Oxford University Hospitals
NHS Foundation Trust

TB2026.09

Integrated Performance Report

M8 (November data)

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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	76.3	68.9	Compliant	November 2025
	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	63.6	66.4	Non compliant	November 2025
	3. Percentage of patients waiting over 52 weeks	2.91	91/131 (low is good)	3.33	End of period	September 2025	2.7	2.6	Non compliant	November 2025
	4. Number of patients waiting over 52 weeks	2,811.00	N/A - Not used for segmentation (leading indicator)				2,263.0	2,182.0	Non compliant	November 2025
Quality Performance	5. Summary Hospital Level Mortality Indicator			2.00	Rolling 12-month		90.5	100.0	Compliant	July 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	49.6	0.0	Compliant	November 2025
	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 8 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 4).

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

We achieved key measures related to patient safety and care experience, including zero MRSA cases, no never events. Our mortality indicators (SHMI and HSMR - excluding hospices) were below 100, indicating fewer deaths than expected and we achieved our monthly C-diff threshold. Pressure ulceration indicators were achieved for hospital acquired category 2, 3 and 4 incidents.

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

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. In month 8, we met targets for core skills training, and non-medical appraisals demonstrating commitment to staff development. Our time to hire standard was also achieved, exhibiting improving SCV. Core skills training exhibited improving SCV and process assurance for consistently meeting the target.

Performance against the operating plan trajectory for A&E was compliant for A&E performance (all types and type 1 within 4 hours) and compliant for the % of patients waiting over 12 hours (both Segmentation indicators).

Operating plan trajectories were off plan in month 8 for RTT % within 18 weeks (all pathways) and the % of pathways over 52 weeks, which are Segmentation indicators. The percentage of patients within 18 weeks for first OP attendances met the operating plan along with the number of patients on the RTT waiting list. Elective RTT activity was higher than the operating plan, overall, and for admitted and non admitted pathway clock stops, which supported a reduction in the size of the overall Patient Tracking List (PTL). The increase in RTT completed pathways is evidenced by NHSE's implied productivity improvement which was +2.3% compared to 24/25. The PTL improvement has also been achieved in the context of an increase in the referral rate compared to the same period last year by +1.1% for GP referrals (YTD between April – November).

Performance in month 7 was worse than the operating plan trajectories for Cancer waits within 62-days (Segmentation indicator), Cancer 31-days, but ahead of plan for the Faster Diagnosis Standard (diagnosis within 28-days), which is a Segmentation indicator. NB. Cancer performance is reported one month in arrears. Diagnostic performance (% within 6 weeks) was below the operating plan in month 8.

The reported surplus was £1.1m in Month 8. The underlying deficit is initially estimated at £7.3m, £4.1m worse than plan but £4.3m better than Month 7. Underlying income, pay and non-pay all improved in month and WTE were stable (+4 WTE overall). The external forecast remains a £2m surplus, but with £16m reported risk. IAC have considered forecast scenarios ranging from a £0.9m deficit to a £48.1m deficit, with a mid-case scenario of a £27.6m deficit forecast outturn position. This would be £29.6m worse than plan. Cash was £21.8m at the end of November, £6.2m lower than the previous month but £18.2m higher than plan. The Trust has deferred c.£19m of supplier payments YTD to preserve cash. Capital cash outflows are also lower than plan (£13.7m) which is supporting the current cash position. The Trust received £11.3m of cash support during November.

Of the 121 indicators currently measured in the IPR, 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
- Number if RIDDORS
- Reactivated complaints

Common cause variation and missed target

- RTT number of incomplete pathways <18 weeks
- Cancer 62 and 31 Day Combined Standard
- Pressure ulceration per 10,000 bed days (Cat 3)
- % of patient with sepsis attending ED received timely antibiotics according to NICE guidelines
- % of complaints responded to in 25 working days
- FFT % likely to recommend OP
- Midwife ratios (birth rate/staffing level)
- Sickness and absence rate (rolling and in month)
- Information Governance and Data Security Training
- Data Subject Access Requests (DSAR)

Special cause variation - improving

- FFT % likely to recommend - ED
- Freedom of Information (FOI) % responded in target
- RTT patients > 65 weeks
- RTT patients > 52 weeks and %

Other*

- Priority 1 incidents

**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 November (M8), **VTE (Venous Thromboembolism) risk assessment** compliance at OUH improved to meet the national target of 95%, following a period of reduced performance after a change in the national metric. The Trust has responded with a comprehensive action plan, including enhanced safety messaging, targeted education, and focused interventions in clinical pathways with delays. %.

Sepsis management remains under scrutiny. In November, three high-risk sepsis patients experienced delays in receiving antibiotics within the recommended one-hour window, and one moderate-risk patient had a significant delay. Contributory factors included delayed escalation, prescribing delays, and workflow issues. All cases are reviewed in detail, with ongoing audits, governance reporting, and the development of an action plan to strengthen timely management.

In November, **Clostridium difficile** cases at OUH remained a focus, with 10 healthcare-associated cases reported. While this is 4 above the annual threshold, it represents a significant improvement—23 fewer cases than at the same point last year. Meanwhile, **MSSA** cases saw the highest monthly total so far this year, with most linked to intravascular devices. The IPC team is actively investigating these MSSA cases and sharing learning across clinical teams, with a quality improvement initiative planned if the trend continues.

Sickness absence performance (rolling 12 months) remained steady at 4.1% in November, with the monthly rate falling to 4.6% as flu season approaches. HR and Occupational Health are working together to address consistent absenteeism by supporting managers and staff, prioritising long-term sickness, and ensuring staff receive guidance to return to work. Proactive training, ongoing workshops, and regular meetings with Wellbeing leads are in place to strengthen sickness absence management and support/.

Overpayments continue to arise mainly from delays in processing leavers, late change forms, and outstanding salary sacrifice balances. Payroll and HR are collaborating on a national improvement programme, providing training, updated guidance, and regular communications to reduce errors. Monthly reports and audits are reviewed by a working group, with ongoing support for affected staff and new systems to reconcile overpayments. Actions are being implemented and monitored, with risks tracked and data quality improvements underway.

RTT patients waiting within 18 weeks in November did not meet the operational target, with 60.4% achieved against a plan of 60.9%. Performance showed a special cause variation following more than six consecutive months below the mean. Actions underway include continued pathway validation through the Validation Sprint, deployment of digital outcome forms to increase Patient Initiated Follow-Up uptake, and use of the Elective Pathway Manager to support resolution of complex validation issues

For **RTT patients waiting over 52 weeks**, performance remained above the planned level, with 2.7% breaching against a plan of 2.6%. Despite this, there has been special cause variation improvement driven by reductions below the lower control limit. A focused programme ensures all patients awaiting their first appointment within the 52-week cohort will be seen by January, supported by additional capacity enabled through Delivery Funds. Weekly assurance meetings review progress against year-end trajectories.

For **RTT patients waiting over 65 weeks**, 80 incomplete pathways remained at the end of November. Specialty-specific recovery actions are in place, including ENT and Urology insourcing, weekend operating lists in Orthopaedics, and completion of Patient Engagement Validation for all 1st outpatient appointments in the 52-week cohort. A live recovery action plan tracks progress against specialty-level trajectories.

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
- Number if RIDDORS
- Reactivated complaints

Common cause variation and missed target

- RTT number of incomplete pathways <18 weeks
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Special cause variation - improving

- FFT % likely to recommend - ED
- Freedom of Information (FOI) % responded in target
- RTT patients > 65 weeks
- RTT patients > 52 weeks and %

Other*

- Priority 1 incidents

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Cancer 31-day and 62-day performance remained below plan and national standards, with 31-day performance at 82.2% and 62-day performance at 63.54%. Improvement actions include structured tumour-site workshops engaging clinical leaders, delivery of 100-day action cycles across UGI, Renal, LGI and Urology pathways, and ongoing implementation of change ideas from earlier sprints. Governance is supported through the Cancer Improvement Group.

For **Diagnostics (DM01)**, 21.9% of patients were waiting more than six weeks at the end of November. Endoscopy continues to improve month-on-month but remains challenged, with actions including rota reviews, increased insourcing, and productivity initiatives. Neurophysiology has expanded insourcing and added internal sessions, while Audiology faces significant sustained demand, mitigated partly through a Delivery Fund scheme. Non-obstetric ultrasound exceeded plan, helping offset underperformance in other modalities.

The percentage of complaints responded to within 25 working days remained low at 36% in November, with 208 complaints received—a 66% increase compared to November 2024. Weekly meetings and reports support divisional leaders in managing and escalating cases, and the Trust is piloting AI solutions with Microsoft to automate complaint summarisation and identify improvement opportunities. Fourteen complaints (7%) were reopened in November, a decrease from October.

Nine **RIDDOR** incidents were reported in November, all involving staff. These included exposure to blood-borne viruses, physical assault, lifting injuries, falls, and being struck by objects. All incidents were locally investigated, with no correlation identified. The Health & Safety team continues to monitor and report any emerging themes.

FFT recommend rates remained high for outpatients (94.0%) and inpatients (95.3%) in November. Positive feedback focused on staff attitude, care implementation, and clinical treatment, while negative themes included waiting lists, discharge, and catering. SMS remains the main method of data collection, while online methods are underused. Efforts are underway to improve response rates.

The midwife-to-birth ratio was 1:26.5 in November, above the recommended 1:22.9, with 650 births recorded—a 12.8% increase over the previous two months. Staff unavailability remains a challenge, with 8.8% of midwifery staff on maternity leave, predicted to peak at 10.1% in Q3. Daily staffing meetings and weekly reviews monitor safe staffing, community on-call hours, and NHSP spend..

In November, **Data Security and Protection Training** compliance was 91.0%, with no divisions meeting the 95% target and 1,472 staff non-compliant. Divisional governance teams have access to reports for support targeted management. Oversight is provided by the Digital Oversight Committee, with standard procedures and training in place.

Freedom of Information performance was 78.3% against an 80% target, with staffing pressures due to maternity leave. A new FOI handling platform went live in January 2025, and a temporary staff member was brought in to assist with the increased workload. The ICO backlog was cleared ahead of deadline, with oversight from the Digital Oversight Committee and TME.

Data Subject Access Request performance remained at approximately 70% on-time closure for the third month, with record-high volumes and a maternity notes backlog being addressed by temporary staff. The new e-Case system began accepting SARs in January 2025. The Information Governance Team has joined Legal Services to consolidate processes and drive improvement. Oversight and standard procedures are in place, with a report on SAR processes due to TME in February.

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	• % of complaints responded to within 25 working days • Number if RIDDORS • 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	L • VTE Submitted Performance Not achieving target H • Number of complaints per 10,000 bed days • Reactivated complaints • Number of complaints Not achieving target	No SPC Not achieving threshold
Growing Stronger Together	• Sickness and absence rate (in month) • Sickness and absence rate (rolling 12 months) Not achieving target			
Operational performance	• RTT number of incomplete pathways (<18 weeks) • 62-day Cancer Standard: >62 days • Cancer 31 Day Combined Standard (2WW, Symptomatic and screening referrals) • % Diagnostic waiting 6 weeks or more Not achieving target	L • RTT patients > 65 weeks and >52 weeks • % of RTT patients waiting over 52 weeks Not Achieving target	L • % of RTT patients waiting within 18 weeks Not achieving target H Not achieving target	
Corporate Support Services	• Efficiency Delivery £'000 • In-month financial performance Surplus/Deficit £'000 • Information) Governance and Data Security Training compliance • Data Subject Access Requests (DSAR) • Cash £'000 Not achieving target	H • Year-to-date financial performance surplus/Deficit £'000 • Freedom of Information % responded to within target time Not achieving target	L • Legal Services: Number of Claims • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % Not achieving target	No SPC • Priority 1 incidents 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: Nov-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Nov-25	0.0	-	-	0.2	-0.5	0.8
MRSA cases: HOHA+COHA	Nov-25	0	0		1	-1	3
C-diff cases: HOHA+COHA per 10,000 beddays	Nov-25	3.1	-	-	3.5	0.4	6.6
C-diff cases: HOHA+COHA	Nov-25	10	10		11	2	21
E. Coli cases: HOHA+COHA per 10,000 beddays	Nov-25	6.3	-	-	5.2	0.9	9.6
E. Coli cases: HOHA+COHA	Nov-25	21	-	-	17	3	31
MSSA cases: HOHA+COHA	Nov-25	11	-	-	6	-1	12
Number of Never Events	Nov-25	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Nov-25	0	-	-	2	-	-
PSII Overdue Actions	Nov-25	22	-	-	34	-	-
VTE- Submitted performance	Nov-25	95.0%	95.0%		95.1%	94.2%	95.9%
% of emergency admissions 65yrs + receiving cognitive screen	Nov-25	65.8%	-	-	59.1%	51.2%	67.0%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Nov-25	84.2%	90.0%	No	88.5%	64.2%	112.8%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Nov-25	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Nov-25	2	-	-	2	-2	7
HSMR Excluding Hospices	Aug-25	93.6	100.0		85.9	-	-
Summary Hospital-level Mortality Indicator	Jul-25	90.5	100.0		91.9	-	-
Neonatal deaths per 1,000 total live births	Sept-25	3.3	3.2	No	3.2	-1.0	7.5
Stillbirths per 1,000 total Live births	Sept-25	3.3	4.0		3.7	-0.2	7.7
National Patient Safety Alerts not completed by deadline	Nov-25	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Nov-25	0.0	-	-	0.0	0.0	0.0
Number of active clinical research studies hosted	Nov-25	1474	-	-	1422	1200	1644
Number of active clinical research studies (commercial)	Nov-25	407	-	-	383	317	449
Number of active clinical research studies (non commercial)	Nov-25	1066	-	-	1039	881	1197
Number of incidents with moderate harm or above per 10,000 beddays	Nov-25	36.7	-	-	42.1	27.2	56.9
Number of patient incidents with moderate harm or above per 10,000 beddays	Nov-25	30.1	-	-	37.3	21.5	53.1
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Nov-25	6.6	-	-	4.8	-2.0	11.5
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Nov-25	16.0	19.0		21.3	10.3	32.4
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Nov-25	1.9	2.0		2.3	0.6	4.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Nov-25	0.0	0.0		0.1	-0.2	0.4
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Nov-25	54.2	-	-	98.4	69.5	127.3
Patient falls (moderate and above) as reported on Ulysses	Nov-25	3	-	-	4	-2	10

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

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Nov-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Nov-25	0.9	-	-	1.3	-0.7	3.2
Health and Safety related incidents - Assault, Aggression and harassment	Nov-25	157	-	-	166	84	248
Adult safeguarding activity	Nov-25	1810	-	-	1090	747	1434
Children's safeguarding activity	Nov-25	556	-	-	596	298	894
Adult safeguarding activity and Children's safeguarding activity	Nov-25	2366	-	-	1687	1191	2183
Safeguarding (Children) training compliance L1 - L3	Nov-25	88.0%	90.0%	No	88.8%	84.1%	93.4%
Safeguarding (Adults) training compliance L1 - L3	Nov-25	94.0%	90.0%		50.6%	43.3%	57.9%
Total Deliveries in month	Nov-25	577	625	-	612	536	687
Babies born	Nov-25	589	-	-	621	545	697
Maternity Bookings (planned + unplanned)	Nov-25	707	750	-	701	548	854
Inductions of labour from iView	Nov-25	105	-	-	137	96	178
Midwife Ratios (birth rate / staffing level)	Nov-25	23.2	22.9	No	25.4	21.2	29.6
Number of Learning MDT Reviews instigated	Nov-25	0	-	-	3	-	-
Percentage of Learning MDT Reviews within 42 days	Nov-25	100.0%	-	-	46.6%	-77.6%	170.7%
After Action Review (AAR)	Nov-25	14	-	-	14	-	-
Percentage of AAR's within 14 days	Nov-25	23.1%	-	-	26.8%	-7.2%	60.9%
Number of complaints	Nov-25	208	-	-	128	75	181
Number of complaints per 10,000 beddays	Nov-25	65.2	-	-	40.2	25.2	55.1
Reactivated complaints	Nov-25	14	1	No	11	3	20
% of complaints responded to within 25 working days	Nov-25	36.5%	85.0%	No	44.8%	24.8%	64.7%
Number of RIDDORs	Nov-25	9	5	No	5	1	9
Friends & Family test % likely to recommend - IP	Nov-25	95.3%	95.0%		95.0%	93.7%	96.3%
Friends & Family test % likely to recommend - OP	Nov-25	94.0%	95.0%	No	93.8%	92.9%	94.6%
Friends & Family test % likely to recommend - ED	Nov-25	82.6%	85.0%	No	79.4%	73.3%	85.5%
FFT maternity % positive (births)	Nov-25	90.7%	90.0%		73.9%	49.1%	98.7%
Inpatient FFT (Response Rate)	Nov-25	20.7%	-	-	24.0%	20.8%	27.2%
Outpatient FFT (response rate)	Nov-25	9.5%	-	-	8.4%	6.8%	10.1%
ED FFT (Response Rate)	Nov-25	15.0%	-	-	21.5%	17.2%	25.9%
Maternity FFT (response rate; births)	Nov-25	9.4%	-	-	8.2%	0.8%	15.6%
PFI: % of total audits completed that achieved 4 or 5 stars JR	Nov-25	97.4%	95.0%		93.2%	84.4%	102.1%
PFI: % of total audits completed that achieved 4 or 5 stars CH	Nov-25	98.3%	95.0%		94.6%	84.4%	104.8%
PFI: % of total audits completed that achieved 4 or 5 stars NOC	Nov-25	97.4%	95.0%		96.5%	89.0%	103.9%
Incident rate of violence and aggression (rate per 10,000 beddays)	Nov-25	49.2	-	-	48.9	23.0	74.7
Trust level: CHPPD vs budget	Nov-25	2.4	-	-	-12.7	-57.1	31.7
Trust level: CHPPD vs required	Nov-25	-4.7	-	-	-4.9	-24.5	14.6

2. b) SPC indicator overview summary

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Nov-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Oct-25	5.6%	-	-	8.5%	4.6%	12.3%
Proportion of ambulance arrivals delayed over 60 minutes	Oct-25	0.3%	-	-	0.9%	-0.1%	1.9%
ED 4Hr perfromance - All	Nov-25	76.3%	68.9%		68.9%	61.2%	76.6%
Mean Ambulance Handover time in seconds for all handovers at trust level	Oct-25	1043	1180		1106	966	1247
ED 4Hr perfromance - Type 1	Nov-25	68.0%	55.6%		61.8%	53.0%	70.6%
Proportion of Type 1 attendances spending more than 12 hours in an emergency department	Nov-25	1.7%	4.4%		4.9%	2.6%	7.3%
Proportion of patients discharged from hospital to their usual place of residence	Nov-25	95.8%	-	-	95.2%	94.5%	96.0%
% of RTT patients waiting for a first appointment	Nov-25	69.0%	66.7%		66.1%	64.1%	68.1%
% of RTT patients waiting within 18 weeks	Nov-25	60.4%	60.9%	No	60.7%	58.7%	62.8%
% of RTT patients waiting over 52 weeks	Nov-25	2.7%	2.6%	No	3.1%	2.8%	3.3%
RTT standard: >52-week incomplete pathways	Nov-25	2263	2182	No	2726	2384	3068
RTT standard: >65-week incomplete pathways	Nov-25	80	0	No	592	372	813
RTT number of incomplete pathways	Nov-25	84101	85358	-	79876	77153	82599
RTT number of incomplete pathways (<18 weeks)	Nov-25	50781	51977	No	50825	49093	51756

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Nov-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Oct-25	81.0%	78.7%		78.4%	73.0%	83.8%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Oct-25	82.2%	82.9%	No	82.2%	74.0%	90.4%
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Oct-25	63.5%	65.1%	No	61.0%	51.7%	70.4%
62-day Cancer standard: incomplete pathways >62-days	Nov-25	334	-	-	347	269	425
% Diagnostic waits waiting 6 weeks or more	Nov-25	21.9%	88.4%		17.5%	12.8%	22.1%
Diagnostic activity vs 2019/20	Nov-25	128.5%	-	-	125.9%	113.9%	137.9%
Total outpatient attendances - EM32in the 25/26 plan	Oct-25	120564	122518	-	111961	88140	135782
Bed Utilisation General & Acute	Nov-25	95.1%	96.0%	No	94.8%	91.5%	98.1%
Average Non elective LOS Trust level for IPR (average so cannot aggregate up)	Oct-25	6.3	6.4		6.8	6.1	7.5
Number of non-discharged patients put onto a PIFU	Nov-25	827	2742	No	1145	346	1944
Cancelled operations within 24hrs (non-clinical reasons)	Nov-25	0.4%	-	-	0.4%	0.2%	0.5%
Cancellations not re-booked within 28 days	Nov-25	2.9%	-	-	12.8%	-11.1%	36.8%
Elective DC spells - SUS	Oct-25	7234	7527	-	6773	5340	8206
Elective IP spells - SUS	Oct-25	1646	1664	-	1517	1241	1794
Average delay (exclude zero delay) of discharges Trust level for IPR (average so cannot aggregate up)- EB46 in the 25/26 plan	Oct-25	5.2	5.7		5.9	4.6	7.2
Percentage of patients discharged on discharge ready date - EB45 in the 25/26 plan	Oct-25	88.2%	89.3%	No	88.7%	87.2%	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: Nov-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Turnover rate with no exclusions	Nov-25	10.5%	-	-	11.1%	10.6%	11.6%
Vacancy rate	Nov-25	4.6%	7.7%		6.6%	4.7%	8.6%
Turnover rate	Nov-25	8.5%	12.0%		10.6%	10.2%	11.0%
Sickness absence rate (rolling 12 months)	Nov-25	4.1%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	Nov-25	94.5%	85.0%		77.9%	44.1%	111.6%
Sickness absence rate (in month)	Nov-25	4.6%	3.1%	No	4.2%	3.3%	5.2%
Core skills training compliance	Nov-25	91.6%	85.0%		90.7%	88.9%	92.5%
Time to hire (average days)	Nov-25	44.0	53.0		48.7	37.2	60.2

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: Dec-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Nov-25	-7346.5	-	-	-5238.5	-8817.9	-1659.2
BPPC £ %	Nov-25	57.2%	95.0%	No	78.8%	72.3%	85.4%
BPPC Volume %	Nov-25	28.7%	95.0%	No	62.2%	54.7%	69.8%
Cash £'000	Nov-25	21762	3600		28770	6190	51351
Efficiency delivery £'000	Nov-25	5433.0	8820.0	No	6054.6	-697.1	12806.3
In-month financial performance Surplus/Deficit £'000	Nov-25	1119.8	1093.0		-520.2	-11830.0	10789.6
In-month ICS CDEL capital expenditure	Nov-25	1379.0	4145.5	-	3212.5	-7180.5	13605.5
Year-to-date financial performance Surplus/Deficit £'000	Nov-25	-5429.4	-5479.0		-13860.5	-23080.3	-4640.7

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

Latest Indicator Period: Dec-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Nov-25	91.1%	95.0%	No	91.1%	89.3%	92.8%
Data Security & Protection Breaches	Nov-25	25	-	-	27	8	47
Externally reportable ICO incidents	Nov-25	0	0		0	-	-
All IG reported incidents	Nov-25	28	-	-	29	12	47
Freedom of Information (FOI) % responded to within target tim	Nov-25	78.3%	80.0%	No	59.6%	35.9%	83.3%
Data Subject Access Requests (DSAR)	Nov-25	71.8%	80.0%	No	70.7%	52.1%	89.3%
Priority 1 Incidents	Nov-25	2	0	No	1	-	-

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

Latest Indicator Period: Nov-2025

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Nov-25	22	-	-	20	5	34

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

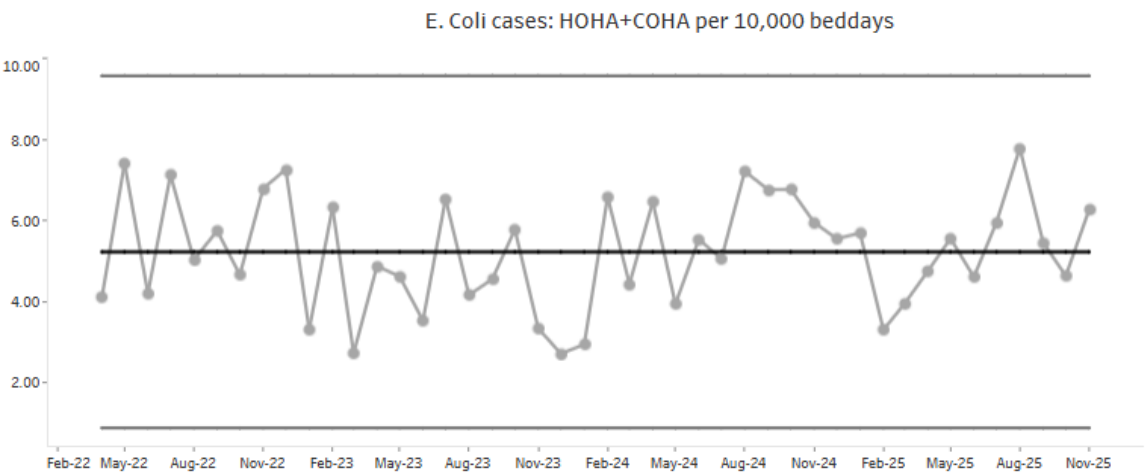
Latest Indicator Period: Dec-2025

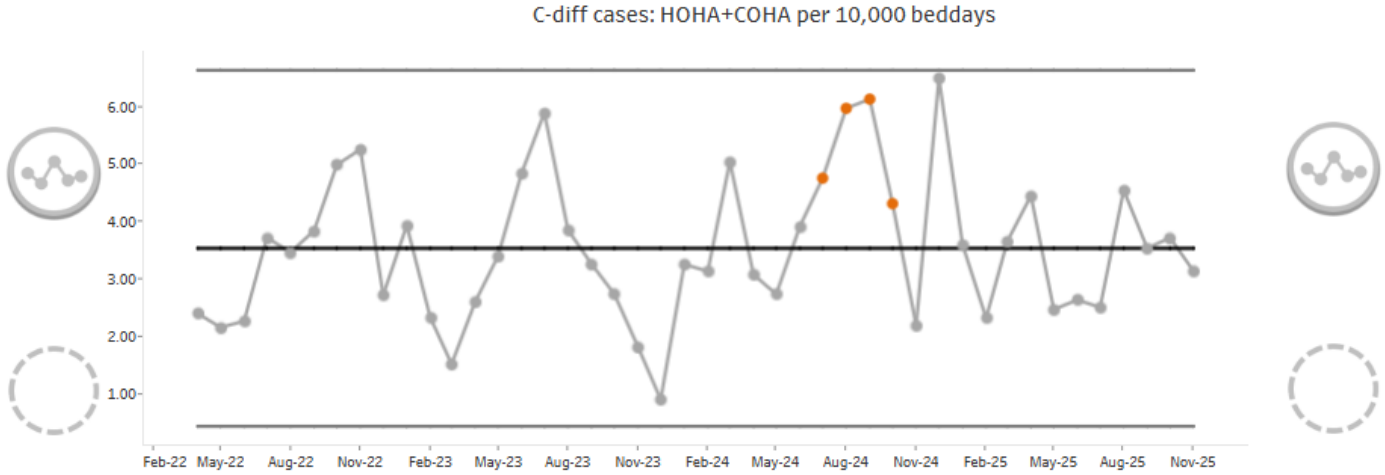
Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Nov-25	0	0		0	-	-

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

03. Assurance reports

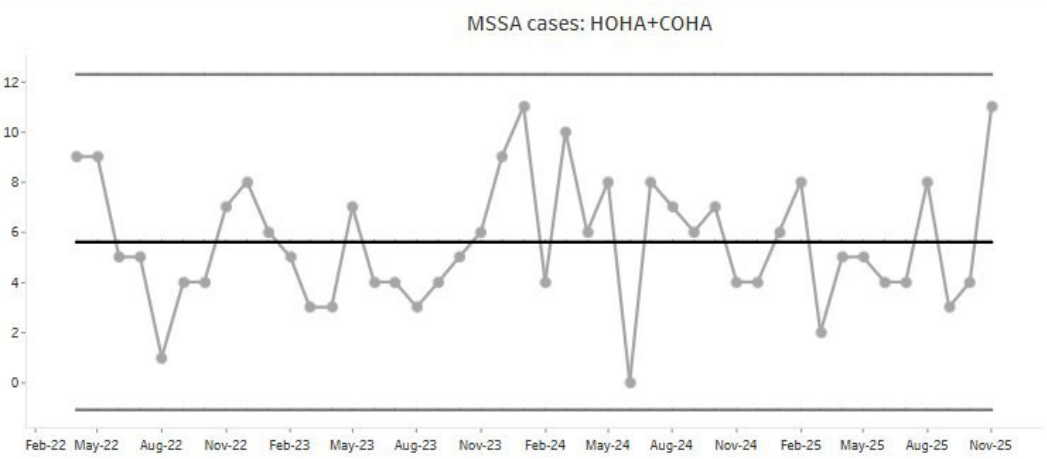
3. Assurance report: Quality, Safety and Patient Experience

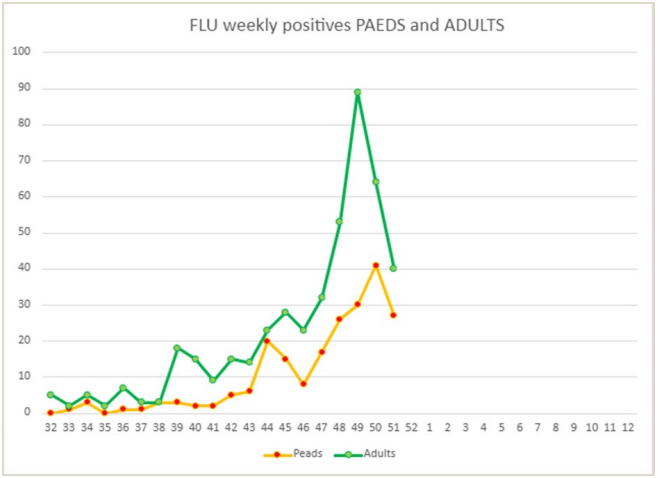


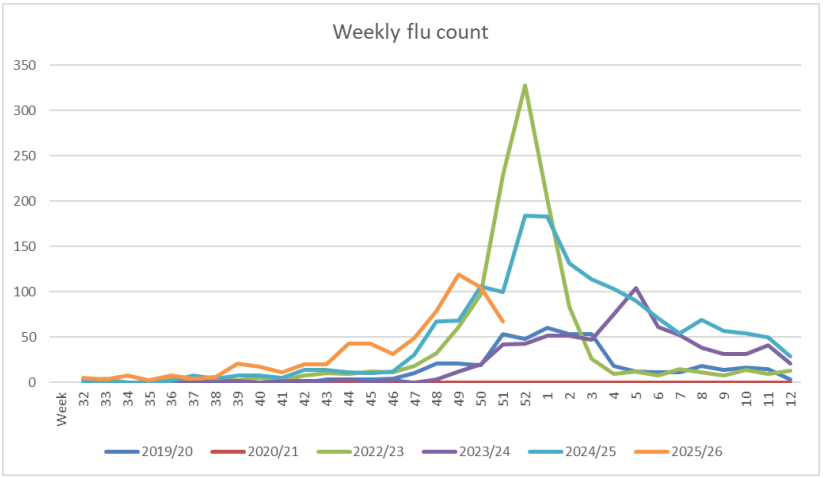


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
***C. diff* infection:** OUH reported 10 healthcare-associated *C. difficile* cases (9 HOHA and 1 COHA) in November to the UK Health Security Agency (UKHSA). We are currently 4 cases above the threshold for the year to date, and 23 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). ***E. coli* bacteraemia**: 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). **Water Safety:** The Trust's external authorising engineer for water (AE(W)) issued an Imminent Danger Notification on 26 November due to finding, while conducting the Churchill site's legionella risk assessment, that no planned preventative maintenance (PPM) schedules were in place for the Sobell House buildings.	***E. coli* bacteraemia**: 4/21 cases in November had a urinary catheter as a likely source; the continence nurse specialists are planning to trial catheterisation packs which have reportedly brought about a reduction in CAUTIs in other organisations. **Staffing:** currently recruiting to a Band 7 vacancy in the IPC nurse team from January. **IPC Surveillance:** The 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 since the introduction of the new LIMS system it has become clear that a single integrated surveillance system is required. There has been no further development of the Eureka platform since July 2025 with no imminent progress likely. It has now been agreed with Chief Officers that funding for a commercial IPC surveillance platform needs to be obtained – this is beginning to progress through the business planning process. **Water Safety:** An incident was reported on Ulysses and the Estates team implemented an investigation and corrective actions. It was discovered that some PPM schedules were in place for the hot water generator (calorifier), cold water tanks, shower heads and flushing of sentinel points. Several items remain outstanding and these are currently being worked through by Estates leads. Progress is being monitored by the Water Safety Group.	Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient

3. Assurance report: Quality, Safety and Patient Experience

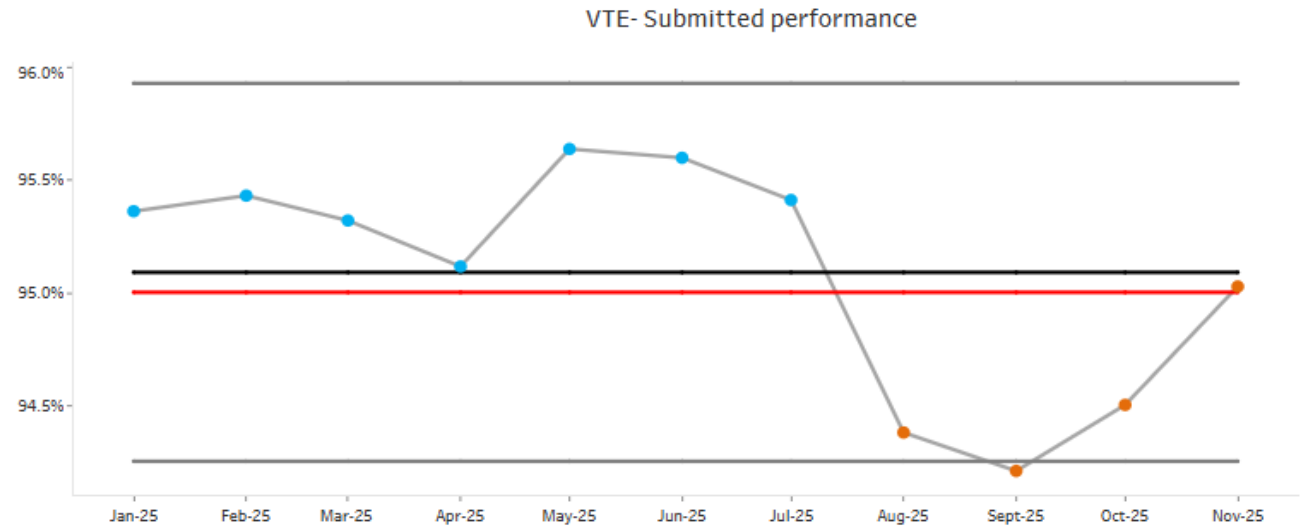






Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
MSSA: Subject to mandatory reporting to UKHSA but no threshold set. We have seen 2 fewer MSSA cases so far this year than we had by the same time last year; however November saw the highest number of cases so far this year with the majority of those (63%) having an intravascular device as the source. **MRSA Bacteraemia: T**here were no cases of MRSA bacteraemia in November, the fifth consecutive month with zero cases. 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). **Influenza:** National and South East influenza modelling and case numbers have not supported the recent publicity on 'superflu'. The current impact on the Trust of admissions is not unusual for the time of year, and less than seen at this time point last year.	**MSSA**: Increase in MSSA cases and prevalence of intravascular device involvement highlighted at both HIPCC and Clinical Governance Committee, including a discussion on the impact of this on patients (and the importance of correctly recording this on Ulysses). IPC team investigating cases and sharing learning with divisional/clinical teams. If the theme continues in upcoming months, a specific quality improvement focus will be introduced to identify and address gaps in clinical practice. **Winter Pressures:** Point of care testing for Influenza, RSV and COVID-19 available in emergency care areas with high uptake. The IPC team are on site 7-days a week to assist with patient placement. Mask wearing has now been introduced in key clinical areas. OUH is the second best performing trust in the South East region for staff **influenza immunisation:** • **6,151** frontline healthcare workers at OUH had had their flu vaccination by 14 December (**50.9%** of our frontline healthcare workers) • OUH vaccination rate is above the national average for NHS trusts in England **(45%)** and the regional (South East) average **(49.6%)**	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

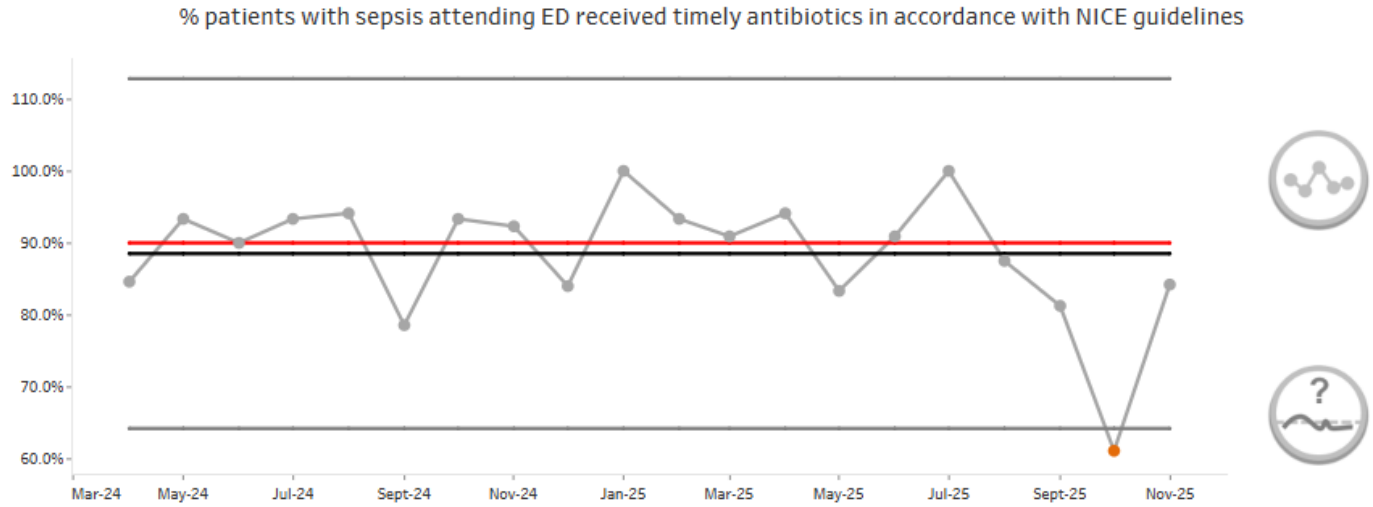
The national target in the NHS, is for at least 95% of all admitted patients aged 16 and over to receive a VTE risk assessment within 14 hours of admission (NICE NG89). Mandatory data collection was reinstated in April 2024 (after a pause during COVID-19).

In November OUH compliance as a Trust rose to 95% to hit the national target of 95%.

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

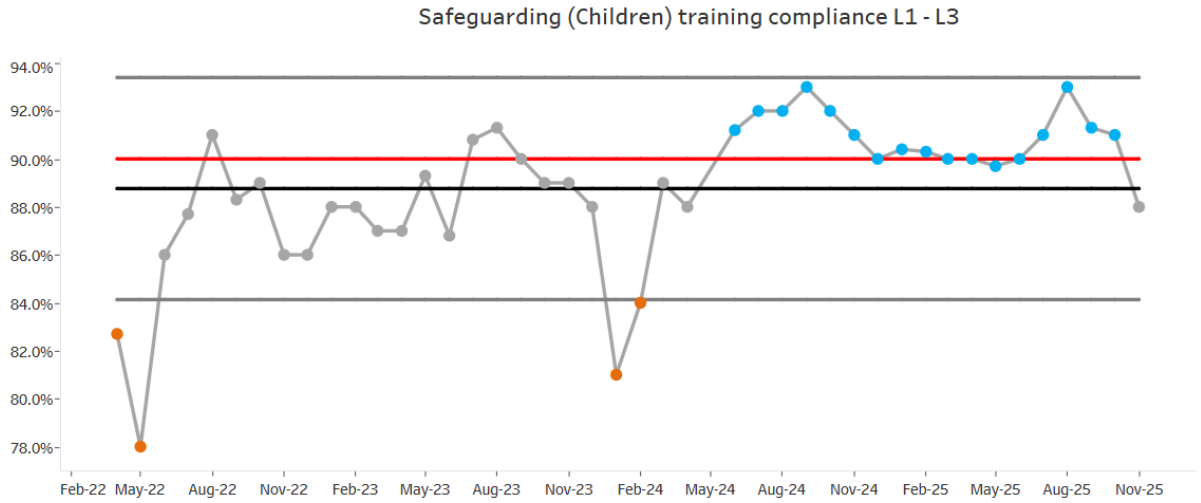
Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality
Historically OUH VTE risk assessment VTE-RA performance has been excellent and a national exemplar. Following a change in the national metric for VTE RA to require earlier assessment, performance fell below the new national threshold. In response, clinical divisions have been working to address performance, and VTE risk assessment compliance has improved to just meet the 95% target for November. A Trust wide action plan is being developed by the VTE team with support from the CMO office to drive and sustain further improvements. This includes: • Development of Safety Message and Video to reinforce the importance of VTE-RA • Education including updated guidance and promotion of Trust guidance and support • Linkage with Standard Work Board Round and Ward Dashboards to support high compliance • Focus on specific clinical pathways with inherent delays to identify solutions	All Divisions report progress to CGC Divisional Meetings and CD support for each Directorate. Data will be scrutinised to see if this method is working. Collaboration with Haematology to improve dose management VTE Task group Maternity Governance meetings Divisional Governance meeting Interventional Radiology M and M meeting		

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



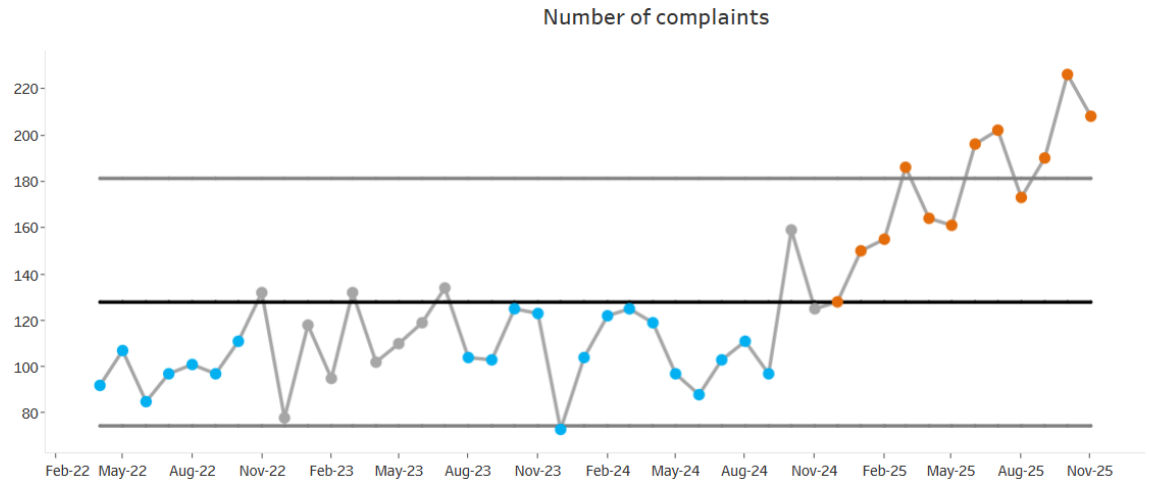
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group	Risk Register	Data quality
In November, three patients who met **high-risk sepsis criteria** experienced a delay in receiving antibiotics within the recommended one-hour timeframe. Review of the electronic patient record (EPR) identified several potential contributory factors. **Moderate-Risk Sepsis Delays** A reduction in performance was also identified among patients meeting **moderate-risk sepsis criteria**, where antibiotics should be administered within 180 minutes of the sepsis alert. One patient experienced a significant delay beyond this timeframe, with antibiotics administered **238 minutes post-alert**.	All cases of treatment delay are reviewed in detail. On further inspection of these cases the following contributing factors were identified: Delayed escalation following sepsis alerts • Prescribing delays despite early clinical review • System and workflow factors affecting continuity of care, particularly overnight-delayed medical clerking and prescription of antibiotics • In 3 cases, no clear documentation or explanation for delay were identified in medical or nursing notes, making it difficult to understand reasons for delay. An action plan is being developed to further strengthen the timely management of sepsis.	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.		

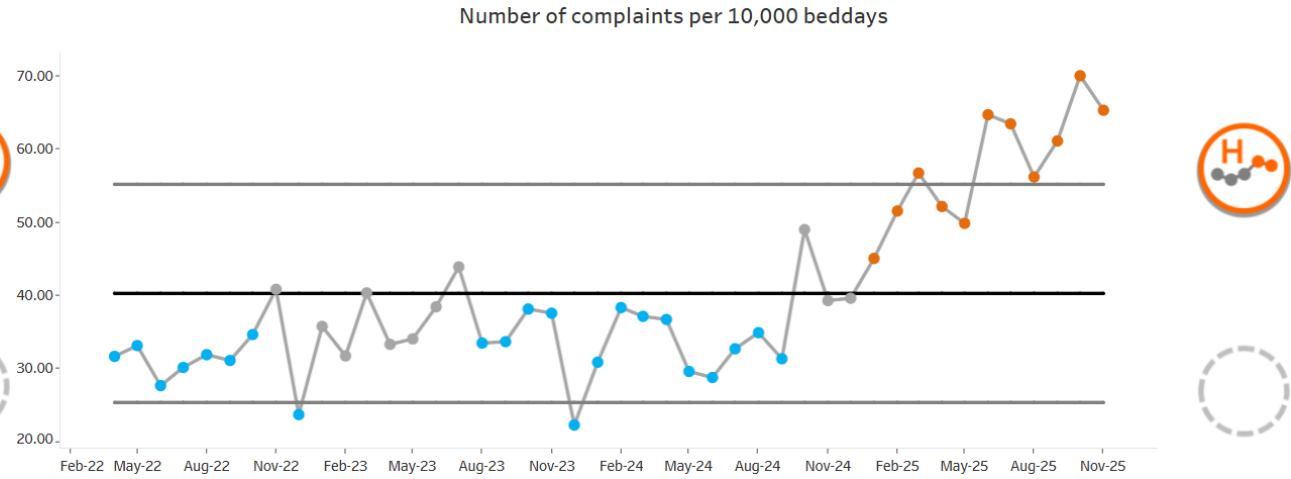
3. Assurance report: Quality, Safety and Patient Experience, *continued*



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
Safeguarding Children level 1 training is at 85.6% requiring 244 staff to complete and level 2 is at 88.9% (961 staff) and level 3 is at 88.2% (811 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 reduced capacity from long term sickness in the team the face to face/MS Teams training is not available. Names of staff requiring training are provided to manager via the MLH reporting and lists are available to obtain for oversight via MLH.	• 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*

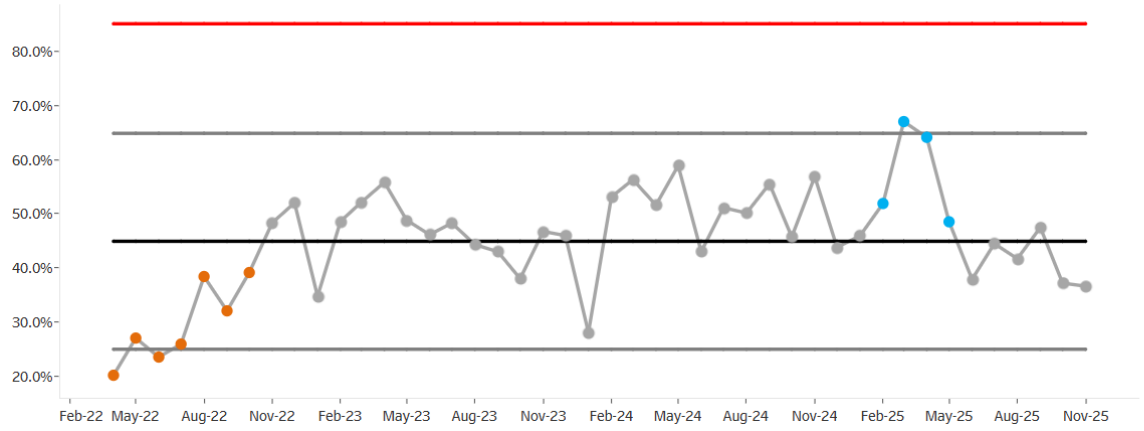




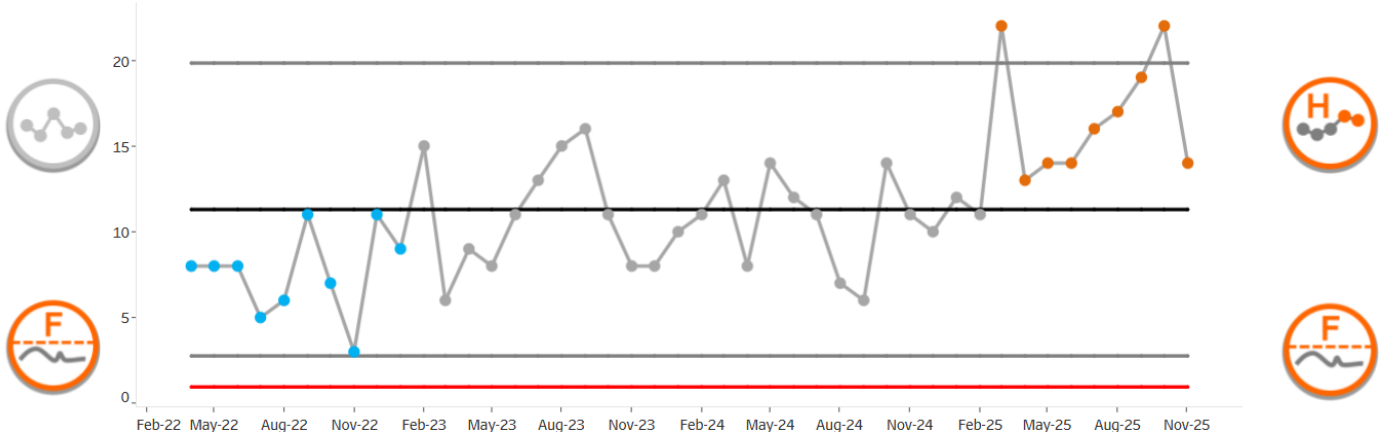
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Continuation of this trend in the volume of patient complaints will result in challenges in organisational capability to meet the 25-day KPI.	208 complaints were received in November, which is a slight reduction from the number received in October (n=226). This does however represent a significant increase in the volume of new complaints in comparison to the number of new complaints received in November 2024 (n=125). The top five categories of these complaints were: Clinical Treatment (n=42/20%), Communications (n=39/19%), Values and Behaviours (n=30/14%), Appointments (n=26/12%) and Patient Care (n=14/7%). The top categories remain consistent with previous months. Gynaecology, ophthalmology are key areas of increased complaint activity. The Complaints team continue to work with the Divisions to understand the drivers behind these themes and to facilitate identification of improvement opportunities to enhance patient experience and reduce complaints with known causes.	Ongoing, reviewed weekly. Oversight by Delivery Committee.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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

% of complaints responded to within 25 working days

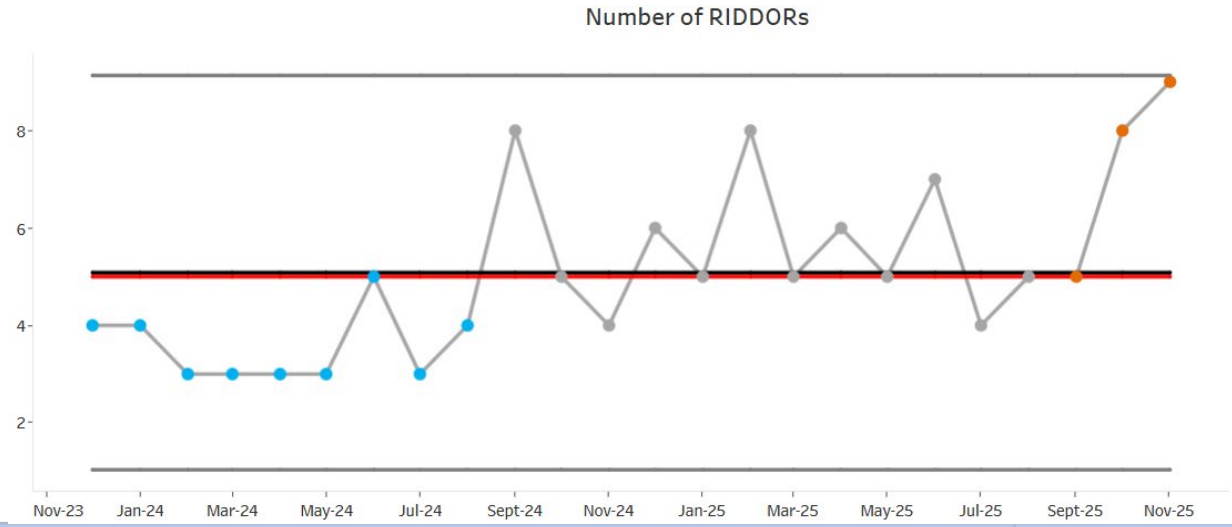


Reactivated complaints



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 November 2025, OUH received a total of 208 formal complaints, continuing the special cause variation (shift) and contributing to ongoing challenges with meeting the 25-day KPI.	The Trust received 208 complaints in November, which is an 8% decrease from October, when 226 complaints were received. Complaints relating to maternity remain high (n=18) for this month along with complaints pertaining to Gynaecology (n=32). Compliance with the 25-day KPI remained consistently below the target of 85% with 37% in October 2025 to 36% in November 2025. In total, 161 complaints were fully closed in November. A proposal to move to adopting a median target of 25 days was supported by Delivery Committee providing greater flexibility to manage complex complaints while maintaining a focus on timeliness. Reporting of the median KPI will commence in February. Reopened complaint decreased in November, when just 14 complaints (7%) were reopened cases resulting from requests for additional information, dissatisfaction with the initial response, or requests for meetings to discuss findings from complaint investigations. This is a decrease from October where 23 (10%) were reopened. Reporting of reactivated complaints will be graphically presented as a proportion (%) of total complaints from February instead of current numbers. Weekly meetings and reports continue to support the Divisional Directors of Nursing, Clinical Leads and Divisional Medical Directors to manage and escalate complaint cases that are in breach. Exploration of AI solutions to support the complaints process continue in partnership with Microsoft. Deidentified and anonymised complaints and response letters have been used to test a new Microsoft Agent designed to summarise complaints, highlight key points, automate administrative tasks and identify opportunities for service improvements. More testing work will take place with Microsoft and the Complaints Team; with the expectation the Agent may be ready to utilise in the coming months.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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

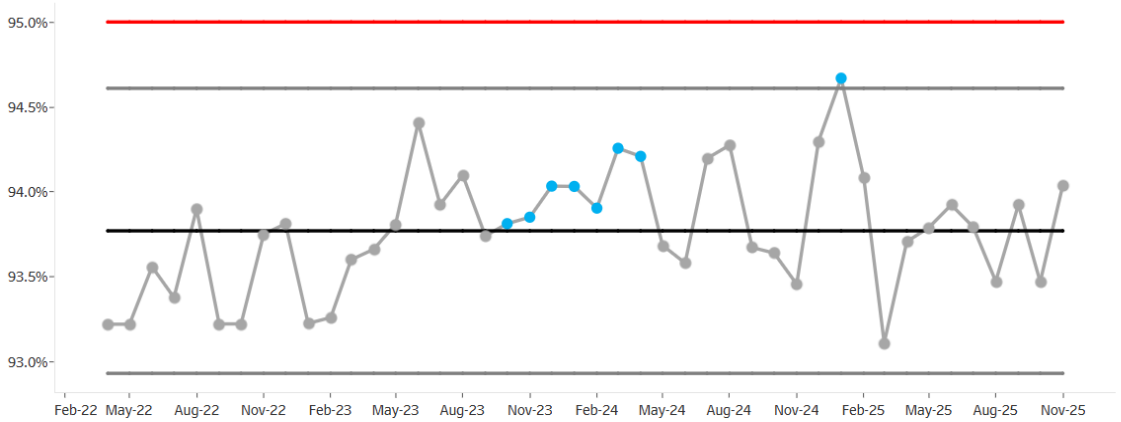


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were nine incidents reported to the HSE in November under RIDDOR. All incidents involved our staff. The incidents that occurred were: • One exposure to a blood-borne virus (BBV) from a splash exposure. • One physical assault by a patient on staff, who punched the member of staff in the face, damaging the eye socket. This resulted in the staff member being unable to perform their normal duties for seven or more days. • Two lifting and handling injuries resulted in staff members being off work for 7 or more days. • Two falls (same level). One incident a member of staff tripped leaving a patient's home and another incident where a member of staff slipped on a recycling bag that had been left on the floor incorrectly. • Three incidents where a member of staff was struck by an object. One incident involved a staff member hitting their head on a cupboard door, which resulted in being off work for 7 or more days. The second incident resulted in a rib fracture where the member of staff came into contact with two pieces of equipment on separate occasions on the same shift. And the last was a carpal bone disruption diagnosed two months after a member of staff hit their wrist on a desk while diluting medicine.	All staff incidents were locally investigated. 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

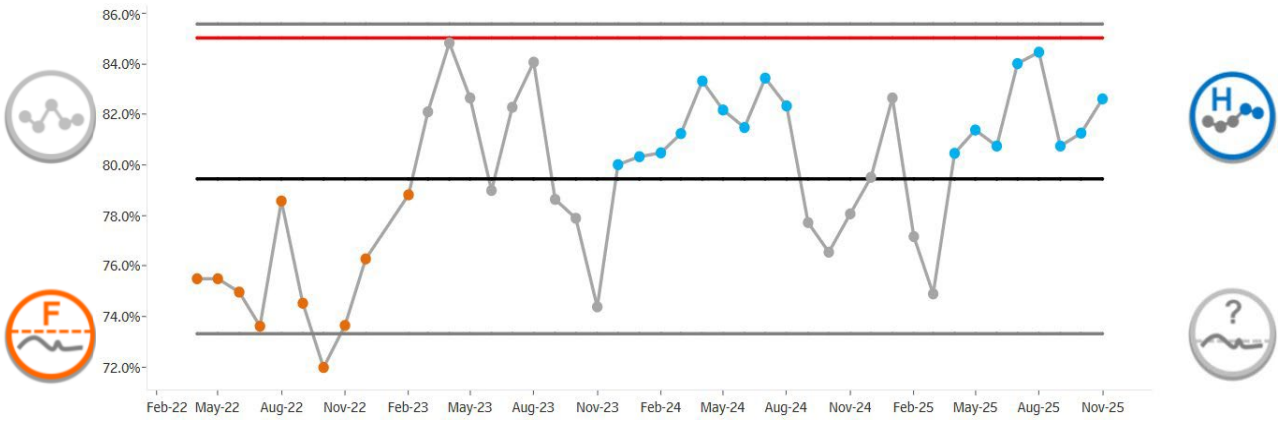
3. Assurance report: Quality, Safety and Patient Experience, *continued*

Oxford University Hospitals NHS Foundation Trust

Friends & Family test % likely to recommend - OP

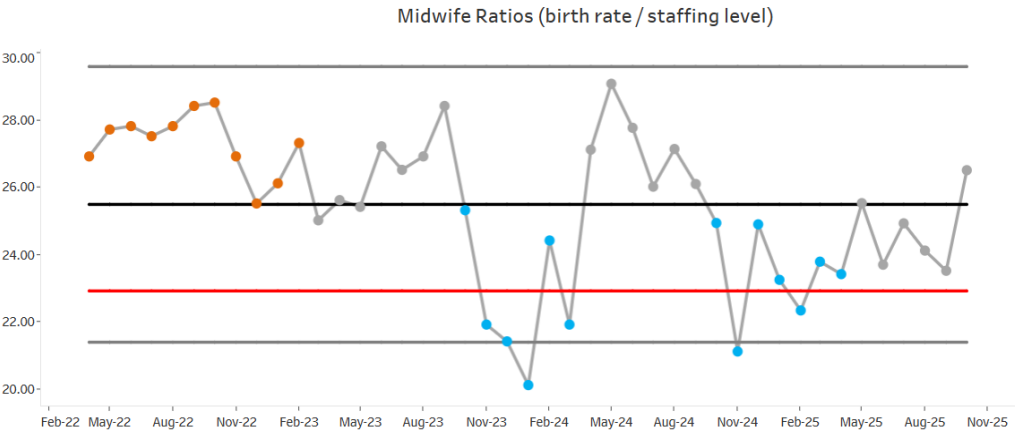


Friends & Family test % likely to recommend - ED



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 10,649 of the total responses received, and the recommended rate has increased to 94.0% in November, compared to 93.5% in October, however this is not statistically significant. 2. The top positive themes during November for outpatients were staff attitude, implementation of care, and admission. The top negative themes were waiting list, discharge and catering. 3. Inpatient responses accounted for 3,223 of the total responses received, and the recommended rate has increased to 95.3% in November, compared to 94.6% in October (not statistically significant). 4. The top positive themes during November for inpatients were staff attitude, implementation of care and clinical treatment. The top negative themes were waiting list, waiting time and discharge.	1. Each division presents an update on patient experience, including FFT data and themes at the PE forum monthly. 2. A deep dive into FFT over an 18-month period was undertaken to look at specific areas that need support with increasing response numbers and recommend rates. The responses showed an overall 93% approval rate across all Divisions, and 4% disapproval rate. The highest volume of responses were collected in MRC, and the highest approval rate was in CSS. 3. SMS has been the main method of FFT collection, accounting for 88% of all responses, and is the most widely used across all Directorates. Online collection methods, including QR codes on flyers and posters, have been the least used, accounting for just 1% of all responses. 4. 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 Family Carer Forum, [PEFC] and the Trust Governors Patient Experience and Membership Committee (PEMQ).	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Summary of challenges & risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance	Risk Register	Data quality
In November 585 mothers birthed at OUH, 65 less than the previous month. Subsequently this was an overall decrease in the birthrate of 9.9%, highlighting the expected peak in activity over September and October. The midwife to birth ratio was 1:23 which 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 two instances in November when 1:1 care was not provided to women in established labour. These occurrences happened while awaiting the arrival of on-call midwives and lasted for a brief period only. Additionally, on two occasions, the Delivery Suite coordinator was not working in a supernumerary capacity at the beginning of the shift; this was for a short duration. There was a significant reduction in the number of on call hours in November, 219 hours, compared with 455 in October. Midwifery staffing unavailability remains a challenge for the service with a current 29.35 wte (8.8%) on Maternity leave.	The service continues with a robust recruitment and retention plan to align with the recommended Birthrate Plus uplift, address staff retention; optimise rostering KPIs and reduce NHSP spend. The service has filled 25.08 WTE Band 5/6 midwife roles to start between October and December, with ongoing interviews to help cover 29.35 WTE maternity leave. This supports national rapid graduate initiatives, backed by NHSE incentives for 23 additional new midwives. With divisional approval, recruitment is exceeding Birthrate Plus levels to address staffing gaps. 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. A targeted review is in progress to consider matters relating to the provision of 1:1 care for women in labour, as well as the supernumerary role of the Delivery Suite Coordinator. The resulting tactical action plan will be designed to strengthen these key areas and help prevent recurrence of similar issues in future.	Ongoing workforce plan to monitor: • Recruitment to birthrate plus uplift including divisional approval to recruit into maternity leave. • Staff retention strategies. • Reduction of NHSP spend. Positive trajectory towards full recruitment by November 2025. Weekly monitoring of: • 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. Quarterly Maternity Safe Staffing assurance paper submitted via Maternity Clinical Governance Committee to Board, aligned to Maternity and Perinatal Incentive Scheme compliance.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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 November 2025. The exceptions were: Paediatric Critical Care Unit (PCCU) level 3 for seven night shifts and six-day shifts; Neonatal Unit level 3 for one night shift, all shifts were mitigated to make the units safe by implementing team nursing supported by the other Critical Care Units, except for one-night shift for PCCU. These shifts were closely monitored by Senior staff. The Trust-wide planned versus actual fill rates were 92.5% for day and 97.55% for night shifts. Where fill rates were less than 90%, all shifts were reviewed, reported, and mitigated by a Matron or above at the safe staffing meeting, and shifts were not left at risk.

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

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

SUWON – Rostering KPI's- Upper GI, SEU-F and Gastroenterology wards had a net hour's difference outside of the KPI, related to students, not substantive staff hours. Red flags not reviewed is being addressed by the DDN. Some wards have low annual leave uptake, however, assurance given that staff are on track with using leave.

MRC – The rostering KPI's for the division are very good. A few wards had low annual leave, but all staff aware of the process to book. The Deputy DDN is liaising with the managers of HH Oak and Complex Medicine Unit-A regarding open red flags. The ward managers have been working clinically more frequently to mitigate staffing shortfalls which can affect the timely review of these. 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 as a result of patients requiring a level of enhanced observation. Shifts were mitigated by ward managers, educators, and support staff working in numbers. Areas with slightly higher CHPPD than budget was due to complex patient needs, or where a minimum level of staff was required to maintain safety, despite at times, a lower patient number. The open red flags have now been reviewed and updated across the adult wards. The Deputy DDN will ensure the open red flags across children's wards are reviewed and updated. Paediatric Critical Care Unit recorded 24 medication incidents and 9 extravasation incidents. Whilst no theme has been identified, including not directly related to staffing, the Deputy DDN is conducting a deeper dive into these incidents. Fill rates of less than 90% were seen across the children's wards. Upon review, this is a result of unrequired shifts not being cancelled. The Deputy DDN will continue to reinforce to Matron's and ward managers, the importance of updating rosters and cancelling unrequired shifts. . The roster KPI's are largely met across the division. One ward was not approved by the manager for payroll. The Deputy DDN is liaising with the Matron regarding this. Net hours for Neuro Blue relate mainly to student hours, however, some substantive hours are outstanding which will be addressed by the ward manager. The lead time for roster publication was not met by two wards. The Division is aiming to have this back on track for next month.

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 November. 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.

Maternity – The CHPPD for Level 6 are higher than budget, due to complex patients requiring additional midwife care. The Intrapartum Team also had higher CHPPD compared to budget, due to an increase in births (up 50 on previous month) with high acuity patients. The Infant Feeding Team have commenced dedicated parent education during the ante natal period, with the aim of increasing the percentage of mothers initiating breastfeeding. Two home births were redirected to the Intrapartum Team as the midwife on call had been required to work onsite due to high acuity of patients. There was no negative feedback from parents because of this change. The roster publication lead time missed the KPI by approximately one week. This was due to the creation of an 24/7 bleep roster which needed to be populated and approved at the same time as the existing rosters.

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

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

There continued to be a strong pipeline of recruitment in all areas, however, the Trust implemented a pause to recruitment at the end of the month. As some areas are likely to be exempt from the pause, a robust process for exceptions is being developed and implemented.

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

Unavailability
All areas 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)

Oxford University Hospitals NHS Foundation Trust

November 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 3.11.25-30.11.25			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
NOTSSCaN																					
Bellhouse / Drayson Ward	8.95	11.21	10.0	88.89%	4	-	-	-	4	1	2	1	7.20%	16.90%	2.70%	3.70%	10.60%	Yes	1.29%	9.57	10.13%
HH Childrens Ward	9.36	9.10	13.1	81.11%	4	2	-	-	1	0	0	0	0.40%	8.90%	4.40%	4.80%	5.20%	Yes	-1.68%	9.57	17.21%
Kamrans Ward	7.67	10.79	9.0	100.00%	-	13	-	1	2	0	0	0	4.80%	6.50%	1.50%	0.00%	4.80%	Yes	1.20%	9.57	15.12%
Melanies Ward	9.82	13.47	14.3	100.00%	2	1	-	-	1	1	1	0	-4.70%	13.50%	6.40%	6.10%	5.80%	Yes	-2.13%	9.57	12.74%
Robins Ward	10.68	10.50	10.4	96.67%	7	-	-	-	5	1	0	2	6.90%	22.30%	6.00%	3.80%	10.40%	Yes	-2.69%	9.57	10.13%
Tom's Ward	8.05	9.64	9.5	97.78%	-	-	-	-	1	1	0	0	8.00%	0.00%	3.70%	6.70%	15.80%	Yes	0.53%	9.57	9.03%
Neonatal Unit	19.92		15.7		-	-	-	-	11	2	0	0	17.80%	7.30%	6.00%	5.70%	24.10%	Yes	-2.26%	8.29	9.10%
Paediatric Critical Care	27.58		28.1		4	-	-	-	24	9	5	0	18.10%	6.30%	5.40%	7.60%	24.30%	Yes	0.20%	5.43	12.11%
BIU	5.98	6.27	6.6	100.00%	1	-	-	-	3		1	1	12.10%	8.10%	3.40%	8.00%	19.20%	Yes	-0.23%	9.29	14.19%
HDU/Recovery (NOC)	9.04		14.9		-	-	-	-	0		0	0	8.80%	11.00%	9.00%	0.00%	16.20%	No	0.15%	7.86	12.63%
Head and Neck Blenheim Ward	7.29	7.86	8.0	97.78%	-	-	-	-	0		1	0	6.20%	0.00%	1.90%	0.00%	6.20%	Yes	-1.92%	8.43	12.41%
HH F Ward	6.98	9.17	7.7	100.00%	-	-	-	-	1		1	3	3.60%	4.20%	4.50%	0.00%	3.60%	Yes	1.15%	8.57	13.67%
Major Trauma Ward 2A	9.13	9.57	9.3	91.11%	3	2	-	-	5		3	5	12.40%	10.30%	4.00%	6.40%	18.00%	No	2.06%	8.29	13.70%
Neurology - Purple Ward	8.92	9.39	7.8	100.00%	3	-	-	-	3		0	4	2.60%	14.30%	6.50%	0.00%	2.60%	Yes	1.58%	9.57	15.92%
Neurosurgery Blue Ward	8.93	9.77	9.1	100.00%	10	-	-	-	1		0	3	4.70%	6.10%	3.50%	4.30%	8.80%	Yes	6.23%	9.43	13.52%
Neurosurgery Green/IU Ward	12.48	10.08	9.9	100.00%	5	-	3	1	1		0	1	12.30%	6.00%	4.20%	2.40%	16.00%	Yes	1.82%	8.57	14.87%
Neurosurgery Red/HC Ward	12.29	11.78	11.4	100.00%	-	5	-	-	2		2	2	-1.10%	8.00%	5.00%	2.60%	3.10%	Yes	-0.28%	9.43	11.11%
Specialist Surgery I/P Ward	7.28	7.56	8.3	100.00%	-	-	-	-	5		0	1	4.80%	2.50%	3.90%	3.20%	9.40%	Yes	0.14%	8.43	9.27%
Trauma Ward 3A	9.16	9.05	9.1	95.56%	5	3	-	-	4		6	4	10.80%	9.70%	8.10%	6.30%	18.30%	Yes	1.89%	4.43	13.94%
Ward 6A - JR	7.53	6.73	7.3	93.33%	6	1	-	-	2		1	6	0.40%	5.80%	2.90%	2.20%	4.30%	Yes	2.89%	8.43	16.21%
Ward E (NOC)	6.30	6.80	7.7	96.67%	-	-	-	-	2		0	4	-11.00%	5.70%	6.00%	5.40%	-2.00%	Yes	2.79%	8.57	8.41%
Ward F (NOC)	6.90	7.76	7.4	100.00%	3	-	-	-	0		0	1	8.40%	2.90%	6.10%	3.10%	14.80%	Yes	0.37%	8.71	9.35%
WW Neuro ICU	28.13		23.9		-	-	-	-	3		0	1	-10.10%	7.90%	5.10%	7.30%	0.00%	Yes	-2.30%	8.86	10.98%

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

Oxford University Hospitals NHS Foundation Trust

November 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 3.11.25-30.11.25			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
MRC																					
Ward 5A SSW	8.34	9.38	8.6	100.00%	1	6	2	2	1		4	7	-2.60%	8.20%	3.50%	10.80%	8.40%	Yes	0.70%	8.71	13.41%
Ward 5B SSW	8.88	9.75	8.6	100.00%	6	-	-	-	1		2	3	-0.30%	5.90%	3.30%	4.40%	4.10%	Yes	0.80%	8.71	11.65%
Cardiology Ward	8.02	6.96	8.4	100.00%	10	3	2	-	8		0	3	9.90%	6.90%	6.60%	2.70%	13.10%	Yes	-2.12%	8.00	12.82%
Cardiothoracic Ward (CTW)	7.82	6.57	7.0	100.00%	6	-	-	-	3		1	1	13.90%	5.40%	4.00%	7.10%	20.00%	Yes	-2.00%	7.86	7.28%
Complex Medicine Unit A	7.66	11.24	8.5	100.00%	19	-	-	3	4		1	5	6.10%	2.40%	9.10%	4.80%	14.50%	Yes	0.42%	9.71	11.84%
Complex Medicine Unit B	11.26	10.07	9.0	100.00%	-	-	-	-	1		4	4	-3.40%	6.20%	5.80%	2.30%	1.40%	Yes	1.14%	9.71	13.03%
Complex Medicine Unit C	9.89	10.55	8.3	100.00%	3	-	-	2	0		2	7	4.80%	9.20%	3.90%	7.20%	11.60%	Yes	-0.61%	9.71	12.47%
Complex Medicine Unit D	8.06	9.26	9.7	100.00%	5	-	-	-	1		2	2	11.90%	17.90%	5.20%	0.00%	13.30%	Yes	1.35%	9.71	9.94%
CTCCU	21.10		20.9		-	-	-	-	5		0	1	18.80%	10.50%	4.50%	2.30%	21.70%	Yes	0.22%	9.71	11.66%
Emergency Assessment Unit	8.53	8.67		95.16%	-	-	-	-	4		0	6	11.00%	10.30%	6.80%	2.30%	13.60%	Yes	-1.27%	9.29	8.67%
JR Emergency Department	19.84				-	-	-	-	3		1	2	16.70%	17.40%	4.30%	2.70%	19.70%	Yes	-2.38%	9.00	13.99%
HH EAU	7.78	7.1		96.77%	-	-	-	-	2		3	10	7.60%	9.40%	6.20%	1.20%	11.60%	Yes	0.70%	9.57	13.38%
HH Emergency Department	22.83				-	-	-	-	1		0	1	6.00%	3.30%	3.20%	5.00%	10.70%	Yes	5.17%	9.86	13.06%
HH Juniper Ward	8.07	11.01	7.8	100.00%	1	-	-	-	0		1	3	-6.80%	4.20%	5.70%	8.10%	3.60%	Yes	0.07%	9.43	12.98%
HH Laburnum	8.00	9.48	7.9	100.00%	-	-	-	-	0		2	3	-1.50%	12.60%	5.60%	3.90%	6.20%	Yes	0.30%	6.29	13.16%
HH Oak (High Care Unit)	10.83		10.6	94.62%	2	2	2	-	2		0	2	-0.90%	4.50%	5.00%	9.70%	8.90%	No	0.29%	9.57	13.65%
John Warin Ward	9.62	10.67	10.2	100.00%	-	15	-	-	0		1	1	3.10%	5.80%	4.70%	7.10%	10.00%	Yes	-0.68%	8.57	13.37%
OCE Rehabilitation Nursing (NOC)	10.67	12.73	10.6	100.00%	6	-	-	-	3		1	2	7.00%	12.40%	4.20%	1.70%	8.60%	Yes	-0.11%	9.57	13.25%
Osler Respiratory Unit	14.47	8.16	12.0	100.00%	-	1	-	-	2		1	1	-3.30%	9.60%	4.00%	4.20%	1.10%	Yes	0.44%	8.71	11.05%
Ward 5E/F	12.01	8.41	9.9	100.00%	17	-	-	-	1		1	7	16.00%	15.20%	5.00%	4.00%	19.40%	Yes	0.73%	8.71	11.53%
Ward 7E Stroke Unit	10.93	9.54	9.3	100.00%	-	-	-	-	1		2	3	-3.30%	8.70%	5.20%	0.50%	-2.80%	Yes	-0.74%	9.57	11.22%

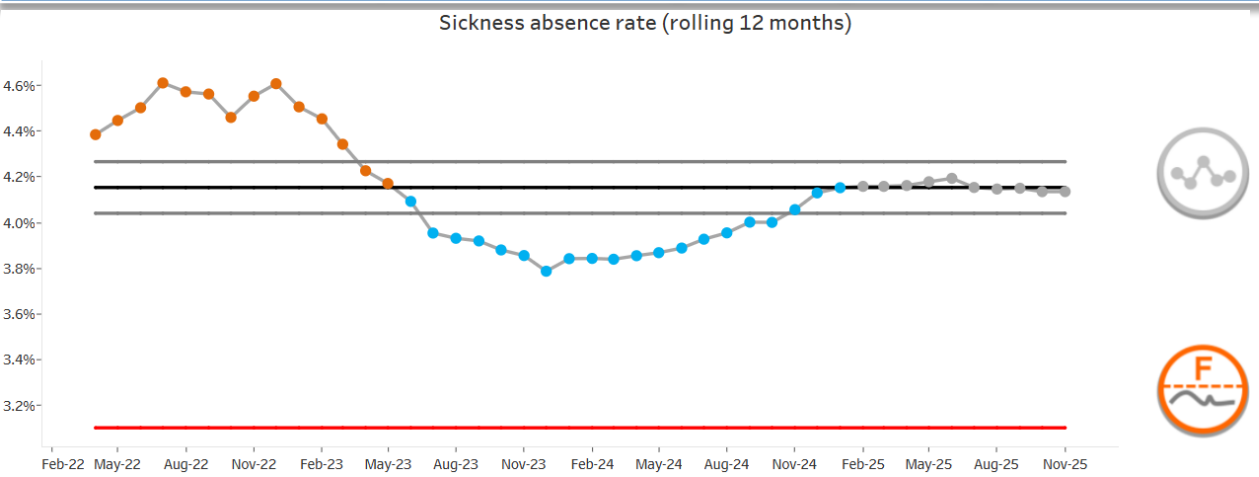
3. Assurance report: Safe Staffing - Dashboard: Part 3 (SuWOn and CSS)

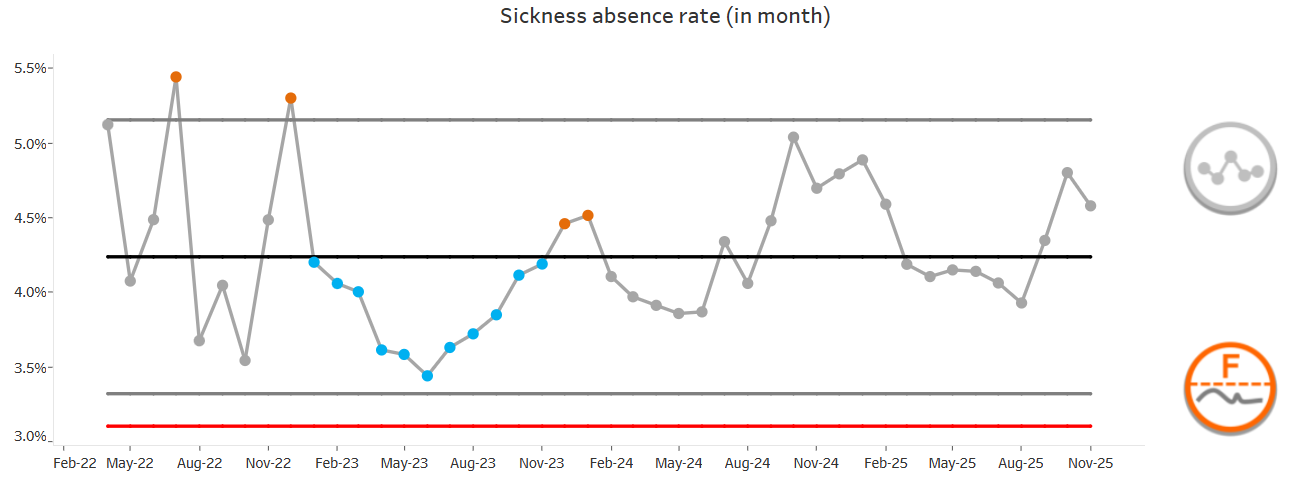
Oxford University Hospitals NHS Foundation Trust

November 2025	Care Hours Per Patient Day			Census	Red Flags				Nurse Sensitive Indicators				HR					Rostering KPIs 3.11.25-30.11.25			
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Open	Reviewed	Resolved	Raised in error	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported Falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%
SUWON																					
Gastroenterology (7F)	7.95	8.29	8.2	95.56%	-	18	4	3	0		1	3	-4.40%	10.30%	6.10%	6.70%	5.10%	Yes	7.75%	8.29	9.83%
Gynaecology Ward - JR	5.14	5.49	7.0	100.00%	1	-	-	-	2		0	1	3.40%	12.80%	6.20%	0.00%	3.40%	Yes	-0.37%	8.57	15.83%
Haematology Ward	7.79	10.74	11.2	95.56%	-	16	13	2	6		0	1	9.70%	14.90%	7.10%	4.40%	13.70%	Yes	3.46%	9.57	14.20%
Katharine House Ward	9.72	7.86	9.3	98.89%	-	4	-	2	0		0	2	15.80%	9.70%	5.80%	0.00%	22.70%	Yes	2.67%	9.57	9.64%
Oncology Ward	7.96	8.52	8.6	96.67%	-	-	1	-	1		1	1	12.50%	8.10%	4.30%	2.90%	15.00%	Yes	1.45%	9.57	13.95%
Renal Ward	8.29	10.40	11.0	100.00%	1	5	1	-	1		0	2	11.80%	15.40%	3.70%	3.60%	15.00%	Yes	0.81%	9.43	14.06%
SEU D Side	7.67	7.85	7.5	100.00%	-	-	-	-	3		2	2	8.20%	9.70%	3.90%	4.40%	12.20%	Yes	-2.07%	9.29	13.31%
SEU E Side	7.92	7.74	7.8	100.00%	-	-	-	-	2		1	1	12.60%	17.90%	7.30%	0.00%	12.60%	Yes	-0.34%	9.29	13.32%
SEU F Side	7.21	8.14	7.8	100.00%	-	-	-	-	1		3	1	21.40%	10.10%	3.20%	3.50%	24.20%	Yes	-8.23%	9.29	10.15%
Sobell House - Inpatients	7.99	8.63	8.6	100.00%	-	8	2	-	0		1	4	10.80%	10.50%	4.60%	7.80%	20.50%	Yes	-2.04%	7.57	14.05%
Transplant Ward	9.09	7.71	8.5	100.00%	2	8	4	1	1		0	1	10.40%	4.00%	6.10%	0.00%	13.40%	Yes	-0.28%	7.57	14.03%
Upper GI Ward	9.68	7.26	8.3	97.78%	4	-	-	-	0		1	1	1.60%	2.70%	5.80%	6.90%	8.30%	Yes	-4.22%	8.71	14.20%
Urology Inpatients	7.99	9.73	8.9	96.67%	9	1	2	1	2		0	2	11.10%	3.30%	5.00%	10.10%	20.10%	Yes	-1.83%	7.57	13.12%
Wytham Ward	6.99	7.58	7.1	97.78%	-	7	1	-	3		0	2	-3.50%	6.70%	5.30%	8.70%	8.60%	Yes	0.73%	8.71	10.42%
MW Intrapartum Team	13.66		16.1		11	-	45	-										Yes	-2.81%	7.00	10.68%
MW Level 5	5.40		5.1		-	-	-	-					-2.60%	14.30%	4.70%	6.60%	5.90%	Yes	-0.20%	7.43	11.79%
MW Level 6	4.60		6.6		-	-	-	-										Yes	-3.36%	7.43	12.73%
CSS																					
JR ICU	31.13		25.0	96.67%	-	-	-	-	6		3	1	10.40%	13.00%	4.30%	4.80%	17.50%	Yes	-0.20%	9.43	12.21%

3. Assurance report: Growing Stronger Together

Oxford University Hospitals NHS Foundation Trust



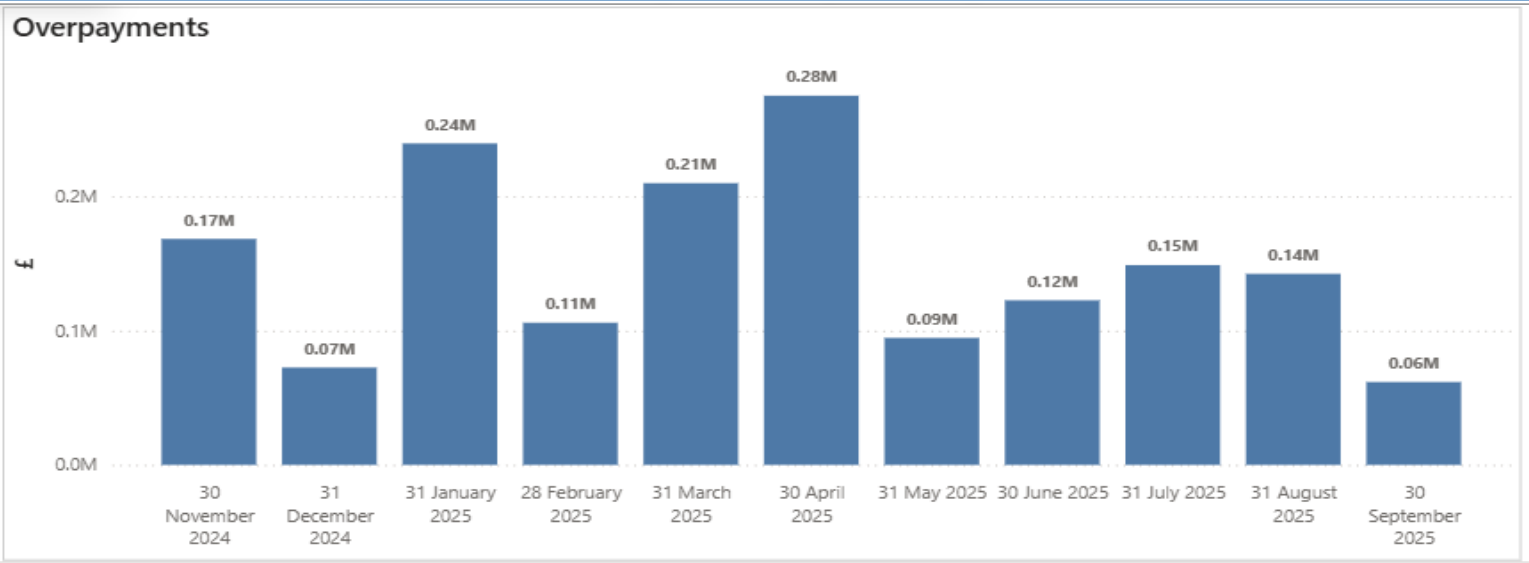


Benchmarking: September 2025 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.23% **National: 5.42%** **Shelford: 4.73%** Buckinghamshire Healthcare NHS Trust: 4.40% Royal Berkshire NHS Foundation Trust: 3.68% Oxford Health: 5.16% South Central Ambulance Service: 6.75%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.1% in November 25 and is once again unaltered. The monthly sickness rate has fallen to 4.6% from 4.8% . As we approach the "flu" season, this will be closely monitored. The key reasons for sickness top 5 continue to be :- • Respiratory System • Mental, Behaviour or Neurodevelopmental • Musculoskeletal • Digestive system • Injury, poisoning or External causes Long-term sickness top 5 reasons:- • Mental, Behaviour or Neurodevelopmental • Musculoskeletal • Injury, poisoning or External causes • Neoplasms • Not elsewhere classified	• Divisions receive a monthly report on the top 20 absences and develop action plans to reduce these numbers. • We are focusing on the top Cost Service Units (CSUs) that have consistent absenteeism. • We are collaborating with Occupational Health to assist managers and staff in reviewing the top three reasons for absenteeism. • There is a call to action regarding long-term sickness, ensuring that staff receive the support needed to return to work successfully. • Managers will be alerted about staff who have triggered absenteeism, with guidance provided to support them through the sickness absence process. • HR is proactively promoting sickness absence management training to help managers effectively implement the new procedures. • RTW forms have been reviewed and updated to make them easier to complete and the narrative is updated to support managers with undertaking the RTW interviews for everyone who has been off. • Sickness absence workshops are ongoing to provide continued support for managers. • Occupational Health colleagues will continue to offer support during monthly meetings to address issues and implement proactive measures. • Monthly meetings with the Wellbeing lead are held to identify additional areas where support may be required. The wellbeing lead is working with hotspot area leads to provide localised support. • Work is ongoing on naming conventions for sickness reasons.	Governance - TME via IPR, HR Governance, Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1616 (Amber)	Satisfactory Standard operating procedures in place, training for staff completed and service evaluation in the previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance

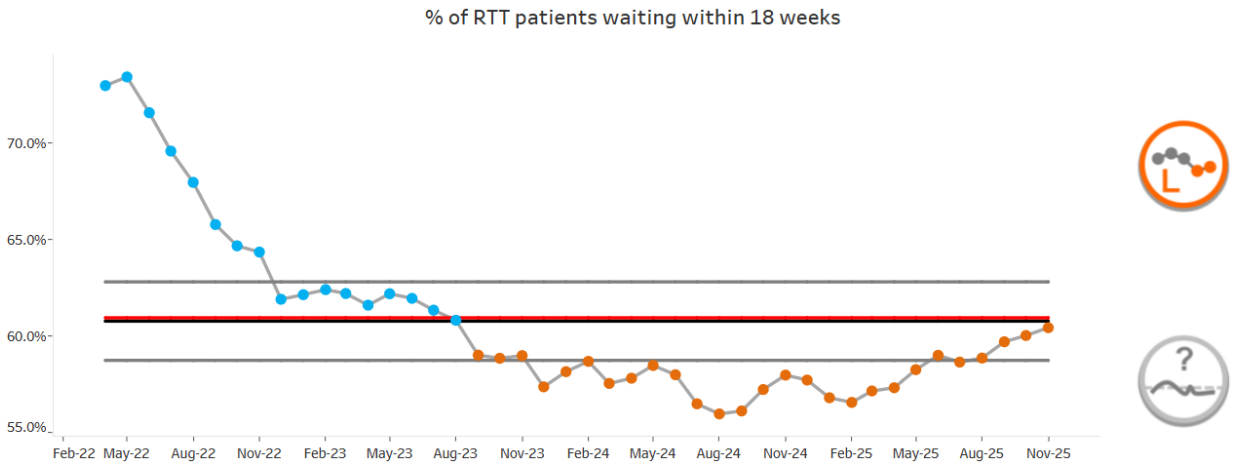
3. Assurance report: Growing Stronger Together



Division	une 2025	31 July 2025	31 August 2025	30 September 2025
Clinical Support Services	£54,919	£97,223	£93,885	£2,672
Corporate	£2,368	£2,428	£3,822	£0
Estates				
Medicine Rehabilitation and Cardiac	£14,671	£16,879	£16,669	£11,638
Neurosciences Orthopaedics Trauma Specialist Surgery Childrens and Neonates	£41,125	£27,902	£11,702	£28,295
Surgery Women and Oncology	£9,520	£4,413	£16,246	£19,129
Total	**£122,603**	**£148,844**	**£142,324**	**£61,735**

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
Overpayments arise from: 1. Poor management of leavers process. 2. Late submission and processing of change forms. 3. Late inputting of Job planning changes 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. • Implemented – reports reviewed monthly by divisions • By 31 Mar 26 • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing	Risk 2578 Risk 3248	

3. Assurance report: Operational Performance, *continued*

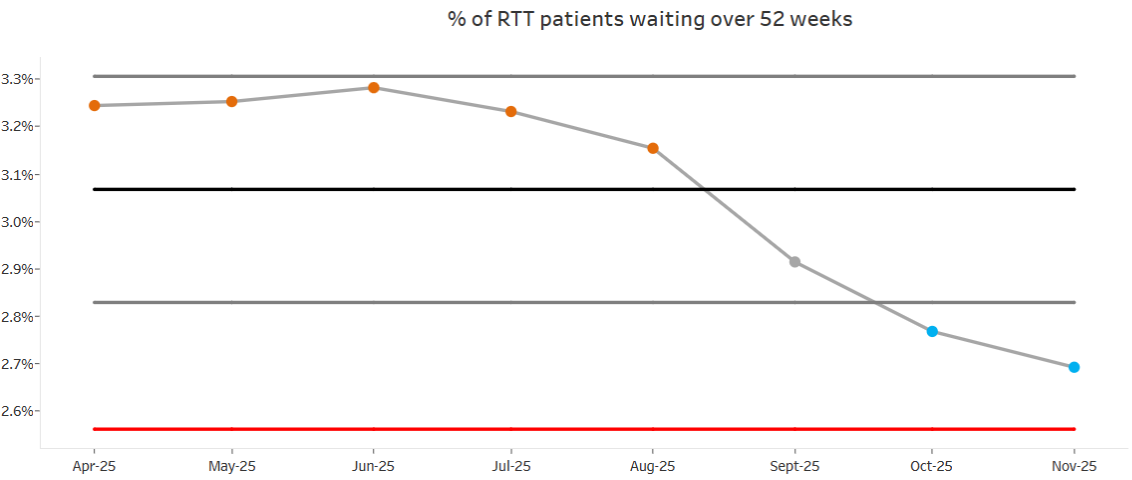


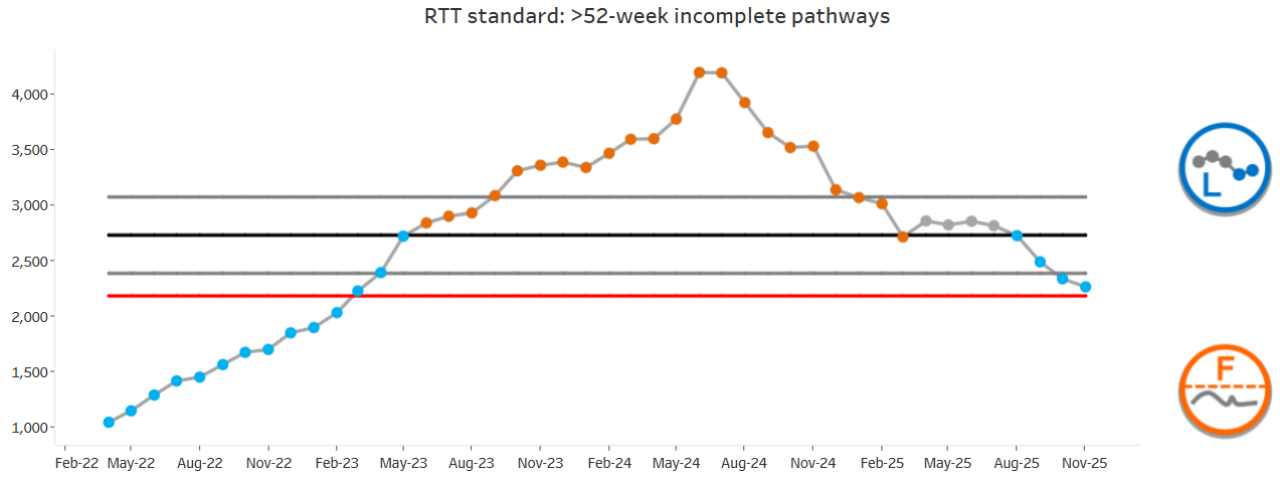
Benchmarking % within 18-weeks: October 2025				
OUH: 59.98%	National: 61.76%	Shelford: 60.60%	BHT: 59.36%	RBH: 81.36%

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 60.4% at the end of November against an operational plan of 60.9%. Performance exhibited special cause of concern due to >six consecutive periods of performance below the mean. Reduction in the denominator is contributed by the Validation Sprint initiative to cleanse the waiting list and reduce total waiting list size. Clinical priority allocated to cancer services over routine treatments. Total incomplete RTT pathway waiting list size is 84,101 with the average weeks waiting for a patient at 17-weeks.	The Trust is on plan for patients waiting within 18 weeks as at the end of December and has consistently achieved plan for the percentage of patients waiting for an outpatient appointment under 18 weeks from M1 – M8. Validation Sprint continues into Q4 – utilisation of resources for validation to scrutinise pathways above 18-weeks and only where logic suggests incorrect pathways (DQ cohorts) for under 18-weeks. Plans for early adopters to onboard digital outcome form which supports clinicians place eligible patients on a Patient Initiated Follow-Up (PIFU), creating capacity for patients clinically required to be seen and potential to converting follow-up slots to new slots. Utilising Elective Pathway Manager tool to constructively address inconclusive validation outcomes such as missing letter or clinical input required.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust



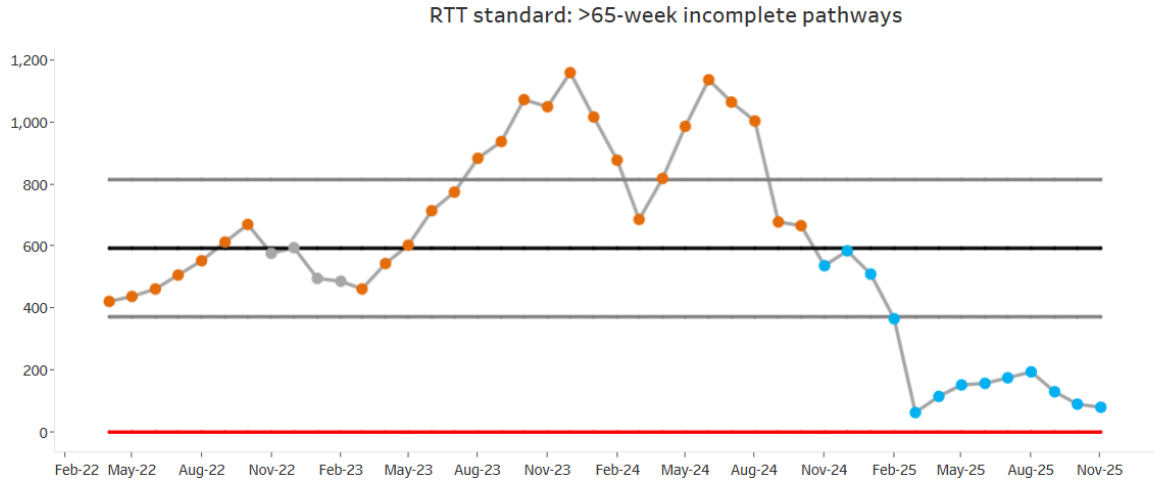


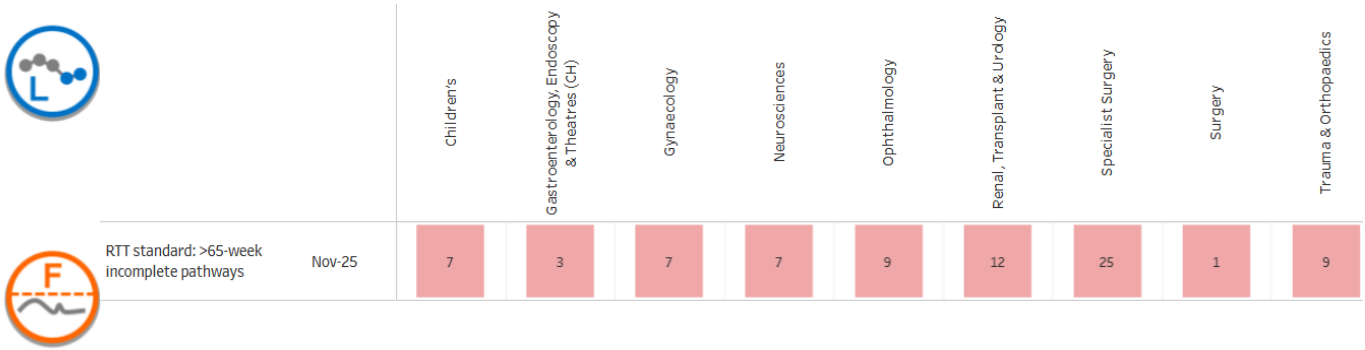
Benchmarking % over 52 weeks: October 2025				
OUH: 2.76%	National: 1.99%	Shelford: 2.09%	BHT: 2.71%	RBH: 0.09%

Benchmarking 52 week breaches: September 2025				
OUH: 2,332	National: 998 (median)	Shelford: 1,766 (median)	BHT: 1,308	RBH: 33

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 2.7% at the end of November against an operational plan of 2.6%. 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 2,262 for November against a plan of 2,182. Over 65-weeks contributing to the position by 80 pathways against a target of nil.	Delivery Funds in place to increase capacity to deliver operating plan, all allocated as at 15/11. All pathways within the 52-week cohort awaiting 1st appointments to be seen by end of January. Some services remain challenged with delivering this objective by December as previous objective, and these are being evaluated through weekly check and challenge meetings led by the COO against forecast year end operating plans. Significant progress made on the total 1st Outpatient cohort for the patients who would be 52week waiters by March 2026.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*



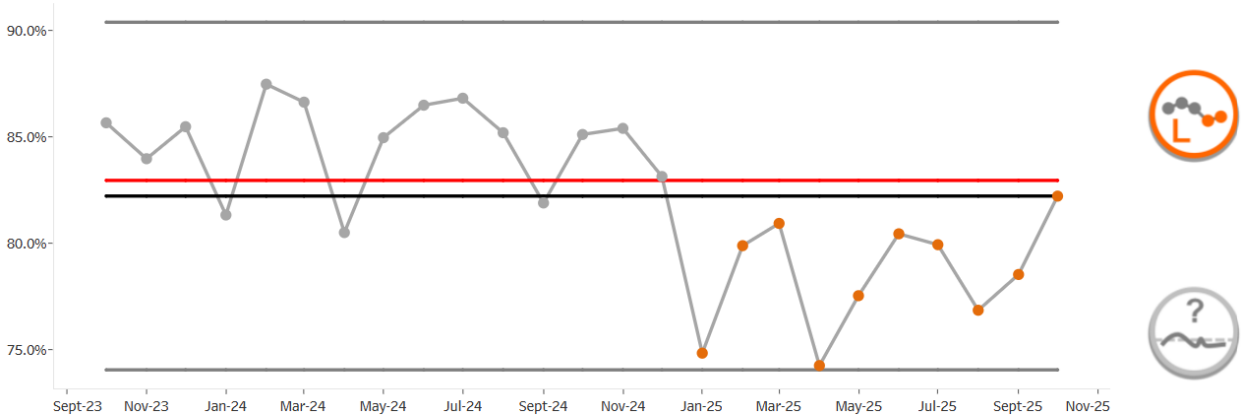


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 65 weeks to start consultant-led treatment was 80 at the end of November. 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 November. **Focus remains on longest wait patients:** **>104 weeks - Nil** incomplete pathways reported. **>78 weeks - 2** incomplete pathways reported. One complex (awaiting a special order) and one capacity, which been treated in December. **>65 weeks – 80** incomplete pathways reported which is a decrease from the previous month by 90 pathways although 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.**	**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 senor level validation being undertaken. **Orthopaedic services:** Weekend lists continue and recovery well. Patient Engagement waiting list validation completed for all 1st appointments in the 52-week cohort. Additional senor level validation being undertaken. **Patient Engagement Validation:** completed 2025/26 52-week cohort with 1st appointments (about 10k referrals), following LMC protocol to discharge non-responsive patients after 3 communication attempts within 40 days. Circa 4.5% removed and c.50% willing to travel to another Provider in BOB – list submitted via APC for capacity within BOB. Following senior level validation, the PEP process will be looked to be undertaken again. **Recovery Action Plan**: Live and populated against specialty level trajectories for delivery of the forecast.	All actions are being reviewed and addressed via weekly Check & Challenge meetings, Elective Delivery Group & Divisional Performance Reviews	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

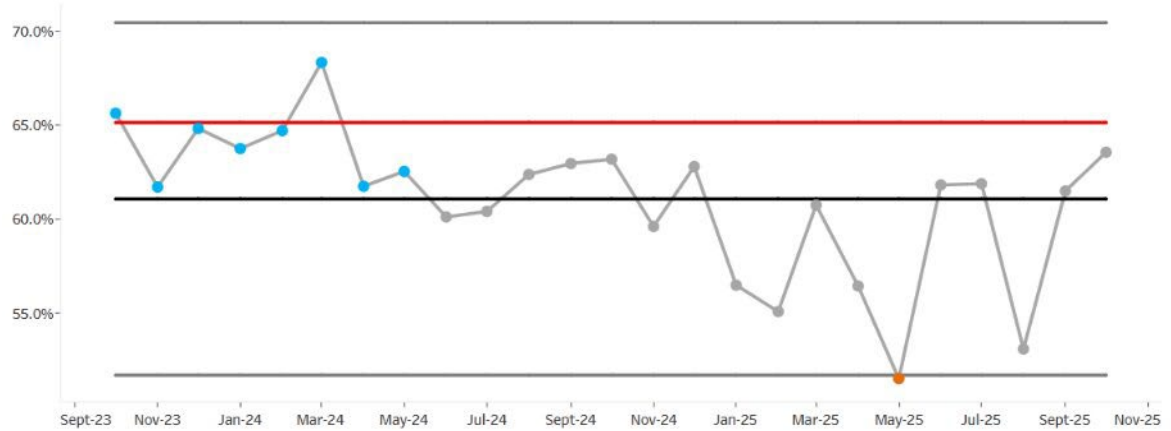
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

Cancer 31 Day combined Standard (First and All Subsequent Treatments)



Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)



Benchmarking: Cancer 31 Day All Stages October 2025

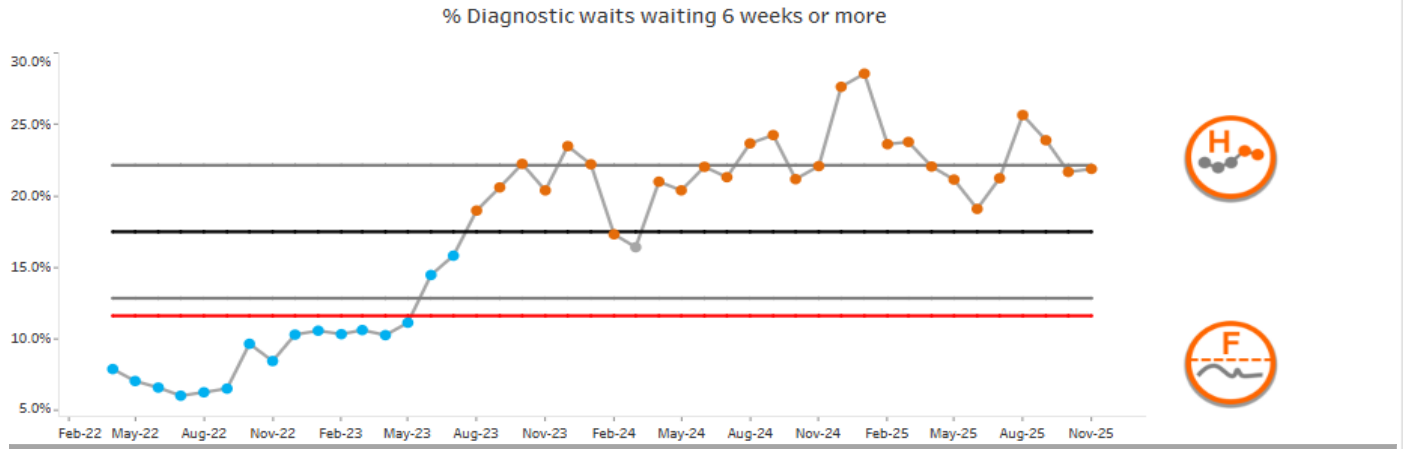
OUH: 82.2% | National: 94.9% | Shelford: 90.5% | BHT: 67.6% | RBH: 72.3%

Benchmarking: Cancer 62 Day Combined Standard October 2025

OUH: 63.54% | National: 71.45% | Shelford: 63.88% | BHT: 67.63% | RBH: 72.34%

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 82.2% in October 2025 against an operational plan of 82.9% and below the national standard of 96.0%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Barin and Other are non-compliant for this standard in October. OUH ranked 124th out of 132 Providers in October and 8th out of the 10 Shelford Group.	**Cohort 3 (Nov): 3-Tumour Site Workshop occurred 26th November** focussing on UGI and Renal with a range of senior leaders, clinical leads and subject matter experts to implement actions over 100-days. **Cohort 2 (Aug):** focussing on LGI with updates following Day-100 presented on 19th December. Urology also locally undertaken and presented in the same forum for governance and support. **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 – November 2025		

3. Assurance report: Operational Performance, *continued*



Benchmarking: Diagnostics – 6 Week Standard October 2025

OUH: 21.64% | National: 14.86% | Shelford: 18.45% | BHT: 67.63% | RBH: 72.34

Percentage point variation to monthly plan by modality

	June 2025	July 2025	August 2025	September 2025	October 2025	November 2025
Variance MRI	5.81%	2.69%	1.56%	1.62%	1.67%	-1.25%
Variance CT Scan	-0.2%	0.0%	-0.0%	0.3%	0.3%	0.3%
Variance Respiratory Physiology	-8.9%	-1.0%	-3.8%	6.2%	2.1%	-9.8%
Variance Gastroscopy	-5.6%	-8.8%	-15.8%	-19.5%	-26.9%	-32.3%
Variance Urodynamics	2.0%	-5.3%	-23.5%	-22.0%	-23.9%	-28.9%
Variance Non-Obstetric Ultrasound	10.6%	12.5%	10.4%	10.2%	11.6%	9.3%
Variance Neurophysiology	-11.3%	2.7%	-35.3%	-25.6%	-41.9%	-46.4%
Variance Electrophysiology	0.0%					
Variance Flexi Sigmoidoscopy	-12.4%	-10.8%	-14.6%	-12.8%	-11.7%	-19.2%
Variance DEXA	-1.7%	-2.6%	-0.1%	-0.2%	0.0%	0.0%
Variance Cystoscopy	2.6%	-13.5%	-14.1%	-6.9%	-10.1%	-16.4%
Variance Colonoscopy	-8.2%	-5.9%	-8.7%	-6.6%	-13.9%	-19.8%
Variance Barium Enema	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Summary of challenges and risks

The number of patients waiting more than 6 weeks as a proportion of the total waiting list was 21.9% at the end of November against an operational plan of 88.4%. Performance exhibited special cause of concern due to >six consecutive periods of performance above the mean.

Endoscopy reporting 56.7% DM01 performance for November. Number of patients waiting over 6 weeks is steadily improving month on month.

Neurophysiology reporting 19.7% DM01 performance for November.

Audiology reporting 19.6% DM01 performance for November. Demand over and above capacity since ENT pathway changes, vacancies and community paediatric audiology exacerbating core capacity. Paediatric audiology is a significant challenge due to requirement to see all community paediatric audiology, which is now reported under acute DM01.

Non-obstetric Ultrasound reporting 99.6% against a plan of 88% DM01 performance for November.

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

Endoscopy
- Clinical Fellow rotas and consultant job plans reviewed to convert clinics/other activities into additional endoscopy capacity.
- Introduction of new triage system since February is reducing unnecessary tests.
- Increased insourcing is working through the backlog.
- Perfect Week supported by the QI team occurred from 22nd to 26th September to pilot additional productivity initiatives.
- Plans underway to replace scopes and IT system which impact on throughput

Neurophysiology
- Another insourcing supplier, MediServices started 09/05/25 in addition to Bespoke.
- 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.

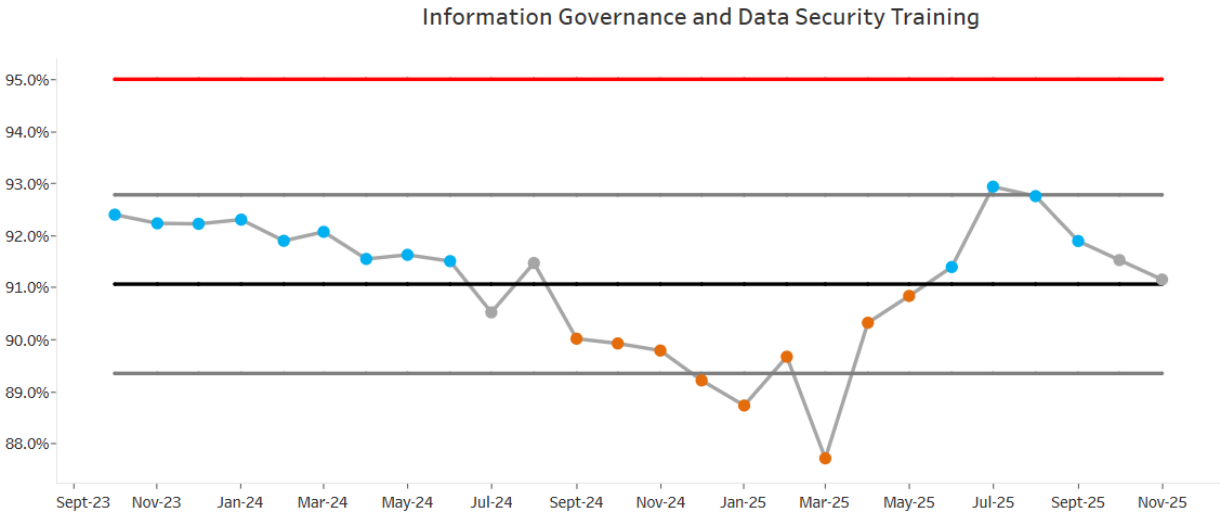
Audiology
- Delivery Fund scheme is in place to insource capacity and is delivering an additional 500 units of activity per month.
- Business case to address concerns approved at TME.
- Estates work within the Horton for a dedicated facility, underway but unlikely to be operational this financial year. Brackley booth ordered. CDC activity agreed and will commence in Dec 2025
- **Based on current position, unlikely to deliver individual March plan for Paediatric Audiology**

Non-obstetric Ultrasound
- Delivery Fund scheme has supported sufficient capacity to tackle demand.
- Sessional tracker in place monitoring substantive gaps as well as NHSP uptake.
- Workforce plan being finalised in conjunction with a workforce growth paper which includes Sonographers to reduce gap posts.
- **Performing above plan, which is offsetting some of the other modalities under performance**

Risk Register

Data quality

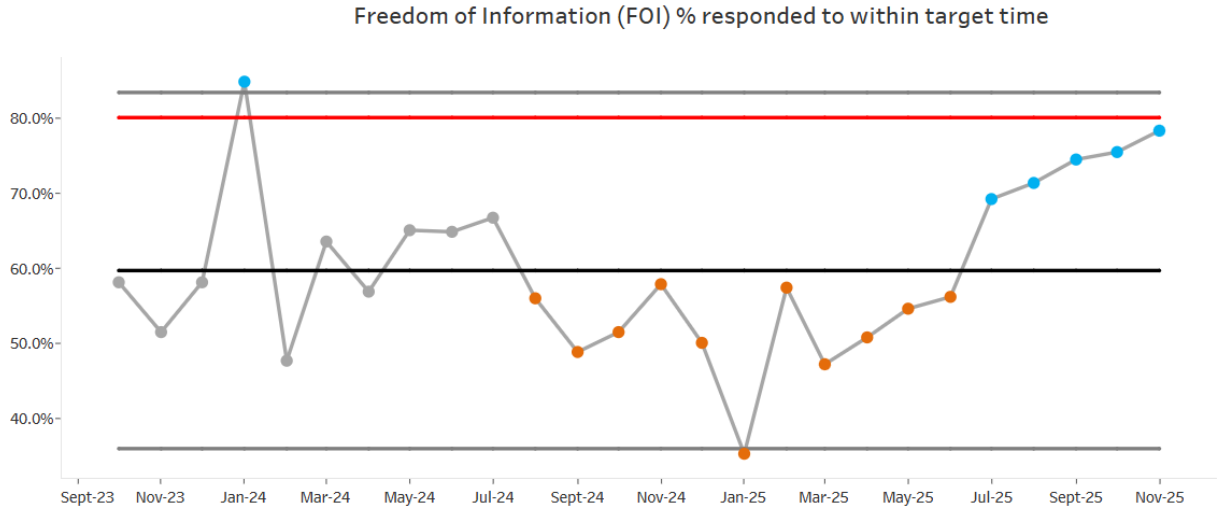
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3607	453	87.40%
SUWON	3441	323	90.60%
MRC	3333	353	89.40%
Clinical Support Services	2408	180	92.50%
Corporate	1039	78	92.50%
Operational Services	207	12	94.20%
Estates	194	14	92.80%
Research and Development	159	24	84.90%

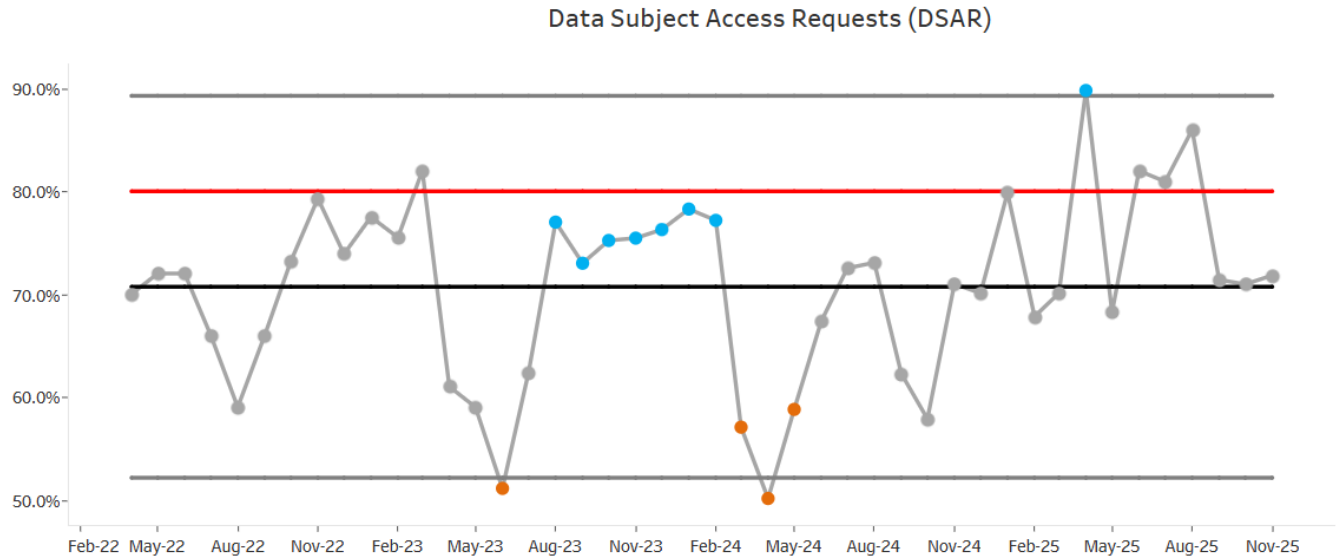
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 91.0% in M8. No divisions are achieving 95% and this month's trend is a general decrease. R&D, MRC and NOTSSCAN are below 90%. Operational Services are now below 95%.	1472 staff are currently non-compliant. All divisional governance teams have visibility of their staff training levels and are able to access reports which name non-compliant individuals to help them manage the situation.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



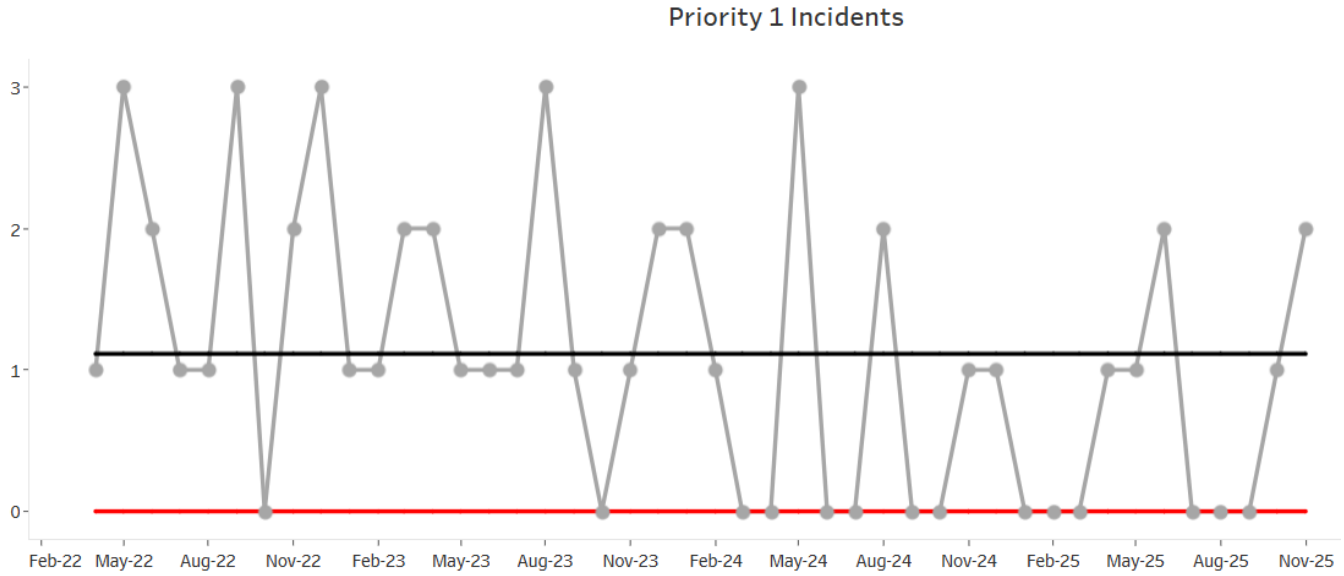
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M8 Freedom of Information (FOI) performance against the 80% target remained below the performance standard at 78.3% and exhibited common cause variation. 185 valid cases were received in M8, of which 122 have been closed, 92 of which were closed on time. This is a similar performance to M7, though the IG/FOI team is currently one staff member down due to maternity. The Trust closed the backlog of cases identified to the ICO ahead of the 31st October deadline, and wrote to the ICO provide them an update. The ICO have acknowledged receipt of the letter but not yet formally responded.	The new FOI handling platform went live on 5th January 2025 and is currently accepting cases. This will provide improved data quality and reporting to drive further performance improvement. A temporary staff member starts on 14th January 2025 to assist with the workload increase as the new system is rolled out.	Updates provided to Digital Oversight Committee and TME – TME paper due December 2025	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



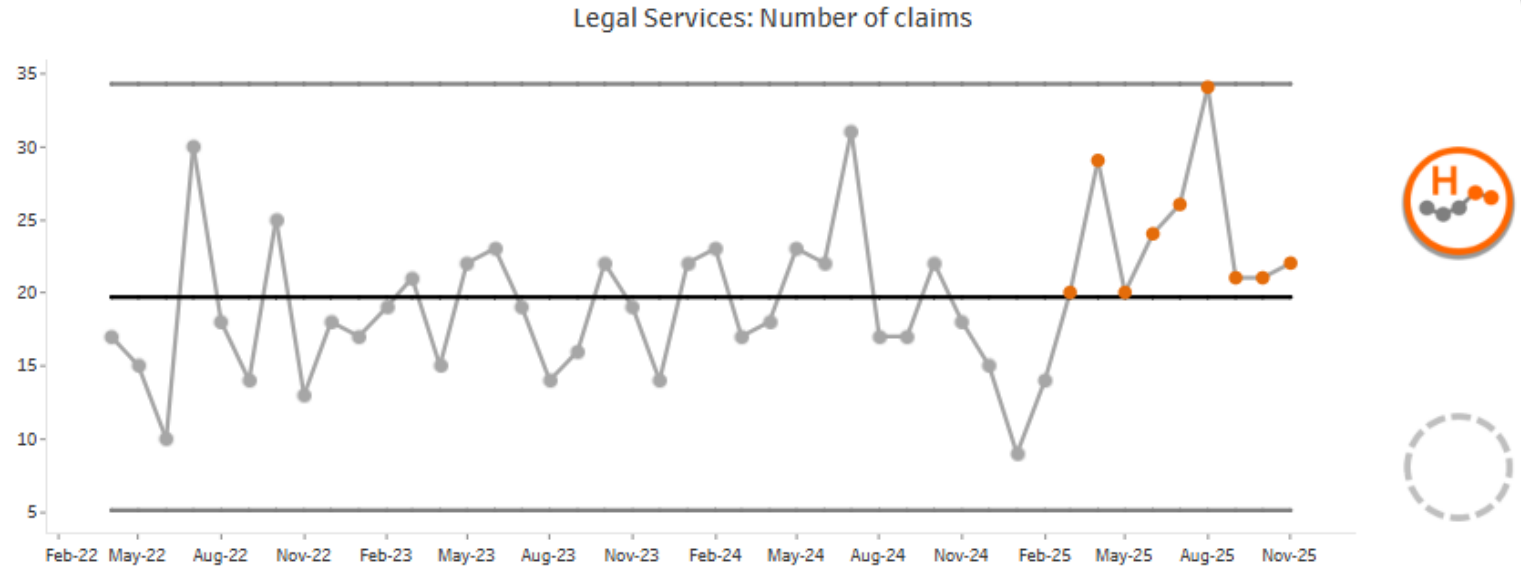
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
DSAR performance has remained at approximately 70% for the 3rd month in a row. The volume of cases being received remains very high – 1306 in M8, the highest number every recorded by the Trust.	Two temporary staff have been brought on by the Legal Services Subject Access Request team to work through the backlog of maternity notes requests. This work has being ongoing in M6 and M7, explaining the dip in overall performance. The e-Case system that has been procured for use by the FOI team is also going to be used to manage SARs – it started accepting cases on the 5th January and is working well so far. 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. 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.	Report on SAR processes and e-Case rollout to be sent to February TME	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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
INC0358407 – 27/11/2025 – Netcall Outage affecting calls and agent statuses	On 27th November, NetCall users had problems making calls and updating agent statuses. The issue was suspected to be caused by Sophos and Windows Defender interfering with Netcall's latest version. Antivirus exclusions were added to the database servers, and the NHSE team helped with further protections. Even after changes and restarts, Netcall reported that Windows Defender was still causing problems, leading to further escalation. The system was monitored over the weekend, and by Monday, no major problems were reported, but the incident is still open until Netcall confirms the fix.	Completed the same day	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*
INC0356172 – 20/11/2025 – Bleep System Outage	On 20 November 2025, major power outages at the JR site led to UPS failures, which disrupted the Multitone bleep system. The bleep system experienced intermittent outages across all locations, prompting the distribution of radio pagers as a backup measure. The underlying cause was traced to a faulty changeover contactor; the primary JR server was rebooted by restoring and stabilising the bleep system. Communications confirming resolution were sent to staff, while switchboard-maintained radios and pagers as a precaution.	Completed the same day		

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 (Y/N)	Data quality rating
• The new NHSR claims management system that came online last year had significant teething problems that resulted in an inability to report up new claims and inquests to NHSR, so it is possible that there was a 'surge' in claims because they were all added in a short period of time. • NHSR have also not submitted any claim closure forms for months, meaning we have more open claims on Ulysses at present as we record the information in the form on costs and learning. They are required to have correct records to start the new financial year so we are anticipating a swell of forms to arrive in the next few months. • The volume of new claims is not something that is within our control as claimants determine when to commence their claim within the statutory time limit (usually 3 years from the date of the incident or date of knowledge unless the claimant lacks mental capacity).	• There is a paper on Legal Services activity, which includes detailed analysis of our claims data, being presented to TME and Board in Jan. • Once we understand more about the underpinning dataset we can consider whether this is the best metric to report on or whether it is redundant or needs to be amended.	Ongoing, reviewed weekly.	*N*	Sufficient

4. Development indicators

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

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

Sufficient	Satisfactory	Inadequate

Oxford University Hospitals NHS Foundation Trust

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

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

2. Framework for levels of assurance:

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