Oxford University Hospitals
NHS Foundation Trust

Integrated Performance Report

M4 (July data)

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

Oxford University Hospitals NHS Foundation Trust

1. Overview of strategic priorities and performance

The month 4 Integrated Performance Report incorporates the key indicators associated with the OUH 3-year plan (2024-2027) and the four strategic pillars for 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. As at M4, the Whole Time Equivalent headcount (excluding R&D) in July was an increase of 4 WTE above June, an overall reduction of 381 WTE since March. The bulk of the reduction has been in temporary staffing (72 WTE agency, 259 WTE bank) and 50 WTE substantive staff. The potential effect on patient care is carefully evaluated by Pay Panels led by Chief Officers and incorporate Quality Impact Assessments (QIAs). Currently the Pay Panels have a circa 80% approval rate.

Income and Expenditure was a £23.8m deficit by Month 4 (year to date) some £5.5m worse than plan, due to industrial action (£2.7m impact) as well as the plan requiring an improvement of £1.8m from the previous month with activity driven income planned to increase while headcount falls. The underlying deficit was £34.3m (year to date) with a deterioration of £1.1m 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 £8.0m at the end of July, £0.4m higher than the previous month but £28.7m worse than plan. The primary driver for cash falling below planned levels is the operating cash deficit being £7.3m worse than plan and a £22.0m deterioration in working capital compared to plan.

In July, our staff supported patient care by meeting targets for the time to hire, non-medical appraisals, core skills and turnover, with core skills and turnover exhibiting improving Special Cause Variation (SCV). Our sickness absence rate, as measuring on a 12-month rolling rate, exhibited improving SCV and we have a lower rate than the National and Shelford averages and the second lowest within the Integrated Care System (ICS).

Measures related to patient safety and experience of care included the achievement of the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). Rates demonstrate fewer patient deaths than expected. Care was also supported by our achievement in targets or thresholds in VTE Risk Assessments and Care Hours Per Patient Day overall. Our learning culture is supported by our Patient Safety Incident Response Framework (PSIRF), which governs how we respond to patient safety incidents for the purpose of learning and improvement, and our Quality Improvement methodology is embedded within the organisation to support the achievement of our Four-Ps.

Pressure Ulcer incidents per 10,000 bed days (Category 2 and 3) were better than the performance thresholds, which is noteworthy given these incorporate new targets in 2024/24 that build in between 20 – 30 percent improvements on last year's targets and/or run-rates. Zero cases were recorded against MRSA and MSSA and there were no Never Events recorded in month. We continued to achieve the target for the percentage of patients with sepsis attending ED receiving timely antibiotics in accordance with NICE guidelines. We achieved our threshold for Safeguarding training compliance for both adults and children (L1-L3), and feedback on our staff experience of care from the Friends and Family Test recorded 95.4% for being likely to recommend in inpatient services, noting that we fell short of the 95% target in both outpatients and ED.

The 4-hour standard for ED (all-types) met the performance target in July, exhibiting improving SCV and showcasing the cumulation of successive achievements. Performance in July was the highest in the ICB and Shelford Group. The Cancer Faster Diagnosis standard achieved the performance standard and, supporting this indicator, the level of diagnostic activity compared to 2019/20 remains above the baseline. Successes raised in Divisional Performance Reviews continue to be recognised, incorporating contributions of our staff in improving the care and experience for our patients, workforce and population. Successes are documented in the summary of the Performance Review meetings and reported to the Integrated Assurance Committee.

Out of the 107 indicators currently measured in the IPR, 30 are reported on in further detail using the standardised assurance templates and are listed in summary on the following page and in further detail within the relevant domain identified in section 3 (Assurance reports). This includes indicators not meeting the performance standard and/or where there has been deteriorating SCV. The review process at Trust Management Executive also enables indicators without a target and not flagging SCV to be included in assurance reporting. Assurance reporting references updates to Tiering requirements for Elective, Cancer and Urgent and Emergency Care. The assurance templates' data quality ratings have been completed and have outcomes ranging from 'satisfactory' to 'sufficient', as per the definitions referenced on page 9.

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

2. Performance challenges: integrated summary of assurance templates

Not achieving target

Special cause variation - deterioration

- Incidents with moderate harm or above per 10,000 beddays
- Number of patient incidents moderate harm or above per 10,000 beddays
- Number of non-patient incidents moderate harm or above per 10,000 beddays
- ED FFT (response rate) & FFT maternity positive (births)
- Maternity FFT (response rate)
- Incident rate of violence and aggression (rate per 10,000 beddays)
- All IG reported incidents
- Vacancy Rate
- % Outpatient activity: first (all) and follow-up (procedures)
- RTT patients > 52 weeks incomplete pathways
- RTT patients > 65 weeks incomplete pathways
- % Diagnostic waits 6 weeks or more
- 62-day Cancer incomplete pathways >62 days

Common cause variation and missed target

- C-diff cases: HOHA+COHA
- Total deliveries in month
- Midwife ratios (birth rate/ staffing level)
- % complaints responded to within agreed timescales
- Reactivated complaints
- Friends & Family test % likely to recommend (OP)
- Cancer 62-Day combined standard (2ww, Consultant upgraded, and screening)
- Cancer 31-day combined standard (first and all subsequent Treatment)
- Data Subject Access Requests (DSAR)
- Sickness and absence rate (in month)

Special cause variation - improving

- Safeguarding (Adults) training compliance L1-L3
- Friends & Family test % likely to recommend – ED
- ED 4hr performance – Type 1
- Proportion of patients spending more than 12 hours in an ED
- RTT Standard: >78-week incomplete pathways
- RTT Standard: >104-week incomplete pathways
- Outpatient follow up attendance activity vs 2019/2020
- Diagnostic activity vs 2019/202
- Turnover rate
- Sickness and absence rate (rolling 12 months)
- Core skills training compliance

Other*

- CQC Overdue Actions
- Safeguarding activity

**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)*

Four Patient Safety Incident Investigations (PSII) were confirmed in July 2024 relating to Obstetrics and Maternity. 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. Within patient safety incidents with moderate harm or above, maternity related incidents and surgical/return to theatre incidents were the most common incident types. Although the indicator exhibited deteriorating special cause variation, this was due to seven consecutive periods above the average, but it was noted that both maternity and return to theatre incidents did decrease in July and the total number of incidents was very close to the average since April 2022. A deep dive review into returns to theatre is being undertaken and will be reported in the M5 IPR.

The midwife to birth ratio did not meet the performance threshold in July. The service has developed a workforce plan to address the gap in recruitment and retention following sign-off of the birthrate plus uplift. Short term initiatives include redeploying other staff from areas to provide support and daily review of risks.

There was one overdue CQC action ('must do') relating one of four points in action six from the Horton Maternity Inspection Report concerning the Trust ensuring effective risk and governance systems are implemented which supports safe, quality care within the midwifery led unit. Challenges relating to delivery and delays are as a direct result of the implementation of a new electronic patient records system, earlier in the year. There is a plan for progress of the dashboard development and a draft dashboard was presented at the August Maternity Clinical Governance Committee.

The PSIRF has been used to review the single pressure ulceration incidents (Hospital Acquired Cat. 4) and clinical Divisions have actions plan as to reduce the overall incidence, and to ensure that there is a cross divisional focus on harm reduction. The organisational work plan will be approved at the August Harm Free Assurance Forum.

C.diff cases were above threshold in July and we recorded five MSSA cases. Both indicators exhibited common cause variation. The antimicrobial stewardship team is continuing to identify areas of high-level Co-amoxiclav usage in SUWON Division.

Violence and Aggression incidents, as well as the related indicator showing non-patient safety incidents with moderate and above harm, continue to be attributed to the clinical condition of the patient and patients lacking capacity. These indicators exhibited deteriorating SCV. Repeating behaviours in, often, a small number of patients result in multiple incidents. It has been identified that the resources available within the Security team are not sufficient to guarantee support due to the number of incidents and time to de-escalate to a safe level. A paper with recommendations to increase Security Officer numbers has been agreed, and funding options are being considered.

The vacancy rate did not meet the performance threshold for July along with staff sickness absence rates (current month and rolling 12-month average). Staff sickness absence is comparatively low compared to other organisations and the rolling 12-month average is exhibiting improving SCV. The common absence reasons include Covid 19, Cold/ flu, Mental Health, and Gastro. Long term sick as measured by working days lost accounts for 40.1% of absences and is broadly unchanged. The increase in the vacancy rate above target and triggering deteriorating SCV was due to an increase in the establishment in month, coupled with a small decrease in the staff in post.

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

- Incidents with moderate harm or above per 10,000 beddays
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Special cause variation - improving

- Safeguarding (Adults) training compliance L1-L3
- Friends & Family test % likely to recommend – ED
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Although feedback from our Friends and Family Test FFT for ED was below target, performance exhibited improving special cause variation and is strongly associated with the improvements in the 4-hour waiting time standard, and patients spending more than 12 hours in ED. FFT performance was below target in outpatients and common themes from comments provided related to concerns about patients' length of time on the waiting list, cancelled procedures and car parking. The waiting time concerns are reflected in the number of long waiting patients on both RTT and cancer pathways.

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 with diagnostic performance. Actions have been outlined for all challenged specialties as well as specialty-wide initiatives, including increases in anaesthetic baseline capacity for theatre lists, adoption of choice guidance and patient engagement validation. Areas of focus within cancer pathways include surgical capacity within theatres, mutual aid for benign general gynae patients, identifying late transfers from other providers and escalation of benign patients awaiting communication. Initiatives to improve productivity are also measured at the Trust's Productivity Committee and theatre utilisation and productivity are a focus of the Theatre Productivity Steering Group (TPSG), chaired by the CMO. There remains a high residual risk related to the achievement of our 78-week, 65-week and Cancer performance trajectory submitted to NHSE. Actions are also in place to review the percentage of outpatient activity that is first or follow up procedures, which is not meeting the performance target.

Alongside the negative comments relating to waiting times, positive themes from FFT feedback reflect the positive experience of care once a patient has been seen, including staff attitude, care and clinical treatment.

Our complaints response time performance and re-activated complaints did not achieve the performance standards in July. A series of robust actions are in place together with a new interactive complaints dashboards to support the oversight and management of the process.

Indicators measuring our Freedom of Information compliance, Information Governance training, Data Subject Access Request response times did not meet performance thresholds, and we reported deteriorating SCV for all IG incidents.

Further information is provided within the templates for each indicator identified for assurance reporting.

2. a) Indicators identified for assurance reporting

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	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:** • C-diff cases: HOHA+COHA • Pressure ulceration incidents per 10,000 beddays (Hospital acquired Cat 4) • Midwife ratios (birth rate/staffing level) • % of complaints responded to within agreed timescales • Reactivated complaints • FFT Outpatient % positive **No target:** • MSSA cases: HOHA+COHA	**Not achieving target:** • FFT ED % positive	**Not achieving target:** • FFT maternity % positive **No target:** • Number of patient incidents per 10000 beddays • Number of Non-patient incidents per 10000 beddays • ED FFT (response) • Maternity FFT (response) • Incident rate of violence and aggression	**No target:** • Adult safeguarding activity • Children's safeguarding activity **Not achieving threshold:** • Non-Thematic Patient Safety Incident Investigations
Growing Stronger Together	**Not achieving target:** • Sickness and absence rate (in month)	**Not achieving target:** • Sickness absence (rolling 12-month)	**Not achieving target:** • Vacancy Rate	
Operational performance	**Not achieving target:** • Cancer 31-day combined Standard • Cancer 62-day combined Standard **No target:** • 62-day Cancer incomplete pathways >104 days	**Not achieving target:** • ED 4-hour performance (type-1) • Proportion of patients spending more than 12 hours in the Emergency Department • RTT patients > 78 weeks • RTT patients > 104 weeks	**Not achieving target:** • % Outpatient firsts and follow-up attendances for procedures **Not achieving target:** • RTT patients > 52 weeks • RTT patients > 65 weeks • % Diagnostic waits under 6 weeks • 62-day Cancer incomplete pathways >62 days	
Corporate Support Services	**Not achieving target:** • Freedom of Information % responded to within target time • Information Governance and Data Security Training compliance **No target:** • Data security & protection breaches • Data Subject Access Requests (DSAR)		**Not achieving target:** • All IG reported incidents	**Not achieving threshold:** • CQC overdue actions

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: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
MRSA cases: HOHA+COHA per 10,000 beddays	Jul-24	0.0	-	-	0.1	-0.4	0.6
MRSA cases: HOHA+COHA	Jul-24	0	0		0	-1	2
C-diff cases: HOHA+COHA per 10,000 beddays	Jul-24	4.7	-	-	3.3	0.6	6.1
C-diff cases: HOHA+COHA	Jul-24	15	9	No	11	2	19
MSSA cases: HOHA+COHA	Jul-24	8	-	-	6	-1	13
Number of Never Events	Jul-24	0	0		0	-	-
Non-Thematic Patient Safety Incident Investigations	Jul-24	4	0	No	2	-	-
VTE- Submitted performance	Jul-24	97.8%	95.0%		98.0%	97.6%	98.4%
% of emergency admissions 65yrs + receiving cognitive screen	Jul-24	53.9%	-	-	57.0%	49.7%	64.3%
% of emergency admissions 75yrs + receiving cognitive screen	Jul-24	71.0%	-	-	76.0%	67.7%	84.2%
% patients with sepsis attending ED received timely antibiotics in accordance with NICE guidelines	Jul-24	91.7%	90.0%		89.9%	-	-
CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jul-24	0	0		0	-	-
Medication incidents causing moderate harm, major harm or death as reported on Ulysses	Jul-24	2	-	-	2	-2	6
Hospital Standardised Mortality ratio	Jul-24	92.2	100.0		92.6	-	-
Summary Hospital-level Mortality Indicator	Jul-24	86.0	100.0		93.1	-	-
Neonatal deaths per 1,000 total live births	Jun-24	1.1	3.2		3.6	-	-
Stillbirths per 1,000 total Live births	Jun-24	3.2	4.0		4.2	-	-
National Patient Safety Alerts not completed by deadline	Jul-24	0	-	-	0	-	-
Potential under-reporting of patient safety incidents: Patient safety incident reporting rate per 10,000 beddays	Jul-24	0.0	-	-	0.0	-	-
Number of active clinical research studies hosted	Jul-24	1472	-	-	1371	1337	1405
Number of active clinical research studies (commercial)	Jul-24	412	-	-	361	347	375
Number of active clinical research studies (non commercial)	Jul-24	1060	-	-	1010	988	1032
Number of incidents with moderate harm or above per 10,000 beddays	Jul-24	48.1	-	-	41.9	25.5	58.3
Number of patient incidents with moderate harm or above per 10,000 beddays	Jul-24	38.6	-	-	37.7	19.7	55.7
Number of non-patient incidents with moderate harm or above per 10,000 beddays	Jul-24	9.5	-	-	4.2	-2.8	11.2
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 2)	Jul-24	18.0	19.0		21.5	9.8	33.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 3)	Jul-24	1.6	2.0		2.2	0.3	4.1
Pressure Ulceration incidents per 10,000 beddays (Hospital acquired Cat 4)	Jul-24	0.3	0.0	No	0.1	-0.2	0.4
Pressure Ulceration incidents per 10,000 beddays (Present on admission Cat 1+)	Jul-24	88.3	-	-	99.0	74.4	123.5
Patient falls (moderate and above) as reported on Ulysses	Jul-24	4	-	-	4	-3	11
Patient falls (moderate and above) as reported on Ulysses per 10,000 beddays	Jul-24	1.3	-	-	1.3	-0.9	3.5

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

Integrated Performance Report (SPC)

Quality, Safety and Patient Experience Summary: All

Latest Indicator Period: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Health and Safety related incidents - Assault, Aggression and harassment	Jul-24	149	-	-	154	72	235
Adult safeguarding activity	Jul-24	1679	-	-	793	519	1066
Children's safeguarding activity	Jul-24	668	-	-	627	326	928
Adult safeguarding activity and Children's safeguarding activity	Jul-24	2347	-	-	1420	984	1856
Safeguarding (Children) training compliance L1 - L3	Jul-24	92.0%	90.0%		87.6%	81.5%	93.7%
Safeguarding (Adults) training compliance L1 - L3	Jul-24	92.0%	90.0%		26.3%	15.6%	36.9%
Total Deliveries in month	Jul-24	618	625	-	618	556	680
Babies born	Jul-24	624	-	-	627	566	688
Maternity Bookings (planned + unplanned)	Jul-24	718	750	-	709	563	855
Inductions of labour from iView	Jul-24	136	-	-	146	112	179
Midwife Ratios (birth rate / staffing level)	Jul-24	26.0	22.9	No	26.1	22.2	30.0
Learning MDT Reviews presented at SLIC	Jul-24	2	-	-	2	-	-
After Action Review (AAR)	Jul-24	15	-	-	14	-	-
Number of complaints	Jul-24	100	-	-	107	56	158
Number of complaints per 10,000 beddays	Jul-24	31.6	-	-	33.5	19.4	47.5
% of complaints responded to within agreed timescales	Jul-24	80.3%	95.0%	No	77.4%	61.7%	93.0%
Reactivated complaints	Jul-24	13	1	No	10	2	18
Number of RIDDORs	Jul-24	3	5		4	-	-
Friends & Family test % likely to recommend - IP	Jul-24	95.4%	95.0%		95.1%	93.9%	96.4%
Friends & Family test % likely to recommend - OP	Jul-24	94.2%	95.0%	No	93.7%	93.0%	94.4%
Friends & Family test % likely to recommend - ED	Jul-24	83.4%	85.0%	No	78.9%	72.8%	85.0%
FFT maternity % positive (births)	Jul-24	0.0%	90.0%	No	85.7%	58.2%	113.1%
Inpatient FFT (Response Rate)	Jul-24	25.6%	-	-	25.3%	21.9%	28.6%
Outpatient FFT (response rate)	Jul-24	6.3%	-	-	7.5%	5.6%	9.4%
ED FFT (Response Rate)	Jul-24	16.5%	-	-	24.6%	19.3%	29.8%
Maternity FFT (response rate; births)	Jul-24	0.0%	-	-	11.2%	2.5%	19.9%
PFI: % cleaning score by site (average) JR	Jul-24	98.0%	95.0%		93.0%	82.2%	103.8%
PFI: % cleaning score by site (average) CH	Jul-24	96.8%	95.0%		94.1%	82.8%	105.4%
PFI: % cleaning score by site (average) NOC	Jul-24	98.0%	95.0%		97.9%	94.3%	101.5%
Incident rate of violence and aggression (rate per 10,000 beddays)	Jul-24	47.2	-	-	48.1	24.5	71.8
Trust level: CHPPD vs budget	Jul-24	-2.5	-	-	-27.1	-69.5	15.4
Trust level: CHPPD vs required	Jul-24	2.1	-	-	-7.1	-26.7	12.6

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

Oxford University Hospitals NHS Foundation Trust

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

Latest Indicator Period: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Vacancy rate	Jul-24	8.3%	7.7%	No	7.1%	6.1%	8.2%
Turnover rate	Jul-24	10.0%	12.0%		11.3%	10.9%	11.7%
Sickness and absence rate (rolling 12 months)	Jul-24	3.9%	3.1%	No	4.2%	4.0%	4.3%
Non Medical Appraisals	Jul-24	93.8%	85.0%		76.5%	40.0%	113.0%
Sickness and absence rate (in month)	Jul-24	4.3%	3.1%	No	4.1%	3.1%	5.2%
Core skills training compliance	Jul-24	92.4%	85.0%		89.9%	87.6%	92.3%
Time to hire (average days)	Jul-24	50.3	53.0		49.8	39.1	60.6

Integrated Performance Report (SPC)
Operational Performance Summary: All

Latest Indicator Period: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Proportion of ambulance arrivals delayed over 30 minutes	Jun-24	7.4%	-	-	9.1%	4.6%	13.7%
Proportion of ambulance arrivals delayed over 60 minutes	Jun-24	0.8%	-	-	1.1%	-0.1%	2.3%
ED 4Hr perfromance - All	Jul-24	78.7%	78.0%		65.5%	57.1%	73.9%
ED 4Hr perfromance - Type 1	Jul-24	72.1%	73.6%	No	59.2%	50.1%	68.2%
Proportion of patients spending more than 12 hours in an emergency department	Jul-24	2.5%	2.0%	No	4.9%	2.6%	7.3%
Proportion of patients discharged from hospital to their usual place of residence	Jul-24	95.6%	-	-	95.0%	94.1%	96.0%
% Diagnostic waits waiting 6 weeks or more	Jul-24	21.3%	5.0%	No	14.2%	10.1%	18.2%
RTT standard: >52-week incomplete pathways	Jul-24	4182	-	-	2582	2264	2901
RTT standard: >65-week incomplete pathways	Jul-24	1063	0	No	735	515	954
RTT standard: >78-week incomplete pathways	Jul-24	88	0	No	152	76	227
RTT standard: >104-week incomplete pathways	Jul-24	4	0	No	8	1	15
Cancer 62 Day Combined Standard (2WW, Consultant Upgrade and Screening)	Jun-24	60.1%	70.0%	No	63.7%	56.2%	71.2%
62-day Cancer standard: incomplete pathways >62-days	Jul-24	384	-	-	326	247	405
62-day Cancer standard: incomplete pathways >104-days	Jul-24	126	-	-	104	72	136
Inpatient Daycase activity vs 2019/20	Jul-24	93.9%	-	-	91.0%	75.0%	107.1%
Inpatient Elective activity vs 2019/20	Jul-24	85.2%	-	-	83.8%	60.0%	107.7%
Outpatient First Attendance activity vs 2019/20	Jul-24	97.8%	-	-	107.5%	83.3%	131.7%
Outpatient Follow Up Attendance activity vs 2019/20	Jul-24	127.2%	-	-	117.7%	92.7%	142.8%
Diagnostic activity vs 2019/20	Jul-24	129.0%	-	-	121.5%	108.1%	134.9%
Cancer First Treatments vs 2019/20	Jul-24	107.7%	-	-	125.6%	84.7%	166.4%
Bed Utilisation General & Acute	Jul-24	93.7%	-	-	95.2%	91.8%	98.6%
Cancer 28 Day combined Standard (2WW ,Breast Symptomatic and Screening Referrals)	Jun-24	81.1%	77.0%		79.0%	72.5%	85.6%
Cancer 31 Day combined Standard (First and All Subsequent Treatments)	Jun-24	86.5%	96.0%	No	84.7%	75.9%	93.5%
% outpatient activity: first (all) and follow-up (procedures)	Jul-24	39.0%	46.0%	No	43.0%	41.2%	44.7%

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: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Adjusted in-month financial performance Surplus/Deficit £'000	Jul-24	-8779.0	-	-	-4535.0	-7354.0	-1716.0
BPPC £ %	Jul-24	70.9%	95.0%	No	87.4%	80.4%	94.5%
BPPC Volume %	Jul-24	50.7%	95.0%	No	75.4%	67.4%	83.4%
Cash £'000	Jul-24	7953	36619	No	36200	11142	61257
Efficiency delivery £'000	Jul-24	5474.9	5660.0	No	5264.6	-1077.5	11606.7
Elective recovery funding (ERF) value-weighted activity % In month	Jun-24	102.4%	107.0%	No	99.5%	88.3%	110.7%
In-month financial performance Surplus/Deficit £'000	Jul-24	-6472.6	-2599.5	No	-1231.6	-11784.7	9321.4
In-month ICS CDEL capital expenditure	Jul-24	165.4	1869.0	-	2383.1	-5663.1	10429.3
Year-to-date financial performance Surplus/Deficit £'000	Jul-24	-23823.0	-18331.3	No	-12776.2	-22608.4	-2943.9

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

Latest Indicator Period: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Information Governance and Data Security Training	Jul-24	90.5%	95.0%	No	91.8%	-	-
Data Security & Protection Breaches	Jul-24	33	-	-	27	8	45
Externally reportable ICO incidents	Jul-24	0	0		0	-	-
All IG reported incidents	Jul-24	38	-	-	29	13	45
Freedom of Information (FOI) % responded to within target time	Jul-24	66.7%	80.0%	No	61.7%	-	-
Data Subject Access Requests (DSAR)	Jul-24	72.5%	80.0%	No	69.2%	52.5%	85.9%
Priority 1 Incidents	Jul-24	0	0		1	-	-

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

Latest Indicator Period: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
Legal Services: Number of claims	Jul-24	31	-	-	19	5	34

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

Latest Indicator Period: Jul-2024

Indicator Description	Period	Performance	Target	Met?	Mean	LCL	UCL
CQC overdue actions ('must do')	Jul-24	1	0	No	0	-	-

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

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

SPC Variation/Performance Icons

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

SPC Assurance Icons

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

OUH Data Quality indicator

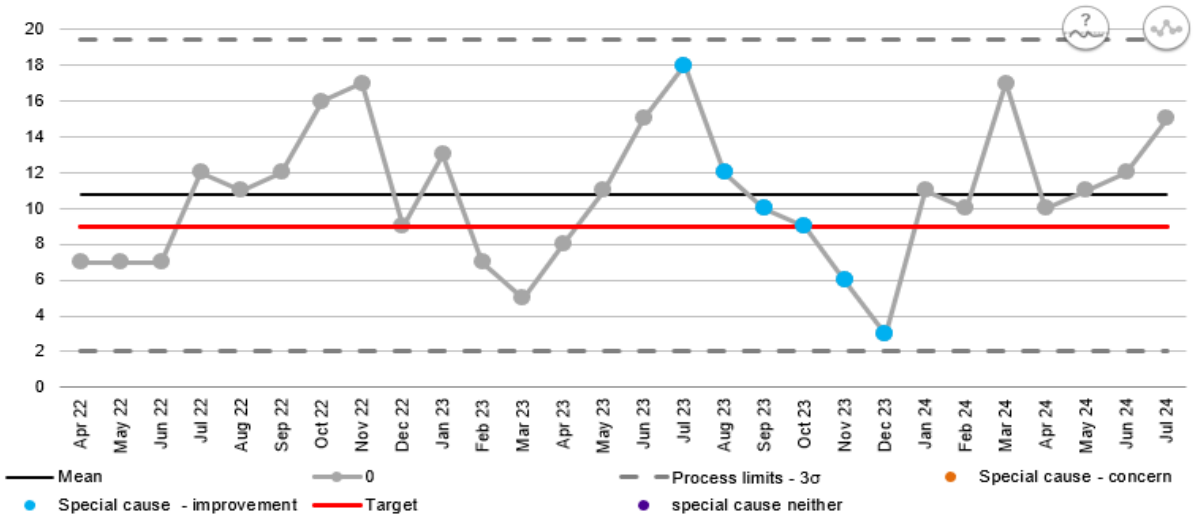
Valid: Information is accurate, complete and reliable. Standard operation procedures and training in place.	**Verified**: Process has been verified by audit and any actions identified have been implemented.	**Timely:** Information is reported up to the period of the IPR or up to the latest position reported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

Sufficient	Satisfactory	Inadequate

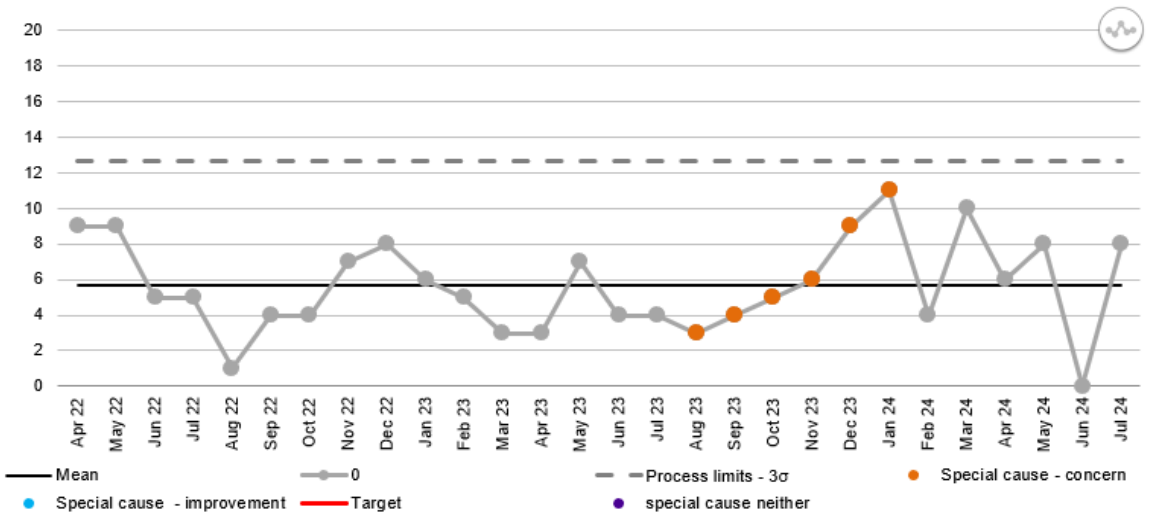
03. Assurance reports

3. Assurance report: Quality, Safety and Patient Experience

C-diff cases: HOHA + COHA- starting 01/04/22

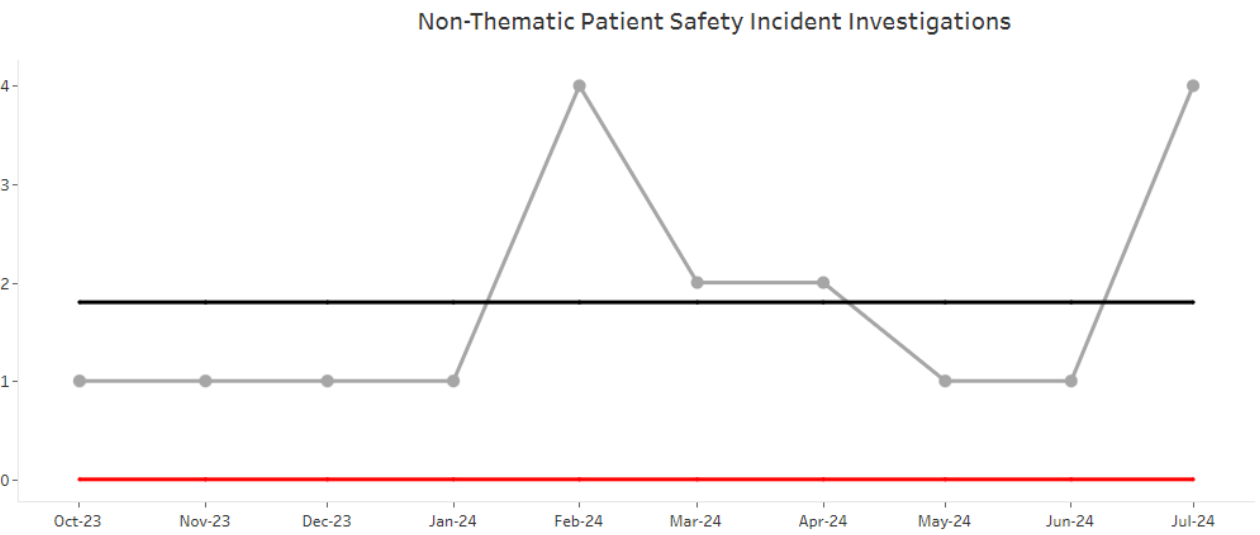


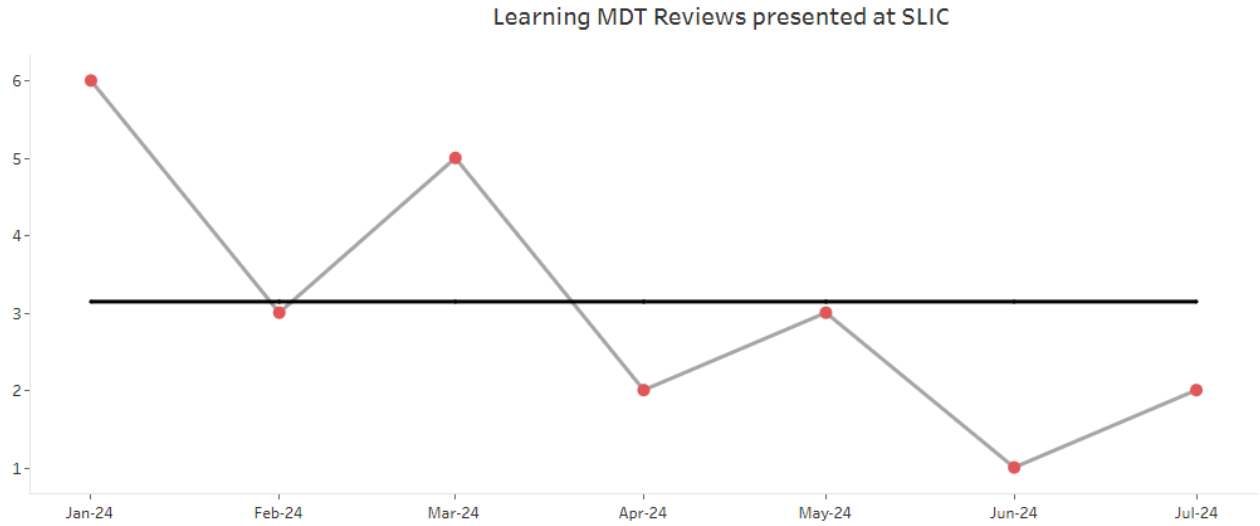
MSSA cases: HOHA + COHA- starting 01/04/22



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
MRSA – no healthcare associated cases in July 2024 **C.difficile** – ten HOHA and five COHA cases in June 2024. This 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) **MSSA** - no healthcare associated cases in June 2024. Five HOHA and three COHA cases in July 2024 **COVID-19** – the number of cases of COVID-19 managed in the Trust was higher than the previous month, and ward-based outbreaks continue to impact on patients, staff, and operational delivery	Work is on-going in the antimicrobial stewardship team to identify areas of continued high-level Co-amoxiclav usage in SUWON Division. IPC nursing staff are working 6-days/week to assist ward staff and operational teams with identification and isolation of COVID-19 positive patients in the Trust. 7-day working is planned to commence in time for the Winter period.	The threshold for 2024/25 is still pending publication for C. diff cases. 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*

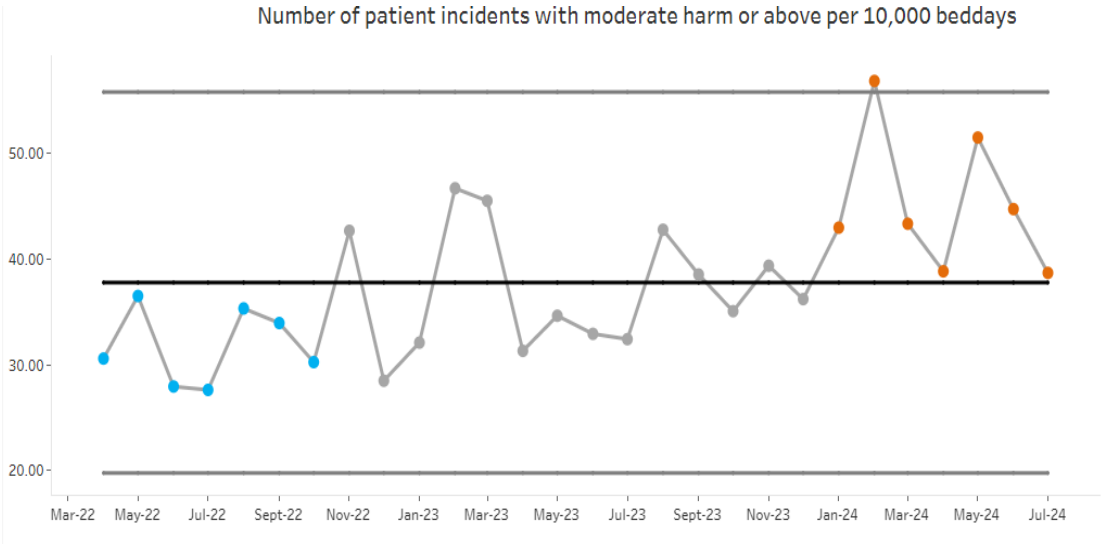
3. Assurance report: Quality, Safety and Patient Experience

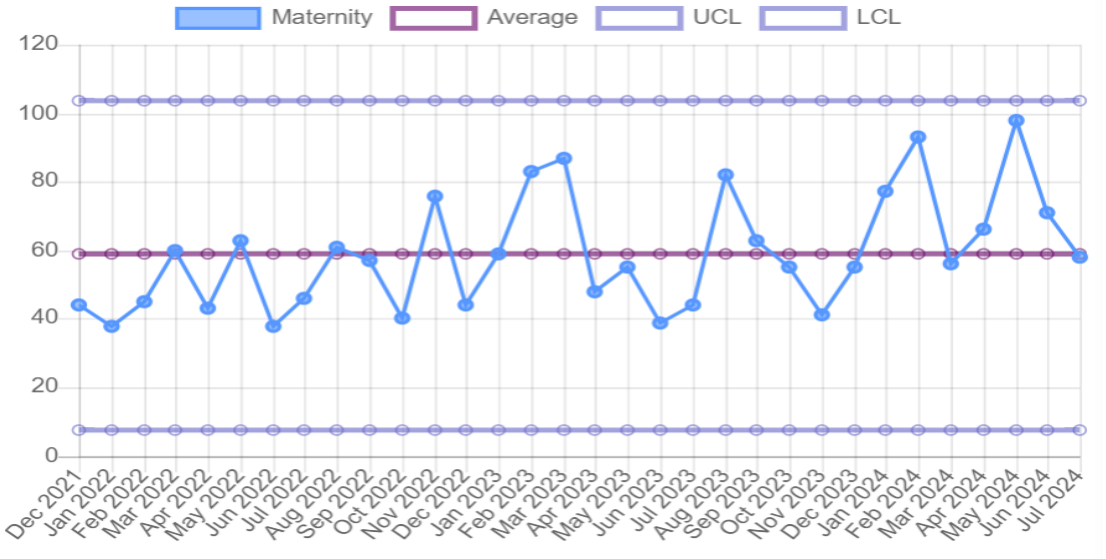




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Four Patient Safety Incident Investigations (PSII) were confirmed in July 2024 (excluding any incidents included in the 4 thematic PSIIs that form part of the Patient Safety Incident Response Framework (PSIRF) patient safety profile). One concerned a patient who experienced a delay in diagnosis of a major obstetric haemorrhage following a Caesarean section, and the other three are investigations to be led by the national Maternity & Newborn Safety Investigations system (2 newborns sent for therapeutic cooling, and 1 intrauterine death). Individual PSIIs are incidents that warrant an extensive system-based review (more than a Learning Multidisciplinary Team Reviews (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 18 non-thematic PSIIs have been confirmed over the last 8 months since OUH moved to the PSIRF framework in October 2023. PSIIs are one of a range of learning responses. They are a detailed investigation using a systems analysis approach which can be applied to individual incidents or a cluster of similar incidents. Other learning responses include After Action Reviews (AARs) and LMDTR. AARs have a target of 2 weeks from the reporting of the incident to complete, and LMDTs 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 July 15 AARs (including harm-free assurance reviews for pressure ulcers & falls) were completed and submitted to PST.	The action is to complete the PSII investigations within the agreed timescale and share the learning across Divisions. The PSII process is monitored by SLIC with responsibility for sign-off of final reports from Division, Head of Clinical Governance, DCMO and CMO/CNO	BAF 4 CRR 1122	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

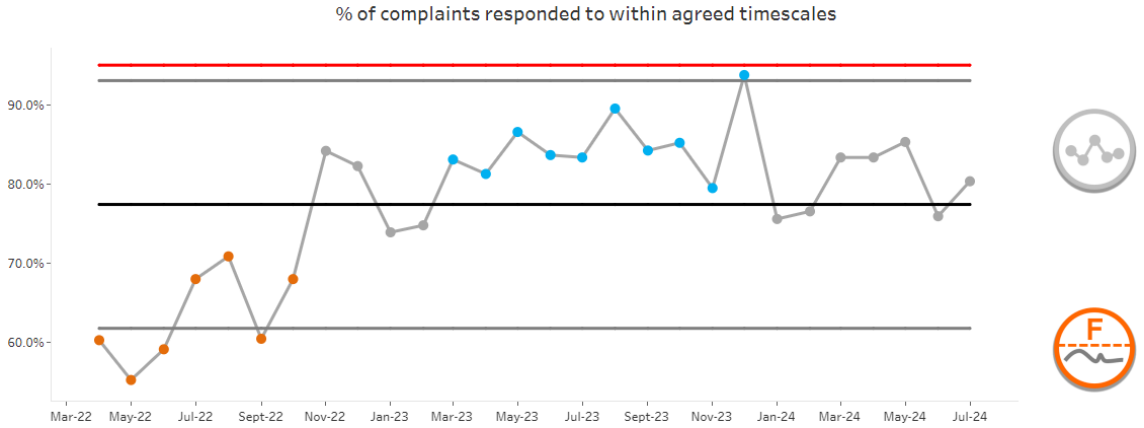
3. Assurance report: Quality, Safety and Patient Experience

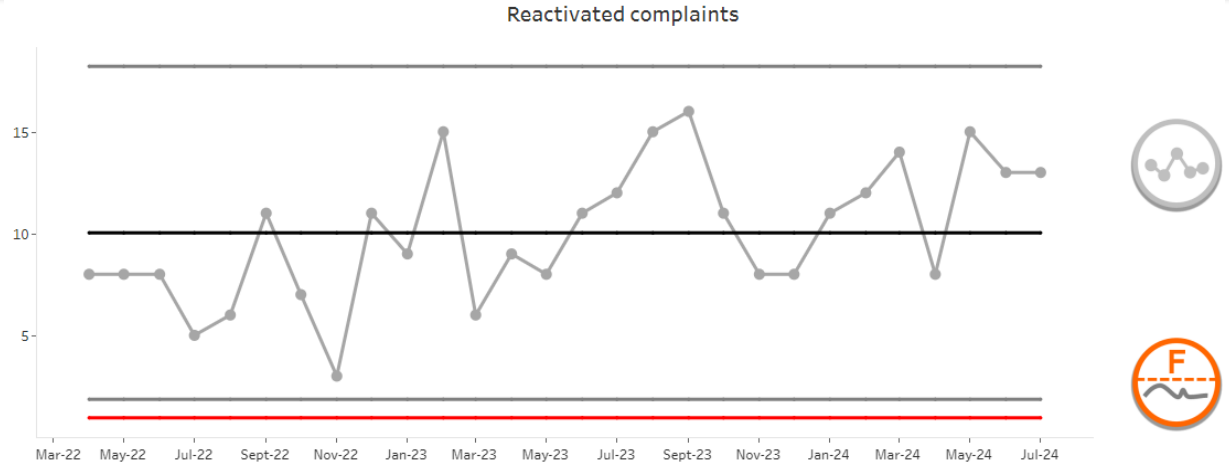




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales & assurance committee	Risk Register	Data quality rating
There were 38.6 patient incidents with moderate harm or above per 10,000 bed days reported in July 2024 (see the **first graph**). The approach to several maternity incidents, such as post-partum haemorrhage, changed during October 2021 The Trust began calling these as Moderate-harm incidents, in line with national practice. This approach was embedded in Maternity over the following 12 months and is now well established. As a result, Maternity Directorate now calls a significant percentage of Moderate+ incidents each month (58 of the 122 absolute incidents in July 2024, or 48%). The **second graph** shows the history of Maternity Directorate's Moderate+ incidents. Note that the scales of the two graphs are different: total incidents are presented per 10,000 bed days in the first graph, compared with absolute number of maternity incidents in the second graph; the Maternity graph also covers a longer period and includes non-patient incidents.	The most common Cause Group for the Moderate+ incidents in July 2024 was Maternity (37 of 122, 30%). The second most common Cause Group was Surgical/ Return to Theatre (29, 24%); this Cause Group includes other surgical incidents in addition to Return to Theatre (RTT) incidents. Within the Surgical/ Return to Theatre Cause Group there were 18 RTT incidents recorded for July, which is a reduction on June's figure of 28. The total number of incidents reduced from 138 in June to 122 in July. The reduction is directly linked to a reduction in the number of Maternity Cause Group incidents from 54 to 37.	65 (53%) of the incidents have been covered by the Safety, Learning & Improvement Conversation (SLIC) review process by mid-August; the mean monthly percentage is 37% (data from November 2023 onwards). Further information, or a formal learning response, will be provided for the incidents still awaiting completion of this process. This is actively tracked by the Patient Safety Team each week in discussion with Divisional governance staff and Deputy CMO. SLIC reports to the Patient Safety & Effectiveness Committee, which in turn reports to Clinical Governance Committee.	No	*Sufficient* *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

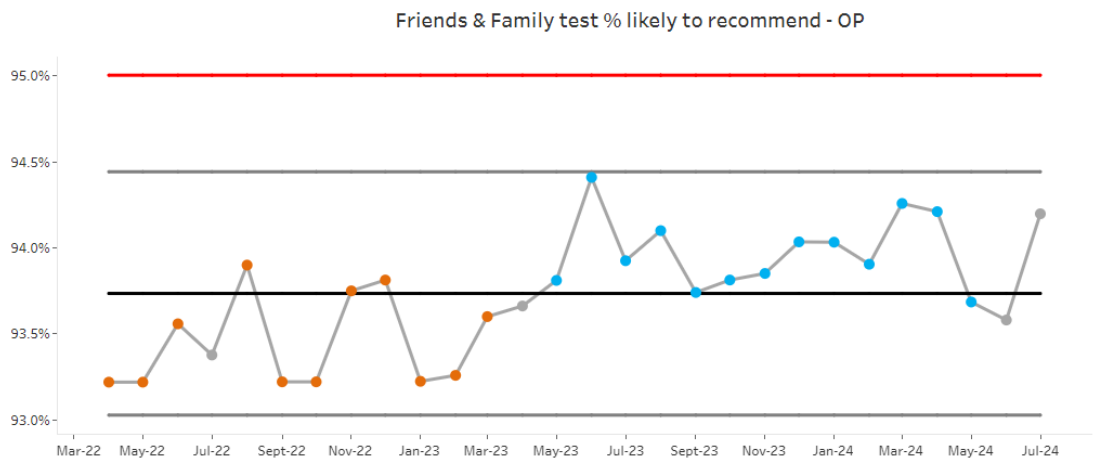
3. Assurance report: Quality, Safety and Patient Experience, *continued*

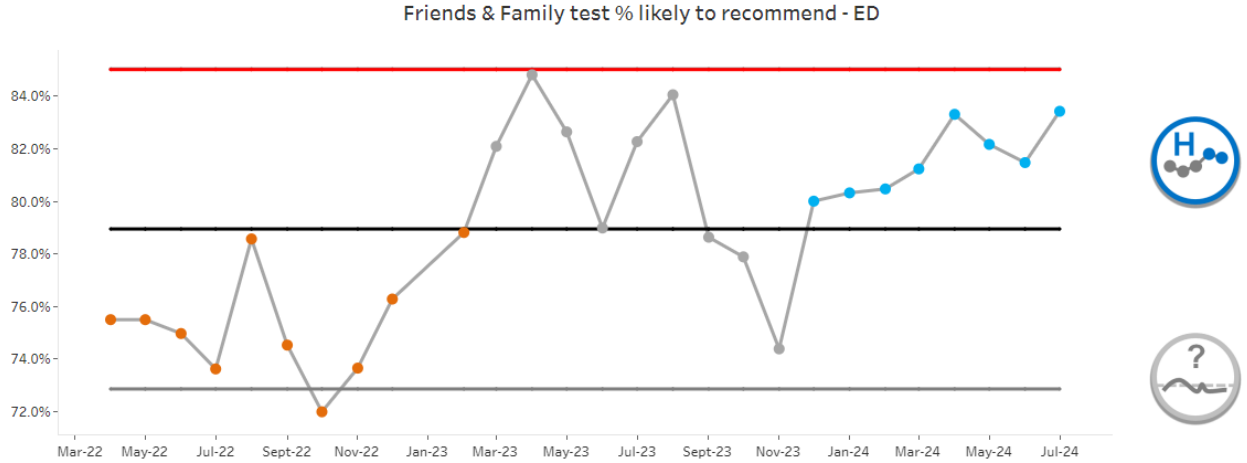




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
In July 2024, 80% of complaints were responded to within 40 days, below the target of 95%. The indicator has consistently not achieved the target. July's performance exhibited common cause variation. There were 13 reactivated complaints and the indicator common cause variation.	The Trust received 100 formal complaints in July and 13 reactivated (reopened) complaints were recorded. Targeted actions to improve the complaints response timeframe from 40 to 25 working days. 1. All new complaints acknowledged and sent to the investigation team on day 1 to maximise the time available for investigation. 2. The weekly autogenerated breach sheet demonstrating the number of complaints currently open over 25 days. For w/c 12 August, 32 complaints open over 25 days. This is distributed to Trust senior leaders. 3. Weekly meeting chaired by the Chief Nursing Officer, Head of Patient Experience and Complaints and Patient Services Manager, to review all open complaints over 35 days, with each one given a planned route to closure. For w/c 12 August there were 7 complaints open over 35 days, these are expected to be closed w/c 19 August. Escalation to the relevant Chief Officers as required to aid their staff in responding to all overdue complaints. 4. Weekly meetings project management held with the Complaints team and Divisional Directors of Nursing, to escalate complaints cases about to breach. 5. Monthly interactive complaints dashboard presenting run rate for open, closed, reopened, theme distributed to Divisions and Trust senior leadership.	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*

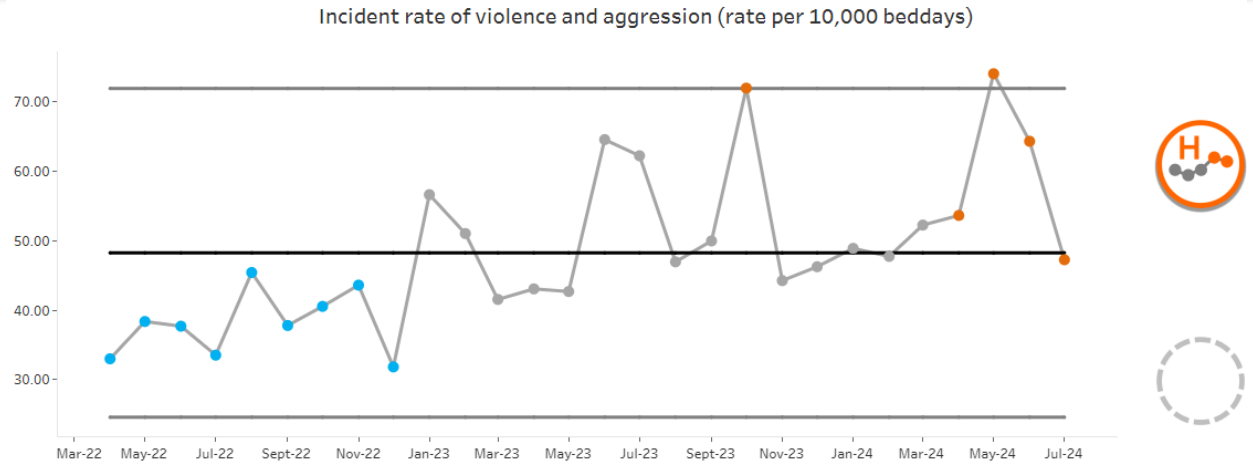
3. Assurance report: Quality, Safety and Patient Experience, *continued*

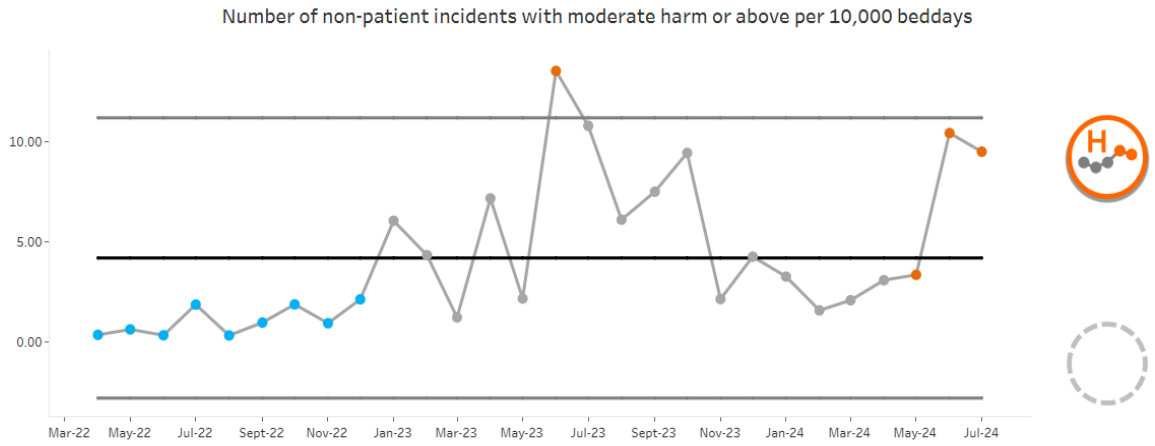




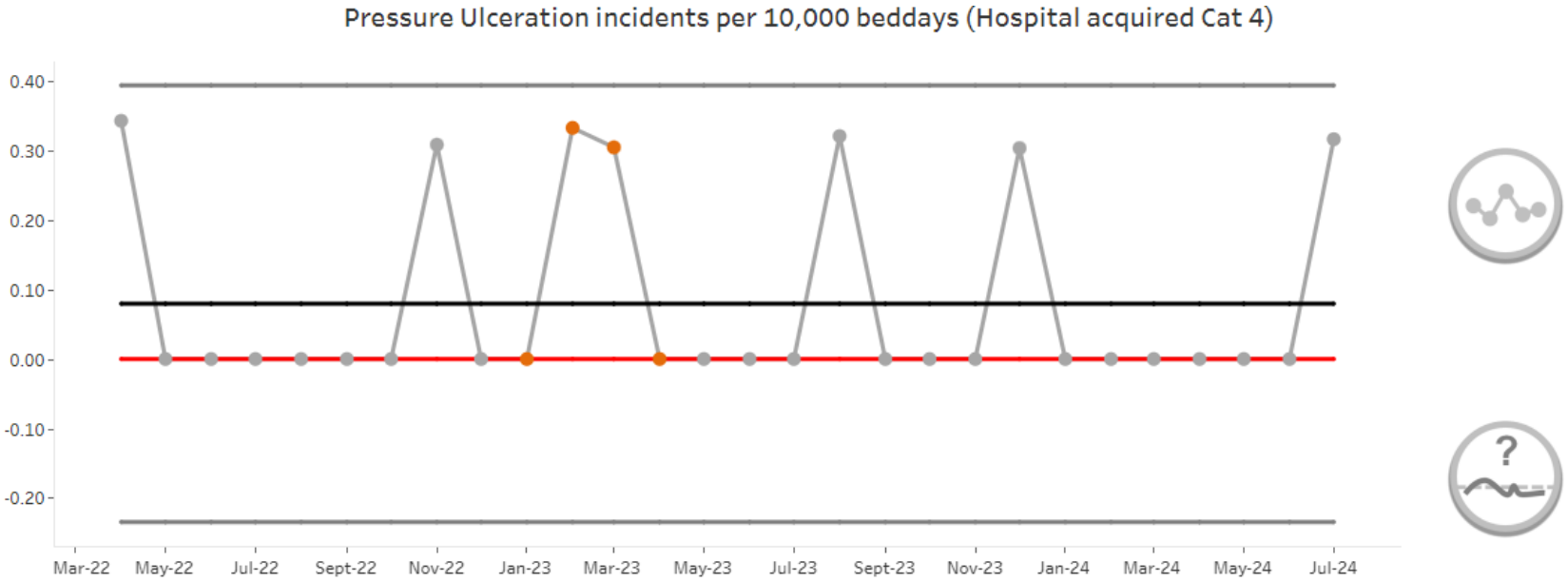
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
1. The recommend rate has increased for both outpatients, and for ED. 2. The negative themed comments during July were length of time on waiting list, car parking, discharge home and cancelled procedures (beginning of the month). Consistently over the over the previous 3 months centre on discharge home, cancelled admission and procedures, car parking and the length of time on waiting lists. 3. The positive themes during July 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 will be on 25th September 2024. 2. The Patient Experience Forum, chaired by the Chief Nursing Officer, will be held on 13th September. The purpose of bi-monthly forum will be for the Divisions to demonstrate service improvements made following feedback, complaints and engagement.	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 gets reported to 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*



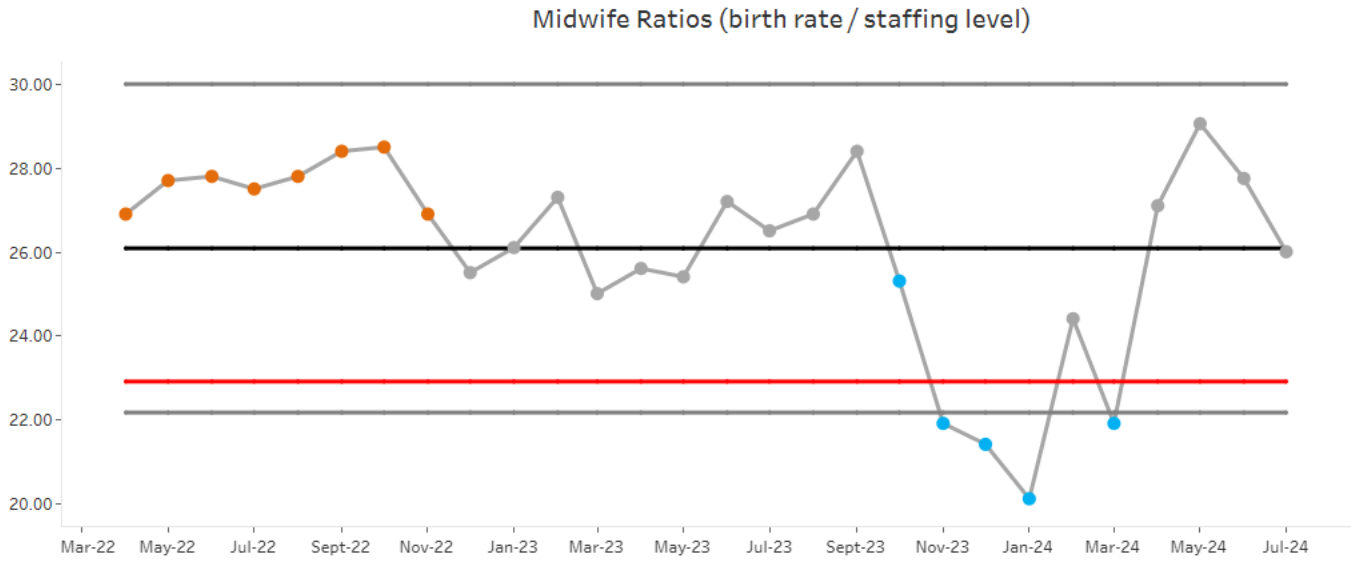


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
There were 47.2 Health and Safety incidents relating to assault, aggression and violence per 10,000 bed days in July, which is a reduction of 17 incidents compared to June. The indicator exhibited special cause variation due to two out of the last three points being within one sigma of the upper control limit. The No Excuses campaign and raising awareness of the importance of reporting incidents of violence and aggression along with a focus on abuse 'not being part of the job' has led to a greater number of Ulysses being completed. This accounts for much of the increase seen in the violence and aggression figures, supported by the fact that although the number of incidents has increased considerably, the number of incidents attended by Security has not increased by the same margin. The next phase of the No Excuses campaign has been concentrating on sexual violence and racial abuse. The majority of violence and aggression incidents continue to be attributed to the clinical condition of the patient and them lacking capacity. Increases in the numbers and complex nature of these patients along with remaining in the acute setting for prolonged periods, due to a lack of suitable locations to enable a timely discharge, continues to be a contributing factor in the rise in incidents. Multiple incidents are often a result of a few patients repeating their behaviour. The resources available within the Security Team are not sufficient to guarantee support due to the number of incidents (especially when there are multiple incidents in different locations) and the often-prolonged length of time incidents can take to de-escalate to a safe level.	Encouraging staff not to accept abusive behaviour and increased reporting is a positive outcome of the No excuses campaign. Clinical Teams within Directorates manage clinically attributed aggression through individual care planning, undertaking level of enhanced observation and utilising security support. The CNO chairs a Violence Reduction Group, and there continue to be regular V&A Safety Groups within directorates. Clinically worn body cameras have been introduced and have been received positively in the areas and the aim is that the use of the cameras will have a de-escalation effect. The Security Teams have undertaken enhanced physical intervention training which is compliant with the Restraint Reduction Network Standards. Conflict Resolution Training has been trialled in a number of areas, and trainer-trainer training in clinical holding is being undertaken in April. A paper with recommendations to increase Security Officer Numbers has been agreed, and funding options are being considered. Throughout July the Trust Security Manager sent out 18 warning letters to the perpetrators of non-medically related violence and aggression. Of those 4 were final yellow warnings and 4 were Acceptable Behavioural Contracts.	VAR group meets monthly. ED V&A Staff Safety Group meets fortnightly, and this model is being rolled out throughout other directorates.	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months*



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 was a single hospital acquired Category 4 pressure ulcer in July which was above the threshold (1 v 0). The patient was on an end-of-life patient pathway and the ulcer deteriorated from a pre-existing Category 3 pressure ulcer. A review into the care delivered for this patient has been undertaken with the Division and areas for learning and improvement identified. The care delivered was focused on respecting the patient's wishes.	All incidents have been reviewed in line with the PSIRF approach, with the identification of learning and remedial action plans for the clinical divisions, where appropriate. The Divisions have local action plans to reduce the overall incidence of HAPU. To ensure that there is a cross divisional focus on harm reduction the organisational work plan will be approved at the August Harm Free Assurance Forum. This focuses on compliance and assurance that Policy is embedded at all levels.	Themes from these incidents will be identified in the Harm Free Assurance Forum scheduled for the August 2024 for shared learning.	BAF 1	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months, and independent audit undertaken in last 18 months*

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



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 July, the number of birthing people who gave birth was 623, marking a reduction from June's figure of 660. Out of these, 236 were caesarean sections, accounting for 37.9% of the total births. There were 718 bookings finalised, which is a decrease of 52 compared to the previous month. Nonetheless, expectations are set for a rise in both deliveries and bookings in the forthcoming months. This expectation, along with the identified bookings from out of area, is likely to escalate the demands on the service. The challenges are amplified as we are now in the summer months, recognised for heightened staffing difficulties.	• Collaborative summer mitigation staffing plan developed and deployed • Redeploying staff from other areas to support • Specialist and management roles redeployed • Efficient and effective utilisation of bank staff • Daily review of staffing and risks triangulation, mitigation put in place and appropriate escalation where required • 'Out of area' proposal to redivert appropriate non-tertiary bookings developed and shared with BOB ICB and OUH Board • Dynamic workforce recruitment and retention plan with Exec Board sponsorship – supports Birthrate Plus establishment uplift	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 2024 • 7 supernumerary status midwives to be up and running by September 2024 to increase establishment. • Currently 9 short course midwifery students of which 4 are due to quality in August 2024. • 2 Midwifery year 1 apprenticeships in progress with 2 additional selected Out of area proposal paper to be presented to Board by end of August 2024 to redivert appropriately by October 2024.	BAF 4 CRR 1145	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

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

Oxford University Hospitals NHS Foundation Trust

Summary of challenges and risks

The Safe Staffing Dashboard in the three slides below triangulates nursing and midwifery quality metrics with CHPPD (Care Hours Per Patient Day) at the inpatient ward level. 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 July 2024. The Trust-wide planned versus actual fill rates were 85.4% during the day and 91.2% at night. Where fill rates were less than 90%, all shifts were reviewed, reported, and mitigated by a Matron or above at the safe staffing meeting, and no shifts were left at risk.

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

Nurse and midwifery staffing levels and the nurse-sensitive indicators below were thoroughly reviewed and validated with the Lead Nurse for Nursing & Midwifery Staffing Regulation , the DDN (Deputy for NOTSSCaN) and the Head Nurse for Workforce. 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 July.

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, the day case patient numbers have not been captured. Roster efficiencies and staff retention KPIs have been flagged to the DDN and will be monitored with increased oversight. 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 July, 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.
Roster KPIs around efficiency are within parameter. The roster KPIs for roster publication fell short, however, assurance was given by the Deputy Head of Midwifery, that the reason of summer planning was communicated to all staff. An improvement will be seen for the September roster period. New senior leadership within the team are recently engaged and working through this to improve rapidly. Upon review, The Spires roster template was found to be inaccurate for this period. The CHPPD have therefore not been reported for this period, as the data is known to be inaccurate. 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 July.

MRC –Actual CHPPD for CMU appears lower than required for July, following validation 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 in reality. There was no escalation of unsafe shifts and senior nurse visibility and oversight of all areas during July to ensure awareness following temporary staffing reduction of safety. Oak CHPPD actual is lower than budget in July due to low number of high acuity patients. Osler have had varying acuity not always aligned to budget, and 5E/F have a high number of side-rooms which requires professional judgement outside of CHPPD for staffing. MRC experienced increased staff sickness in June which continued into July, particularly following several covid outbreaks at the Horton and JR. Roster efficiencies and performance is very good. 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 July.

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

Oxford University Hospitals NHS Foundation Trust

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

NOTSSCAN – Neuro Purple actual CHPPD remains closely monitored by the DDN as they appear to be low compared to requited, however professional judgement, senior oversight and shift by shift scrutiny have shown them to be safely staffed, and senior oversight and discussion is in place. PICU have been staffed safely despite having lower actual CHPPD than budgeted as they have not required full budget to be safe in July due to acuity and empty beds. Roster efficiencies and KPI adherence is closely monitored by the DDN, one area was not approved for payroll. Kamrans' ward reports a high number of overworked hours, however, this relates to one student (hours need to be corrected) and one substantive staff member, for which a plan will be discussed. Neuro Green report a high number of unused hours, however, when scrutinised, this is due to the small roster size,. Blenheim have ongoing challenges to ensure staff have taken AL and have asked for HR support for this going forward. 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 July.

CSS – JR ICU – New senior leadership are engaged to review the CHPPD budget and roster, as budgeted CHPPD appears high. Actual CHPPD does not align with budgeted as was not required at that high level in July 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 will be a full review of the roster in the Check & Confirm meeting booked for September. 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 July.

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

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

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

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

July 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
NOTSSCaN																		
Bellhouse / Drayson Ward	9.0	10.6	11.0	95.7%	3	1	0	0	4.2%	5.3%	3.0%	2.7%	6.8%	Yes	0.9%	9.7	17.1%	88.6%
Kamrans Ward	10.2	10.9	9.0	97.9%	1	0	0	0	0.9%	4.2%	1.2%	3.9%	4.7%	Yes	-5.8%	8.7	12.5%	100.0%
Melanies Ward	11.6	12.4	12.6	97.9%	1	0	0	0	-30.8%	9.6%	2.8%	2.0%	-28.2%	Yes	-0.7%	9.7	17.5%	92.6%
Robins Ward	11.4	11.4	11.2	100.0%	4	1	0	1	22.1%	17.2%	3.4%	3.8%	25.1%	Yes	-0.3%	10.0	15.8%	100.0%
Tom's Ward	8.1	9.4	8.5	94.6%	5	1	0	0	-0.1%	6.7%	2.0%	5.3%	5.2%	Yes	-0.2%	10.6	14.9%	91.4%
Neonatal Unit	19.4		23.1		17	6	0	0	12.0%	8.1%	6.5%	3.9%	19.6%	No	-3.7%	8.7	13.8%	
Paediatric Critical Care	32.0		23.8		20	3	3	0	1.8%	7.7%	4.6%	6.6%	8.3%	Yes	0.2%	7.9	13.5%	
BIU	6.1	6.6	6.4	100.0%	2		3	3	17.1%	15.2%	3.6%	3.1%	19.6%	Yes	-0.5%	8.4	14.7%	
Head and Neck Blenheim Ward	7.3	8.3	9.1	97.9%	1		0	0	13.7%	5.1%	5.5%	4.0%	24.5%	Yes	3.9%	8.3	8.5%	100.0%
HH F Ward	8.3	8.4	8.9	97.9%	0		2	3	1.5%	4.6%	6.0%	4.1%	7.7%	Yes	-0.2%	9.6	16.1%	100.0%
Major Trauma Ward 2A	9.6	9.2	9.5	98.9%	3		4	2	13.3%	6.2%	2.5%	0.0%	15.1%	Yes	0.4%	8.3	11.9%	87.5%
Neurology - Purple Ward	9.0	12.0	10.3	100.0%	0		1	3	3.3%	6.2%	5.8%	0.0%	6.2%	Yes	0.8%	8.7	14.5%	100.0%
Neurosurgery Blue Ward	8.9	9.8	9.5	100.0%	1		0	5	11.1%	2.2%	4.7%	4.4%	15.1%	Yes	2.9%	8.4	14.9%	96.3%
Neurosurgery Green/IU Ward	9.6	10.5	10.9	98.9%	0		0	2	3.3%	0.0%	3.5%	3.1%	6.2%	Yes	7.0%	8.6	10.5%	100.0%
Neurosurgery Red/HC Ward	11.7	12.8	12.3	100.0%	1		1	3	3.1%	11.3%	4.9%	2.7%	6.7%	Yes	-0.9%	9.4	12.6%	100.0%
Specialist Surgery I/P Ward	8.5	7.9	8.5	83.9%	4		0	6	11.1%	10.2%	3.6%	1.6%	12.5%	Yes	1.1%	8.3	14.6%	85.7%
Trauma Ward 3A	9.2	10.1	9.6	96.8%	1		1	3	6.7%	8.1%	4.0%	5.2%	11.5%	Yes	1.3%	8.3	13.0%	100.0%
Ward 6A - JR	7.4	7.7	7.6	97.9%	4		0	6	9.5%	13.4%	2.7%	0.0%	10.6%	Yes	1.3%	8.3	10.5%	98.5%
Ward F (NOC)	6.7	7.8	7.3	80.7%	1		0	3	7.8%	10.8%	4.7%	5.6%	15.6%	Yes	0.4%	8.4	15.1%	50.0%
WW Neuro ICU	25.4		27.8		2		0	0	19.9%	10.3%	3.4%	1.1%	22.3%	Yes	-3.7%	7.9	16.5%	

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

July 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/- 2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
MRC																		
Ward 5A SSW	8.9	10.0	9.0	100.0%	1		3	1	7.1%	6.6%	3.3%	1.9%	-3.1%	Yes	-1.3%	8.3	13.8%	
Ward 5B SSW	8.9	8.8	8.7	98.9%	0		2	4	6.7%	7.3%	4.0%	6.6%	12.8%	Yes	4.1%	8.4	13.2%	94.1%
Cardiology Ward	7.9	6.7	6.9	97.9%	4		1	4	10.6%	14.9%	3.9%	2.2%	12.6%	Yes	0.1%	8.6	14.5%	100.0%
Cardiothoracic Ward (CTW)	7.8	7.7	5.9	100.0%	1		0	1	13.8%	9.1%	2.2%	7.6%	20.4%	Yes	1.5%	10.4	10.4%	100.0%
Complex Medicine Unit A	8.9	10.9	8.8	100.0%	0		1	9	0.1%	5.3%	5.7%	9.6%	11.9%	Yes	2.0%	8.7	14.7%	100.0%
Complex Medicine Unit B	11.3	11.5	9.5	100.0%	0		2	6	3.6%	7.2%	2.9%	8.5%	2.9%	Yes	1.5%	8.7	12.2%	100.0%
Complex Medicine Unit C	8.8	10.9	8.6	100.0%	0		0	4	3.2%	9.5%	2.4%	0.0%	3.2%	Yes	-0.3%	8.7	15.8%	96.3%
Complex Medicine Unit D	9.5	8.8	8.2	98.9%	0		4	5	3.8%	10.4%	5.7%	0.0%	12.1%	Yes	2.0%	8.7	15.6%	100.0%
CTCCU	21.9		23.7		3		3	0	9.0%	9.7%	3.6%	5.8%	16.6%	Yes	-1.0%	8.7	12.8%	
Emergency Assessment Unit (EAU)	8.5	8.5		94.6%	2		1	5	15.4%	5.7%	4.5%	6.8%	22.7%	Yes	0.8%	8.6	12.7%	
HH EAU	9.8	6.9		86.7%	2		3	9	0.8%	6.8%	5.4%	3.4%	3.8%	Yes	-2.0%	9.9	14.8%	
HH Emergency Department	22.8				3		1	3	13.3%	7.9%	4.1%	8.2%	21.1%	Yes	-1.7%	8.7	13.7%	86.4%
JR Emergency Department	17.2				6		0	4	15.3%	16.0%	5.3%	4.9%	21.0%	Yes	1.5%	8.9	15.2%	81.9%
HH Juniper Ward	8.1	9.0	8.0	97.9%	0		2	4	2.9%	4.7%	5.4%	1.1%	4.6%	Yes	-3.7%	9.4	14.6%	61.9%
HH Laburnum	9.6	8.3	8.8	97.9%	1		1	6	2.7%	4.8%	7.4%	5.9%	12.9%	Yes	-0.6%	8.0	12.7%	50.0%
HH Oak (High Care Unit)	20.1		11.2	94.6%	3		3	5	0.0%	7.8%	4.9%	0.0%	4.1%	Yes	1.8%	8.0	14.7%	
John Warin Ward	10.1	8.3	9.2	100.0%	3		1	4	4.0%	6.6%	3.1%	5.0%	9.8%	Yes	-1.2%	8.4	12.1%	94.1%
OCE Rehabilitation Nursing (NOC)	10.5	10.8	10.5	100.0%	1		0	1	7.1%	2.9%	4.6%	5.1%	17.0%	Yes	-2.7%	8.4	11.2%	54.3%
Osler Respiratory Unit	14.4	9.4	12.4	100.0%	3		1	2	6.4%	8.4%	4.2%	0.0%	7.7%	Yes	0.2%	8.3	12.4%	47.8%
Ward 5E/F	11.1	8.3	9.8	96.8%	1		1	5	21.6%	10.7%	3.6%	6.0%	26.3%	Yes	0.8%	8.6	12.4%	54.5%
Ward 7E Stroke Unit	10.9	8.8	9.6	100.0%	2		0	1	0.7%	14.7%	4.8%	4.4%	5.3%	Yes	-5.9%	8.4	16.8%	

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

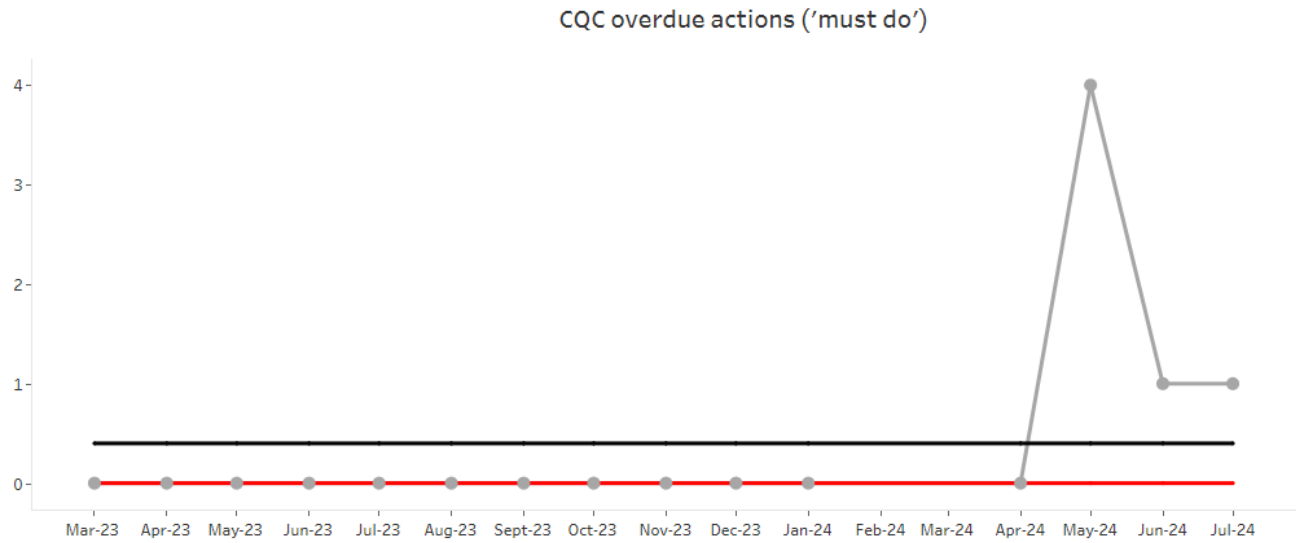
Oxford University Hospitals NHS Foundation Trust

July 2024	Care Hours Per Patient Day			Census	Nurse Sensitive Indicators				HR					Rostering KPIs				FFT
Ward Name	Budgeted Overall	Required Overall	Actual Overall	Census Compliance (%)	Medication Administration Error or Concerns	Extravasation Incidents	Pressure Ulcers Category 2,3&4	All reported falls	Vacancy (%)	Turnover (%)	Sickness (%)	Maternity (%)	Revised Vacancy HR Vacs plus LT Sick & Mat Leave (%)	Roster manager approved for Payroll	Net Hours 2/-2%	8 week lead time	Annual Leave 12-16%	% Extremely likely or likely
SUWON																		
Gastroenterology (7F)	7.0	7.6	7.9	88.2%	7		1	9	11.7%	5.7%	3.7%	5.0%	16.2%	No	-4.0%	8.6	13.3%	100.0%
Gynaecology Ward - JR	6.0	5.8	7.8	100.0%	0		1	0	12.9%	2.6%	6.6%	0.0%	12.9%	Yes	27.5%	9.0	14.1%	97.2%
Haematology Ward	6.9	7.6	8.0	100.0%	7		0	1	14.7%	10.6%	4.6%	2.5%	14.7%	Yes	3.7%	3.9	17.7%	100.0%
Katharine House Ward	9.2	7.7	10.0	100.0%	0		1	2	13.2%	13.1%	6.4%	2.8%	15.7%	Yes	2.1%	8.4	18.4%	
Oncology Ward	8.7	7.9	8.0	100.0%	10		4	4	35.2%	5.8%	3.4%	6.1%	40.3%	Yes	-0.1%	9.3	12.9%	87.5%
Renal Ward	9.3	8.5	10.3	100.0%	1		0	2	11.6%	3.3%	4.8%	10.2%	26.7%	Yes	-20.3%	10.3	12.1%	100.0%
SEU D Side	8.7	8.1	8.6	97.9%	3		1	6	29.8%	0.0%	5.1%	7.5%	36.9%	Yes	0.9%	8.4	13.5%	87.1%
SEU E Side	8.4	8.1	8.7	97.9%	2		0	2	21.5%	11.0%	3.2%	0.0%	23.6%	Yes	0.7%	8.4	15.2%	98.6%
SEU F Side	7.5	8.5	7.8	97.9%	1		2	1	35.9%	24.7%	2.2%	0.0%	35.9%	Yes	-11.2%	8.4	11.7%	100.0%
Sobell House - Inpatients	8.7	7.7	7.9	100.0%	0		3	3	31.9%	14.7%	4.3%	0.0%	33.5%	Yes	-8.7%	8.4	14.0%	
Transplant Ward	9.4	7.4	9.8	98.9%	2		0	2	22.2%	3.1%	4.1%	5.1%	26.2%	Yes	-0.1%	8.4	12.3%	95.5%
Upper GI Ward	9.7	8.0	8.5	95.7%	2		0	4	18.0%	2.8%	4.5%	2.6%	20.1%	Yes	-7.8%	8.3	16.5%	80.0%
Urology Inpatients	8.8	10.1	10.0	98.9%	0		0	3	34.5%	3.8%	2.0%	3.8%	38.6%	Yes	-1.3%	8.6	12.1%	98.0%
Wytham Ward	7.7	7.4	7.1	100.0%	0		0	2	13.3%	3.4%	5.1%	0.0%	18.8%	Yes	1.9%	8.3	13.5%	96.3%
MW Delivery Suite	15.2		23.6											Yes	-2.2%	6.3	11.8%	
MW Level 5	6.7		5.1											No	7.9%	4.7	10.9%	
MW Level 6	4.5		7.3											No	-1.2%	4.7	11.4%	
CSS																		
JR ICU	34.5		27.1		14		5	0	22.2%	7.5%	5.4%	5.8%	28.8%	Yes	-0.6%	7.4	12.2%	

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.

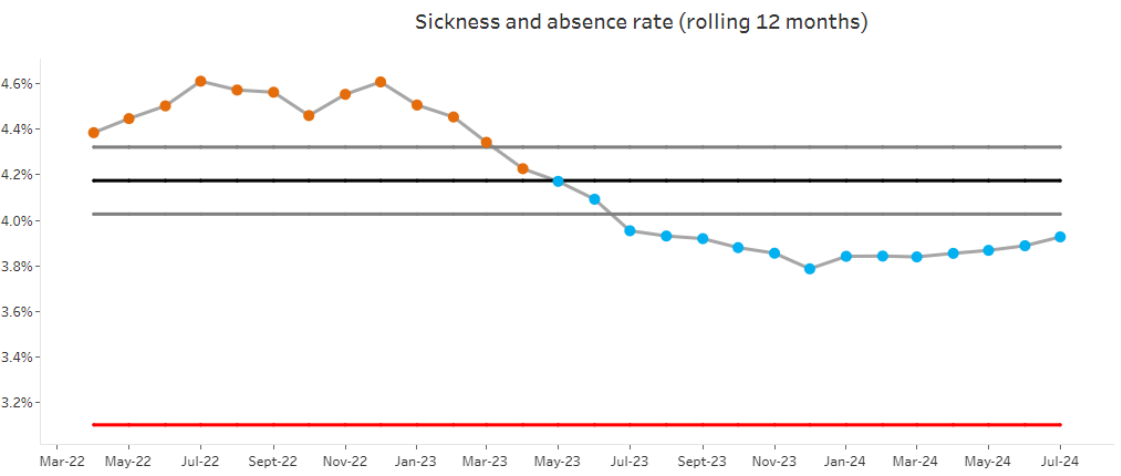
3. Assurance report: Quality, Safety and Patient Experience

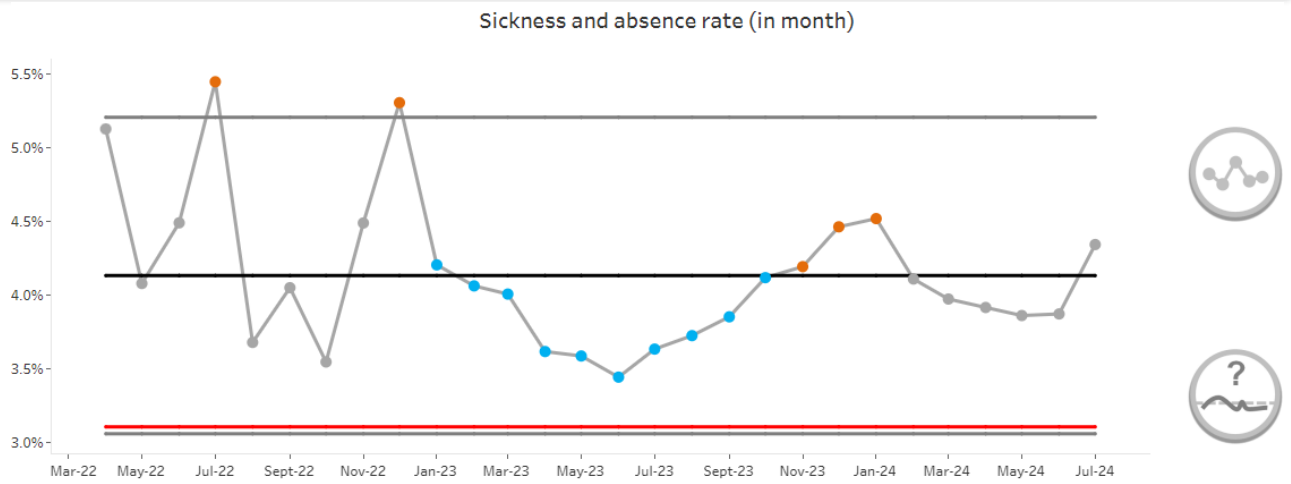


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register (Y/N)	Data quality rating
An update was provided at Public Trust Board on 10 July 2024 and the Evidence Review Group has been set up to monitor assurance levels around extent to which actions are securely embedded. The one must do action that is overdue relates to one of four points in action six from the Horton Maternity Inspection Report: The trust must ensure effective risk and governance systems are implemented which supports safe, quality care within the midwifery led unit. Regulation 17(1)(2)(a)(b). Challenges relating to delivery delays are as a direct result of the implementation of a new electronic patient records system, earlier in the year.	Evidence review group led by the Chief Nursing Officer will meet monthly for future evidence reviews, the outcome of which may also inform maternity safety Champions meetings discussions. Maternity Clinical Governance Committee received an update paper on 22 July 2024 about the community dashboard development work that is being led by a Consultant Midwife. Due to the impact of the changeover to BadgerNet electronic records system in February 2024, the delivery of this action is delayed. Work continues with the development of the dashboard related to data collection via the new platform.	There is a plan for progress of the dashboard development and a draft dashboard to be presented at the August Maternity Clinical Governance Committee. Limited assurance around embedding.	*Yes*	

3. Assurance report: Growing Stronger Together

Oxford University Hospitals NHS Foundation Trust



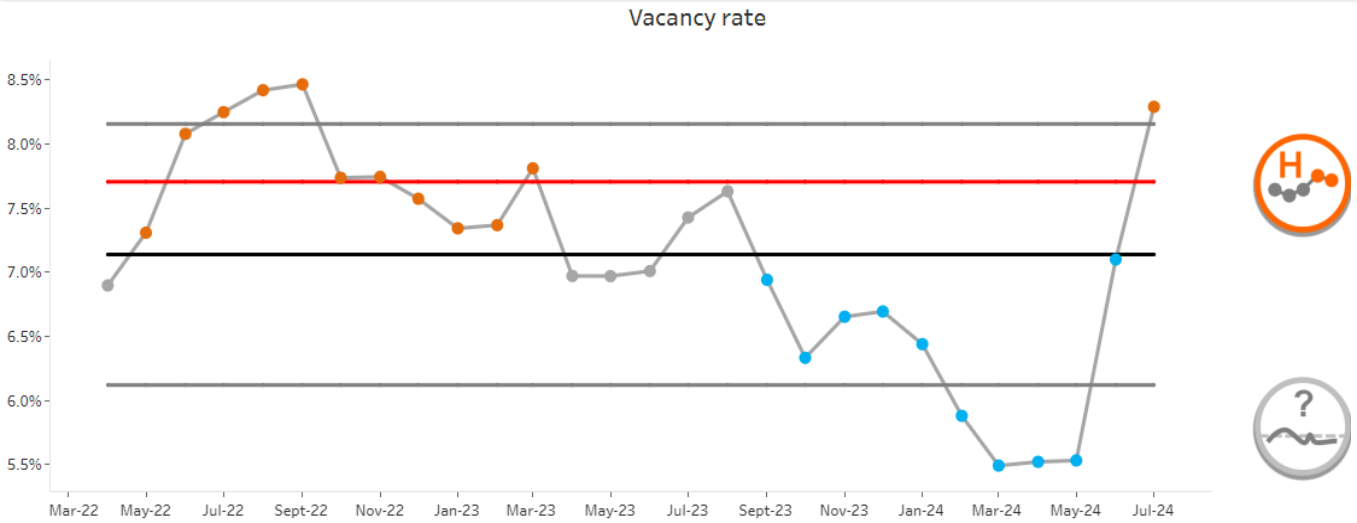


Benchmarking: April 24 (monthly performance – *lag due to availability of published data from National Sickness Absence Rate report*).

OUH: 3.8% **National: 4.8%** **Shelford: 4.4%** Buckinghamshire Healthcare NHS Trust: 4.1% Royal Berkshire NHS Foundation Trust: 3.6% Oxford Health: 4.3% 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 3.9% in July with an in month increase from 3.7% and had previously remained static since April. Performance exhibited special cause improving variation performing 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 starting to track upwards with this month showing the first increase of 0.2%. In month figure was 4.3% in July with a significant in month increase from 3.7% . There is no one single absence reason accounting for sickness within the Trust. No one absence reason accounts for the change, although the top 4 absence reasons have increased to varying degrees between months (Covid 19, Cold/ flu, Mental Health, and Gastro). Long term sick as measured by working days lost accounts for 40.1% of absences and is broadly unchanged.	We are continuing to offer a full range of well-being support including wellbeing, financial, environmental and psychological. This includes stress management training. • Focus on staff who reached 'absence monitoring' stage without any level of improvement recorded by managers. • OH reports requested with regards to 'DNAs' following referral of staff to OH for assessments as well as number of 'not appropriate' referrals being made to support 'education' of managers. • The DHOWs identified key points to include as part of the Sickness Absence Management (SAM) Communication Plan e.g. Local Initial Adjustment Plan (LIAP), effective referrals, alternative options to referrals. • Continued focus on RTW compliance ongoing, with support, advice and coaching of managers with regular reports. • Ongoing focus on weekly provision of frequent absence reports to managers is continuing to provide support. • Utilising support from OH with regular meetings which includes escalation of areas such as MSK referrals and specific cases. • Review of open absences and managers contacted to offer support. • Sickness absence workshops in progress to support managers. • A new absence policy due to go to the next Board meeting.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

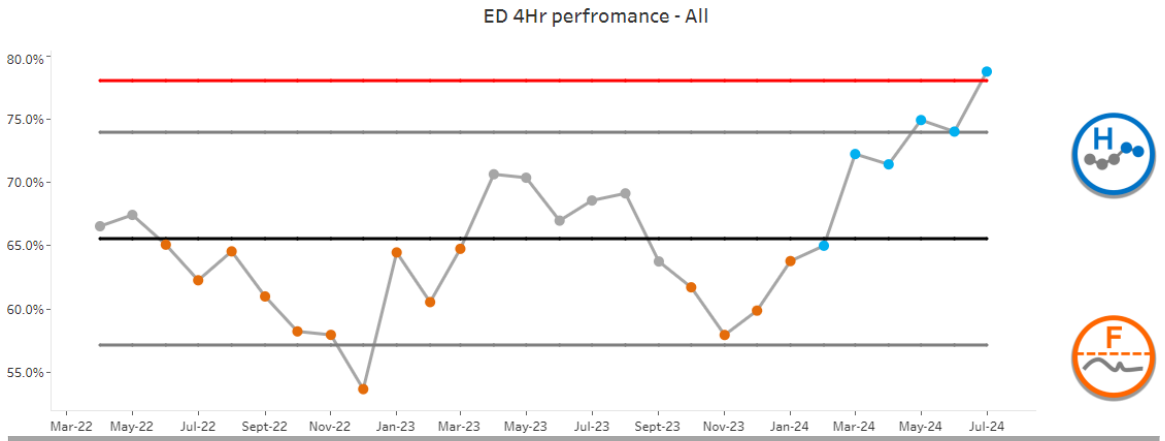
3. Assurance report: Growing Stronger Together

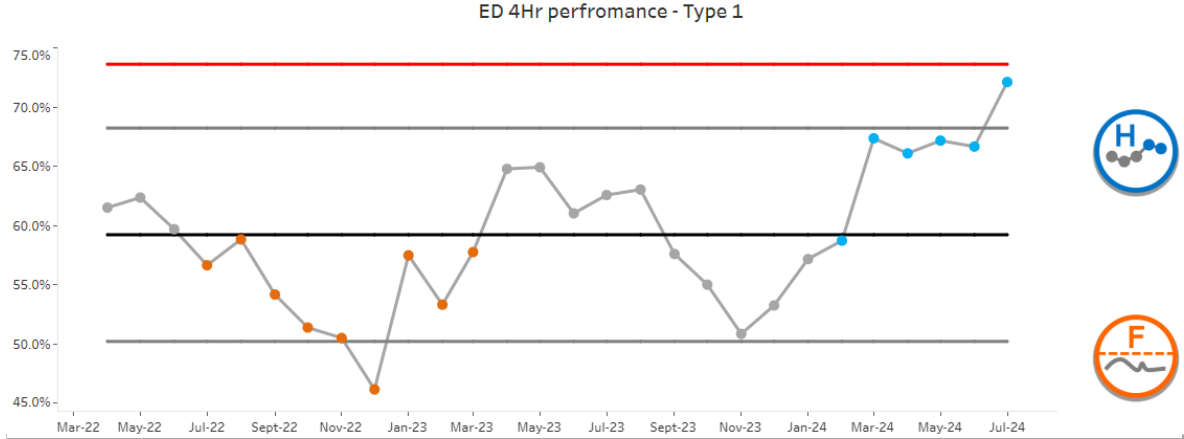


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
An increase in the establishment in month, coupled with a small decrease in the staff in post has caused vacancies to increase to 8.3% in month against a target of 7.7%. There is a high number of HCSW's in the pipeline via centralised recruitment who are waiting for allocations, this impacts the time to hire. Work is underway with the divisions on allocating these candidates and it is hoped that 1P1P will make it clearer on the vacancies within directorates. A review of temporary staffing spend for vacancy usage vs areas that are declaring no vacancies is underway. Monthly meetings scheduled with the Heads of Workforce have been implemented to support local issues and develop recruitment plans with the retention leads, prioritising the vacancy hot spot areas. Medical Staffing are mirroring this process to support Medical recruitment.	There is collaborative work underway with the clinical and divisional workforce teams to review high vacancy areas and to have targeted interventions to improve time to hire. There is continuous dialogue with divisional teams on the placement of the HSCW's. A recruitment deep dive is continuing to identify areas / line managers who might need additional support with the Trac process to reduce their time to hire. This will be a targeted approach, and FAQs developed to support other managers across the organisation. The launch of the management of honorary contract holders on TRAC should give the divisional teams the ability to challenge roles and assist with reducing the volume. Trac audits with Trac are underway to support an improved performance. The Trust is meeting with Trac on the 12th July to review opportunities for development In line with the People Plan, further work is underway on reviewing how technology can help reduce the admin workload within Resourcing and improve the onboarding experience/time to hire. Engaging with new starters for candidate experience feedback and using the time to talk and listening events within the wider P & C directorate to review ideas and options to improve time to hire.	Governance - TME via IPR, HR Governance Monthly meeting & Divisional meetings All actions are ongoing	BAF 1 BAF 2 CRR 1144 (Amber)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

3. Assurance report: Operational Performance

Oxford University Hospitals NHS Foundation Trust





Benchmarking: ED (All types): July 24

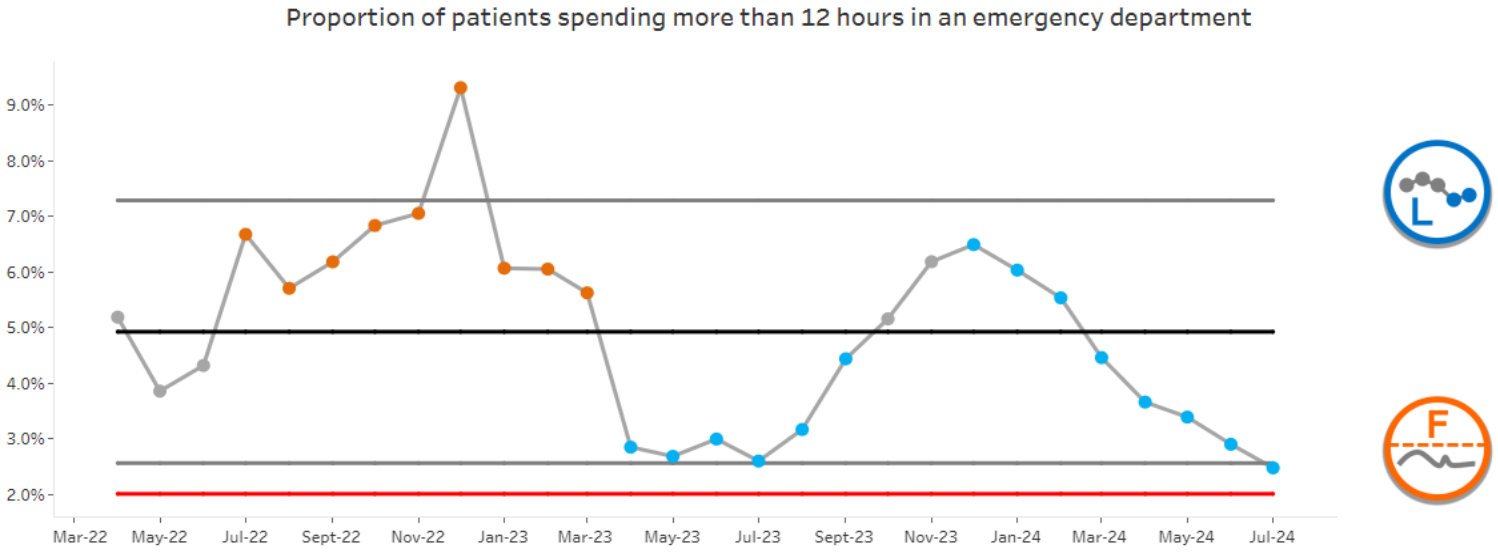
OUH: 78.7%	**National: 73.8%**	**Shelford: 73.9%**	BHT: 72.6%	RBH: 73.6%

ICS key

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

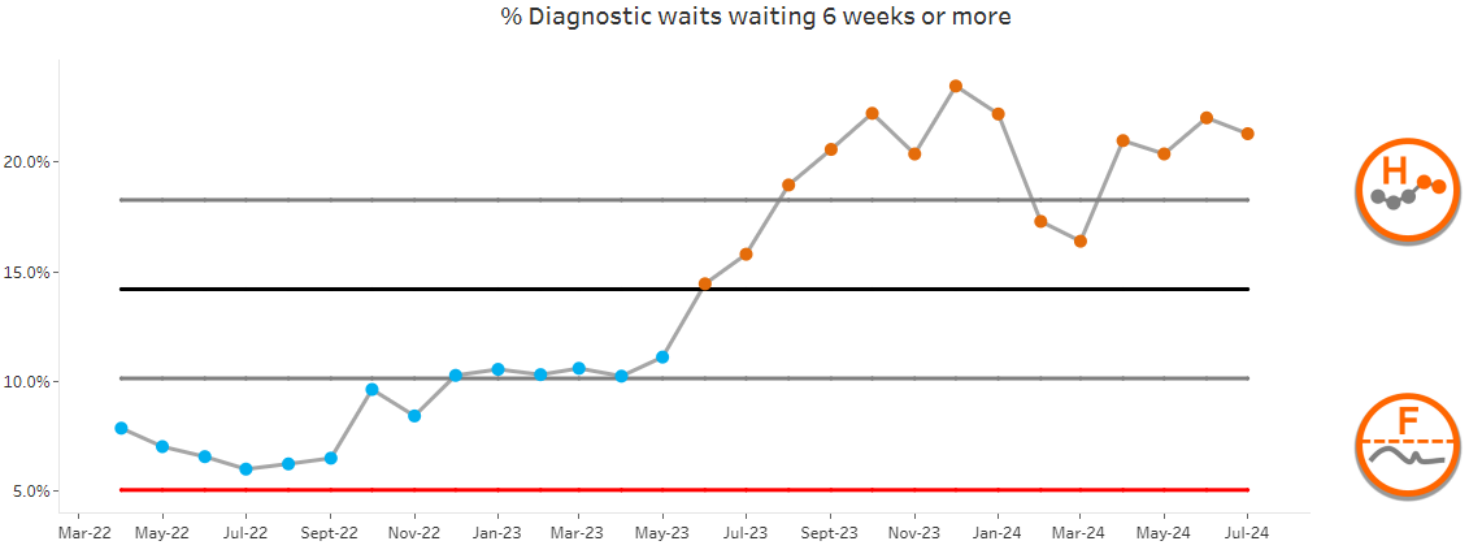
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The Emergency Department 4hr performance (all types) was better than target in July and therefore would not normally be included in an assurance report. This has been retained to illustrate the significant improvement in 2024. **All types 4-hr Trust performance was 78.7% in July, making OUH best in the ICB and Shelford Group.** Type 1 performance was 72.1% making OUH second best in the ICB and Shelford Group. Breach performance by site was 72.86% for all types and 65.78% for Type 1 at the John Radcliffe Hospital (JR) and 91.4% for all types and 87.71% for type 1 at the Horton Hospital in July. There was a continuation in high monthly attendances through July. 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 58% of all 4-hour breaches in July 2024. Of increasing concern is non admitted breaches where 70% of breaches were due to waiting to be seen. Skill mix of medical staffing is a key area of focus and whilst recruitment takes place, as an interim solution, shifts have been offered on an additional session basis but with limited fill rate. The ED Observation and Review Unit continues to make a positive impact on patient experience and safety. This could be fully maximised once funding approved, and post recruited to (RN's and senior decision makers 24/7). A focus on breaches through the day is becoming sustainably embedded in the Operational site meetings.	**Senior Medical Decision Maker (Consultant) in the JR ED in the overnight period.** • ED workforce models – supported by Trust Management Executive. Consultation complete with existing workforce and recruitment underway. • One overnight shift can start in October 2024 and increasing to 2 nights by November 2024. • **Metrics:** - 4hr breach performance (Type 1) - 12hr Length of Stay (LOS) performance **Implement 'Clinically Ready to Proceed' (CRtP) functionality on FirstNet.** • Approval at Trust Wide Urgent Care Group to automate the process for non-admitted patients to increase engagement by using the discharge time as a surrogate marker – completed. Reporting in place. • Non admitted target compliance 70% by the end of Q3 – performance in May 2024 was 87%. **Departure from ED within 60mins of CRtP** • Focus on Non-admitted performance – using discharge time. Process mapping has highlighted the main constraints – target 50% of non-admitted patients. • Improvement projects underway within ED with a focus on pharmacy and transfer lounge usage in the first instance. Triage models being reviewed in line with feedback from visit to exemplar Trust. **Urgent and Emergency Care Quality Improvement Programme 2024/25 is** in development. Trust wide session held with multidisciplinary teams to prioritise improvement ideas. Proposal shared with the Trust wide Urgent Care Group in June and supported by TME.	Completed - Recruitment approach underway through 2024/25 Completed Quarter 1 & 2: Improvement cycles being undertaken into 2024/25	BAF 4 CRR 1133 (Red)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months, and independent audit completed in last 18 months*

3. Assurance report: Operational Performance, *continued*



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
The proportion of patients with a length of stay of more than 12 hours in the Emergency Department was 2.44% in July, sustaining improvement since December 2023. This is the fifth consecutive month of achieving below the mean average of 5.6%, however remains just above the target of 2%. The indicator has consistently not achieved the target. There was exceptional performance at the Horton with 0.67% of patients residing in ED for more than 12 hours. The John Radcliffe improved at 3%. Trust occupancy of General and Acute beds in July has reduced from last month but remains high at 93.71%. The ED Conversion rate to admission was high for the month at 35.19% at the JR and 23.46% at the Horton. This is above the 2-year average by 2.78% at the John Radcliffe and 4.26% at the Horton Hospital. SDEC capacity has been protected and there was no overnight opening of AAU. A programme of summer bed closures have come in effect from 1st June to enable capacity to be flexed up as needed in the autumn and to reduce temporary workforce requirements. Patients whose discharge was delayed remain a challenge with 2737 bed days lost in July to this cohort of patients. The average number of days delayed was lower than last month by 1.6 days at 5.7 days in July. 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 attendances, is the medical and social complexity of patients, and there has been an increase in the number of patients becoming medically optimised for discharge with the Transfer of Care Hub reviewing a very large number of referrals per day. The new Discharge Sit rep came into effect late in May which will result in an increased ability to accurately articulate the reason a patient's discharge is delayed and increase the number of patients returning to their normal place of residence. OUHFT is holding its position as the best performing Shelford Trust for patients with a length of stay over 21 days.	**Departures within 60mins of the Decision to Admit** • Three pathways are being supported through the UEC QI Programme – Mental Health, Frailty and Heart Failure. Each pathway has a number of initiatives that are currently progressing through the PDSA cycles of improvement. • The live bed state programme launched in Q3 23/24 with phase 1 successfully implemented across the Trust during Q4. Work continues to develop scope and plans for phase 2 which is due to launch later this year. • Pilots of the Board Round policy have been underway which have seen positive impacts on length of stay on those wards.	Trust Wide Urgent Care Group	BAF 4 Link to 1133 (Red)	Sufficient *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: June 24 DM01	
OUH	22.0%
National	19.1%
Shelford	28.7%
ICS	BHT: 16.7% RBH: 24.4%

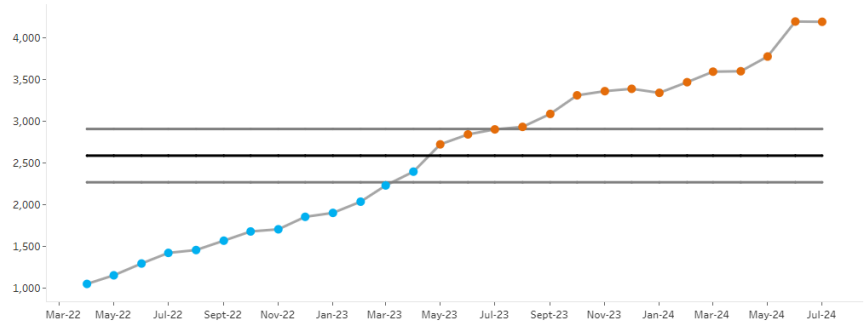
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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 21.3% in July. 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%. **Complex Audiology**: • Significant increase in demand and vacancies has driven a deficit with capacity due to ENT pathway change. **Endoscopy:**. • 1 Consultant fixed term contract ends 06/08/24 with expected 6-month gap • 1 Nurse Endoscopist undergoing training	**Audiology:** • The transfer of a cohort of clinically appropriate patients to Another Qualified Provider (AQP) has commenced. • Approved Business case to replace 2023/24 ERF scheme. Recruitment is underway. New ERF scheme for 2024/25 approved to provide additional capacity and accelerate backlog recovery with implementation underway. New provider being sourced. • Waiting list validation has been undertaken across the PTL. • Capital programme scoped to provide additional capacity at the Horton General Hospital and a re-review at the Community Diagnostic Centre. **Endoscopy:** • Triaging pilot has now been adopted as BAU • Training list requirements have been reviewed • Ongoing work on efficient booking processes to actively avoid breaches • Demand and capacity modelling identified deficit - Business Case to be completed and submitted to increase capacity and recover backlog • Weekend lists ongoing although limited uptake over summer holidays • 2 Nurse Endoscopists have commenced training for 12-months • All consultants to do 12-point lists unless training list • Insourcing options are being considered as part of ERF allocation	Weekly Assurance meeting will monitor all actions on a bi-weekly basis **Audiology:** Improvement expected once transfer to AQP agreed via ICS – take effect from 8th July 2024 **Endoscopy:** Demand did not level off in Q4 as expected. This has contributed to a delay with backlog recovery. ERF funding approved in May and a re-appointment of a locum will commence in due course – this will support backlog recovery and timescale will be determined upon appointment.	BAF 4 Link to CRR 1136 (Red)	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

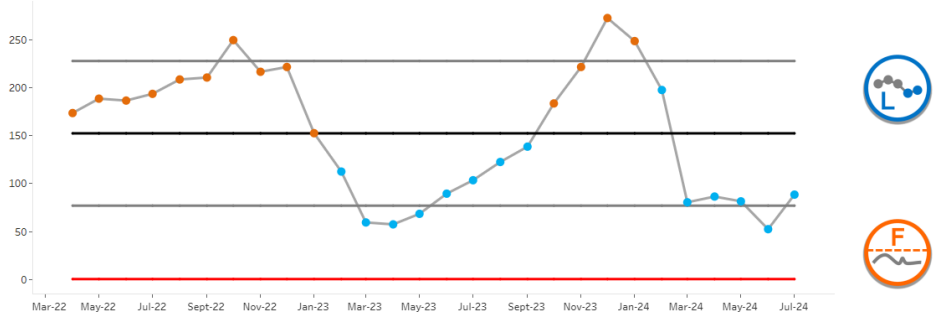
3. Assurance report: Operational Performance, *continued*

Oxford University Hospitals NHS Foundation Trust

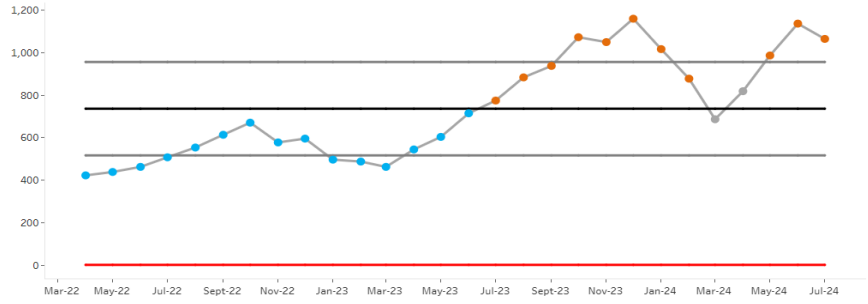
RTT standard: >52-week incomplete pathways



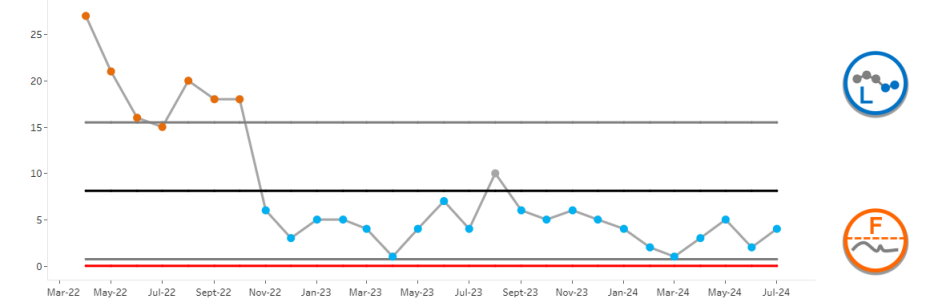
RTT standard: >78-week incomplete pathways



RTT standard: >65-week incomplete pathways



RTT standard: >104-week incomplete pathways

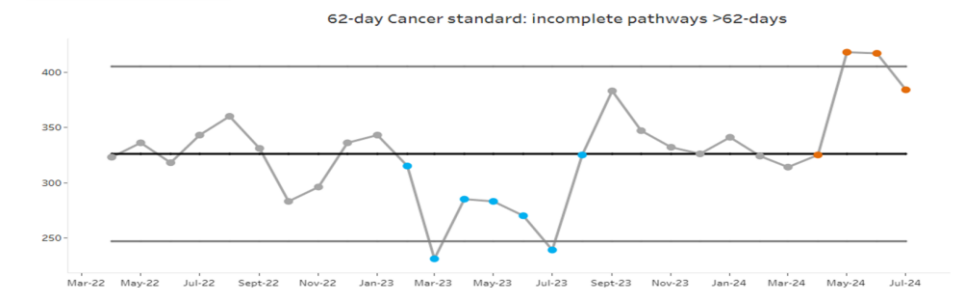


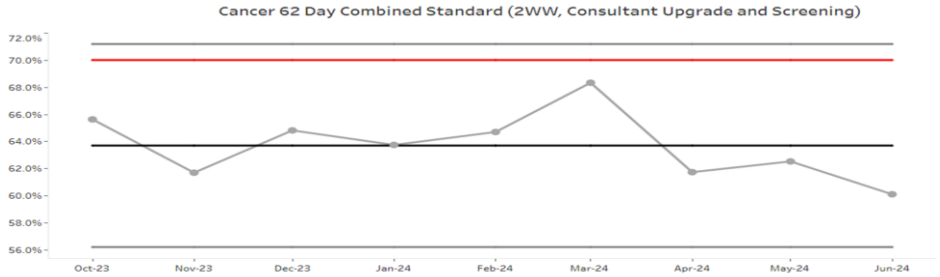
Benchmarking >52-weeks: June 24	
OUH	4,180
National	1,604 (avg.)
Shelford	3,979 (avg.)
ICS	BHT: 1,915 RBH: 26

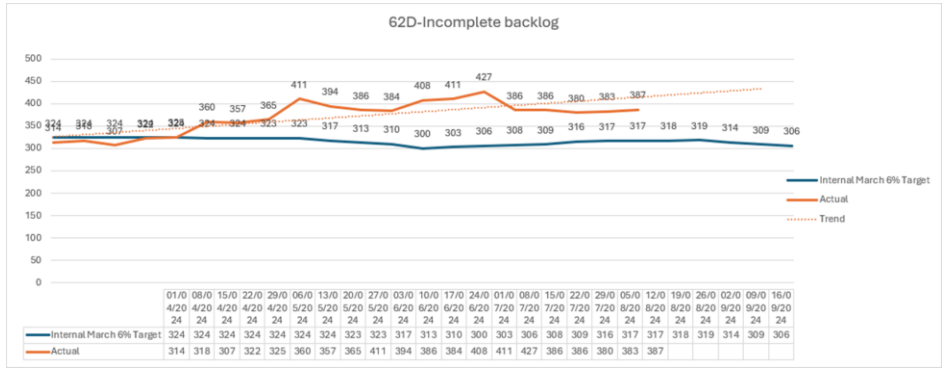
ICS key	
BHT	Buckinghamshire Healthcare NHS Trust
RBH	Royal Berkshire NHS Foundation Trust

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 4,182 at the end of July. 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** - Four incomplete pathways in total breached. 2 x Choice and 2x Capacity. **78 weeks** - **88** incomplete pathways of which 49 were due to capacity, 11 due to Patient Choice reportable (C1), 27 due to Complex pathways, and 1 Corneal transplant. **65 weeks –** 1,063 incomplete pathways reported which is a decrease from the previous month. Focus remains in place to deliver nil pathways beyond 65-weeks by end of September in line with the Trust's Operating Plan 2024/25. Services not as challenged are undertaking recovery of **52-week backlog.**	• **Orthopaedic services** contract in place with additional 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 has started. • **Gynaecology, Urology & ENT services** have started transfer of H2 1st outpatients willing to travel to BOB partners. Extended theatre sessions in place. • **Adoption of the national Interim Choice Guidance** has reduced the number of reported incomplete RTT Pathways. Tracking of these patients continue via Elective Assurance meeting led by the Chief Operating Officer. • **Elective Recovery Fund** schemes live and tracked at ECRG • **Anaesthetic services** 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 - forecasting >10% reduction in the cohort by end of July for this cohort. Phase 2 started, which includes contacting booked patients in the future to be offered an earlier date at BOB Partner providers.	Delivery of 65-week plan by September 2024 All actions are being reviewed and addressed via weekly Assurance meetings and Elective Recovery Group	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local and Corporate audit undertaken in last 12 months*

3. Assurance report: Operational Performance, *continued*







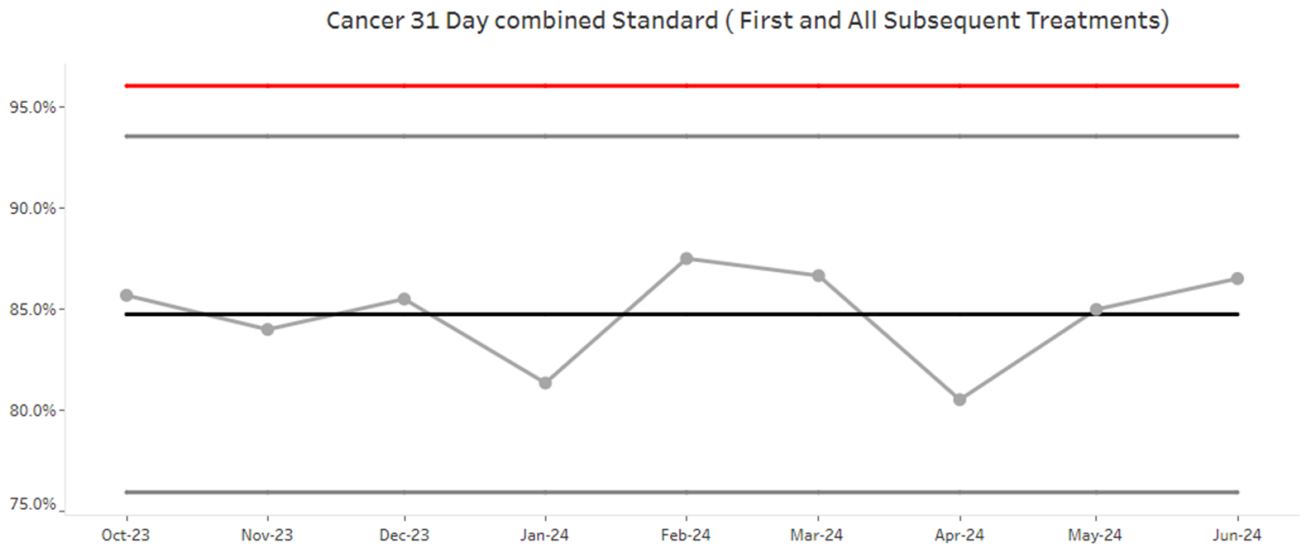
01/04/24	08/04/24	15/04/24	22/04/24	29/04/24	06/05/24	13/05/24	20/05/24	27/05/24	03/06/24	10/06/24	17/06/24	24/06/24	01/07/24	08/07/24	15/07/24	22/07/24	29/07/24	05/08/24	12/08/24	19/08/24	26/08/24	02/09/24	09/09/24	16/09/24
24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24
Internal March 6% Target	324	324	324	324	324	324	324	323	323	317	313	310	300	303	306	308	309	316	317	317	318	319	314	309	306
Actual	314	318	307	322	325	360	357	365	411	394	386	384	408	411	427	386	386	380	383	387					

Benchmarking: June 24 62-day General Standard	
OUH	60.1%
National	70.4%
Shelford	62.7%
ICS	BHT: 61.2% RBH: 72.5%

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

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards have changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 62 days combined standard was 60.1% in June 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 Brain, Children, Haematology –Leukaemia, Sarcoma, Skin, and Urology - Testicular are non-compliant for this standard in June. **Challenges identified:** • Complex tertiary level patients (8%) • Some slow pathways and processes (1%) • Capacity for some surgery, diagnostics and oncology (73%) • Late inter provider transfers (15%) • Patient reasons (3%) **>62-day combined PTL** has decreased in size but remains above trajectory of delivering 6% proportion of long waits in June 2024.	**The Cancer Improvement Programme is** focussing on 28-day Faster Diagnosis Standard (FDS). For June, **the Trust reported 81.1% and has delivered above the 75% standard consecutively since June 2022**. FDS remains a key priority for 2024/25 as well as addressing the challenges faced with delivering treatment for our patients by day 62. **Performance of >62-day PTL vs plan –** recovery includes: • Incomplete and late Inter-Provider Transfer analysis and escalation • Surgical capacity through theatre reallocation • Patient engagement through the Personalised Care agenda • SOP and escalation of benign patients awaiting communication **Waiting List Census 13/08/2024:** **Urology** remains the highest deficit to plan for >62-days (146) and significantly above trajectory (87). PET PSMA delays have 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 revised in conjunction with this improvement. **Head and Neck** – holds the second highest volume (45) and are significantly above trajectory (25). Recruitment to additional consultant staff underway. TVCA schemes to include additional theatre lists, MOS biopsy sessions and outpatient clinics. **Lower GI** – holds the third highest volume (42) which is significantly above trajectory (23).Additional endoscopy capacity being identified, shortfall in staff in colorectal USC nursing team, some posts recruited to with training underway.	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)	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*

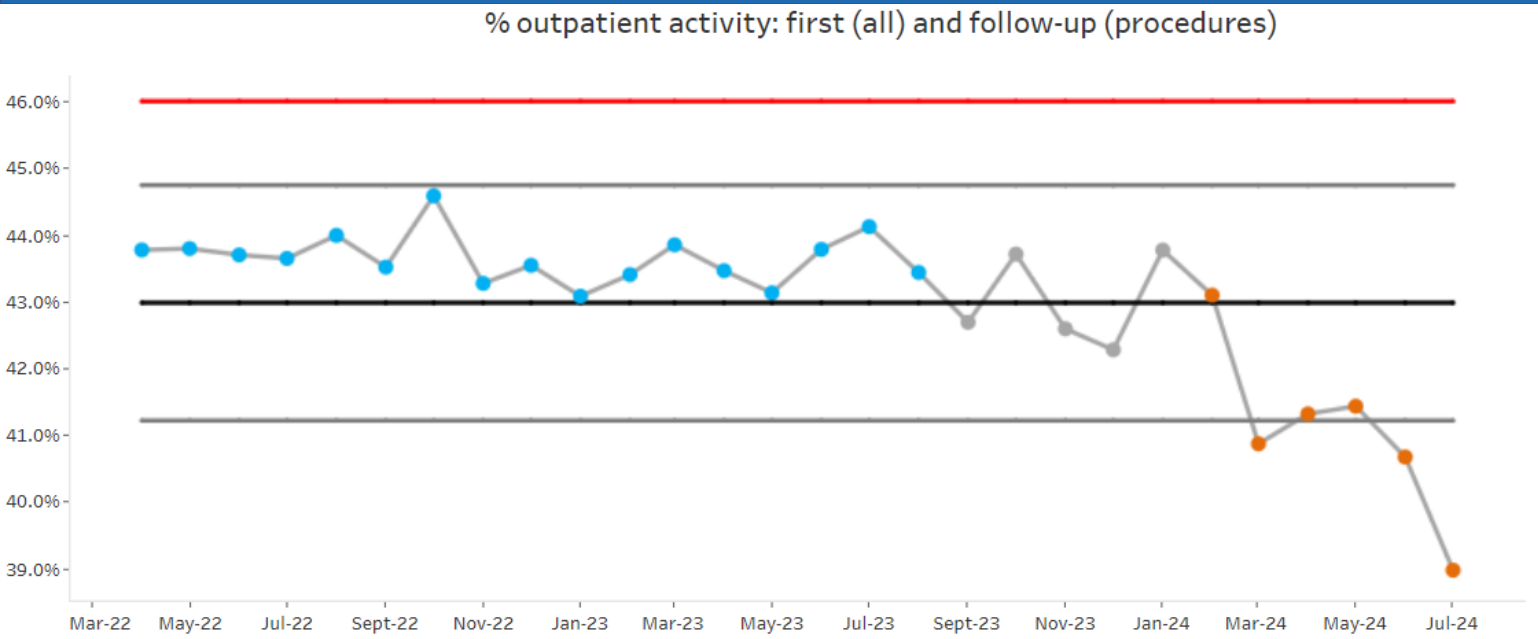


Benchmarking: June 24 31-day General Standard	
OUH	86.5%
National	93.2%
Shelford	88.9%
ICS	BHT: 81.6% RBH: 93.2%

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

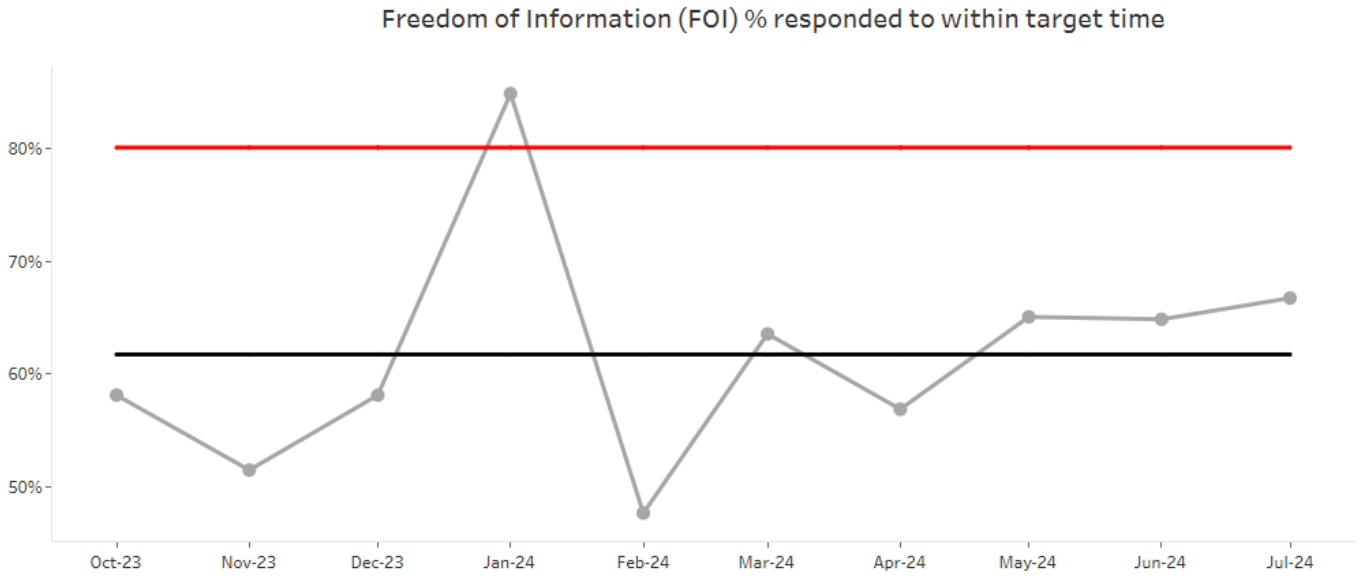
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Reporting of Cancer Standards changed from October 2023 in line with the National Cancer Waiting Times guidance. Cancer performance against the 31-day combined standard was 86.5% in June, 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 April was 80.5% 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 patients transferred between BHT/RBH as a whole pathway. This will release theatre capacity to support 65-week backlog and cancer surgical treatment within 31-days. Agreement to run a minimum 96% theatre lists during term time and a minimum of 89% during peak holiday periods throughout the year. Mitigating cancellation reasons and utilisation lists from 6-4-2 process. Process map of Prehab services to redesign a lean digitise process underway to expand provision within the workforce establishment to bridge gap in unmet need and increase opportunity for improved uptake of theatre slots within 31-days relating to fitness, willingness and ability. Also supporting post recovery to improve patient experience. This follows on from the Onko pilot in 2023/24.	Q4 2023/24 Q4 2023/24 staggering into 2024/25 for other specialties not named. Q3 2024/25	BAF 4 Link to CRR 1135 (Amber)	Sufficient *Standard operating procedures in place, staff training in place, local audit undertaken in last 12 months and independent audit undertaken in previous 18 months*

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 *37.5% in July. 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 to review any patterns or variation to previous year's performance at specialty level. Findings will be discussed via ECRG. This will help identify some opportunities. 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 - July 2024 ECRG – July 2024	BAF 4 Link to CRR 1135 (Amber)	

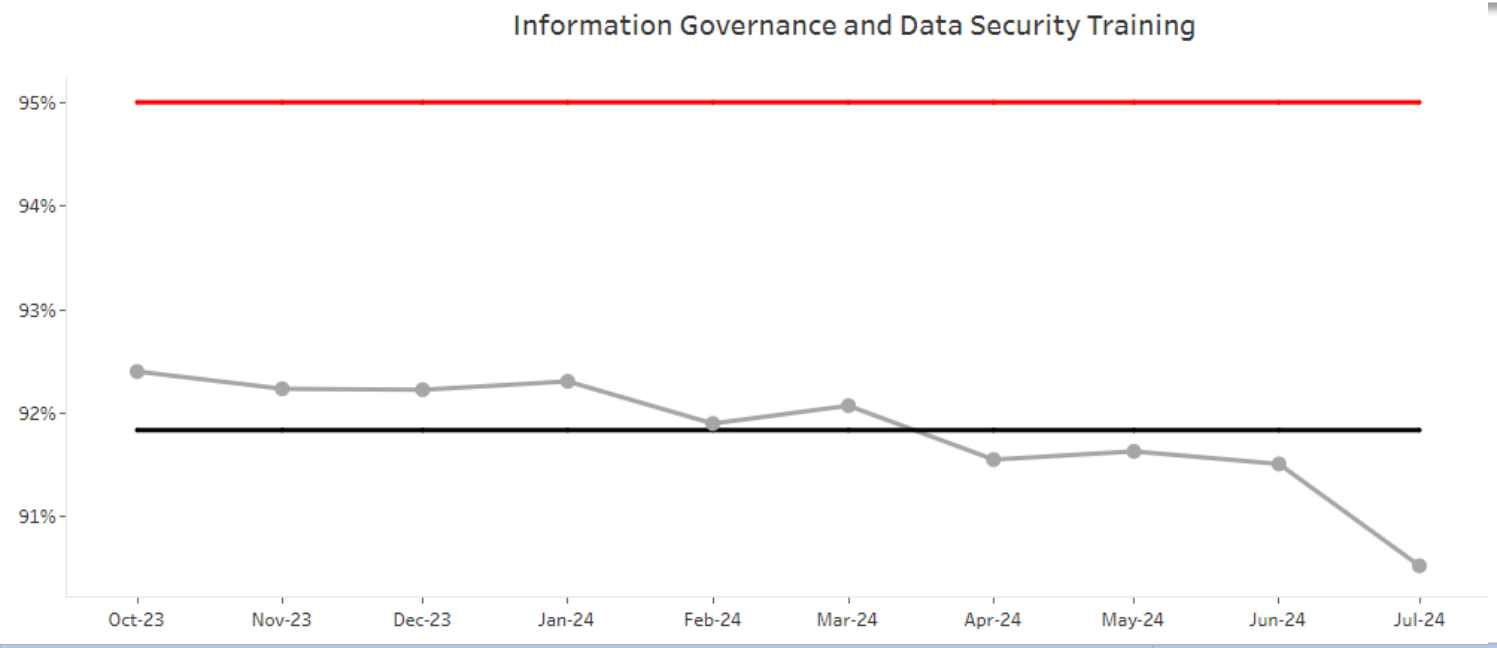
3. Assurance report: Corporate support services - Digital, *continued*



Month	Number of requests received by month	Number of requests closed within 20 working days	Perecentage of received requests closed within 20 working days
Feb-24	63	30	48%
Mar-24	63	40	63%
Apr-24	44	25	57%
May-24	60	39	65%
Jun-24	71	46	65%
Jul-24	81	54	67%

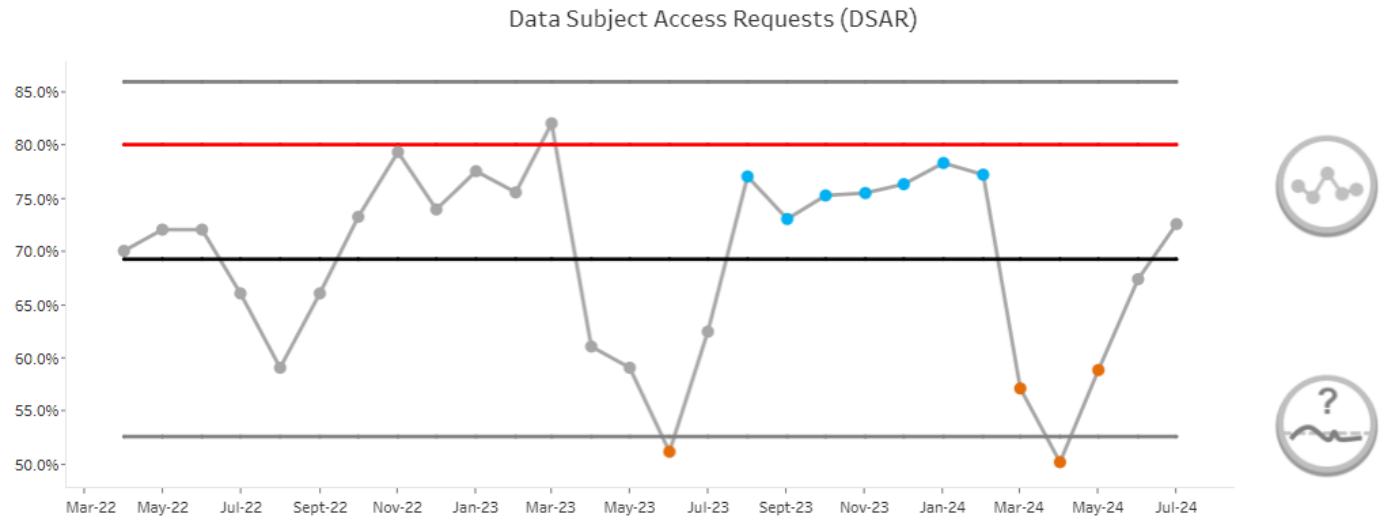
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
M4 FOI performance against the 80% target remained below the performance standard at 67.0% and exhibited common cause variation. A further increase in the number of cases received means that although 54 cases were closed on time, the 2nd highest number ever closed on time and an improvement on the 46 closed in M3, means that performance as a percentage has only improved 2 points to 67% In the last 4 months significant amount of IG staff time has been taken up processing 3 very large (>500 page) staff Subject Access Requests. This work is very time consuming and has similar legal status to FOI requests. Usually only 1 or 2 of these would be received per year. Complex requests and signoff with clinical areas also means these SARs are taking longer to complete.	Performance (completed work) as an absolute figure continues to increase with staff becoming more familiar with the processes 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. 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.	The effect of increased team capacity and process will be visible in M2 with full compliance anticipated by M6 Review of pilot by M3 and paper with recommendations to follow in M4 (presented to Sept DOC) Assurance reviewed at Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



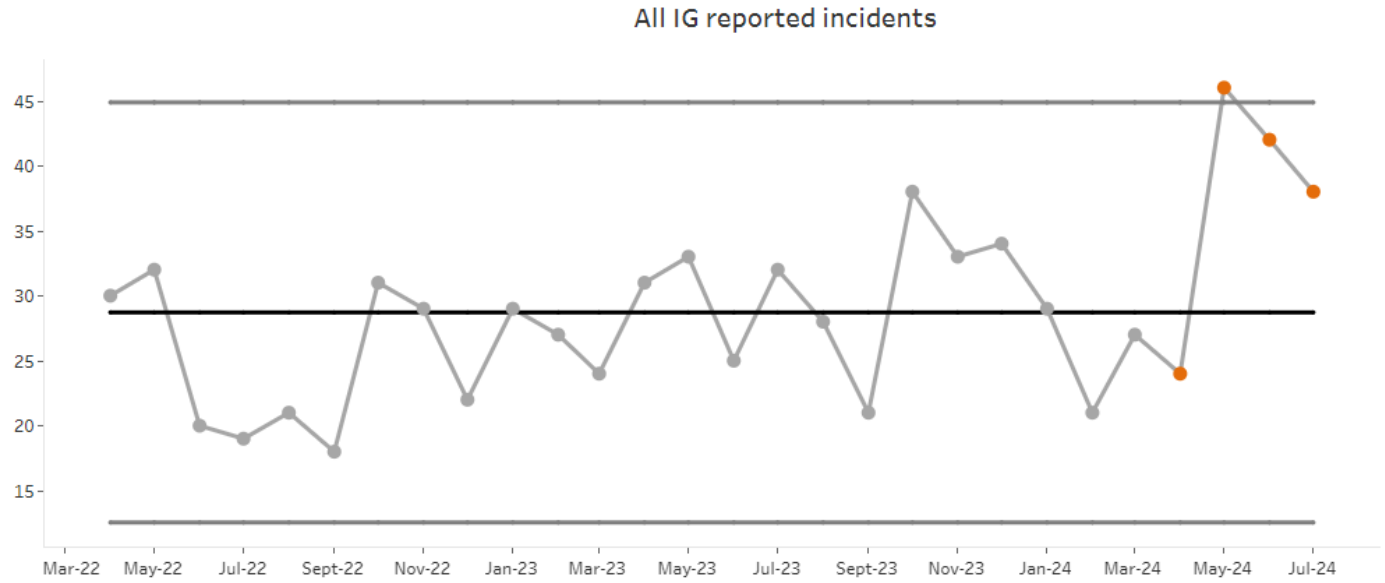
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
Data security and Protection Training (DSPT) compliance was 90.5% in M4 – this is a drop of 0.9% since M3 and suggests that over 1600 staff dropped out of compliance between M4 and M4 Completion of IG training forms part of the mandatory training associated with VBAs, so the completion rate should have improved the VBA window went on – this was observed in previous years but has not happened in 2024. The sharp dip in reported compliance in M4 does not correlate with the reported VBA completion rate. The sharp drop off shows how many were completed with VBAs in the last 4 weeks of last year that have not been this year. All staff need to understand this is “everyone's” responsibility, IG are reporting the Trust position.	IG, Data & Analytics and Leadership & Culture teams to meet to discuss discrepancy between VBA and IG training performance. 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. This will be added to the Divisional KLOEs to ensure it is managed at a local level.	Actions and performance are overseen by the Digital Oversight Committee First meeting to discuss new DSPT requirements & format is September	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 M4 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 95% of their 189 requests on time, and Information Governance 66% of their three requests. PACS are still recovering M12's issues and clearing their backlog, and M4 performance was 69% of their 234 cases closed on time, an improvement of 9% over M3 Subject Access to medical records team within legal services returned 64% of their 422 cases on time, consistent with last month's performance of 63%	PACS' situation has not changed since M2– they 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 will not start to have an impact on the 30 day target performance until M5.	Actions and performance are overseen by the Digital Oversight Committee	BAF 6	Satisfactory *Standard operating procedures in place, training for staff completed and service evaluation in previous 12 months, but no Corporate or independent audit yet undertaken for fuller assurance*

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



Summary of incident	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data quality rating
37 incidents were reported to IG in M4, a high number but no pattern or theme observable this month. 3 instances of lost/found printed paperwork which is a reduction from M2 and M3	Work with colleagues in ED to investigate and give assurance on their concerns regarding colleagues inappropriately opening the records of patients with “interesting” reasons for visits is continuing IG and Data & Analytics teams are working to develop a tool using staff data in servicenow and EPR to significantly reduce the time needed to generate the data needed to perform an inappropriate access investigation. Comms about using Powerchart touch instead of printing out ward lists being developed as this is still an issue.	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

Oxford University Hospitals NHS Foundation Trust

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

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

2. Framework for levels of assurance:

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