Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M2 (May data)

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Table of Contents

1. Executive summary

Oxford University Hospitals NHS Foundation Trust

Overview

In May, our staff supported patient care by meeting targets for the vacancy rate and turnover, both exhibiting improving Special Cause Variation (SCV), as well as core skills training (although exhibiting deteriorating SCV). Measures related to patient safety and experience of care included the achievement of the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). Rates demonstrate fewer patient deaths than expected. Care was also supported by our achievement in targets or thresholds in VTE Risk Assessments and Care Hours Per Patient Day overall. Pressure Ulcer incidents per 10,000 beddays (Category 3, 2 and present on admission Category 1+) were better than the performance thresholds and 93% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines.

The Cancer Faster Diagnosis standard achieved the performance standard, and supporting this indicator, the level of diagnostic activity compared to 2019/20 remains above the baseline. Successes raised in Divisional Performance Reviews continue to be recognised, incorporating contributions of our staff in improving the care and experience for our patients, workforce and population. Successes are documented in the summary of the Performance Review meetings and reported to the Integrated Assurance Committee.

Out of the 107 indicators currently measured in the IPR, 37 are reported on in further detail using the standardised assurance templates and are listed within the relevant domain below, and on the following page. This includes indicators not meeting the performance standard and/or where there has been deteriorating SCV. The review process at Trust Management Executive also enables indicators without a target and not flagging SCV to be included in assurance reporting. Assurance reporting references updates to Tiering requirements for Elective, Cancer and Urgent and Emergency Care.

Quality, Safety and Patient experience

Performance targets were not achieved for Non-Thematic Patient Safety Incidents, and FFT percentage positive responses for ED and Outpatients. Gram-negative bloodstream infections (GNBSI) covering cases of E. Coli, Klebsiella and Pseudomonas, have been removed from the IPR and will be reported in the DIPC Annual Report and by exception only going forwards. We recorded hospital infections worse than our monthly threshold for MRSA and Clostridium difficile. The target was not met for our complaint response times and reactivated complaints (deteriorating SCV). Safeguarding training for Children and Adults did not meet the performance standard but exhibited improving SCV for Children. Adult Safeguarding activity continues to exhibit high volumes of activity (increasing SCV) in response to high demand. Health and Safety assault, aggression and harassment incidents recorded deteriorating SCV, and we reported one Never Event. Cleaning scores used to measure our PFI sites were below the performance threshold at the John Radcliffe and Churchill Hospital. Medication incidents causing moderate or above harm have been reviewed as part of the assurance process and the harm level of two incidents have been downgraded resulting in the indicator no longer triggering deteriorating SCV. As a result, an Assurance template has not been included. The CQC actions have been completed with the exception of one action that is being tracked by the CNO and CAO.

Growing Stronger Together

The rolling 12-month sickness absence rate exhibited improving SCV but remains above the target. The monthly sickness absence rate was also above target (exhibiting Common Cause Variation - CCV), but favourable performance relative to the National, Shelford and ICS providers. Due to the new appraisal window opening, non-clinical appraisals decreased significantly (deteriorating SCV), and in May the target time to hire did not meet the performance standard,

Operational Performance

Assurance reports are also included for patients waiting over 52, 65, 78 and 104 weeks, the diagnostic (DM01) standard and 62-day and 31-day Cancer Standards. Patients attending our emergency departments and being seen within four hours did not meet the performance standard but exhibited improving SCV. The number of patients spending over 12 hours in the department was below target (CCV).

Finance

The Income and Expenditure (I&E) reported performance in May was a £5.1m deficit, on plan in month. This included non-recurrent expenditure items and adjustments with a net benefit to the reported position of £3.2m. The estimated underlying in-month deficit in May was £8.3m, this is a similar level to last month. After adjusting out the pay inflation uplift for this year, the underlying deficit is largely unchanged from the last quarter of last financial year. Cash was £11.3m at the end of May, £24.4m lower than the previous month and £0.3m higher than plan. The decrease in the cash balance is due to a catch up of paying for last year's capital expenditure (capital creditors at year end). The cash position would be significantly worse, but for the active cash management measures currently in place. The need for cash support is being monitored on a regular basis.

Digital

We have also included assurance templates on DSPT / information governance training compliance, Freedom of Information request performance, Data Subject Access Request (DSAR) response times, IG reported incidents and Priority 1 incidents.

Data quality

The assurance templates' data quality ratings have been completed and have outcomes ranging from 'satisfactory' to 'sufficient', as per the definitions referenced on page 8.

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	• MRSA cases: HOHA+COHA • C-diff cases: HOHA+COHA • FFT ED % positive • Safeguarding (Adults) training compliance L1 - L3 • Midwife to birth ratio • PFI cleaning score (JR) • PFI cleaning score (Churchill) Not achieving target	• % of complaints responded to within agreed timescales • FFT Outpatient % positive • Safeguarding (Children) training compliance L1 - L3 Not achieving target	• Reactivated complaints • Medication safety incidents • Health and Safety Assault, aggression and harassment incidents Not achieving target	• Adult safeguarding activity No target No SPC • Non-Thematic Patient Safety Incident Investigations • Never event Not achieving threshold No target
Growing Stronger Together	• Sickness absence (monthly) • Time to hire Not achieving target	• Sickness absence (rolling 12-month) Not achieving target	• Appraisal compliance (non-medical) Not achieving target	
Operational performance	• Proportion of patients spending more than 12 hours in the Emergency Department Not achieving target	• Patients waiting more than 78 weeks • Patients waiting more than 104 weeks Not achieving target • ED 4-hour performance (all types) • ED 4-hour performance (type-1) Not achieving target	• % Outpatient firsts and follow-up attendances for procedures Not achieving target • Patients waiting more than 52 weeks • Patients waiting more than 65 weeks • % Diagnostic waits under 6 weeks (DM01) Not achieving target	No SPC • 62- day General Standard • 31-day General Standard Not achieving threshold
Corporate Support Services	• Freedom of Information % responded to within target time Not achieving target		• Information Governance and Data Security Training compliance • Data Subject Access Requests Not achieving target • All IG reported incidents Not achieving target	No SPC • CQC overdue actions • 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: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	May-24	0.3	-	-	0.1	-0.4	0.7
MRSA cases: HOHA+COHA	May-24	1	0	No	0	-1	2
C-diff cases: HOHA+COHA per 10,000 beddays	May-24	2.7	-	-	3.3	0.5	6.0
C-diff cases: HOHA+COHA	May-24	11	9	No	11	2	19
MSSA cases: HOHA+COHA	May-24	8	-	-	6	0	12
Number of Never Events	May-24	1	0	No	0	-	-
Non-Thematic Patient Safety Incident Investigations	May-24	1	0	No	2	-	-
VTE- Submitted performance	May-24	97.7%	95.0%		98.0%	97.6%	98.3%
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	May-24	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	May-24	7	-	-	2	-1	6
Hospital Standardised Mortality ratio	May-24	90.3	100.0		92.6	-	-
Summary Hospital-level Mortality Indicator	May-24	86.0	100.0		93.6	-	-
Neonatal deaths per 1,000 total live births	Mar-24	6.1	3.2	No	3.9	-	-
Stillbirths per 1,000 total Live births	Mar-24	1.7	4.0		4.3	-	-
National Patient Safety Alerts not completed by deadline	May-24	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	May-24	0.0	-	-	0.0	-	-
Number of active clinical research studies hosted	May-24	1448	-	-	1367	1334	1400
Number of active clinical research studies (commercial)	May-24	397	-	-	359	347	372
Number of active clinical research studies (non commercial)	May-24	1051	-	-	1008	986	1030
Number of incidents with moderate harm or above per 10,000 beddays	May-24	57.8	-	-	41.4	24.0	58.8
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	May-24	17.0	26.0		21.7	9.5	33.8
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3 and 4)	May-24	2.4	3.0		2.3	0.4	4.2
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	May-24	91.5	114.0		99.2	75.1	123.3
Patient falls (moderate and above) as reported on Ulysses	May-24	5	-	-	4	-3	12

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

Quality, Safety and Patient Experience Summary

Latest Indicator Period: Apr-2024

Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	May-24	1.5	-	-	1.4	-0.9	3.7
Health and Safety related incidents - Assault, Aggression and harassment	May-24	244	-	-	152	74	230
Adult safeguarding activity	Mar-24	939	-	-	740	541	939
Children's safeguarding activity	Mar-24	672	-	-	597	297	897
Adult safeguarding activity and Children's safeguarding activity	Mar-24	1611	-	-	1337	910	1764
Safeguarding (Children) training compliance L1 - L3	Apr-24	88.0%	90.0%	No	87.2%	81.1%	93.4%
Safeguarding (Adults) training compliance L1 - L3	Apr-24	89.0%	90.0%	No	21.0%	9.8%	32.2%
Total Deliveries in month	May-24	654	625	-	619	564	674
Babies born	May-24	661	-	-	628	573	683
Maternity Bookings (planned + unplanned)	May-24	757	750	-	710	563	856
Inductions of labour from iView	May-24	140	-	-	146	112	180
Midwife Ratios (birth rate / staffing level)	May-24	29.1	28.0	No	26.0	22.1	29.9
Learning MDT Reviews presented at SLIC	May-24	3	-	-	4	-	-
After Action Review (AAR)	May-24	19	-	-	19	-	-
Number of complaints	May-24	96	-	-	108	55	161
Number of complaints per 10,000 beddays	May-24	29.2	-	-	33.7	18.9	48.5
% of complaints responded to within agreed timescales	May-24	86.8%	95.0%	No	77.9%	63.8%	92.0%
Reactivated complaints	May-24	23	1	No	11	1	21
Number of RIDDORs	May-24	3	5		3	-	-
Friends & Family test % likely to recommend - IP	May-24	95.4%	95.0%		95.1%	93.8%	96.5%
Friends & Family test % likely to recommend - OP	May-24	93.7%	95.0%	No	93.7%	93.0%	94.4%
Friends & Family test % likely to recommend - ED	May-24	82.1%	85.0%	No	78.6%	72.3%	85.0%
FFT maternity % positive (births)	May-24	50.0%	90.0%	No	88.7%	76.2%	101.1%
Inpatient FFT (Response Rate)	May-24	20.1%	-	-	25.4%	22.4%	28.4%
Outpatient FFT (response rate)	May-24	7.7%	-	-	7.4%	6.1%	8.8%
ED FFT (Response Rate)	May-24	33.3%	-	-	25.2%	21.3%	29.0%
Maternity FFT (response rate; births)	May-24	0.4%	-	-	12.1%	2.7%	21.5%
PFI: % cleaning score by site (average) JR	May-24	92.0%	95.0%	No	92.7%	81.7%	103.7%
PFI: % cleaning score by site (average) CH	May-24	92.0%	95.0%	No	94.0%	82.3%	105.7%
PFI: % cleaning score by site (average) NOC	May-24	100.0%	95.0%		97.9%	94.5%	101.4%
Incident rate of violence and aggression (rate per 10,000 beddays)	May-24	74.2	-	-	47.6	24.9	70.3
Trust level: CHPPD vs budget	May-24	14.6	-	-	-29.3	-73.4	14.7
Trust level: CHPPD vs required	May-24	10.0	-	-	-8.0	-28.5	12.4

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

Oxford University Hospitals NHS Foundation Trust

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

Latest Indicator Period: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Vacancy rate	May-24	5.5%	7.7%		7.1%	6.3%	7.9%
Turnover rate	May-24	10.2%	12.0%		11.4%	11.0%	11.9%
Sickness and absence rate (rolling 12 months)	May-24	3.9%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	May-24	23.3%	85.0%	No	77.0%	45.1%	108.9%
Sickness and absence rate (in month)	May-24	3.9%	3.1%	No	4.1%	3.0%	5.2%
Core skills training compliance	May-24	89.0%	85.0%		89.8%	87.6%	91.9%
Time to hire (average days)	May-24	54.7	53.0	No	49.7	38.5	60.8

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Apr-24	7.8%	-	-	9.3%	4.4%	14.1%
Proportion of ambulance arrivals delayed over 60 minutes	Apr-24	0.4%	-	-	1.1%	-0.2%	2.4%
ED 4Hr perfromance - All	May-24	74.9%	78.0%	No	64.7%	56.2%	73.2%
ED 4Hr perfromance - Type 1	May-24	67.1%	73.6%	No	58.4%	49.3%	67.5%
Proportion of patients spending more than 12 hours in an emergency department	May-24	3.4%	2.0%	No	5.1%	2.6%	7.5%
Proportion of patients discharged from hospital to their usual place of residence	May-24	94.9%	-	-	95.0%	94.0%	96.0%
% Diagnostic waits waiting 6 weeks or more	May-24	20.4%	5.0%	No	13.6%	9.5%	17.7%
RTT standard: >52-week incomplete pathways	May-24	3767	-	-	2459	2160	2759
RTT standard: >65-week incomplete pathways	May-24	985	0	No	707	493	920
RTT standard: >78-week incomplete pathways	May-24	81	0	No	158	84	233
RTT standard: >104-week incomplete pathways	May-24	5	0	No	9	1	16
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Apr-24	61.7%	70.0%	No	64.4%	55.8%	72.9%
62-day Cancer standard: incomplete pathways >62-days	May-24	418	-	-	320	238	402
62-day Cancer standard: incomplete pathways >104-days	May-24	122	-	-	101	72	131
Inpatient Daycase activity vs 2019/20	May-24	92.5%	-	-	90.9%	74.4%	107.4%
Inpatient Elective activity vs 2019/20	May-24	92.2%	-	-	83.6%	58.9%	108.3%
Outpatient First Attendance activity vs 2019/20	May-24	100.7%	-	-	107.9%	82.6%	133.2%
Outpatient Follow Up Attendance activity vs 2019/20	May-24	125.8%	-	-	116.8%	89.9%	143.8%
Diagnostic activity vs 2019/20	May-24	124.1%	-	-	120.8%	106.7%	134.9%
Cancer First Treatments vs 2019/20	May-24	116.6%	-	-	125.0%	84.3%	165.6%
Bed Utilisation General & Acute	May-24	94.0%	-	-	95.3%	91.7%	98.9%
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Apr-24	76.6%	77.0%	No	78.8%	72.0%	85.5%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Apr-24	80.5%	96.0%	No	84.4%	75.3%	93.5%
% outpatient activity: first (all) and follow-up (procedures)	May-24	40.4%	46.0%	No	43.2%	41.5%	44.8%

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

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

Oxford University Hospitals NHS Foundation Trust

Integrated Performance Report (SPC)
Finance Summary: All

Latest Indicator Period: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	May-24	-8280.5	-	-	-4205.2	-7026.2	-1384.1
BPPC £ %	May-24	72.5%	95.0%	No	88.7%	81.3%	96.1%
BPPC Volume %	May-24	53.7%	95.0%	No	77.2%	68.9%	85.6%
Cash £'000	May-24	11263	11021		38385	11745	65025
Efficiency delivery £'000	May-24	4767.0	3266.0		5234.3	-1317.5	11786.2
Elective recovery funding (ERF) value-weighted activity % In month	Mar-24	99.7%	107.0%	No	98.7%	87.6%	109.8%
In-month financial performance Surplus/Deficit £'000	May-24	-5077.1	5095.3	No	-844.4	-12093.2	10404.4
In-month ICS CDEL capital expenditure	May-24	1808.7	1668.0	-	2511.6	-6003.4	11026.7
Year-to-date financial performance Surplus/Deficit £'000	May-24	-11290.9	11319.1	No	-12175.3	-21460.7	-2890.0

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

Latest Indicator Period: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	May-24	91.6%	95.0%	No	92.0%	-	-
Data Security & Protection Breaches	May-24	41	-	-	26	7	45
Externally reportable ICO incidents	May-24	0	0		0	-	-
All IG reported incidents	May-24	46	-	-	28	11	44
Freedom of Information (FOI) % responded to within target tim	May-24	65.0%	80.0%	No	60.7%	-	-
Data Subject Access Requests (DSAR)	May-24	58.8%	80.0%	No	69.2%	52.6%	85.7%
Priority 1 Incidents	May-24	3	0	No	1	-	-

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

Latest Indicator Period: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	May-24	23	-	-	19	4	33

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

Latest Indicator Period: May-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	May-24	4	0	No	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.

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*

03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience

Oxford University Hospitals NHS Foundation Trust

Chart 1:

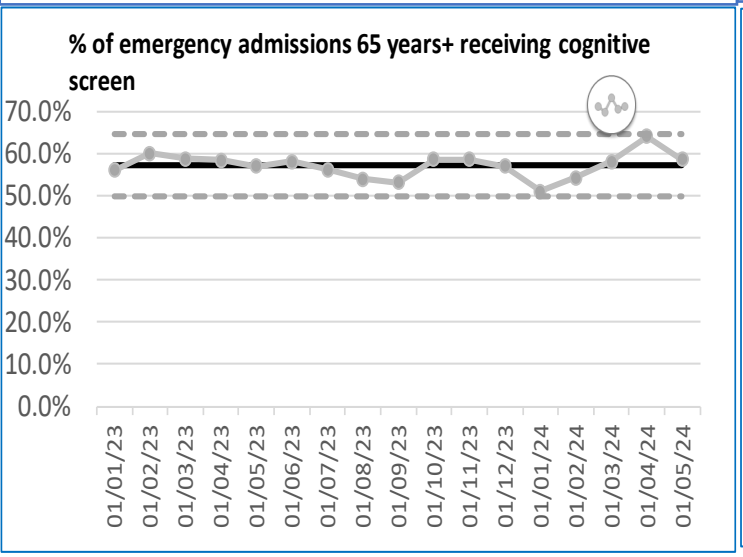
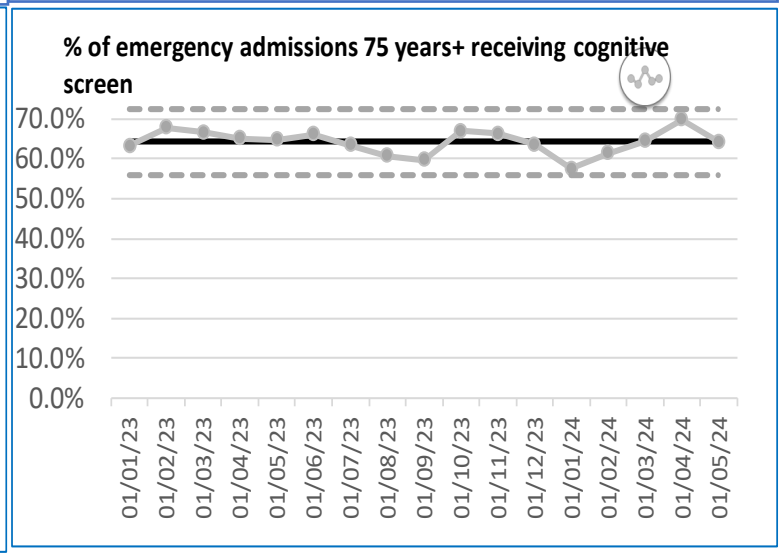


Chart 2:



Benchmarking:

NHSE Dementia strategy advised screening all unplanned admissions aged 75 and above who were in hospital for more than 72 hours. Reporting to this standard was discontinued in 2021.

Newer combined guidance from RCP, GIRFT, NHSI and BGS on management of front door frailty advises screening all unplanned admissions aged 65 and over for cognitive and physical frailty, but there is no target set.

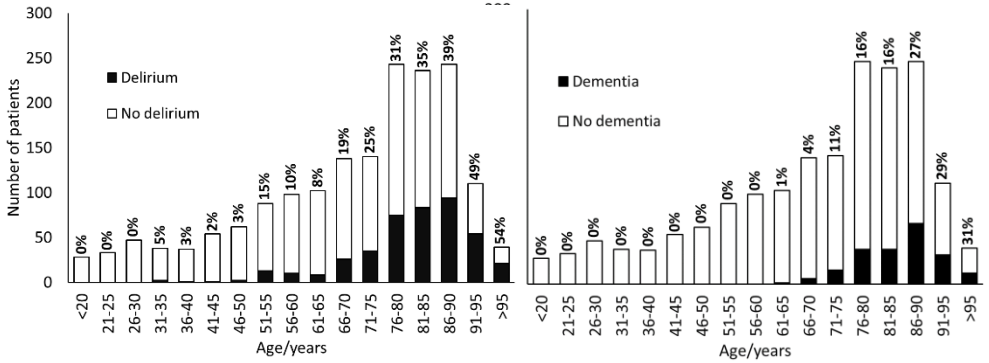
Benchmarking via National Geriatric Medicine GIRFT team indicates that many Trusts do not collect data on cognitive screening rates in this cohort, and where they do, screening rates are around 30%. Higher rates are seen where there is a mandatory EPR screen (which might be at the expense of accuracy) or a shorter form of cognitive screen (SQID) with lower utility.

OUH performance therefore appears to compare well with available comparator data, albeit with room for further improvement.

See next slide for data on incidence of delirium

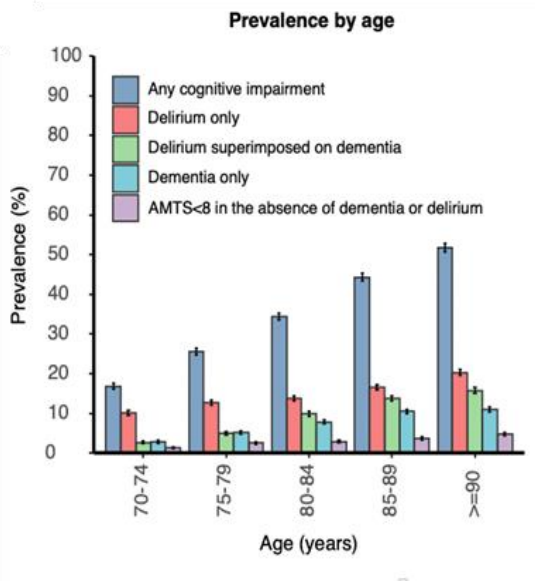
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In May 2024, 58.6% of eligible patients aged 65+ years admitted via an emergency pathway received a cognitive screen. In the same period, 64.2% of patients aged 75+ received a cognitive screen. Frailty identification for emergency admissions is done by triple assessment of Clinical Frailty Score, Cognitive screen (AMTS and / or 4AT) and NEWS2. Cognitive screening tool now aligned with national recommendations (screen all unplanned admissions aged 65 and over) and the Trust Orbit report has been updated accordingly. Ward level data available. Many ward-based teams are slowly improving rates. The biggest challenge remains in fast turnover, high volume, short length of stay areas (specifically EAU at the JR and HGH) where lower performance impacts on overall Trust rates given large patient numbers. Improvement in current screening rates to be driven by linking to resulting improvements in patient pathways/care. Please note that headline metrics only will be included in future IPRs.	Regular review of screening rates in governance and performance reviews to ensure accountability Focussed QI work in EAU Delirium and dementia care bundles (multi-disciplinary) established on CMU wards, with plans for dissemination Safeguarding processes guided by screening Pathway work (right patient, right place) underway	Frailty Steering Group, MRC Divisional Governance, PS EC.	BAF 4	To follow

Prevalence of delirium and pre-existing dementia by age

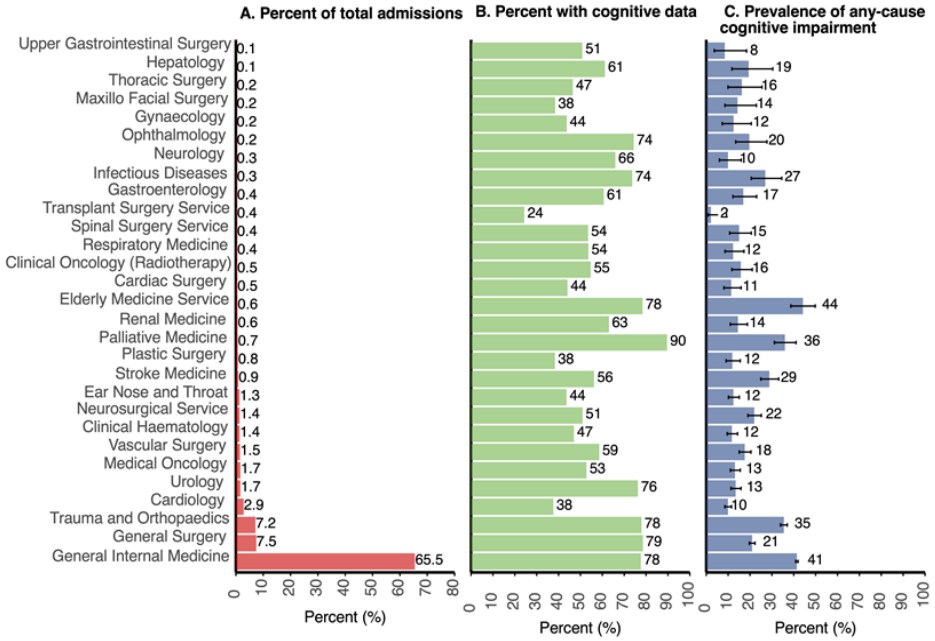


Consecutive admissions to acute medicine Smith/Pendlebury N~1800 (2010-2018)
Delirium rises rapidly after age 65 years justifying routine screening

Delirium is the most common cognitive problem in older patients with unplanned admission in OUHFT



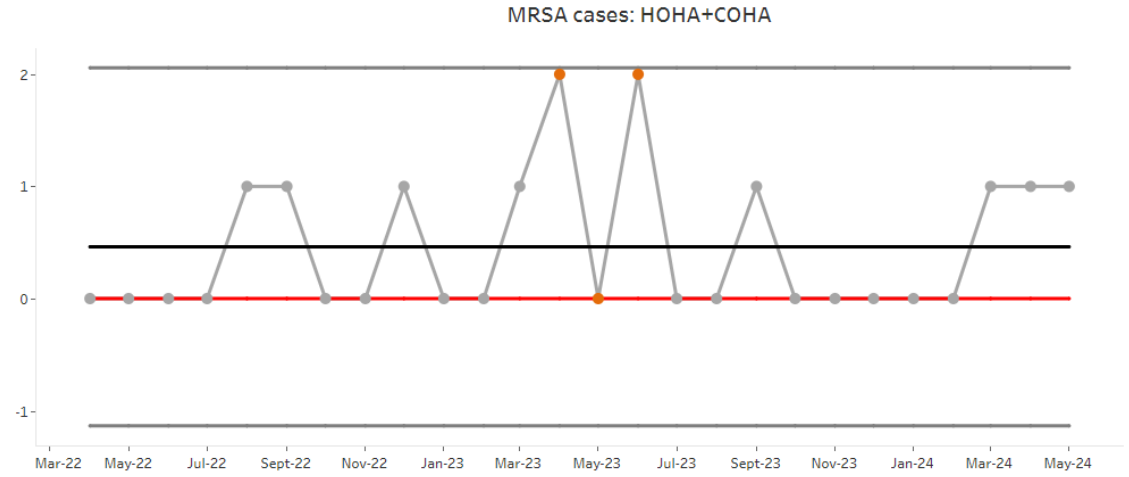
Any cognitive impairment, delirium only, delirium on dementia, dementia only, and low AMTS in OUHFT unplanned admissions
N~40,000 admissions (2017-19), age >/=70 years

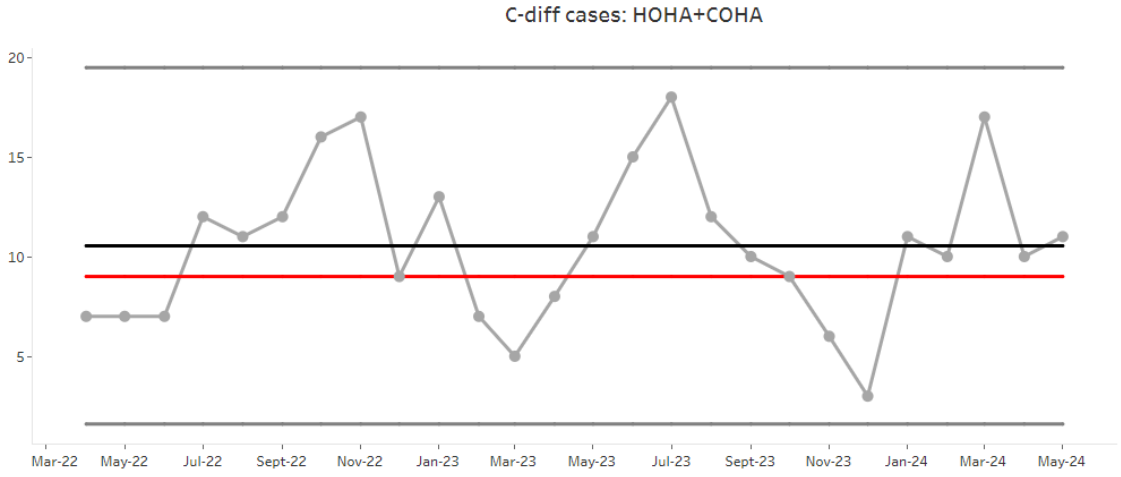


Cognitive impairment is common in older patients with unplanned admission across many OUHFT specialties justifying Trust-wide screening
N~40,000 admissions (2017-19), age >/=70 years

Pendlebury, ORCHARD-EPR unpublished

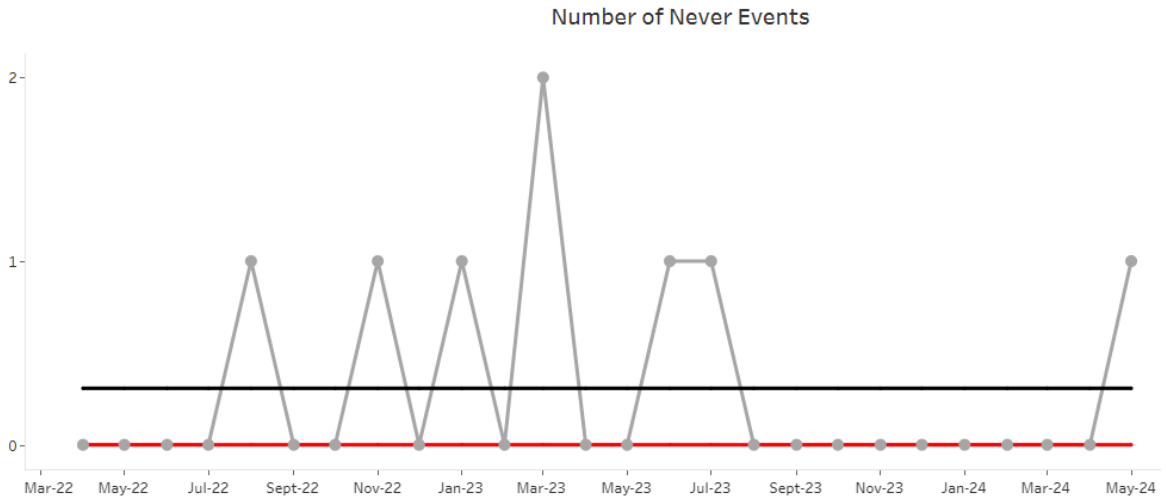
3. Assurance report: Quality, Safety and Patient Experience





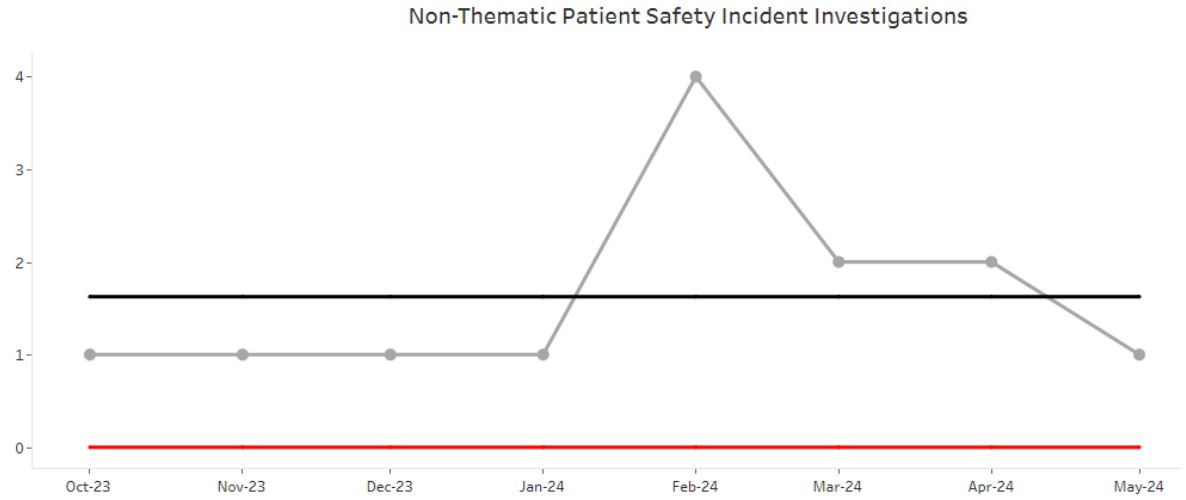
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
MRSA – one COHA case in April 2024 **C.difficile** – seven HOHA and three COHA cases	MRSA - became bacteraemic following surgical intervention, source thought to be urinary. 3 HOHA cases and one COHA of Cdiff in oncology, samples to be sent for ribotyping. Weekly AMS ward rounds continue as part of routine practice on oncology which in general have demonstrated limited use of broad-spectrum antibiotics and prescribing within OUH guidelines.	No threshold yet set for Cdiff cases, On review correcting the C. difficile data for 2023/24 using discharges as a measure of OUH activity shows no change from 2022-23.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

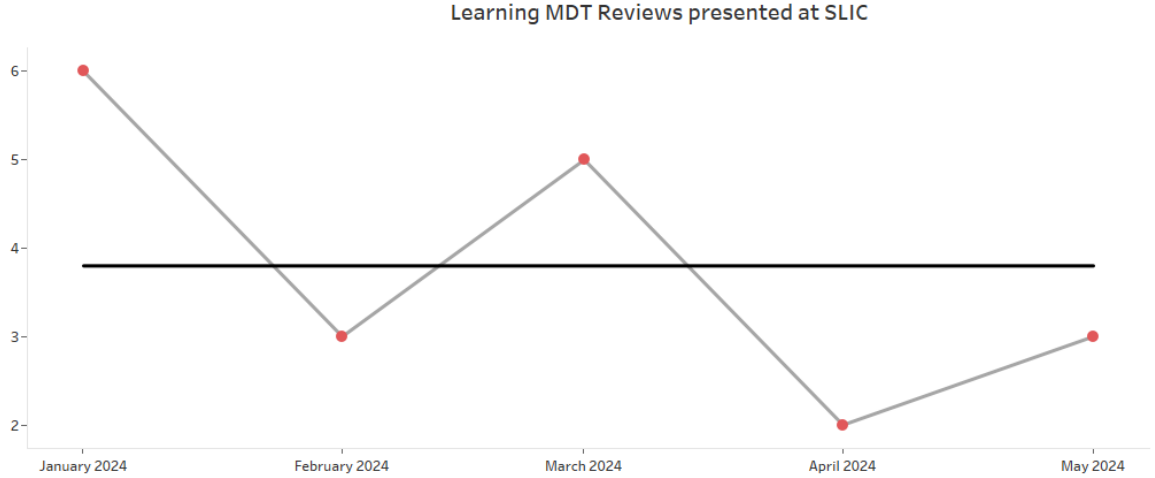
3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
A new Never Event was confirmed in May 2024, in which the incorrect valve ventriculoperitoneal shunt was inserted during a neurosurgical procedure, which meets the criteria for a Wrong Implant/Prosthesis Never Event. A Patient Safety Incident Investigation is underway, and discussions with staff have begun.	Immediate potential learning has been identified in the following areas: ○ Pre-operative checks against the shunt registry to identify the details of any shunts patients have in situ ○ Discussion of local shunt availability at the WHO surgical safety checklist sign-in ○ Explore whether the method and manner of storage of the different shunts could be improved.	The target for final Trust sign-off of the report is 22 August 2024. An interim status report will be presented to SLIC in July.	No	Sufficient

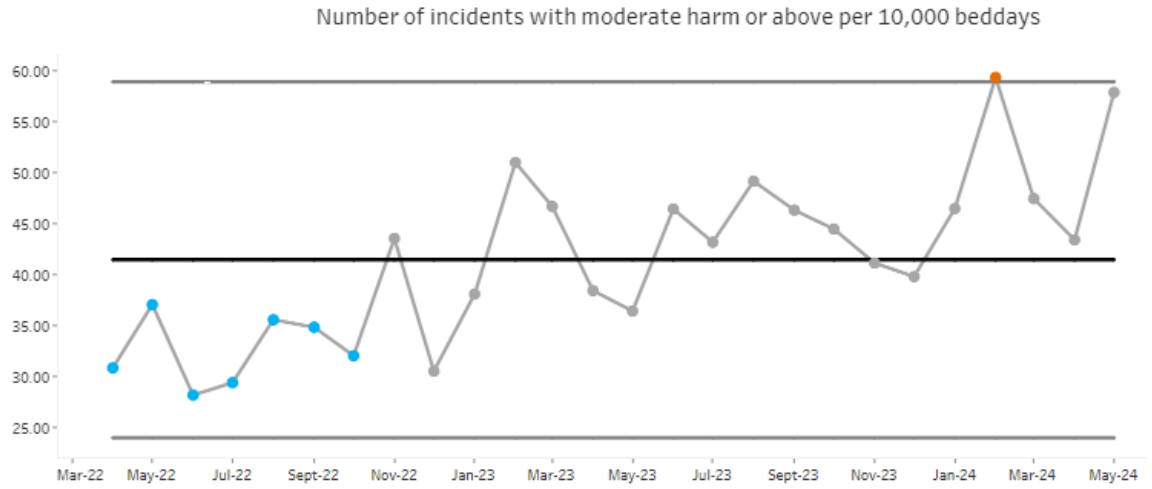
3. Assurance report: Quality, Safety and Patient Experience

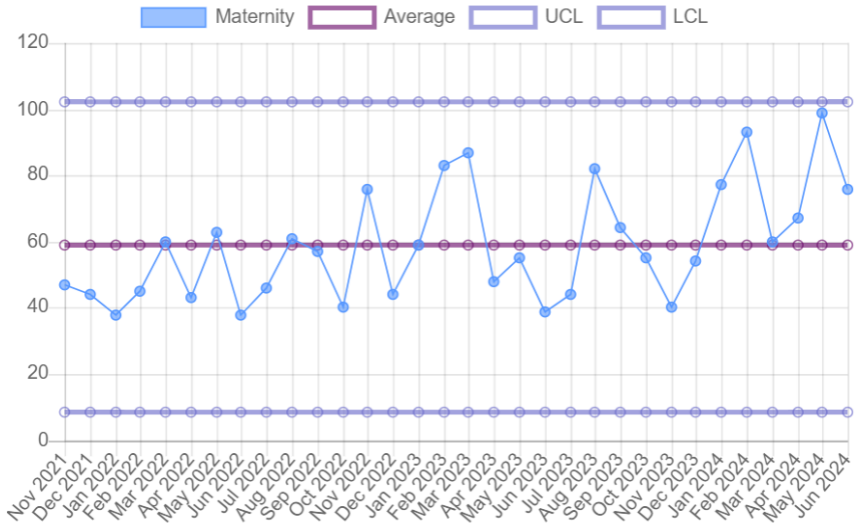




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
One Patient Safety Incident Investigation (PSII) was confirmed in May 2024 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile): this is the Never Event covered by the previous slide. Individual PSIIs are incidents that warrant an extensive system-based review (more than a Learning MDT Review response). The learning and improvement will be shared once the PSII has concluded, within 3-6 months. The specific timeline for PSIIs is set by the service in conjunction with the patient and family and confirmed at the weekly Safety Learning & Improvement Conversation (SLIC).	A total of 13 non-thematic PSIIs have been confirmed over the last 8 months since OUH moved to the PSIRF framework in October 2023. PSIIs are one of a range of learning responses. They are a detailed investigation using a systems analysis approach which can be applied to individual incidents or a cluster of similar incidents. Other learning responses include After Action Reviews (AAR) and Learning Multidisciplinary Team reviews (LMDT). AARs have a target of 2 weeks from the reporting of the incident to complete, and LMDTs 6 weeks. The default timeframe for PSIIs is 3 months but exact durations are agreed at SLIC. AARs were initially underreported in Ulysses. The Patient Safety Team now tracks all completed AARs, and AARs will be included once 3 monthly data points have been collected. In May 19 AARs (including harm-free assurance reviews for pressure ulcers & falls) were completed and submitted to PST.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. The PSII process is monitored by SLIC with responsibility for sign-off of final reports from Division, Head of Clinical Governance and DCMO.	BAF 4 CRR 112 2	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

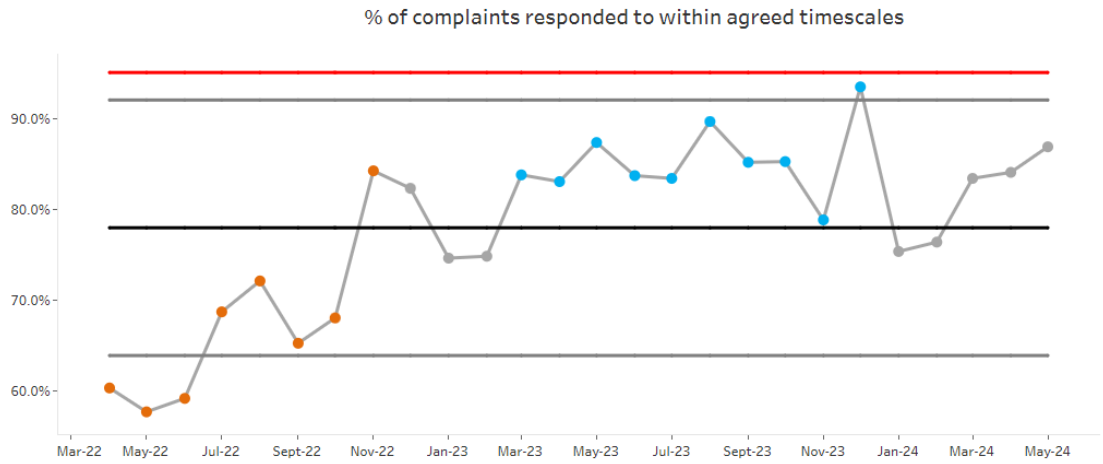
3. Assurance report: Quality, Safety and Patient Experience

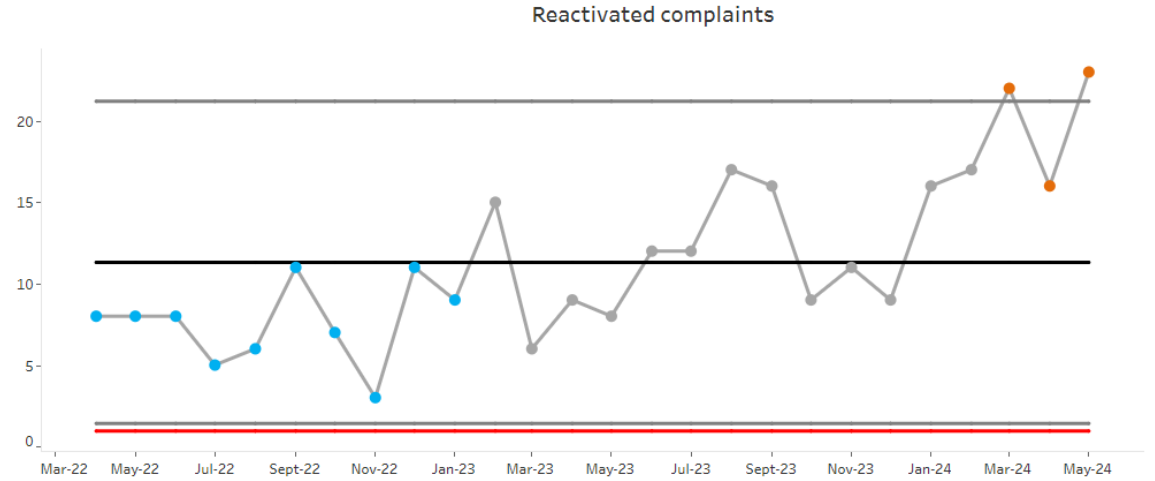




Summary of challenges and risks		Action timescales & assurance committee	Risk Register	Data quality rating
There were 57.8 incidents with moderate harm or above per 10,000 bed days in May 2024. The approach to several maternity incidents, such as post-partum haemorrhage, changed during October 2021 The Trust began calling these as Moderate-impact incidents, in line with national practice. This approach was embedded in Maternity over the following 12 months and is now well established. As a result, Maternity Directorate now calls a significant percentage of Moderate+ incidents (99 of the 183 incidents in May 2024, or 54%). The second graph shows the history of Maternity Moderate+ incidents. Note that the scales of the two graphs are different: total incidents are presented per 10,000 bed days in the first graph, compared with absolute number of maternity incidents in the second graph; the Maternity graph also covers a longer period.	The most common Cause Group for these cases in May 2024 was Maternity (72 of 183, 39%). The second most common Cause Group was Surgical/Return to Theatre (36 of 183, 20%); this is an increase on April's figures (23, 16%). All of these Surgical/RTT incidents have been confirmed as local investigations, with the exception of 2 for which information is awaited to allow the learning response to be confirmed. The Surgical Mortality & Morbidity dashboards include return to theatre data, these are being adopted across surgical services. Apart from Maternity, the Directorate with the most Moderate+ incidents in April 2024 was Surgery (22 of 183, 12%). One of these was a Cardiac Arrests, 2222 Calls & Patient Deterioration incident, which is being reviewed locally, and the remaining 21 are Surgical/RTT cases, as discussed above.	173 of the 183 incidents reported this month were patient incidents, and by the start of July, 64 (37%) of which have been covered by the Safety, Learning & Improvement Conversation (SLIC) review process; the mean monthly percentage is 35% (data from November 2023 onwards). Further information, or a formal learning response, will be provided for the incidents still awaiting completion of this process. This is actively tracked by the Patient Safety Team each week in discussion with Divisional governance staff and Deputy CMO. SLIC reports to the Patient Safety & Effectiveness Committee, which in turn reports to Clinical Governance Committee.		*Sufficient* *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

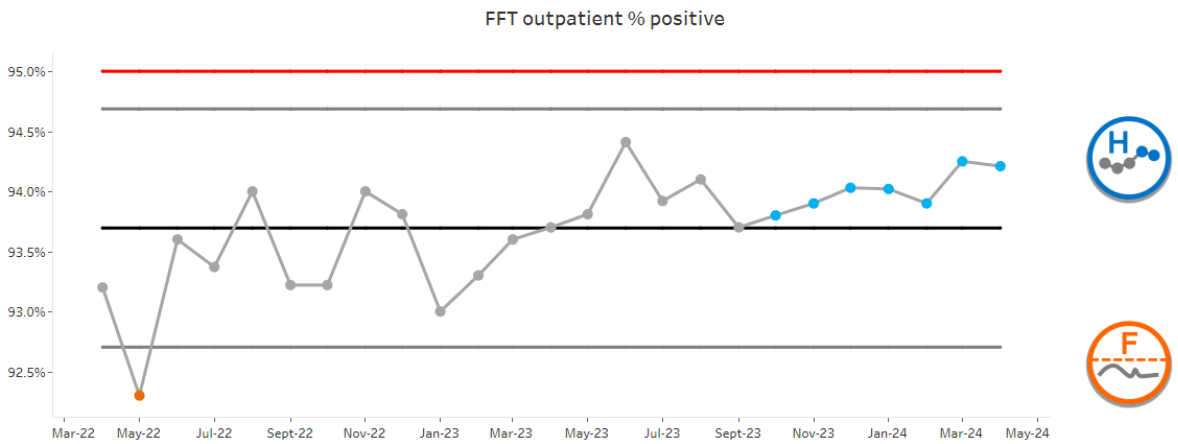
3. Assurance report: Quality, Safety and Patient Experience, *continued*

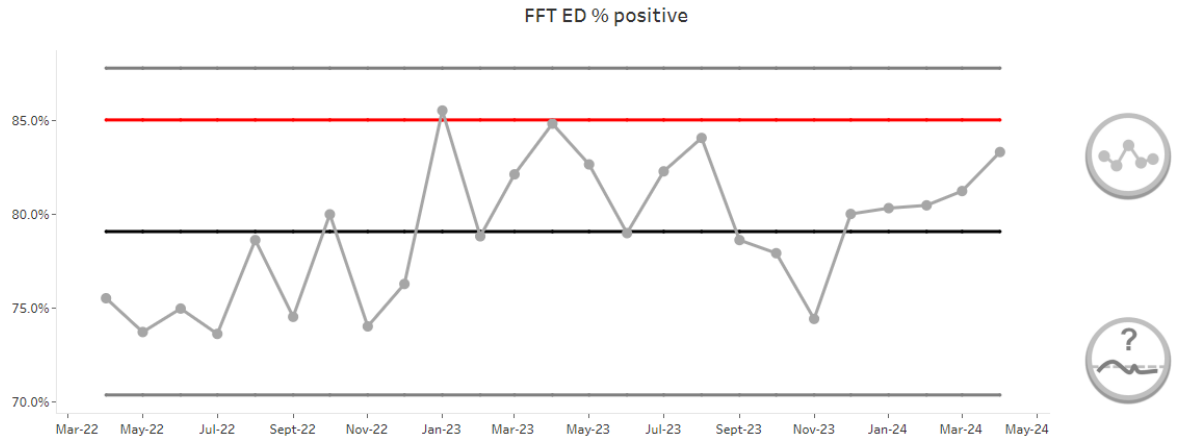




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In May 2024, 86.8% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. May's performance exhibited common cause variation. There were 23 reactivated complaints and the indicator exhibited deteriorating special cause variation two out of the last three periods within one sigma of the upper control limit.	The Trust received 98 formal complaints in May. Reactivated (reopened) complaints increased. The analysis of these reopened complaints has shown several reasons, including ongoing issues with appointment cancellations, wait for surgery, requests for resolution meetings (to review and discuss the findings of the first response), and requests for further clarity. Out of the reopened complaints, seven are from the MRC Division. The division is working to resolve these issues through face-to-face discussions and resolution meetings. A thematic review of all reopened complaints to identify the root causes and opportunities for improvement. Efforts to improve the complaints response timeframe from 40 to 25 working days continue. A QI-facilitated workshop was conducted with the Divisions and members of the Complaints Team to identify the bottlenecks in the system and revise the process. A comprehensive action plan has been developed and implemented to manage complaint response times and prevent breaches. The weekly auto-generated breach sheet is still being sent to Divisions to help them keep track of overdue complaints. Complaints open for over 25 working days are now highlighted, with the expectation that they will be resolved promptly. These open complaints are also being discussed in weekly meetings between the Divisions and the Complaints team.	Ongoing, reviewed weekly. Oversight by Delivery Committee	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

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

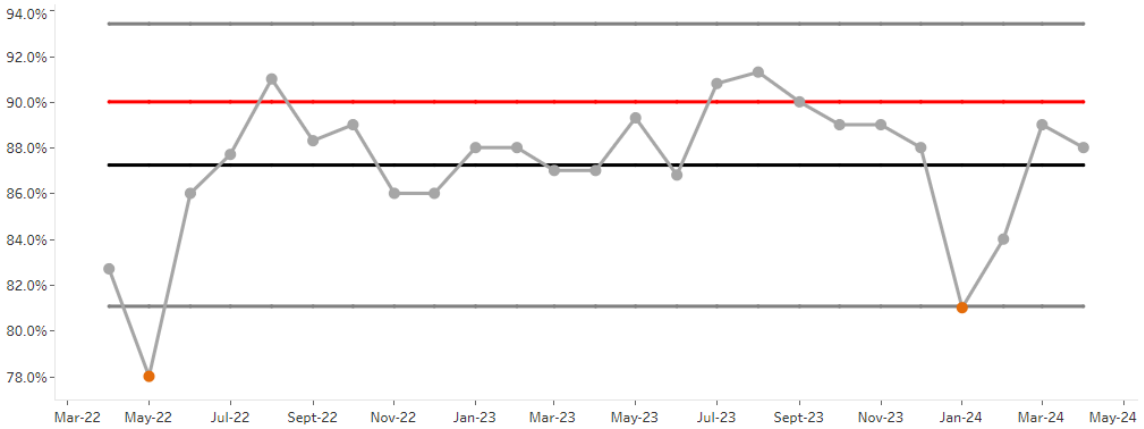




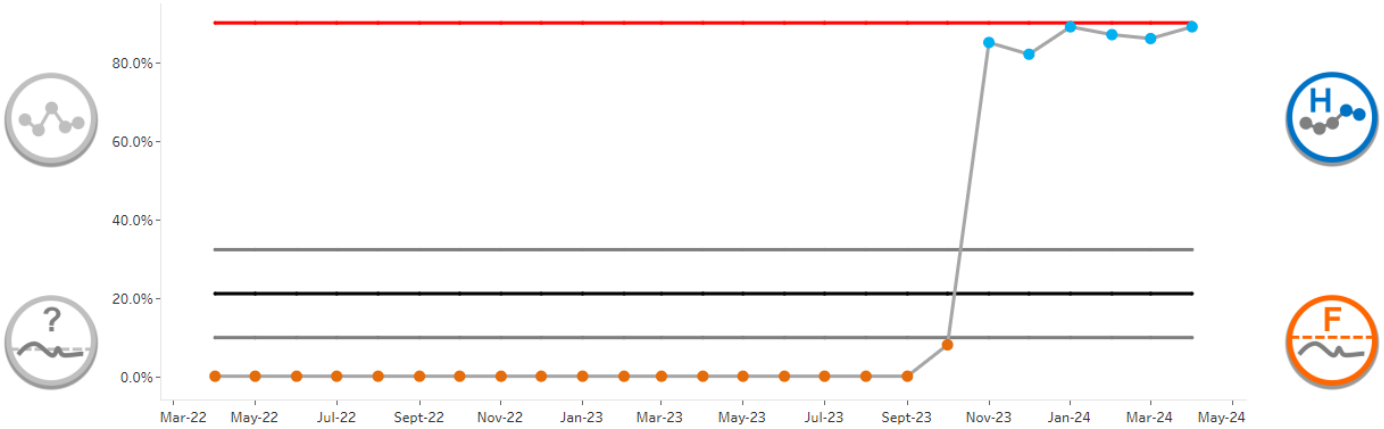
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Friends and Family Test (FFT): The percentage positive rates were below the 95% target for outpatient and ED although there has been an increase in positivity in both. ED's results fluctuate more than the other services and is in response to the operational pressures within the service. Due to the switch to badger notes, the Trust is not currently collecting automated FFT data for Maternity Services. The team are currently working through this logistics of this with the Maternity team.	The Trust has implemented the fully managed service which aims to increase the FFT response rates and offer more inclusive methods of collection, such as translation options. Additionally, this has included implementing IVM (Instant Voice Message – patients can leave a two -minute voice message as their feedback) and increasing the number of services using SMS for feedback to reduce the use of paper, although this will not be eliminated. We have started to see these coming through and will now focus on working with teams directly to increase feedback and advertise FFT more prominently within their areas.	Implementation is complete. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which gets reported to Patient Safety and Effectiveness Committee [PSEC]	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*

Safeguarding (Children) training compliance L1 - L3

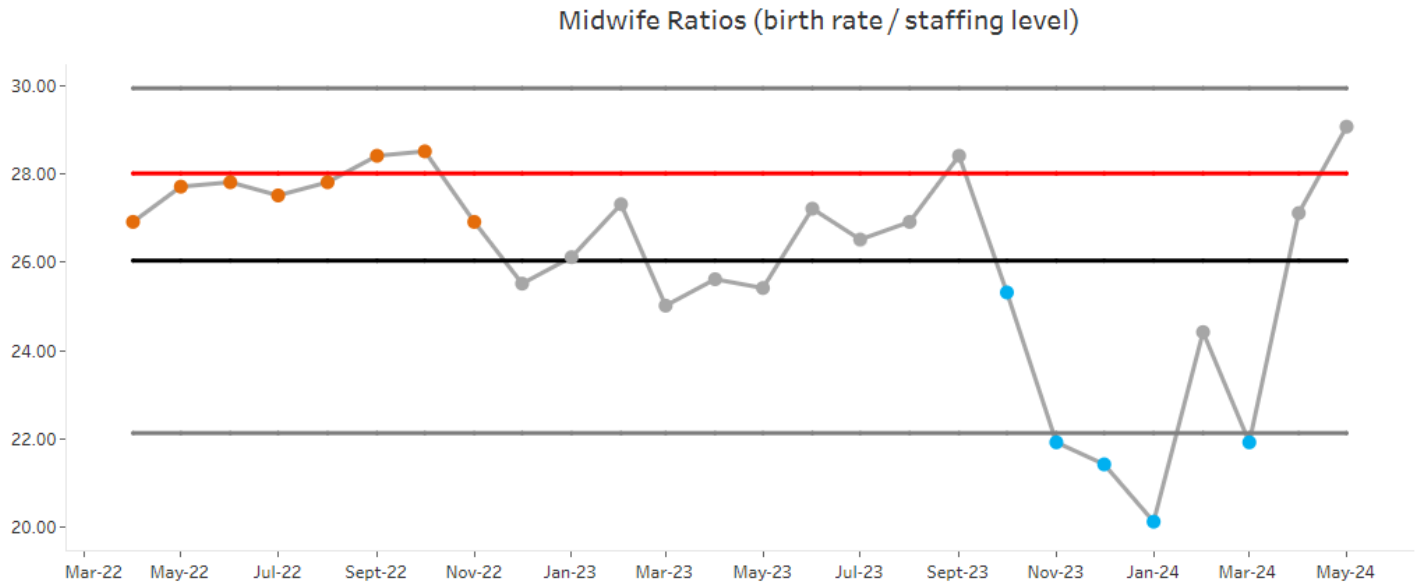


Safeguarding (Adults) training compliance L1 - L3



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
Safeguarding children training L1-L3 compliance decreased by 1% to 89%. Level 3 children safeguarding compliance improved 1% to 85% although both were below the KPI of 90%. Level 1-3 adult training dropped 1% to 88% below the KPI of 90%. MLH have requested senior sign off the amend the mapping for CSS Division for lab and pathology staff to move them to the correct level of training which will improve compliance.	Training options available online and face to face. Additional training is offered to teams. Data shared at meetings (Div. governance, matrons and PSEC) to request staff encouraged to undertake training. PSEC and each Divisional governance report template provides details of gaps for training. MLH meetings to ensure review of mapping for groups of staff is corrected.	PSEC monthly assurance report divisional governance reports and presented to the Trust clinical governance committee. Safeguarding steering group quarterly.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The service had a high number of births in May, with 669 deliveries. At the same time, the service had a high level of midwifery sickness absence and maternity leave, which reduced the available workforce. The service had 10 WTE midwives on sick leave and 15 WTE midwives on maternity leave, representing 12-15% of the total midwifery workforce. Additionally, the service has a gap in the staffing levels according to the Birthrate Plus model of 16wte clinical midwives.	• Redeploying staff from other areas to support • Specialist and management roles redeployed • Using bank staff to fill the gaps in the rota • Daily review of staffing and risks, mitigation put in place and escalation where required.	The service has developed a recruitment plan to address the gap in the staffing level and to improve the midwife to birth ratio and staffing pipeline. The plan includes: • Recruitment 16 FTE midwives to meet the Birthrate Plus standard, with a target date of September 2024 • Summer recruitment of students • 6.92 wte IEMWs will be in the midwifery numbers July 24 • Currently 9 short course midwifery students • 2 Midwifery year 1 apprenticeships in progress.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Oxford University Hospitals NHS Foundation Trust

Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level for May 2024. It is an NHSE requirement for this to be reviewed by Trust Boards each month. The coloured sections on the dashboard assist with the review, and any indicator not meeting the target is indicated in red. 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 three times a day and was maintained at Level 2 (Amber) throughout May 2024. The Trust-wide planned versus actual fill rates were 86% during the day and 91% at night. 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 no shifts were left at risk.

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

Nurse and midwifery staffing levels and the nurse-sensitive indicators below were thoroughly reviewed and validated. The review aimed to determine whether these indicators are linked to harm caused by staffing in each division. Following the review, all divisions have confirmed that there were no instances of harm related to nurse or midwifery staffing levels in May.

SuWOn – During the monthly review, it was noted that there were discrepancies in the vacancy data. Specifically, the Gynae ward and Sobell House were discussed, and the vacancy rate was significantly lower. This issue is being addressed as part of the validation process for 15% and above vacancy data across all divisions. The validation process is underway and is expected to be completed in September.
Maternity – The service is working to the Birthrate+ numbers, and work is ongoing to ensure this is reflected in the budgets. As the revised staffing numbers have not yet been reflected in the budget at the time of reporting, the vacancy data does not fully represent the current position.
The Deputy Chief Nurse for Workforce is leading the service on a proactive recruitment campaign and trajectory to reduce midwifery vacancies.
The number of delays in induction of labour (IOL) due to midwifery staffing levels were no harm events and were managed and reviewed on a case-by-case basis.

CSS – JR ICU - There were no harm events related to safe staffing in ICU.
MRC – There were no harm events related to safe staffing across the division.
NOTSSCaN – There were no harm events related to safe staffing across the division

Critical Care Recruitment
Work has commenced under the Deputy Chief Nurse for the Workforce to develop a joint recruitment campaign for critical care nurses across all OUH Critical Care settings. This multi-faceted work involves understanding the current critical care nurse landscape and defining and employing creative strategies to attract and retain skilled professionals.

Vacancies above 15%
All areas with a vacancy rate above 15% are under review to develop a recruitment strategy. The review will take a local and trust-wide approach and implement a comprehensive plan that addresses immediate and long-term staffing needs in these areas. The review examines and assesses each area's specific requirements, care complexity, and the reasons behind the high vacancy rate to address underlying issues.

Unavailability
All areas with a high unavailability of workforce (HR data – vacancy, maternity leave, long term sickness) were mitigated to maintain a safe level of staffing with the use of Ward Managers and Clinical educators supporting, and temporary workforce where required (NHSP, Agency, Flexible Pool shifts). All metrics including rostering efficiencies and professional judgement, patient acuity, enhanced care observations requirements, skill mix, bed availability, RN:patient ratios are reviewed each shift to maintain safe and efficient staffing levels.

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

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

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

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

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

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

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

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

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

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

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

Oxford University Hospitals NHS Foundation Trust

May 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	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%	% Extremely likely or likely
NOTSSCaN																		
Bellhouse / Drayson Ward	7.7	10.3	10.5	82.8%	2	0	0	0	12.6%	5.5%	3.0%	5.2%	17.1%	Yes	0.1%	8.0	6.7%	89.4%
HH Childrens Ward	10.2	9.2	16.9	98.9%	2	1	0	0	13.7%	3.1%	5.0%	4.3%	17.4%	Yes	-0.1%	8.0	11.4%	95.0%
Kamrans Ward	10.2	10.5	9.6	100.0%	1	0	0	0	0.9%	7.3%	1.3%	3.9%	4.7%	Yes	-5.9%	8.0	10.7%	75.0%
Melanies Ward	11.7	9.2	9.7	96.8%	1	0	0	1	-38.1%	6.0%	2.6%	1.2%	-33.8%	Yes	-0.5%	10.4	14.8%	89.5%
Robins Ward	11.4	10.5	11.0	96.8%	1	1	0	0	14.3%	12.1%	2.3%	0.0%	14.3%	Yes	1.1%	9.3	12.1%	100.0%
Tom's Ward	8.1	9.4	8.8	100.0%	8	1	1	0	0.9%	13.4%	2.0%	5.3%	6.2%	Yes	-0.9%	10.4	11.5%	91.3%
Neonatal Unit	19.4		19.2		4	2	0	0	9.9%	6.7%	6.6%	3.6%	18.1%	No	-2.5%	8.6	12.9%	
Paediatric Critical Care	32.6		29.2		11	3	0	0	-2.2%	8.7%	5.1%	5.2%	5.4%	Yes	0.4%	8.7	10.3%	
BIU	6.1	6.0	7.4	96.8%	1		0	5	20.7%	19.7%	3.4%	3.2%	23.2%	Yes	-1.4%	8.7	14.5%	
HDU/Recovery (NOC)	22.2		38.5		0		0	0	12.1%	15.1%	4.8%	8.8%	23.7%	Yes	-0.3%	8.6	10.2%	
Head and Neck Blenheim Ward	7.3	8.5	9.3	100.0%	0		0	2	15.1%	5.5%	6.5%	4.0%	29.3%	Yes	0.6%	8.1	11.7%	85.7%
HH F Ward	8.3	8.3	8.3	100.0%	0		3	2	3.2%	2.5%	5.7%	4.3%	13.4%	Yes	-1.3%	8.6	11.8%	100.0%
Major Trauma Ward 2A	9.6	9.5	10.2	97.9%	5		2	1	17.5%	9.9%	2.4%	0.0%	19.1%	Yes	0.4%	8.4	12.3%	100.0%
Neurology - Purple Ward	9.0	12.5	10.3	100.0%	0		1	3	6.2%	9.1%	6.1%	0.0%	6.2%	Yes	2.1%	8.9	12.5%	
Neurosurgery Blue Ward	8.9	10.7	10.5	100.0%	4		0	4	11.1%	5.7%	4.5%	2.2%	17.0%	Yes	0.9%	8.4	7.5%	100.0%
Neurosurgery Green/IU Ward	9.6	11.1	10.4	100.0%	0		1	0	0.3%	1.7%	4.1%	3.0%	5.1%	Yes	2.2%	8.6	12.4%	100.0%
Neurosurgery Red/HC Ward	11.7	12.6	12.7	100.0%	3		2	4	3.1%	11.6%	4.9%	3.4%	9.0%	Yes	1.3%	8.6	11.3%	97.4%
Specialist Surgery I/P Ward	8.5	8.0	8.6	100.0%	2		2	2	13.6%	7.2%	3.4%	0.0%	13.6%	Yes	4.3%	8.3	9.9%	83.3%
Trauma Ward 3A	9.2	9.4	9.3	98.9%	0		3	2	9.1%	15.0%	4.1%	4.1%	12.8%	Yes	0.4%	8.1	10.4%	100.0%
Ward 6A - JR	7.4	7.7	7.3	98.9%	3		2	3	5.6%	10.2%	2.8%	2.2%	7.7%	Yes	-0.6%	8.3	9.9%	100.0%
Ward E (NOC)	6.3	8.2	7.5	82.8%	0		0	1	22.2%	23.8%	7.2%	0.0%	22.2%	Yes	1.0%	8.1	11.4%	100.0%
Ward F (NOC)	6.7	6.9	7.5	79.6%	3		0	1	10.4%	10.9%	4.5%	11.0%	22.9%	Yes	-1.1%	8.6	10.7%	100.0%
WW Neuro ICU	25.4		29.3		4		3	0	20.1%	11.8%	3.3%	3.0%	23.1%	Yes	-3.9%	8.3	12.6%	

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

Oxford University Hospitals NHS Foundation Trust

May 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	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%	% Extremely likely or likely
MRC																		
Ward 5A SSW	8.8	9.2	8.6	100.0%	0		2	3	0.0%	6.7%	2.7%	5.7%	5.7%	Yes	-2.2%	8.4	13.3%	100.0%
Ward 5B SSW	8.9	9.3	8.8	100.0%	2		2	5	9.5%	9.9%	4.1%	2.3%	13.6%	Yes	3.4%	8.4	10.8%	100.0%
Cardiology Ward	6.2	6.8	7.0	93.6%	1		1	5	7.4%	14.5%	4.0%	3.5%	10.6%	Yes	4.6%	8.6	11.2%	100.0%
Cardiothoracic Ward (CTW)	7.8	7.2	6.2	97.9%	1		0	1	16.0%	17.0%	4.2%	2.6%	18.2%	Yes	-13.2%	7.0	12.5%	100.0%
Complex Medicine Unit A	8.9	10.5	8.5	90.3%	2		0	5	2.5%	5.4%	6.0%	4.9%	9.7%	Yes	1.7%	7.9	10.2%	100.0%
Complex Medicine Unit B	11.3	11.4	9.5	94.6%	0		2	6	-5.2%	9.6%	3.2%	6.2%	1.3%	Yes	0.9%	7.7	11.1%	100.0%
Complex Medicine Unit C	8.8	10.7	8.7	98.9%	1		3	3	-1.0%	7.5%	2.4%	0.0%	-1.0%	Yes	0.4%	8.4	13.2%	100.0%
Complex Medicine Unit D	9.5	8.5	8.7	91.4%	0		0	4	1.7%	11.4%	5.3%	0.0%	14.2%	Yes	7.0%	8.9	7.8%	100.0%
CTCCU	21.9		24.1		10		1	0	8.2%	9.6%	3.6%	4.6%	14.8%	Yes	-1.3%	9.3	11.3%	
Emergency Assessment Unit (EAU)	8.5	8.5		68.8%	3		0	3	15.2%	5.7%	3.9%	4.8%	21.4%	Yes	-1.0%	8.4	12.1%	
HH EAU	9.8	7.0		86.7%	1		1	7	-0.5%	8.1%	5.8%	5.3%	7.0%	Yes	0.4%	8.6	14.7%	
HH Emergency Department	22.8				1		0	3	17.1%	6.8%	4.2%	10.0%	26.1%	Yes	-0.6%	8.7	12.4%	85.4%
JR Emergency Department	17.2				4		0	9	15.9%	15.3%	5.5%	6.8%	24.1%	Yes	1.2%	8.3	8.4%	80.4%
HH Juniper Ward	8.1	10.4	7.9	98.9%	0		1	6	10.2%	6.1%	5.7%	3.0%	13.6%	Yes	-1.2%	7.4	11.1%	62.5%
HH Laburnum	9.6	8.5	8.4	83.9%	0		5	3	5.0%	4.9%	6.6%	6.1%	10.8%	Yes	-1.0%	5.7	15.3%	54.5%
HH Oak (High Care Unit)	20.1		11.1	94.6%	5		2	2	5.2%	11.6%	4.4%	0.0%	7.7%	Yes	2.2%	8.6	12.9%	100.0%
John Warin Ward	10.1	8.8	9.8	97.9%	1		0	2	3.1%	7.9%	3.3%	5.0%	12.7%	No	-1.9%	8.3	14.2%	100.0%
OCE Rehabilitation Nursing (NOC)	10.4	10.0	10.3	100.0%	0		1	0	5.1%	7.1%	4.4%	5.0%	15.1%	Yes	-2.8%	8.0	6.9%	57.1%
Osler Respiratory Unit	14.5	9.9	12.7	98.9%	2		3	3	8.0%	5.7%	3.7%	0.0%	9.3%	Yes	-0.5%	8.3	13.5%	56.0%
Ward 5E/F	11.1	7.6	9.9	100.0%	2		1	5	20.0%	8.5%	4.0%	3.9%	24.7%	Yes	2.8%	8.4	11.4%	53.8%
Ward 7E Stroke Unit	10.9	8.8	9.1	100.0%	1		1	3	-2.8%	14.3%	4.5%	1.4%	1.3%	Yes	-2.2%	8.0	7.3%	

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

Oxford University Hospitals NHS Foundation Trust

May 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	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%	% Extremely likely or likely
SUWON																		
Gastroenterology (7F)	7.0	7.04	7.4	98.9%	1		1	2	13.8%	6.1%	3.9%	5.6%	18.7%	Yes	-3.7%	8.0	12.7%	100.0%
Gynaecology Ward - JR	6.0	5.86	8.1	100.0%	4		1	1	28.2%	0.9%	6.7%	0.0%	28.2%	Yes	3.0%	8.4	10.8%	95.0%
Haematology Ward	6.9	7.31	7.6	98.9%	3		1	3	7.6%	14.7%	4.9%	4.6%	11.9%	Yes	3.0%	3.3	8.4%	100.0%
Katharine House Ward	9.2	8.23	9.4	97.9%	0		2	1	3.5%	18.0%	6.0%	2.8%	10.6%	Yes	1.5%	8.9	13.7%	
Oncology Ward	8.7	9.32	8.6	97.9%	3		3	6	26.1%	5.8%	3.3%	8.5%	32.4%	No	2.5%	5.9	7.1%	100.0%
Renal Ward	9.3	8.67	9.2	100.0%	0		1	5	0.5%	6.2%	3.9%	9.4%	13.0%	Yes	1.8%	7.9	9.5%	100.0%
SEU D Side	8.7	8.02	8.4	100.0%	4		0	4	25.7%	3.1%	5.3%	7.3%	34.8%	Yes	-0.7%	8.0	14.2%	85.7%
SEU E Side	8.4	7.86	8.5	100.0%	0		1	2	8.9%	11.2%	3.3%	0.0%	8.9%	Yes	-0.6%	8.0	17.1%	93.0%
SEU F Side	7.5	7.66	7.4	98.9%	1		1	1	26.3%	28.1%	2.5%	0.0%	26.3%	Yes	-7.5%	8.0	6.1%	92.3%
Sobell House - Inpatients	8.7	8.03	8.1	100.0%	6		1	5	36.3%	18.1%	3.8%	8.5%	43.4%	Yes	0.7%	8.4	14.8%	
Transplant Ward	9.4	7.38	9.7	97.9%	2		0	3	26.1%	3.1%	4.4%	8.0%	32.0%	Yes	0.1%	8.4	13.5%	77.8%
Upper GI Ward	9.7	8.52	8.0	98.9%	2		2	1	13.8%	2.8%	4.2%	4.9%	20.2%	Yes	-9.0%	8.0	10.4%	100.0%
Urology Inpatients	8.8	9.48	9.5	97.9%	2		0	1	30.8%	3.8%	2.3%	3.8%	35.1%	Yes	1.2%	8.6	5.1%	100.0%
Wytham Ward	7.7	7.41	7.1	100.0%	2		0	1	18.0%	8.8%	5.0%	0.0%	23.3%	Yes	-1.5%	8.0	9.9%	100.0%
MW The Spires	27.5		34.7		0		0	0	-7.4%	13.3%	5.0%	4.3%	1.5%	Yes	-6.3%	6.3	8.0%	
MW Delivery Suite	15.2		19.8		2		0	0						Yes	-2.2%	4.9	10.1%	
MW Level 5	6.7		4.8		4		0	0						Yes	0.6%	6.3	12.1%	
MW Level 6	4.5		6.3		2		0	0						Yes	-1.9%	6.3	9.4%	
CSS																		
JR ICU	34.5		19.4		7		2	0	25.8%	9.2%	4.8%	5.8%	32.3%	Yes	-0.3%	7.9	9.2%	

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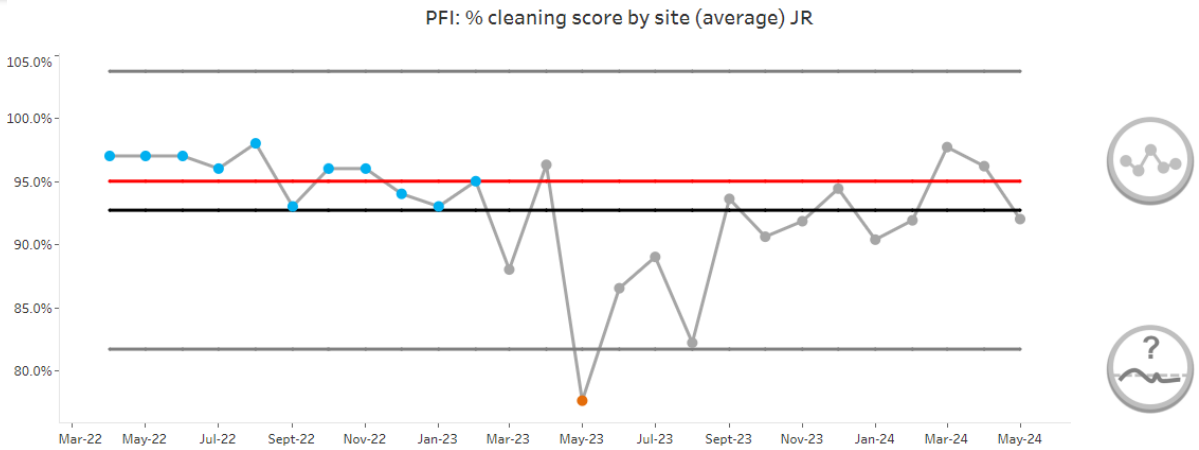
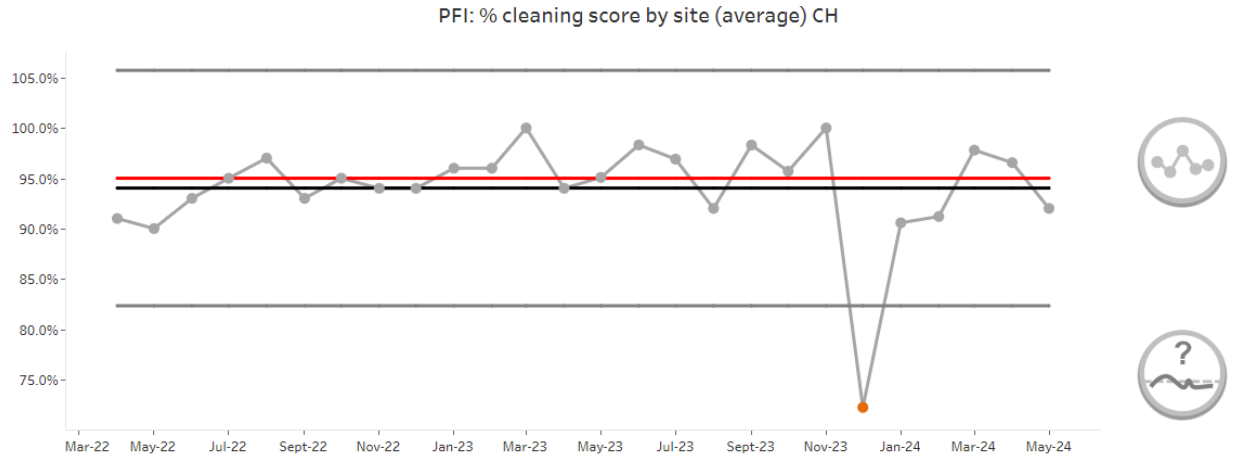
3. Assurance report: Estates, Facilities and PFI



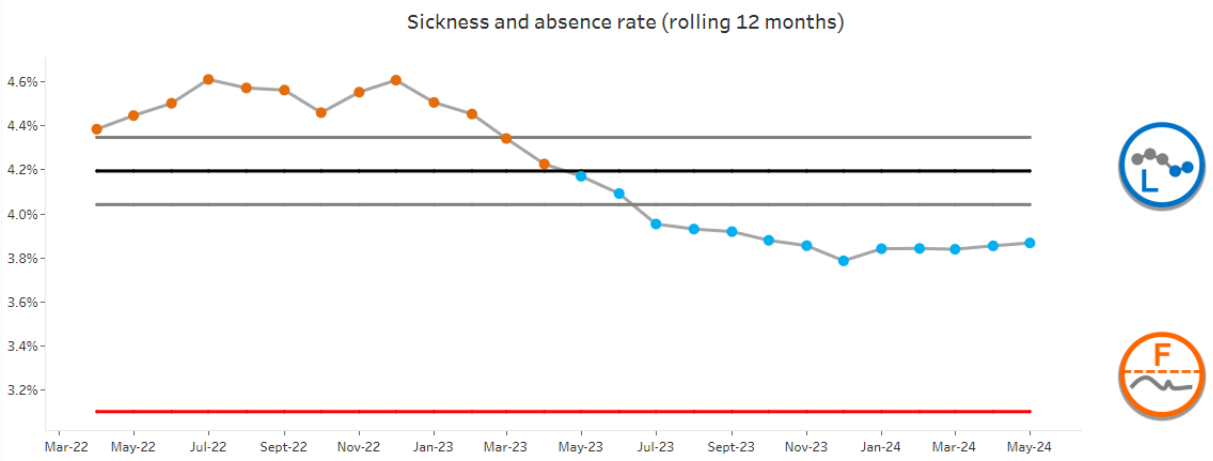
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In May 2024, the combined PFI % cleaning score by site (average) for the JR was 96.13%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, decreased from the previous month by 4.65% to 91.54% which is below the 95% target. In total, 272 audits were conducted, 23 of which did not meet the 4-star requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2021. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating.	Mitie completed the planned number of audits at JR in May, and 8% of those audits failed to achieve the set target of 4 or 5 stars. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how.	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2024 at OJR. 2) Information cascade - Monitoring carried out utilising the Synbiotix auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

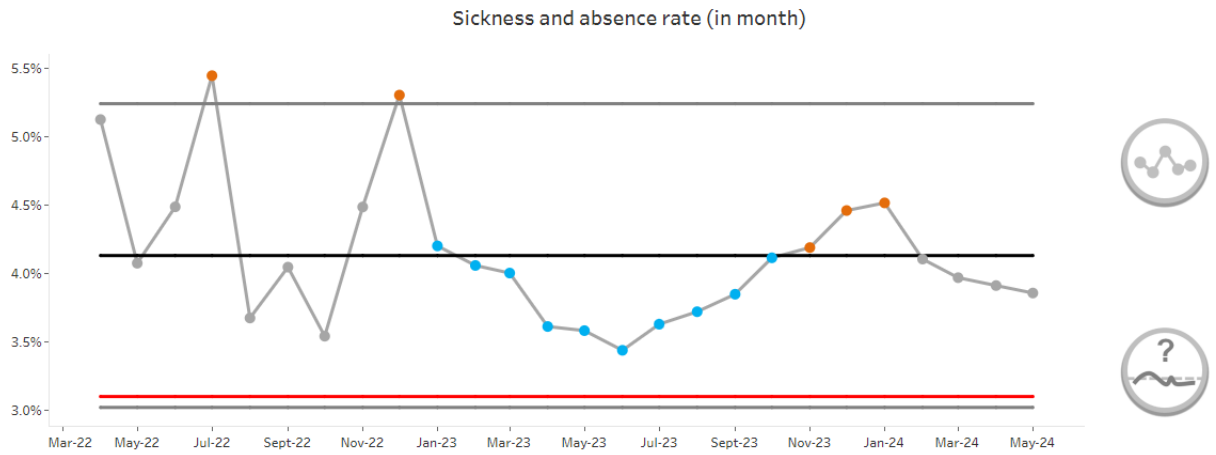
3. Assurance report: Estates, Facilities and PFI



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In May 2024, the combined PFI % cleaning score by site (average) for the Churchill was 94.07%. However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, decreased from the previous month by 5% to 91.55% which is below the 95% target. In total, 71 audits were conducted, 6 of which did not meet the 4-star requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 2021. These standards require all areas of healthcare facilities to be audited and meet specific combined cleaning percentage thresholds based on risk levels, including FR1 (98%), FR2 (95%), FR4 (85%), and FR6 (75%), to receive a 5-star rating. It is important to note that a lower star rating does not necessarily indicate uncleanliness. The purpose of audits is to identify and address any issues promptly, with a follow-up audit conducted after rectification to ensure improvements have been made and to re-evaluate the star rating.	G4S completed the planned number of audits at Churchill in May 2024, and 8% of those audits failed to achieve the set target. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. When it comes to managing cleaning risks, patient safety is our top priority. At our Trust, we believe in working together to maintain cleanliness in all our facilities. Whenever an area scores three stars or below, Service Providers create action plans that include responsibilities for domestic, estates, and clinical staff to improve those areas. The Trust PFI management team oversees the implementation of those plans, while domestic supervisors and the Trust PFI team monitor the progress with the support of IP&C. We work collaboratively with the Domestic Service Teams, Clinical teams, and IP&C to enhance the cleanliness of our facilities. The PFI team is discussing with the CEFO to redefine the KPIs for cleaning scores to align them more closely to the NSC. The objective is to determine the appropriate measures and provide a better understanding of what is being measured, by whom, and how.	1) Improvement to work towards the 95% target for 4 & 5-star cleaning audits for 2024 at CHU & OJR. 2) Information cascade - Monitoring carried out utilising the Synbiotix auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Growing Stronger Together



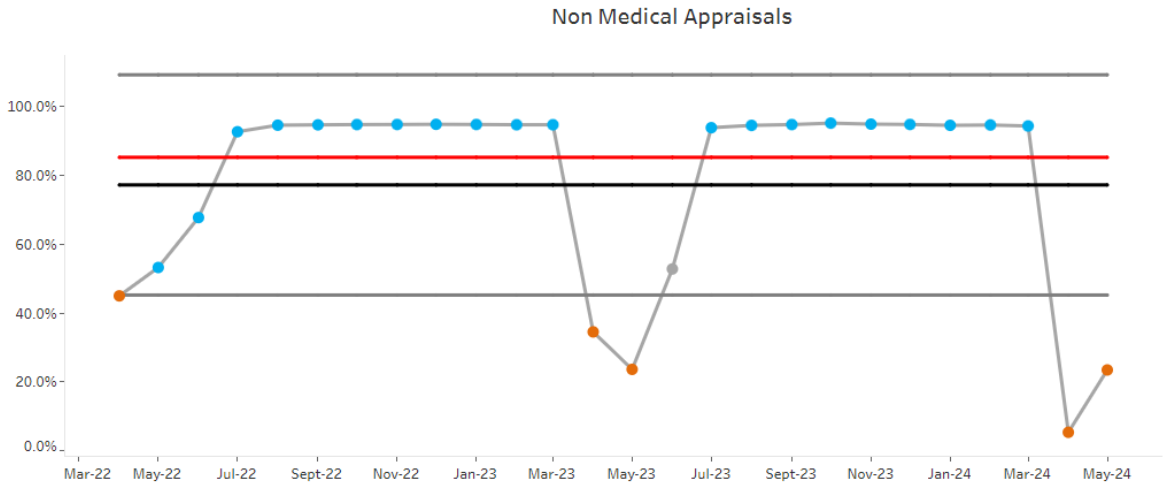


Benchmarking: January 24 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 4.4% **National: 5.5%** **Shelford: 4.9%** Buckinghamshire Healthcare NHS Trust: 4.6% Royal Berkshire NHS Foundation Trust: 3.6% Oxford Health: 5.0% South Central Ambulance Service: 7.4%

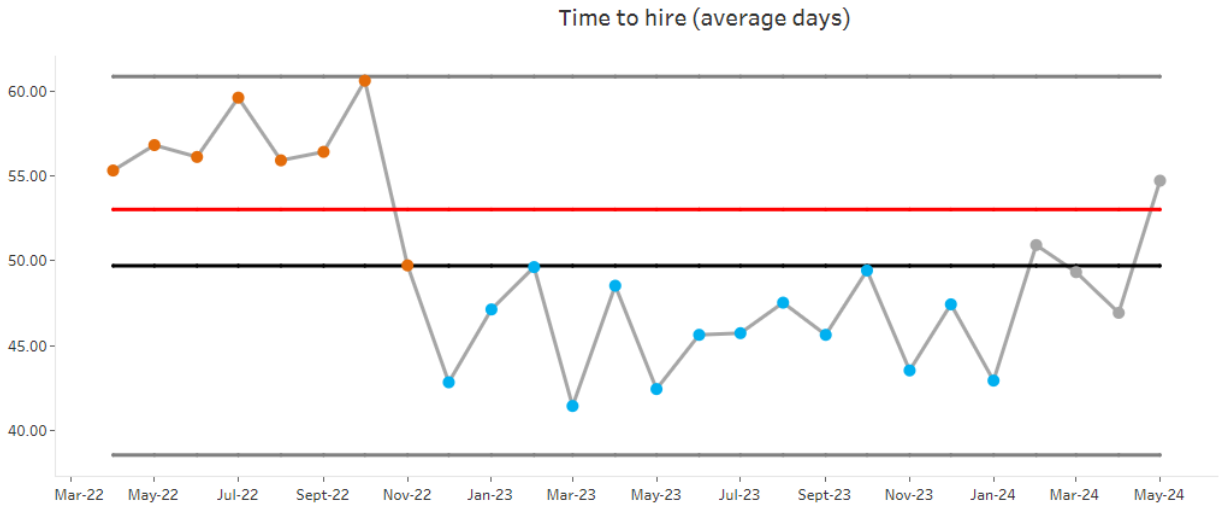
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 3.9% in May and has remained static since April. Performance exhibited special cause improving variation performing below the lower control limit. This indicator is generally on a downward trend and had been reducing every month since the last quarter of 2022/23. In month figure has also remained unchanged to 3.9% as well. This is no one single absence reason accounting for sickness within the Trust. No one absence reason accounts for the change, although 3 of the top 4 absence reasons have increased to varying degrees between months (Mental Health, Gastro and COVID19). Long term sick as measured by working days lost accounts for 40.5% of absences and is unchanged.	We are continuing to offer a full range of well-being support including wellbeing, financial, environmental and psychological. This includes stress management training. • Continued focus on RTW compliance ongoing, with support to managers with regular reports. • Continued focus on weekly provision of frequent absence reports to managers is continuing to provide support. • Utilising support from OH with regular meetings which includes escalation of areas such as MSK referrals and specific cases. • Review of open MSK absences undertaken and managers being contacted to offer support. • Monthly meetings continuing with Head of Wellbeing to identify where interventions may help with absence due to stress anxiety and depression. • Sickness absence workshops in progress to support managers.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Growing Stronger Together



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
At the end of M2 compliance is at 23.3%, which is broadly at the same level as last year at this stage. Weekly progress reports are produced as well as employee level data. M2 is the second month of the new value-based appraisal window, which is between 1st April – 31st July. Divisional Workforce colleagues are provided with weekly reports noting progress and names of compliant/ noncompliant staff.	We are offer a full range of communication, resource and leadership support corporately and with our Divisional Workforce teams. • Divisional communications encouraging all managers and staff to book and prepare for their appraisals. • Bespoke team brief emphasis on 'quality' appraisals – using toolkit and guidance available on MLH. • Service Leads drafting e-mail to all managers to share 'approach' taken with longer serving members of staff and/or staff not interesting in career progression and not seeing value of VBA to focus discussion on Values when delivering services/outcome. • Appraisals are being promoted by the Divisional Workforce Team at every meeting and time to talk session. • Signposting staff and managers to the appraisal resources. • Access to an OD Consultant and the VBA Q & A sessions throughout the VBA window. • Targeting Directorates with supportive intervention who are behind the Divisional curve for shared learning.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Growing Stronger Together



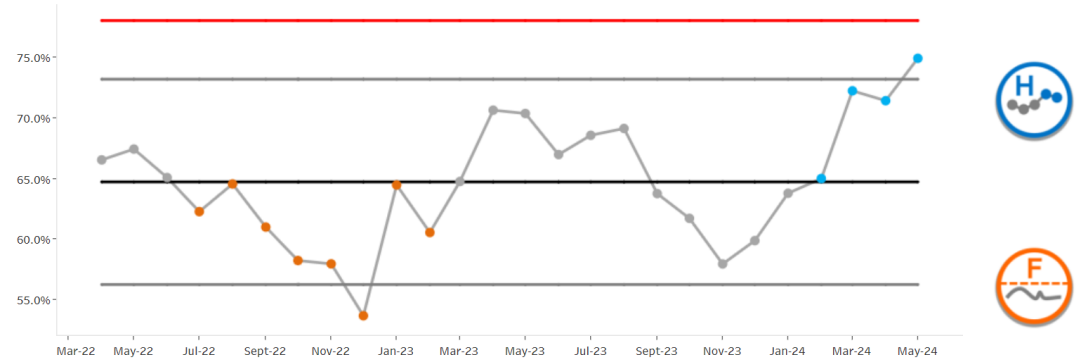
HR Metric	Performance	SLA Target	People Plan Target
Time to Hire	54.7	47	42

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
• **Time to Hire**: 54.7 days and SLA 47 days. • There is a high number of HCSW's and Band 5 nurses in the pipeline via centralised recruitment who are waiting for allocations, this impacts the time to hire. Work is underway with the divisions on allocating these candidates and it is hoped that 1P1P will make it clearer on the vacancies within directorates. A review of bank spend vs areas that are declaring no vacancies is underway. • The team have seen an increase in the number of honorary/observer applications which is diverting recruitment support to this area. • The team also faced some challenges with the BOT during May and this led to delays in the conditional offer letters being sent to candidates. This has now been rectified.	There is collaborative work underway with the clinical and divisional workforce teams to review high vacancy areas and to have targeted interventions to improve time to hire. • There is continuous dialogue with divisional teams on the placement of the HSCW's and Band 5 nurses. • A recruitment deep dive is underway to identify areas / line managers who might need additional support with the Trac process to reduce their time to hire. This will be a target approach and FAQs developed to support other managers across the organisation. • The launch of the management of honorary contract holders on TRAC should give the divisional teams the ability to challenge roles and assist with reducing the volume. • A Trac review has been booked for July to understand opportunities for development and new technology integration (TrustID). • In line with the People Plan, further work is underway on reviewing how technology can help reduce the admin workload within Resourcing and improve the onboarding experience/time to hire. • Engaging with new starters for candidate experience feedback and using the time to talk and listening events within the wider P & C directorate to review ideas and options to improve time to hire.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

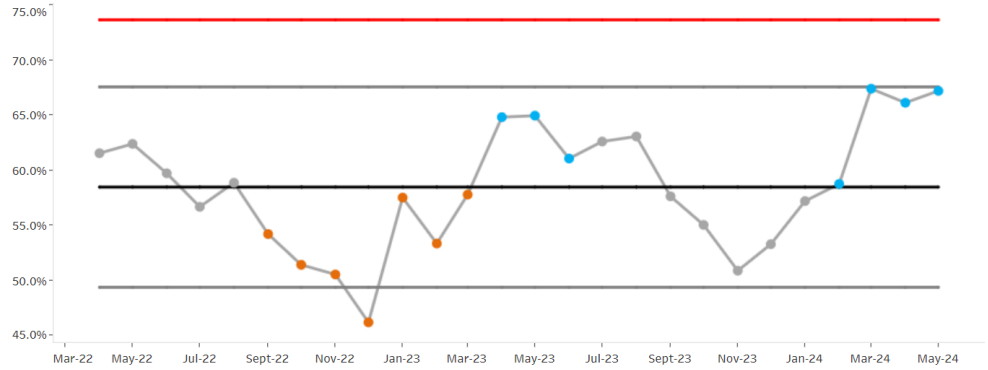
3. Assurance report: Operational Performance

Oxford University Hospitals NHS Foundation Trust

ED 4Hr perfromance - All



ED 4Hr perfromance - Type 1

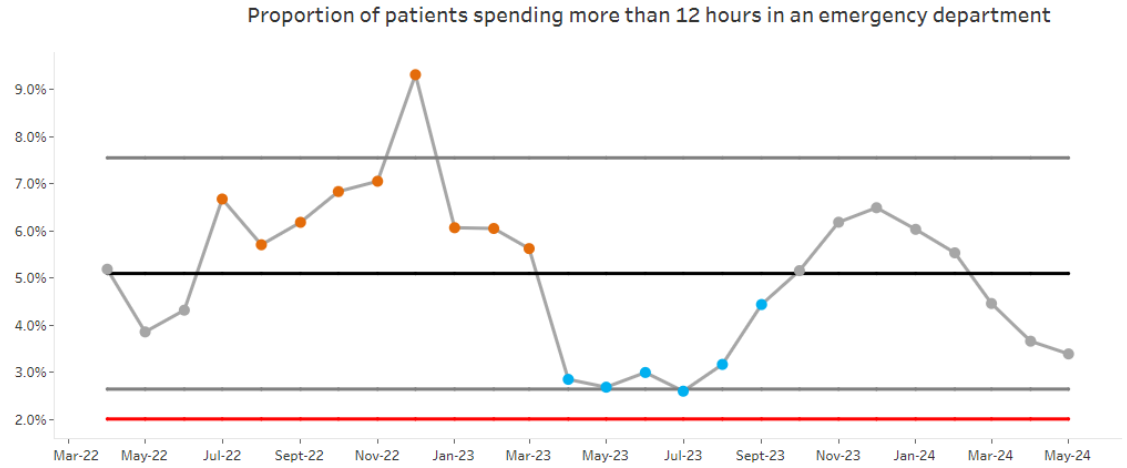


Benchmarking: ED (All types): February 24				
OUH: 65.0%	**National: 69.8%**	**Shelford: 65.8%**	BHT: 69.8%	RBH: 67.8%

ICS key			
BHT	Buckinghamshire Healthcare NHS Trust	**RBH**	Royal Berkshire NHS Foundation Trust

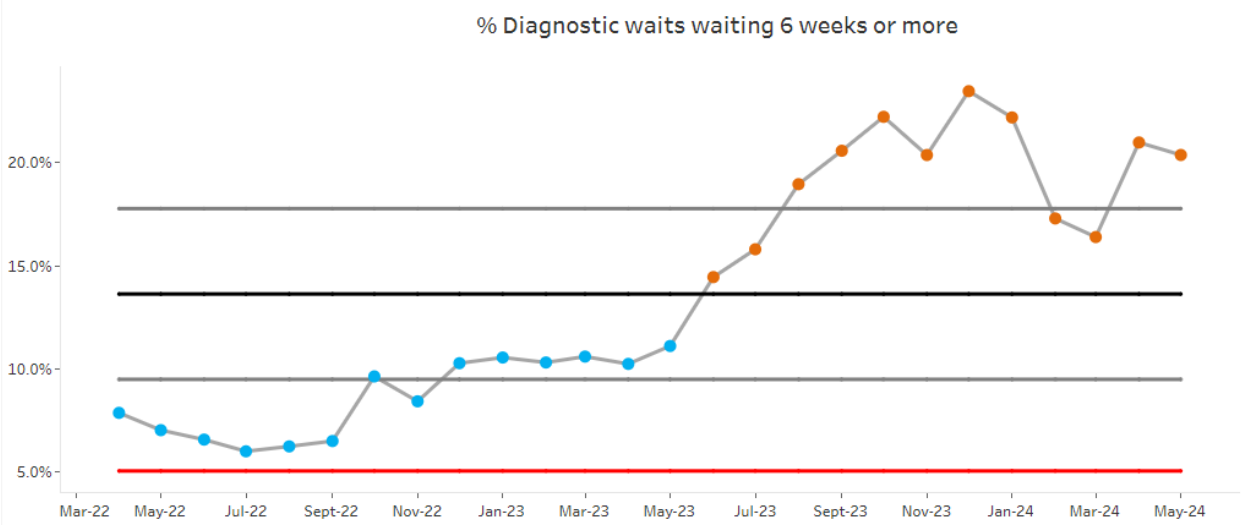
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In May 2024, NHSE approved the Fiennes Centre activity and performance to be included in the OUH monthly submission from March 2024 onwards. For May 2024, OUH performance includes Fiennes activity, and this will continue for the remainder of 2024/25. As the approval for reporting came after the submission of March and April performance, this was not able to be included in the monthly submissions and therefore is not shown nationally. March 2024 and April 2024 activity and performance data will be re-submitted to incorporate Fiennes activity when the NHSE re-submission window opens, which is on a rolling six-month basis. This means that the respective updates will be made to NHSE in August and September 2024. As a result, please note that March and April performance will change to 75.0% and 74.6%, respectively. The Emergency Department (ED) 4-hour performance (All types) was 75.21% in May. Type 1 performance was 67.1% making OUH the best performing Trust in the ICB and Shelford Trust. 4-hour performance (all types) and Type-1 performance exhibited common cause variation. The indicators have consistently not achieved the target. Breach performance by site was 69.32% for all types and 61.68% for Type 1 at the John Radcliffe Hospital (JR) and 86.70% for all types and 80.64% for type 1 at the Horton Hospital in May. May 2024 saw the highest monthly attendances figures for the last three years, most notable at the JR. Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing to 63% of all 4-hour breaches in May 2024. Of increasing concern is non admitted breaches where 75% of breaches were due to waiting to be seen. Skill mix of medical staffing is a key area of focus and whilst recruitment takes place, as an interim solution, shifts have been offered on an additional session basis but with limited fill rate. The Quality Improvement initiatives that commenced in January are progressing well and are beginning to have some impact for those that have come to fruition. Most notably the ED Observation and Review Unit concept has been tested with positive feedback and impact on helping to reduce overcrowding in the department, as well as contributing to the improved 4-hour performance. A focus on breaches through the day is becoming sustainably embedded in the Operational site meetings.	**Senior Medical Decision Maker (Consultant) in the JR ED in the evenings.** • Pilot conducted during the Consolidated Improvement Cycle with early indication of improvement and SPCs being aligned to the shifts to correlate with any improvement. • Options paper developed for sustainable ED workforce models – supported by Trust Management Executive. Recruitment approach underway. • Metrics: - 4hr breach performance (Type 1) - 12hr Length of Stay (LOS) performance **Implement 'Clinically Ready to Proceed' (CRtP) functionality on FirstNet.** • Approval at Trust Wide Urgent Care Group to automate the process for non-admitted patients to increase engagement by using the discharge time as a surrogate marker – completed. Reporting in place. • Non admitted target compliance 70% by the end of Q3 – performance in May 2024 was 87%. **Departure from ED within 60mins of CRtP** • Focus on Non-admitted performance – using discharge time. Process mapping has highlighted the main constraints – target 50% of non-admitted patients. • Improvement projects underway within ED with a focus on pharmacy and transfer lounge usage in the first instance. Triage models being reviewed in line with feedback from visit to exemplar Trust. **Urgent and Emergency Care Quality Improvement Programme 2024/25 is** in development. Trustwide session held with multidisciplinary teams to prioritise improvement ideas. Proposal to be shared with the Trustwide Urgent Care Group in June.	Completed - recruitment approach underway through 2024/25 Completed Quarter 1: Improvement cycles being undertaken into 2024/25	BAF 4 CRR 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 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 proportion of patients with a length of stay of more than 12 hours in an emergency department was 3% in May, slight improvement upon April. This is the third consecutive month of achieving below the mean average of 5.6%, however remains above the target of 2%. The indicator has consistently not achieved the target. The Horton performed very well with just 1% of patients with a total length of stay of more than 12 hours in the ED. The John Radcliffe was 4% which is the same as the previous month. Trust occupancy of General and Acute beds in May has reduced from last month but remains high at 94.05%. The ED Conversion rate to admission was high for the month at 33.87% at the JR and 20.35% at the Horton. This is above the 2-year average by 1.57% at the John Radcliffe and 1.40% at the Horton Hospital. SDEC capacity has been protected and there was no overnight opening of AAU. A programme of summer bed closures have come in effect from 1st June to enable capacity to be flexed up as needed in the autumn and to fund additional winter capacity. Patients whose discharge was delayed remain a challenge with 3179 bed days lost in May to this cohort of patients. Average number of days delayed was 6.3 days in May. The patients with the longest delays were Oxfordshire patients waiting for pathway 3 or out of county delays. Whilst Discharge To Assess (D2A) is now embedded and there are minimal delays for Oxfordshire residents on this pathway, delays for Pathway 3 continue to be an area of concern for patients in all Oxfordshire bed bases. Associated with the increase in attendances, is the medical and social complexity of patients, and there has been an increase in the number of patients becoming medically optimised for discharge with the Transfer of Care Hub reviewing a very large number of referrals per day. The new Discharge Sit rep came into effect late in May which will result in an increased ability to accurately articulate the reason a patient's discharge is delayed and increase the number of patients returning to their normal place of residence. OUHFT is holding its position as the best performing Shelford Trust for patients with a length of stay over 21 days.	**Departures within 60mins of the Decision to Admit** • Three pathways are being supported through the UEC QI Programme – Mental Health, Frailty and Heart Failure. Each pathway have a number of initiatives that are currently progressing through the PDSA cycles of improvement. • The live bed state programme launched in Q3 23/24 with phase 1 successfully implemented across the Trust during Q4. Work continues to develop scope and plans for phase 2 which is due to launch later this year. • Pilots of the Board Round policy have been underway which have seen positive impacts on length of stay on those wards.	Trust Wide Urgent Care Group	BAF 4 Link to 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

3. Assurance report: Operational Performance, *continued*

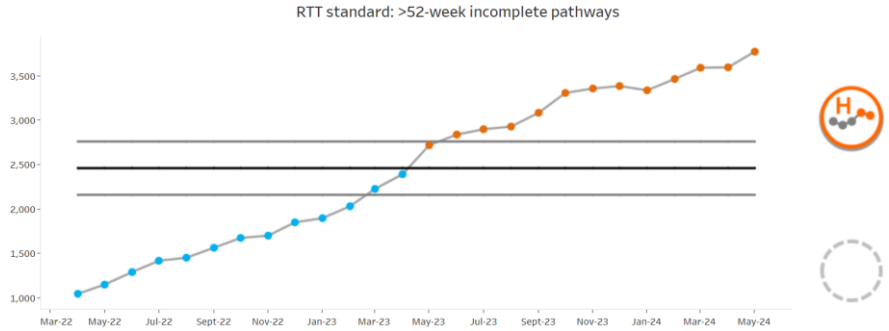


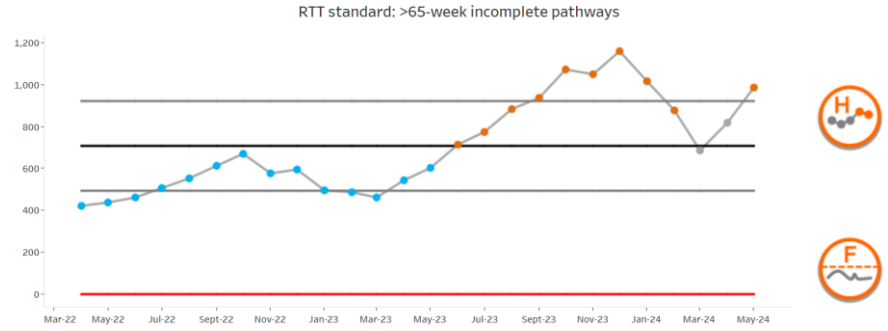
Benchmarking: April 24 DM01	
OUH	20.1%
National	20.3%
Shelford	29.2%
ICS	BHT: 17.8% RBH: 22.6%

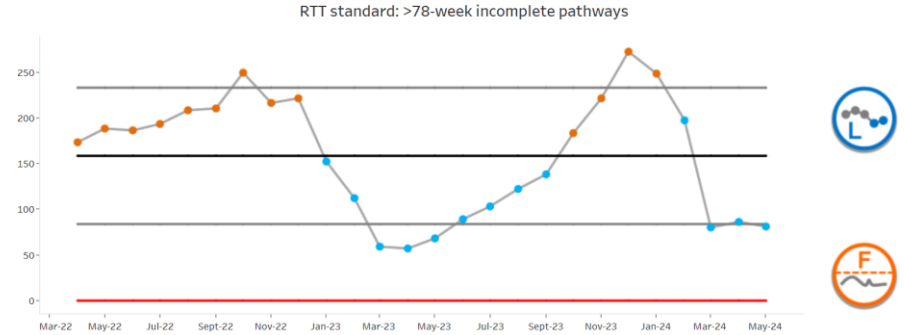
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

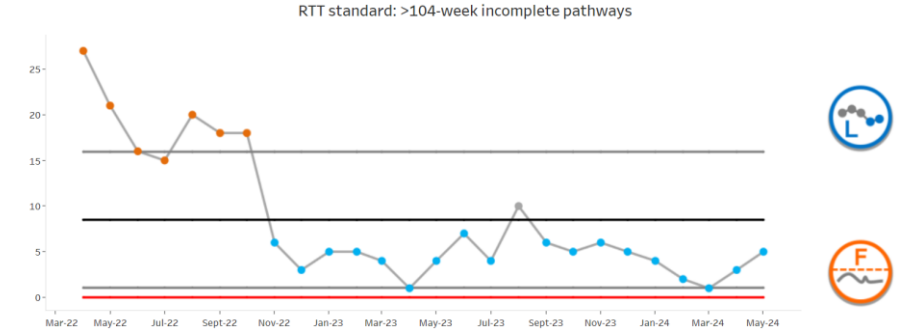
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of diagnostic waits waiting under 6 weeks+ (DM01) was 20.4% in May. The indicator exhibited special cause deteriorating variation due to performance being below the mean for more than six successive periods, as well as below the lower process control limit. The indicator has consistently not achieved the target of 95.0%. **Complex Audiology**: • Significant increase in demand and vacancies has driven a deficit with capacity due to ENT pathway change. **Endoscopy:**. • 1 Consultant fixed term contract ends 06/08/24 with expected 6-month gap • 1 Nurse Endoscopist undergoing training	**Audiology:** • Agreement to transfer a cohort of clinically appropriate patients to Another Qualified Provider (AQP). A 6-months' notification has been given to take effect from 8th July 2024. • Approved Business case to replace 2023/24 ERF scheme. Recruitment is underway. New ERF scheme for 2024/25 approved to provide additional capacity and accelerate backlog recovery with implementation underway. • Waiting list validation has been undertaken across the PTL. • Capital programme being scoped to provide additional capacity at the Horton General Hospital. **Endoscopy:** • Triaging pilot has now been adopted as BAU • Training list requirements have been reviewed • Ongoing work on efficient booking processes to actively avoid breaches • Demand and capacity modelling identified deficit - Business Case to be completed and submitted to increase capacity and recover backlog • Weekend lists approved for 12-weeks • 2 Nurse Endoscopists have commenced training for 12-months • All consultants to do 12-point lists unless training list	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Improvement expected once transfer to AQP agreed via ICS – take effect from 8th July 2024 **Endoscopy:** Demand did not level off in Q4 as expected. This has contributed to a delay with backlog recovery. ERF funding approved in May and an appointment of a locum will commence in due course – this will support backlog recovery and timescale will be determined upon appointment.	BAF 4 Link to CRR 1136 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Operational Performance, *continued*







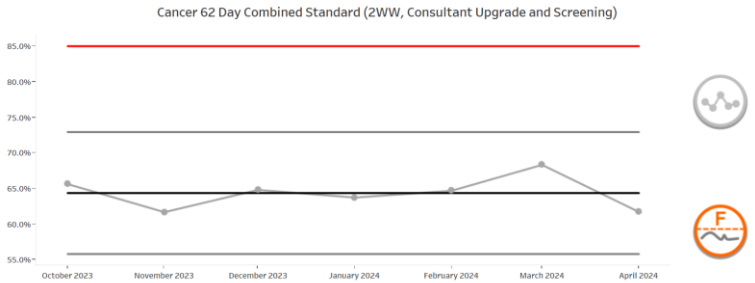


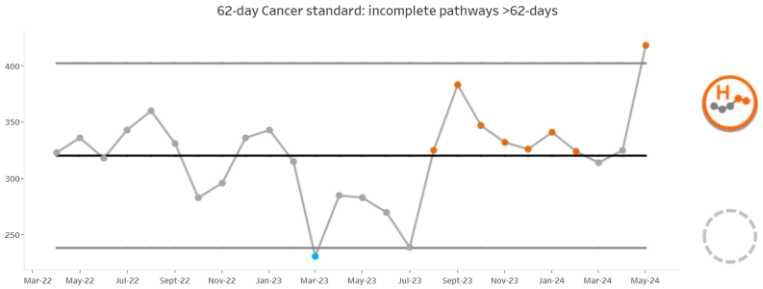
Benchmarking >52-weeks: April 24	
OUH	3,590
National	1,668 (avg.)
Shelford	3,515 (avg.)
ICS	BHT: 2,302 RBH: 23

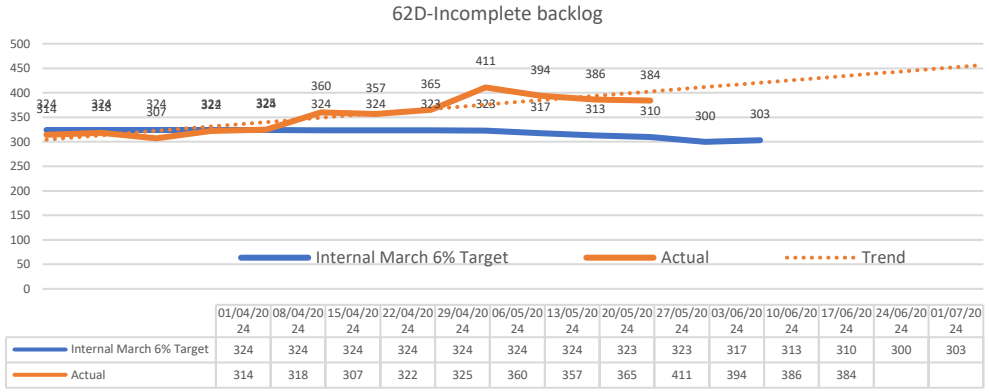
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of patients waiting more than 52 weeks to start consultant-led treatment was 3,767 at the end of May. Performance exhibited special cause variation due to >six consecutive periods of deteriorating performance above the mean and exceeding the upper process control limit. **104 weeks** - Five patients in total breached. 1 x Paed Plastic patient transitory illness, and 1 x Vascular and 1 x Orthopaedic patients stopped in June, 1 x Cornea patient and 1 x Vascular scheduled in June. **78 weeks** - 81 incomplete pathways of which 35 were due to capacity, 19 due to Patient Choice, 20 due to Complex pathways, 5 were Corneal transplants and 2 were Paediatric Spinal patients. **65 weeks –** 1,010 incomplete pathways reported which is an increase from the previous month. Focus remains in place to deliver nil pathways beyond 65-weeks by September in line with the Trust's Operating Plan 2024/25. Services not challenged in the longer wait cohorts are undertaking recovery of **52-week backlog.**	• **Orthopaedic services** contract in place with Independent Sector Provider. Additional capacity has been sought from across the BOB ICB, partner ICB and insourcing providers. • **Spinal services** contracts to Independent Sector Providers at The Portland and Royal National Orthopaedic Hospital are in place and working well. • **Ophthalmology services** are implementing mutual aid pathways within the BOB ICB to support long-waiting patients. • **Plastic services** are discussed at System level with no immediate capacity therefore seeking Regional support for Mutual Aid further afield. • **Gynaecology services** are working closely with partner Trusts in the BOB ICB to implement mutual aid pathways • **Adoption of the national Interim Choice Guidance** has reduced the number of reported incomplete RTT Pathways. Tracking of these patients continue via Elective Assurance meeting led by the Chief Operating Officer. • **Elective Recovery Fund** schemes live and tracked at ECRG • **Anaesthetic services** have appointed Locums to bridge capacity gap and increase baseline activity to support the agreed delivery of a minimum 96% of theatre lists running in term time and a minimum of 89% during peak holiday periods. • **Patient Engagement Validation** re-launched across entire undated 1st outpatient H2 65-week cohort, with support from ERF to administer - forecasting >10% reduction in the cohort.	Delivery of 65-week plan by September 2024 All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery Group	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*





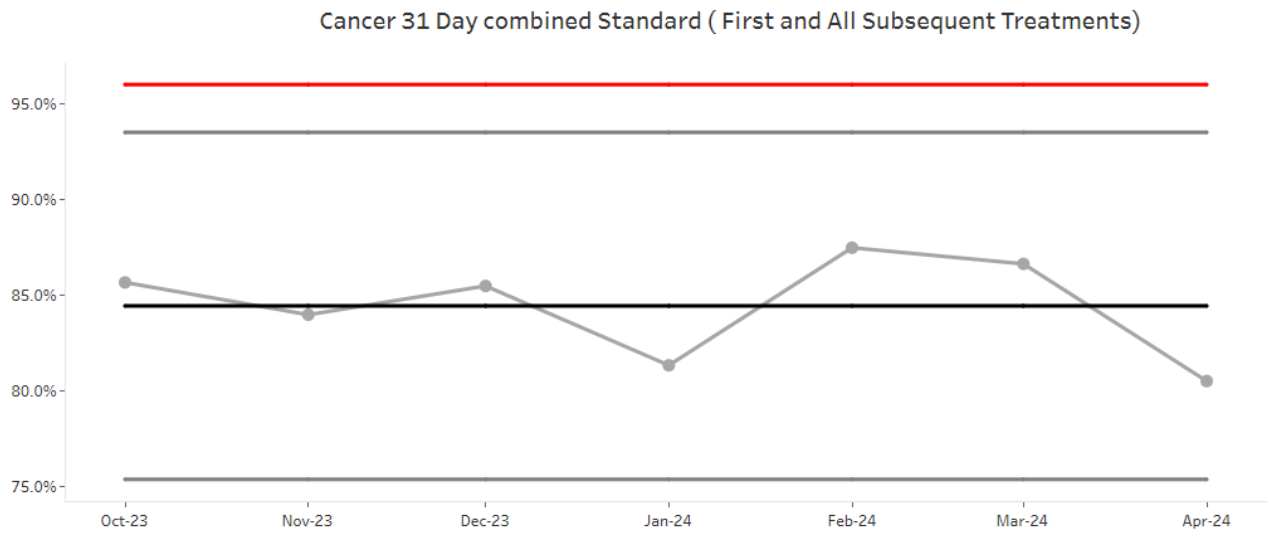


	01/04/20 24	08/04/20 24	15/04/20 24	22/04/20 24	29/04/20 24	06/05/20 24	13/05/20 24	20/05/20 24	27/05/20 24	03/06/20 24	10/06/20 24	17/06/20 24	24/06/20 24	01/07/20 24
Internal March 6% Target	324	324	324	324	324	324	324	323	323	317	313	310	300	303
Actual	314	318	307	322	325	360	357	365	411	394	386	384		

Benchmarking: April 24 62-day General Standard	
OUH	61.7%
National	69.3%
Shelford	60.3%
ICS	BHT: 63.5% RBH: 68.8%

ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

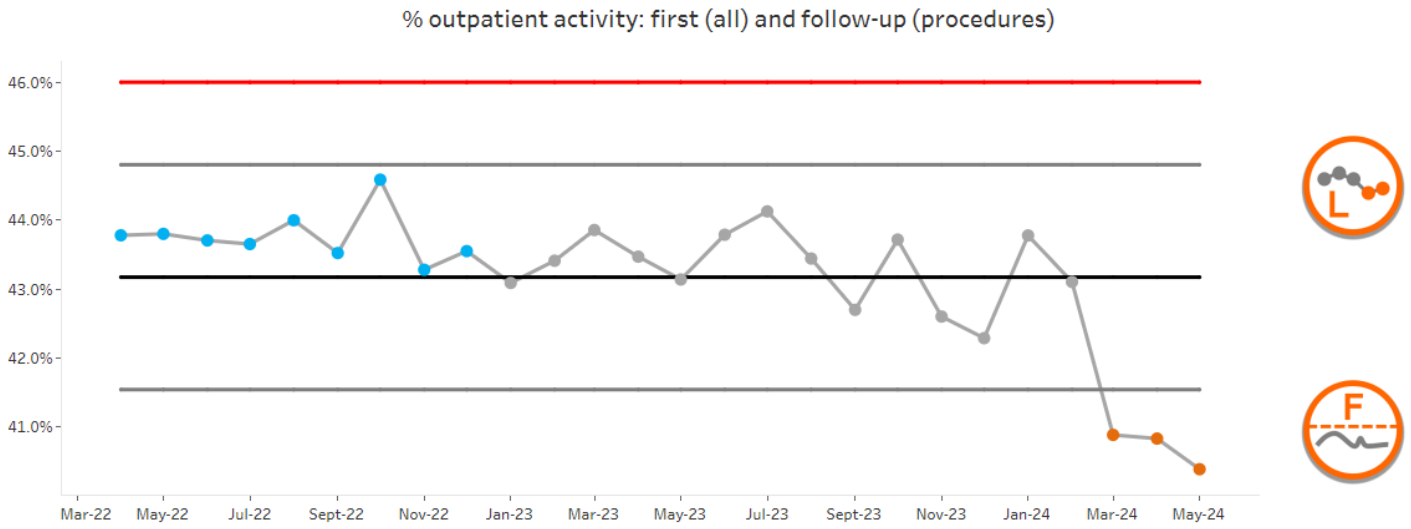
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards have changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 62 days combined standard was 61.7% in April 2024, and below the performance target of 85%. Performance is reported one month in arrears due to the extended reporting period for this indicator. All tumour sites apart from Children, Haematology – Non-Acute Leukaemia and Myeloma, Skin and Urology - Testicular are non-compliant for this standard in April. **Challenges identified:** • Complex tertiary level patients (5%) • Some slow pathways and processes (4%) • Capacity for some surgery, diagnostics and oncology (56%) • Late inter provider transfers (29%) • Patient reasons (6%) **>62-day combined PTL** has decreased in size but remains above trajectory of delivering 6% proportion of long waits in June 2024.	**The Cancer Improvement Programme is** focussing on 28-day Faster Diagnosis Standard (FDS). For April, **the Trust reported 76.6% and has delivered this standard consecutively since June 2022**. FDS remains a key priority for 2024/25 as well as addressing the challenges faced with delivering treatment for our patients by day 62. **Performance of >62-day PTL vs plan –** recovery includes: • Incomplete and late Inter-Provider Transfer analysis and escalation • Surgical capacity through theatre reallocation • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication **Waiting List Census 19/06/2024:** **Urology** still holds the highest proportion of long waiting patients (149) and significantly above trajectory (88). Deep dive has been undertaken and a recovery plan is in place – mitigating actions forecasting delivery of target at year end (46) to be secured. **Lung** holds the second highest volume (49) and are marginally above their individual trajectory (39). Deep dive completed and recovery plan under review to ensure delivery of 6% by end of year (21) . **Gynaecology** holds the third highest volume (41) and are significantly above their individual trajectory (27). Consultant triaging of appropriate pathways to control demand has been adopted. Pre-hysteroscopy clinic has reduced demand for diagnostics. Recovery plan has been completed and review underway to ensure delivery by March 2025 (26)	Faster Diagnostic Standards (FDS) to be achieved by all tumour sites outlined within the FDS Framework 2023/2024 186 patients over 62 days on the Combined Patient Tracking List to deliver 6% ask. Above trajectory (310) with 384 patients (124%) 30/06/2024 30/06/2024 30/06/2024	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*



Benchmarking: April 24 31-day General Standard	
OUH	80.5%
National	93.5%
Shelford	83.8%
ICS	BHT: 82.4% RBH: 84.9%

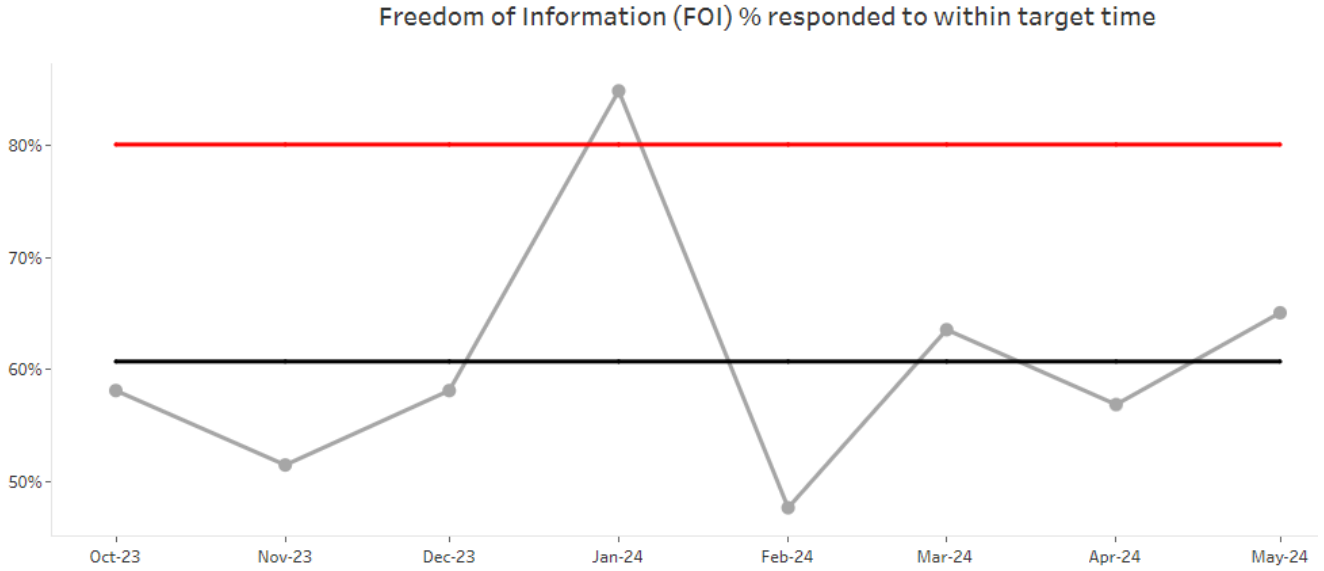
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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
Reporting of Cancer Standards changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 80.5% in April, and below the performance target of 96%. Performance is reported one month in arrears due to the extended reporting period for this indicator. Performance in March was 86.6% therefore a deteriorating position. Surgery capacity is the key issue affecting performance with over 70% of breaches due to surgery capacity.	Mutual aid for benign general capacity within the Acute Provider Collaborative being worked through. Example, c.600 general gynae patients (pending patient uptake) to be shared between BHT/RBH as a whole pathway. This will release theatre capacity to support 65-week backlog and cancer surgical treatment within 31-days. Agreement to run a minimum 96% theatre lists during term time and a minimum of 89% during peak holiday periods throughout the year. Mitigating cancellation reasons and utilisation lists from 6-4-2 process. Process map of Prehab services to redesign a lean digitise process underway to expand provision within the workforce establishment to bridge gap in unmet need and increase opportunity for improved uptake of theatre slots within 31-days relating to fitness, willingness and ability. Also supporting post recovery to improve patient experience. This follows on from the Onko pilot in 2023/24.	Q4 2023/24 Q4 2023/24 staggering into 2024/25 for other specialties not named. Q3 2024/25	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*



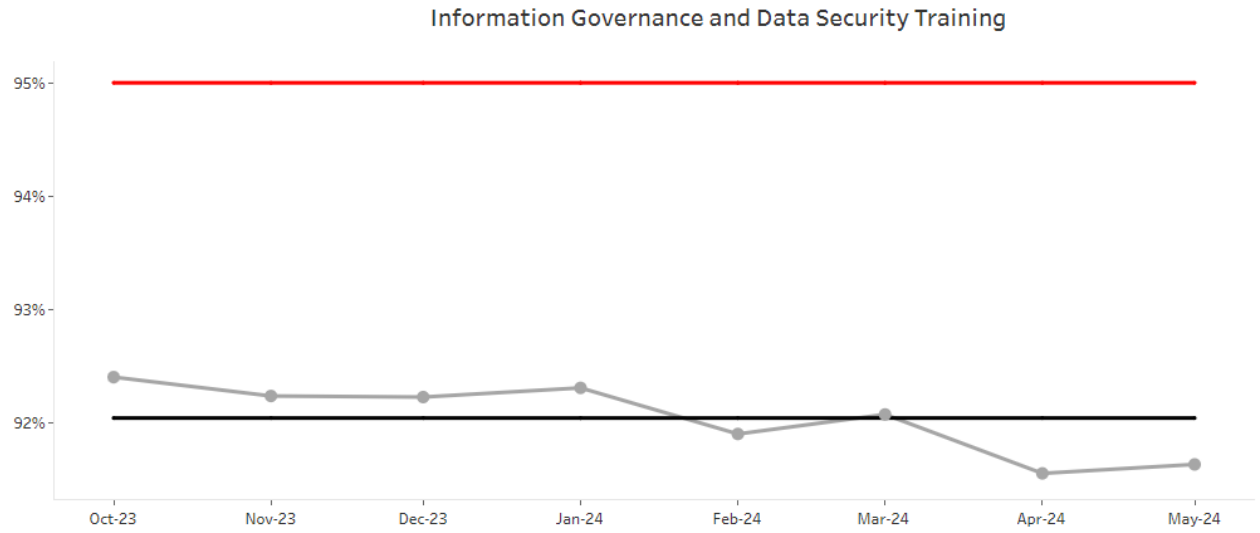
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of first new outpatient and follow-up outpatient appointments with procedures was *40.4% in May. The indicator exhibited special cause deteriorating variation due to performance being below the lower process control limit. The indicator has consistently not achieved the target of 46.0%.	Presentation to consider various change ideas to support recovery of 65-week backlog includes the need to optimise outpatient procedure activity by evaluating daycase procedures for conversion to an outpatient setting as well as one-stop services in outpatients, thus releasing theatre time.	Clinical Operational Forum – June 2024	BAF 4 Link to CRR 1135 (Amber)	
Delayed completion of outcome forms to identify procedures in recent months under-reports performance Possibility of some procedures being carried out in theatres instead of an outpatient setting.	The Further Faster Programme cohort 3 commenced in May 2024 and features initiatives in association with GIRFT to support this objective. BOB ICB are supporting with data to assist with identifying areas of improvement at specialty pathway level, with best practive being shared across the Trusts.	Outpatient Steering Group - Timescale TBD		
*the most recent month's position may increase due to the completion of processing outpatient procedure coding.	Director of Data and Analytics to review any patterns or variation to previous year's performance at specialty level. Findings will be discussed via ECRG. This will help identify some opportunities.	ECRG - July 2024		
	Trust-wide campaign to complete clinic outcomes in a timely fashion to be undertaken.	ECRG – June 2024		

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



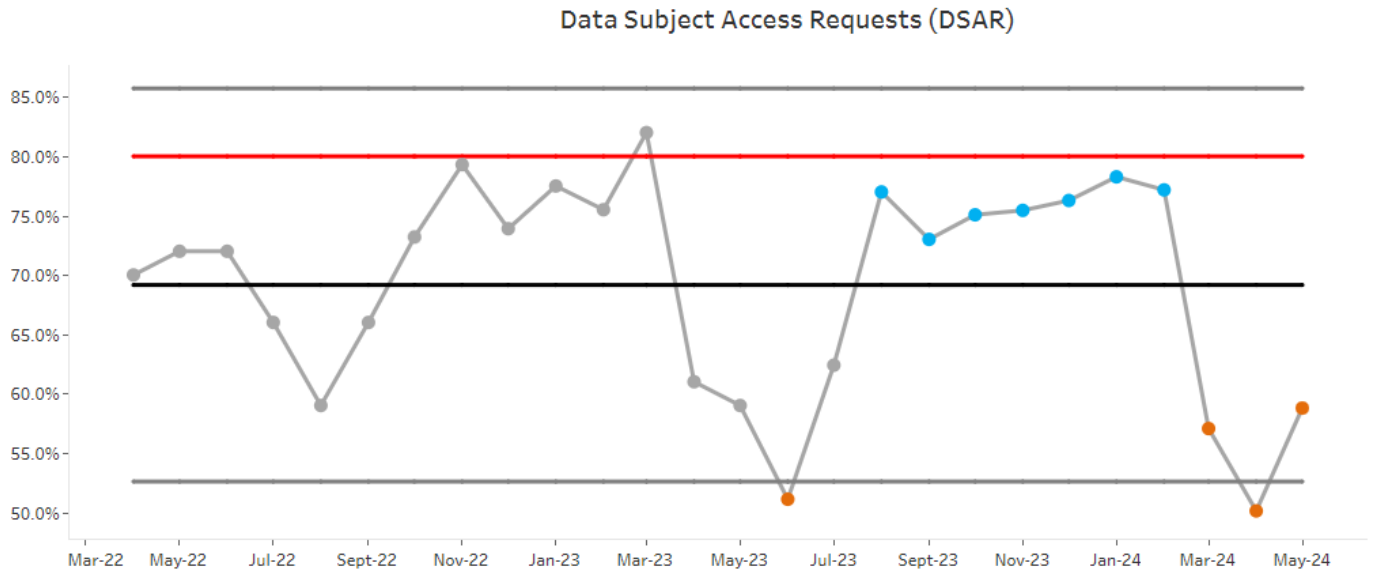
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M2 FOI performance against the 80% target remained below the performance standard at 65.0%, and exhibited common cause variation. The FOI response time to comply is 20 working days from the date of receipt. A high number of cases were received in M2 so although the total number of cases closed was the 3rd highest in the last 12 months at 39, performance in relation to the number closed within the target time did not increase as much as it would have done had a regular number of cases been received.	A new team member has started within the FOI team and is working on live cases. As a result, it is estimated that the post will have capacity to support closing the backlog of FOI cases by working closely with the teams involved with providing data for FOI. Any deviation to this trajectory where FOIs planned to be completed lapse will be escalated to the relevant Chief Officer whose teams have responsibility for the FOI. An alternative model for distribution and sign off of cases is being used for finance requests. If this demonstrates an improvement in performance a paper suggesting its full adoption will be presented.	The effect of increased team capacity and process will be visible in M2 with full compliance anticipated by M6 Review of pilot by M3 and paper with recommendations to follow in M4 Assurance reviewed at 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*



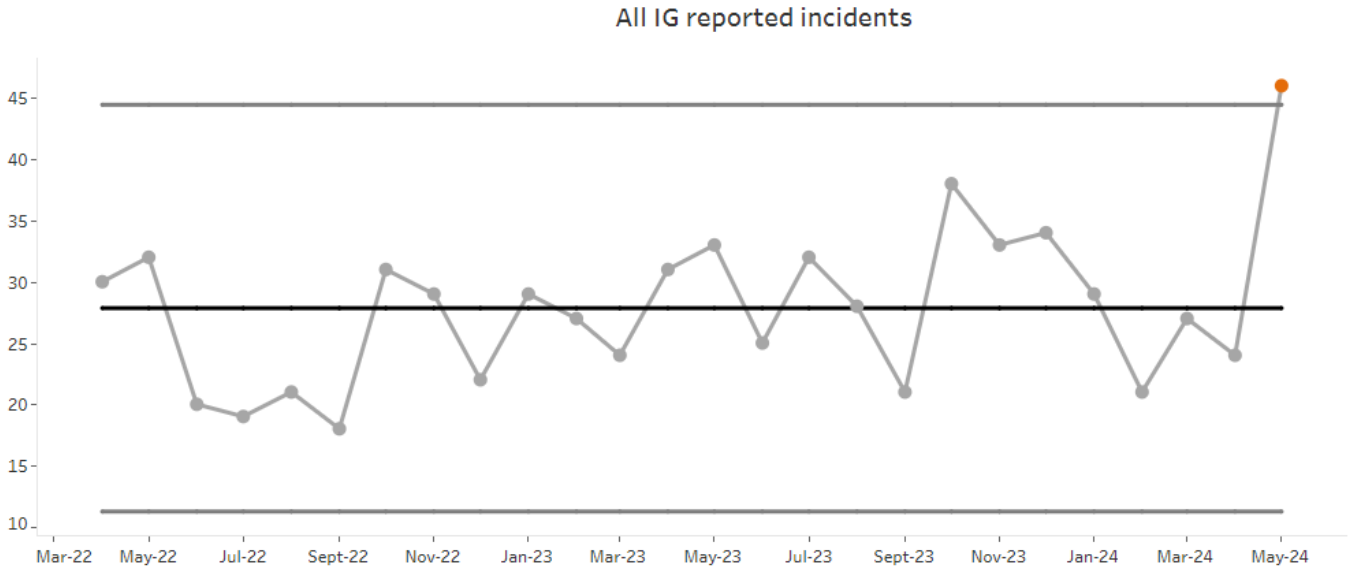
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 91.6% in M2, below the target of 95%. Performance exhibited deteriorating special cause variation due to successive periods of performance improvement (>6 months) below the mean.	Completion of IG training forms part of the mandatory training associated with VBAs, so the completion rate will improve as we enter the appraisal window. Assurance can be taken from the equivalent level and then subsequent improvement at the same period last year. An all staff email reminding everyone of the importance of IG training and cyber security awareness has been sent All staff Briefing will also reiterate the importance of training in the coming weeks As part of DSPT compliance an education campaign for IG and cyber security issues has started – reminders and tips to complete IG training are included within this package.	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 incident	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In M2 DSAR performance has remained below the target and usual performance level. Within the main areas responsible for DSAR performance, Occupational Health returned 91% of their 134 requests and Information Governance 100% of their two requests. PACS are still recovering M12's issues and clearing their backlog, and M2 performance was 46% of their 486 cases closed on time. 486 is double the number of requests they received in M1 Subject Access to medical records team within legal services returned 63% of their 430 cases on time. 430 cases was also the number received in M1.	PACS DSAR performance did not recover as expected as they received double the number of requests as in April. The PACS team have 1 staff member currently seconded to NHSE, and 1 vacancy on hold due to the current financial controls. They do not have dedicated staff to handle SARs so large projects (for example TLHC) have an impact on their capacity – this is an ongoing risk. The Subject Access Request team within legal services are still working through a larger backlog dating from when they were understaffed last winter so their recovery will be slower. Two fixed term posts have been funded and one is currently filled. The overall backlog is reducing but will not start to have an impact on the 30 day target performance until M5	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 incident	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
46 incidents were reported to IG in M2, a significant jump from the usual range of 20-35. Analysis of the reports shows two themes – an increase in requests for assistance in analysing suspected inappropriate access to EPR from colleagues in ED, and an unusually high number of paper notes & wristbands being found unattended/discarded in public areas.	The IG team and DPO are working with ED management to provide advice and guidance on detecting and investigating suspected EPR misuse. None of the reported suspected cases have resulted in a proven incident of inappropriate access thus far, though analysis continues. The increase in reported cases may be as a result of increased vigilance rather than issues with staff behaviour or culture. The process to acquire a new software tool to simplify/speed up the analysis process is under way. An all staff communication to remind them of the importance of securing patient wristbands, and of putting paper notes in the confidential waste bin as soon as they are finished with it, will be drafted and sent out.	Actions and performance are overseen by the Digital Oversight Committee Work with ED complete by M4 EPR analysis tool Business case prepared by M6 Communication about paper notes/wristbands sent out by end of M3	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 incident	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. On 01/05/2024 SEND was unavailable for all users. The system crashed after a patient record merge error. 2. On 02/05/2024 the ACE building at NOC lost network connection both wired and wireless. This was caused by a power issue within the main NOC server room. 3. On 13/05/2024 there was a power outage at the OCDEM Data Centre (DC) on the Churchill site, the result was loss of multiple services across the OUH. The Uninterruptable Power Supply (UPS) (batteries) depleted before power was restored by Estates.	The system was recovered after a re-start. Investigations have identified the record merge was the cause of the issue and recommended process changes have been implemented within Digital to reduce the likelihood of recurrence. The server room power including the UPS is provided by the PFI and the UPS failed during local generator tests. The PFI found that some of the battery cells had failed and have since replaced them, to permanently resolve the issue. At 2135hrs Estates powered up the generator and the UPS started recharging. At 2230hrs Estates switched the DC power feed to the OCDEM building supply because the risk of recurrence was not present in that feed. Estates monitored the power for any further issues. Digital instigated the necessary recovery actions. Estates has identified the root cause and is implementing a permanent resolution in June.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

4. Development indicators

Chief Officer	Domain	Reporting section	Indicator type	Indicator	Comments
COO	Operational Performance	Elective access	National	Cancer: % patients diagnosed at stages 1 and 2	Further information due on the calculation method of this indicator within the National Planning Guidance

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