Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M10 (January data)

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Table of Contents

Oxford University Hospitals NHS Foundation Trust

Segmentation dashboard: selected indicators

		Segmentation performance (*nationally reported position - Q2 25/26*)					Latest performance (*monthly internal data*)			
Domain	Indicator	Performance	Segmentation national ranking	NOF score	Segmentation measurement period	Segmentation reporting data inclusion date	Latest monthly performance	Latest monthly performance target (operational plan)	Latest monthly performance vs plan	Period of latest monthly performance
Operational Performance	1. Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	82.80	13/123 (low is good)	1.00	Rolling 3-month	September 2025	77.6	71.9	Compliant	January 2026
	2. Percentage of patients treated for cancer within 62 days of referral	59.14	106/118 (low is good)	3.74	Rolling 12-month	September 2025	67.5	67.5	Compliant	December 2025
	3. Percentage of patients waiting over 52 weeks	2.91	91/131 (low is good)	3.33	End of period	September 2025	2.4	2.4	Compliant	January 2026
	4. Number of patients waiting over 52 weeks	2,811.00	N/A - Not used for segmentation (leading indicator)				2,011.0	2,000.0	Non compliant	January 2026
Quality Performance	5. Summary Hospital Level Mortality Indicator			2.00	Rolling 12-month		89.5	100.0	Compliant	September 2025
Financial Performance	6. Variance year-to-date to financial plan	0.03	19/134 (low is good)	1.00	Year to date	September 2025	22.1	0.0	Compliant	January 2026
	7. Planned surplus/deficit score	-1.02	57/134 (low is good)	3.00	Annual plan	April 2025				

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

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 10 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, the internal PowerBI dashboard is included for selected Segmentation Indicators (on page 3).

We achieved key measures related to patient safety and care experience, no never events, fewer c-diff cases vs the monthly threshold and VTE assessments better than the national target. Our mortality indicators (SHMI and HSMR - excluding hospices) were below 100, indicating fewer deaths than expected. 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 and children (L1-L3) was achieved.

Lower staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our sickness absence rate was above threshold for the month and rolling 12-month position, with the monthly position exhibiting deteriorating SCV. However, rates remain lower than National and Shelford averages, and the second lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets and exhibited improving Special Cause Variation (SCV).

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In month 10, we met targets for core skills training, and non-medical appraisals demonstrating commitment to staff development, and both exhibited improving SCV. Our time to hire standard was also achieved.

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).

In month 10, the % of pathways over 52 weeks, which is a segmentation indicator met the operating plan trajectory, though the number of 52-week waiters exceeded the operational plan. The indicator for RTT % within 18 weeks (all pathways), which is a segmentation indicator, and the percentage of patients within 18 weeks for first OP attendances did not meet the operating plan. Elective RTT activity was higher than the operating plan in M10 for admitted and non admitted pathway clock stops, though due to a focus on validating long waiting patients the overall size of the Patient Tracking List (PTL) increased to a level above the operating plan for the total number of patients on the RTT waiting list.

Performance in month 9 met the operating plan trajectory for Cancer waits within 62-days and for the Faster Diagnosis Standard (diagnosis within 28-days), which are both Segmentation indicators, but did not meet the operating plan trajectory for the Cancer 31-day indicator. NB. Cancer performance is reported one month in arrears. Diagnostic performance (% within 6 weeks) was below the operating plan in month 10.

The reported surplus was £1.2m in Month 10. The underlying deficit is initially estimated at £6.3m, £3.2m worse than plan but £3.4m better than Month 9. Underlying pay and non-pay both improved in month. WTE were stable in month at 14,263 (including R&D). The Board has agreed to the steps required to deliver the £2m surplus forecast including a number of non-recurrent items. Month 10 performance is in line with expectation against that forecast. Cash was £25.4m at the end of January, unchanged from the previous month and £19.4m higher than plan. Capital expenditure has been lower than plan by £13.7m, supporting the cash position. More supplier payments have been deferred than originally planned to manage the Trust's cash. £11.3m of cash support was received in November. Additional financial controls had been agreed and were in place until the end of January. The next steps are under review, including a proposal to release Clinical Service Units (CSUs) from the recruitment pause based on financial performance (if they were on pay budget or overall EBITDA budget as at M9 YTD).

In month 10, there were zero digital priority 1 incidents, no externally reportable ICO incidents and response times for Freedom of Information requests met the performance standard. Performance standards were not achieved for Information Governance and Data Security Training, which exhibited deteriorating SCV, and response times for Data Subject Access Requests.

Of the 122 indicators currently measured in the IPR, 25 indicators that triggered 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 41.

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
- % Diagnostic waiting 6 weeks or more
- Percentage of patients discharged on discharge ready date
- % of complaints responded to in 25 working days
- Reactivated complaints
- Number of Complaints
- Sickness Absence Rate (in month)
- Information Governance and Data Security Training

Common cause variation and missed target

- % of RTT patients waiting for first appointment
- RTT number of incomplete pathways (<18 weeks)
- Cancer 62 Combined Standard
- Bed utilisation general and acute
- Timely antibiotics according to NICE guidelines
- RIDDOR
- FFT % likely to recommend OP
- Midwife ratios (birth rate/staffing level)
- Safeguarding training compliance (children)
- Sickness and absence rate (rolling)
- Data Subject Access Requests (DSAR)

Special cause variation - improving

- FFT % likely to recommend - ED, and maternity
- RTT patients > 65 weeks
- RTT patients > 52 weeks

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)*

In January (M10), **Clostridium difficile** performance remained stable, with 7 cases reported, keeping the Trust 1 case below the year-to-date threshold and maintaining the strong improvement seen over the past year. National benchmarking continues to show progress, with OUH holding 61st place. The continued absence of a fully functioning IPC surveillance system remains a high-risk issue, with limited system development since July.

MSSA cases continued to run high, with recent months above average and most cases linked to intravascular devices, driving the need for focused learning and a planned Trust-wide audit. **MRSA** bacteraemia increased with two cases in January, though overall performance and national position continue to show improvement following previously low case numbers. Seasonal patterns were similar to national trends, with influenza activity declining after the mid-December peak and Norovirus causing seven outbreaks across two OUH sites during January.

Sepsis management saw delays affecting seven high-risk patients and one moderate-risk patient. Although prescribing-to-administration times have improved compared to earlier months, performance remains below standard. There were no identified adverse outcomes arising from the delays. Ongoing governance review, ED-led deeper-dive analyses, strengthened feedback loops, and consideration of a Sepsis Patient Group Direction (PGD) continue to support improvements in timely antibiotic delivery.

RTT performance for patients waiting within 18 weeks remained below the operational plan, delivering 59.71% against a trajectory of 61.93%. Performance continues to exhibit special cause of variation. Actions underway include sustained pathway validation, prioritisation of the longest waiters, deployment of digital outcome forms to increase PIFU uptake, and continued use of the Elective Pathway Manager to address inconclusive validation outcomes.

RTT patients waiting **over 52 weeks** showed marginal improvement, with 2.36% of the waiting list breaching against a plan of 2.38%. Although the proportion met the planned trajectory, the volume exceeded plan and challenges persist in some services delivering all first outpatient appointments by the January deadline. Capacity expansion is supported through Delivery Funds and Q4 Sprint schemes, including outsourcing across key specialties and targeted diagnostic weekend activity.

RTT patients waiting over 65 weeks was above the zero-breach operating plan. Specialty specific actions include ENT and Audiology insourcing, Urology outpatient and diagnostic insourcing, and Orthopaedics weekend operating lists. Patient Engagement Validation has been completed for the entire 52-week first appointment cohort, and a live Recovery Action Plan remains in place.

Cancer performance for the 31-day standards remains below both plan and national benchmarks, with December reporting 78.6% for 31-day performance. Improvement continues through structured tumour site workshops delivered in cohort cycles, including 100-day action plans for UGI and Renal, ongoing progress reviews for LGI and Urology, and continued monitoring of change schemes originating from earlier sprint cycles. Oversight is maintained through the Cancer Improvement Group, ensuring governance and escalation where required.

For **Diagnostics (DM01),** 23.87% of patients were waiting more than six weeks at the end of January. Endoscopy capacity continues to be supported through insourcing and targeted outsourcing. Neurophysiology activity is strengthened through two insourcing suppliers, additional internal sessions, and an approved Neurology post. Audiology demand pressures remain significant but are partially mitigated by an insourcing scheme delivering approximately 500 additional activity units per month, alongside estate developments for additional capacity. Non obstetric ultrasound continues to perform above plan, helping offset under performance in other diagnostic modalities.

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Oxford University Hospitals NHS Foundation Trust

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Safeguarding Children training showed mixed performance, with Level 1 remaining stable at 95%, Level 2 decreasing slightly to 88.5%, and Level 3 improving marginally to 88.5%. Training capacity continues to be affected by long term sickness within the safeguarding team, limiting delivery of face-to-face sessions, though activity has now resumed. Divisions are being supported through targeted compliance and safeguarding performance remains under regular review through PSEC and divisional governance structures.

Maternity activity increased in January with 612 mothers giving birth to 626 babies, representing a 4.15% rise. The midwife to birth ratio remained stable at 1:23.47, broadly aligned to Birthrate Plus guidance, and 1:1 care in labour. Workforce unavailability remains a challenge, with circa 9% of staff on maternity leave, though recruitment remains strong with 6.72 WTE midwives commencing in post. Daily safe staffing meetings, targeted retention actions, and continued focus on fill rate accuracy support service resilience as the trajectory towards full establishment continues.

Formal **complaints** rose to 201 in January, continuing the upward special cause trend and reflecting increasing complexity of issues raised, including AI generated correspondence. Key themes remain consistent with previous reporting, with communications and clinical treatment most prominent. KPI performance against the 25-day target remains below trajectory, with a median of 26 days recorded in January. Reactivated complaints increased to 26 cases (13%), largely due to requests for further clarification or dissatisfaction with initial responses. Divisions continue to receive strengthened support through Delivery Committee oversight.

Six **RIDDOR** incidents were reported in January, comprising one patient fall and five staff related injuries, including a physical assault, two manual handling injuries, one trip, and one struck by object incident. All incidents were investigated locally, with no emerging patterns or links between incidents were identified.

FFT performance remained strong across Outpatients, with a recommended rate of 93.6%, and ED performance increased to 84.2%. Positive themes continued to focus on staff attitude, implementation of care, and clinical treatment, while negative themes centred on car parking, discharge processes, and catering. Divisions present FFT themes bi-monthly to the Patient Experience and Engagement Committee, and work is ongoing to promote online collection methods and improve response rates.

Sickness absence performance (rolling 12 months) remained stable at 4.2%, with the monthly rate increasing to 5.0% as seasonal pressures rise. Respiratory-related absences are a major contributor, forming one of the two largest categories alongside mental health, and overall increases were seen across most of the top ICD categories. HR and Occupational Health continue to support divisions through monthly reporting, manager alerts, long-term case management, simplified return-to-work processes, targeted training, and ongoing wellbeing discussions to strengthen sickness management and maintain consistent oversight.

Overpayments continue to arise from late leaver processes, delayed or incorrect change forms, job-planning and hours amendments not processed on time, and outstanding salary-sacrifice balances for leavers. Payroll and HR are progressing a national programme with stronger guidance, clearer procedures, and training for managers to reinforce timely and accurate data entry. Monthly reporting, audits, and an established working group provide continued oversight, while new system interfaces and updated salary-sacrifice policies aim to improve reconciliation and reduce future errors. Actions remain on track, with risks monitored and data quality rated satisfactory.

Data Subject Access Request performance has dipped slightly, with high case volumes continuing to place pressure on the service. A backlog persists within the Medical Records SAR team as they transition between the Infreemation and e-Case systems, though additional staffing is in place. The Information Governance Team, newly merged with Legal Services, is reviewing SAR processes and applying learning from the FOI improvement programme. Transfer of remaining legacy cases into e-Case is underway and expected to streamline workflow. An update on performance and improvement actions will be reported to the March Digital Oversight Committee.

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	• FFT % Likely to recommend OP • Midwife ratios (birth rate/staffing level) • % patients with Sepsis receiving timely antibiotics in accordance with NICE Not achieving target	• FFT % Likely to recommend –ED and Maternity	L Not achieving target H • Number of complaints per 10,000 bed days • Reactivated complaints • Number of complaints • % of complaints responded to within 25 working days Not achieving target	No SPC Not achieving threshold
Growing Stronger Together	• Sickness and absence rate (rolling 12 months) Not achieving target		H • Sickness and absence rate (in month) Not achieving target	
Operational performance	• % of RTT of patients waitingg for a first appointment • Number of incomplete pathways (<18 weeks) • Cancer 31 Day Combined Standard (2WW, Symptomatic and screening referrals) Not achieving target	L • RTT patients > 65 weeks and >52 weeks Not Achieving target	L • % of RTT patients waiting within 18 weeks • % Diagnostic waiting 6 weeks or more • Percentage of Patients discharged on discharge ready date Not achieving target H Not achieving target	
Corporate Support Services	• Efficiency Delivery £'000 • In-month financial performance Surplus/Deficit £'000 • Data Subject Access Requests (DSAR) Not achieving target	H Not achieving target	L • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % • Information) Governance and Data Security Training compliance Not achieving target	No SPC Not achieving threshold

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Jan-26	0.6	-	-	0.2	-0.5	0.8
MRSA cases: HOHA+COHA	Jan-26	2	0	No	1	-1	3
C-diff cases: HOHA+COHA per 10,000 beddays	Jan-26	2.2	-	-	3.5	0.5	6.5
C-diff cases: HOHA+COHA	Jan-26	7	10		11	2	21
E. Coli cases: HOHA+COHA per 10,000 beddays	Jan-26	6.9	-	-	5.2	0.8	9.7
E. Coli cases: HOHA+COHA	Jan-26	22	-	-	17	3	31
MSSA cases: HOHA+COHA	Jan-26	8	-	-	6	-1	12
Number of Never Events	Jan-26	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Jan-26	0	-	-	2	-	-
PSII Overdue Actions	Jan-26	34	-	-	33	-	-
VTE- Submitted performance	Jan-26	95.3%	95.0%		95.1%	94.4%	95.9%
% of emergency admissions 65yrs + receiving cognitive screen	Jan-26	70.1%	-	-	59.5%	51.8%	67.3%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Jan-26	75.0%	90.0%	No	87.7%	64.5%	110.8%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jan-26	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Jan-26	2	-	-	3	-2	7
HSMR Excluding Hospices	Nov-25	93.7	100.0		86.1	-	-
Summary Hospital-level Mortality Indicator	Sept-25	89.5	100.0		91.8	-	-
Neonatal deaths per 1,000 total live births	Dec-25	2.2	3.2		3.2	-1.0	7.3
Stillbirths per 1,000 total Live births	Dec-25	3.8	4.0		3.8	-0.1	7.6
National Patient Safety Alerts not completed by deadline	Jan-26	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Jan-26	0.0	-	-	0.0	0.0	0.0
Number of active clinical research studies hosted	Jan-26	1471	-	-	1424	1210	1637
Number of active clinical research studies (commercial)	Jan-26	408	-	-	384	321	447
Number of active clinical research studies (non commercial)	Jan-26	1063	-	-	1040	888	1192
Number of incidents with moderate harm or above per 10,000 beddays	Jan-26	49.6	-	-	42.4	28.3	56.5
Number of patient incidents with moderate harm or above per 10,000 beddays	Jan-26	45.6	-	-	37.6	22.3	52.8
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Jan-26	4.1	-	-	4.8	-1.7	11.4
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Jan-26	19.7	19.0	No	21.3	10.7	32.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Jan-26	2.8	2.0	No	2.3	0.6	4.0
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Jan-26	0.0	0.0		0.1	-0.2	0.3
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Jan-26	98.6	-	-	98.8	71.4	126.2
Patient falls (moderate and above) as reported on Ulysses	Jan-26	6	-	-	4	-2	10

3. Indicators th a zero in e current onth's erformance d no SPC ons are not rrently ailable and ll follow.

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Jan-26	1.9	-	-	1.3	-0.7	3.3
Health and Safety related incidents - Assault, Aggression and harassment	Jan-26	163	-	-	167	89	246
Adult safeguarding activity	Jan-26	1312	-	-	1113	746	1479
Children's safeguarding activity	Jan-26	273	-	-	588	287	890
Adult safeguarding activity and Children's safeguarding activity	Jan-26	1585	-	-	1701	1174	2227
Safeguarding (Children) training compliance L1 - L3	Jan-26	89.8%	90.0%	No	88.8%	84.3%	93.3%
Safeguarding (Adults) training compliance L1 - L3	Jan-26	90.6%	90.0%		52.4%	45.3%	59.6%
Total Deliveries in month	Jan-26	608	625	-	611	537	685
Babies born	Jan-26	621	-	-	621	546	695
Maternity Bookings (planned + unplanned)	Jan-26	668	750	-	700	551	849
Inductions of labour from iView	Jan-26	118	-	-	136	96	176
Midwife Ratios (birth rate / staffing level)	Jan-26	23.5	22.9	No	25.3	21.3	29.4
Number of Learning MDT Reviews instigated	Jan-26	1	-	-	2	-	-
Percentage of Learning MDT Reviews within 42 days	Jan-26	100.0%	-	-	50.9%	-68.8%	170.6%
After Action Review (AAR)	Jan-26	14	-	-	14	-	-
Percentage of AAR's within 14 days	Jan-26	14.3%	-	-	25.0%	-8.5%	58.5%
Number of complaints	Jan-26	202	-	-	131	76	185
Number of complaints per 10,000 beddays	Jan-26	63.1	-	-	41.0	25.7	56.3
Reactivated complaints	Jan-26	26	1	No	12	3	21
% of complaints responded to within 25 working days	Jan-26	23.6%	85.0%	No	44.3%	23.9%	64.7%
Number of RIDDORs	Jan-26	6	5	No	5	1	10
Friends & Family test % likely to recommend - IP	Jan-26	95.3%	95.0%		95.0%	93.6%	96.4%
Friends & Family test % likely to recommend - OP	Jan-26	93.6%	95.0%	No	93.8%	92.9%	94.6%
Friends & Family test % likely to recommend - ED	Jan-26	84.2%	85.0%	No	79.6%	73.7%	85.6%
FFT maternity % positive (births)	Jan-26	88.9%	90.0%	No	74.9%	49.9%	99.8%
Inpatient FFT (Response Rate)	Jan-26	20.3%	-	-	23.8%	20.5%	27.1%
Outpatient FFT (response rate)	Jan-26	9.8%	-	-	8.5%	6.8%	10.1%
ED FFT (Response Rate)	Jan-26	15.2%	-	-	21.3%	17.1%	25.5%
Maternity FFT (response rate: births)	Jan-26	2.4%	-	-	7.9%	0.2%	15.6%
PFI: % of total audits completed that achieved 4 or 5 stars JR	Jan-26	97.2%	95.0%		93.4%	84.8%	102.0%
PFI: % of total audits completed that achieved 4 or 5 stars CH	Jan-26	95.7%	95.0%		94.7%	84.8%	104.6%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	Jan-26	100.0%	95.0%		96.6%	89.3%	103.9%
Incident rate of violence and aggression (rate per 10,000 beddays)	Jan-26	50.9	-	-	49.4	24.8	74.1
Trust level: CHPPD vs budget	Jan-26	-4.1	-	-	-12.3	-55.1	30.5
Trust level: CHPPD vs required	Jan-26	-15.2	-	-	-5.2	-24.5	14.1

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Dec-25	6.0%	-	-	8.4%	4.6%	12.2%
Proportion of ambulance arrivals delayed over 60 minutes	Dec-25	0.3%	-	-	0.9%	-0.2%	1.9%
ED 4Hr perfromance - All	Jan-26	77.6%	71.9%		69.2%	61.8%	76.7%
Mean Ambulance Handover time in seconds for all handovers at trust level	Dec-25	1043	1180		1103	970	1237
ED 4Hr perfromance - Type 1	Jan-26	69.4%	59.9%		62.1%	53.6%	70.6%
Proportion of Type 1 attendances spending more than 12 hours in an emergency department	Jan-26	3.9%	4.4%		4.9%	2.5%	7.3%
Proportion of patients discharged from hospital to their usual place of residence	Jan-26	95.5%	-	-	95.3%	94.5%	96.0%
% of RTT patients waiting for a first appointment	Jan-26	67.0%	68.0%	No	66.3%	64.1%	68.4%
% of RTT patients waiting within 18 weeks	Jan-26	59.7%	61.9%	No	60.7%	58.7%	62.7%
% of RTT patients waiting over 52 weeks	Jan-26	2.4%	2.4%		2.9%	2.7%	3.2%
RTT standard: >52-week incomplete pathways	Jan-26	2011	2000	No	2697	2355	3039
RTT standard: >65-week incomplete pathways	Jan-26	75	0	No	570	357	782
RTT number of incomplete pathways	Jan-26	85063	83932	-	80072	77369	82776
RTT number of incomplete pathways (<18 weeks)	Jan-26	50791	51977	No	50758	49662	51855

Integrated Performance Report (SPC)
Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Dec-25	80.4%	79.2%		78.6%	73.5%	83.7%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Dec-25	78.6%	84.6%	No	81.8%	73.4%	90.3%
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Dec-25	67.5%	67.5%		61.4%	52.3%	70.5%
62-day Cancer standard: incomplete pathways >62-days	Jan-26	352	-	-	347	269	424
% Diagnostic waits waiting 6 weeks or more	Jan-26	23.9%	8.2%	No	17.7%	13.1%	22.3%
Diagnostic activity vs 2019/20	Jan-26	132.9%	-	-	126.4%	114.2%	138.7%
Total outpatient attendances - EM32in the 25/26 plan	Dec-25	105511	111864	-	111661	88220	135102
Bed Utilisation General & Acute	Jan-26	92.5%	96.0%	No	94.7%	91.3%	98.1%
Average Non elective LOS Trust level for IPR (average so cannot aggregate up)	Dec-25	9.0	6.4	No	6.9	5.9	7.9
Number of non-discharged patients put onto a PIFU	Jan-26	849	4236	No	1131	362	1899
Cancelled operations within 24hrs (non-clinical reasons)	Jan-26	0.4%	-	-	0.4%	0.2%	0.6%
Cancellations not re-booked within 28 days	Jan-26	5.6%	-	-	12.8%	-11.9%	37.6%
Elective DC spells - SUS	Dec-25	6086	6873	-	6738	5295	8180
Elective IP spells - SUS	Dec-25	1220	1519	-	1506	1201	1812
Average delay (exclude zero delay) of discharges Trust level for IPR (average so cannot aggregate up)- EB46 in the 25/26 plan	Dec-25	5.9	6.5		5.9	4.6	7.1
Percentage of patients discharged on discharge ready date - EB45 in the 25/26 plan	Dec-25	87.0%	88.4%	No	88.6%	87.0%	90.1%

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: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Vacancy rate	Jan-26	5.5%	7.7%		6.6%	4.7%	8.5%
Turnover rate	Jan-26	8.1%	12.0%		10.5%	10.1%	10.9%
Turnover rate with no exclusions	Jan-26	10.2%	-	-	10.9%	10.4%	11.4%
Sickness absence rate (rolling 12 months)	Jan-26	4.2%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	Jan-26	93.7%	85.0%		78.6%	46.2%	110.9%
Sickness absence rate (in month)	Jan-26	5.0%	3.1%	No	4.3%	3.4%	5.2%
Core skills training compliance	Jan-26	91.2%	85.0%		90.7%	89.0%	92.5%
Time to hire (average days)	Jan-26	49.6	53.0		48.6	37.3	60.0

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Jan-26	-6298.0	-	-	-5306.3	-8862.5	-1750.2
BPPC £ %	Jan-26	57.4%	95.0%	No	77.9%	71.5%	84.3%
BPPC Volume %	Jan-26	27.5%	95.0%	No	60.8%	53.5%	68.1%
Cash £'000	Jan-26	25385	5967		28623	6832	50414
Efficiency delivery £'000	Jan-26	5304.0	9182.0	No	6026.6	-442.7	12495.9
In-month financial performance Surplus/Deficit £'000	Jan-26	1209.9	1210.0	No	-447.1	-11260.4	10366.3
In-month ICS CDEL capital expenditure	Jan-26	2051.7	5698.5	-	3162.7	-6811.9	13137.3
Year-to-date financial performance Surplus/Deficit £'000	Jan-26	-3106.9	-3129.0		-13419.3	-22366.6	-4472.0

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

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Jan-26	90.5%	95.0%	No	91.0%	89.4%	92.7%
Data Security & Protection Breaches	Jan-26	25	-	-	27	8	47
Externally reportable ICO incidents	Jan-26	0	0		0	-	-
All IG reported incidents	Jan-26	25	-	-	29	12	47
Priority 1 Incidents	Jan-26	0	0		1	-	-

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

Latest Indicator Period: Jan-2026

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Jan-26	15	-	-	19	5	34
Freedom of Information (FOI) % responded to within target tim	Jan-26	86.4%	80.0%		60.8%	35.7%	86.0%
Data Subject Access Requests (DSAR)	Jan-26	67.4%	80.0%	No	70.7%	52.5%	88.9%

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

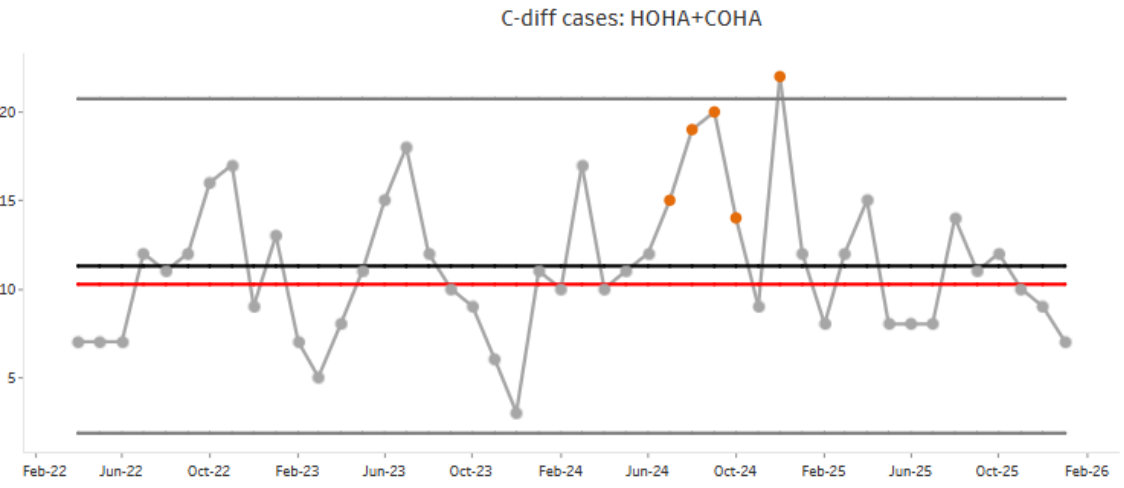
Latest Indicator Period: Jan-2026

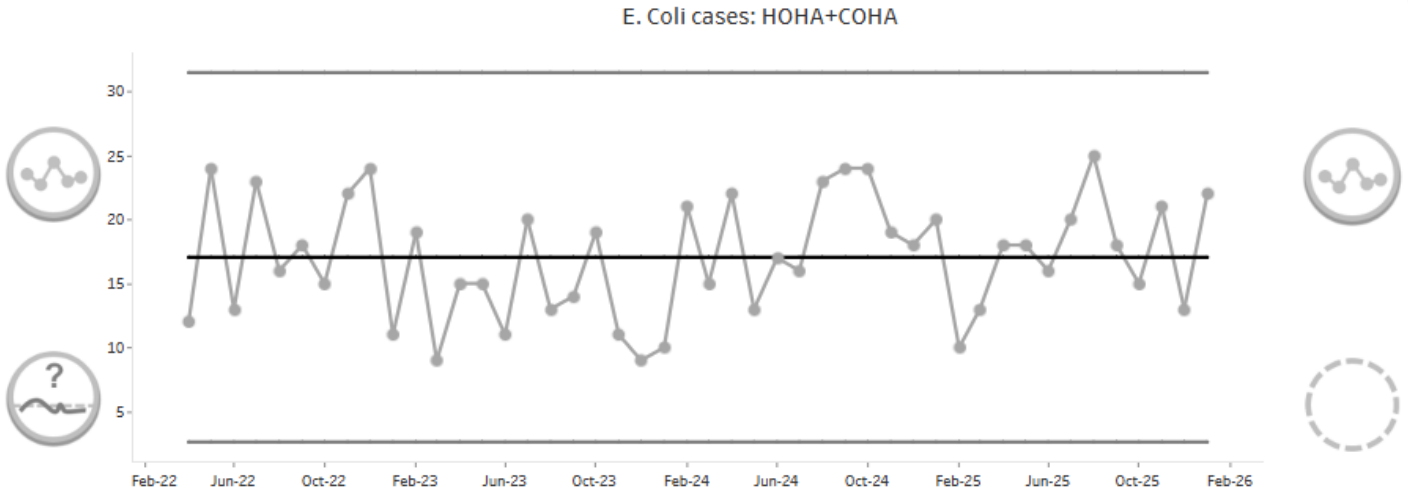
Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Jan-26	0	0		0	-	-

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

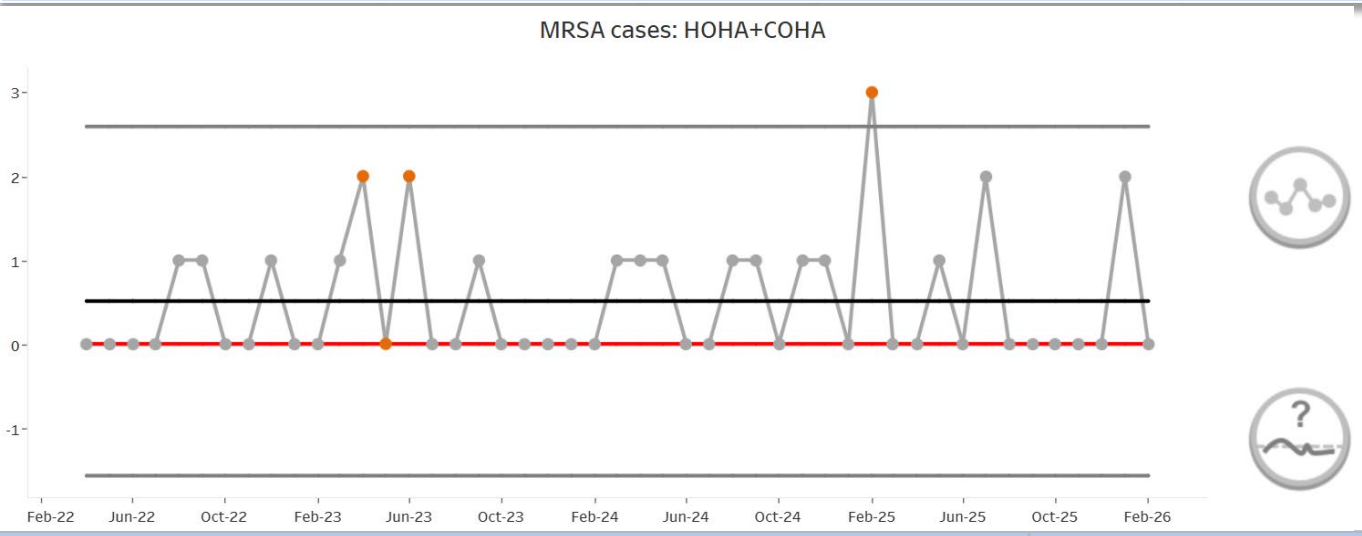
3. Assurance report: Quality, Safety and Patient Experience



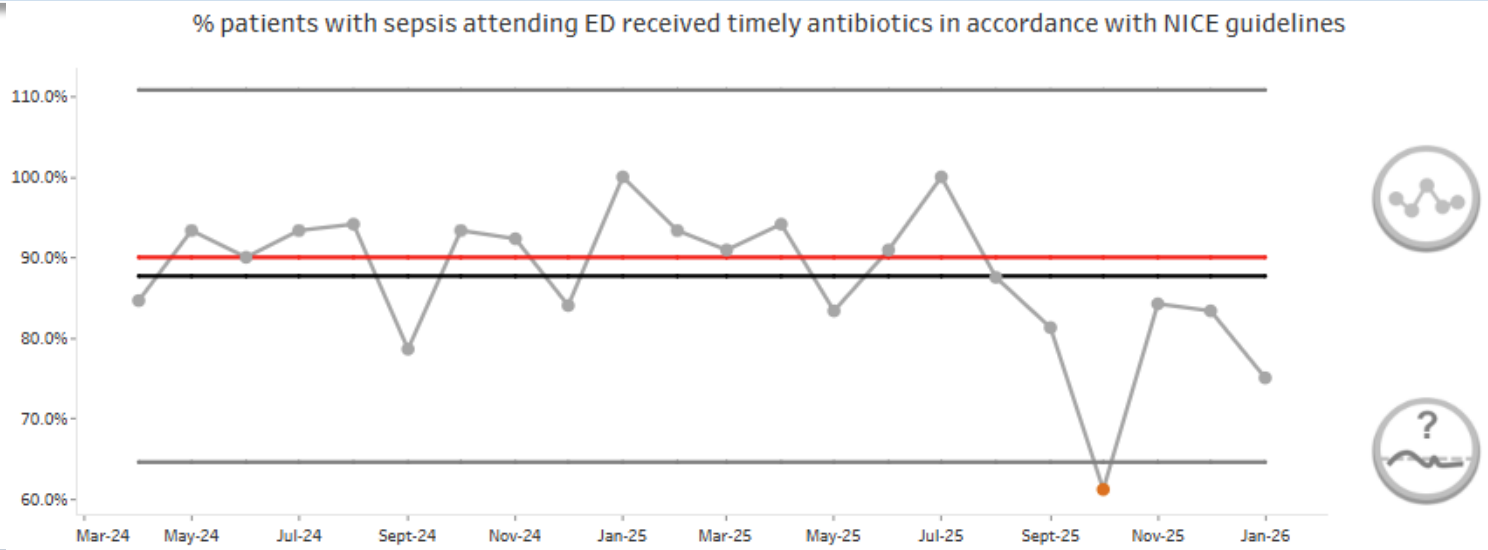


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***C. difficile* infection:** OUH reported 7 healthcare-associated *C. difficile* cases (5 HOHA and 2 COHA) in January to the UK Health Security Agency (UKHSA). We are currently 1 case below the threshold for the year to date, and 43 cases below where we were at this time last year. The number of *C. difficile* cases assigned to OUH between October 2024 and September 2025 has given the Trust a score of 2.38 in the NHS Oversight Framework Acute Trust league table, placing us 61st out of 134 Trusts – this is a significant improvement on the previous quarter (3.28, 92/134), and is based on 142 cases. We are reporting 128 cases to end of 2025 so the next dataset will show a further improvement. ***E. coli* bacteraemia**: There were 22 cases of *E. coli* reported in January (12 HOHA and 10 COHA). Our position in January 2026 was 5 cases higher than in January 2025 and we are 48 cases above our cumulative limit for the year to date. The number of *E. coli* cases assigned to OUH between October 2024 and September 2025 has given the Trust a score of 3.54 in the NHS Oversight Framework Acute Trust league table, placing us 108th out of 134 Trusts (previous quarter 3.46, 104/134). **IPC Surveillance:** The loss and continuing lack of an IPC surveillance system remains high-risk on the Trust Risk Register. Partial mitigation using a variety of systems and human resources is in place but does not give easy visibility of emerging concerns, nor real-time alerting of infectious cases. **A single integrated surveillance system is required for compliance with the Board Assurance Framework for IPC**.	***E. coli* bacteraemia**: Sources of these continue to suggest improving catheter practice is likely to have some impact, and the Continence team continue to progress the use of catheter packs which have been shown to reduce infection rates in other trusts. **Staffing:** no appointment made at recent interviews for Senior IPC Practitioner vacancy; the post has been readvertised. **IPC Surveillance**: There has been no further development of the Eureka platform since July 2025 with no imminent progress likely, and gaps in our surveillance remain. Meetings are on-going with the CDIO and leads from IM&T to identify potential funding for a commercial IPC surveillance platform – this is beginning to progress through the business planning process, however the impact of the current financial position is a concern.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

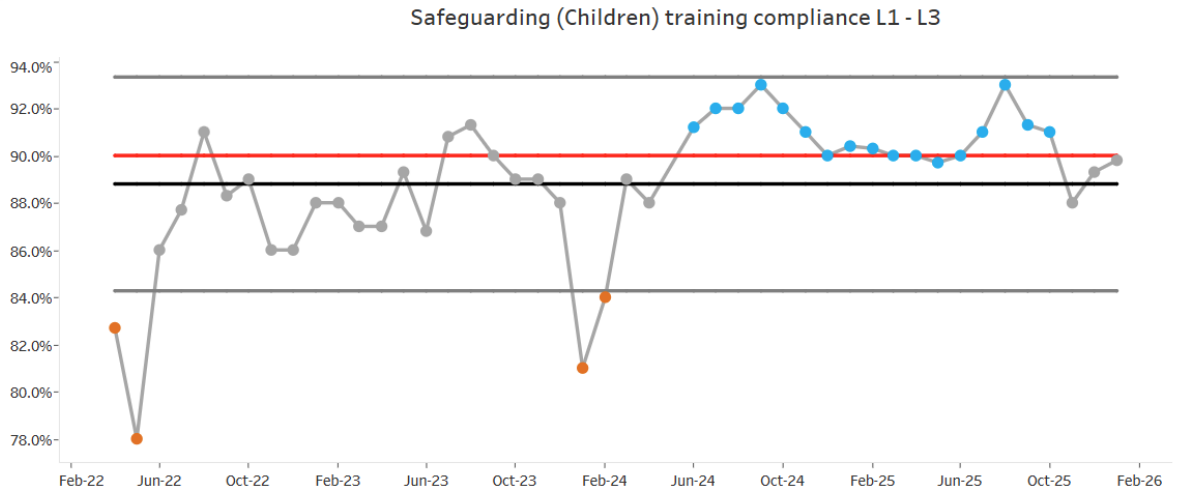
3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MSSA: Subject to mandatory reporting to UKHSA but no threshold set. We have seen one more MSSA case so far this year than we had by the same time last year, however the last two months have seen higher than average numbers, with the majority of those (61%) having an intravascular device as the source. **MRSA Bacteraemia:** There were 2 cases of healthcare associated MRSA bacteraemia in January, our first cases for six months. The number of MRSA bacteraemia cases assigned to OUH between October 2024 and September 2025 has given the Trust a score of 3.74 in the NHS Oversight Framework Acute Trust league table, placing us 119th out of 134 Trusts which is an improvement on the previous quarter (3.88,127/134), based on a count of 8 cases. We will be reporting 6 cases in the next Acute Trust league table to the end of 2025. **Influenza:** National and South East influenza modelling and case numbers support our local data with a reduction in influenza positivity and admission following a mid-December peak. The Trust has managed a small number of ward based influenza acquisitions and out breaks. **Norovirus:** Nationally there are a number of bed closures due to Norovirus in place with a higher than usual number of norovirus cases and expected to rise in the next 2 weeks. Locally we have managed 7 outbreaks of Norovirus across 2 sites in January.	**MSSA**: Learning from cases around the management of IV devices is being identified and shared with clinical and divisional teams, as well as through the IPC bimonthly update to SLIC. A Trustwide audit of IV device practice is being planned. **MRSA**: Changes to MRSA screening practice, to increase detection and treatment of MRSA colonisation, were trialled on Ward 6A in December and will be rolled out Trustwide from February. **Winter Pressures:** Point of care testing (POCT) for Influenza and COVID-19 continues to be available in emergency care areas but case numbers are declining. The IPC team are on site 7-days a week to assist with patient placement. Enhanced Mask wearing is no longer required in line with the reduction in local figures and national surveillance. RSV point of care testing (POCT) has now been withdrawn as the RSV season is over.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

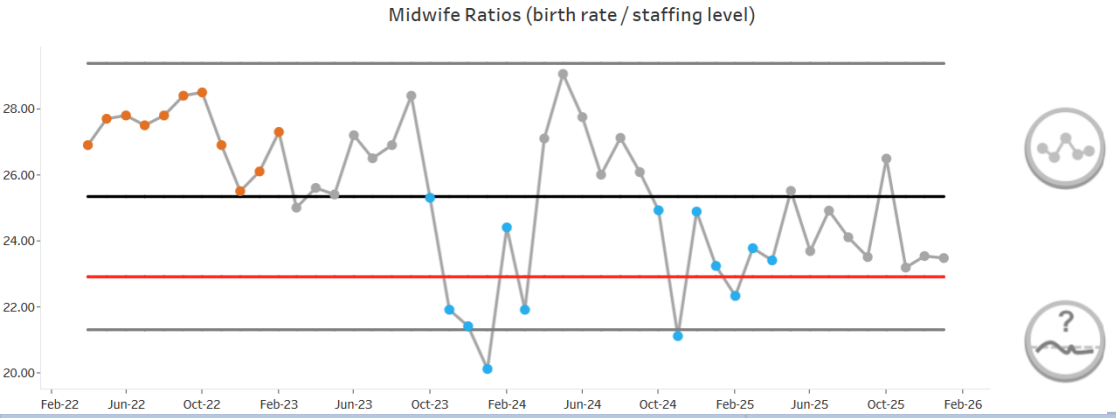


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
High risk Sepsis In January, 7 patients who met high-risk sepsis criteria experienced a delay in receiving antibiotics within the recommended one-hour timeframe. Review of the electronic patient record (EPR) identified potential contributory factors. • **2 patients had long ambulance queue wait and corridor nursing** • **1 patient had difficult IV access documented by nursing staff** • **1 patient was medically expected and review delayed** For some patients, a possible cause was not easily identifiable. • 6/8 of the delays happened during the evening/overnight. • Delays to antibiotics ranged from 64 to 174 minutes **Moderate Risk Sepsis** In January, 1 patient who met moderate risk sepsis criteria experienced a delay in receiving antibiotics within the recommended three-hour timeframe. For this patient, an initial differential diagnosis of stroke was made, ED then handed over to the medical team and the plan to follow through with antibiotics and fluids came from their review.	**Summary** Although the number of cases reviewed is small, any deviation from the sepsis standards has a disproportionate impact on overall performance metrics. Review of the causes for delays identified the following themes: • Clinical decision-making prior to prescribing, particularly where diagnostic imaging was prioritised • Delays between prescription and documented administration, despite timely medical review. However while the average time from prescription to administration (30 minutes) exceeded the local 15-minute standard, this represents a notable improvement compared to November. • Extended time to senior clinical review following the initial sepsis alert • Competing clinical priorities and diagnostic pathways overnight **Patient Outcomes** • All patients survived and were discharged home. • Length of stay ranged from 1 to 5 days. • No adverse outcomes related to delayed antibiotic administration were identified.	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 team collaborate with the ED governance lead Nurse consultant who reviews those with delays and provides a deeper dive into any factors causing delay within ED such as corridor care nursing, staffing and ED acuity. These issues are then reported back into the clinical area for improvements and learnings. Introduction of a Sepsis PGD is under consideration by the ED and Infection teams.		

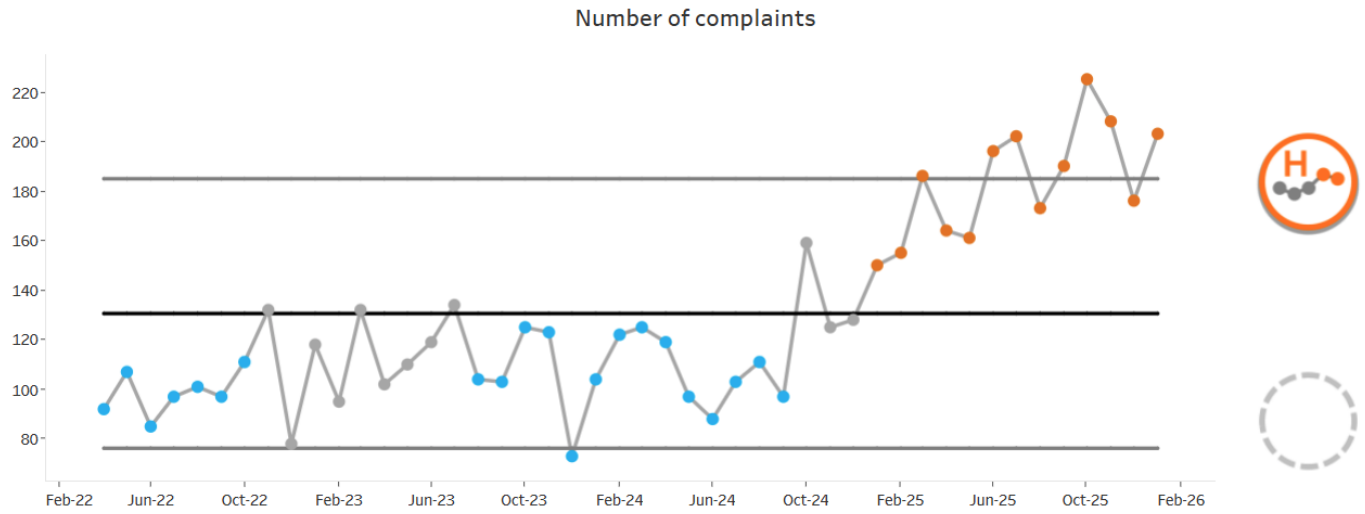


Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
Safeguarding Children level 1 training remains at 95%, level 2 dropped slightly to 88.5% (1010 staff) and level 3 improved slightly by 1% 88.5% - there are 257 staff not compliant with training out of the 1792 staff. The KPI is at 90%.	Divisions are requested to encourage compliance. Level 1 and 2 are online courses. Level 3 training is available as online training and face to face/ teams. Due to ongoing reduced capacity from long term sickness in the team there has been limited face to face / MS Teams training available. This has recommenced. Names of staff requiring training are available to managers via the MLH reporting and lists are available to obtain for oversight via MLH. The Head of Safeguarding has provided ED and NOTSSCaN with lists of staff who are non-compliant, with a request for follow up to ensure completion.	• PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee. • Chair of PSEC reiterated to divisional reps the need to undertake training and taking to Trust Clinical Governance Committee as an exception. • Divisions are requested to encourage staff to attend as part of reporting. • Safeguarding Steering group quarterly update on training compliance.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

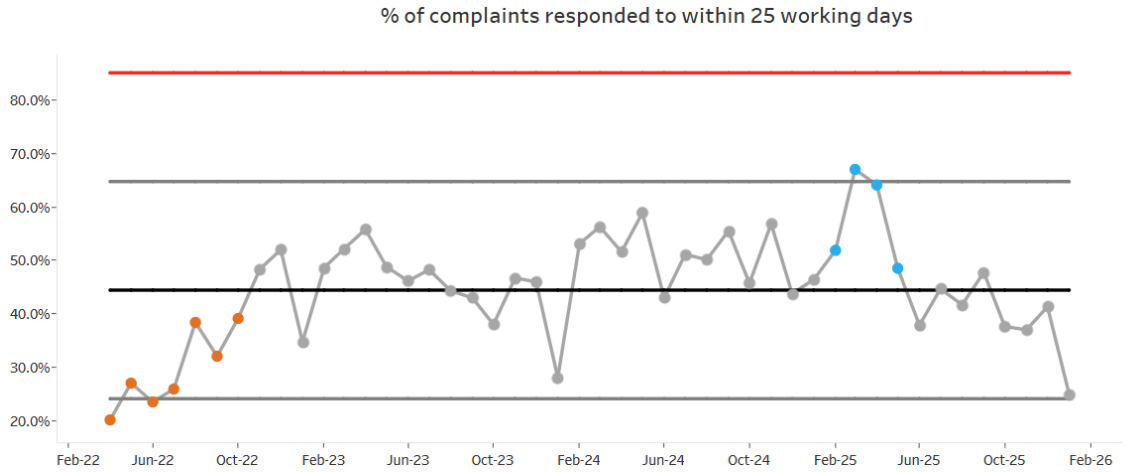


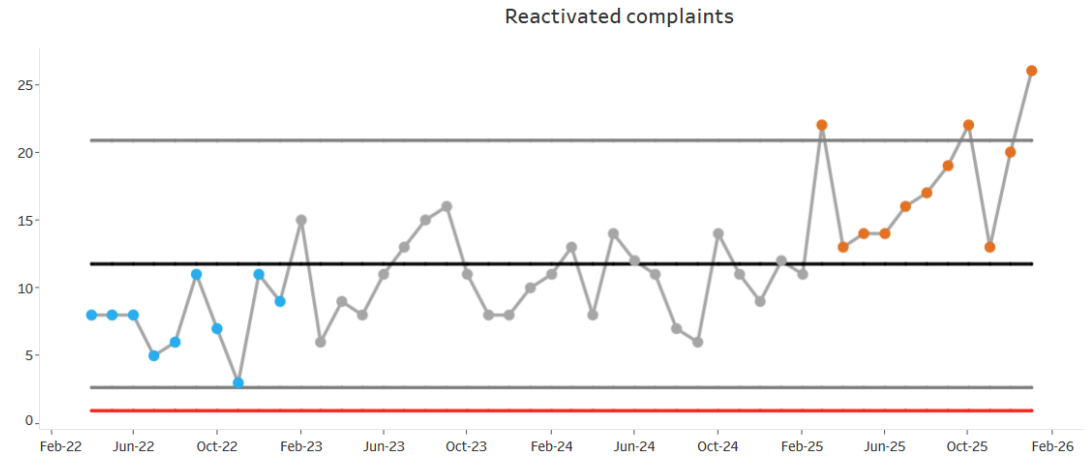
Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
In January, a total of 612 mothers gave birth to 626 babies at OUH. Subsequently this was an increase in the birthrate of 4.15%. The current midwife to birth ratio is 1: 23.47 and has been static since November 2025. This correlates with increased available clinical staffing and reduced birth rate and is aligned to 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 occasions when the Delivery Suite (DS) coordinator was not supernumerary and no occasions where the service could not provide 1:1 care in labour. On-call utilisation decreased, with 116.75 hours of on-call time used compared with 211.55 hours in the previous month. Within this total, hospital on-call usage decreased from 121.3hours to 96.25 hours, demonstrating the service's ability to flex resources to meet clinical demand and ensure safe staffing during periods of heightened activity. In January, the midwifery workforce stood at 340.7 WTE, representing a true vacancy of 14.3 WTE which highlights the ongoing challenge of unavailability due to maternity leave which is circa. 9% of the workforce.	In January the midwifery workforce stood at 340.7 WTE, representing a true vacancy of 14.3 WTE (4%). Recruitment pipeline and activity remains strong, with 6.72 WTE Band 5/6 midwives commencing in post during January. A strong recruitment pipeline is in place, providing assurance that the service is progressing to full establishment, supported by an ongoing pro-active recruitment campaign. 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. Additional community night on-calls are now consistently rostered in addition to the hospital on-call roster.	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 including unavailability by March 2026. Weekly monitoring of: • One to one care in labour. • Supernumerary status of Delivery Suite Coordinator. • Accuracy of Safe Staffing fill rates. • Community on-call hours required. • Community based births • NHSP spend. CNO establishment review is being undertaken in February/March 2026 Birthrate Plus assessment is ongoing within the service with a draft report anticipated by the end of Q4 2025/26.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*



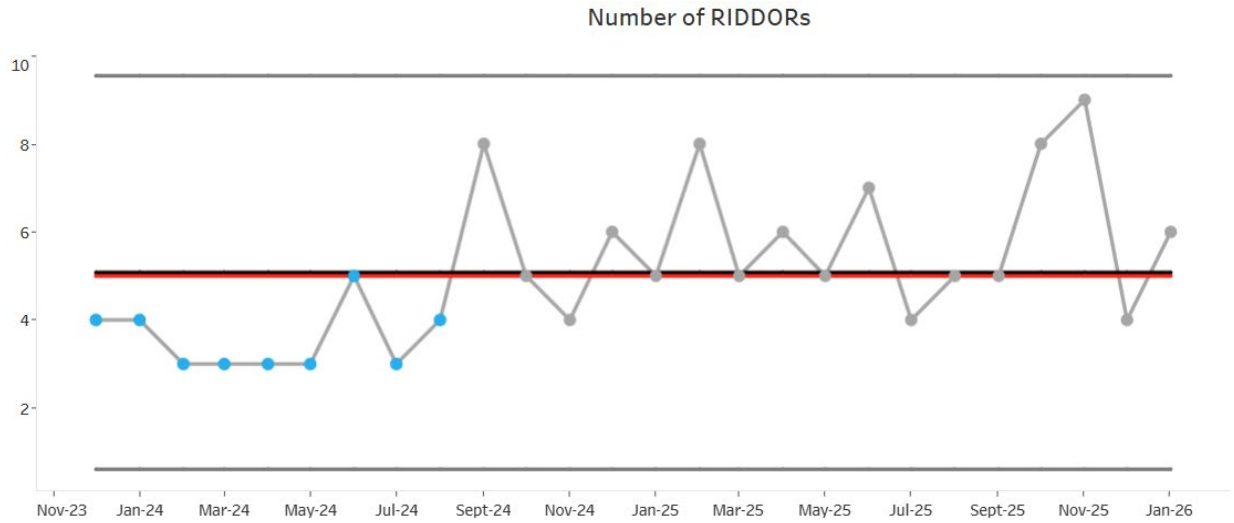
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Continuation of upward trend in the volume of patient complaints is creating ongoing challenges with timeliness and quality of complaint responses. This is further exacerbated by increasing complexity of complaint letters and emergence of complaints written using Artificial Intelligence platforms resulting in loss of clarity of the subject of the complaint and unrealistic demands being made. These issues are being seen nationally.	201 formal complaints were received in January, an increase of 14.9% compared to the number received in December (n=175). The top five categories of these complaints were: Communications (n=38/19%), Clinical Treatment (n=30/15%), Appointments (n=23/11%), Trust Admin/Policies/Procedures (n=14/7%) and Patient Care (n=13/6%). The top categories remain consistent with previous months. Discussion at the new Patient Experience and Engagement Committee on 16/02/2026 focused on strategies to empower staff to resolve issues in the moment (especially in Outpatients) and to streamline complaints processes using templated responses for common (simple) complaint issues. The new committee will also review new patient experience reports highlighting Trust-wide issues and trends with a view to work collaboratively on addressing the more 'wicked' problems that are driving volume.	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*





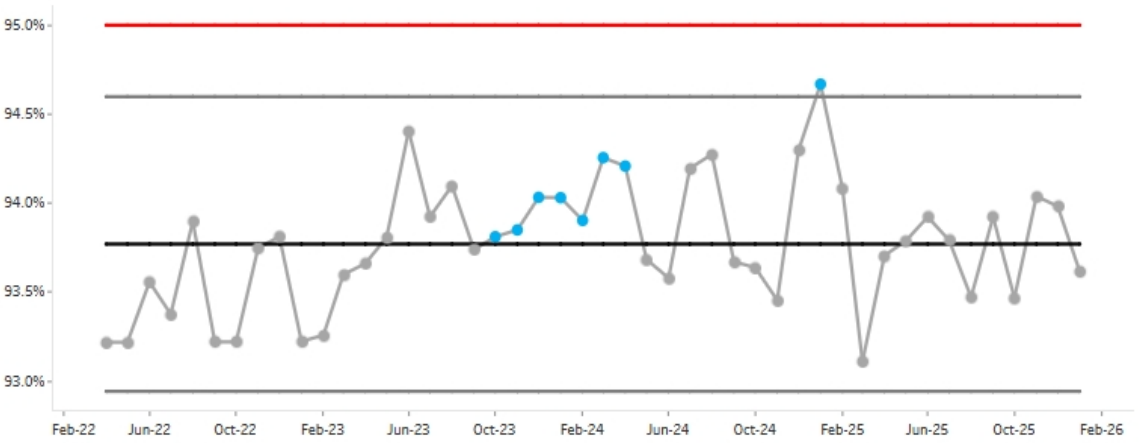
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
In January 2026, OUH received a total of 201 formal complaints, continuing the special cause variation (shift) and contributing to ongoing challenges with meeting the 25-day KPI.	The Trust received 201 complaints in January, which is a 14.9% increase from December, when the Trust received 175 complaints. Complaints relating to maternity remain high (n=19) for this month along with complaints pertaining to Gynaecology (n=13),.Children's (n=16) and Emergency Medicine (n=27). From January, the Trust's measurement of compliance with the 25-day KPI is being measured using a median value. In January 2026, the Trust took a median average of 26 days to investigate and respond in full to complaints. This highlights that most breaches are within a few days of the target, and allows a stronger focus on accountability for complaints that remain open for extended periods. In total 152 complaints were closed in January. Reopened complaints increased in January, with 26 complaints (13%) reopened. 11 of these reopened complaints were within the MRC Division. Most requests relate to a want for more information, dissatisfaction with the initial response, or requests for meetings to discuss findings from complaint investigations. This is an increase from December where 21 cases (12%) were reopened. Reporting of reactivated complaints will be graphically presented as a proportion (%) of total complaints from February instead of current numbers. New reporting templates for patient experience will be tested in March. These will provide a structured approach to exploring the themes and trends at divisional and directorate level, using triangulation of data to identify priorities and establish formal quality improvement activities to address themes. AI solutions to support the recording and investigation stages of complaints continues at pace with Microsoft. It is hoped to move to a testing phase shortly prior to a rollout in selected directorates. Feedback on this work will continue to be reported through this forum.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*



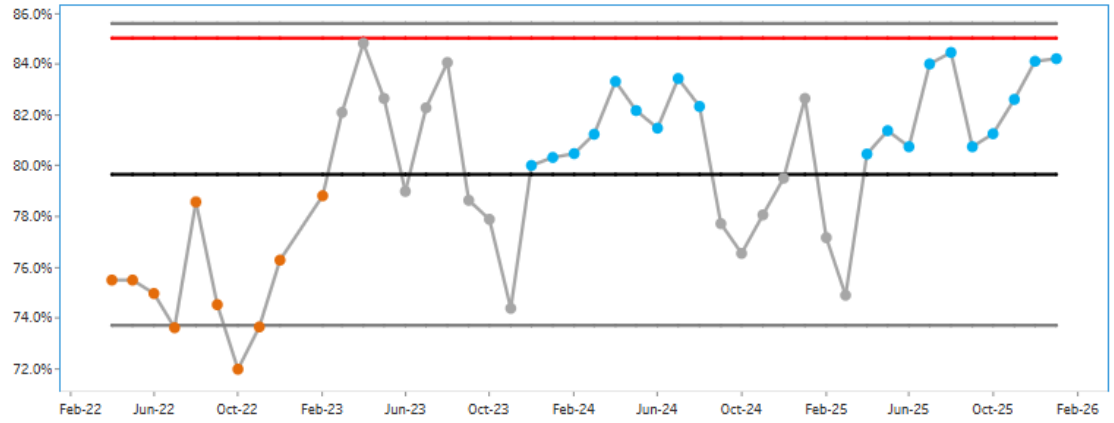
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were six incidents reported to the HSE in January under RIDDOR. Five incidents related to staff and one incident was Patient related. The Patient incident was a fall on SSIP. However, in the Harm Free meeting it was discussed that the handover from EAU was poor and had this been comprehensive with SBAR then ECCO 3 (close observation) would have been started sooner, and the fall may have been prevented. The staff incidents that occurred were: • One physical assault by a patient on staff that resulted in the staff member being off for more than 7 days • Two lifting and handling injuries resulted in staff members being off work for 7 or more days. • One trip incidents that resulted in the staff member being off for more than 7 days • One struck against injury when a shelf fell on top of a member of staff that resulted in them having more than 7 days off work.	All staff incidents were locally investigated. The patient incident was investigated at Harm Free level with local actions being taken forward by the departments. There is no correlation between the incidents. The H&S team will continue to monitor and report any themes.	Incidents reported under RIDDOR are reported to the H&S Committee and Falls Prevention Group.	BAF 4	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months

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

Friends & Family test % likely to recommend - OP



Friends & Family test % likely to recommend - ED



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. Outpatient responses accounted for 11,414 of the total responses received (70%) and the recommended rate has remained at 93.6%. 2. The top positive themes during January for outpatients were staff attitude, implementation of care, and clinical treatment. The top negative themes were car parking, discharge and cancelled admission/procedures. 3. ED responses accounted for 1,341 (8.22%) of the total responses received, and the recommended rate has increased to 84.2% in January. 4. The top positive themes during January for ED were staff attitude, implementation of care and clinical treatment. The top negative themes were catering and discharge.	1. Each division presents an update on patient experience, including FFT data and themes at the Patient Experience and Engagement Committee bi-monthly. 2. Further work to promote online collection methods and improved response rates are being considered and will be further supported by the Patient Experience and Engagement Strategy that is currently in development.	1. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 2. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 3. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group, Patient and Engagement Committee [PEEC] and the Trust Governors Patient Experience and Membership Committee (PEMQ).	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

Summary of challenges and risks

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 December 2025. The exceptions were: Paediatric Critical Care Unit (PCCU) level 3 for ten-night shifts and five-day shifts; Shifts were mitigated to make the unit safe by implementing team nursing supported by the other Critical Care Units. The Children's Hospital declared level 3 on two-day shifts, and two-night shifts. These were mitigated by reducing capacity. MRC also declared level 3 for one-day shift. These shifts were closely monitored by Senior staff. The Trust-wide planned versus actual fill rates were 92.25% for day and 97.75% 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 metrics 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/midwifery-sensitive harm indicators are directly related to staffing levels. The December review confirmed across all divisions, there were no instances of nurse/midwifery-sensitive harm indicators directly linked to nursing or midwifery staffing levels. The HR data is being reviewed, as following amendments to budgets, 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.

SUWON – Rostering KPI's- Upper GI and SEU-F wards had a net hour's difference outside of the KPI, related to students, not substantive staff hours. Red flags not reviewed at the time the data was pulled, have since all been reviewed, except for Wytham and Renal wards, which is being addressed by the DDN.

MRC – The rostering KPI's were not met by six wards for manager approval for payroll. Two wards were not approved at all, three were approved by the ward manager, but not Matron, with the remaining ward approved, but then impacted by a sickness absence. This has been addressed with the Matron's by the DDN. HH EAU has a net hours difference, relating to a Nursing Assistant, this is being investigated by the Deputy DDN. There were no concerns the reported nurse sensitive indicators related to unsafe staffing.

NOTSSCAN – Some wards' CHPPD was in line with budget, however slightly lower than required, mainly because of patients requiring a level of enhanced observation. Shifts were mitigated by ward managers, educators, and support staff working in numbers. Fill rates of less than 90% were seen across the children's wards. Upon review, some shifts were required and remained unfilled, but in addition, some shifts not required, had not been cancelled. This is being addressed by the DDN.

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 December. The actual CHPPD was lower than the budgeted. However, the difference is accounted for, as the supernumerary coordinators and shift float (senior nurse) are not included in the figure. The Annual Leave was above KPI, as due to low patient numbers throughout December, the unit approved some additional adhoc leave. This had no detrimental impact to patient care or cost for temporary workforce.

Maternity – The CHPPD for Level 6 are higher than budget, due to complex patients requiring additional midwifery care. The Deputy DDN has reviewed the data since it was pulled and confirms that all red flags have now been reviewed and resolved. The roster lead time has also been reviewed, with the Lead Nurse for staffing confirming the lead time of 8 weeks was met on the shown rosters.

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

Recruitment and Vacancies
Following the recent budget allocations, there continue to be some discrepancies in the vacancy data in ESR and the ledger. However, the divisions have worked closely with their finance teams to ensure staffing numbers utilised are aligned with the CNO approved safe staffing requirements following the establishment reviews for inpatient wards. Alignment work is now underway in ESR and the roster templates.

The Trust implemented a pause to recruitment at the end of the November 2025. Some areas are exempt from the pause, with a robust process now in place for exceptions.

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

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

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

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

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

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

HR Vacancy: For the designated areas this figure is the establishment (Budget FTE) minus the contracted FTE in post as at the last day of the month. The vacancy figure is then divided by the establishment. The figures presented reflect both registered and unregistered staff. **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 at Trust level triangulated with other Trust level metrics allows the Board to see where there are increased capacity and acuity, (required) versus budget.	N	***Sufficient*** Information reported at required level. Staff appropriately trained and quality assurance process in place each month for audit. Corporate validation/audit undertaken with DDNs and Deputy Chief Nurse workforce team monthly.

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

January 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR				Rostering KPIs 29.12.25-25.1.26				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Censur Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2/- 2%	8 week lead time	Annual Leave 12-16%	1 - Extremely Likel	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
NOTSSCaN																										
Bellhouse / Drayson Ward	8.91	11.03	9.7	83.87%	2				3	2	0	0	8.95%	14.11%	3.16%	6.64%	Yes	-0.20%	8.29	13.90%	23	7	2	0	1	0
HH Childrens Ward	9.29	8.99	11.4	88.17%		4			1	0	0	0	1.84%	4.94%	5.28%	4.88%	Yes	-1.86%	7.86	15.57%	40	5	0	1	0	1
Kamrans Ward	10.11	10.73	9.9	100.00%		19			1	0	0	0	4.84%	6.43%	1.92%	3.95%	Yes	-0.54%	8.86	15.33%	10	1	0	1	0	0
Melanies Ward	9.73	11.80	10.9	100.00%					0	0	0	0	-8.17%	10.59%	6.83%	5.88%	Yes	-1.84%	9.57	16.04%	17	5	0	1	1	0
Robins Ward	10.61	12.76	10.2	91.40%	16				5	0	0	0	15.29%	22.04%	5.90%	4.12%	Yes	-2.61%	8.86	14.08%	8	4	0	0	0	0
Tom's Ward	8.00	9.43	9.3	100.00%		2			1	0	0	0	10.44%	2.88%	4.62%	7.82%	Yes	0.13%	9.57	15.59%	27	2	1	0	2	0
Neonatal Unit	19.37		18.1						7	2	0	0	18.68%	5.53%	6.19%	5.74%	Yes	-1.33%	8.29	14.75%	1	0	0	0	0	0
Paediatric Critical Care	27.59		27.4						17	4	2	0	14.37%	5.02%	5.49%	5.89%	Yes	0.15%	8.86	14.94%	0	0	0	0	0	0
BIU	6.27	7.18	7.2	100.00%					3		0	2	17.57%	14.04%	2.56%	8.55%	No	0.46%	9.29	12.12%	0	0	0	0	0	0
HDU/Recovery (NOC)	4.82		17.6						3		1	0	8.78%	6.94%	9.26%	0.00%	No	0.44%	8.43	20.92%	0	0	0	0	0	0
Head and Neck Blenheim	7.29	7.45	7.5	100.00%					0		0	3	5.90%	0.00%	2.34%	0.00%	Yes	0.20%	9.29	15.58%	23	0	0	0	0	0
HH F Ward	7.44	9.24	7.6	100.00%					3		1	1	3.75%	2.11%	4.28%	0.00%	Yes	-0.22%	9.29	13.92%	9	1	0	0	0	0
Major Trauma Ward 2A	9.22	9.42	8.9	91.40%		9			5		3	0	13.34%	9.31%	3.96%	8.68%	No	0.27%	7.71	16.67%	14	9	1	1	1	0
Neurology - Purple Ward	8.92	10.49	8.4	100.00%					3		1	5	5.41%	11.46%	6.01%	0.00%	Yes	2.15%	9.29	14.02%	5	1	0	0	0	0
Neurosurgery Blue Ward	8.94	9.98	8.9	100.00%		6			1		0	1	6.72%	2.01%	3.90%	4.40%	Yes	3.14%	9.29	12.99%	15	3	0	0	0	0
Neurosurgery Green/IU	12.57	9.95	9.5	100.00%		1	3		1		0	2	12.28%	8.93%	4.98%	5.41%	Yes	2.56%	8.57	16.46%	0	0	0	0	0	0
Neurosurgery Red/HC Ward	12.28	11.85	11.7	100.00%		8			0		0	5	-3.11%	6.23%	4.74%	5.81%	Yes	-0.47%	9.29	13.70%	1	0	0	0	0	0
Specialist Surgery I/P Ward	7.25	7.16	8.1	100.00%		4	1		3		0	12	5.11%	2.56%	4.13%	4.82%	Yes	-0.17%	9.43	14.56%	2	0	0	0	0	0
Trauma Ward 3A	9.17	9.59	8.9	95.70%	3	4		1	0		3	0	10.47%	9.72%	7.10%	6.27%	Yes	1.12%	7.71	15.48%	12	3	1	1	2	0
Ward 6A - JR	7.74	6.55	6.9	100.00%		2	2		0		0	3	4.52%	2.34%	3.16%	0.00%	Yes	1.67%	9.43	18.44%	21	8	0	0	0	0
Ward E (NOC)	6.30	7.46	7.4	84.95%					2		0	0	-4.82%	1.83%	5.83%	5.86%	No	3.07%	8.86	17.01%	32	3	2	0	0	1
Ward F (NOC)	6.65	8.97	7.3	100.00%			2		0		1	1	9.13%	5.58%	8.07%	3.12%	No	1.60%	9.29	16.79%	6	0	0	0	0	0
WW Neuro ICU	28.09		29.5						3		3	0	-12.91%	5.73%	5.13%	7.14%	Yes	-1.76%	8.00	11.75%	0	0	0	0	0	0

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

Oxford University Hospitals NHS Foundation Trust

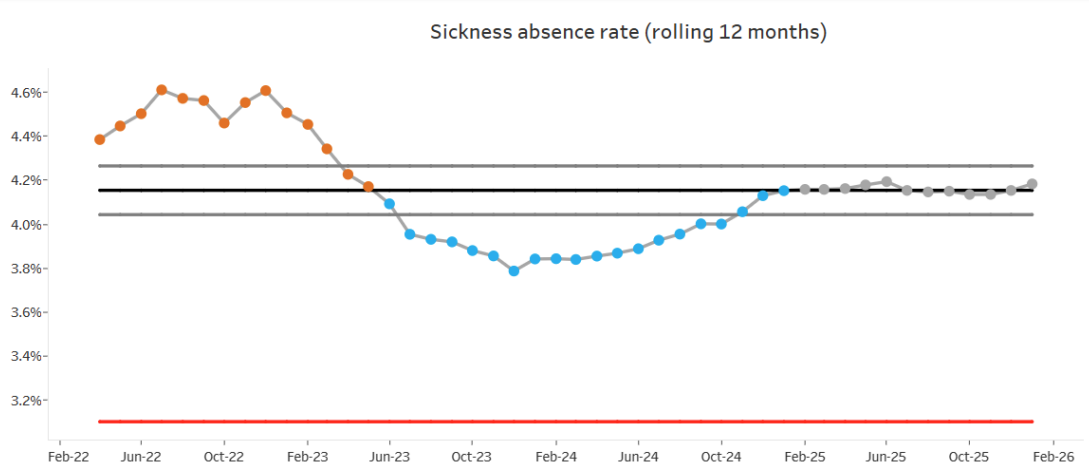
January 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR				Rostering KPIs 29.12.25-25.1.26				FFT - Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Censur Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2+-2%	8 week lead time	Annual Leave 12-16%	1 - Extremely Likel	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
MRC																										
Ward 5A SSW	9.02	9.24	8.0	100.00%		14	1	6	1		3	2	-4.24%	6.09%	3.16%	6.33%	Yes	0.49%	9.71	13.61%	20	9	1	0	0	0
Ward 5B SSW	8.88	9.45	8.5	100.00%		23			2		3	7	1.93%	5.79%	2.76%	4.47%	Yes	1.65%	9.71	12.16%	2	2	0	0	0	0
Cardiology Ward	8.02	7.09	8.5	100.00%		31	7	5	9		1	2	7.80%	6.46%	6.01%	6.62%	Yes	-0.08%	8.29	14.75%	3	0	0	0	0	0
Cardiothoracic Ward (CTW)	7.82	6.42	6.6	100.00%		8	1		2		0	3	13.86%	5.42%	4.10%	7.07%	Yes	-0.09%	8.43	16.72%	16	2	1	0	0	0
Complex Medicine Unit A	8.94	10.99	8.6	100.00%		8		3	2		2	7	10.87%	4.71%	9.26%	5.13%	Yes	2.03%	7.71	15.01%	4	0	0	0	0	0
Complex Medicine Unit B	9.48	10.16	8.7	98.92%	1				0		0	4	-1.02%	6.24%	6.82%	2.36%	Yes	1.93%	7.71	12.64%	7	4	1	0	0	0
Complex Medicine Unit C	8.88	10.55	8.1	100.00%	1				1		0	1	7.08%	6.91%	3.10%	9.78%	Yes	-0.37%	7.71	12.41%	31	5	1	0	0	0
Complex Medicine Unit D	9.21	9.21	9.3	98.92%		1			1		2	6	13.32%	16.68%	4.58%	2.62%	Yes	0.84%	7.71	14.63%	4	0	3	0	0	0
CTCCU	21.10		21.1						1		2	0	15.64%	9.12%	4.58%	1.24%	Yes	0.21%	8.86	13.74%	2	0	0	0	0	0
Emergency Assessment	9.23	8.69		95.16%		3			5		1	8	12.37%	10.44%	6.83%	2.38%	Yes	-0.35%	8.29	15.96%						
JR Emergency Department	19.84								7		0	4	17.86%	16.41%	4.00%	2.79%	Yes	-2.96%	8.57	14.09%	511	146	53	39	38	18
HH EAU	9.77	7.08		96.77%					2		1	12	4.55%	11.23%	7.23%	1.20%	Yes	2.53%	9.29	11.78%	0	0	0	0	0	0
HH Emergency Department	22.08								1		0	1	6.12%	4.61%	3.50%	7.70%	Yes	-1.58%	9.29	15.15%	380	92	22	11	29	2
HH Juniper Ward	8.12	10.47	7.8	100.00%					0		9	4	-5.08%	5.85%	5.59%	6.58%	Yes	0.02%	9.43	15.69%	4	1	0	4	0	0
HH Laburnum	9.66	9.93	8.0	100.00%					1		0	1	-5.41%	12.16%	5.02%	3.71%	Yes	0.88%	8.57	11.97%	2	0	0	2	0	0
HH Oak (High Care Unit)	10.58		11.1	94.62%	5				0		4	1	0.76%	2.54%	4.51%	12.15%	Yes	-1.29%	9.43	13.33%	8	0	0	0	0	0
John Warin Ward	10.72	11.48	10.2	98.92%		21		2	2		0	3	-1.73%	5.80%	4.08%	7.20%	No	0.27%	8.86	14.01%	14	4	1	0	0	0
OCE Rehabilitation Nursing	11.68	10.24	9.7	94.62%	2		3		0		0	3	10.78%	13.21%	4.12%	1.76%	Yes	-3.11%	9.43	15.46%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
Osler Respiratory Unit	14.58	9.16	12.1	96.77%		4	4		1		1	0	-0.83%	7.07%	4.23%	2.87%	Yes	-1.28%	8.86	14.61%	6	0	0	6	1	0
Ward 5E/F	11.18	7.83	9.6	96.77%		16	1	3	1		1	1	15.38%	10.65%	4.39%	3.95%	Yes	0.80%	9.71	12.74%	5	6	0	5	0	0
Ward 7E Stroke Unit	10.93	9.15	9.1	94.62%		4	7		2		1	4	0.76%	7.18%	5.43%	3.99%	Yes	0.09%	8.86	14.87%	18	4	1	1	1	0

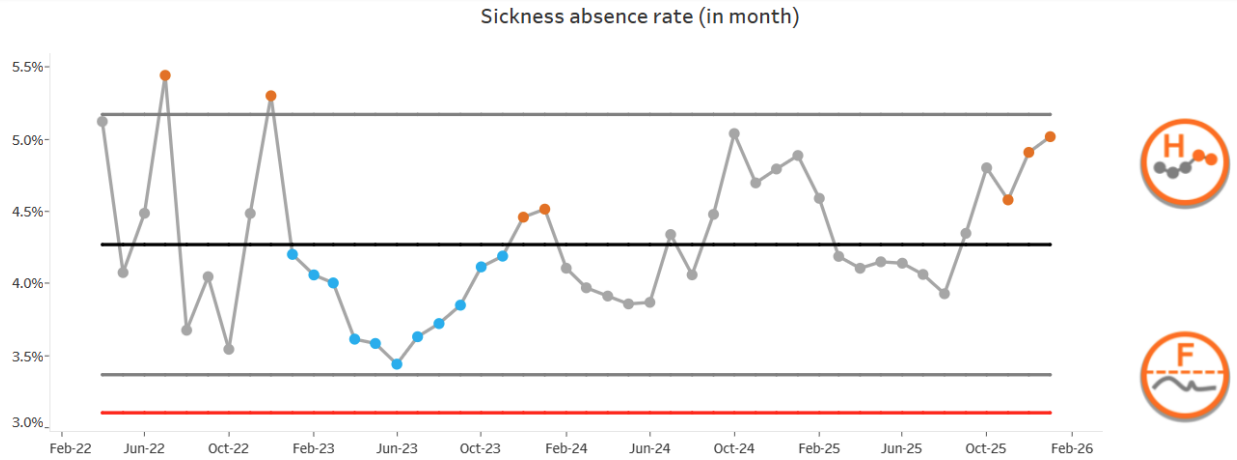
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

January 2026	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR				Rostering KPIs 29.12.25–25.1.26				FFT – Total responses in each category for each ward					
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Censur Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Injury Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Roster manager approved for Payroll	Net Hours 2/- 2%	8 week lead time	Annual Leave 12-16%	1 - Extremely Likel	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
SUWON																										
Gastroenterology (7F)	7.50	7.90	7.8	100.00%		23			1		2	4	-4.41%	5.24%	5.39%	9.09%	Yes	-1.63%	7.86	12.72%	9	4	1	0	0	0
Gynaecology Ward - JR	5.14	5.37	7.6	100.00%					1		0	0	6.57%	10.25%	6.36%	0.00%	Yes	-0.39%	8.71	16.97%	10	0	0	0	0	0
Haematology Ward	7.46	9.10	9.6	95.70%		8	6	1	4		0	1	9.38%	12.49%	6.99%	11.16%	Yes	-3.39%	7.29	16.83%	8	2	1	0	0	0
Katharine House Ward	8.63	8.80	9.7	95.70%		6	7	1	2		0	1	11.61%	6.75%	5.92%	0.00%	Yes	1.72%	9.57	15.15%	0	0	0	0	0	0
Oncology Ward	7.47	7.97	7.7	97.85%		3	6		3		7	5	10.25%	5.63%	4.37%	4.44%	Yes	-0.13%	9.43	14.98%	6	1	0	0	0	0
Renal Ward	7.01	10.52	10.5	100.00%	1	6	3	2	1		0	1	8.67%	15.16%	3.83%	3.49%	Yes	4.48%	9.71	13.77%	3	1	0	0	0	0
SEU D Side	7.99	7.68	8.0	98.92%					1		2	3	10.18%	9.86%	4.62%	4.45%	Yes	-0.81%	9.29	13.57%	14	5	2	0	1	1
SEU E Side	7.92	8.02	8.2	98.92%					2		1	0	15.22%	18.22%	7.55%	0.00%	Yes	0.34%	9.29	13.88%	32	7	0	0	0	0
SEU F Side	7.51	8.50	8.2	98.92%					0		0	1	15.89%	13.34%	3.26%	3.29%	Yes	-10.75%	9.29	13.86%	41	18	0	1	0	0
Sobell House - Inpatients	7.76	8.27	7.6	100.00%		7			2		4	7	8.64%	8.74%	5.20%	5.89%	Yes	-2.74%	9.57	13.10%						
Transplant Ward	9.22	7.54	8.3	100.00%		14			1		0	0	12.86%	2.06%	6.73%	2.04%	Yes	-0.48%	8.71	15.30%	21	1	1	0	0	0
Upper GI Ward	9.39	7.10	8.4	100.00%		5			0		5	0	2.71%	2.68%	5.32%	11.66%	Yes	-3.60%	9.00	15.29%	33	2	0	0	0	0
Urology Inpatients	9.12	8.77	8.8	94.62%		13	4	2	1		0	6	11.07%	3.37%	4.30%	10.12%	Yes	-2.33%	8.71	19.27%	42	3	0	0	0	0
Wytham Ward	6.78	7.50	6.7	100.00%		17			1		2	0	-3.50%	9.22%	5.72%	2.89%	Yes	-7.51%	9.00	21.05%	26	7	2	0	0	0
MW Intrapartum Team	13.66		17.5				39	1									Yes	-2.81%	7.00	10.68%						
MW Level 5	5.40		5.4										-3.73%	13.08%	4.81%	6.12%	Yes	0.51%	7.86	12.06%						
MW Level 6	4.60		7.7														Yes	-1.08%	7.86	8.23%						
CSS																										
JR ICU	31.13		23.2	100.00%	-	-	-	-	9		2	1	12.65%	13.87%	4.48%	4.75%	Yes	-1.75%	8.57	11.97%						

3. Assurance report: Growing Stronger Together

Oxford University Hospitals NHS Foundation Trust



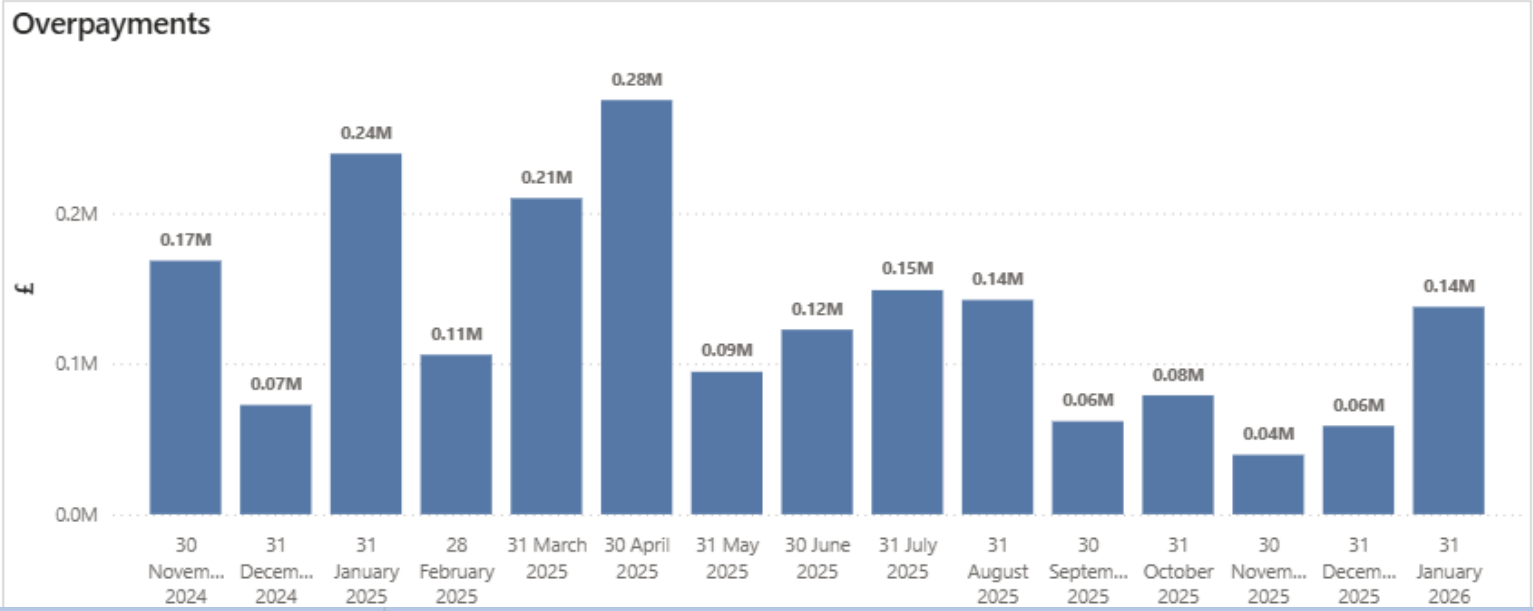


Benchmarking: October 2025 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.62% **National: 5.83%** **Shelford: 5.04%** Buckinghamshire Healthcare NHS Trust: 4.78% Royal Berkshire NHS Foundation Trust: 3.92% Oxford Health: 5.47% South Central Ambulance Service: 7.28%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.2% in January 26 – the same rate as December 25. The monthly sickness rate has increase to 5.0% from 4.9% . As we are in the "flu" season, this will be closely watched. The key reasons for sickness top 5 continue to be :- • Mental, Behavioural or Neurodevelopmental • Respiratory system • Musculoskeletal or Connective Tissue • Digestive system • Injury, Poisoning or External causes Long-term sickness top 5 reasons:- • Mental, Behavioural or Neurodevelopmental • Musculoskeletal or Connective Tissue • Injury, Poisoning or External causes • Neoplasms • Not elsewhere classified	• Divisions receive a monthly report on the top 20 reasons for absenteeism and develop action plans to address these issues, particularly focusing on the Cost Service Units (CSUs) with high rates of absenteeism. • We are working with Occupational Health to help managers and staff review the leading causes of absences. There is an emphasis on providing support for staff with long-term sickness to aid their return to work. • Managers will be notified about staff members triggering absenteeism alerts, with guidance available for handling the process. HR is promoting training for managers on sickness absence management. • Return-to-Work (RTW) forms are now easier to complete, and the narrative has been updated to assist managers conducting RTW interviews. Local workshops on sickness absence continue to support managers, while Occupational Health will provide ongoing assistance during monthly meetings to tackle issues proactively. • Monthly meetings with the Wellbeing lead help identify additional support needs, and efforts are being made to establish consistent 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

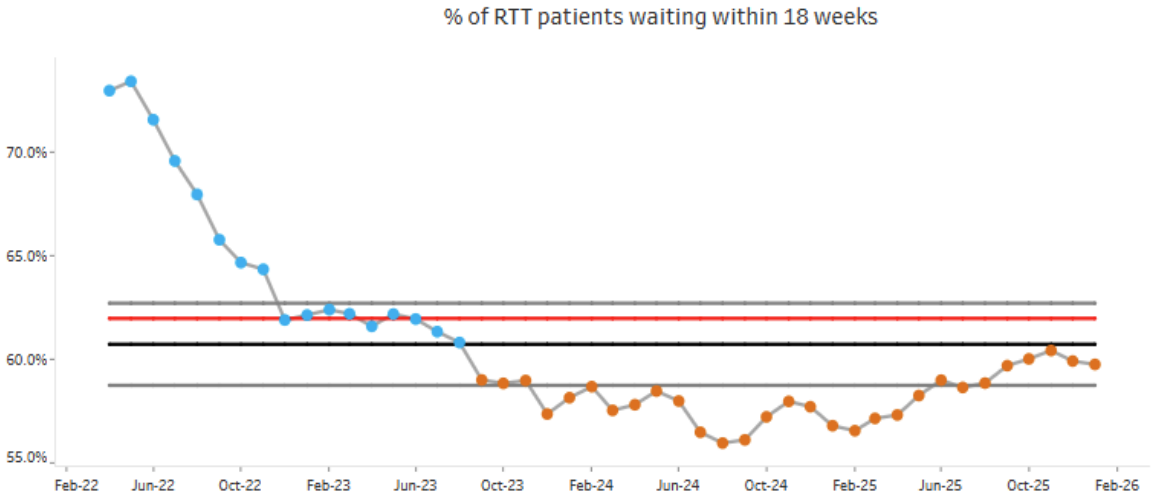
3. Assurance report: Growing Stronger Together



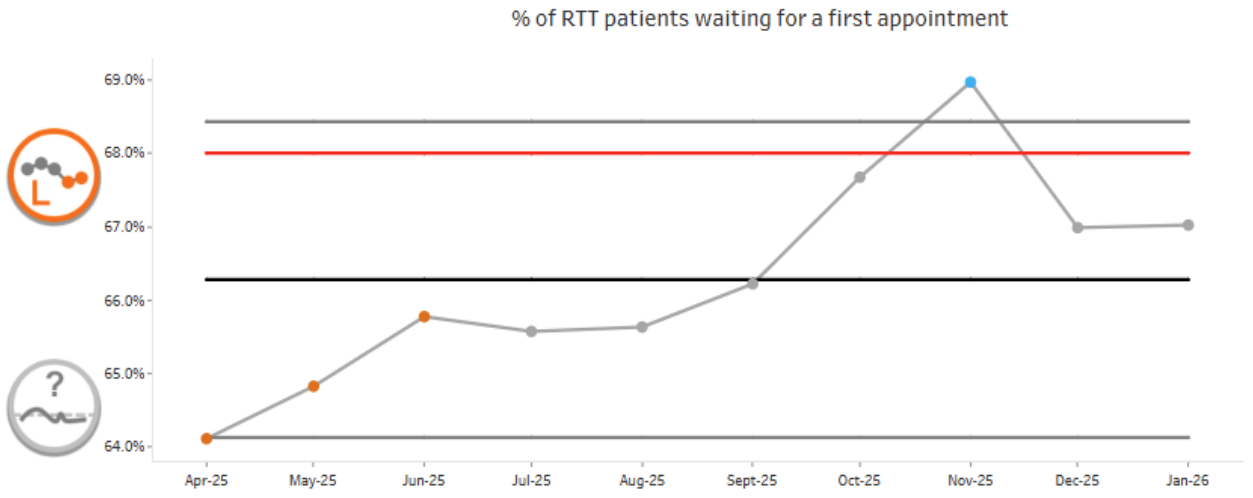
Division	25	30 November 2025	31 December 2025	31 January 2026
Clinical Support Services	498	£6,470	£8,343	£26,153
Corporate	286	£2,748	£9,493	£1,202
Education and Training				£2,014
Estates				£0
Medicine Rehabilitation and Cardiac	464	£5,794	£4,088	£42,832
Neurosciences Orthopaedics Trauma Specialist Surgery Childrens and Neonates	333	£14,216	£3,824	£44,796
Operational Services				£0
Research and Development				£309
Surgery Women and Oncology	385	£10,244	£32,930	£20,385
Total	**966**	**£39,472**	**£58,678**	**£137,691**

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality rating
Overpayments arise from: 1. Poor management of leavers process (there was an increase of late leaver forms in Dec 25 and Jan 26 which contributed to the increase) 2. Late submission and processing of change forms. 3. Late inputting of Job planning changes and change in hours have resulted in an increase in Jan 26. 4. Minimum Salary sacrifice payment levels and outstanding salary sacrifice balance for leavers.	Work is being undertaken as part of the payroll improvement programme that is being led nationally to address payroll errors (including overpayments). Actions include: • Rolling out understanding your payslip sessions across the Divisions. • Introduction of a handbook for managers setting out payroll procedures and FAQs. • Regular comms covering topics such as advising individuals to review their payslips and complete the offboarding process as soon as a leaver is identified. Other mitigating actions include: • Implementation of a new interface between medirota and ESR and health roster and ESR to reconcile overpayments. • Introduction of a new salary sacrifice policy, more information to support the schemes and the creation of a salary sacrifice mailbox for queries on absences and leaving the organisation. • Overpayments are reviewed and monitored at Senior Leadership level across the Divisions. • Payroll provide a monthly report of overpayments which is reviewed by the overpayment working group. • The working group discusses ways to reduce overpayments, shares best practice and measures the impact of mitigating actions being implemented. • Payroll audit salary sacrifice schemes and expenses to identify and address overpayments. • A leavers report highlighting individuals with outstanding salary sacrifice payments is shared with finance for reconciliation. • The EAP can provide support to staff impacted by overpayments. Salary finance provide financial wellbeing advice and support.	• Payroll improvement actions will be implemented by 31 Mar 26. • In progress – target delivery Apr 26. • Policy is progressing through socialisation – publication aim – Apr • BAU • BAU • Ongoing • Audit and corrections completed Dec 25 • BAU	Risk 2578 Risk 3248	Satisfactory

3. Assurance report: Operational Performance, *continued*

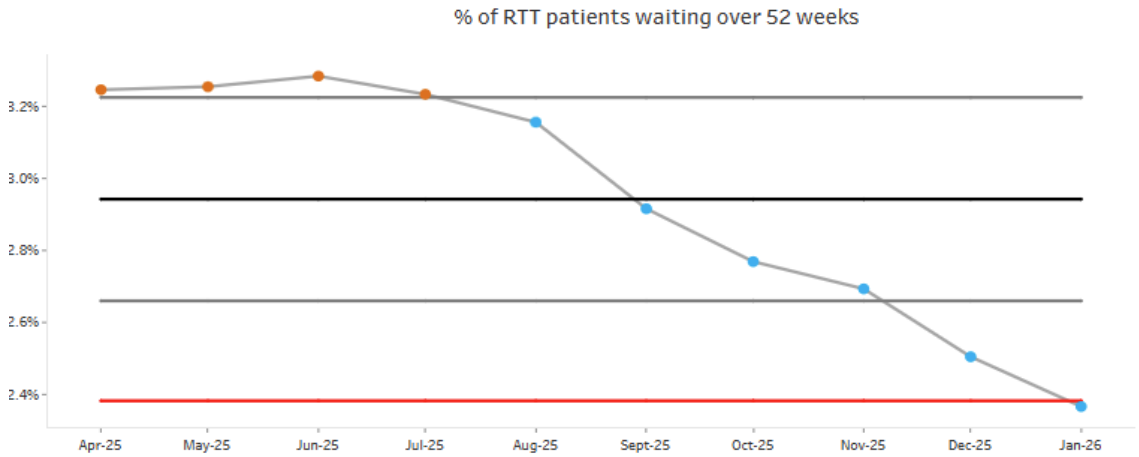


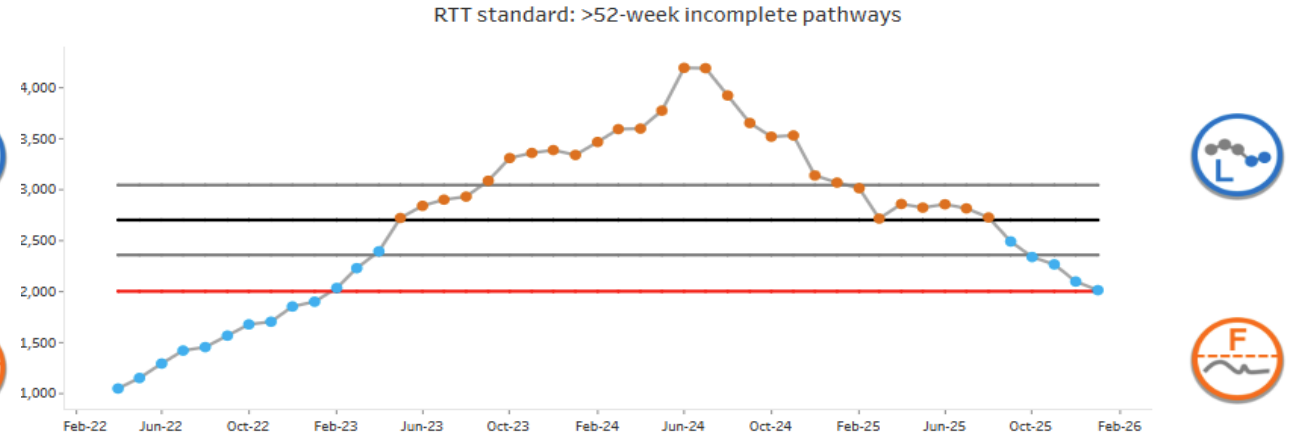
Benchmarking % within 18-weeks: December 2025				
OUH: 59.87%	National: 61.93%	Shelford: 61.50%	BHT: 59.06%	RBH: 82.15%



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 59.71% at the end of January against an operational plan of 61.93%. Performance exhibited special cause of concern due to more than six consecutive periods of performance below the mean. Clinical priority allocated to cancer services over routine treatments. Total incomplete RTT pathway waiting list size is 85,063 with 67.02% of patients awaiting a first appointment below 18-weeks.	The Trust is not on plan for patients waiting within 18 weeks as at the end of January, with a key focus on treating patients with the longest waits across all specialties. Validation Sprint continues into Q4 – utilisation of resources for administrative validation to scrutinise pathways above 18-weeks. Further review of prioritising all resources for Q4 for patients waiting above 18-weeks, and to support the implementation of Patient Engagement validation across all specialties for the patient cohort are between 30 weeks and 65 weeks. this cohort. We have changed our focus from total waiting list to the longest waiting patients, which we expect will lead to an increased waiting list for February and March. Plans are in place for additional specialties to use a digital outcome form in March which supports clinicians to place eligible patients on a Patient Initiated Follow-Up (PIFU), based on the work in the NOC, creating capacity for patients clinically required to be seen and potential to converting follow-up slots to new slots thus driving productivity opportunities. Utilising Elective Pathway Manager tool to constructively address inconclusive validation outcomes such as missing letter or clinical input required by all specialities.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

3. Assurance report: Operational Performance, *continued*



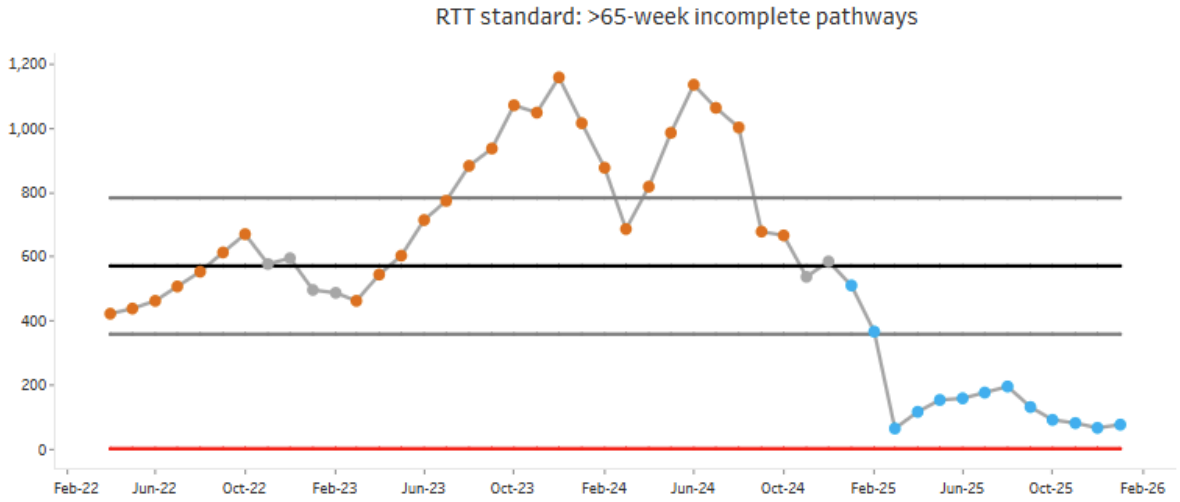


Benchmarking % over 52 weeks: December 2025				
OUH: 2.50%	National: 1.54%	Shelford: 1.52%	BHT: 2.36%	RBH: 0.12%

Benchmarking 52 week breaches: December 2025				
OUH: 2,095	National: 677 (median)	Shelford: 1,130 (median)	BHT: 1	RBH: 1

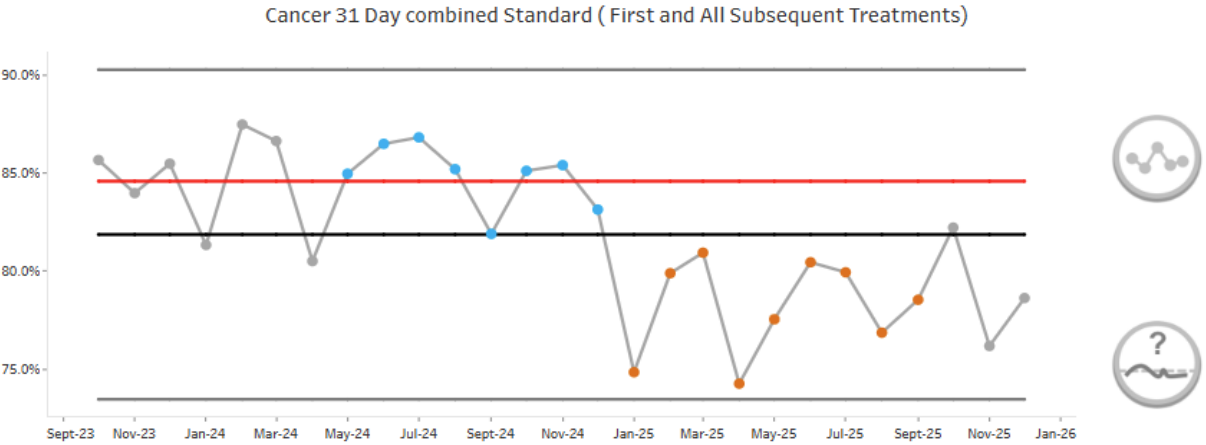
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks as a proportion of the total waiting list was 2.36% at the end of January against an operational plan of 2.38%. the lowest performance (positive) in the last 12 months. Performance exhibited special cause of improvement due to periods of performance outside the lower control limit. Incomplete RTT pathway size waiting over 52-weeks is 2,011 for January against a plan of 2,000. Over 65-weeks contributing to the position by 75 pathways against a target of nil.	January 52 week percentage of total waiting list plan was achieved, but volume missed plan by 11 patients. Delivery Funds are in place to increase short term capacity to support delivery of the operating plan, with all schemes fully mobilised. Q4 National Sprint funds allocated mid-January with schemes to commence as early as the beginning of February: - Outsourcing for general surgery, dermatology, and gastroenterology - WLIs for diagnostics (SeHCAT, PAE/VE, echo's), radiology navigator, psychology, neurology, sleep, and gynae All pathways within the 52-week cohort (March 26) awaiting 1st appointments were to be seen by the end of January. 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 52-week waits by March 2026, activity is above plan and specifically for the focus on 1st OPA which illustrates our deliberate move to increase this specific activity.	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*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 65 weeks to start consultant-led treatment was 75 at the end of January. Performance exhibited a positive special cause of variation due to exceeding below the lower control limit. The target was nil therefore was unable to deliver the operating plan for January **Focus remains on longest wait patients:** **>104 weeks - Nil** incomplete pathways reported. **>78 weeks - 2** incomplete pathways reported. Both Urology patients. **>65 weeks – 75** incomplete pathways reported which is an increase from the previous month by 10 pathways and not meeting the operating plan of zero. Focus remains in place to deliver nil pathways. Other less challenged services have moved to recovering **52-week backlog.**	**January reporting of long waits: nil 104s | 2x 78s | 75x 65s total** **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. Service may require additional interventions – this is being aligned to the peer review action plan. **Urology services:** Insourcing continues, focusing on outpatients and diagnostics. Patient Engagement waiting list validation completed for all 1st appointments in the 52-week cohort. Additional senior level validation being undertaken. **Orthopaedic services:** Weekend lists continue and are recovering well. Patient Engagement waiting list validation completed for all 1st appointments in the 52-week cohort. Additional senor level validation being undertaken. We have a few specialities who have a few breaches each, these specialities have been asked to elimate these prior to the end of March. **Patient Engagement Validation (PEP):** 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. Following senior level validation, the PEP process for undated 1st appointments commenced again 12th Feb. **Recovery Action Plan**: Live and populated against specialty level trajectories for delivery of the plan to deliver March 2026 end position.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & monthly Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months

3. Assurance report: Operational Performance, *continued*

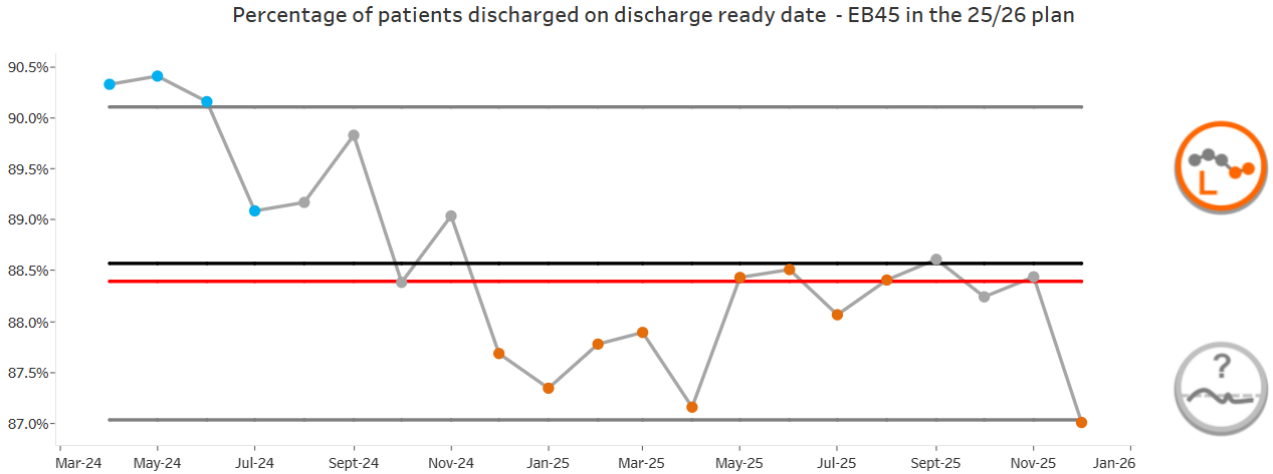


Benchmarking: Cancer 31 Day All Stages December 2025				
OUH: 78.6%	National: 92.5%	Shelford: 90.2%	BHT: 88.7%	RBH: 93%

Benchmarking: Cancer 62 Day Combined Standard December 2025				
OUH: 67.5%	National: 71.9%	Shelford: 65.24 %	BHT:72.82 %	RBH:79.57 %

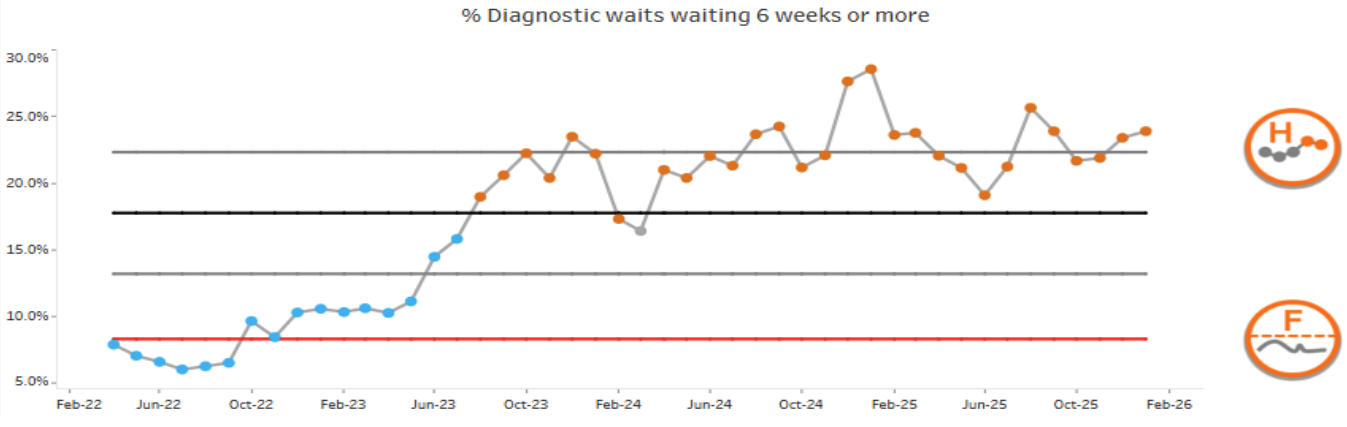
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
Cancer performance for 31 days Decision to Treat was 78.6% in December 2025 against an operational plan of 86.4% and below the national standard of 96.0%. OUH ranked 133rd out of 135 Providers and 9th out of the 10 Shelford Group. Cancer performance for 62 days Referral to Treat was 67.5% in December 2025 achieving the operational plan of 67.5% but below the national standard of 85.0%. OUH ranked 102nd out of 135 Providers for GP referrals within standard and 5th out of the 10 Shelford Group. Performance is reported two months in arrears due to the extended reporting period for this indicator.	**Cohort 4 (March):** The next group of Tumour sites to attend a scheduled workshop include Bladder, NSS and SACT. This is planned for the 20th March 2026 **Cohort 3 (Nov): 3-Tumour Site Workshop held on 26th November** focussing on UGI and Renal with a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. Day 75 review of 100 day plans to take place at cancer strategy group on 27th March 2026 **Cohort 2 (Aug):** focussing on LGI with updates following Day-100 presented on 19th December. Urology also locally undertaken and presented in the same forum for governance and support. Ongoing actions to continue at local level with the ability to escalate to Cancer Improvement Group every month by exception. **Cohort 1 (May): 50-Day Sprint completed** to achieve remaining change ideas shared updated in November with a continuation of some schemes to be tracked locally with escalations to be raised through the Cancer Improvement Group meetings	Cancer Improvement Group – March 2026		

3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The percentage of patients NOT discharged on their Discharge Ready Date reflects the increased proportion of patients who have been discharged on Pathways 1-3 from inpatient beds. The Discharge To Assess (D2A) pathway reached capacity from a social work perspective for large packages mid way last year. Combined with the reduction of Short Stay Hub Beds (SSHB) resulted in long delays for some patients on Pathways 1 and 2. This correlates with deterioration shown in the above chart. However, despite this the Oxfordshire system performs well with the lowest percentage of patients not meeting the National Criteria to Reside in the South East Region for December 2025.	• Ward areas with the lowest percentage of patients discharged on their discharge ready date have been reviewed; they have seen an increase in very long delayed patients due to a small number of unique cases. • The broader root cause is being addressed with system partners with movement from very large community packages to SSHB with a clear focus on trajectories for length of stay for this bed base which is being tracked monthly via the Urgent and Emergency Care (UEC) sit rep. • Out of County Delays and escalation pathway, involving COO at an earlier stage. • Weekly senior system partner review of themes of delays and medically optimised position with recommended actions fed back to Oxfordshire System Urgent Care Delivery Group • Quality Improvement Project on reducing cancelled discharges. The group have met the target ahead of the deadline and continue to seek further improvements.	January 2026 – complete Oxfordshire system Urgent Care Delivery Group - ongoing Ongoing Commenced December 2025 TWUCG March 2026		

3. Assurance report: Operational Performance, *continued*



Benchmarking: Diagnostics – 6 Week Standard December 2025

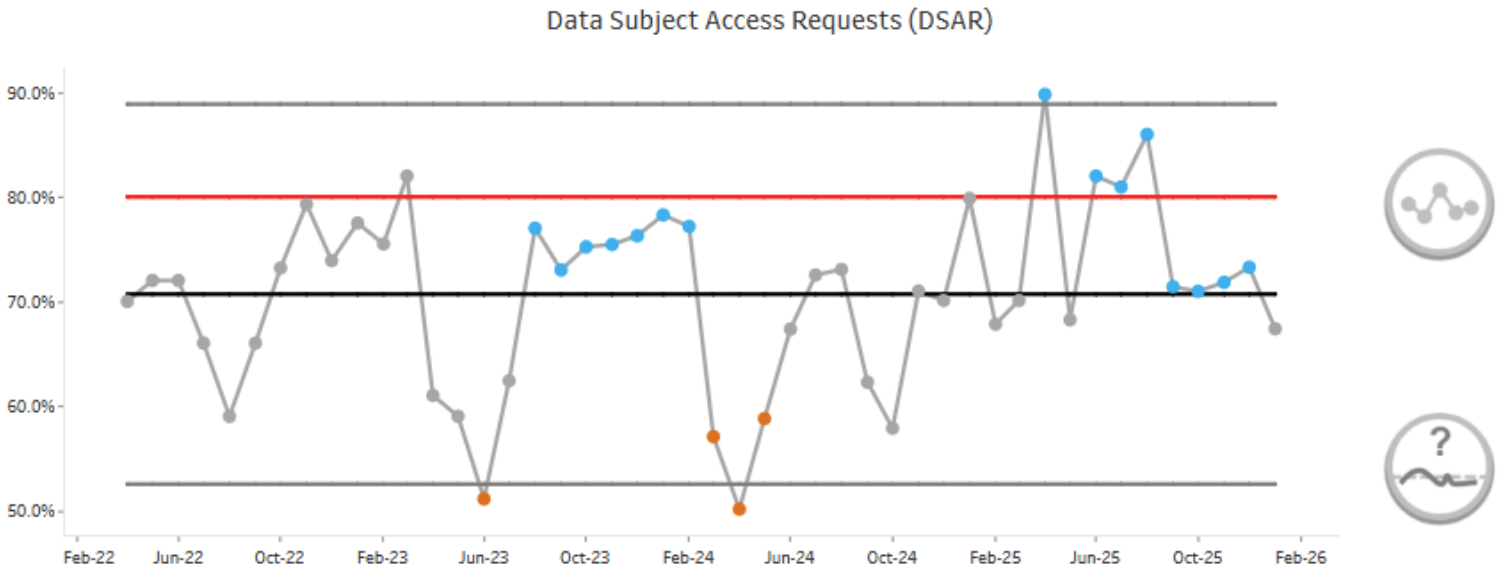
OUH: 23.37% National: 20.60% Shelford: 23.50% BHT: 2.36 % RBH: 0.12%

Percentage point variation to monthly plan by modality

	September 2025	October 2025	November 2025	December 2025	January 2026
Variance MRI	1.62%	1.67%	-1.25%	-7.44%	-10.44%
Variance CT Scan	0.3%	0.3%	0.3%	0.3%	0.3%
Variance Respiratory Physiology	6.2%	2.1%	-9.8%	-21.5%	-31.6%
Variance Gastroscopy	-19.5%	-26.9%	-32.3%	-38.2%	-45.7%
Variance Urodynamics	-22.0%	-23.9%	-28.9%	-12.8%	-11.7%
Variance Non-Obstetric Ultrasound	10.2%	11.6%	9.3%	7.4%	3.0%
Variance Neurophysiology	-25.6%	-41.9%	-46.4%	-55.7%	-73.6%
Variance Electrophysiology					
Variance Flexi Sigmoidoscopy	-12.8%	-11.7%	-19.2%	-22.7%	-32.7%
Variance DEXA	-0.2%	0.0%	0.0%	-0.1%	0.0%
Variance Cystoscopy	-6.9%	-10.1%	-16.4%	-7.7%	-5.2%
Variance Colonoscopy	-6.6%	-13.9%	-19.8%	-27.7%	-38.0%
Variance Barium Enema	0.0%	0.0%	0.0%	0.0%	0.0%

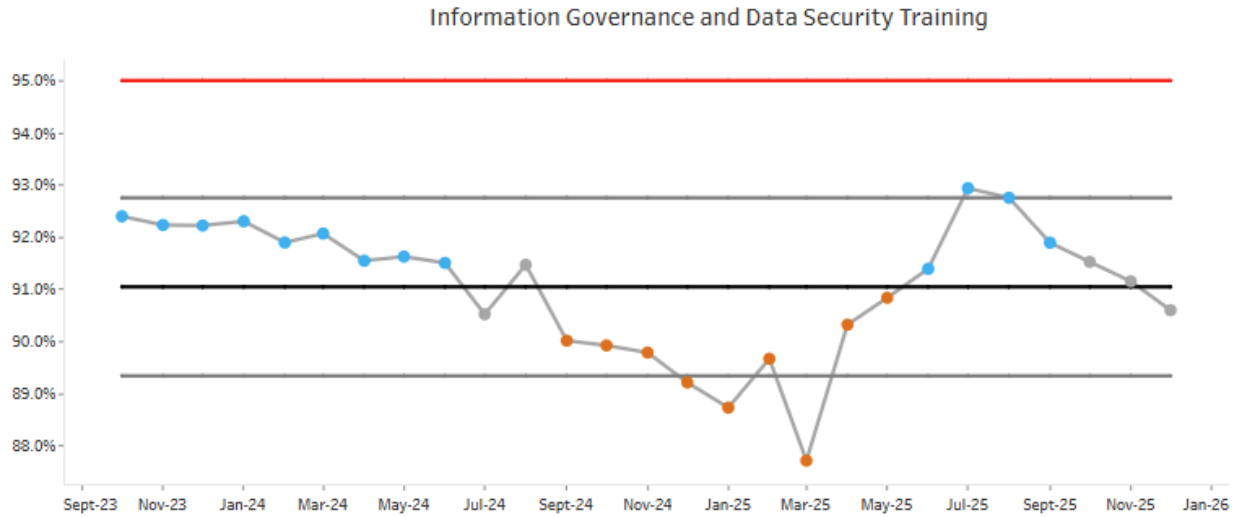
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
The number of patients waiting more than 6 weeks as a proportion of the total waiting list was 23.87% at the end of January against an operational plan of 99%. Performance exhibited special cause of concern due to >six consecutive periods of performance above the mean.	The Team have asked all specialities to over deliver to support "total" delivery. Focus has remained on the under 17-year-old cohort as well as total waiting list. **Endoscopy** Several initiatives in place and maintained including insourcing Additional funding allocated for outsourcing a cohort of gastroenterology demand. An external offer of support from the regional team has been taken up and this is in place for March. Additional capacity through waiting lists is in place from the last weekend in February. Additional capital for newer scopes (with efficiency) have been secured through NHS E capital funding allocation and delivered in March. **Neurophysiology** Two insourcing suppliers in place Extra sessions internally running each month (5 per month). An approved Neurology post will provide additional activity benefit in Q4 and has been agreed as an exception to the vacancy pause. **Audiology** Delivery Fund scheme is in place to insource capacity and is delivering an additional 500 units of activity per month. Business case to address concerns approved at TME. Estates work within the Horton for a dedicated facility, underway but unlikely to be operational this financial year. Brackley booth ordered. CDC activity agreed and to commence in Feb 2026 Based on current position, unlikely to deliver individual March plan for Paediatric Audiology. Recall patients completed & external review colleagues from NHS E welcomed and taking place in March. **Non-obstetric Ultrasound** Delivery Fund scheme has supported sufficient capacity to tackle demand. Performing above plan, which is offsetting some of the other modalities under performance			

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
DSAR performance has worsened slightly though run rate remains high 1195 cases received in M10 of which 796 were responded to on time. There remains a backlog of cases in the Medical Records SAR team, who are in the transition phase of working in both the new e-Case system and old Infreemation system, making run rate a challenge. A new staff member joined the team on the 23rd and is currently being trained.	The Information Governance Team has joined Legal Services and taken over the running of the medical records subject access team. A review of their processes is underway with some measures already in place Consolidating these teams and applying learning that the IG team have from the FOI improvement plan will bring an increase in performance and provide a significant improvement on the experience of Data Subjects contacting the Trust. Work to transfer open cases from the Infreemation system into e-Case is being done w/c 23rd February, after which it will be closed and all cases will be managed in e-Case.	Update on performance and steps being taken will be reported at the March Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3610	474	86.9%
SUWON	3471	347	90.0%
MRC	3320	362	89.1%
Clinical Support Services	2410	215	91.1%
Corporate	1093	75	93.1%
Operational Services	208	18	91.3%
Estates	194	13	93.3%
Research and Development	167	31	81.4%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 90.5% in M10. No divisions are achieving 95% and this month's trend is a general decrease. R&D, MRC and NOTSSCAN are below 90%.	1572 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*

- MRSA Screening compliance

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