Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M6 (September data)

Accessible Information Standard notice: We are committed to ensuring that everyone can access this document as part of the Accessible Information Standard. If you have any difficulty accessing the information in this report, please contact us.

Table of Contents

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

1. Overview of strategic priorities and performance

The month 6 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the four strategic pillars: People, Patient Care, Performance and Partnerships.

Within our key priorities for our people and financial performance, we have set a plan to reduce temporary staffing by 700 by the end of Q2. The plan has been set in agreement with the Integrated Care Board (ICB) and NHSE. Up to the end of Month 6 (September) £9.2m has been saved on temporary staffing against a £12.8m target. The WTE reduction for this achieved at M6 was 272 WTE against a plan of 700 WTE. The potential effect on patient care is carefully evaluated by Pay Panels led by Chief Officers and incorporate Quality Impact Assessments (QIAs). The Pay Panels have a circa 80% approval rate and there is ongoing work to reduce bank and agency to support our headcount reduction target.

We achieved key measures related to patient safety and care experience, including the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI), which show fewer patient deaths than expected. We also met targets in VTE Risk Assessments and Care Hours Per Patient Day, which support high quality patient care.

Our Patient Safety Incident Response Framework (PSIRF) guides our response to safety incidents for learning and improvement, while our Quality Improvement methodology supports our strategic goals. Safeguarding training compliance for both adults and children (L1-L3) was achieved, and neonatal deaths and stillbirth rates were below threshold levels. No "never events" were recorded in September, and while category 2 pressure ulcers exceeded our threshold, category 3 and 4 pressure ulcers were below the threshold.

Appraisals provide feedback, recognition, and identify development opportunities, aligning staff performance with our strategic pillars. Compliance with core skills training, which supports high-quality care, showed improvement with Special Cause Variation (SCV). In September, we met targets for non-medical appraisals and core skills training, demonstrating commitment to staff development.

Lower staff sickness rates, vacancies, and turnover contribute to better patient care and reduced costs from temporary staffing. Our 12-month rolling sickness absence rate showed improving SCV, with rates lower than the National and Shelford averages, and the second lowest within the Integrated Care System (ICS). Vacancy and turnover rates also performed better than targets.

Income and Expenditure was a £25.8m deficit by Month 6 (year to date) some £8.7m worse than plan. The underlying deficit was £45.4m (year to date) with an improvement in the underlying run rate of £1.2m from the previous month. The Trust's plan requires a sharp improvement in future months with activity driven income planned to increase while headcount falls. Cash was £3.6m at the end of September, £0.4m higher than the previous month. However, the deteriorating cash position meant the Trust had to draw down PDC revenue support of £10m during September to be able to pay some revenue creditors (reflected in this closing cash balance). Performance in September has shown some improvement compared to last month and the YTD (on pay and income). The underlying position in September was a £5.7m deficit, until August it had consistently been over £7m deficit a month, driven by under-performance on income and pay overspends. Tight control of headcount will need to be maintained.

The Cancer Faster Diagnosis standard achieved the performance threshold and, supporting this indicator, the level of diagnostic activity compared to 2019/20 remains above the baseline and is exhibiting improving SCV. The Cancer Faster Diagnosis standard measures the percentage of patients diagnosed or who have cancer ruled out within 28 days of being referred. It is an important indicator to show that patients receive a diagnosis as soon as possible, which can improve clinical outcomes, or provide peace of mind when cancer can be ruled out. Our performance against this standard is the highest within the ICS and better than both the national and Shelford group averages.

Successes highlighted in Divisional Performance Reviews continue to be acknowledged, reflecting the contributions of our staff in enhancing patient care and experience. These successes are documented in the summary of the Divisional Performance Review meetings and reported to the Integrated Assurance Committee.

Of the 107 indicators currently measured in the IPR, 29 are detailed further using standardised assurance templates. These indicators, which include those failing to meet performance standards or showing deteriorating SCV, are listed in summary on the following page and elaborated within the relevant domain in section 3 (Assurance reports).

The Trust Management Executive review process also considers indicators without targets and those not flagging SCV in assurance reporting. Assurance reporting includes updates to Tiering requirements for Elective, Cancer, and Urgent and Emergency Care. The data quality ratings of the assurance templates range from 'satisfactory' to 'sufficient', as defined on page 10.

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

Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- C-diff cases: HOHA+COHA
- % Outpatient firsts and follow-up attendances for procedures
- RTT standard: >52-week incomplete pathways
- % Diagnostic waits under 6 weeks

Common cause variation and missed target

- MRSA Cases: HOHA + COHA
- Pressure ulceration incidents per 10,000 bed days (Cat 2)
- Midwife ratios (birth rate/staffing level)
- % of complaints responded to
- Reactivated complaints
- FFT % positive OP, IP and ED
- PFI: % cleaning score by site (average) JR, CH and NOC
- Number of RIDDORs
- Sickness and absence rate (in month)
- RTT standard: >65-week incomplete pathways
- Cancer 31-day combined Standard
- Cancer 62-day combined Standard (2ww, Consultant upgrade and screening)
- Information Governance and Data Security Training compliance
- Data Subject Access Requests (DSAR)

Special cause variation - improving

- Sickness absence (rolling 12-month)
- ED 4-hour performance (type-1) and All
- ED 4-hour performance All
- RTT patients > 78 weeks
- RTT patients > 104 weeks
- Proportion of patients spending more than 12 hours in the Emergency Department

Other*

- Adult safeguarding activity
- Non-Thematic Patient Safety Incident Investigations
- Freedom of Information % responded to within target time

**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)*

The PSIRF has been used to review the pressure ulceration incidents (Hospital Acquired Cat. 3 and 4) and its outcome supports learning and improvement. The organisational work programme, which incorporates clinical leadership, data, and education and research, is scheduled to be approved by the Harm Free Assurance Forum (HFAF).

Healthcare-associated infection results in poor outcomes for patients as well as increased length of stay. C. diff cases were above threshold in September and we recorded one MRSA case. C. diff cases exhibited deteriorating SCV. Work continues with the antimicrobial stewardship team to identify areas of continued high-level Co-amoxiclav usage and the IPC nursing team are assisting ward staff with identification and isolation of COVID-19 patients. 7-day working has now commenced within the IPC team.

The number of hospital-acquired Category 2 pressure ulcer incidents exceeded the threshold in September, with 91 cases reported. The Tissue Viability Team verified 59 of these incidents, identifying 35 clinical areas involved, and noted an increase in pressure ulcer risks. Additionally, 10% of incidents were in hospice areas, and some incidents lacked clinical photographs for verification. All incidents should be reviewed by the clinical area following the PSIRF approach, identifying learning points and creating remedial action plans. Clinical areas reporting skin damage without images (NOC, HGH, Churchill, and Theatres) will be contacted to understand the absence of photographs. A Power BI HAPU dashboard has been developed to provide oversight of incidents, with accessibility from Ward to Board. The Q2 audit showed 95% compliance in 67 clinical areas with 945 patients. Future audits will be monthly from November 2024. E-learning compliance is 83% for nurses and midwives, and 75% for AHPs. The HAPU Quality Improvement Programme will be monitored at the Harm Free Assurance Forum.

Two Patient Safety Incident Investigations (PSII) were confirmed in September 2024, incorporating an intrauterine death that was diagnosed following a placental abruption, and a patient admission to intensive care with sepsis following a second-trimester miscarriage. A total of 26 non-thematic PSIIs have been confirmed over the last 12 months since OUH moved to the PSIRF framework in October 2023.

The indicator measuring the percentage of patients with Sepsis attending ED receiving antibiotics within NICE guidelines did not meet the performance standard for September. Themes contributing to the delays, noting that this related to three patients, have identified administrative factors, communication and prescription signing. Actions are in place to discuss these within the Emergency Department and Practice Development team.

The midwife to birth ratio did not meet the performance threshold. In September, 605 mothers gave birth, with a decrease in births and planned bookings compared to the previous month. Caesarean sections accounted for 35% of births, despite a slight decline from August. Challenges include increased capacity demand and theatre staffing issues. Measures taken include redeployment of staff, reassignment of specialist roles, efficient use of bank staff, daily staffing reviews, and the development of an 'Out of Area' proposal. Additionally, two extra weekend caesarean lists per month are planned to address capacity needs.

Eight RIDDOR incidents were reported to the HSE, including two dangerous occurrences and six slips, trips, and falls. There were no emerging concerns relating to these incidents and all were investigated locally and addressed with preventive actions.

PFI cleaning scores did not meet our performance standards at the JR, Churchill and NOC in September. The method does not necessarily indicate uncleanliness. Mitie completed all planned audits at the JR, rectifying 15 failures within the required timeframe. G4S completed 67 out of 97 audits at Churchill and 42 out of 50 at NOC, with a 9% failure rate at Churchill and three failures at the NOC, all rectified promptly. Increased clinical failures prompted closer collaboration with IPC and ward/department leads.

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

Oxford University Hospitals NHS Foundation Trust

2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- C-diff cases: HOHA+COHA
- % Outpatient firsts and follow-up attendances for procedures
- RTT standard: >52-week incomplete pathways
- % Diagnostic waits under 6 weeks

Common cause variation and missed target

- MRSA Cases: HOHA + COHA
- Pressure ulceration incidents per 10,000 bed days (Cat 2)
- Midwife ratios (birth rate/staffing level)
- % of complaints responded to
- Reactivated complaints
- FFT % positive OP, IP and ED
- PFI: % cleaning score by site (average) JR, CH and NOC
- Number of RIDDORs
- Sickness and absence rate (in month)
- RTT standard: >65-week incomplete pathways
- Cancer 31-day combined Standard
- Cancer 62-day combined Standard (2ww, Consultant upgrade and screening)
- Information Governance and Data Security Training compliance
- Data Subject Access Requests (DSAR)

Special cause variation - improving

- Sickness absence (rolling 12-month)
- ED 4-hour performance (type-1) and All
- ED 4-hour performance All
- RTT patients > 78 weeks
- RTT patients > 104 weeks
- Proportion of patients spending more than 12 hours in the Emergency Department

Other*

- Adult safeguarding activity
- Non-Thematic Patient Safety Incident Investigations
- Freedom of Information % responded to within target time

**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)*

The staff sickness absence rate (current month and rolling 12-month average) did not meet the performance standard in September. Staff sickness absence is comparatively low relative to the Shelford and National average and the rolling 12-month average is exhibiting improving SCV. Sickness within the Trust doesn't have a single cause, and the top five reasons—cold/flu, mental health, headache/migraine, COVID, and gastro—are all on the rise. Long-term sickness now accounts for 40.8% of absences, up by 0.7%. The Trust is offering comprehensive wellbeing support, including stress management, and is focusing on consistent absence reasons within top clinical areas. Collaborative efforts with Occupational Health, proactive HR measures, and continuous managerial support aim to address and reduce sickness absences.

Reviewing feedback from patients can provide a direct insight into how the organisation delivers care and opportunities for improvement as well as celebrating success. Two areas used by the OUH are the Friends and Family Test (FFT) and Complaints. In September, negative FFT comments focused on waiting times, car parking, discharge home, and catering, while positive feedback highlighted staff attitude, care implementation, and clinical treatment. Over the past three months, concerns remained consistent about discharge, cancelled procedures, and waiting times, but patients consistently praised the professional and caring staff. The Patient Experience (PE) team established a monthly feedback group to enhance service analysis, with the first meeting held on 25th September 2024. The Patient Experience Forum, chaired by the Chief Nursing Officer, held its initial meeting on 13th September 2024 to review service improvements and the 2023 Inpatient Survey results, aiming to develop an action plan for improvement based on CQC identified areas.

Our complaints response time performance and re-activated complaints did not achieve the performance standards in September. The complaint-handling process has been streamlined to reduce response times, with new complaints now forwarded to the investigation team on the first day. Weekly and monthly reports ensure senior leaders stay engaged in resolving issues. Weekly meetings with nursing Directors and a monthly complaints dashboard provide insights and escalate urgent cases. A training program has also been rolled out to support divisions in managing complaints.

Prolonged wait times at the emergency department (ED) are associated with increased morbidity and mortality, and decreased patient satisfaction. ED 4hr performance was below target in September. Although below target, the indicator continued to exhibit improving SCV. In September, OUH was the top-performing Trust for all type performance in BOB ICB and the second-best Shelford Trust for Type 1 performance. The main cause of breaches was waiting times to be seen, accounting for 62% of all 4-hour breaches. Efforts to improve medical staffing are ongoing, with interim solutions showing limited success. The ED Observation and Review Unit has positively impacted patient experience and performance, with full benefits expected upon complete staffing. Operational meetings are focusing more sustainably on addressing breaches throughout the day.

Assurance reports are included for indicators not meeting elective access standards across 62-day and 31-day cancer standards, long waiting pathways (RTT pathways over 52, 65, 78 and 104 weeks), and diagnostic performance. Actions have been outlined for all challenged specialties and cancer tumour sites. Initiatives to improve productivity are also measured at the Trust's Productivity Committee as well as the Theatre Productivity Steering Group (TPSG). There remains a high residual risk related to the achievement of our 78-week, 65-week and Cancer performance trajectory submitted to NHSE.

Indicators measuring our Freedom of Information compliance, Information Governance training, Data Subject Access Request response times did not meet performance thresholds. Further information is provided within the templates for each indicator identified for assurance reporting.

2. a) Indicators identified for assurance reporting

Oxford University Hospitals NHS Foundation Trust

	Common cause variation	Special cause variation - improving	Special cause variation - deterioration	Other (where an increase or decrease has not been deemed improving or deteriorating, where SPC is not applicable, or the indicator has been identified for assurance reporting in the absence of performance vs target or special cause variation)
Quality, Safety and Patient Experience	Not achieving target • MRSA Cases: HOHA + COHA • Pressure ulceration incidents per 10,000 bed days (Cat 2) • Midwife ratios (birth rate/staffing level) • % of complaints responded to • Reactivated complaints • FFT % positive OP, IP and ED • PFI: % cleaning score by site (average) JR, CH and NOC • Number of RIDDORs		H • C-diff cases: HOHA+COHA Not achieving target	No target • Adult safeguarding activity No SPC • Non-Thematic Patient Safety Incident Investigations Not achieving threshold
Growing Stronger Together	• Sickness and absence rate (in month) Not achieving target	L • Sickness absence (rolling 12-month) Not achieving target		
Operational performance	• RTT standard: >65-week incomplete pathways • Cancer 31-day combined Standard • Cancer 62-day combined Standard (2ww, Consultant upgrade and screening) Not achieving target	H • ED 4-hour performance (type-1) and All • ED 4-hour performance All Not achieving target L • RTT patients > 78 weeks • RTT patients > 104 weeks • Proportion of patients spending more than 12 hours in the Emergency Department Not Achieving target	L • % Outpatient firsts and follow-up attendances for procedures Not achieving target H • RTT standard: >52-week incomplete pathways • % Diagnostic waits under 6 weeks Not achieving target	
Corporate Support Services	• Information Governance and Data Security Training compliance • Data Subject Access Requests (DSAR) • Elective Recovery Funding weighted activity Not achieving target		L • Adjusted in-month financial performance surplus/deficit £'000 • BPPC £% • BPPC Volume % • Cash £'000 • Year-to-date financial performance surplus/Deficit £'000 Not achieving target	No SPC • Freedom of Information % responded to within target time 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: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Sept-24	0.3	-	-	0.1	-0.4	0.6
MRSA cases: HOHA+COHA	Sept-24	1	0	No	0	-1	2
C-diff cases: HOHA+COHA per 10,000 beddays	Sept-24	6.1	-	-	3.5	0.8	6.2
C-diff cases: HOHA+COHA	Sept-24	20	10	No	11	3	20
MSSA cases: HOHA+COHA	Sept-24	6	-	-	6	-1	12
Number of Never Events	Sept-24	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Sept-24	2	0	No	2	-	-
VTE- Submitted performance	Sept-24	97.7%	95.0%		98.0%	97.6%	98.3%
% of emergency admissions 65yrs + receiving cognitive screen	Sept-24	53.4%	-	-	56.9%	49.7%	64.0%
% of emergency admissions 75yrs + receiving cognitive screen	Sept-24	67.8%	-	-	75.5%	67.5%	83.5%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Sept-24	78.6%	90.0%	No	89.0%	-	-
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Sept-24	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Sept-24	2	-	-	2	-1	6
Hospital Standardised Mortality ratio	Sept-24	93.8	100.0		92.6	-	-
Summary Hospital-level Mortality Indicator	Sept-24	86.0	100.0		92.6	-	-
Neonatal deaths per 1,000 total live births	Sept-24	2.2	3.2		3.4	-	-
Stillbirths per 1,000 total Live births	Sept-24	2.1	4.0		4.0	-	-
National Patient Safety Alerts not completed by deadline	Sept-24	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Sept-24	0.0	-	-	0.0	-	-
Number of active clinical research studies hosted	Sept-24	1410	-	-	1376	1337	1415
Number of active clinical research studies (commercial)	Sept-24	403	-	-	365	350	379
Number of active clinical research studies (non commercial)	Sept-24	1007	-	-	1011	986	1037
Number of incidents with moderate harm or above per 10,000 beddays	Sept-24	41.5	-	-	41.9	26.1	57.7
Number of patient incidents with moderate harm or above per 10,000 beddays	Sept-24	37.0	-	-	37.7	20.4	55.1
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Sept-24	4.5	-	-	4.2	-2.7	11.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Sept-24	22.2	19.0	No	21.5	10.3	32.6
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Sept-24	1.9	2.0		2.2	0.3	4.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Sept-24	0.0	0.0		0.1	-0.2	0.4
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Sept-24	84.7	-	-	98.4	73.7	123.1
Patient falls (moderate and above) as reported on Ulysses	Sept-24	2	-	-	4	-2	11
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Sept-24	0.6	-	-	1.3	-0.8	3.4
Health and Safety related incidents - Assault, Aggression and harassment	Sept-24	150	-	-	154	75	234

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

Latest Indicator Period: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adult safeguarding activity	Sept-24	1338	-	-	831	546	1117
Children's safeguarding activity	Sept-24	468	-	-	619	320	918
Adult safeguarding activity and Children's safeguarding activity	Sept-24	1806	-	-	1450	994	1906
Safeguarding (Children) training compliance L1 - L3	Sept-24	93.0%	90.0%		87.9%	82.1%	93.7%
Safeguarding (Adults) training compliance L1 - L3	Sept-24	92.0%	90.0%		30.8%	20.8%	40.9%
Total Deliveries in month	Sept-24	603	625	-	617	559	676
Babies born	Sept-24	611	-	-	626	568	685
Maternity Bookings (planned + unplanned)	Sept-24	693	750	-	707	560	853
Inductions of labour from iView	Sept-24	124	-	-	144	111	177
Midwife Ratios (birth rate / staffing level)	Sept-24	26.1	22.9	No	26.1	22.3	30.0
Learning MDT Reviews presented at SLIC	Sept-24	3	-	-	3	-	-
After Action Review (AAR)	Sept-24	4	-	-	13	-	-
Number of complaints	Sept-24	97	-	-	107	57	156
Number of complaints per 10,000 beddays	Sept-24	31.2	-	-	33.5	19.9	47.1
% of complaints responded to within agreed timescales (40 working days)	Sept-24	83.1%	95.0%	No	77.9%	61.0%	94.7%
Reactivated complaints	Sept-24	7	1	No	10	2	18
Number of RIDDORs	Sept-24	8	5	No	4	-	-
Friends & Family test % likely to recommend - IP	Sept-24	94.8%	95.0%	No	95.1%	93.9%	96.4%
Friends & Family test % likely to recommend - OP	Sept-24	93.7%	95.0%	No	93.7%	93.0%	94.5%
Friends & Family test % likely to recommend - ED	Sept-24	77.7%	85.0%	No	79.0%	72.8%	85.2%
FFT maternity % positive (births)	Sept-24	0.0%	90.0%	No	79.6%	54.2%	105.0%
Inpatient FFT (Response Rate)	Sept-24	24.8%	-	-	25.3%	22.1%	28.5%
Outpatient FFT (response rate)	Sept-24	10.4%	-	-	7.7%	5.5%	9.9%
ED FFT (Response Rate)	Sept-24	15.5%	-	-	24.0%	18.9%	29.1%
Maternity FFT (response rate; births)	Sept-24	0.0%	-	-	10.4%	2.4%	18.5%
PFI: % cleaning score by site (average) JR	Sept-24	93.6%	95.0%	No	93.1%	82.6%	103.5%
PFI: % cleaning score by site (average) CH	Sept-24	91.0%	95.0%	No	94.1%	83.0%	105.1%
PFI: % cleaning score by site (average) NOC	Sept-24	92.9%	95.0%	No	97.4%	92.9%	102.0%
Incident rate of violence and aggression (rate per 10,000 beddays)	Sept-24	48.3	-	-	48.3	25.4	71.2
Trust level: CHPPD vs budget	Sept-24	70.9	-	-	-22.3	-68.7	24.0
Trust level: CHPPD vs required	Sept-24	8.5	-	-	-5.9	-25.2	13.4

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

Oxford University Hospitals NHS Foundation Trust

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

Latest Indicator Period: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Sept-24	90.0%	95.0%	No	91.6%	-	-
Data Security & Protection Breaches	Sept-24	32	-	-	27	10	44
Externally reportable ICO incidents	Sept-24	0	0		0	-	-
All IG reported incidents	Sept-24	35	-	-	29	14	45
Freedom of Information (FOI) % responded to within target tim	Sept-24	48.8%	80.0%	No	60.1%	-	-
Data Subject Access Requests (DSAR)	Sept-24	62.3%	80.0%	No	69.1%	52.5%	85.7%
Priority 1 Incidents	Sept-24	0	0		1	-	-

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Aug-24	8.4%	-	-	9.0%	4.6%	13.4%
Proportion of ambulance arrivals delayed over 60 minutes	Aug-24	0.8%	-	-	1.0%	-0.2%	2.3%
ED 4Hr perfromance - All	Sept-24	73.1%	78.0%	No	66.1%	57.8%	74.5%
ED 4Hr perfromance - Type 1	Sept-24	65.3%	73.6%	No	59.7%	50.7%	68.7%
Proportion of patients spending more than 12 hours in an emergency department	Sept-24	3.7%	2.0%	No	4.8%	2.5%	7.2%
Proportion of patients discharged from hospital to their usual place of residence	Sept-24	95.5%	-	-	95.1%	94.1%	96.0%
% Diagnostic waits waiting 6 weeks or more	Sept-24	24.2%	5.0%	No	14.8%	10.8%	18.9%
RTT standard: >52-week incomplete pathways	Sept-24	3646	-	-	2662	2316	3008
RTT standard: >65-week incomplete pathways	Sept-24	677	0	No	742	502	982
RTT standard: >78-week incomplete pathways	Sept-24	47	0	No	147	71	223
RTT standard: >104-week incomplete pathways	Sept-24	0	0		8	0	15
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Aug-24	62.4%	70.0%	No	63.3%	56.7%	69.9%
62-day Cancer standard: incomplete pathways >62-days	Sept-24	375	-	-	329	253	405
62-day Cancer standard: incomplete pathways >104-days	Sept-24	119	-	-	106	72	140
Inpatient Daycase activity vs 2019/20	Sept-24	99.3%	-	-	91.4%	75.7%	107.1%
Inpatient Elective activity vs 2019/20	Sept-24	85.8%	-	-	84.1%	61.6%	106.6%
Outpatient First Attendance activity vs 2019/20	Sept-24	95.6%	-	-	107.0%	84.1%	129.8%
Outpatient Follow Up Attendance activity vs 2019/20	Sept-24	121.0%	-	-	118.3%	94.1%	142.4%
Diagnostic activity vs 2019/20	Sept-24	126.9%	-	-	121.9%	109.2%	134.6%
Cancer First Treatments vs 2019/20	Sept-24	106.3%	-	-	125.4%	87.2%	163.6%
Bed Utilisation General & Acute	Sept-24	93.7%	-	-	95.1%	91.8%	98.4%
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Aug-24	79.0%	77.0%		79.1%	73.3%	84.9%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Aug-24	85.2%	96.0%	No	84.9%	77.4%	92.5%
% outpatient activity: first (all) and follow-up (procedures)	Sept-24	40.2%	46.0%	No	42.9%	41.4%	44.4%

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: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Sept-24	-5470.0	-	-	-4596.9	-7489.8	-1704.0
BPPC £ %	Sept-24	70.0%	95.0%	No	86.3%	79.6%	92.9%
BPPC Volume %	Sept-24	47.3%	95.0%	No	73.6%	65.8%	81.4%
Cash £'000	Sept-24	3552	-3076		34009	10201	57818
Efficiency delivery £'000	Sept-24	11794.3	6656.0		5464.1	-1158.5	12086.8
Elective recovery funding (ERF) value-weighted activity % In month	Sept-24	101.7%	107.0%	No	99.9%	89.6%	110.2%
In-month financial performance Surplus/Deficit £'000	Sept-24	3277.0	-840.0		-1214.4	-11933.9	9505.2
In-month ICS CDEL capital expenditure	Sept-24	2877.7	1818.0	-	2363.8	-5376.3	10103.9
Year-to-date financial performance Surplus/Deficit £'000	Sept-24	-25767.4	-21009.8	No	-13751.5	-23685.1	-3817.8

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

Latest Indicator Period: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Sept-24	90.0%	95.0%	No	91.6%	-	-
Data Security & Protection Breaches	Sept-24	32	-	-	27	10	44
Externally reportable ICO incidents	Sept-24	0	0		0	-	-
All IG reported incidents	Sept-24	35	-	-	29	14	45
Freedom of Information (FOI) % responded to within target tim	Sept-24	48.8%	80.0%	No	60.1%	-	-
Data Subject Access Requests (DSAR)	Sept-24	62.3%	80.0%	No	69.1%	52.5%	85.7%
Priority 1 Incidents	Sept-24	0	0		1	-	-

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

Latest Indicator Period: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Sept-24	17	-	-	19	4	34

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

Latest Indicator Period: Sept-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Sept-24	0	0		0	-	-

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

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

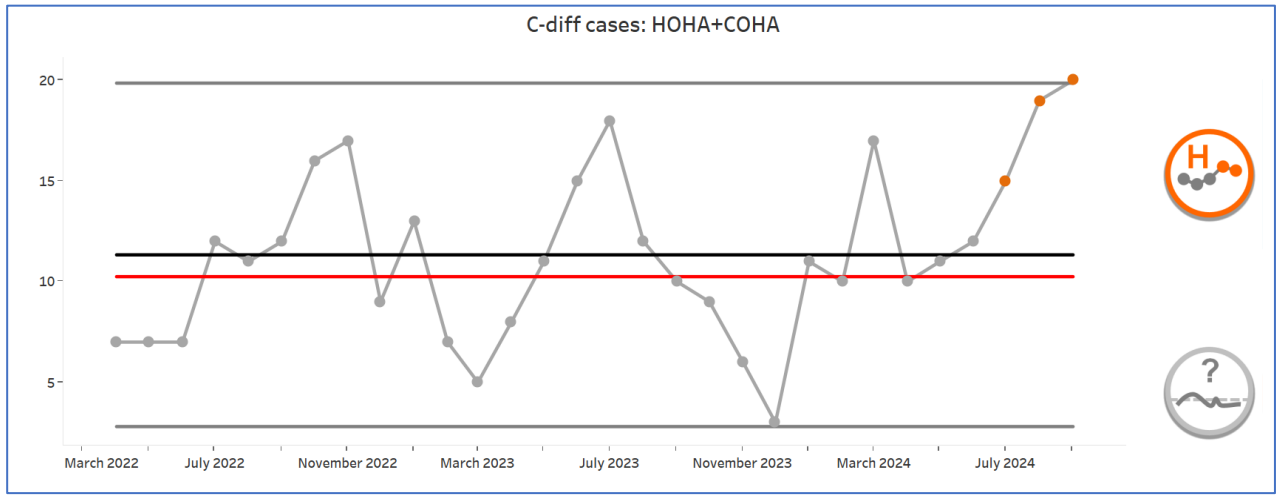
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

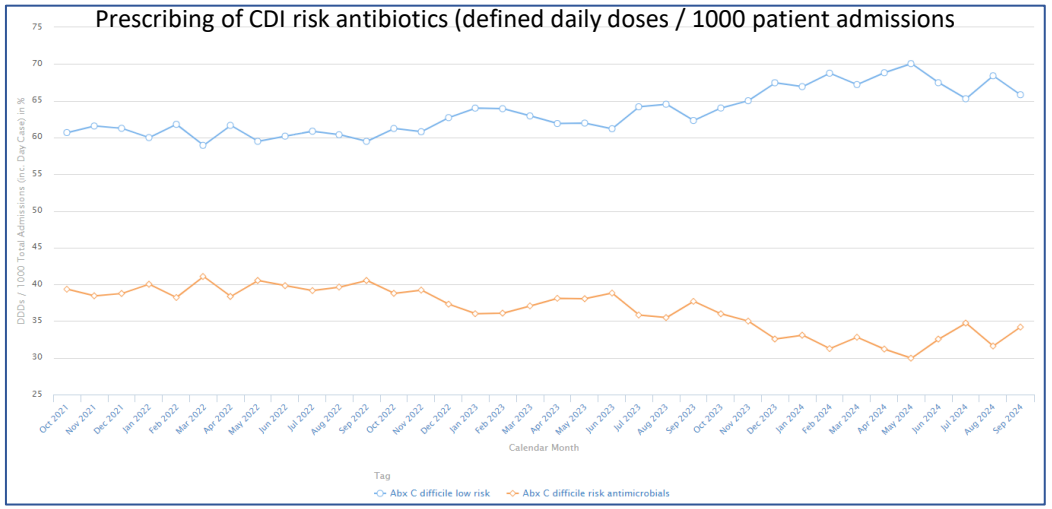
Sufficient	Satisfactory	Inadequate

03. Assurance reports

1.antibiotics and reduction in use of *C. difficile* risk antibiotics.

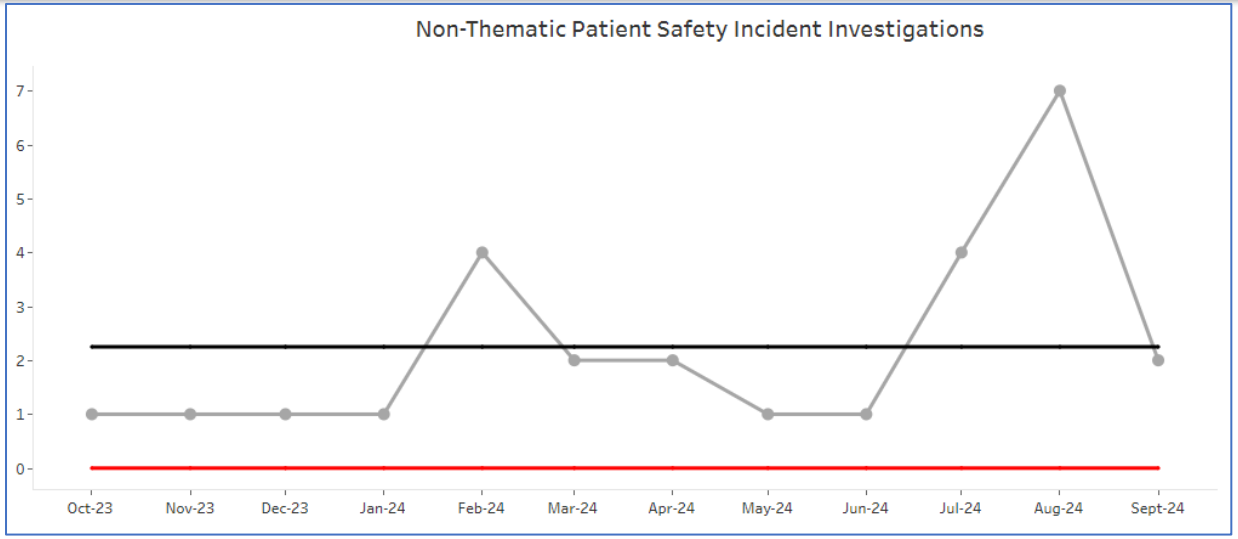
3. Assurance report: Quality, Safety and Patient Experience

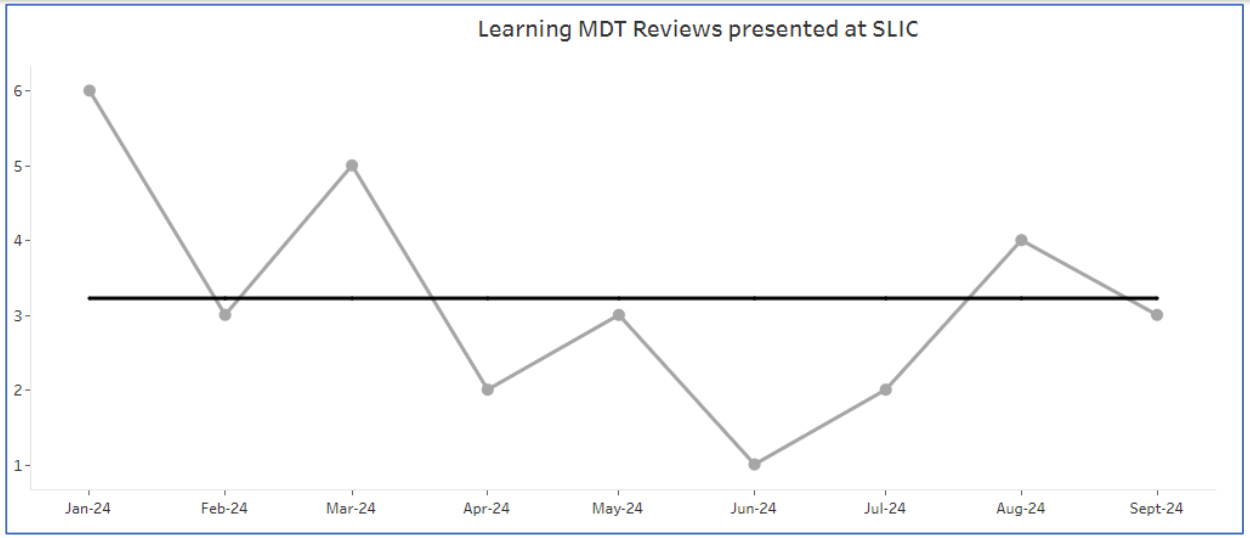




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
C.difficile – thirteen HOHA and four COHA cases in September 2024. Cases are equally distributed across the Trust, 2 COHA cases attributed to Acute Hospital at Home. The overall increase is on a background of a national increase in C.difficile infection (CDI; hospital-onset CDI cases increased by 9.4% in Jan-Mar2024 compared with same quarter 2023). OUH Prescribing data demonstrates overall progress in reducing use of antibiotics associated with the highest risk of CDI. **MSSA** - Three HOHA and three COHA cases in Sept 2024 **MRSA** – One HOHA case in CMU, source unknown	Work is on-going in the antimicrobial stewardship team .The team presented a verbal update to HIPCC, summary to be presented in PSEC paper. Very encouraging results seen with change in antibiotic prescribing at OUH: a) steady decline in watch WHO antibiotics and increase in Access group antibiotics over past 12 months at OUH b) Similar rate of decline of antibiotics more associated with CDI also seen over last 12 months across OUH sites AMS activities that have resulted in these improvements in antibiotic prescribing have included: a) AMS ward rounds – on all sites of OUH b) point prevalence surveys – quarterly c) educational efforts – including all members of MDT d) antibiotic prescribing reviews on all cases of CDI e) individual feedback to prescribers – consultant dashboard to “go live” within a few weeks f) updating of antibiotic guidelines – regularly and ongoing IPC nursing staff now commenced 7 day working.	The threshold C. difficile for 2024/25 is 123 cases. This 20 more cases than 2023/24. Assurance group – IPC report to PSEC via HIPCC. The DIPC chairs HIPCC.	BAF 4	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

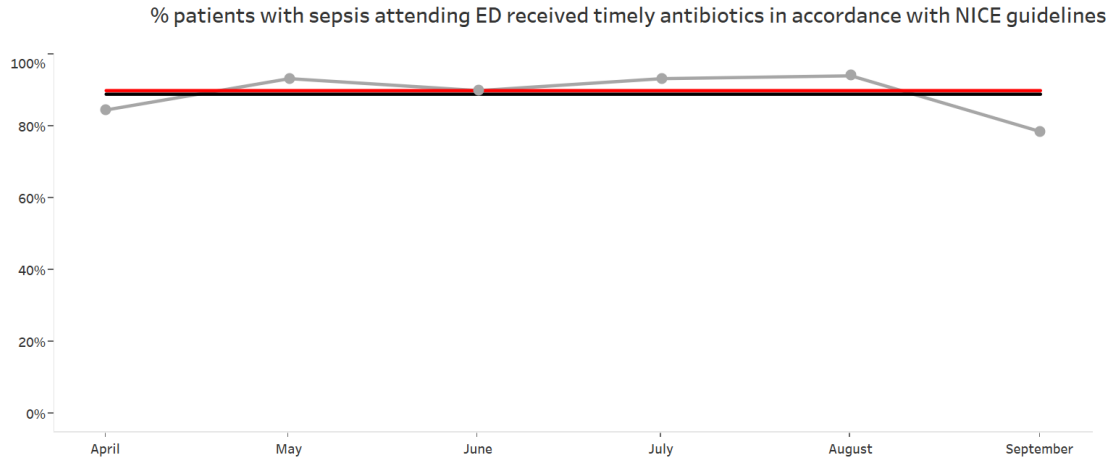
3. Assurance report: Quality, Safety and Patient Experience





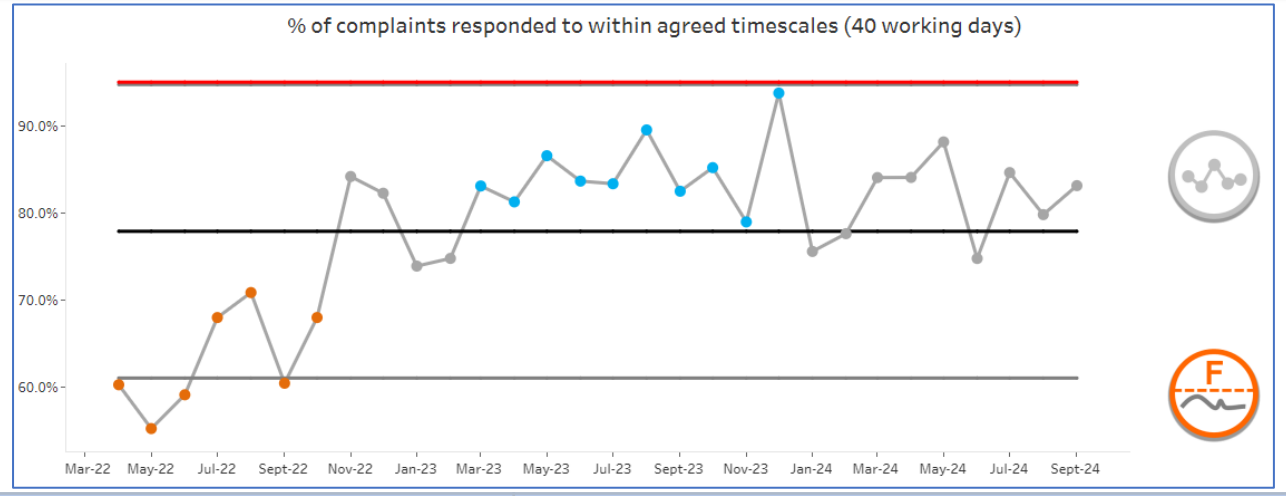
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Two patient safety incident investigations (PSII) were confirmed in September 2024 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile). One of these concerned an intrauterine death that was diagnosed following a placental abruption, and the other a woman admitted to intensive care with sepsis following a second-trimester miscarriage. Individual PSIIs are incidents that warrant an extensive system-based review (more than a learning multidisciplinary team review (LMDTR)). 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/or family and confirmed at the weekly Safety Learning & Improvement Conversation (SLIC).	A total of 26 non-thematic PSIIs have been confirmed over the last 12 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 (AARs) and LMDTR. AARs have a target of 2 weeks from the reporting of the incident to be completed, and LMDTRs 6 weeks. AARs were initially underreported in Ulysses. The Patient Safety Team now tracks all completed AARs, and AARs will be included once 6 monthly data points have been collected. In September 4 AARs (including harm-free assurance reviews for pressure ulcers and 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, DCMO and CMO/CNO	BAF 4 CRR 112 2	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

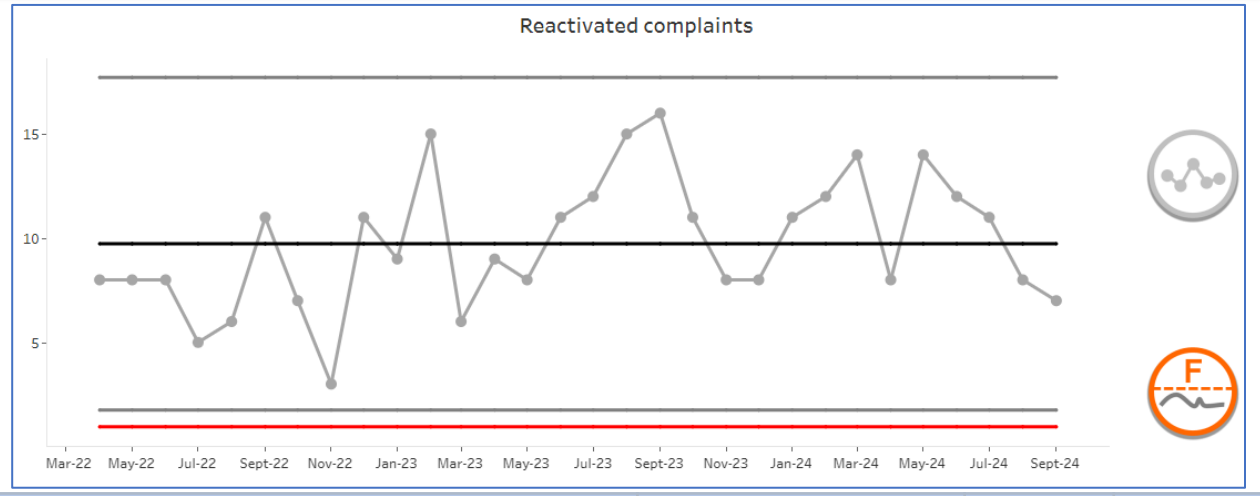
3. Assurance report: Quality, Safety and Patient Experience



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
September Sepsis Performance: In September, 11 out of 14 patients (79%) presenting to the Emergency Department (ED) with sepsis received timely antibiotics in accordance with NICE guidelines NG51. This marks a decline in performance, as three patients classified as high-risk for sepsis did not receive antibiotics within the recommended one-hour timeframe. With few patients with confirmed sepsis during this reporting period, any one case with delayed antimicrobial administration will have a large effect on the overall performance. The Emergency Department reports staffing challenges this month with every shift short-staffed. This, coupled with a high number of new starters, may contribute to the poorer performance this month.	Upon examining the data, several key themes emerged that may have contributed to the decline in performance: • **Delays in Administration**: The three high-risk patients experienced significant delays between their antibiotic prescriptions and administration. One patient had a delay of 103 minutes, while the other two waited up to 60 minutes to receive their antibiotics after the prescription was made. • **Communication Challenges**: A recurring issue highlighted by nursing staff in the Emergency Department is poor communication from medical staff regarding antibiotic prescriptions. This lack of timely notification can hinder nurses' ability to administer antibiotics promptly. • **Prescription Signing Practices**: Another possible contributing factor is that nursing staff sometimes do not sign the prescription at the time of antibiotic administration. This can create an impression of a delay that may not accurately reflect the actual timing of care. Highlighting communication of prescription and time-critical nature is a feature of ongoing rolling education strategy. We will offer refresher training in the ED regarding the timeliness of antibiotic administration and signing of prescription.	Pro-active discussion with Emergency Department and Practice Development Team to identify any barriers to prompt antimicrobial delivery. Ongoing review with monthly audit.		Sufficient

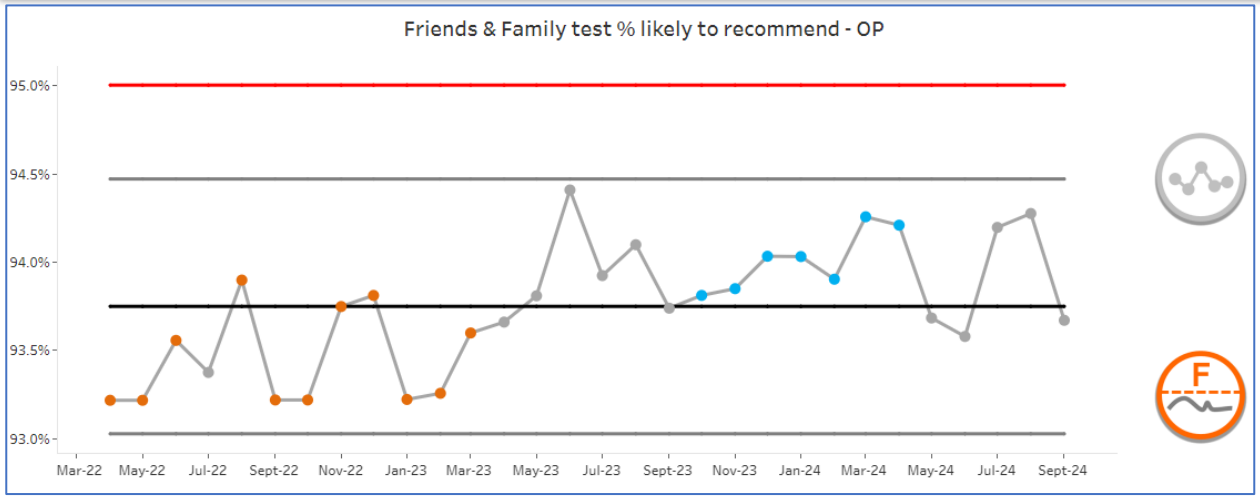
3. Assurance report: Quality, Safety and Patient Experience, *continued*

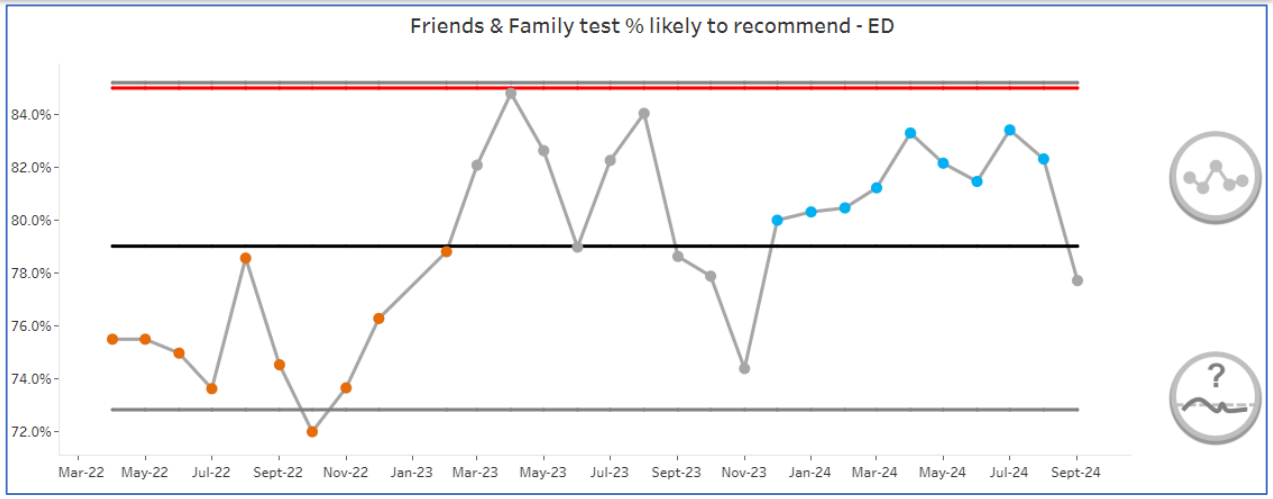




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2024, 82% of complaints were responded to within 40 days, below the target of 95% and there were 7 reactivated complaints .	The Trust received 98 formal complaints in September, and 7 reactivated (reopened) complaints were recorded. The complaint-handling process has been reviewed to simplify and standardise it, with the aim of reducing response time delays. It continues to be reviewed for effectiveness and necessary adjustments. To ensure timely response to complaints, all new complaints are acknowledged and forwarded to the investigation team on Day 1 to maximise the available time for investigation, as opposed to by Day 3 under the old process. A weekly report showing the number of open complaints over 25 days is shared and discussed with senior leaders and ensures they are engaged in resolving response times and provided with the necessary resources and support. Weekly meetings are held with the Complaints Team and Divisional Directors of Nursing, to escalate complaints cases about to breach. A monthly interactive complaints dashboard has been developed, which provides the divisions with a score for open, closed, reopened, and complaint themes. This is circulated to all Divisions for use in their Divisional Performance Reviews. Additionally, a weekly meeting led by the Chief Nursing Officer reviews all open complaints over 25 days, with each one given a planned route to closure. Escalation to the relevant Chief Officers as required to aid their staff in responding to all overdue complaints. A training programme to support Divisions with the management of their complaints has been developed and has been rolled out by the Complaints and PALS teams to all areas with training completed so far for MRC, Corporate, CSS and NOTSSCAN, with SUWON's training to take place before the end of October 2024.	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*

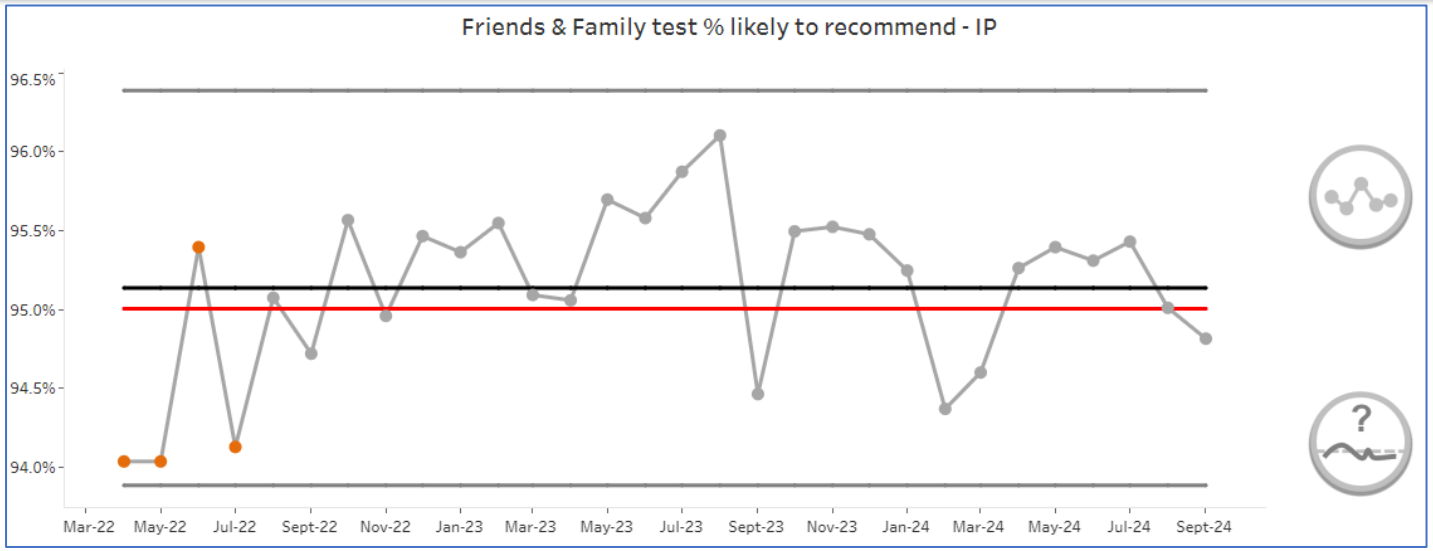
3. Assurance report: Quality, Safety and Patient Experience, *continued*





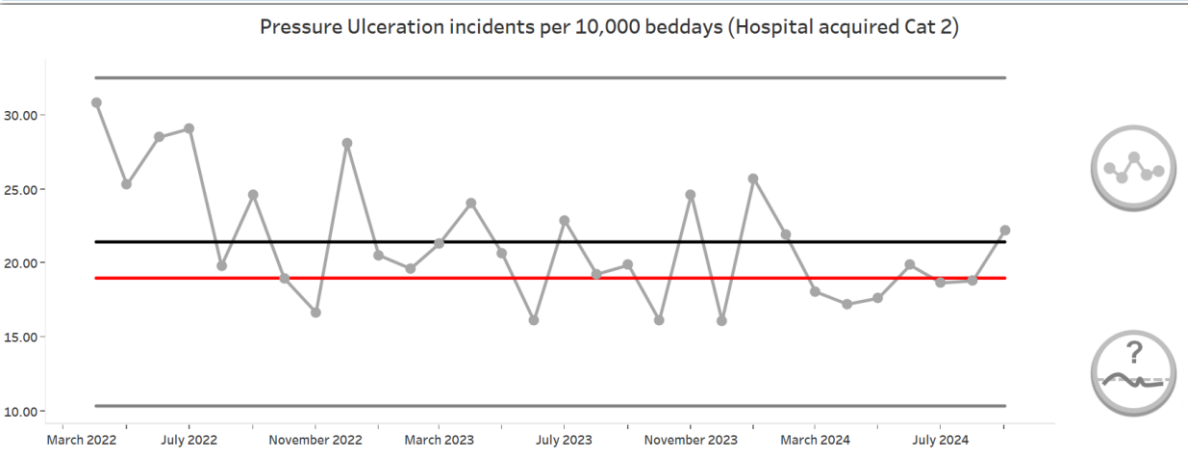
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. The negative themed comments during September were length of time on waiting list, car parking, discharge home and Catering. Over the over the previous 3 months, comments consistently centre on discharge home, cancelled admission and procedures, car parking and the length of time on waiting lists. 2. The positive themes during September were staff attitude, implementation of care, admission procedures and clinical treatment. consistent positive themed comments over the previous months centre on patients' appreciation of staff attitude, implementation of care and clinical treatment. 3. This continues to indicate that whilst patients are concerned about delays in their treatment, going home and parking, they experience good clinical care supported by professional staff who display a positive attitude.	1. The PE team has established a monthly feedback group for divisional and operational leads to improve the use of feedback to inform service analysis and change. The first meeting was held on 25th September 2024. 2. The Patient Experience Forum, chaired by the Chief Nursing Officer, was held on 13th September 2024. The purpose of the monthly forum is for the Divisions to demonstrate service improvements made following feedback, complaints and engagement. The initial meeting focussed on the Inpatient Survey 2023 results, which will be discussed in more detail at the operational group. Once the detailed ward level results are received, an action plan will be developed based on the five areas identified for improvement by the CQC and fed back through the Clinical Governance Committee.	1. 30th September 2024. 2. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 3. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 4. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group and the Trust Governors Patient Experience and Membership Committee (PEMQ) every month.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



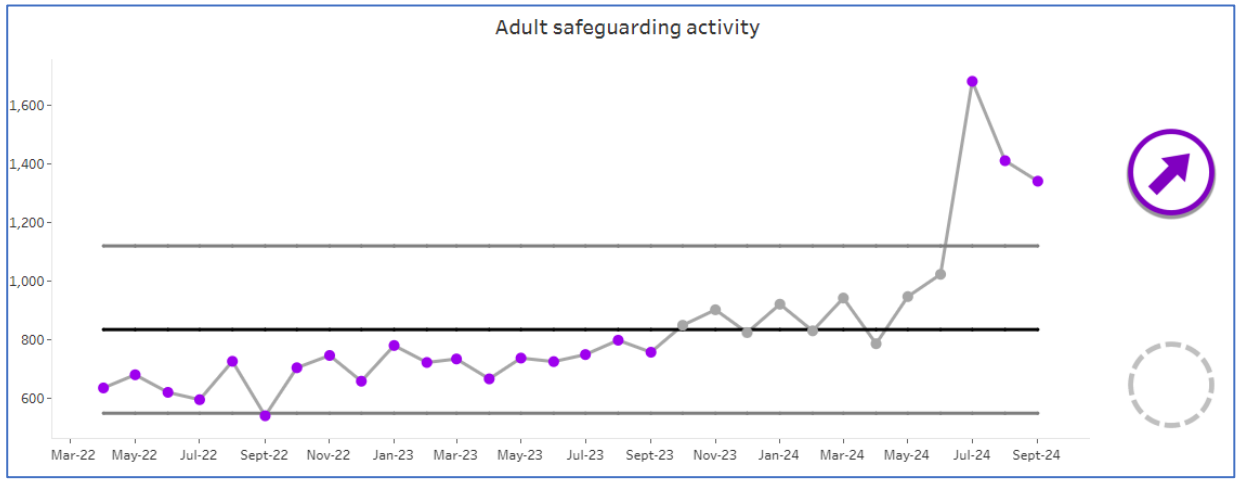
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. The recommend rate remains on an upward trajectory for Outpatients but decreased slightly for ED. 2. The negative themed comments during August were length of time on waiting list, car parking, discharge home and Catering. Over the over the previous 3 months, comments consistently centre on discharge home, cancelled admission and procedures, car parking and the length of time on waiting lists. 3. The positive themes during August were staff attitude, implementation of care, admission procedures and clinical treatment. consistent positive themed comments over the previous months centre on patients' appreciation of staff attitude, implementation of care and clinical treatment. 4. This continues to indicate that whilst patients are concerned about delays in their treatment, going home and parking, they experience good clinical care supported by professional staff who display a positive attitude.	1. The PE team has established a monthly feedback operational group for divisional and operational leads to improve the use of feedback to inform service analysis and change. The first meeting was held on 25th September 2024. 2. The Patient Experience Forum, chaired by the Chief Nursing Officer, was held on 13th September 2024. The purpose of the monthly forum is for the Divisions to demonstrate service improvements made following feedback, complaints and engagement. The initial meeting focussed on the Inpatient Survey 2023 results, which will be discussed in more detail at the operational group. Once the detailed ward level results are received, an action plan will be developed based on the five areas identified for improvement by the CQC and fed back through the Clinical Governance Committee.	1. 30th September 2024. 2. FFT data continues to be monitored on an ongoing basis. Ward / Clinical areas receive their reports automatically on a monthly basis. 3. The PE team report FFT data weekly to Incidents, Claims, Complaints, Safeguarding, Inquests [ICCSIS] which reports to the Patient Safety and Effectiveness Committee [PSEC]. 4. The data is also reported to the Safety Learning and Improvement conversation (SLIC), Nursing Midwifery and Allied Health Professional Group and the Trust Governors Patient Experience and Membership Committee (PEMQ) every month.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



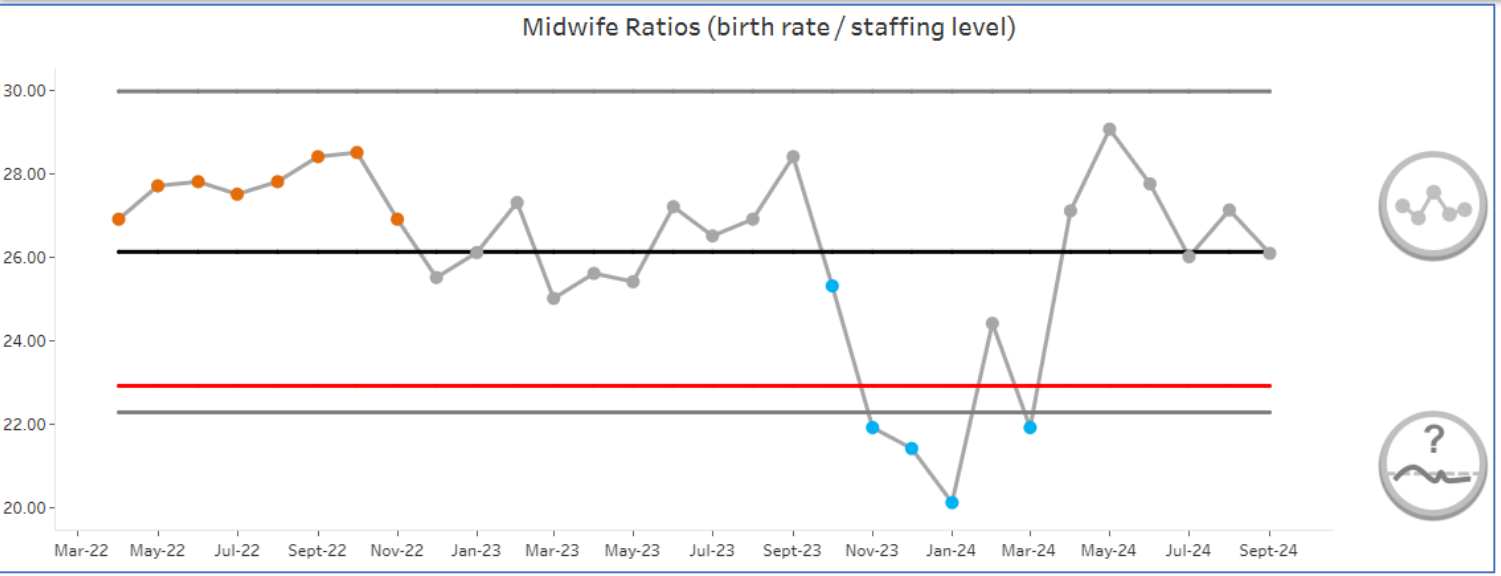
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The number of pressure ulcer incidents per 10,000 bed-days (Hospital acquired Category 2) was above the threshold for September (22 vs 19). A total of 91 incidents were reported as HAPU Category 2 in September 2024. All incidents were reviewed by the Tissue Viability Team. A total of 35 clinical areas were associated with the 59 incidents verified as HAPU Category 2, with 19 areas reporting more than one HAPU Category 2. 10% of the verified Category 2 incidents were identified in the two hospice areas. It is noted that September also saw a rise in the incidents reported as present on admission for Category One and Moisture Associated Skin Damage , from 92 in August to 116 in September, both indicators of increased risk of pressure ulcer risk profile.	The clinical area reviews all incidents using the PSIRF approach, identifying learning and remedial action plans. **Data Dashboard:** A HAPU dashboard has been developed in Power BI to provide oversight of reported incidents. Work is underway to ensure this is accessible from Ward to Board to identify improvement areas. The Tissue Viability Team, with their commitment to providing accurate and up-to-date information, will aim to verify all Category 2 and above HAPU within one working week to enable the contemporary upload from Ulysses. **Audit:** Q2 Pressure Ulcer Prevention Audit Compliance is **95%** . The audit was completed in 67 clinical areas with a sample size of 945 patients. The findings from the audit will be reported in December 2024 and supported by a trust-wide action plan. Future pressure ulcer prevention and management audits will be scheduled monthly with revised standards for completion starting in November 2024. **HAPU QI Programme:** The HAPU Quality Improvement Programme has also been established, focusing on targeted improvement efforts. Progress on these actions will be monitored and reported at the Harm-Free Assurance Forum.	Themes from these incidents will be presented by the Clinical Divisions at the Harm Free Assurance Forum scheduled for the October 2024 to understand issues in current practice and identify themes.	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and scheduled for October 2024.*

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



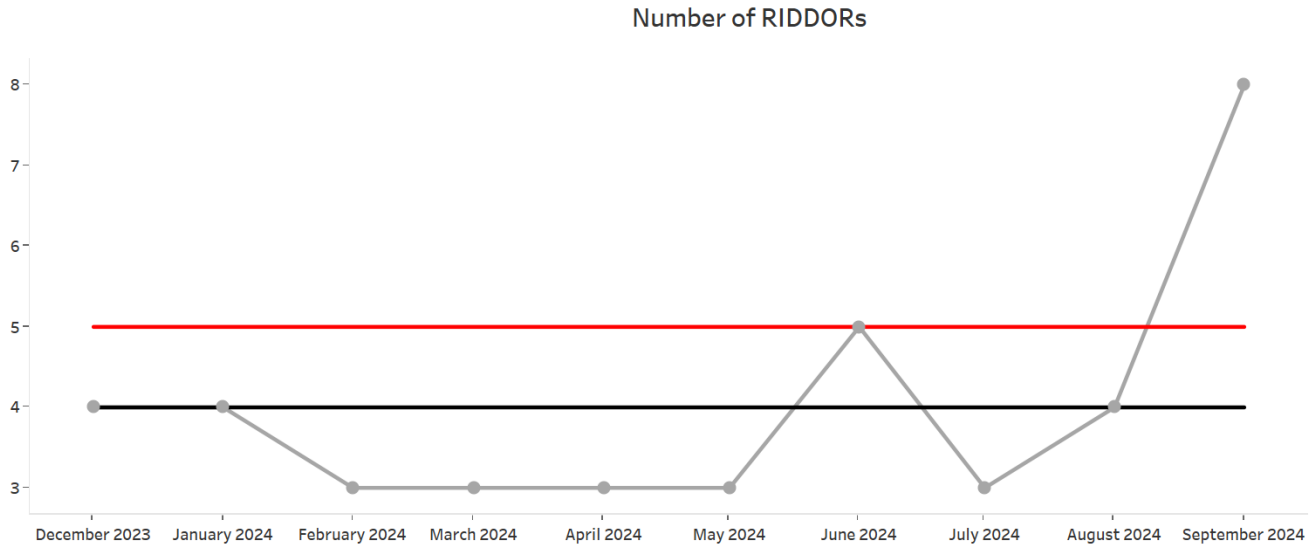
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Since April 2024 the adult safeguarding activity now includes the maternity safeguarding data. This is demonstrated in the increase as seen on the chart. Prior to this it was included in the **children** activity. This changed when the safeguarding Ulysses module was used to record all safeguarding and DoLS activity. September activity for adults (with maternity) was 1,337 in total related to 648 cases. The maternity specific activity was 325 adults and 39 children. There were a total of **111** DoLS applications to local authorities in September, no escalations were required for authorisations to be completed. Children activity was 468 related to 322 cases.	Activity varies each month. The complexity of cases continues to increase which is shown in the acitivity:cases ratio. Themes relate to domestic abuse, neglect, mental health issues and drug and alcohol. Complex discharge is a theme requiring support and multi-agency working. **Children –** PED supported with delayed discharges for children presenting with mental health issues and safe placement concerns. Escalations to the LA in and out of hours regarding private carer concerns have been managed well. Ongoing discussions in progress to avoid future presentations and alternative care provision. Safeguarding children liaison referrals increased by 123 cases in September (n=902) as expected due to schools returning. The increase of 22 (n=70) adults with caring responsibilities for children attending ED with mental health, alcohol and drugs use. Information is shared with primary care and social care for open cases.	ICCSIS updated on weekly themes. PSEC monthly assurance report, safeguarding is embedded in divisional governance reports and presented to the Trust clinical governance committee. Safeguarding Steering group quarterly.	BAF 4	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
605 mothers gave birth in September 2024, which is 25 lower than the previous month. 699 planned bookings were completed, which is 48 less than the previous month however predicted bookings for Q3 are increased. 212 caesarean sections were performed, which accounts for 35% of the mothers birthed in September 2024 although a 2.6% decrease from August 2024 the capacity increase demand remains a significant challenge for the service. Alongside this the challenges regarding theatre staffing adds to the complexity of any solution. The was one occasion where community services were suspended due to high activity however no women were affected.	• Staff from other areas have been redeployed to provide additional support. • Specialist and management roles have been reassigned. • Bank staff are being utilised efficiently and effectively. • Daily reviews of staffing and risk triangulation are conducted, with mitigation measures implemented and appropriate escalation where necessary. • An 'Out of Area' proposal to redirect appropriate non-tertiary bookings has been developed and will be presented at TME. •Additional weekend LSCS lists x2 required per month to mitigate the increased capacity where staffing allows	The service has developed a workforce plan to address the gap in recruitment and retention following sign off of the birthrate plus uplift: • 30+ new midwives recruited to start in September - November 2024 • Concentrated efforts on retention within the Midwifery profession • Escalation of challenges in relation to OOA and LSCS increased capacity.	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
There were 8 incidents reported to the HSE in September under RIDDOR. Two of these were reported as dangerous occurrences under RIDDOR (exposures to harmful substances (needlestick injuries)) and 6 were slips, trips and falls, of which two resulted in a specified injury (fracture) and 4 resulted in a member of staff being off for more than 7 days and were therefore reported as injuries. No RIDDOR reportable incident related to patients, all were staff related.	There are no emerging concerns relating to these incidents. Each incident was investigated locally with assistance from the Health and Safety Team as required. Local actions are put in place to avoid other similar incidents. The Slips, Trips and Falls happened in various locations across the trust and are not linked. The Health and Safety team have been working with Occupational Health to build a system that effectively reports exposures to harmful substances. This is the first month that this system has come into effect and demonstrates that the system is now working. The H&S team will continue to monitor slips, trips and falls and report if a trend is spotted.	Incidents reported under RIDDOR are reported to the H&S Committee and Falls Prevention Group.		**Sufficient**

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

Oxford University Hospitals NHS Foundation Trust

Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level. It is an NHSE requirement for this to be reviewed by Trust Boards each month. The 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 September 2024. The Trust-wide planned versus actual fill rates were 82.55% during the day and 88.95% 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 shifts were not 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 with the Lead Nurse for Nursing & Midwifery Staffing Regulation , the DDN and the Deputy Chief Nurse. The review aimed to triangulate all data in line with National Quality Board standards and determine whether these harm indicators were linked to staffing. Following the review, all divisions have confirmed that there were no instances of harm related to nurse or midwifery staffing levels in September.

SUWON – CHPPD for Katherine House is due to the small bed capacity and requirement for nurse- to -patient ratios to remain safe. Gynae CHPPD is under review, as day case patients are often cared for by ward team, however, day case patient numbers are not captured as the patients are discharged before the patient data is captured at midnight.. Roster efficiencies and staff retention KPIs have been flagged to the DDN and will be monitored with increased oversight.. All areas were safely staffed in September, using temporary workforce when appropriate.

Maternity – The service is aligning with the Birthrate+ numbers, and efforts are ongoing to ensure these are reflected in the budgets. Since the revised staffing numbers have not yet been incorporated into the budget at the time of reporting, the vacancy data does not fully represent the current situation, and the budgeted CHPPD is less than required, therefore the actual CHPPD will appear higher than budget at times to accommodate safe staffing in the clinical areas. The Deputy Chief Nurse for Workforce is working with the service on the implementation of a proactive recruitment and retention campaign and trajectory to reduce midwifery vacancies. The 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.
Upon review, The Spires roster template was found to be inaccurate for this period. The template has been adjusted to be effective from October the roster. No harms were due to staffing, harms detail can be viewed outside of the staffing report within the relevant section of the IPR. All areas were safely staffed in September.

MRC –Actual CHPPD for CMU wards appears lower than required for September. Following validation with the DDN, this appears to be due to supernumerary workers who were physically moved to support safety, not being moved electronically on the system and therefore the actual CHPPD appears lower than it was. There was no escalation of unsafe shifts and senior nurse visibility and oversight of all areas during September to ensure awareness following temporary staffing reduction of safety. MRC continued to experience high levels of sickness, across both the JR and Horton sites. Roster efficiencies and performance is very good. All areas were safely staffed in September.

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

NOTSSCAN – Paediatric Critical Care Unit (PCCU) has an extraordinarily high number of CHPPD. During this period, the PCCU relocated to the Oxford Critical Care Unit building. To facilitate the move, the number of planned elective patients was reduced, therefore requiring less staff to provide direct care. However, extra staff were on duty to physically move and set up equipment from the old to new locations. This process took approximately one week. These staff members have been captured in the CHPPD but were not providing direct care. Roster efficiencies and KPI adherence is closely monitored by the DDN, some areas were not approved for payroll. This was an oversight by two Matrons who were on leave and study time. This is not a theme for these Matron's. Kamrans' ward reports a high number of overworked hours, however, this relates to one student (hours not yet corrected) and one substantive staff member, for which a plan will be discussed.

CSS – JR ICU – New senior leadership are engaged to review the CHPPD budget and roster, as budgeted CHPPD appears high, however, this is in part due to staffing 2 floors in one unit with an additional unit on another site. Actual CHPPD does not align with budgeted as was not required at that high level in September with beds remaining closed and not all patients were critical care level 3 patients requiring 1:1 nursing, which is incorporated in the budget. There is now a twice daily review of staffing to ensure appropriate senior cover is available across the two sites. All areas were safely staffed in September.

Nurse Sensitive Indicators
Of the 116 Medication incidents reported, 71 pressure ulcer incidents and 152 falls reported, the DDN's have confirmed that none of these incidents related to unsafe staffing concerns. Incidents have been reviewed in other forums which are reported within the IPR.

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. There are 8 new starters in the pipeline due to commence between September and December.

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

September	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	9.0	13.0	11.8	98.9%	4	0	0	0	3.8%	11.7%	3.0%	2.7%	6.3%	Yes	1.4%	9.6	12.5%	93.3%
HH Childrens Ward	8.7	9.5	13.2	100.0%	0	0	0	0	-2.4%	3.0%	3.4%	4.0%	1.7%	Yes	-0.6%	8.4	14.4%	92.5%
Kamrans Ward	10.2	10.9	10.5	100.0%	3	0	0	0	0.2%	0.0%	1.1%	0.0%	0.2%	Yes	-6.9%	8.4	15.0%	100.0%
Melanies Ward	11.5	10.2	10.3	100.0%	1	0	0	0	-19.7%	7.7%	3.0%	3.5%	15.4%	Yes	0.3%	10.9	12.8%	92.9%
Robins Ward	10.7	11.6	13.4	98.9%	3	1	0	1	15.7%	16.2%	3.3%	3.4%	21.4%	Yes	1.1%	10.0	11.1%	87.5%
Tom's Ward	8.1	9.4	9.9	100.0%	4	0	0	0	-19.7%	5.8%	2.6%	4.4%	12.4%	Yes	0.1%	10.3	12.6%	97.3%
Neonatal Unit	19.4		37.0		4	1	0	0	12.7%	7.9%	6.6%	3.9%	18.8%	Yes	-3.1%	9.7	14.6%	
Paediatric Critical Care	24.5		80.9		9	0	4	0	0.4%	9.0%	4.5%	5.3%	7.9%	Yes	1.0%	10.4	13.6%	
BIU	6.1	6.3	6.6	100.0%	2		0	1	13.2%	11.4%	3.6%	5.8%	18.3%	No	-0.5%	8.3	14.9%	100.0%
HDU/Recovery (NOC)	12.1		21.8		1		2	0	16.4%	9.0%	6.2%	4.6%	20.3%	Yes	0.2%	7.9	12.6%	
Head and Neck Blenheim Ward	7.3	7.5	9.3	100.0%	0		1	0	13.5%	0.0%	5.8%	0.0%	15.3%	No	0.2%	7.7	21.0%	100.0%
HH F Ward	7.7	8.2	7.9	100.0%	0		2	1	-0.1%	6.1%	6.2%	2.1%	4.0%	Yes	-0.8%	8.9	14.2%	95.0%
Major Trauma Ward 2A	9.6	9.9	9.4	100.0%	2		2	3	11.8%	8.2%	3.9%	0.0%	14.8%	Yes	3.3%	8.1	13.0%	100.0%
Neurology - Purple Ward	9.0	9.9	8.4	100.0%	0		1	4	3.3%	3.2%	5.3%	0.0%	6.2%	Yes	0.8%	9.6	12.7%	100.0%
Neurosurgery Blue Ward	8.9	10.5	9.2	100.0%	2		0	3	12.9%	5.9%	4.4%	2.3%	14.9%	Yes	1.9%	8.6	14.9%	94.7%
Neurosurgery Green/IU Ward	11.8	9.9	9.7	100.0%	0		0	2	3.3%	0.0%	3.6%	0.0%	5.1%	Yes	3.2%	8.9	15.0%	100.0%
Neurosurgery Red/HC Ward	12.8	12.1	12.2	100.0%	2		0	5	-2.6%	8.1%	5.0%	1.0%	2.6%	Yes	0.2%	9.3	12.9%	96.6%
Specialist Surgery I/P Ward	8.5	6.5	8.7	100.0%	3		0	6	12.2%	9.1%	3.3%	4.6%	16.3%	No	0.6%	8.4	12.6%	85.7%
Trauma Ward 3A	9.2	8.7	8.7	100.0%	3		4	2	3.9%	8.7%	3.6%	3.1%	8.7%	Yes	2.5%	8.1	11.9%	88.9%
Ward 6A - JR	7.4	6.5	8.0	96.7%	3		4	2	9.5%	8.8%	2.7%	0.0%	9.5%	No	0.0%	8.6	10.8%	94.7%
Ward E (NOC)	6.3	7.6	7.2	95.6%	0		0	0	13.6%	8.1%	6.7%	0.0%	17.0%	No	1.2%	8.0	10.8%	100.0%
Ward F (NOC)	6.7	8.1	8.6	84.4%	2		1	2	10.6%	7.8%	4.9%	5.7%	15.6%	No	1.8%	8.9	13.1%	100.0%
WW Neuro ICU	26.1		26.6		4		0	0	17.1%	12.3%	3.7%	1.1%	19.5%	Yes	-2.7%	7.9	11.8%	

NB. HH Children's Ward and HDU/Recovery NOC data excluded as currently under review

Key to colour formatting: Any indicator meeting or not meeting the target is clearly indicated (Red or green). For indicators without targets, the performance indicator is formatted to help focus readers' attention on the range of variation between indicators and to easily identify outliers.

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

Oxford University Hospitals NHS Foundation Trust

September	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	8.9	8.4	8.2	100.0%	0		1	5	-10.5%	6.5%	3.6%	1.8%	-4.4%	Yes	-0.1%	8.6	11.7%	100.0%
Ward 5B SSW	8.9	9.3	8.2	100.0%	1		0	4	10.7%	12.1%	4.0%	4.6%	16.1%	Yes	0.9%	8.4	13.3%	
Cardiology Ward	7.9	6.8	6.7	100.0%	0		2	4	8.4%	16.5%	4.2%	1.3%	10.6%	Yes	3.6%	8.3	13.2%	95.5%
Cardiothoracic Ward (CTW)	7.8	7.5	6.0	95.6%	2		0	8	6.9%	6.5%	2.3%	7.0%	13.4%	Yes	-1.2%	8.6	12.6%	100.0%
Complex Medicine Unit A	8.9	11.1	8.4	95.6%	1		1	2	0.1%	10.0%	5.6%	9.6%	13.6%	Yes	1.5%	7.6	11.4%	100.0%
Complex Medicine Unit B	10.2	10.1	8.7	100.0%	0		3	1	-1.2%	9.5%	2.8%	6.4%	7.7%	Yes	1.8%	7.9	14.5%	100.0%
Complex Medicine Unit C	8.8	10.6	8.6	100.0%	1		2	3	3.2%	11.5%	2.3%	0.0%	3.2%	Yes	-0.1%	8.9	11.9%	97.3%
Complex Medicine Unit D	9.5	8.2	8.3	96.7%	0		0	3	8.4%	10.5%	6.3%	0.0%	18.8%	Yes	4.1%	8.4	12.9%	
CTCCU	21.9		24.2		1		1	0	9.5%	9.7%	3.6%	4.7%	18.1%	Yes	-0.5%	10.4	14.6%	
Emergency Assessment Unit (EAU)	8.5	8.9		85.6%	6		0	9	8.1%	7.4%	4.5%	4.1%	13.5%	Yes	1.1%	8.6	14.0%	
HH EAU	9.8	6.8		86.7%	2		0	8	-1.6%	7.4%	4.7%	3.4%	3.0%	Yes	-0.1%	8.7	12.7%	
HH Emergency Department	22.8				3		0	2	11.2%	8.1%	3.8%	6.6%	18.3%	Yes	-1.2%	9.7	13.7%	81.0%
JR Emergency Department	17.7				9		0	6	22.1%	14.6%	4.6%	3.5%	26.7%	Yes	15.4%	7.9	14.5%	75.9%
HH Juniper Ward	8.1	10.0	8.0	100.0%	0		4	5	0.7%	3.4%	4.5%	1.0%	5.1%	Yes	-2.0%	8.9	13.8%	50.0%
HH Laburnum	9.6	8.6	8.4	100.0%	1		1	5	2.2%	5.9%	7.4%	5.9%	11.3%	Yes	0.7%	8.7	15.2%	52.9%
HH Oak (High Care Unit)	10.1		11.6	94.6%	1		4	2	2.6%	7.6%	5.4%	5.3%	10.3%	Yes	4.1%	8.7	14.1%	
John Warin Ward	10.1	8.6	9.0	97.8%	0		1	1	0.7%	7.9%	3.7%	4.8%	8.9%	No	-0.3%	6.9	13.0%	96.7%
OCE Rehabilitation Nursing (NOC)	10.4	10.1	10.3	100.0%	0		0	0	0.8%	4.7%	5.3%	4.7%	7.1%	Yes	-0.9%	8.6	13.6%	50.0%
Osler Respiratory Unit	14.4	10.2	12.6	100.0%	1		2	1	6.4%	5.6%	4.2%	1.3%	8.4%	Yes	-0.7%	8.3	13.9%	56.3%
Ward 5E/F	12.0	9.1	9.9	94.4%	0		0	6	21.6%	12.3%	3.5%	6.0%	26.3%	Yes	3.3%	9.4	10.6%	50.0%
Ward 7E Stroke Unit	10.9	8.5	8.9	100.0%	1		0	7	-4.5%	15.5%	4.7%	5.2%	2.5%	Yes	3.4%	8.6	10.0%	

Key to colour formatting: Any indicator meeting or not meeting the target is clearly indicated (Red or green). For indicators without targets, the performance indicator is formatted to help focus readers' attention on the range of variation between indicators and to easily identify outliers.

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

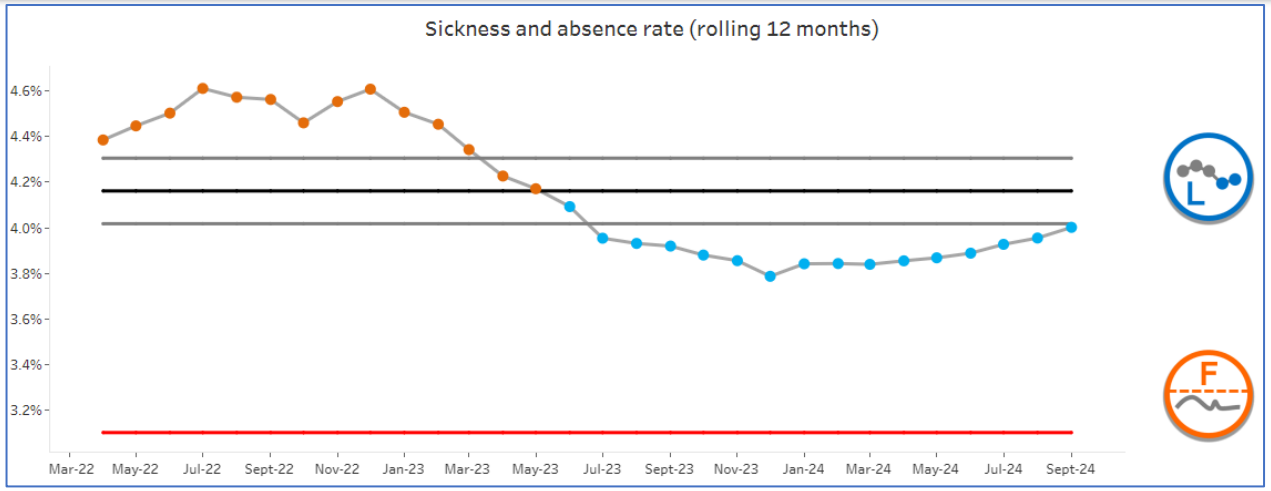
Oxford University Hospitals NHS Foundation Trust

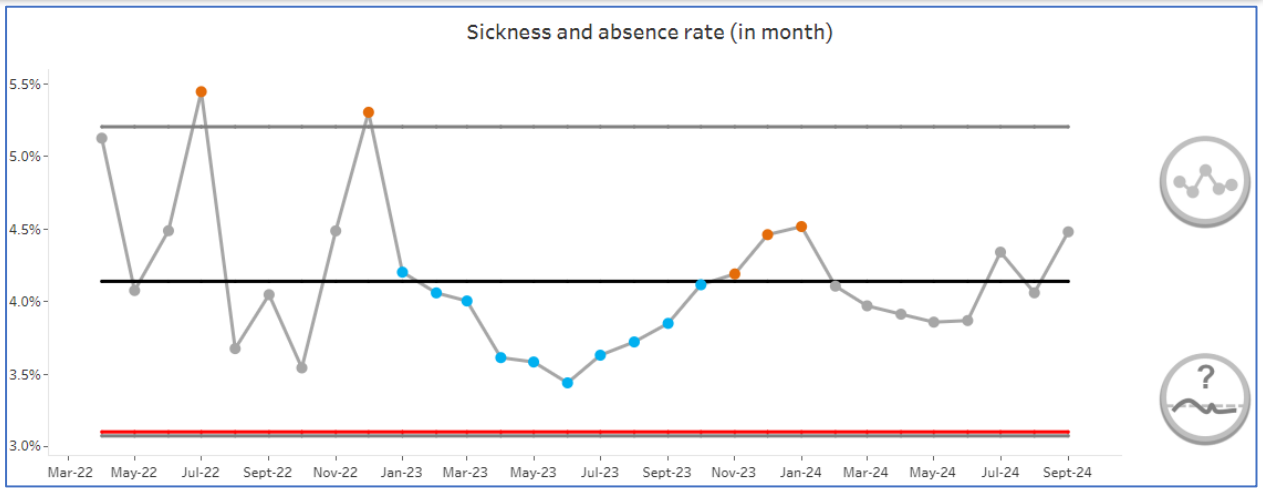
September	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	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	6.3	7.6	96.7%	2		2	5	7.1%	7.6%	3.6%	4.9%	14.2%	No	-2.6%	8.4	6.6%	94.4%
Gynaecology Ward - JR	6.0	5.9	7.9	97.8%	0		0	2	11.6%	2.5%	6.1%	0.0%	11.6%	Yes	34.8%	8.4	13.7%	100.0%
Haematology Ward	6.9	7.5	7.8	100.0%	1		0	4	17.7%	14.3%	4.8%	0.0%	20.4%	Yes	3.8%	4.3	12.6%	100.0%
Katharine House Ward	9.2	7.9	9.7	98.9%	1		2	2	10.8%	7.9%	6.0%	4.5%	14.8%	Yes	4.6%	8.3	13.7%	
Oncology Ward	8.7	7.7	7.6	96.7%	6		4	8	22.0%	2.8%	2.7%	5.7%	28.7%	Yes	-0.2%	8.9	13.4%	100.0%
Renal Ward	9.3	8.3	9.4	98.9%	0		0	3	8.6%	3.2%	5.4%	9.9%	20.6%	Yes	0.1%	8.7	14.5%	100.0%
SEU D Side	8.7	7.9	8.6	100.0%	5		2	3	23.4%	0.0%	5.7%	4.7%	28.7%	Yes	-0.4%	8.4	10.2%	97.9%
SEU E Side	8.4	8.4	9.1	100.0%	0		3	1	16.5%	7.2%	3.0%	0.0%	16.5%	Yes	0.2%	8.4	11.4%	97.0%
SEU F Side	7.5	8.1	8.0	100.0%	1		5	0	37.6%	20.2%	2.6%	0.0%	37.6%	Yes	-11.8%	8.4	10.7%	89.9%
Sobell House - Inpatients	8.7	7.7	7.9	97.8%	6		5	5	35.0%	10.1%	5.0%	0.0%	35.0%	Yes	-8.5%	8.4	15.1%	
Transplant Ward	9.4	8.6	10.6	100.0%	2		1	1	20.2%	6.4%	4.5%	3.2%	25.3%	Yes	-0.8%	9.0	14.1%	97.0%
Upper GI Ward	9.7	6.9	8.3	94.4%	2		1	1	20.9%	2.8%	4.9%	15.4%	35.3%	Yes	-7.3%	8.3	13.1%	100.0%
Urology Inpatients	8.8	9.3	9.3	98.9%	0		0	1	31.2%	3.7%	2.4%	3.8%	38.0%	Yes	-2.4%	8.6	12.2%	97.8%
Wytham Ward	7.7	6.7	7.6	100.0%	1		0	2	5.1%	3.2%	5.0%	2.9%	10.5%	Yes	-1.0%	8.3	13.7%	84.8%
MW Delivery Suite	15.2		18.5						-5.0%	17.9%	5.1%	5.0%	3.0%	Yes	-1.8%	7.3	8.9%	
MW Level 5	6.7		5.6											Yes	-0.3%	7.3	11.2%	
MW Level 6	4.5		6.0											No	-0.6%	7.3	9.7%	
CSS																		
JR ICU	34.5		26.7		7		4	0	18.8%	9.7%	5.5%	6.0%	25.7%	Yes	-0.5%	7.1	11.9%	

NB. MW The Spires data excluded as currently under review

Key to colour formatting: Any indicator meeting or not meeting the target is clearly indicated (Red or green). For indicators without targets, the performance indicator is formatted to help focus readers' attention on the range of variation between indicators and to easily identify outliers.

3. Assurance report: Growing Stronger Together



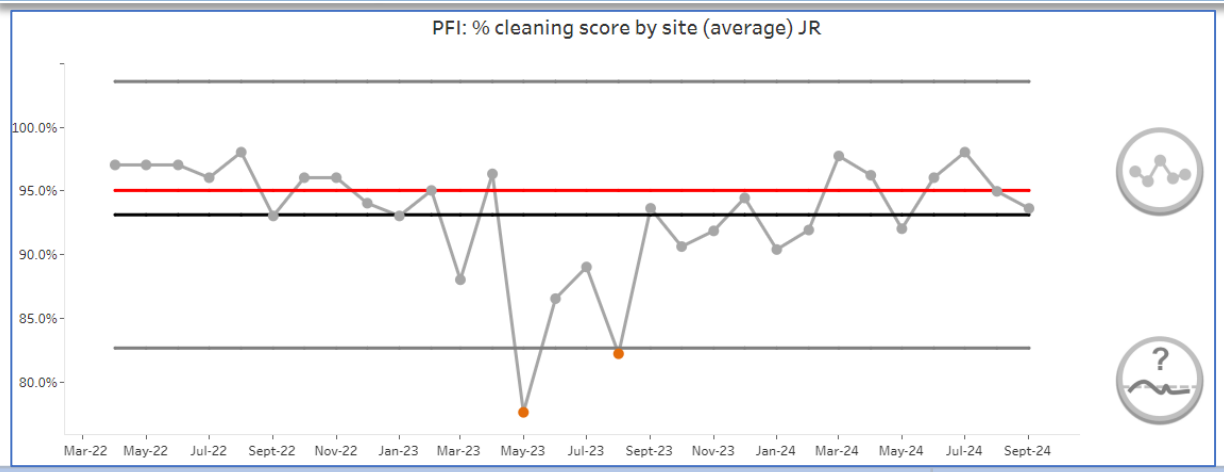


Benchmarking: June 24 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 3.8% **National: 4.9%** **Shelford: 4.5%** Buckinghamshire Healthcare NHS Trust: 3.7% Royal Berkshire NHS Foundation Trust: 3.7% Oxford Health: 4.4% South Central Ambulance Service: 6.1%

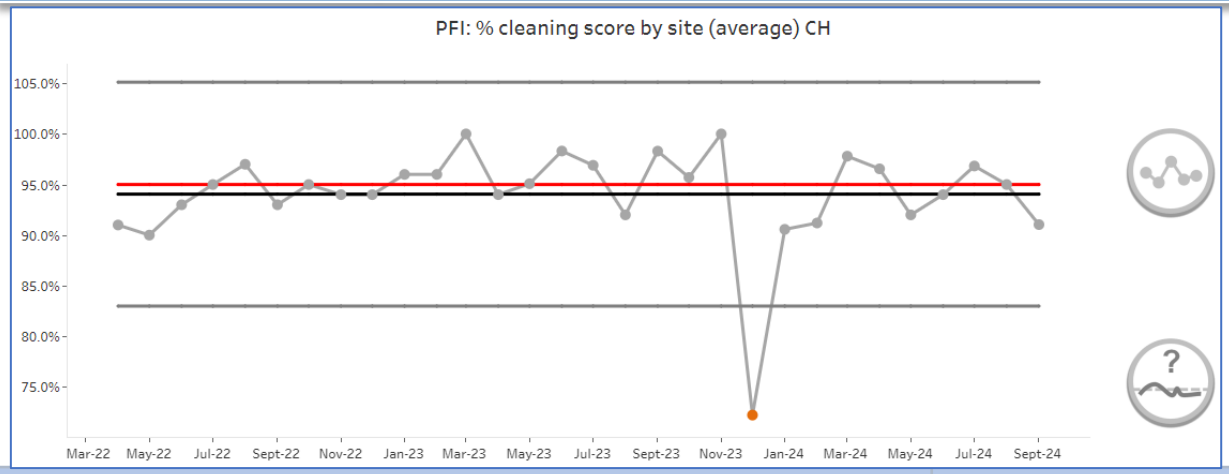
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Sickness absence performance (rolling 12 months) was 4.0% in September with a marginal increase in month from 3.9% and had previously remained static since April. Performance exhibited special cause variation performing just below the lower control limit. This indicator had generally been on a downward stable trend and had been reducing every month since the last quarter of 2022/23. It is now tracking upwards with this month showing a small increase of 0.1%. In month figure was 4.5% in September with an in month increase from 4.3% . This is no one single absence reason accounting for sickness within the Trust. No one absence reason accounts for the change, although the top 5 absence reasons have increased to varying degrees between months (Cold/ flu, Mental Health, Headache/ Migraine, Covid and Gastro). Long term sick as measured by working days lost accounts for 40.8% of absences and has increased by 0.7%.	We are continuing to offer a full range of well-being support including wellbeing, financial, environmental and psychological. This includes stress management and wellbeing training. •A focus on the top CSUs who have a consistent absence. •Collaborative work with Occupational Health to support managers and staff with a review on the top three absence reasons. •A call to action on long term sickness making sure that staff are supported to successfully return to work, •Alerting managers on staff who have triggered, signposting them to support and coaching them through the sickness absence process •HR pro-actively reviewing SAM training content to reflect changes in new policy, to be launched shortly. •HR to work closely with managers to ensure RTW's are completed. •Sickness absence workshops continuing to support managers •Continuation of support from OH colleagues at monthly meetings to unblock issues and support with proactive actions •Monthly meetings with Wellbeing lead in place to identify areas where additional support may be needed.	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: Estates, Facilities and PFI



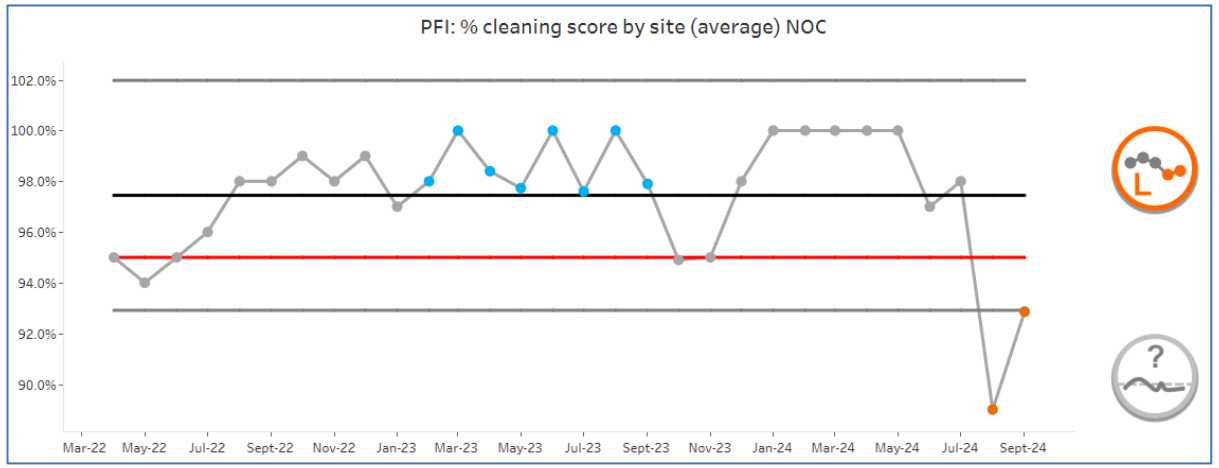
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2024, the combined PFI % cleaning score by site (average) for the JR was 96.13%. Which is a positive increase on August However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 93.59% which is slightly below the 95% Trust target. In total, at the JR, 234 audits were conducted, 15 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 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 along with re training if required, review of cleaning equipment etc.	Mitie completed the planned number of audits at JR in September 2024, and 15 of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. We have seen an increase in clinical failures therefore working closely with IPC and the ward/department leads. 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 JR. 2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Estates, Facilities and PFI



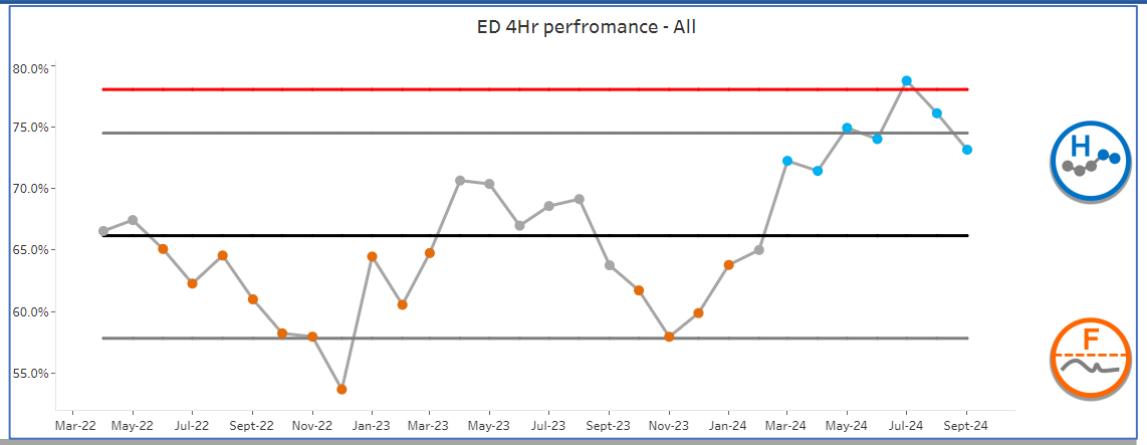
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2024, the combined PFI % cleaning score by site (average) for the Churchill was 94.13%. Which is a positive increase on August However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 91.04% which is slightly below the 95% Trust target. In total, at the Churchill, 67 audits were conducted, 6 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 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 along with re training if required, review of cleaning equipment etc.	G4S unfortunately did not complete the planned number of audits at Churchill in September 2024 – 97 were due and 67 were completed. This was due to staff absence so the focus was on the FR1 and FR2 audits with support of visual audits for the FR4 and FR6 areas. Of the 67 audits completed, 9% of those audits failed to achieve the Trusts 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 the Churchill. 2) Information cascade - Monitoring carried out utilising the My Audit auditing platform, which reports each audit to the PFI management team, area Matron, ward manager and senior housekeeper at the time of completion. 3) Actions reviewed weekly at the service providers/Trust PFI domestic services meeting, Monthly reporting to HIPCC 4) Review current KPI metrics and align with NSC with redefined metrics clearly set out for ongoing IPR Reports	BAF 4 CRR 1123	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

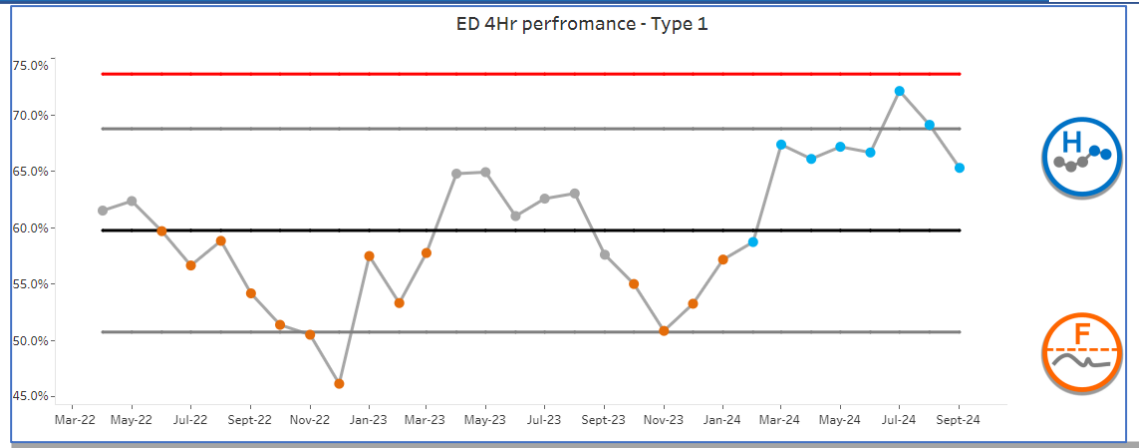
3. Assurance report: Estates, Facilities and PFI



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In September 2024, the combined PFI % cleaning score by site (average) for the NOC was 96.21%. Which is a positive increase on August However, the above graph demonstrates the percentage of total audits undertaken that achieved 4 or 5 stars, which sits at 92.86% which is slightly below the 95% Trust target but an increase on last month. In total, at the NOC, 42 audits were conducted, 3 of which did not meet the 4* requirement during the first round. As a Trust, we strive to achieve a completion rate of 95% for audits that meet or exceed 4 stars every month. However, this is not a nationwide target outlined in the National Standards of Cleanliness 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 along with re training if required, review of cleaning equipment etc.	G4S unfortunately did not complete the planned number of audits at NOC in September 2024. 50 were due and 42 were completed. These were FR4 audits which have a 3 month period so completed in October 24. Three of those audits failed to achieve the set Trust target under domestic and clinical responsibility. However, all the failed audits were rectified within the required timeframe, resulting in an improvement in the reported percentage. We have seen an increase in clinical failures therefore working closely with IPC and the ward/department leads. 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 NOC. 2) Information cascade - Monitoring carried out utilising the My Audits 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: Operational Performance





Benchmarking: ED (All types): September 24

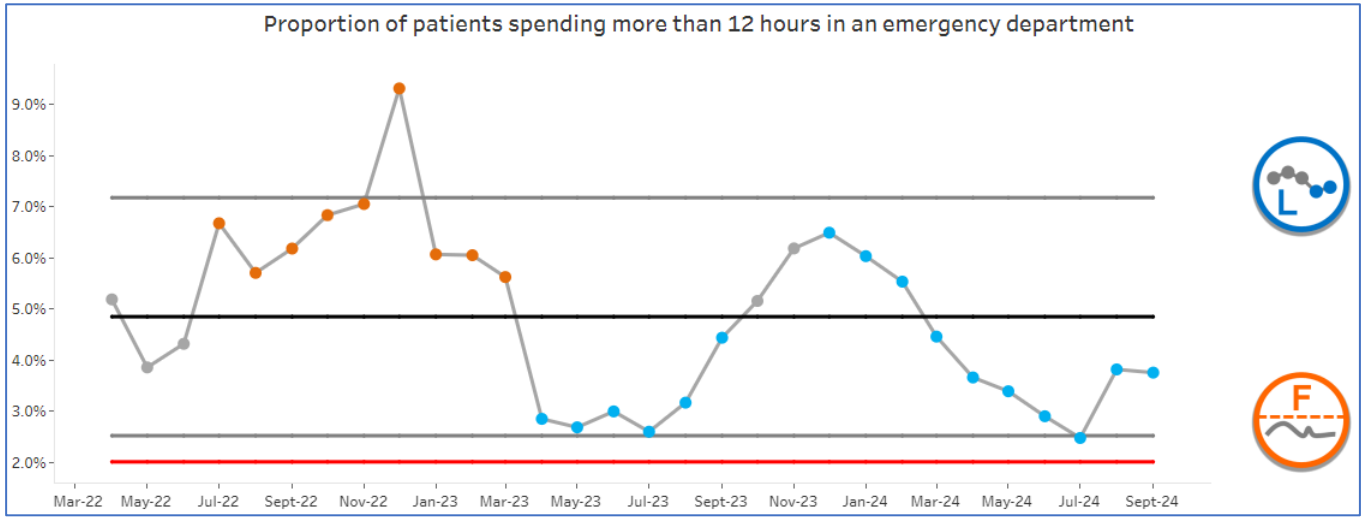
OUH: 73.1% **National: 73.0%** **Shelford: 73.1%** BHT: 70.7% RBH: 71.6%

ICS key

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

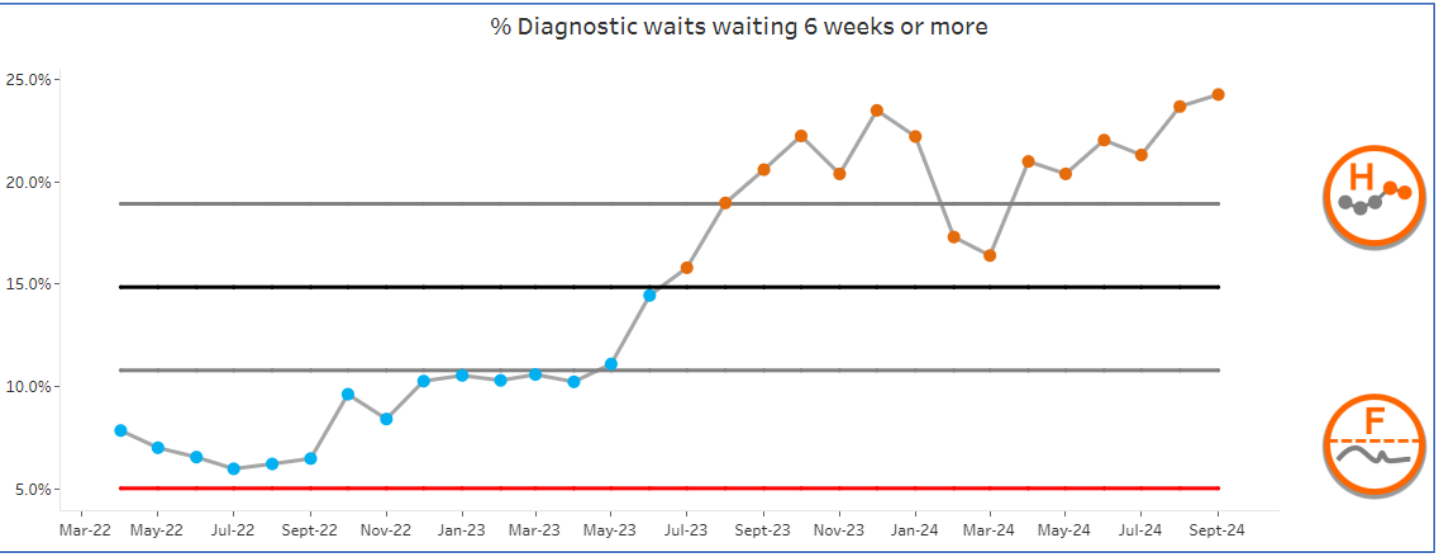
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Emergency Department 4hr performance (all types) was 73.10% in September for the Trust overall. Whilst a deterioration from the previous month, performance remains above trajectory. Type 1 performance was 65.3% for the Trust overall. In comparison, OUH was the best performing Trust for all type performance in BOB ICB and retained its position of second-best performing Shelford Trust for Type 1 performance in September. Breach performance by site was 66.60% for all types and 58.33% for Type 1 at the John Radcliffe Hospital (JR), and 87.41% for all types and 82.36% for Type 1 at the Horton Hospital in September. Monthly attendance had increased this month and were higher in comparison to the same period in 2023/24. Monthly attendance figures have been steadily increasing over the last three years. Wait to be seen continues to be the most significant breach reason on both sites for admitted and non-admitted patients attributing to 62% of all 4-hour breaches in September 2024. 73% of non-admitted breaches were due to wait to be seen which has been slowly increasing. ED Consultant recruitment is underway to support provision of 24/7 senior decision makers within the JR Emergency Department.	**Senior Medical Decision Maker (Consultant) in the JR ED in the overnight period.** • ED workforce models – supported by Trust Management Executive. Consultation complete with existing recruitment underway. • One overnight shift per week covered in October 2024 and increasing to 2 nights in November 2024. In addition, there are now 3 Consultants on duty until midnight. The Urgent and Emergency Care Quality Improvement Programme 2024/25 has been approved by Trust Wide Urgent Care Group and TME. Five key national priorities have been agreed, with the Senior Decision Maker and Rapid Assessment & Treatment / Childrens Urgent Care Pathway priorities commencing in October. The two working groups will launch first with key stakeholders from multidisciplinary teams collaboratively working together to agree aims, performance / productivity metrics and change ideas using QI methodology. The ideas for change will form part of the overall workplan and updates will be provided to the Trust Wide Urgent Care Group every three weeks. The other three working groups will commence in early 2025 with the ability to adapt them to emerging guidance and ensure review of current priorities. Ad-hoc QI support is being provided to other QI initiatives within the Divisions. This will allow scale and spread of improvement at pace with trained QI staff within Divisions being involved and leading improvement initiatives.	Completed - Recruitment approach underway through 2024/25 Quarter 3 & 4 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 the Emergency Department was 3.73% in September. Whilst this is above the target, it is a sustained improvement in performance. The Horton has achieved very well with this indicator with only 0.34% of patients residing in the ED for greater than 12 hours. The JR position was on a par with the previous month at 4.82% in September. The average total length of stay in both ED's rose in September in contrast to a steady decline seen this year. Trust occupancy of General and Acute beds in September had reduced to similar figures seen in July and was 93.65%. This was as a result of the planned summer bed closure programme. SDEC capacity has remained protected, with just one occasion of overnight opening on 23 September. This was due to very high attendances (higher than the 12 week and Monday averages) and conversion rate to admission. Protecting SDEC capacity remains a focus of the Trust's Winter Plan. The ED Conversion rate to admission rose again for the third consecutive month. This is particularly notable at the Horton which has risen steadily from 20.35% in May to 25.32% in August. The JR was 35.53%. Patients whose discharge was delayed remain a challenge with approx. 2823 bed days lost in September to this cohort of patients. The average number of days delayed was on a par with the previous month. 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 and housing related discharge delays continue to be an area of concern for patients in all Oxfordshire bed bases. Associated with the increase in ED attendances, is the medical and social complexity of patients and the impact of D2A where there is a significant increase in care package size and support required for a person to return home. Average length of stay for non-elective patients who are not delayed has steadily reduced each month from 4.2 days in December 2023 to 3.5 days in September. Additionally, OUH is holding its position as the best performing Shelford Trust for patients with a stay over 21 days.	• The live bed state programme launched in Q3 23/24 with phase 1 successfully implemented across the Trust during Q4. Work continues to finalise plans for phase 2 which is due to launch by January 2025. • Board Round policy relaunched successfully in pilot wards; Trustwide roll-out will be undertaken over the coming months through the Quality Improvement (QI) Standard Work Programme.	Trust Wide Urgent Care Group January 2025 Q3/Q4 2024/25	BAF 4 Link to 1133 (Red)	Sufficient *SOP's are 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*

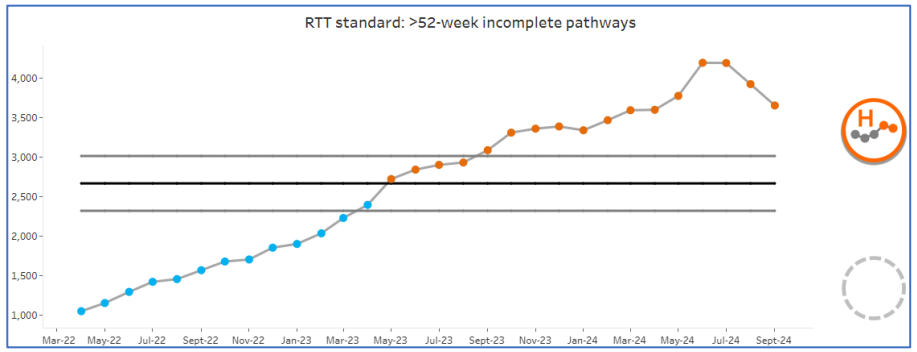


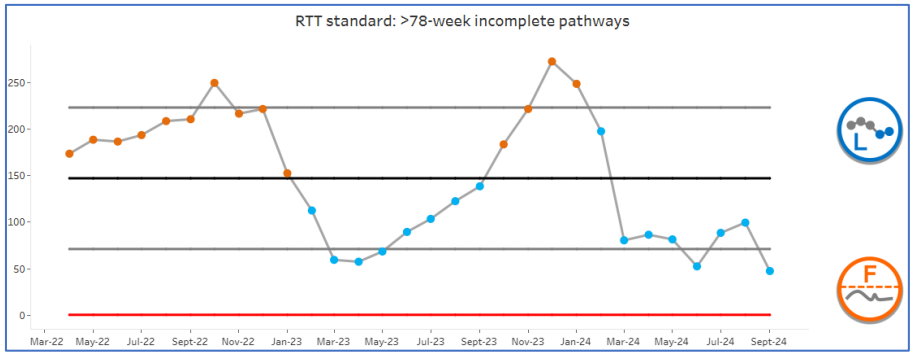
Benchmarking: August 24 DM01	
OUH	23.6%
National	19.4%
Shelford	31.2%
ICS	BHT: 19.8% RBH: 19.6%

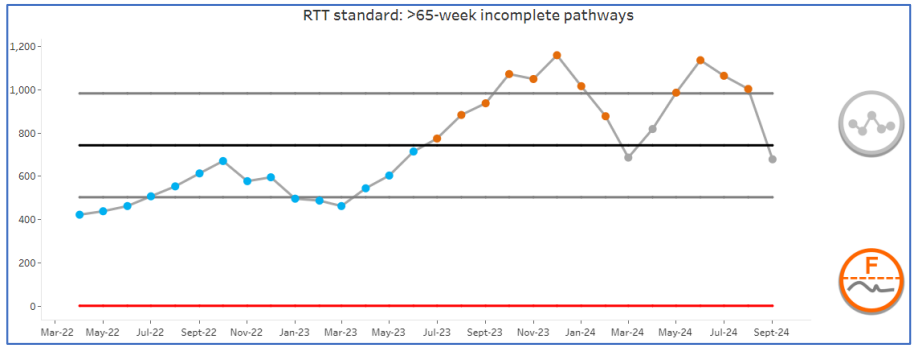
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

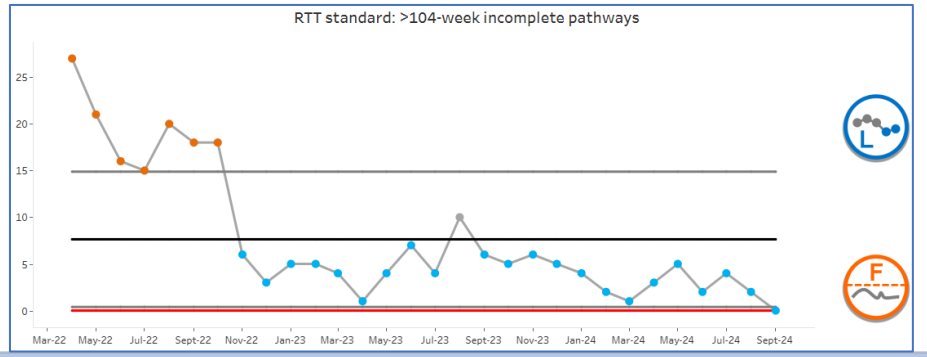
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The percentage of diagnostic waits waiting over 6 weeks+ (DM01) was 24.23% in September. The indicator exhibited special cause 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%. **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:** • Demand and Capacity mismatch by several hundred – backlog was 2,300 patients • ERF scheme to procure additional resource started mid-October to address backlog by March 2025, alongside supporting elective recovery. • AQP pushed back further from July 2024 to now September by Northamptonshire ICB • Seeking mutual aid via DMAS to no avail. • Business Case to merge acute and community paediatric audiology requiring £600k investment to locate an additional hearing booth at HGH site to be ascertained. • Exploring options with Community Diagnostic Centre. Awaiting outcome on site visit. **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 – Briefing Paper completed outlining plan to increase capacity and recover backlog • Weekend lists ongoing although limited uptake over summer holidays • 2 Nurse Endoscopists have commenced training for 12-months • All consultants to do 12-point lists unless a training list • Insourcing and Mutual Aid options are being considered as part of ERF allocation	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Expected to recover standard by March 2025 **Endoscopy:** Expected to recover standard by March 2025	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*







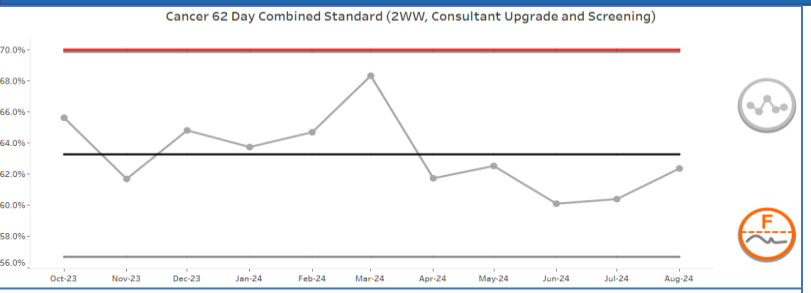


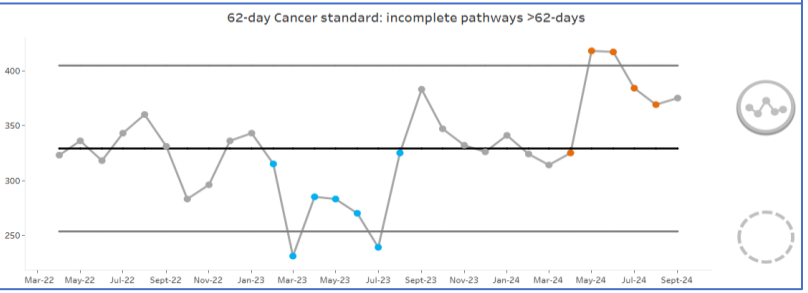
Benchmarking >52-weeks: August 24	
OUH	3,911
National	1,508 (avg.)
Shelford	3,859 (avg.)
ICS	BHT: 3,911 RBH: 71

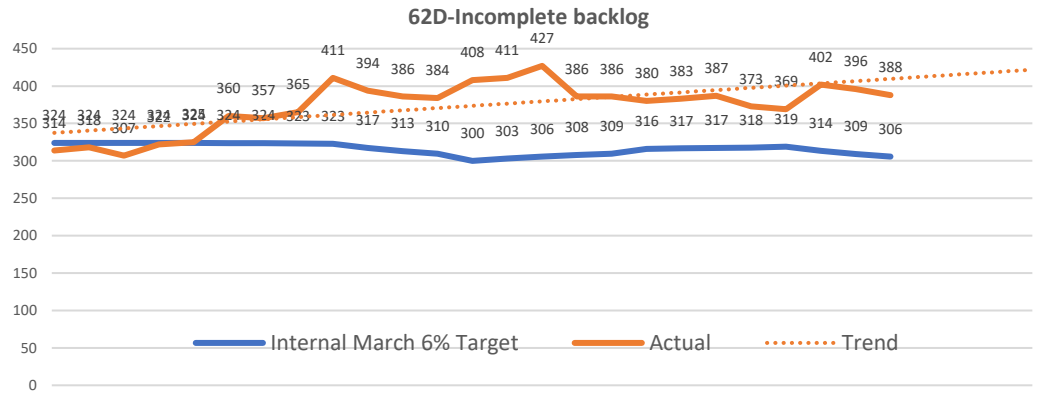
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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 3,646 at the end of September. 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** - nil incomplete pathways reported **78 weeks** - **47** incomplete pathways of which 36 were due to capacity, 4 due to Patient Choice reportable (C1), and 7 due to Complex pathways **65 weeks – 677** incomplete pathways reported which is a decrease from the previous month by 325 pathways. Focus remains in place to deliver nil pathways beyond 65-weeks. Services not as challenged are undertaking recovery of **52-week backlog.**	• **Orthopaedic services** contracts in place with several Independent Sector Providers. • **Spinal services** contracts to Independent Sector Providers at The Portland and Royal National Orthopaedic Hospital are in place and working well. • **Plastic services** are discussed at System level; Regional support in place seeking Mutual Aid within Region. Transfer of H2 1st outpatients willing to travel to BOB partners is completed. Exercise begun for admitted pathway. • **Gynaecology, Urology & ENT services** have transferred H2 1st outpatients willing to travel to BOB partners. Extended theatre sessions in place. Patient Engagement and Mutual Aid exercise begun for admitted pathway. • **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 Elective Care Recovery Group. • **Anaesthetic services** are supporting an increase in 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. Phase 2 completed, which includes contacting booked patients in the future to be offered an earlier date at BOB Partner providers. PDSA cycle underway to improve process and scale across all areas. Patient Engagement and Mutual Aid exercise begun for admitted pathway.	Delivery of 65-week plan by December 2024 (indicative) 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*







Benchmarking: August 24 62-day General Standard	
OUH	62.4%
National	71.7%
Shelford	61.8%
ICS	BHT: 65.6% RBH: 74.8%

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

Summary of challenges and risks

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 62.4% in August 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 Breast, Children, Haematology – non-Acute Leukaemia, Skin, and Urological – Testicular are non-compliant for this standard in August.

Challenges identified:
- Complex tertiary level patients (7%)
- Some slow pathways and processes (3%)
- Capacity for some surgery, diagnostics and oncology (72%)
- Late inter provider transfers (17%)
- Patient reasons (1%)

>62-day combined PTL as at 20th October 2024 remains above trajectory of delivering 6% proportion of long waits.

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

The Cancer Improvement Programme is focussing on 28-day Faster Diagnosis Standard (FDS). For August , **the Trust reported 79.0% and has delivered above the 75% standard consecutively since July 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 19/09/2024:
Urology remains the highest deficit to plan for >62-days (115) although seeing a recovery trend – yet remains above trajectory (78). PET PSMA delays contributed to the backlog. Mitigation plan underway leading to a 50% improvement on performance of this pathway. Urology backlog outlined and forecast trajectory to be finalised in conjunction with this improvement.
Lung – holds the second highest volume (48) which is above trajectory (36). Additional Bronchoscopy capacity was being identified, reviewing the reconfiguration of JR lists and options for additional capacity at the Churchill site. Productive meeting with higher performing Southampton team to informally peer review and look for opportunities to improve. Locum consultant appointed with start date TBC – this will support weekend thoracic surgery operating.
Gynae – holds the third highest volume (41) and are significantly above trajectory (23). Pilot commenced on extending the benign pre-hysteroscopy clinic to cancer pathways, minimising unnecessary demand on hysteroscopy services and reducing pathway timeline for GA hysteroscopy. Some theatre lists are extended which has shown to improve backlog position. This requires more consistency.

Action timescales and assurance group or committee

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 (309) with 386 patients (11.9% vs 6% target)

Risk Register

BAF 4

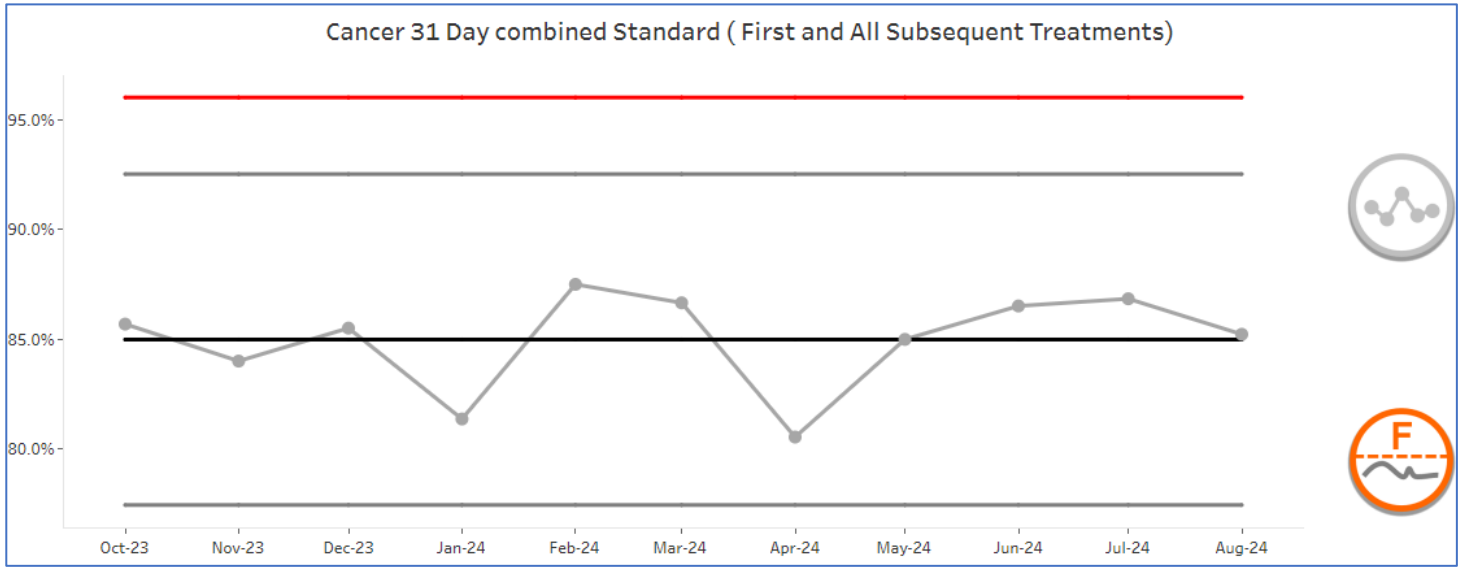
Link to CRR 1135 (Amber)

Data quality rating

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

3. Assurance report: Operational Performance, *continued*

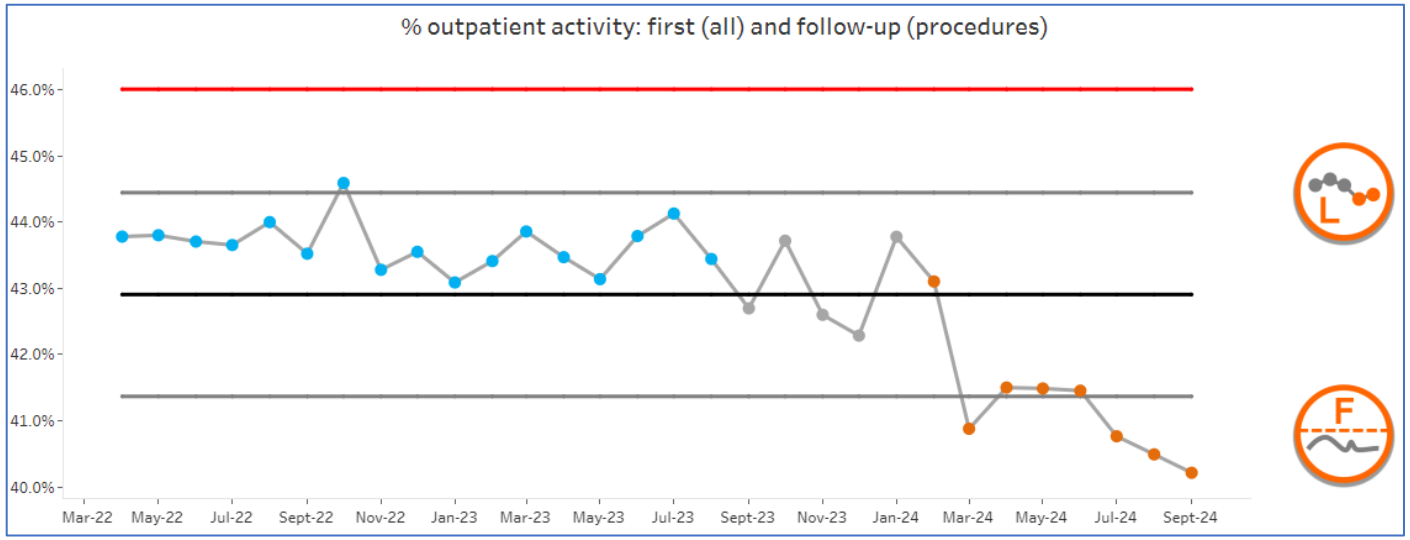


Benchmarking: August 24 31-day General Standard	
OUH	85.2%
National	93.6%
Shelford	87.4%
ICS	BHT: 81.3% RBH: 93.3%

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

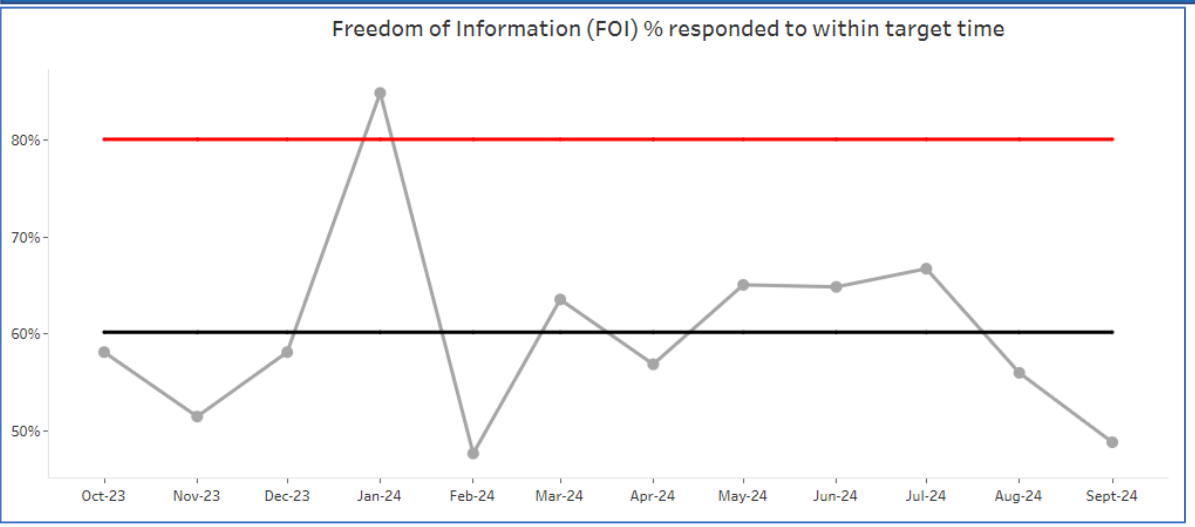
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 85.2% in August, 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 June was 86.5% therefore an improving 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.150 general gynae outpatients transferred between BHT/RBH as a whole pathway. This should release some 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*

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 percentage of first new outpatient and follow-up outpatient appointments with procedures was 40.2% in September. 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%. 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 most recent month's position may increase due to the completion of processing outpatient procedure coding.	Evaluation of individual specialties to optimise outpatient procedure activity by reviewing daycase procedures for conversion to an outpatient setting, releasing theatre capacity as well as modelling a one-stop services in outpatients, thus reducing follow-up activity. Using Model hospital GIRFT procedure specific analysis. The Further Faster Programme cohort 3 commenced in May 2024 and features initiatives in association with GIRFT to support this metric. BOB ICB are supporting with data to assist with identifying areas of improvement at specialty pathway level, with best practice from cohorts 1 and 2 being shared across the Trusts. Director of Data and Analytics has reviewed for any patterns or variation to previous year's performance at specialty level. Findings discussed via ECRG and divisional recovery focussed meetings. This will help identify some opportunities. Trust-wide campaign to complete clinic outcomes in a timely manner to be undertaken.	Clinical Operational Forum – June 2024 Outpatient Steering Group - Timescale TBD Data analysis complete. ECRG discussed - July 2024 Agreed via ECRG – July 2024	BAF 4 Link to CRR 1135 (Amber)	

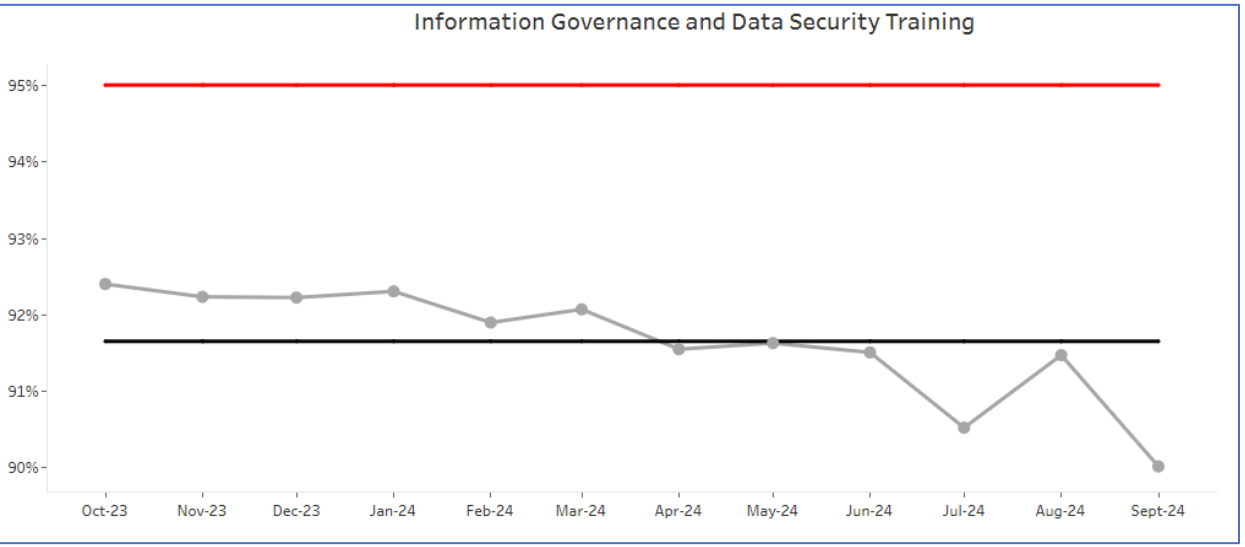
3. Assurance report: Corporate support services - Digital, *continued*



Month	Number of requests received by month	Number of requests closed within 20 working days	Perecentage of received requests closed within 20 working days
Apr-24	44	25	57%
May-24	60	39	65%
Jun-24	71	46	65%
Jul-24	81	54	67%
Aug-24	59	33	56%
Sep-24	82	40	49%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M6 FOI performance against the 80% target remained below the performance standard at 48% and exhibited common cause variation. An exceptionally high number of 82 cases were received in M6 – 40 were closed on time which is an above average number but the high volume of incoming exceeded the Trust's capacity to return cases on time.	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. This is to be presented at DOC on 4th November IG working with Procurement to generate a publishable list of the software used by the Trust – this will cut down on staff time needed to answer individual granular requests.	DOC has been moved to 4th November – paper on changed distribution/sign off method trialled with Finance to be presented. 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*

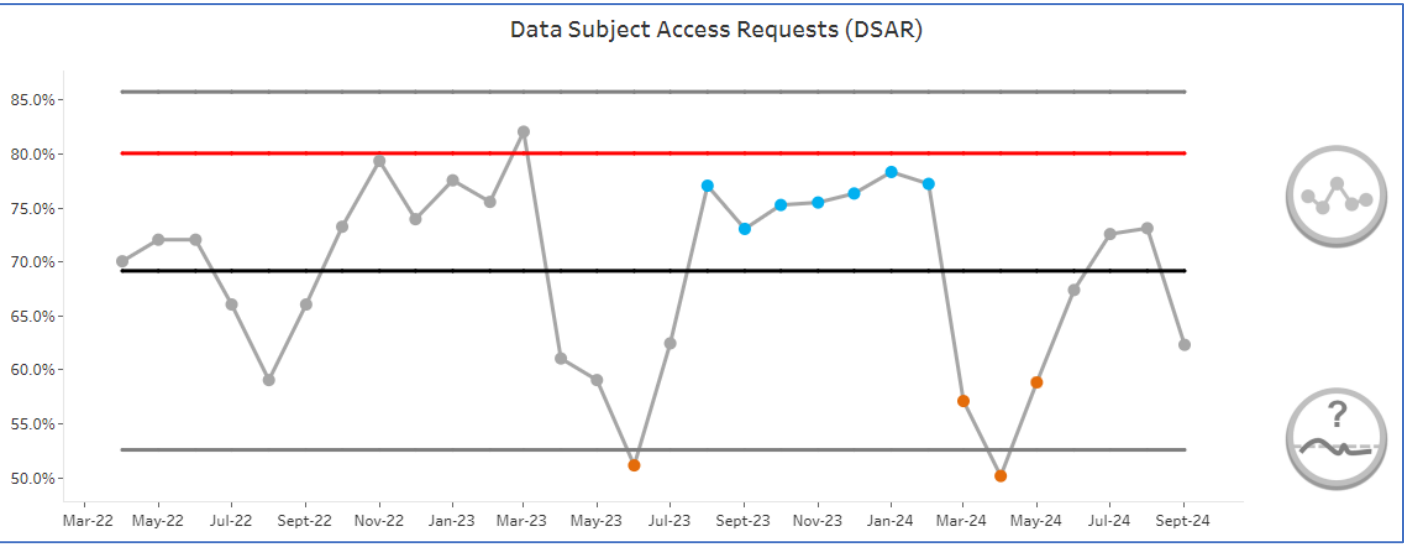
3. Assurance report: Corporate support services – Digital, *continued*



Division	Employees Total Number	Heads Outstanding	% Completed
NOTSSCAN	3667	472	87.10%
Medicine Rehabilitation and Cardiac	3353	335	90.00%
Surgery Women and Oncology	3318	387	88.30%
Clinical Support Services	2390	254	89.40%
Corporate	1009	81	92.00%
Operational Services	208	14	93.30%
Estates	203	29	85.70%
Research and Development	156	19	87.80%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 90.0% in M6 – this is a further fall away from the target of 95%. With the change in calculation method, a breakdown per Division is now available and included at the top of this slide. No Divisions are currently achieving the 95% target.	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 in a communications plan. October is Cyber Security Awareness Month, IG training is mentioned in the campaign materials that have been used. This was added to the Divisional KLOEs to ensure it is managed at a local level in September Targeted messaging of non-compliant staff via their managers continues.	Actions and performance are overseen by the Digital Oversight Committee DSPT Audit has been postponed until November/December as NHSE have not published guidance or audit requirements yet.	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 M6 DSAR performance has improved but not yet recovered to the target performance of 80% of cases closed within 1 month of receipt. Within the main areas responsible for DSAR performance, Occupational Health returned 92% of their 210 requests on time, and Information Governance 66% of their three requests. PACS returned 109 of their 253 requests on time – 43% Subject Access received 486 cases – their highest on record – closing 304 on time consistent with M5 and now their 3rd highest figure on record – resulting in a 62% on time closure rate. As a result overall performance has increased slightly	PACS' situation has deteriorated due to clinical pressures. They also have one staff member on secondment and one vacancy on hold due to recruitment pause. Performance has improved this month due to reduced clinical demand. 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 the expected improvement in 30 day performance in M6 did not occur due to the large overall number of cases received that month.	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