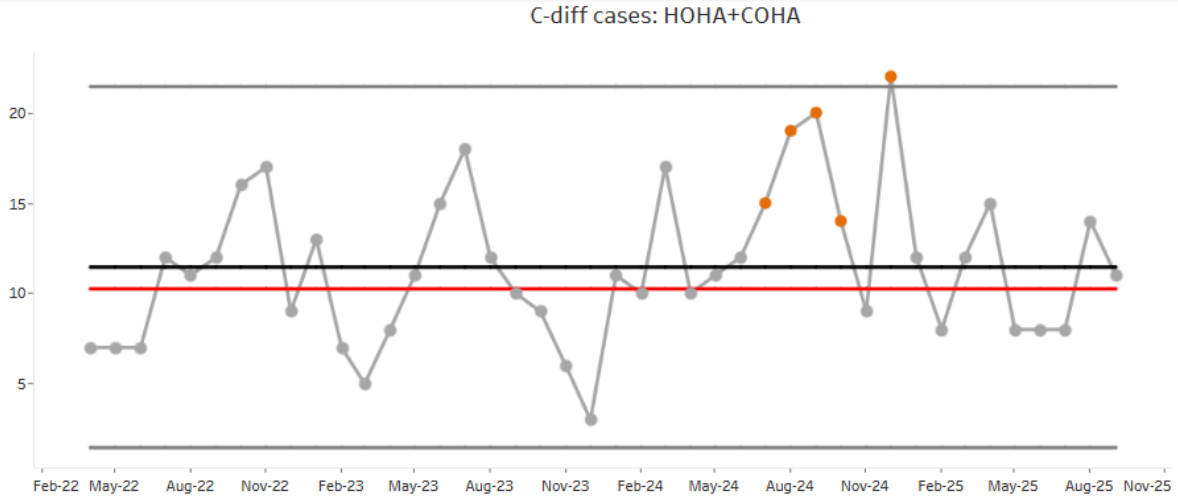
The national target in the NHS, is for at least 95% of all admitted patients aged 16 and over to receive a VTE risk assessment within 14 hours of admission (NICE NG89). Mandatory data collection was reinstated in April 2024 (after a pause during COVID-19).

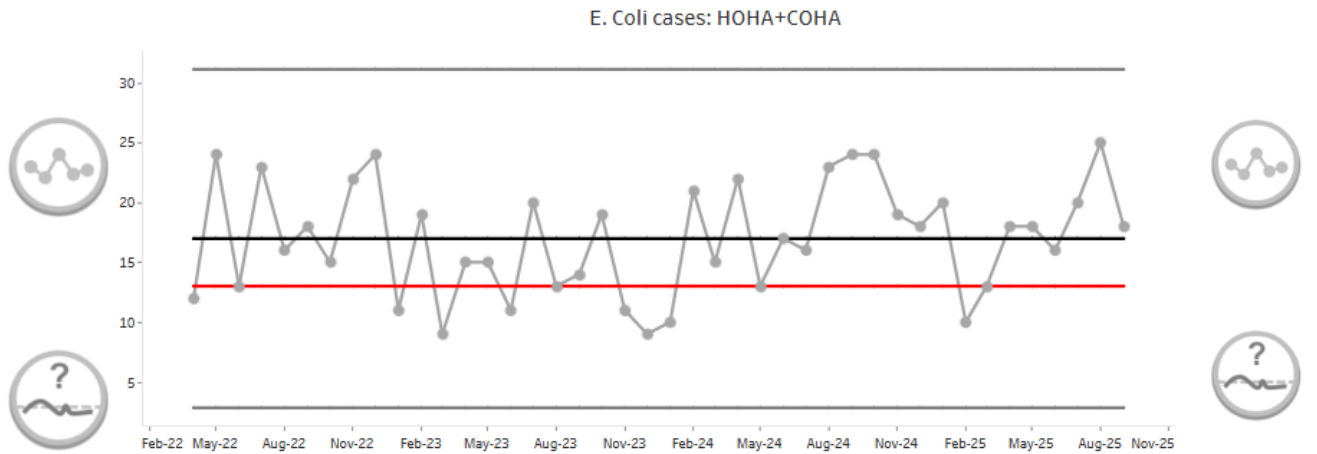
In September OUH compliance fell just below the national target of 95% to 94.2%.

Delayed VTE risk assessment and prophylaxis represents a greater risk of a patient developing a potentially preventable Hospital Associated Thrombosis (HAT). Pharmacological VTE prevention reduces the risk of VTE by about 50% (variably depending on patient cohort). The later a patient receives their pharmacological therapy, the higher the risk of a HAT.

Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
VTE risk assessment compliance is just below the 95% target for September. A Trust wide action plan is being developed by the VTE team with support from the CMO office. In additional, all the clinical Divisions have been asked to review and address performance. Divisional actions are summarised below:	All Divisions report progress to CGC		
MRC – 90.1%. There are several actions being taken to improve performance: Governance & Oversight – VTE risk assessment compliance is a standing item on all directorate and local governance meetings; Targeted projects & Reviews – AMR have proposed a project to identify barriers to VTE compliance, Cardiothoracic are reviewing process issues in Cardiac Angiography suite; Education & Communication: doctors' induction; the need for repeat VTE assessments when patient transfer between wards; Data Quality & Reporting: COO and VTE prevention team communication to improve the accuracy of compliance reporting, and review of data anomalies.	Divisional Meetings and CD support for each Directorate. Data will be scrutinised to see if this method is working.		
NOTSSCAN- 96.9%. Except Ophthalmology all directorates are below the 95% target: Trauma & Orthopaedics: 87.7%, Specialist Surgery: 88.3%, Children's: 79.8%, and neuroscience 93.4%. The DMD is collaborating with directorate and divisional colleagues to develop and distribute an educational video for all doctors emphasising the clinical importance of early VTE assessment, prophylaxis and prescription using case studies to illustrate the impact of non-compliance. Monthly Directorate Governance meetings have been instigated with the DMD, where improvement plans are presented with incremental PDSA cycles.	Collaboration with Haematology to improve dose management		
SUWON- 97.3%. The Division is compliant with VTE risk assessment when including cohorts, but not when excluding them, mainly due to Endoscopy patients being included in VTE performance data. These patients are usually day cases and should be excluded, but some are flagged as non-compliant due to late discharge. The system marks them as non-compliant before the discharge date is corrected. Action: The Matron has contacted the Performance Team to amend the Endoscopy cohort and exclude these patients from the data. Manual checking and review of missed assessments are being used in the meantime, with better results seen by early October.	VTE Task group		
Maternity directorate – 79.2% recorded in Orbit, work ongoing to validate the data reported for this metric and to align Badgernet and Orbit. New VTE guidance was approved in August 2025, but digital pathways need to be confirmed prior to launch. Parallel audit ongoing to assess compliance and accuracy of VTE assessment and thromboprophylaxis prescriptions in maternity. A maternity Safety Message has been issued 08/10/25.	Maternity Governance meetings Divisional Governance meeting		
CSS- 93.2%. Compliance dropped in September in Radiology from 99% to 95.7%. Action taken includes adding VTE risk assessment to the day case admission checklist at CH/NOC sites to prevent future omissions. Standing agenda item on Radiology Clinical Governance meetings.	Interventional Radiology M and M meeting		

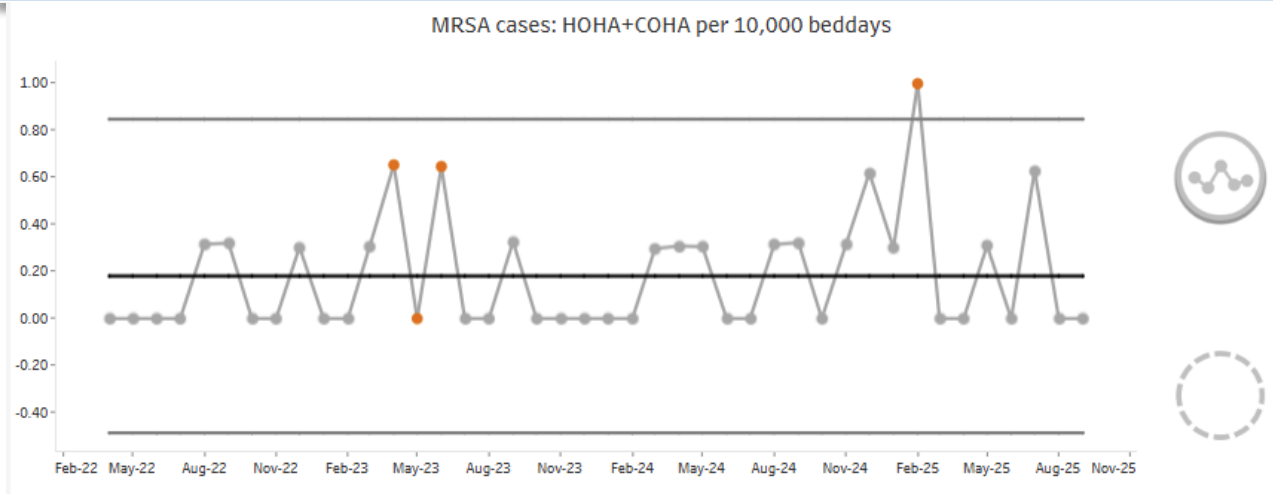
3. Assurance report: Quality, Safety and Patient Experience

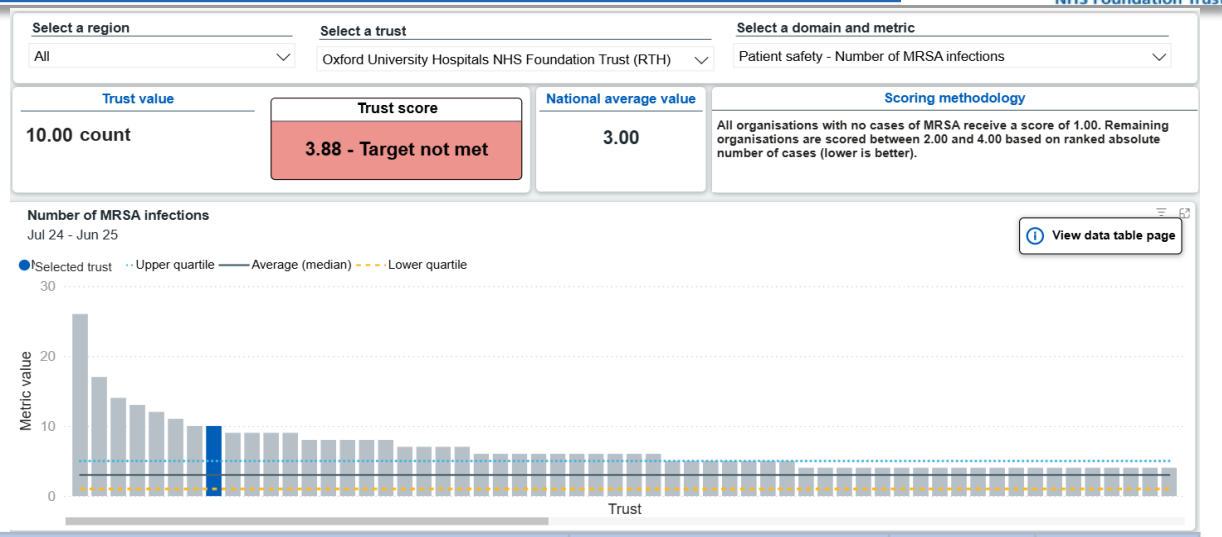




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MRSA Bacteraemia – see next slide. **E. coli bacteraemia** – We have seen 16 more cases than seen by the same time last year and are 32 cases above our cumulative limit for September 2025. **C. diff infection** – Our position is 21 cases lower than at the same time last year, with reductions in broad-spectrum antibiotic use a likely contributor to the decline; however we remain 4 cases above our cumulative limit for September 2025. **Safe Water Management** – some progress with closing 2019 Churchill PFI SIRI actions since August 2025 and an updated SIRI action tracker has been received. All outlets continue to have point of use filters (POUF) fitted and a surveillance period is in progress.	**Staffing –** Successful recruitment of substantive IPC lead nurse / manager in July; the new appointee started on 13th October. **E.coli - a recent publication from our colleagues in t**he National Institute for Health Research Health Protection Research Unit in Healthcare Associated Infections and Antimicrobial Resistance at the University of Oxford showed that *E. coli* bacteraemia's are largely driven by known risk factors and frailty, highlighting the importance of monitoring these factors and targeting modifiable risks where possible. **IPC Surveillance** – the lack of an IPC surveillance system remains high-risk on the Trust Risk Register. The OUH Digital Engineering service launched a web-based information management system to provide partial mitigation in May; progress has been slow and it is not yet providing a comprehensive / reliable alert system. Funding is required for a commercial IPC surveillance platform which will need to go through the business planning process.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

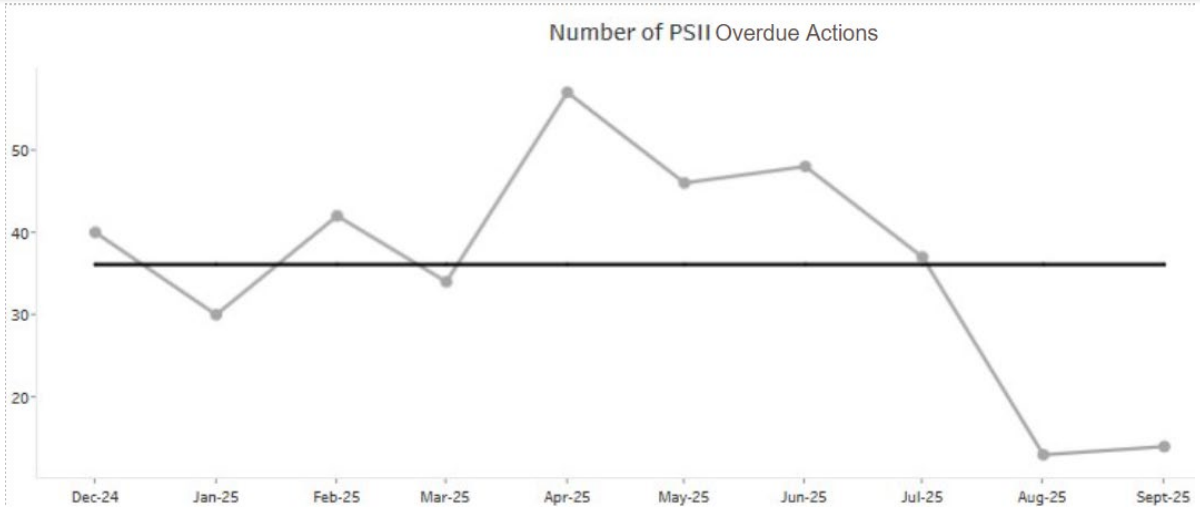
3. Assurance report: Quality, Safety and Patient Experience

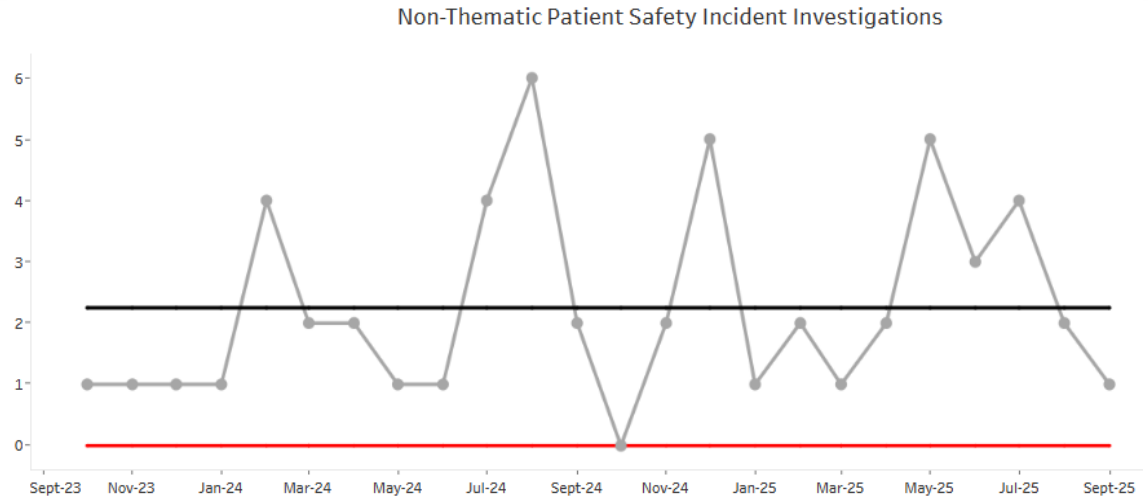




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MRSA Bacteraemia – There were no cases of healthcare-associated MRSA bacteraemia in September 2025. July 2024 – June 2025 there were 8 cases of MRSA bacteraemia. This takes account of 2 cases that have been re-classified as community onset after review of the decision to admit time which is part of the case definition. This correction of the data has not yet been reflected in the NHS Oversight League Table of acute Trusts (see figure above) which was published prior to the correction.	A task and finish group has been created to transition from single site (nose) screening for MRSA to multi-site swabbing (nose, throat, axilla, groin) to improve detection rates of MRSA colonisation from around 50% to over 90%. This proposal is aimed at reducing hospital associated MRSA bacteraemia cases and MRSA surgical site infections by enhanced surveillance and MRSA decolonisation. A thematic analysis of all MRSA bacteraemia cases over the last 3 years has highlighted areas in the Trust for further investigation and potential quality improvement work.	Aim to have multi-site MRSA screening in place across the Trust in Q4 2025/26. Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

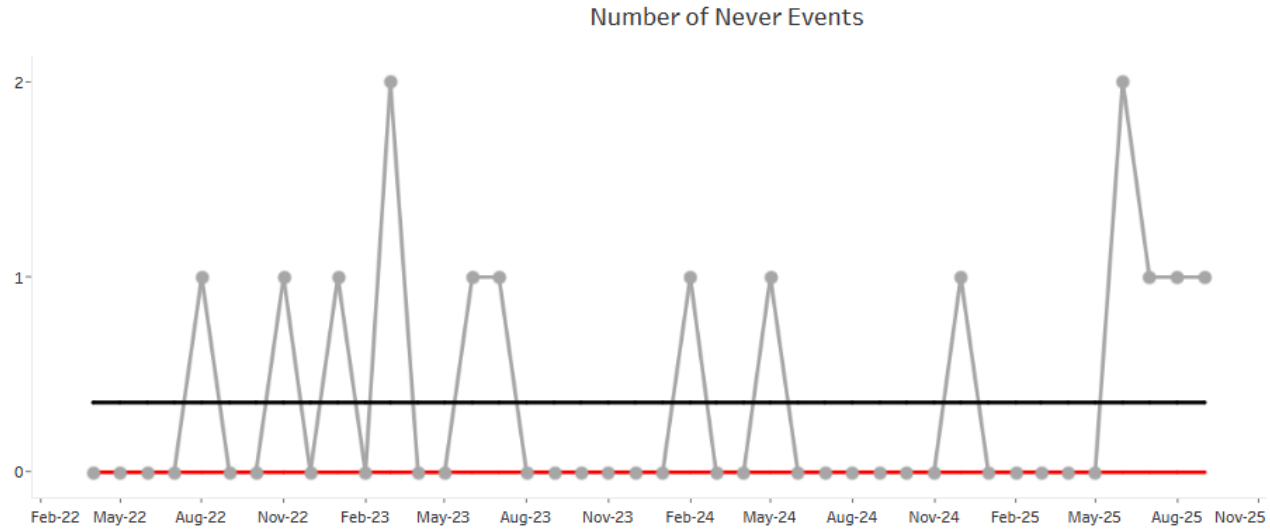
3. Assurance report: Quality, Safety and Patient Experience



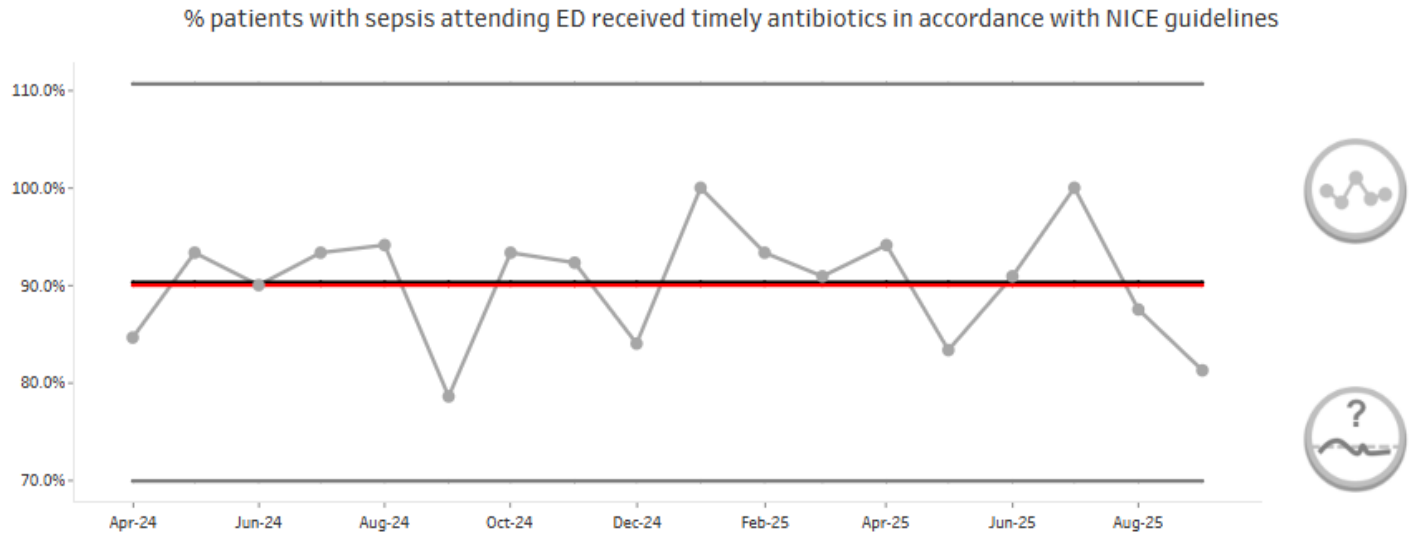


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
One new non-thematic PSII was confirmed in September. It is a Never Event detailed on the following slide. The learning and improvement will be shared once the PSII has concluded.	A total of 53 non-thematic PSIIs have been confirmed since the launch of PSIRF in October 2023 (excluding any subsequently reclassified), 26 (49%) of which have been fully completed and a final report circulated. Actions are underway to improve the timeliness of PSII completion and to ensure learning is implemented and improvements in safety can be demonstrated. A standard target timeframe for completing PSII investigations was agreed with the CMO in October. The number of overdue PSII actions is sourced from the Divisional papers at the monthly Clinical Governance Committee (CGC) meetings. From October 2025 there will be a monthly discussion amongst Divisional governance staff of those actions which are to be undertaken by staff from a Division separate from that which oversaw the PSII process.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. A quality improvement project has been created to address this. The PSII process is monitored by SLIC with CMO/CNO having responsibility for sign-off of final reports, following reviews by Divisional management, Patient Safety, Head of Clinical Governance, and DCMO. Challenges relating to actions arising from PSIIs are reported to CGC, and in August 2025 a total of 13 PSII actions were overdue, the lowest total since CGC started tracking this (Trustwide data was not available at the September meeting)	BAF 4 CRR 1122	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Quality, Safety and Patient Experience

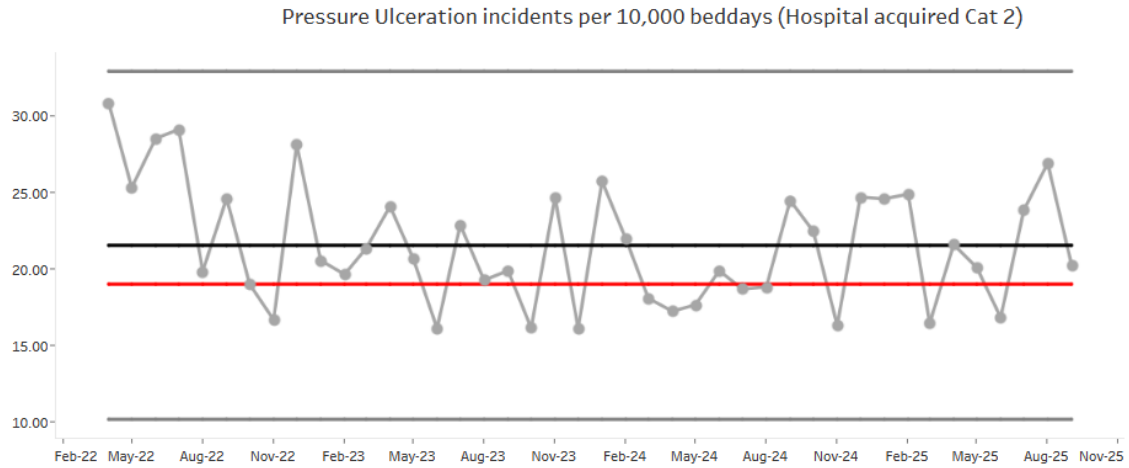


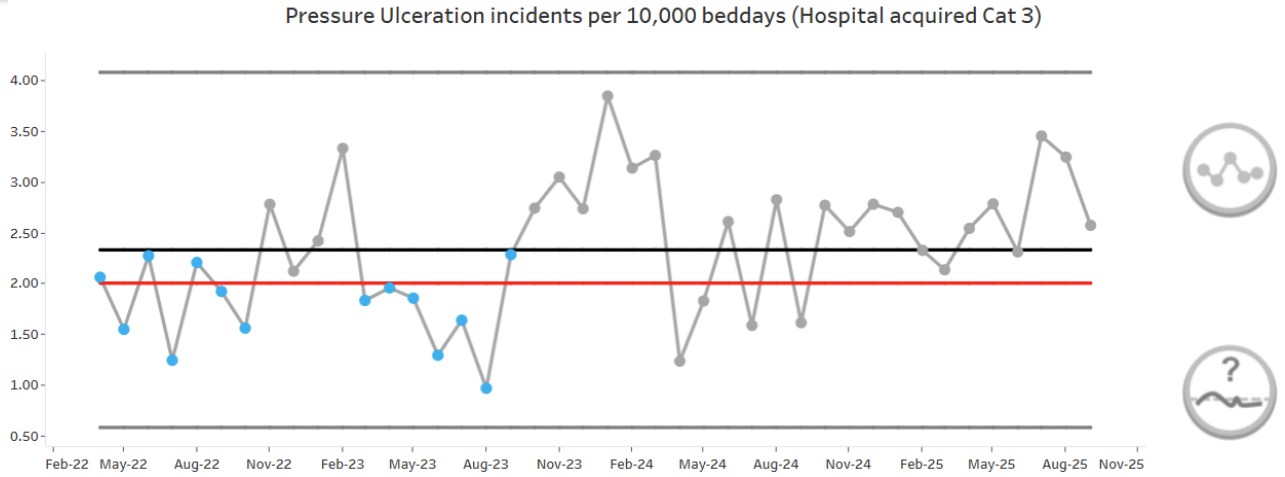
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
One Never Event was raised as a PSII in September. This concerned a patient with glaucoma who received laser surgery to the right eye instead of the left eye as planned (Wrong Site Surgery). The intended left eye was treated immediately afterwards. The doctor apologised and explained that the treatment delivered to the right eye would not cause harm.	Immediate actions taken or planned to address the risk of the wrong eye being injected include: • From 10 September all doctors undertaking laser eye treatment are required to mark the patient's forehead to indicate the intended eye in conjunction with consent, clinical management plan and WHO checklist • Local WHO checklist variant to be amended to include a requirement to confirm that the equipment is set up for the intended laterality • A clinical support worker "runner" role is being considered for laser clinics, who can ensure that WHO checklists are addressed prior to treatment • Review of the volume of planned activity, exploring methods to reduce footfall in the department • An *Ophthalmology Improvement Group* is also being established, chaired by the CMO, to provide oversight, assurance and support in reviewing and strengthening the ophthalmology service to ensure patient safety and clinical effectiveness; good patient and staff experience; workforce planning, supervision and training; and good governance and assurance.	Timetables for completion of these investigations and associated reports are set with the lead investigators.		



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
September Sepsis Performance: In September 2025, 13/16 (81%) of patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines (NG51). Of these patients 3 patients who met the high-risk criteria had a delay in receiving their antibiotics. It is important to note that the data set reviewed comprised a small number of cases, meaning any single deviation from the sepsis 6 one-hour standard has a disproportionate impact on overall compliance.	A detailed review was undertaken of two high-risk sepsis cases in which antibiotics were not administered within the recommended one-hour timeframe. The following contributory themes were identified: • **Delay in prescription:** In the three cases, there was a delay in the prescribing of antibiotics, likely linked to a delay in medical review. • **Timing of presentation:** All instances of delay presented after the sepsis team's working hours or over the weekend, meaning no specialist support was available. This indicated that reduced staffing or response capacity may be a contributing factor. • **Delay in administration:** In some of the cases there was a delay between prescription and administration. Current Trust guidance recommends that antibiotics for sepsis should be administered within **15 minutes of prescription**; potentially due to communication gaps between the prescribing clinician and the nursing team.	Ongoing review with monthly audit. Report to AGM clinical governance meetings each month The Sepsis Team continue to screen and review patients within working hours (07:30-5pm), supporting the front-line service with delivery of the sepsis care bundle as needed. The importance of communicating the prescription to nursing staff is being emphasised in teaching. Bespoke training to be provided to A&E registrars in October to reinforce timely recognition, escalation, and management of sepsis.		

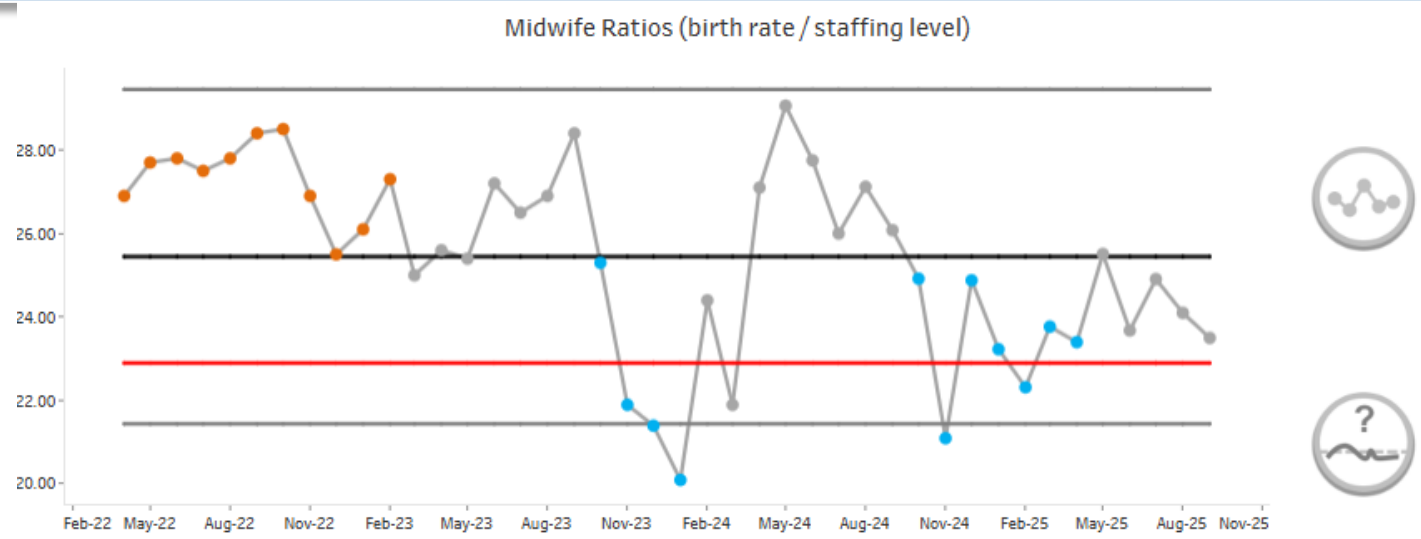
3. Assurance report: Quality, Safety and Patient Experience





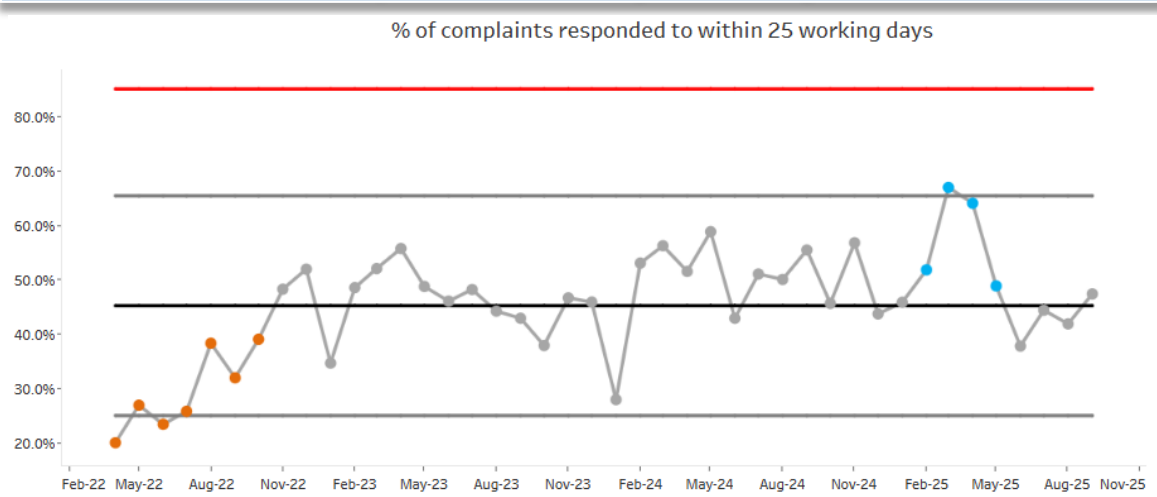
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Trust continues to demonstrate a proactive and data-informed approach to the prevention and management of pressure ulcers. In September 2025, the data indicate a decrease in Hospital Acquired Category 2 pressure ulcer incidents from 80 in August to 63 in September, which is a decrease of 17. There were 8 incidents of Hospital Acquired Category 3 in September, matching the number reported in August. 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. • Compliance with monthly pressure ulcer prevention audits remains above the scoring target, with all eligible inpatient areas demonstrating a 93.3% compliance in September (up from 92.7% in August). • 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.	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*

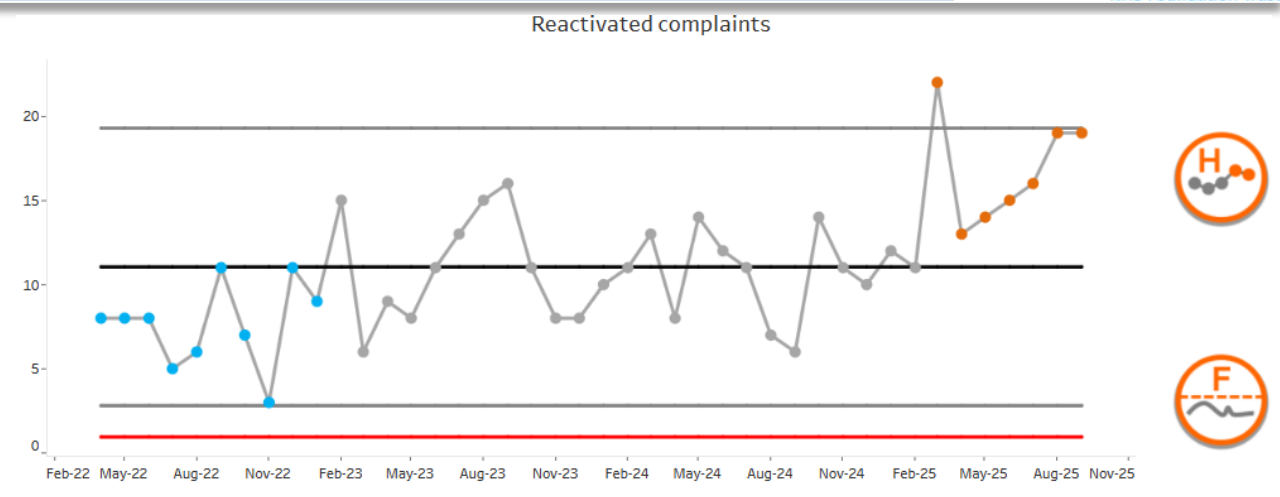
3. Assurance report: Quality, Safety and Patient Experience, *continued*



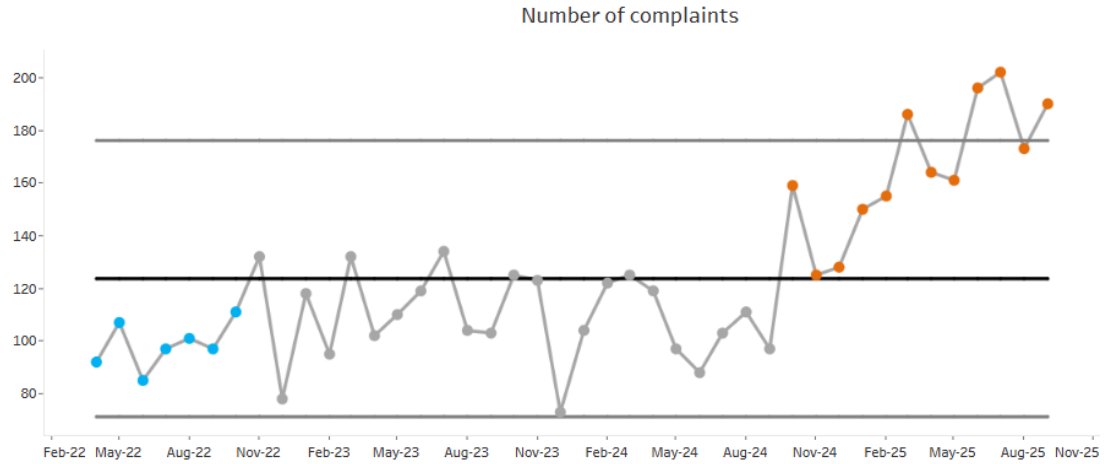
Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
In September 630 mothers birthed at OUH, 51 more than the previous month The midwife to birth ratio was 1:23.5 which is above the Birthrate Plus recommendation of 1:22.9 and inclusive of all NHSP vacancy/unavailability backfill spend and clinical hours allocated by specialist roles. There were no reported occasions in August when 1:1 care was not provided for women in established labour. Unavailability remains a challenge for the service with a current 28.41 wte (8.6%) on Maternity leave. This is predicted to peak to 32.17wte (10.1%) in Q3 2025/26 which is at the peak of high activity for the service.	The service continues with a robust recruitment and retention plan to align with the recommended Birthrate Plus uplift, address staff retention; optimise rostering KPIs and reduce NHSP spend. The service has offered 25.08 WTE Band 5/6 midwife positions all starting in post between September and November, with interviews ongoing to cover a proportion of the 28.41 WTE maternity leave. Additional adverts are due out, and targeted recruitment is in progress. These actions align with national plans to support this year's newly qualified midwives through a rapid graduate programme. Daily staffing meetings aligned to Trust safe staffing meetings continue, to monitor and enable tactical responses to mitigation and trigger escalation as required and ensure safe staffing across the service. Maternity safe staffing % fill rates improvement plan continues in collaboration with the Trust Safe Staffing team, this includes a weekly review of accuracy of planned V's actual fill rates and a tactical staff education programme. An upward improvement trajectory is noted for August. Further controls for NHSP authorisation now implemented for agreement at Matron level and above only. Additional community night on-calls are now consistently rostered in addition to the hospital on-call roster. Cross service review commissioned of all short and long term sickness management and return to work processes to assure alignment to new absence policy.	Ongoing workforce plan to monitor: ➢Recruitment to birthrate plus uplift including divisional approval to recruit into maternity leave ➢Staff retention strategies ➢Reduction of NHSP spend. Positive trajectory towards full recruitment by November 2025. Weekly monitoring of: ➢Accuracy of Safe Staffing fill rates ➢Community on-call hours required ➢Community based births ➢NHSP spend Quarterly Maternity Safe Staffing assurance paper submitted via Maternity Clinical Governance Committee to Board, aligned to Maternity and Perinatal Incentive Scheme compliance.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

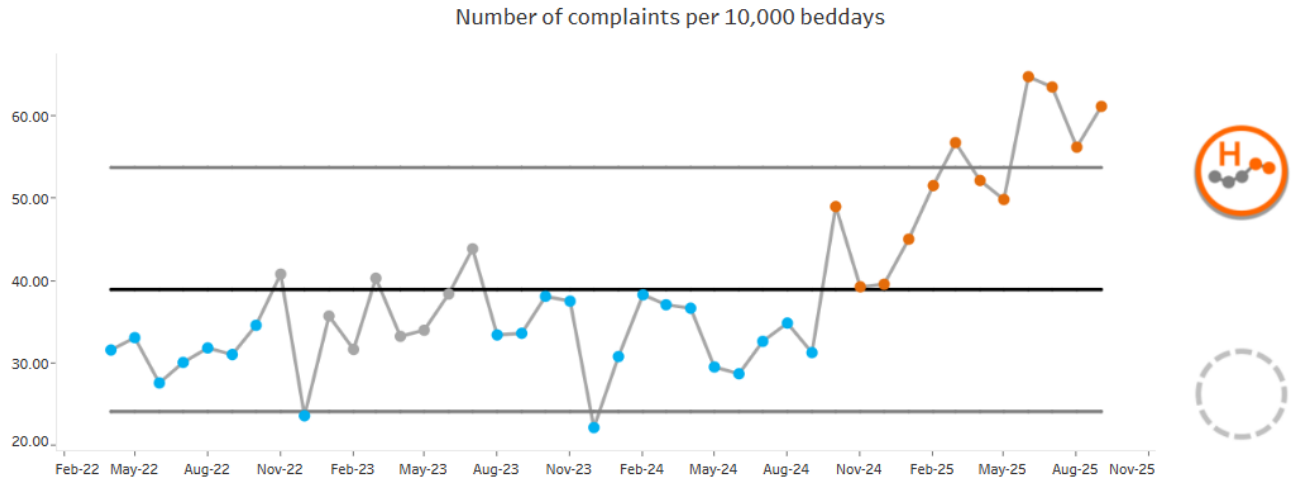
3. Assurance report: Quality, Safety and Patient Experience, *continued*





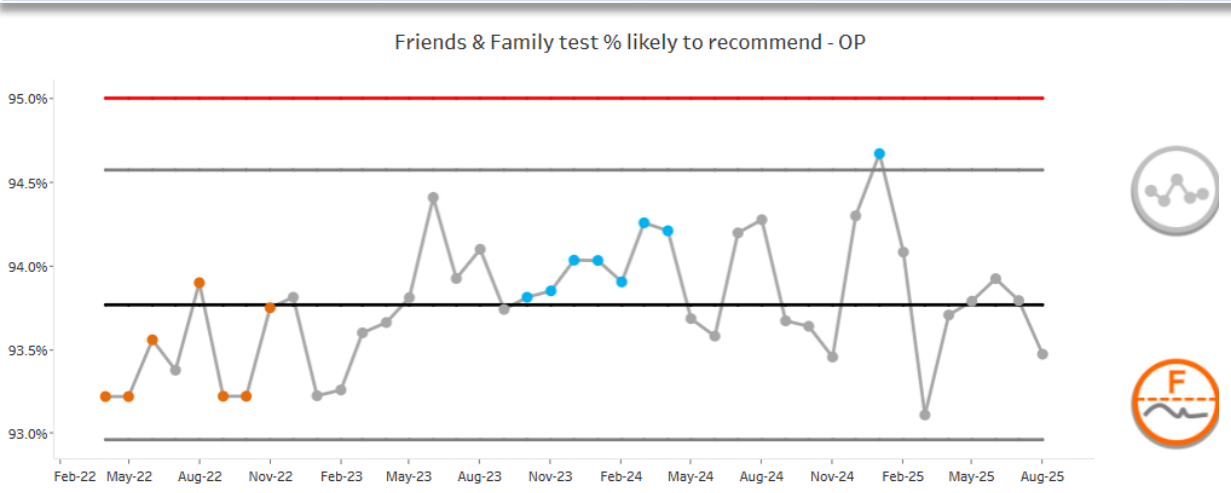
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2025, OUH received a total of 190 formal complaints continuing the special cause variation (shift) and contributing to ongoing challenges with meeting the 25-day KPI.	The Trust received 190 complaints in September, which is a 9% increase from August, when 174 complaints were received. In September 19 complaints (10%) were reopened cases from previous complaints requiring further investigation and/or requesting to meet with senior staff to discuss the findings of the complaint investigation. The Trust continues its 8-year record of no complaint fully upheld by the Parliamentary and Health Services Ombudsman, which is, in part, due to the willingness of the Trust to work with the complainant to reach a satisfactory resolution and reflects the high-quality investigations occurring within the divisions. Compliance with the 25-day KPI increased from 42% in August 2025 to 47% in September 2025. In total, 178 complaints were successfully closed in September, compared to 156 in August. A weekly report detailing all open complaints with a breakdown of compliance with time-related targets for each of stage of the process continues to be circulated to the divisions to facilitate prioritisation and timely progression of their respective complaints. Additionally, weekly meetings are held with the Divisional Directors of Nursing who work with the Clinical Leads and Divisional Medical Directors to escalate complaint cases that are in breach. The Head of Patient Experience, Complaints and Patient Services Manager and Informatics Lead have begun work to analyse the known bottlenecks within the complaints investigation process with a view to identify process improvement opportunities. Additionally, the Head of Patient Experience, Complaints and Patient Services Manager and the Divisional Directors of Nursing will be working together to discuss further improvements to the process. Alongside this, work is being undertaken in conjunction with Microsoft to develop an agent that will support the initial summary of the complaint, allowing investigators a clearer steer on the concerns raised in each complaint and supporting a better way to understand the time required to complete the investigation.	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*

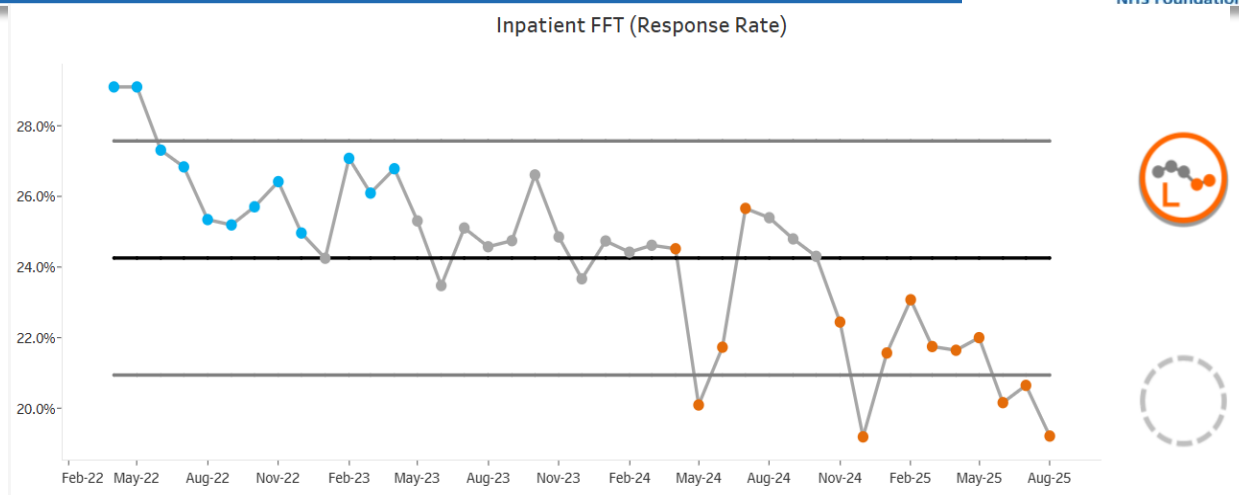




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Continuation of this trend in the volume of patient complaints will result in challenges in organisational capability to meet the 25-day KPI.	190 complaints were received in September, the top five categories of these complaints were: Clinical Treatment (n=43/23%), Communications (n=43/23%), Patient Care (n=23/12%), Appointments (n=18/9%) and Values and Behaviours (n=16/8%). The categories remain consistent with previous months. The Complaints team continue to work with the Divisions to understand the key drivers behind these themes and to facilitate identification of improvement opportunities to enhance patient experience and reduce complaints with known causes.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

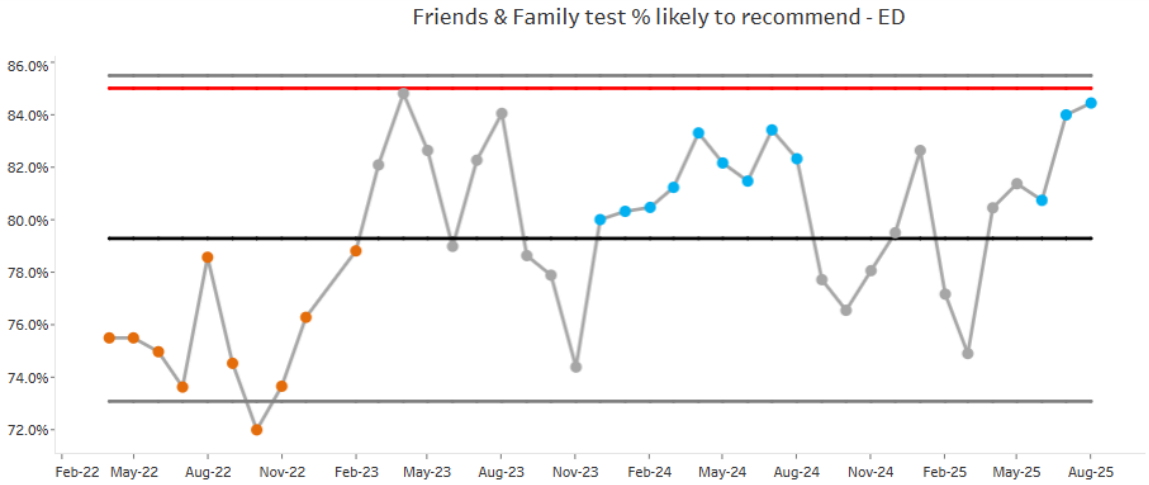
3. Assurance report: Quality, Safety and Patient Experience, *continued*

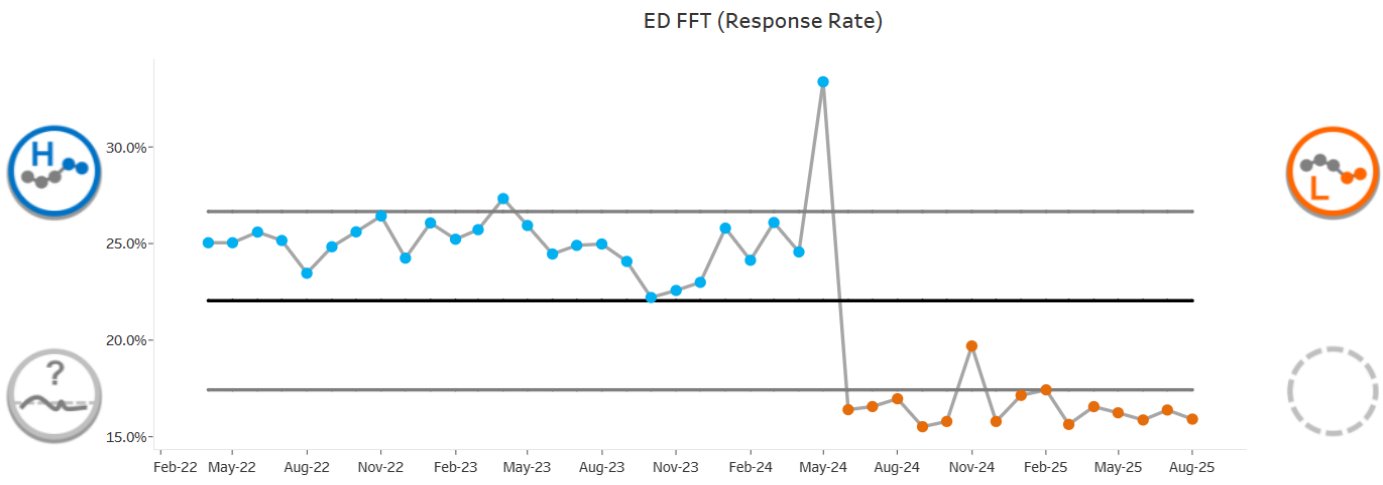




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses accounted for 11,587 of the total responses received, and the recommend rate has increased to 93.8% in September, compared to 93.5% in August. 2. The top positive themes during September for outpatients were staff attitude, implementation of care, and clinical treatment. The top negative themes were waiting list, cancelled admission / procedures and discharge. 3. Inpatient responses accounted for 3,198 of the total responses received, and the recommend rate has increased to 95.7% in September, compared to 95.2% in August. 4. The top positive themes during September for inpatients were staff attitude, implementation of care and admission. The top negative themes were car parking, discharge and waiting time.	1. A dashboard for FFT is being developed by the performance team. 2. Each division presents an update on patient experience, including FFT data and themes at the PE forum monthly. 3. A deep dive into FFT over an 18-month period was undertaken to look at specific areas that need support with increasing response numbers and recommend rates. The responses showed an overall 93% approval rate across all Divisions, and 4% disapproval rate. The highest volume of responses were collected in MRC, and the highest approval rate was in CSS. 4. SMS has been the main method of FFT collection, accounting for 88% of all responses, and is the most widely used across all Directorates. Online collection methods, including QR codes on flyers and posters, have been the least used, accounting for just 1% of all responses. 5. Further work to promote online collection methods will be undertaken.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Family Carer Forum, [PEFC] 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*

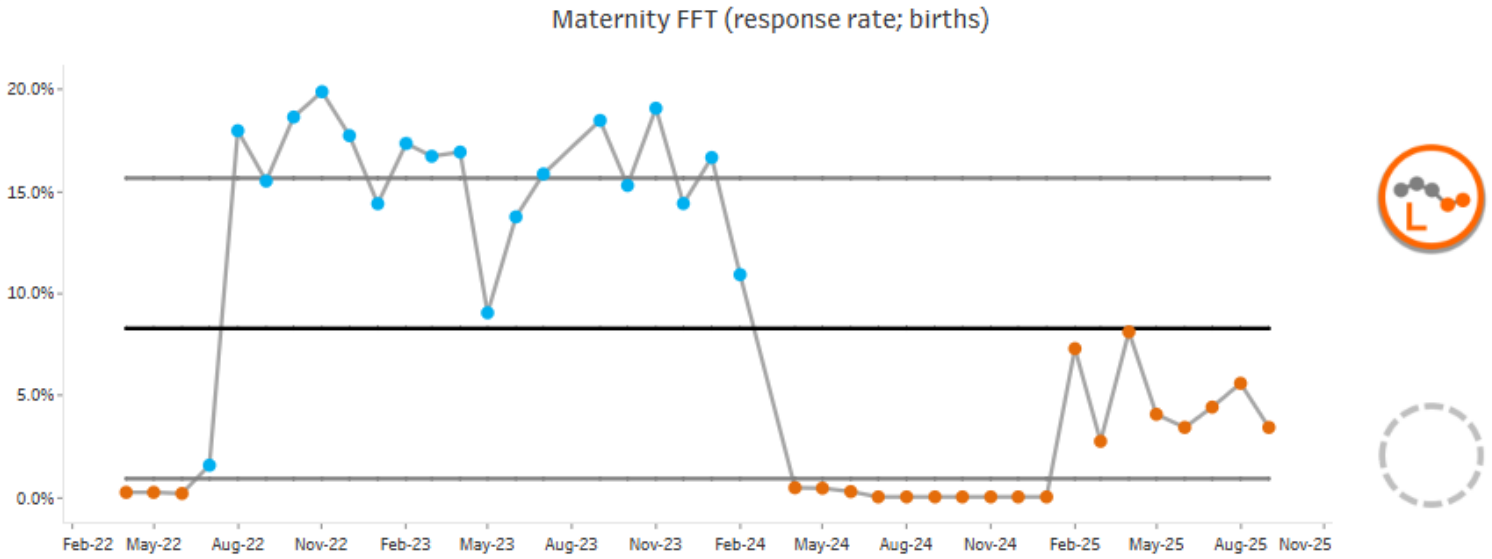
3. Assurance report: Quality, Safety and Patient Experience, *continued*





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. ED response numbers were 1311, with a positive recommend rate of 81.2% in September which has decreased in comparison to 84.4% in August. 2. The top positive themes during September for ED were staff attitude, waiting list and implementation of care. The top negative themes were discharge, catering and cancelled admission / procedures.	1. A dashboard for FFT is being developed by the performance team. 2. Each division presents an update on patient experience, including FFT data and themes at the PE forum monthly. 3. A deep dive into FFT over an 18-month period was undertaken to look at specific areas that need support with increasing response numbers and recommend rates. The responses showed an overall 93% approval rate across all Divisions, and 4% disapproval rate. The highest volume of responses were collected in MRC, and the highest approval rate was in CSS. 4. SMS has been the main method of FFT collection, accounting for 88% of all responses, and is the most widely used across all Directorates. Online collection methods, including QR codes on flyers and posters, have been the least used, accounting for just 1% of all responses. 5. Further work to promote online collection methods will be undertaken.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Family Carer Forum, [PEFC] 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 group or committee	Risk Register	Data quality rating
1. Maternity response numbers for September were 354, which shows is an increase in comparison to 243 responses in August. 2. Antenatal had a 84.6% positive recommendation rate, which has increased in comparison to 82.8% in August. 3. Birth had a 96.2% positive recommendation rate which has increased in comparison to 92.5% in August. 4. Postnatal Ward had a 91.8% positive recommendation rate which is consistent with August figures. 5. Postnatal Community had a 100% positive recommendation rate which has remained the same in comparison to August, however, this is attributed to only 3 responses.	1. Maternity FFT data has been challenging since the service transitioned to BadgerNet. This has resulted in the loss of SMS to push surveys out to service-users and relies on continuous promotion by staff to encourage service users to complete the surveys using QR codes or paper questionnaires. 2. The Maternity team have been working with Patient Experience to ensure accurate data is manually extracted and available to each clinical area for reporting and presentation purposes. 'Say on the Day' devices have been introduced to provide an additional platform to collect Patient Experience data and this is proving effective. 3. Plans are underway (under the Perinatal Improvement Programme) to enhance patient experience data and reporting through piloting a core question set allowing greater granularity and analysis of themes and trends, and through collaboration with clinical analytics to explore options to automate processes and enhance response rates, improving reliability and validity of FFT data reporting.	1. Stakeholder identification and working group meeting to explore automation, reintroduce SMS methodology and enhance data reliability and improve response rates to commence in November 2025. 2. New infographic template for reporting and presentation of FFT data available from end October 2025. 3. Additional survey questions for piloting to be rolled out by December 2025		

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

Oxford University Hospitals NHS Foundation Trust

Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level. It is an NHSE requirement for this to be reviewed by Trust Boards each month. The NICE Safe Staffing guidelines inform the nurse-sensitive, paediatric, and maternity-sensitivity indicators summarised below.

Nursing and midwifery staffing is reviewed at a Trust level twice daily and was maintained at Level 2 (Amber) throughout September 2025. The exceptions were: Paediatric Critical Care Unit (PCCU) level 3 for one-night shift; Neonatal Unit level 3 for one night shift, both were mitigated to make the units safe by implementing team nursing supported by the other Critical Care Units; Children's directorate on one night shift, mitigated by reducing capacity for the shift, and MRC division level 3 on six late shifts. These shifts were closely monitored by Senior staff. The Trust-wide planned versus actual fill rates were 93.45% for day and 97.7% for night shifts. Where fill rates were less than 90%, all shifts were reviewed, reported, and mitigated by a Matron or above at the safe staffing meeting, and shifts were not left at risk.

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

Staffing levels for nurses and midwives, including nurse-sensitive indicators, are consistently reviewed and validated with divisional directors of nursing (DDN) and deputy DDNs. Each monthly review triangulates all relevant data in accordance with National Quality Board standards and assesses whether these nurse-sensitive harm indicators are directly related to staffing levels. The September review confirmed across all divisions that there were no instances of nurse-sensitive harm indicators directly linked to nursing or midwifery staffing levels. The HR data is being reviewed, as following amendments to budgets, based on M11, the data is inaccurate. Divisions will work with HR and finance teams to ensure budgets are aligned with safe staffing requirement following the establishment reviews and CNO approval. It is anticipated the data will be updated and accurate by October 2025.

SUWON – Rostering KPI's- two wards were not approved for payroll; however, this is not usual for these wards, and the DDN is following up with the relevant Matron to ensure cover is in place if unexpected absence occurs. Upper GI ward has a net hours difference outside of the KPI, related to RAF staff and students. Both SEU-F and Wytham wards also have net hours difference relating to student hours. Red flags not reviewed has been addressed by the DDN. Some wards have low annual leave update, however, assurance given that staff are on track with using leave.

MRC – The rostering KPI's for the division are good, except three wards not approved for payroll. This is not a recurring issue for these wards, the DDN will follow up to ensure any unexpected absence is covered. There are more open red flags than normal, reflecting the ward managers working clinically more frequently to mitigate staffing shortfalls. The DDN will follow up with Matrons to ensure the remaining open flags are reviewed. There were no concerns that the nurse sensitive indicators reported, related to unsafe staffing.

NOTSSCAN – Some wards CHPPD was slightly higher than required due to lower activity over the summer months. Staff were redeployed whenever possible. The open red flags have now been reviewed and updated. Four wards not approved for payroll. This oversight is being addressed by the DDN to ensure when the Matron is off, cover is in place. Roster efficiencies and KPI adherence are being closely monitored by the DDN. Although an improvement on last month, fill rates of less than 90% were again seen for some wards. Education continues for the ward managers on the importance of updating rosters and cancelling unrequired shifts.

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

CSS – There were no issues or concerns for the month of September..

Maternity –

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

Recruitment
Following the recent budget allocations, there continues to be some discrepancies between the vacancy data and the ledger. However, the divisions have worked closely with their finance teams to ensure staffing numbers are aligned with safe staffing requirements following the recent establishment reviews, and finance will now commence work to reconcile the Ledger. Once this is complete work will start to align ESR with the Ledger and in turn the roster templates.

There continues to be a strong pipeline of recruitment in all areas and this is closely monitored and maintained.

Vacancies
Following the budgets being set at outturn and CIPs applied, the finance ledger's data for ESR is inaccurate for vacancies in all areas. Work is ongoing to reconcile this for the nursing inpatient areas following the CNO establishment reviews.

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

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

Oxford University Hospitals NHS Foundation Trust

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

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

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

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

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

HR Vacancy: For the designated areas this figure is the establishment (Budget FTE) minus the contracted FTE in post as at the last day of the month. The vacancy figure is then divided by the establishment. The figures presented reflect both registered and unregistered staff. **Please note any change to staffing establishments recently agreed, have not yet been reflected in HR Data. Therefore, the vacancy reported is likely to be higher than it is**.

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

Please note that all data is taken at the last day of the month. This is how data is reported internally to Board and externally to national submissions. This ensures consistent reporting and assurance that the data is being taken at the same point each month for accurate comparisons to be made.

Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
The Trust has commenced developing actions tailored to improving roster efficiency and effectiveness in nursing and midwifery. This work will ensure a balanced skill mix during each shift. Assurance of ongoing oversight and assurance that nursing and midwifery staffing remains safe. Although CHPPD should not be reviewed in isolation as a staffing metric, and always at ward level. Reviewing it at Trust level triangulated with other Trust level financial metrics allows the Board to see where there are increased, capacity and acuity, (required) versus budget.	N	***Sufficient*** Information reported at required level. Staff appropriately trained and quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse workforce team monthly. External audit not undertaken in last 18-months.

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

Oxford University Hospitals NHS Foundation Trust

September 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs (11.8.25 - 7.09.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
NOTSSCaN																					
Bellhouse / Drayson Ward	8.95	10.53	9.8	94.44 %	-	-	-	-	2	0	0	0	24.02%	18.64%	2.85%	1.97%	25.52%	Yes	1.69%	8.29	15.17%
HH Childrens Ward	9.36	9.28	14.2	75.56 %	-	17	-	-	1	0	0	0	3.32%	7.88%	4.79%	12.46%	15.37%	Yes	-0.57%	8.14	11.70%
Kamrans Ward	7.67	10.84	9.1	100.00 %	-	12	-	1	2	0	0	0	8.76%	6.39%	1.66%	2.33%	10.89%	Yes	0.93%	8.29	13.88%
Melanies Ward	9.77	9.73	9.3	98.89 %	2	-	-	-	1	0	0	0	15.16%	12.83%	5.94%	3.61%	24.88%	Yes	0.53%	8.29	10.95%
Robins Ward	10.68	9.30	10.6	82.22 %	-	-	-	-	2	0	0	0	9.65%	26.02%	6.31%	3.94%	13.20%	Yes	-0.97%	8.29	12.01%
Tom's Ward	8.05	10.13	9.0	100.00 %	4	-	-	-	3	0	0	0	7.03%	0.00%	3.16%	6.72%	19.31%	Yes	-0.14%	9.43	14.50%
Neonatal Unit	19.92		16.4		-	-	-	-	9	2	0	0	19.54%	8.61%	5.97%	4.21%	26.12%	Yes	-2.79%	8.43	13.80%
Paediatric Critical Care	27.58		28.1		3	-	-	-	18	8	1	0	22.49%	7.22%	5.43%	5.60%	27.68%	Yes	1.66%	6.57	14.54%
BIU	6.27	5.92	8.1	100.00 %	-	-	-	-	0		0	3	6.60%	9.55%	3.29%	7.72%	13.81%	No	-1.27%	8.86	13.44%
HDU/Recovery (NOC)	9.04		18.0		-	-	-	-	1		2	0	8.78%	11.45%	7.18%	4.08%	16.23%	No	0.12%	9.43	10.53%
Head and Neck Blenheim Ward	7.29	7.59	8.5	97.78 %	-	-	-	-	0		0	1	14.74%	0.00%	1.74%	0.00%	14.74%	Yes	-0.61%	9.43	12.65%
HH F Ward	7.39	8.79	7.5	98.89 %	-	-	-	-	0		3	1	1.87%	4.10%	4.24%	0.00%	1.87%	Yes	-0.17%	9.86	15.50%
Major Trauma Ward 2A	9.12	9.01	8.8	91.11 %	-	3	3	-	4		3	1	15.94%	11.61%	4.20%	4.00%	20.96%	Yes	2.65%	7.86	10.99%
Neurology - Purple Ward	8.92	9.19	8.4	100.00 %	-	8	6	-	1		1	4	18.09%	11.90%	5.98%	2.98%	20.53%	Yes	1.97%	9.00	13.84%
Neurosurgery Blue Ward	8.94	9.61	9.2	100.00 %	-	4	1	-	0		0	6	6.58%	6.08%	3.25%	0.00%	6.58%	Yes	4.43%	8.00	15.07%
Neurosurgery Green/IU Ward	12.50	9.60	9.8	100.00 %	-	-	-	-	0		1	2	3.17%	6.03%	4.51%	2.49%	5.58%	Yes	1.58%	7.57	9.89%
Neurosurgery Red/HC Ward	12.30	11.84	11.8	100.00 %	-	4	-	-	4		0	0	2.02%	11.09%	4.56%	4.29%	8.77%	Yes	-0.10%	9.00	14.64%
Specialist Surgery I/P Ward	7.28	6.77	8.5	88.89 %	-	-	1	-	1		2	2	9.93%	2.58%	3.33%	6.29%	17.02%	Yes	1.46%	9.43	12.98%
Trauma Ward 3A	9.15	9.21	9.1	96.67 %	9	2	-	-	1		3	5	12.38%	9.89%	9.05%	4.25%	19.69%	Yes	2.98%	7.86	13.76%
Ward 6A - JR	7.52	7.08	7.6	97.78 %	-	12	-	2	1		2	4	-3.19%	4.74%	2.60%	4.27%	1.21%	Yes	1.99%	8.29	16.33%
Ward E (NOC)	6.30	6.77	8.2	95.56 %	-	-	-	-	1		0	2	-4.54%	5.71%	6.44%	2.69%	2.16%	No	1.71%	10.43	13.76%
Ward F (NOC)	6.65	7.28	7.3	96.67 %	-	-	-	-	1		1	3	2.66%	2.83%	4.92%	2.91%	5.49%	No	-0.36%	3.86	15.14%
WW Neuro ICU	28.11		34.7		-	-	-	-	2		0	1	-5.48%	9.29%	4.94%	5.64%	2.50%	Yes	-0.52%	7.86	14.74%

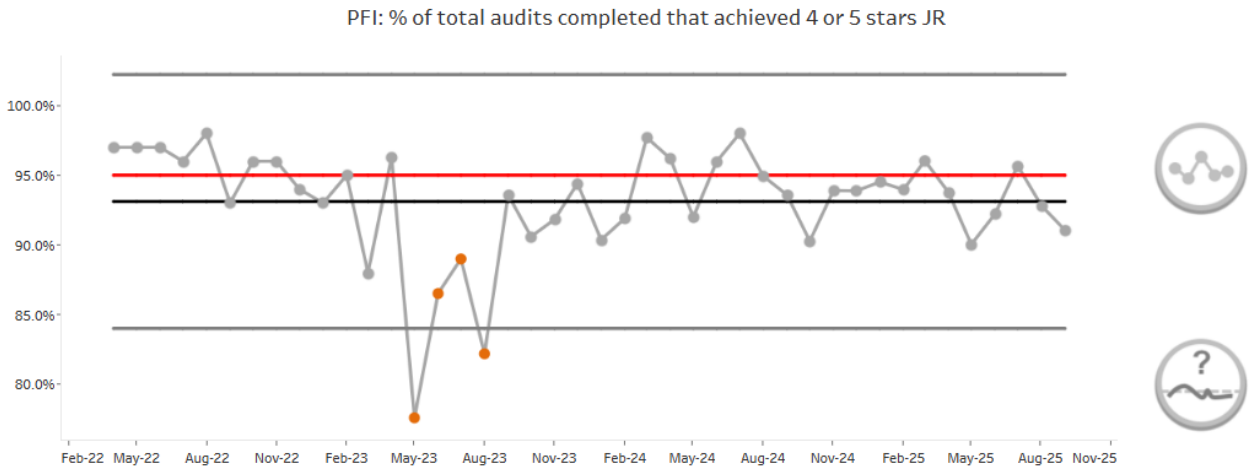
3. Assurance report: Safe Staffing - Dashboard: Part 1 (MRC)

September 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs (11.8.25 - 7.09.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
MRC																					
Ward 5A SSW	8.85	8.76	8.2	97.78 %	-	12	17	13	1		3	2	6.45%	7.93%	3.90%	6.61%	12.63%	No	1.74%	9.43	15.24%
Ward 5B SSW	8.88	8.71	8.1	97.78 %	13	4	1	1	5		0	5	10.28%	6.20%	3.47%	4.37%	14.21%	No	2.19%	9.43	13.04%
Cardiology Ward	7.85	7.23	8.5	98.89 %	5	9	3	3	2		1	4	12.69%	8.72%	6.97%	1.37%	15.67%	Yes	-0.34%	8.71	11.63%
Cardiothoracic Ward (CTW)	7.82	6.21	6.9	90.00 %	5	-	-	-	0		0	4	7.54%	3.07%	3.44%	2.36%	11.90%	Yes	0.75%	8.86	13.74%
Complex Medicine Unit A	8.94	11.04	8.2	92.22 %	12	-	2	2	0		2	4	5.37%	2.41%	8.81%	2.19%	14.64%	Yes	-0.58%	9.71	11.32%
Complex Medicine Unit B	10.15	9.4	8.9	97.78 %	1	-	1	-	0		1	1	-3.97%	6.11%	5.23%	2.29%	2.25%	Yes	2.40%	9.71	14.09%
Complex Medicine Unit C	8.75	10.42	8.2	98.89 %	6	-	1	-	0		2	1	8.87%	6.75%	4.07%	8.75%	16.84%	Yes	-0.20%	9.71	10.97%
Complex Medicine Unit D	9.21	8.96	9.1	100.00 %	3	-	1	1	2		1	4	4.70%	17.74%	6.39%	0.00%	6.99%	Yes	2.02%	9.71	12.84%
CTCCU	21.10		22.7		-	-	-	-	2		1	0	8.87%	10.35%	4.77%	2.24%	12.07%	Yes	-1.03%	9.29	15.10%
Emergency Assessment Unit (EAU)	9.23	8.06		95.16%	7	-	-	1	2		1	6	7.09%	12.67%	6.89%	2.30%	9.74%	Yes	-0.73%	8.71	12.02%
HH EAU	9.77	7.04		96.77%	-	-	-	-	4		1	14	7.00%	6.59%	5.85%	1.18%	10.47%	Yes	2.71%	9.71	13.90%
HH Emergency Department	22.83				-	-	-	-	4		0	0	5.59%	5.73%	3.40%	4.96%	12.57%	Yes	-1.39%	9.71	14.51%
JR Emergency Department	19.84				-	-	-	-	0		0	3	16.87%	17.99%	4.55%	3.40%	19.69%	Yes	-0.19%	8.43	13.45%
HH Juniper Ward	8.06	11.19	8.0	100.00 %	-	-	-	-	2		3	3	6.15%	5.20%	5.28%	6.48%	16.70%	Yes	0.36%	9.71	12.02%
HH Laburnum	9.65	9.62	8.1	100.00 %	-	-	-	-	1		1	2	8.33%	13.70%	6.35%	4.97%	14.62%	Yes	0.49%	9.57	15.75%
HH Oak (High Care Unit)	10.58		13.4	94.62%	4	-	-	-	0		0	3	-1.82%	4.69%	5.97%	7.47%	8.32%	Yes	-0.10%	9.71	13.43%
John Warin Ward	10.12	10.63	9.5	100.00 %	2	30	2	-	0		0	2	0.20%	5.91%	4.90%	9.61%	9.79%	Yes	-0.75%	9.43	11.24%
OCE Rehabilitation Nursing (NOC)	10.55	11.23	10.0	100.00 %	-	3	3	-	0		1	4	8.33%	10.53%	4.80%	1.71%	10.67%	Yes	-1.44%	9.71	15.07%
Osler Respiratory Unit	14.44	8.67	11.2	98.89 %	-	6	4	-	2		1	0	2.43%	9.43%	4.21%	2.81%	5.17%	Yes	1.36%	9.00	16.85%
Ward 5E/F	11.02	9.09	9.7	97.78 %	11	1	-	2	0		4	2	4.60%	12.92%	5.25%	3.61%	8.05%	No	0.10%	9.43	12.53%
Ward 7E Stroke Unit	10.93	9.83	9.3	95.56 %	5	1	-		3		0	5	7.33%	12.06%	5.27%	0.52%	10.69%	Yes	-1.26%	8.00	13.15%

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

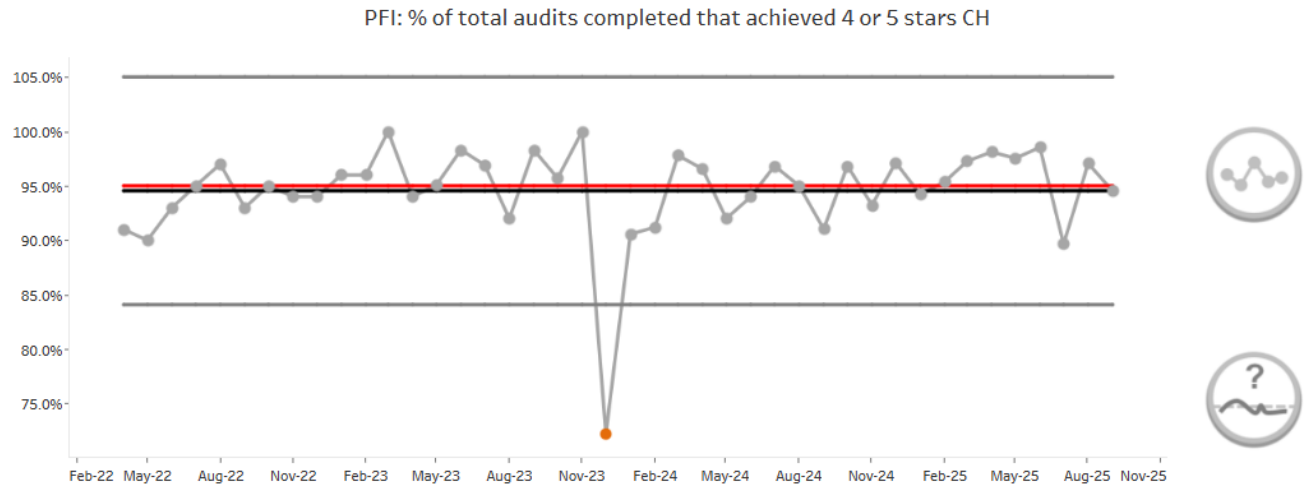
September 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs (11.8.25 - 7.09.25)			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
SUWON																					
Gastroenterology (7F)	7.50	8.11	8.2	95.56 %	-	13	2	-	7		1	1	0.24%	10.28%	6.63%	8.99%	9.20%	Yes	-0.78%	8.57	10.12%
Gynaecology Ward - JR	5.14	5.70	7.8	100.00 %	-	-	-	-	1		0	0	0.38%	12.50%	6.06%	2.74%	7.91%	Yes	-0.21%	8.86	11.53%
Haematology Ward	7.63	9.04	9.5	100.00 %	7	28	2	2	3		0	4	19.40%	14.01%	7.64%	4.27%	22.84%	No	2.57%	8.71	12.27%
Katharine House Ward	9.19	8.56	11.6	98.89 %	2	1	-	-	2		1	0	10.80%	9.64%	4.90%	2.91%	16.34%	Yes	0.33%	9.71	16.57%
Oncology Ward	7.71	7.80	7.8	98.89 %	1	5	1	-	5		7	5	13.95%	8.44%	4.04%	2.94%	18.53%	No	0.73%	9.57	14.91%
Renal Ward	7.67	8.49	9.2	98.89 %	8	6	3	1	1		0	0	17.14%	20.69%	2.98%	11.24%	26.46%	Yes	0.12%	8.86	13.78%
SEU D Side	8.69	7.77	7.8	100.00 %	-	-	-	-	3		5	2	17.16%	8.76%	3.30%	4.49%	22.07%	Yes	-0.17%	9.43	14.48%
SEU E Side	8.39	8.28	8.2	100.00 %	-	-	-	-	2		0	2	13.78%	11.97%	7.18%	0.00%	18.53%	Yes	-0.25%	9.43	9.93%
SEU F Side	7.51	7.73	7.4	100.00 %	-	-	-	-	0		1	3	25.32%	11.02%	3.03%	3.88%	28.21%	Yes	-4.24%	9.43	11.28%
Sobell House - Inpatients	8.34	7.88	7.3	96.67 %	2	10	-	-	1		5	1	5.07%	7.39%	4.41%	6.52%	14.03%	Yes	-0.30%	9.57	14.53%
Transplant Ward	9.43	7.40	7.9	95.56 %	15	3	-	-	2		0	2	13.59%	3.96%	6.70%	0.00%	16.43%	Yes	-0.59%	8.57	13.68%
Upper GI Ward	9.52	7.81	8.3	97.78 %	21	-	1	-	0		3	0	2.34%	2.68%	5.52%	6.78%	8.96%	Yes	-7.51%	9.29	13.88%
Urology Inpatients	8.86	9.43	8.5	100.00 %	3	-	2	1	1		1	0	18.89%	3.55%	5.10%	6.98%	27.39%	Yes	-1.55%	8.57	8.43%
Wytham Ward	7.69	8.29	7.3	97.78 %	12	9	-	-	2		0	2	-14.97%	7.19%	4.94%	11.22%	1.28%	Yes	-5.55%	9.29	12.48%
MW Delivery Suite	13.66		15.0		1	-	149	-										Yes	-2.81%	7.00	10.68%
MW Level 5	5.40		4.8		-	-	-	-										Yes	-0.15%	6.71	10.77%
MW Level 6	4.60		6.0		-	-	-	-										Yes	-2.58%	7.86	9.67%
MW The Spires	15.52		41.9		4	-	5	-										Yes	0.76%	7.86	12.67%
CSS																					
JR ICU	31.13		27.0	100.00 %	-	-	-	-	11		0	1	15.55%	10.63%	4.14%	5.20%	21.11%	Yes	0.17%	8.29	13.66%

3. Assurance report: Estates, Facilities and PFI



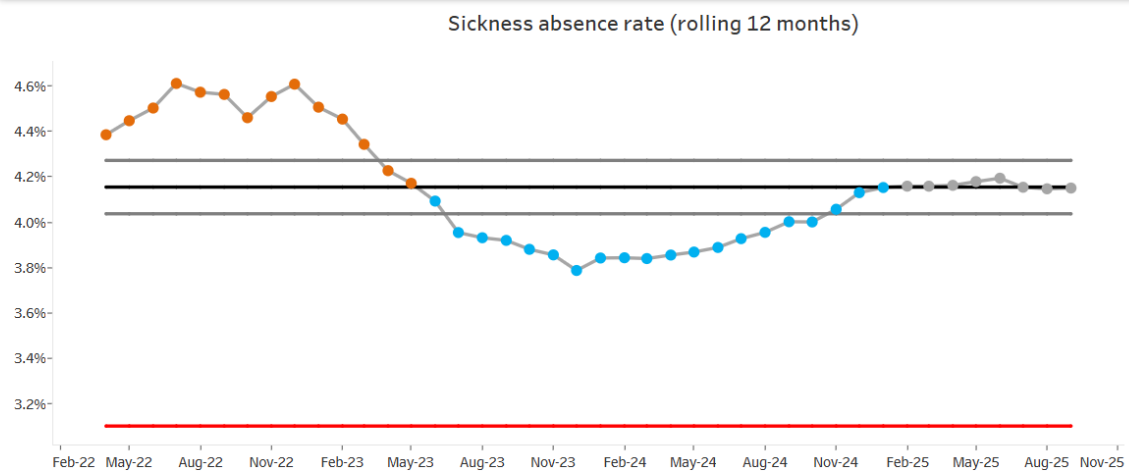
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In September 2025, the combined PFI % cleaning score by site (average) for the JR was 96.07% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, with JR sitting at 91.06 which is below the 95% Trust target. In total, at the JR, 235 audits were conducted,21 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2025. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating along with re training if required, review of cleaning equipment etc.	Unfortunately, Mitie did not complete the planned number of audits at the JR in September 2025. 242 audits were scheduled and 235 completed. Mitie had 21 of the 235 audits fail to achieve the set Trust target under domestic and clinical. However, all the failed audits are rectified. In September we still see failed audits in ED at JR, but the other failed audits do not show a trend and are shown across the site. Mitie and IPC are working together to improve the audit scores in ED and continued monitoring. Mitie and the ward/department leads and are completing additional audits with the management, increased supervision from Mitie and clinical staff when areas are cleaned. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at the JR. 2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

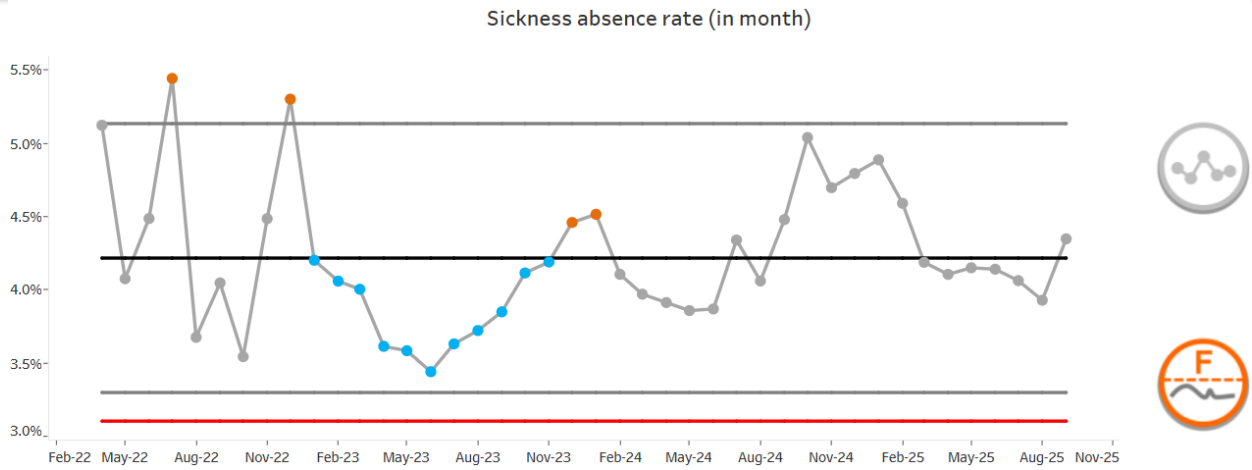
3. Assurance report: Estates, Facilities and PFI



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In September 2025, the combined PFI % cleaning score by site (average) for the CH was 95.77% which is an excellent standard. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, with CH sitting at 94.52 which is slightly below the 95% Trust target. In total, at the CH they conducted 73 audits, 4 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2025. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating along with re training if required, review of cleaning equipment etc.	G4S did complete the planned number of audits at the CH in September 2025. CH were scheduled to complete 72 audits and completed 73. G4S had 4 audits that did not achieve the set Trust target under domestic and clinical. However, all the failed audits are rectified, resulting in an improvement in the reported percentage. In September at CH, we did not see a defined trend for failed audits, while most were FR1 they did not fail again in the following auditing periods. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2025 at the CH 2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Growing Stronger Together



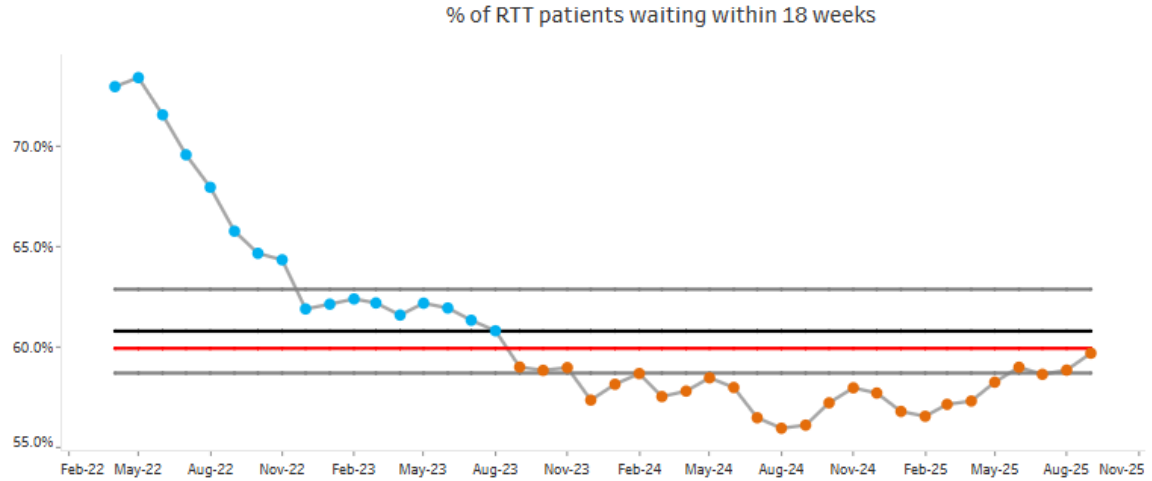


Benchmarking: May 2025 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 3.98% **National: 4.75%** **Shelford: 4.18%** Buckinghamshire Healthcare NHS Trust: 3.58% Royal Berkshire NHS Foundation Trust: 3.43% Oxford Health: 4.24% South Central Ambulance Service: 5.64%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.1% in Aug 25 and remains un-altered in Sept 25. However, the monthly sickness rate has risen sharply to 4.3% As we approach the "flu" season, this will be closely monitored. The key reasons for sickness top 5:- • Respiratory System • Mental, Behaviour or Neurodevelopmental • Musculoskeletal • Digestive system • Injury, poisoning or External causes Long-term sickness top 5 reasons:- • Mental, Behaviour or Neurodevelopmental • Musculoskeletal • Injury, poisoning or External causes • Neoplasms • Not elsewhere classified	• Divisions receive a monthly report on the top 20 absences and develop action plans to reduce these numbers. • We are focusing on the top Cost Service Units (CSUs) that have consistent absenteeism. • We are collaborating with Occupational Health to assist managers and staff in reviewing the top three reasons for absenteeism. • There is a call to action regarding long-term sickness, ensuring that staff receive the support needed to return to work successfully. • Managers will be alerted about staff who have triggered absenteeism, with guidance provided to support them through the sickness absence process. • HR is proactively promoting sickness absence management training to help managers effectively implement the new procedures. • HR is closely working with managers to ensure that Return-to-Work (RTW) meetings are completed. • Sickness absence workshops are ongoing to provide continued support for managers. • Occupational Health colleagues will continue to offer support during monthly meetings to address issues and implement proactive measures. • Monthly meetings with the Wellbeing lead are held to identify additional areas where support may be required. • Work is ongoing on naming conventions for sickness reasons.	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: Operational Performance, *continued*

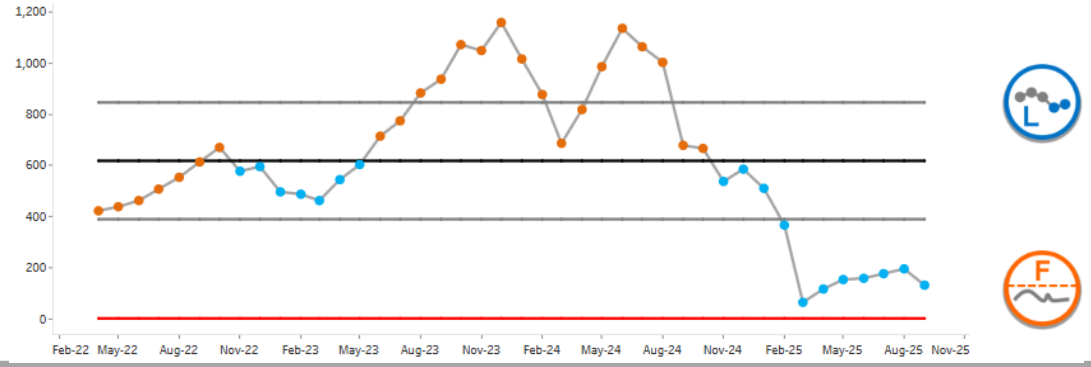


Benchmarking % within 18-weeks: August 2025				
OUH: 58.8%	National: 61.0%	Shelford: 59.4%	BHT: 58.7%	RBH: 79.7%

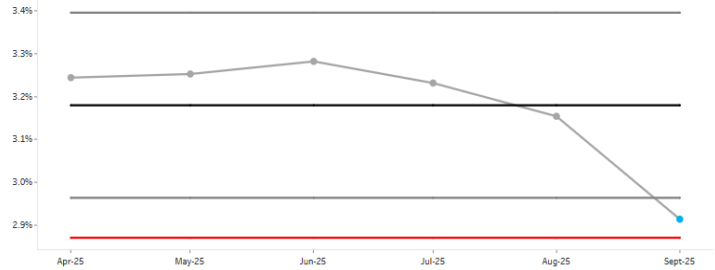
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting less than 18 weeks as a proportion of the total waiting list was 59.7% at the end of September against an operational plan of 59.9%. Performance exhibited special cause of concern due to >six consecutive periods of performance below the mean and exceeding the lower process control limit. Reduction in the denominator is contributed by the Validation Sprint initiative to cleanse the waiting list and reduce total waiting list size. Clinical priority allocated to cancer services over routine treatments 66.2% (35,536) of patients awaiting a 1st appointment below 18-weeks therefore 33.8% (18,144) were waiting over 18-weeks.	The Trust is on plan for patients waiting within 18 weeks as at the end of September and has consistently achieved plan for the percentage of patients waiting for an outpatient appointment under 18 weeks. Validation Sprint – utilisation of resources for validation to scrutinise pathways above 18-weeks and only where logic suggests incorrect pathways (DQ cohorts) for under 18-weeks. Drive early adopters to onboard digital outcome form which supports clinicians 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. Elective Delivery Funds in place to increase capacity to deliver operating plan. Utilising Elective Pathway Manager tool to constructively address inconclusive validation outcomes such as missing letter or clinical input required. All pathways within the 52 week cohort awaiting 1st appointments to be seen by end of December. Some services remain challenged with delivering this objective, and these are being evaluated through weekly check and challenge meetings led by the COO against forecast year end operating plans. Significant progress made on the total 1st Outpatient cohort for the patients who would be 52week waiters by March 2026.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*

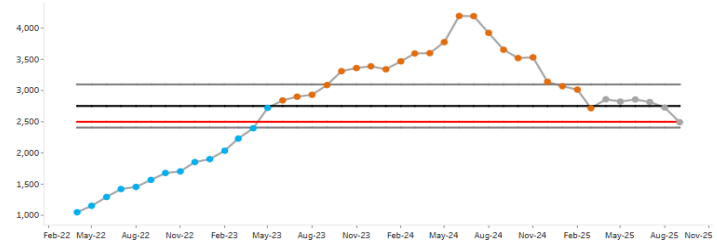
RTT standard: >65-week incomplete pathways



% of RTT patients waiting over 52 weeks



RTT standard: >52-week incomplete pathways



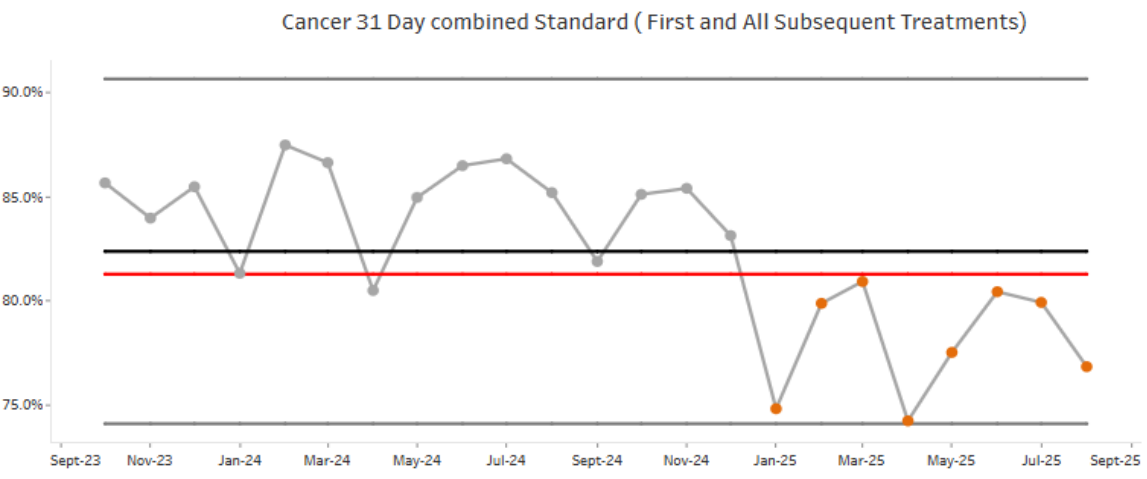
Benchmarking % over 52-weeks: August 2025				
OUH: 3.15%	National: 2.27%	Shelford: 2.55%	BHT: 2.75%	RBH: 0.07%

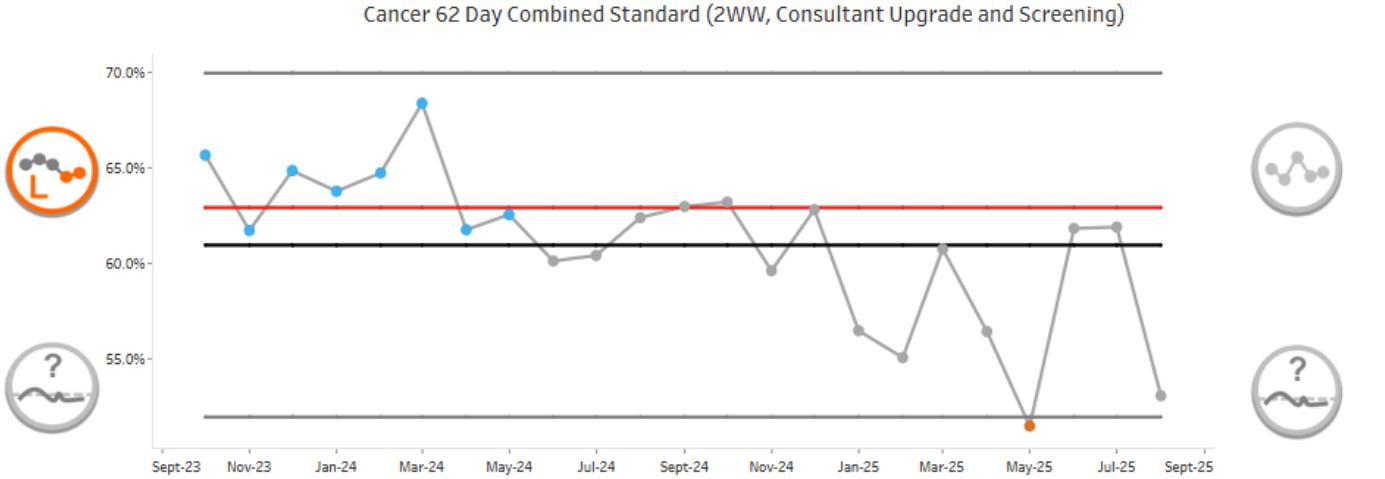
Benchmarking 52-week breaches: August 2025				
OUH: 2,721	National: 965 (median)	Shelford: 2,623 (median)	BHT: 1,382	RBH: 23

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 2,487 at the end of September. Performance exhibited a common cause - no significant change. The target was 2,494 therefore was able to deliver the operating plan for September. **Focus remains on longest wait patients:** **>104 weeks - Nil** incomplete pathways reported. **>78 weeks - 3** incomplete pathways reported. One complex and two capacity related. **>65 weeks – 130** incomplete pathways reported which is a decrease from the previous month by 64 pathways and meeting the trajectory plan. Focus remains in place to deliver nil pathways beyond 65-weeks by 21st December. Services are moving to recovering **52-week backlog.**	**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. Patient Engagement waiting list validation completed for all 1st appointments in the 52-week cohort. Additional senor level validation being undertaken. **Urology services**: Insourcing continues, focusing on outpatients and diagnostics. Patients waiting for HOLEP procedure offered mutual aid have been transferred. Patient Engagement waiting list validation completed for all 1st appointments in the 52-week cohort. Additional senor level validation being undertaken. **Orthopaedic services:** Weekend lists continue and recovery well. Patient Engagement waiting list validation completed for all 1st appointments in the 52-week cohort. Additional senor level validation being undertaken. **Patient Engagement Validation:** completed 2025/26 52-week cohort with 1st appointments (about 10k referrals), following LMC protocol to discharge non-responsive patients after 3 communication attempts within 40 days. Circa 4.5% removed and c.50% willing to travel to another Provider in BOB – list submitted via APC for capacity within BOB. Following senior level validation, the PEP process will be looked to be undertaken again. **Recovery Action Plan**: Live and populated against specialty level trajectories for delivery of the forecast.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 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*

Oxford University Hospitals NHS Foundation Trust



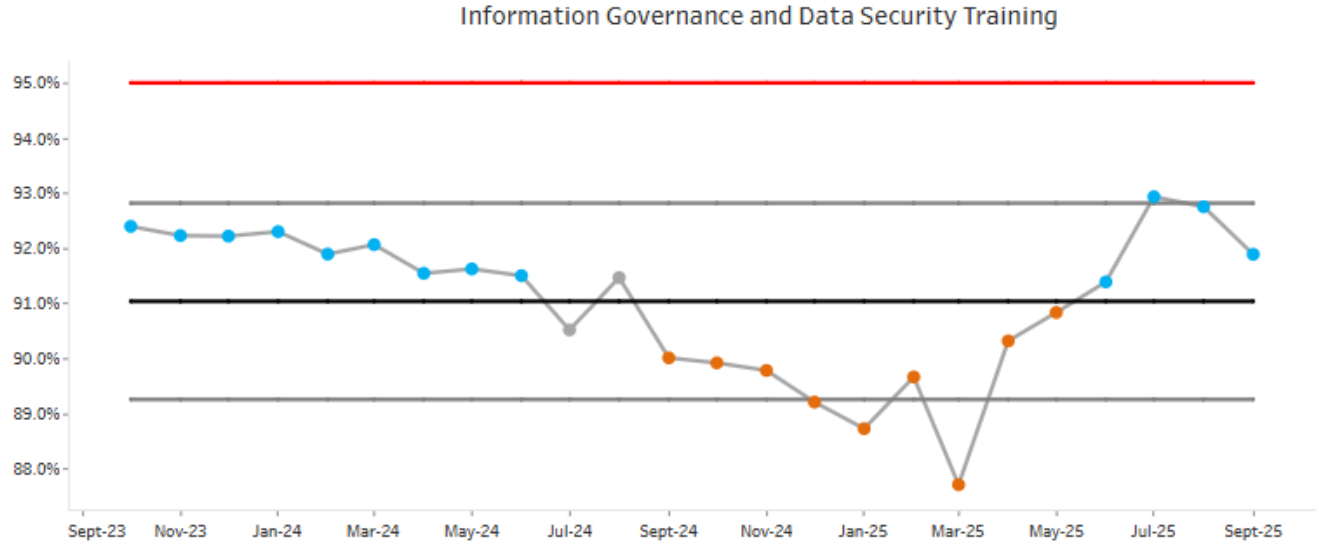


Benchmarking: Cancer 31 Day Faster Diagnosis August 2025				
OUH: 79.9%	National: 94.9%	Shelford: 90.2%	BHT: 88.2%	RBH: 91.0%

Benchmarking: Cancer 62 Day Combined Standard August 2025				
OUH: 53.06%	National: 71.07%	Shelford: 64.53%	BHT: 59.16%	RBH: 78.26%

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 against the 31 days Decision to Treat was 76.8% in August 2025 against an operational plan of 81.3% and below the national standard of 96.0%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Children's, Haematology – Acute & Non-Acute Leukaemia, Head and Neck, and Urological – Other/Penil/Testicular are non-compliant for this standard in August. OUH ranked 132nd out of 135 Providers in August and 10th out of the 10 Shelford Group.	**Cohort 3 (Nov): 3-Tumour Site Workshop planned 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. **Cohort 2 (Aug):** focussing on LGI with updates following Day-25/100 presented on 4th October confirming on track. Day-50 updates due 7th November. **Cohort 1 (May): 50-Day Sprint commenced in August** to achieve remaining change ideas and share all measures for success on 7th November. **Performance of >62-day PTL vs plan – recovery includes cross-cutting elements:** Incomplete and late Inter-Provider Transfer review and escalation to referring Providers – awaiting IPT policy by TVCA Surgical capacity through theatre reallocation Patient engagement through the Personalised Care agenda SOP and escalation of benign patients awaiting communication Pathway mapping of tumour sites against Best Practice Timed Pathways **Waiting List Context (census) 16/10/2025:** **Urology** holds the largest volume of pathways >62-days (141) and backlog is reducing. Running additional MRI results clinics, additional flexi diagnostic activity. Additional sessions in histopathology, additional theatre lists on Sundays and evenings. **Gynaecology** – several change ideas undergoing mobilisation including new referral proforma (awaiting TVCA rollout), ambient voice technology pilot in pre-hysteroscopy clinics, working to become pilot for WID-easy test, ring-fenced theatre lists **Lung** – several change ideas undergoing mobilisation including patient engagement to mitigate missed appointments and cancellations, clinical representation at PTL meetings to rapidly troubleshoot bottle-necks at pathway level, additional theatre lists to increase from fortnightly to weekly.	Cancer Improvement Group – November 2025		

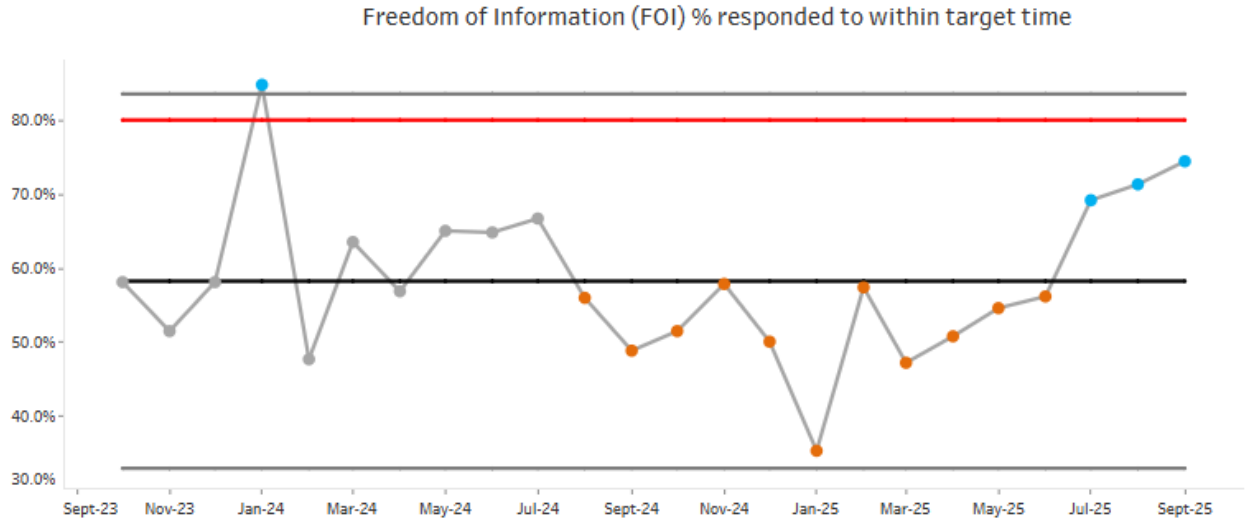
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3478	363	89.6%
Surgery Women and Oncology	3310	306	90.8%
Medicine Rehabilitation and Cardiac	3225	292	90.9%
Clinical Support Services	2309	193	91.6%
Corporate	998	78	92.2%
Operational Services	213	8	96.2%
Estates	191	13	93.2%
Research and Development	152	23	84.9%

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 92% in M6. No divisions are achieving 95% and this month's trend is a general decrease. R&D and NOTSSCAN are below 90% and Operational Services are above target at 96.2% .	1304 staff are currently non-compliant. All divisional governance teams have visibility of their staff training levels and are able to access reports which name non-compliant individuals to help them manage the situation.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Historic case backlog:

01/05/2025	897
01/06/2025	855
14/07/2025	575
14/08/2025	230
14/09/2025	110
27/10/2025	**All closed**

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
M6 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 74.4% and exhibited common cause variation. 169 valid cases were received in M6, of which 129 have been closed, 96 of which were closed on time. This is the highest number closed in one month by OUH, for the third month in a row, 20% higher than in M5 The Trust is facing significant challenges in managing FOI requests, prompting the Information Commissioner's Office (ICO) to issue an Enforcement Notice requiring OUH to respond with a plan by 14th May and implement that action plan by 31st October 2025.	All outstanding FOI cases that the requester confirmed they still wished to receive a response have been answered and closed. The IG team are actively engaged in procuring an appropriately designed system to manage FOI cases as the current one is not fit for purpose. This is being done in conjunction with Legal Services – the "testing and education" version of this platform is built and IG staff are completing training and work-up to go live in November. The new approach to the distribution and collation of FOI cases across the divisions is now starting to bed in and is generating an improvement in performance – staffing levels and other pressures continue to compete for staff time but as a result of the changes, the IG team only need to contact one of nineteen named contacts to send out an FOI request, down from >180 before the changes. Work to identify and recruit temporary resources to assist with the backlog is ongoing, since TME support was provided.	Completion of all actions: 31st October 2025 Updates provided to Digital Oversight Committee and TME	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

4. Development indicators

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

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

Sufficient ***Satisfactory*** ***Inadequate***

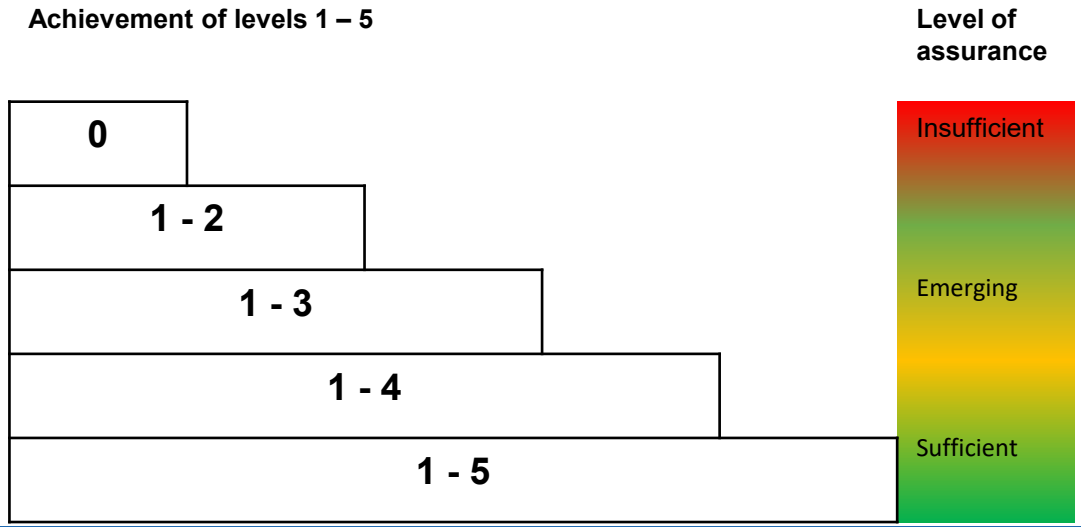
Oxford University Hospitals NHS Foundation Trust

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



Oxford University Hospitals NHS Foundation Trust

Segmentation dashboard: selected indicators

		Segmentation performance (*nationally reported position - Q1 25/26*)					Latest performance (*monthly internal data*)			
Domain	Indicator	Performance	Segmentation national ranking	NOF score	Segmentation measurement period	Segmentation reporting data inclusion date	Latest monthly performance	Latest monthly performance target (operational plan)	Latest monthly performance vs plan	Period of latest monthly performance
Operational Performance	1. Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	79.80	96/123 (high is good)	1.00	Rolling 3-month	June 2025	78.6	72.1	Compliant	September 2025
	2. Percentage of patients treated for cancer within 62 days of referral	56.77	12/118 (high is good)	3.74	Rolling 12-month	June 2025	53.1	62.9	Non compliant	August 2025
	3. Percentage of patients waiting over 52 weeks	3.28	97/131 (low is good)	3.33	End of period	June 2025	2.9	2.9	Non compliant	September 2025
	4. Number of patients waiting over 52 weeks	2,811.00	N/A - Not used for segmentation (leading indicator)				2,487.0	2,494.0	Compliant	September 2025
Quality Performance	5. Summary Hospital Level Mortality Indicator			2.00	Rolling 12-month		90.3		N/A	June 2025
Financial Performance	6. Variance year-to-date to financial plan	0.01	88/205 (high is good)	1.00	Year to date	June 2025	271.5	0.0	Compliant	September 2025
	7. Planned surplus/deficit score	-1.02	121/205 (high is good)	3.00	Annual plan	April 2025				

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