Integrated Performance Report (IPR) Report: May 2022

April 2022 data

Assuring the Board on the delivery of the Trust's 4 strategic objectives; quality, people, sustainability and research and education

Section 1:

Introduction to the Trust strategy 2021-2026

Introduction to the Trust Strategy 2021-2026

Executive Summary: Martyn Ward, Director of Strategy and CIO

Introduction to the Trust Strategy 2021-26

Oxford Health NHS Foundation Trust (OHFT, the Trust) has developed an organisational strategy for the five year period 2021-26. The aim of the strategy is to set the Trust's long-term direction, guide decision-making and address strategic challenges – for example rising demand for and complexity of healthcare, recruiting and retaining a stable workforce, and ensuring sufficient resourcing. Following the publication of the 2021 NHS White Paper, the NHS is likely to change over the period of the strategy - shifting from a commissioner/provider model to one characterised more by system working and collaboration with healthcare partners (NHS, local authority, independent and third sector) focused on collectively improving overall population health and addressing health inequalities.

The Trust's vision is Outstanding care by an outstanding team, complemented by the values of being Caring, Safe & Excellent. Flowing from the vision and values are four strategic objectives:

1. Deliver the best possible care and outcomes (Quality)
2. Be a great place to work (People)
3. Make the best use of our resources and protect the environment (Sustainability)
4. Become a leader in healthcare research and education (Research & Education)

Key focus areas and Objective Key Results

To move the strategy into a focus on delivery, each strategic objective has been developed into a set of key focus areas (workstream descriptors). The aim of the key focus areas is to identify priority activities and workstreams for the Trust over the coming years and to provide a bridge between the high-level ambitions of the strategic objectives and a set measures and metrics to track progress. Existing and new measures and metrics have been gathered and/or created using an Objective Key Results (OKRs) approach. OKRs allow for measurement of activities that contribute to key areas of focus and workstreams and will be reported to relevant Board committees and Board via an Integrated Performance Reporting approach.

While the key focus areas are intended to be fixed for the lifespan of this strategy, the OKRs can be updated and added to as required. To enable this, the OKRs are an appendix to the main Trust strategy document. This approach allows for a consistency of approach for the strategy but the flexibility to adapt the metrics used to measure progress. For example, a specific OKR may be achieved and can then be replaced with a new target.

This report reports delivery of the strategy and performance against the OKRs. Supporting data and narrative is supplied where there is underperformance.

Section 2:

Trust Headlines;

Key risks, issues and highlights from Executive Managing Directors

Directorate highlights and escalations: Mental Health, Learning Disabilities and Autism

Executive Director commentary:
Grant MacDonald, Executive Managing Director, Mental Health, Learning Disabilities and Autism

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Workforce challenges	Issue	The central recruitment team have recovered capacity and capability as described below to support the services in ensuring there are a rolling campaign to fill vacancies alongside exploring creative approaches to attraction. Alongside this there are several 'new role' initiatives being pursued as well as opportunities for appropriate oversees recruitment; together with a range of organizational development activities to support retention. Finally temporary staff are used to maintain service levels and the agency management work programme is aiming to reduce reliance on temporary workers sourced in this way.
CIP programme	Risk	Initial progress has been made in identifying cost improvements in the directorates and further work is ongoing to identify recurrent savings from budgets to move towards targets.
Cost Control	Risk	Alongside the agency reduction programme and work to reduce out of area placements the key cost reduction work is aimed right sizing the requirements for additional staff to manage fluctuations in acuity.
Waiting times to assessment and treatment	Issue	The trust is taking part in a southeast region collaboration to benchmark waiting times and share learning on management strategies. The first draft of information is being used to improve and clarify definition of outputs. Alongside this the trust is engaging clinical colleagues in developing measures where no national measures exist to aid understanding of the issue and support decision making on resource allocation to address.
Acute Out of Area Placements	Risk	This continues to be a challenge for the trust and appropriate and inappropriate acute OAPs combined for April were slightly higher than any month in the previous year. There are a range of plans in place to improve management which are being reviewed and developed in the context of changing infection control arrangements.

Directorate highlights and escalations: Primary, Community and Dental Care

Executive Director commentary:
Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Workforce challenges	Issue	International recruitment has resulted in successful recruitment for CHs and Community Nursing (DN service has recruited 15 international nurses). Some challenges with practical issues to resolve (e.g. driving licences and accommodation).
CIP programme	Risk	Significant savings to be identified in addition to reduction on covid funding. Approach agreed with finance team; detailed planning work is underway on optimising costs in OOH GP and CH services in particular.
OOH GP service	Risk	Risks with sustaining service at peak times due to high demand and ongoing workforce and rota challenges. Additional management support being put in place to respond to identified issues, with support from HR team on rota issues
Childrens Therapy Service Waits	Issue	Verbal offer from commissioners for c.£700K for CIT (children's therapy) service to address increasing waits and patient need, following business case
Intensive Community Care	For information	Workshop planned in May with Oxfordshire system partners to develop plan for 'Intensive Community Care' pathway, including integration proposals for hospital at home, urgent community response and ambulatory care services.
Managing demand and capacity risks	Highlight	Discussion at Audit Committee: •There are examples of good risk management in many services, but a recent review indicates a more systematic and data-driven QI approach would be of benefit •Strategic developments over the next year will focus on optimising capacity and efficiency (e.g. provider collaborative and Oxfordshire integrated improvement programmes) •Members expressed a need for more protected resource and expertise to enable root cause analysis of capacity gaps and targeted work on monitoring the impacts of waiting times on patients in certain services

Section 3:

NHS Oversight Framework performance

National objective: Compliance with the NHS Oversight Framework

This year, the NHS Oversight Framework indicators that have targets are;	Target	National position	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	72.3% (Apr)	91% (Apr)	↓
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	71% (Dec)	75.6% (Mar)	↓
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	64.6% (Mar)	97.9% (Mar)	↑
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	46.9% (Mar)	48% (Mar)	↓
(N5) IAPT - Percentage of people waiting six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	75%	89.7% (Jan)	99% (Jan)	↑
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.4% (Jan)	100% (Jan)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	13 (Apr)	↑
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	192 (Apr)	↑

Governance:
Executive Director: Director of Digital and Transformation | **Responsible Committee**: Quality Committee | **Responsible reporter:** Claire Page

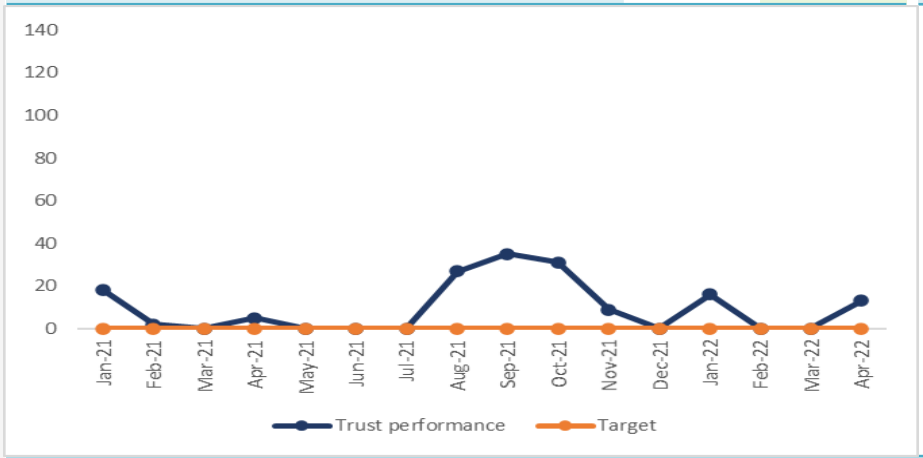
Executive Summary: Martyn Ward, Director of Digital and Transformation | **Narrative updated**: 13 May 2022

About: The NHS Oversight Framework replaced the provider Single Oversight Framework and the clinical commissioning group (CCG) Improvement and Assessment Framework (IAF) in 2019/20 and informs assessment of providers. It is intended as a focal point for joint work, support and dialogue between NHS England and NHS Improvement, CCGs, providers and sustainability and transformation partnerships, and integrated care systems. The table above shows the Trust's performance against the **targeted** indicators in the framework. Areas of non-compliance are explained overleaf.

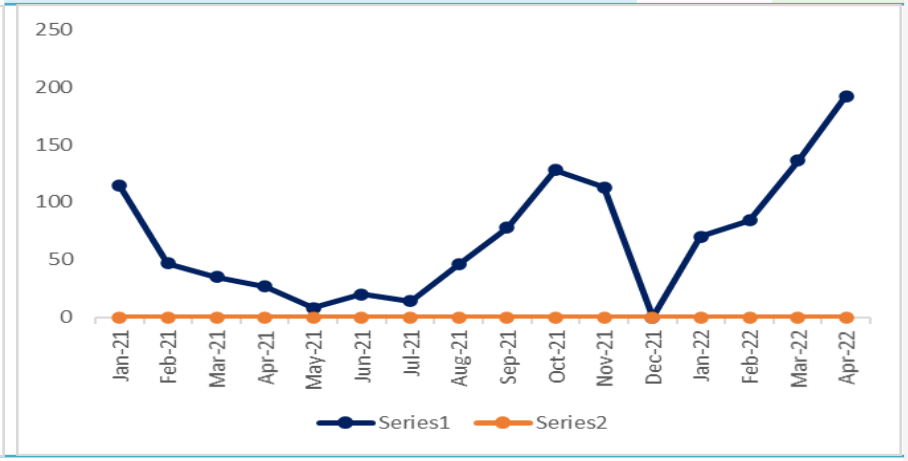
Performance: Overall performance is good with all indicators consistently achieved over the past 12 months, with the exception of the number of inappropriate out of area placements. Please see overleaf for more information on OAPs

National Objective: areas of underperformance

NHS Oversight Framework Metric	Target	Actual
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Bucks)	0	13



NHS Oversight Framework Metric	Target	Actual
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Oxon)	0	192



Executive Director commentary: Martyn Ward, Director of Strategy and CIO
Narrative updated: 10 March 2022

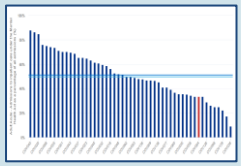
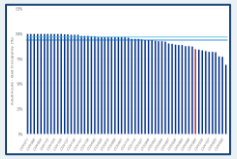
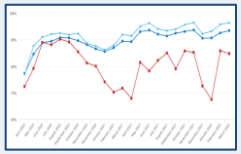
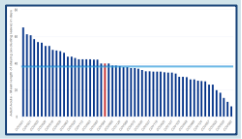
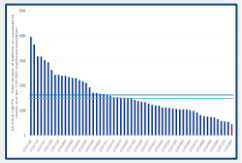
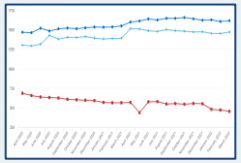
The issue and cause
The Trust achieved the OAPs target in December. The Trust continues to have reduced bed capacity as a result of Infection Prevention Control (IPC) guidance. The Trust has been operating throughout the year with up to 15% less capacity in the Adult and Older Adult Mental Health wards. The interim closure of beds has resulted in additional Out of Area placements which the Trust has mitigated by purchasing a block contract beds.

The plan or mitigation
Following recent NHSE/I guidance the Trust has reviewed the use of OAPs and is assured that continuity of care principles are adhered to. Reporting from April 2021 reflects this change and please note this change when viewing performance against historical trend. **April 2022 locally reported usage was 13 OAP beddays in Bucks, and 192 OAP beddays in Oxon.** In April, changes to IPC guidance have allowed the facilitation of patients who have completed their 14-day period of isolation and are COVID negative to be repatriated to vacant Oxford Health beds. Therefore, maximising bed capacity and reducing the need to purchase further inappropriate OAP.

Section 4a:

Comparative/Benchmarking Data

How do we benchmark (March 22* MH & LD Covid-19 Monthly Benchmarking) *latest data available

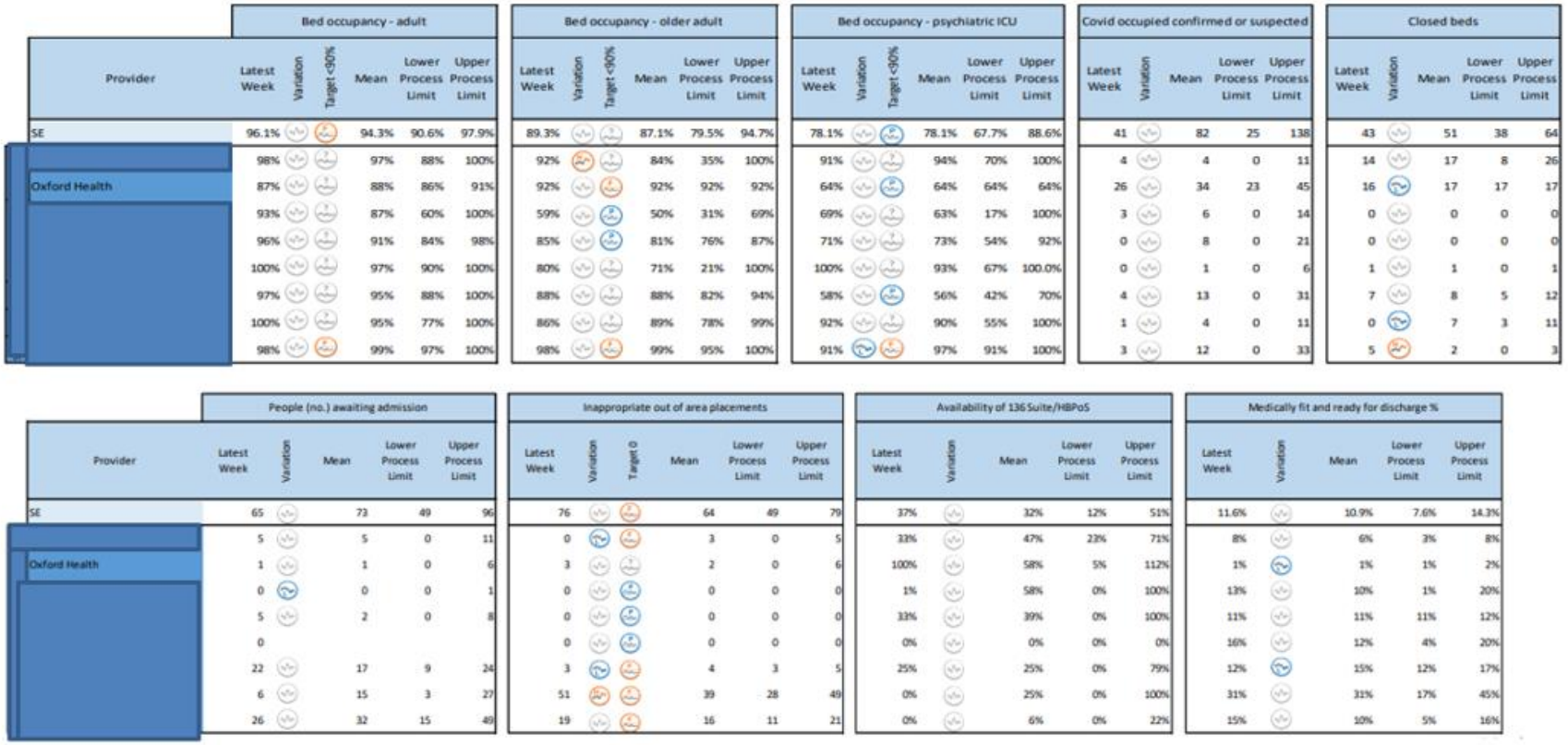
Service Area / Currency	Latest Trust Position OHFT Red bar, other Trusts in blue	Trust Trend OHFT red line, national averages in blue	Latest Trust Position	National average (mean)	OHFT versus National	Commentary
Admissions to inpatient care under the MHA as a % of all admissions			33.33%	50.97%	Lower	In March admissions under the MHA was lower than the national average for the first time in 12 months. The annual benchmarking indicates that the Trust bed provision is more costly per OBD than the national average.
Adult Acute Bed Occupancy (%)			84.77%	93.41%	Lower	OHFT has continued to have reduced bed occupancy to facilitate compliance with infection prevention controls. This has more impact in Oxon where the age of estate presents greater challenges. Oxon adult acute wards occupancy May 21 to April 22 average is 80.51% compared to 81.95% in Bucks.
Adult Acute Mean LOS (exc leave) in Days			40.00	37.75	Higher	OHFT LOS in March 22 was higher than national average. There is variation month on month in LOS. Operational services are exploring ways of reducing LOS in Oxfordshire. In the annual benchmarking for the same measure the Trust was the highest nationally based on 20/21 data
Adult CMHTs Total number of patients on caseload at month end per 100,000 reg pop			449.20	1613.58	Lower	This monthly benchmarking exercise only counts as being on caseload where there are two face to face contacts delivered. There are a number of factors why this approach would make OHFT lower: • Our high use of digital/telephone methods of delivery of care • Our system configuration does not allow for transfer from team to team so we may not achieve 2 contacts within a referral as quickly as other Trusts who can transfer the referral from one service to another • Challenges in some services with accurately recording all appointments delivered. Enhancements to Carenotes were introduced at the end of Nov 21 to support easier recording of activity information. In the annual benchmarking for the measure total cost per contact to Adult CMHTs the Trust benchmarked higher than the national average.

Section 4b:

SE Regional Performance including Provider Collaborative Performance

Mental Health - pressures

Weekly data 12 weeks to 03 May 2022



Provider	Bed occupancy - adult					Bed occupancy - older adult					Bed occupancy - psychiatric ICU					Covid occupied confirmed or suspected				Closed beds				
	Latest Week	Variation	Target <90%	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Target <90%	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Target <90%	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Mean	Lower Process Limit	Upper Process Limit
SE	96.1%			94.3%	90.6%	97.9%	89.3%			87.1%	79.5%	94.7%	78.1%			78.1%	67.7%	88.6%	41		82	25	138	43		51	38	64
	98%			97%	88%	100%	92%			84%	35%	100%	91%			94%	70%	100%	4		4	0	11	14		17	8	26
Oxford Health	87%			88%	86%	91%	92%			92%	92%	92%	64%			64%	64%	64%	26		34	23	45	16		17	17	17
	93%			87%	60%	100%	59%			50%	31%	69%	69%			63%	17%	100%	3		6	0	14	0		0	0	0
	96%			91%	84%	98%	85%			81%	76%	87%	71%			73%	54%	92%	0		8	0	21	0		0	0	0
	100%			97%	90%	100%	80%			71%	21%	100%	100%			93%	67%	100.0%	0		1	0	6	1		1	0	1
	97%			95%	88%	100%	88%			88%	82%	94%	58%			56%	42%	70%	4		13	0	31	7		8	5	12
	100%			95%	77%	100%	86%			89%	78%	99%	92%			90%	55%	100%	1		4	0	11	0		7	3	11
	98%			99%	97%	100%	98%			99%	95%	100%	91%			97%	91%	100%	3		12	0	33	5		2	0	3

Provider	People (no.) awaiting admission					Inappropriate out of area placements					Availability of 136 Suite/HBPoS				Medically fit and ready for discharge %				
	Latest Week	Variation	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Target 0	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Mean	Lower Process Limit	Upper Process Limit	Latest Week	Variation	Mean	Lower Process Limit	Upper Process Limit
SE	65		73	49	96	76			64	49	79	37%		32%	12%	51%	11.6%		10.9%	7.6%	14.3%
	5		5	0	11	0			3	0	5	33%		47%	23%	71%	8%		6%	3%	8%
Oxford Health	1		1	0	6	3			2	0	6	100%		58%	5%	112%	1%		1%	1%	2%
	0		0	0	1	0			0	0	0	1%		58%	0%	100%	13%		10%	1%	20%
	5		2	0	8	0			0	0	0	33%		39%	0%	100%	11%		11%	11%	12%
	0					0			0	0	0	0%		0%	0%	0%	16%		12%	4%	20%
	22		17	9	24	3			4	3	5	25%		25%	0%	79%	12%		15%	12%	17%
	6		15	3	27	51			39	28	49	0%		25%	0%	100%	31%		31%	17%	45%
	26		32	15	49	19			16	11	21	0%		6%	0%	22%	15%		10%	5%	16%

Please see the following slide for performance headlines in relation to the above.

Regional Performance – South East Integrated Performance Report - 6 May 2022

Bed Occupancy (Adult Acute):

- Oxford Health adult bed occupancy was the lowest in the region, averaging 87% over the past 12 weeks compared to the region average of 96.1%.
- OHFT has continued to have reduced bed occupancy to facilitate compliance with infection prevention controls. This has more impact in Oxon where the age of estate presents greater challenges.

Bed Occupancy (Older Adult):

- Oxford Health older adult bed occupancy was among the highest in the region, averaging 92% over the past 12 weeks compared to the region average of 89.3%.

Bed Occupancy (Psychiatric Intensive Care Unit):

- Oxford Health Psychiatric ICU bed occupancy was among the lowest in the region, averaging 64% over the past 12 weeks compared to the region average of 78.1%. Occupancy has been low due to clinical operational reasons.

MH No. of People Awaiting Admission:

- The number of people awaiting admission to Oxford Health is low in the region, averaging 1 people over the past 12 weeks.
- Across 7 providers the total number of people awaiting admission is 65 on average each week. On average, 2% of people awaiting admission in the region are to Oxford Health

Inappropriate OAPs:

- Oxford Health had low numbers of inappropriate out of area placements the latest weekly snapshot position reported was 3.
- Across 8 providers the total number of inappropriate OAPS was 76. 4% of inappropriate OAPs in the region relate to Oxford Health.

Availability of 136 suite:

- 136 suite availability in Oxford Health is one of the highest in the region averaging 100% availability as at the weekly snapshot position over the past 12 weeks compared to the regional average of 37%.

Mental Health – Children and Young People Services

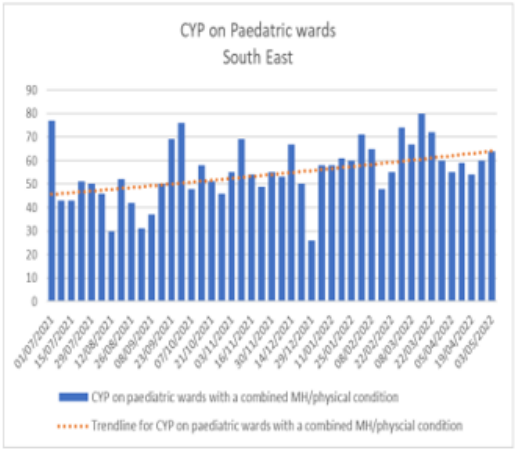
CAMHS T4 bed occupancy

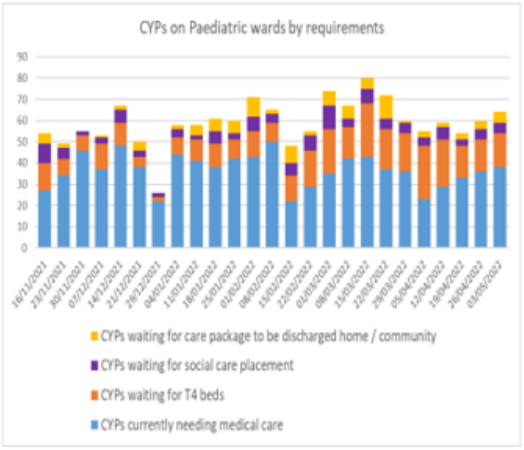
Weekly data 12 weeks to 03 May 2022

NB the table below does not count temporarily closed beds as occupied, and so should not be taken as showing the proportion of beds that are currently available

	CAMHS bed occupancy					
Provider	Latest Week	Variation	Target <85%	Mean	Lower Process Limit	Upper Process Limit
SE	85%			85%	74%	96%
	100%			100%	100%	100%
	90%			89%	87%	92%
	82%			76%	3%	100%
Oxford Health	100%			100%	100%	100%
	8%			40%	23%	56%
	83%			84%	74%	94%
	88%			65%	7%	100%

CYP on acute paediatric wards





Number of CYPs on Paediatric wards: 64

CYPs currently needing medical care: 38
CYPs waiting for social care placement: 5
CYPs waiting for transfer to MH bed: 16
CYPs waiting for MH community care package to be discharged home: 5

Number of CYPs waiting/admitted to s.136 suite or waiting in A&E: 2
Number of CYPs waiting in the community for MH bed: 6

Regional Performance – South East Integrated Performance Report Provider Collaborative - 6 May 2022

Commentary by:
Gillian Combe, Consultant Child and Adolescent Psychiatrist

Demand:

- In March there was a surge in referrals to the Thames Valley T4 CAMHS Provider Collaborative (TVPC), particularly for Eating Disorder services, and this has now settled. There was a similar increase in pre-admission demand in other areas in the South East, namely Wessex & Dorset PC and Kent & Sussex PC. The TVPC achieved the biggest reduction in pre-admission demand between end of March and the beginning of May.

- A current area of focus for the FY2021-2022 is to address the **delayed discharges** of CYP.

Initiatives:

- The TVPC established The Hospital at Home ED (**H@H ED**) pilot with views to reducing the need for T4 admission for ED treatment. The pilot has been successful and the H@H ED is expanding; we have recruited two more RMNs in the last 2 weeks.

- The Berkshire Healthcare NHS FT partner has finished the first year of running the CAMHS **Tier 4 Out of Hospital Care** Services at Phoenix House resulting in fewer young people requiring inpatient admission

Current pressures:

- HHM - Legacy quality issues at the Maidenhead site

- OHFT - High acuity on wards particularly Highfield

Section 5:

Delivery of our four strategic objectives

Objective 1: Quality - Deliver the best possible care and outcomes

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee
All data relates to **April** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results (OKRs) are;	Target	Comm Services	Oxon & BSW	Bucks	LD	Forensics	Pharm	**Trust***	**Trust Trend**
(1a) Clinical supervision completion rate	85%	23.5%	31%	41%		44%		31%	→
(1b) Staff trained in restorative just culture	25 YE	-	-	-	-	-	-	26 (Q4)	→
(1c) BAME representation across all pay bands including board level – **quarterly**	19%	13.4% ↑	17.9% →	31.2% ↓	11.2%↓	45.1% ↑	23.9%↑	19.7% (Q4)	↑
(1d) Cases of preventable hospital acquired infections - YTD	<3 YE	-	-	-	-	-	-	0 YTD	→
(1e) Reduction in use of prone restraint by 25% in year 1 – YTD	<240 YE	-	-	-	-	-	-	251 (YE)	↓ positive
(1f) Patient safety partners employed to be part of the governance structure by August 2022 – **quarterly**	2	-	-	-	-	-	-	0 (Q4)	n/a
(1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP)	90%	-	93%	87%	-	-	-	90.2%	→
(1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT	75%	-	59%	64%	-	-	-	61.5%	→
(1g) Evidence patients have been involved in creating their care plan (clinical audits) - **bi-monthly**	95%	No relevant audits	92%	92%	No relevant audits	91%	-	92% (Q4)	↑
(1h) 30% of clinical staff in non-learning disability services have completed internal eLearning on autism	30% YE	-	-	-	-	-	-	See narrative	→

Objective 1: Quality - Deliver the best possible care and outcomes

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee
All data relates to **April** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results (OKRs) are;	Target	Comm Services	Oxon & BSW	Bucks	LD	Forensic	**Trust***	**Trust Trend**
(1i) Numbers of Pressure Ulcers developed in service category 3 and grade 4	TBC	14	0	0	0	0	14	↓
(1j) 48 hour follow up for those discharged from mental health wards	TBC	-	-	-	-	-	-	-
(1k) 72 hour follow up for those discharged from mental health wards	80%	-	78% (23/30)	100% (19/19)	-	-	86% (April)	↑
(1l) Inpatient Length of Stay (LOS) excl delay/leave – Mental Health Adult Acute	TBC		44 days	49 days			47 days	↓
(1m) Inpatient Length of Stay (LOS) – EMU	TBC	10 days	-	-	-	-	10 days	↑
(1n) Inpatient Length of Stay – Stroke	TBC	40 days	-	-	-	-	40 days	↑
(1o) Inpatient Length of Stay – Rehab	TBC	25 days	-	-	-	-	25 days	↓
(1p) Delayed Transfers of Care (DToC) – Community	TBC	17	-	-	-	-	17	↓

The arrows indicate the trend against the last reported position.

Objective 1: Quality - Deliver the best possible care and outcomes

Governance
Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee

Executive Summary: Marie Crofts, Chief Nurse
Narrative updated: May 2022

The majority of the Quality OKRs are a sub-list of the quality objectives which form the annual Quality Account. Eight new quality OKRs were added in March 2022, fully populated in this months report.

The Quality Account objectives were reviewed/ consulted on and the new objectives for 2022/23 are shared in the following slide.

Three of the OKRs are highlighted as underperforming:
- Clinical supervision
- Completion of the Lester physical health tool for relevant patients on the AMHT caseloads
- Autism training across non-learning disability services.

Please see overleaf for more information by measure on the cause of the underperformance and the plans to mitigate and improve performance.

The Trust has started the following Quality Improvement Projects to address the relevant OKRs in the Quality section;
- Positive and Safe – reduction in restrictive practice
- Improving the Physical Health monitoring of patients with SMI
- Risk Assessment formulation and documentation
- Working with families and carers
- Measuring success of race equality framework for change

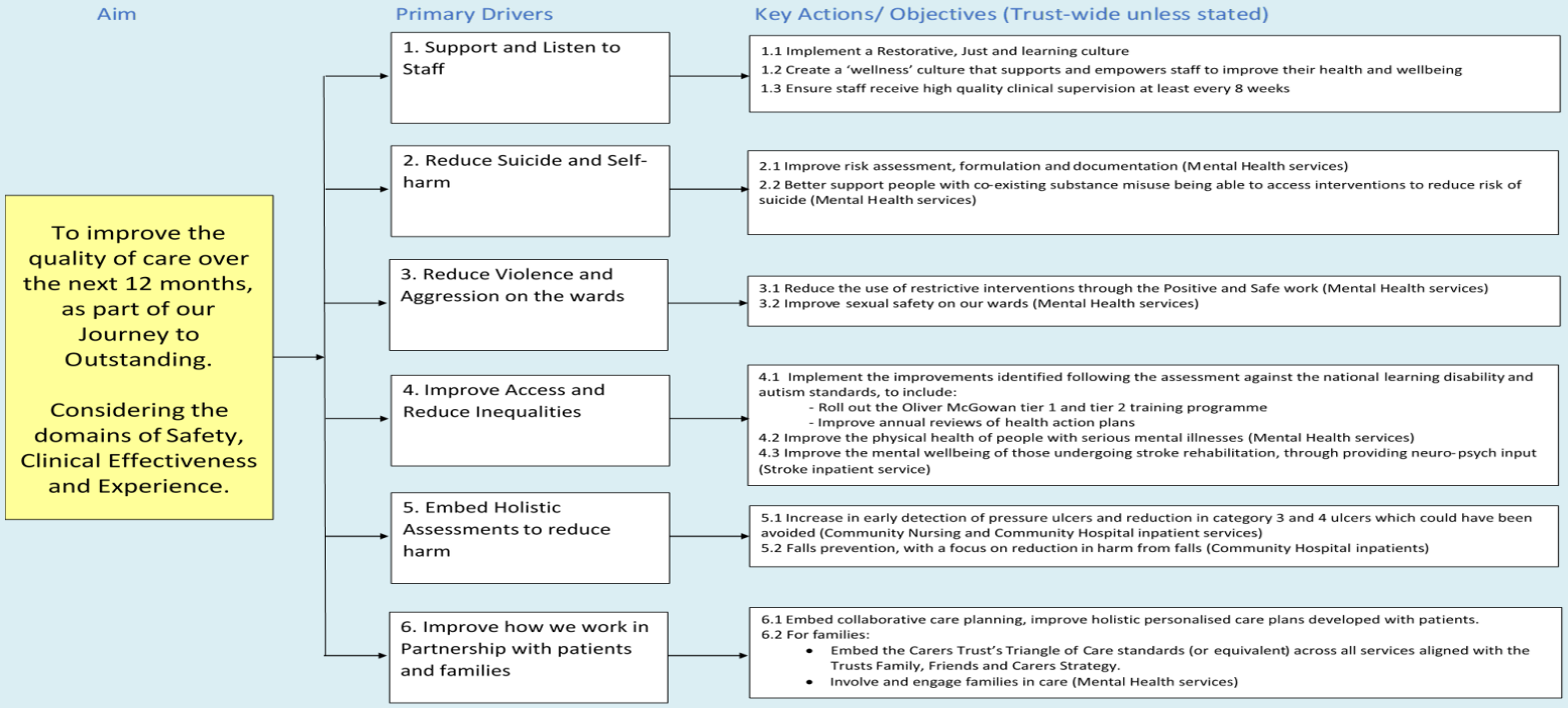
Objective 1: Quality - Deliver the best possible care and outcomes

Governance
Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee

Executive Summary: Marie Crofts, Chief Nurse
Narrative updated: May 2022

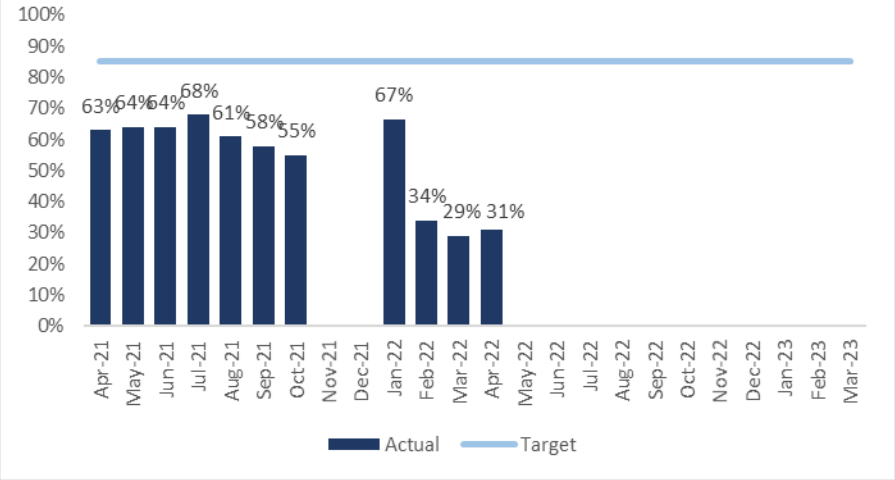
We have identified the following quality objectives for 2022/23, showing our commitment to continually make improvements to the quality of care. The quality improvement plan is formatted into a driver diagram

The plan is considerable and rightly ambitious. It is not, however, unrealistic and is a reflection of the Trust's potential.



Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	85%	31%



Executive Director commentary:
Marie Crofts, Chief Nurse

The risk or issue
The risk is staff may be struggling in their role and feel unsupported to manage difficult situations which may then impact on their well-being.

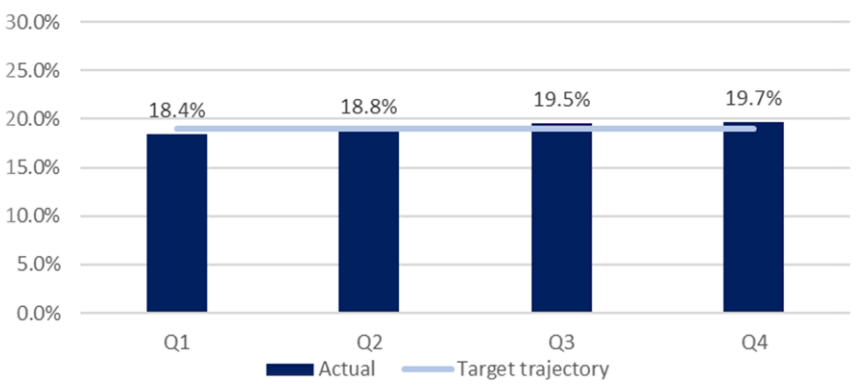
The cause
Operational pressures due to recovering from COVID-19, increased demand and issues with accuracy of reporting from OTR. A graph is not provided while the reported figures are checked.

What is the plan or mitigation?

- Actions are being led and monitored by a supervision steering group. Each directorate also has a task and finish group which reports into the steering group. The group have developed a driver diagram to identify the actions to take. The four key drivers of the workplan are;
  - compliance with professional standards
  - Training
  - policy and definitions
  - staff experience and quality of supervisions.
- Deep dives are being completed with services to ascertain reasons for levels of low compliance and any inaccuracies addressed. More support from the HR systems team is occurring to diagnose and address the ongoing problems with the new OTR system.
- Each directorate is planning to sample a number of teams to understand the actual compliance with completing supervision.
- The role of Professional Nurse Advocates have been introduced, we have over 30 nurses trained so far. The training programme is focused on restorative supervision.
- A number of QI projects across directorates are being carried out to understand barriers to low compliance and recording challenges.
- Supervision training relaunched and available from Nov 2021
- Policy has been updated and waiting for sign off.

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1c) BAME representation across all pay bands including board level - **quarterly**	19%	19.7% Q4



Executive Director commentary:
Marie Crofts, Chief Nurse

The risk or issue
Overall the target of 19% has now been reached although not across every directorate or every pay band.

Based on modelling from the 2011 census, the Joint Strategic Needs Assessments show 16% of the Oxfordshire population are from ethnically diverse backgrounds and 14% of the Buckinghamshire population are from ethnically diverse backgrounds.

Executive Director commentary:
Marie Crofts, Chief Nurse

The target is not being met in the Oxon Community Services Directorate (13.4%); Oxon & BSW Directorate (17.9%); or Learning Disability services (11.2%). There is also an underrepresentation across the Trust at higher pay bands (8a and above). Our organisation will benefit from an ethnically diverse workforce which represents the communities we serve.

The cause
The under-representation of ethnic minority groups in certain bands and occupational groups within Oxford health and the NHS is widely known.

What is the plan or mitigation?
There is an Integrated Care System level action plan to improve the race disparity ratio and meet the six national EDI actions.

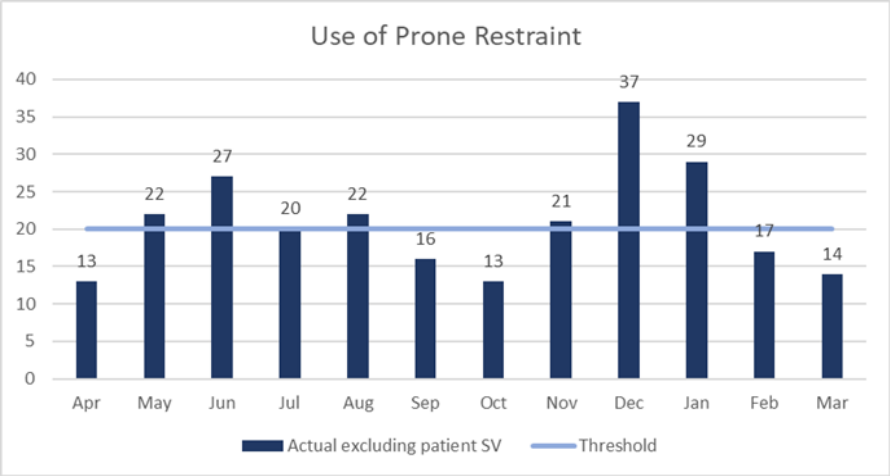
The Trust has developed a Race Equality 'Framework for Change' Strategy. The deliverables for 2022/23 are being reviewed by the Chief Nurse and the Chief People Officer.

The NHS Workforce Race Equality Standard Report published April 2022 highlights improvements in the Trust;

- An overall increase in the proportion of BAME staff
- An increase in the % of BAME staff believing the Trust provides equal career opportunities
- An increase in the % of BAME applicants more likely to be appointed from shortlisting

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint by 25%	240 YE	251 YE (excl. use of prone for 1 patient)



Executive Director commentary:
Marie Crofts, Chief Nurse

The risk or issue
Use of prone restraint carries increased risks for patients and should be avoided and only used for the shortest possible time.

The cause
We have seen a reduction in use of prone restraint. But not the 20% reduction we were aiming for.

In 2021/22 we used prone restraint 251 times against a local target of 240. This information excludes the use for one very unwell patient with extreme acute needs who has been waiting for a more suitable placement.

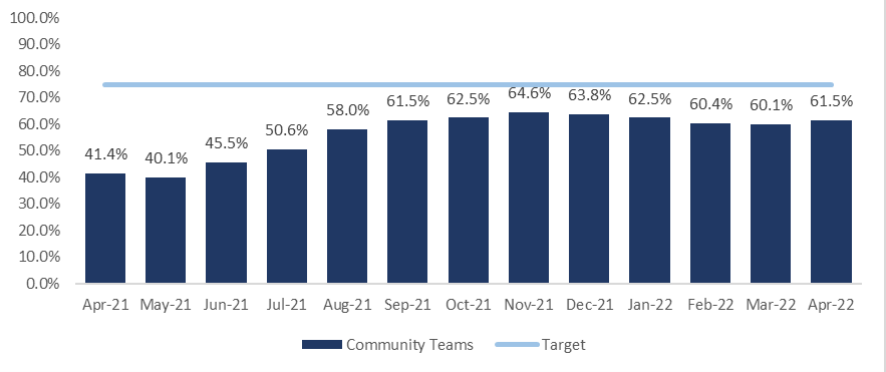
What is the plan or mitigation?
A large-scale QI programme was launched in May 2021 to reduce the use of restrictive interventions. This is part of the national mental health patient safety programme.

Following detailed analysis and liaison with QI sponsors 6 wards were identified to be part of the programme to reduce restrictive practices. Bespoke QI training has been delivered to each of the inpatient teams. Progress with the QI project actions, and impact is monitored through the Positive and Safe Committee. In addition to the QI work on each ward there is Trust-wide work happening around using alternative injection sites for rapid tranquilisation including roll out of training for staff as well as the introduction of safety pods to reduce the need for prone restraint.

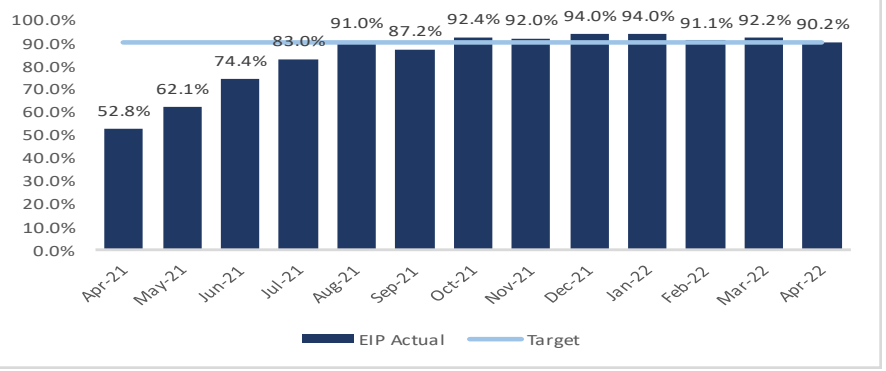
On a weekly basis all prone restraints are reviewed at the Weekly Review Meeting, including looking at duration of prone restraints. All prone restraints lasting longer than 5 mins are reviewed by a Head of Nursing.

Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1fb) Improved completion of the Lester Tool for people with enduring serious mental illness (AMHTs for patients on CPA)	75%	61.5%



Objective Key Result (OKR)	Target	Actual
(1fa) Improved completion of the Lester Tool for people with enduring serious mental illness (EIP teams for patients on CPA)	90%	90.2% achieved



Executive Director commentary: Marie Crofts, Chief Nurse

Context
The indicator is based on the completion of the comprehensive Lester physical health assessment tool for patients with a serious mental illness. The tool covers 8 elements including smoking status, lifestyle, BMI, blood pressure, glucose and cholesterol, and the associated interventions.

The risk or issue
There is significant evidence that people with mental health issues are at higher risk of morbidity and mortality, resulting in a life expectancy of 15-25 years compared to the general population.

The cause
There was a lack of focus on implementing the Lester tool across directorates which has resulted in a compliance rate below expected.

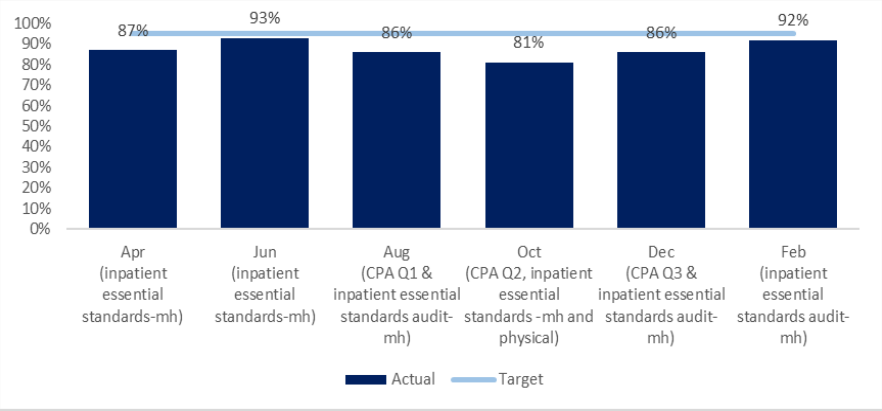
The plan or mitigation
A recovery plan is in place and delivered through a task and finish group led by a senior clinician. This group reports regularly to the Quality and Clinical Governance Sub-Committee.

Key actions being taken include;
- New physical assessment form introduced in Feb 2022.
- Review of reporting specification, amendments made for example to include information gathered in any physical health form completed in the last 12 months not just the latest form.
- Change in senior lead for work who is reviewing current structures/processes within both directorates, looking at gaps and to agree with directorates and PH leads where we need to concentrate our energy and focus to strengthen our interventions.

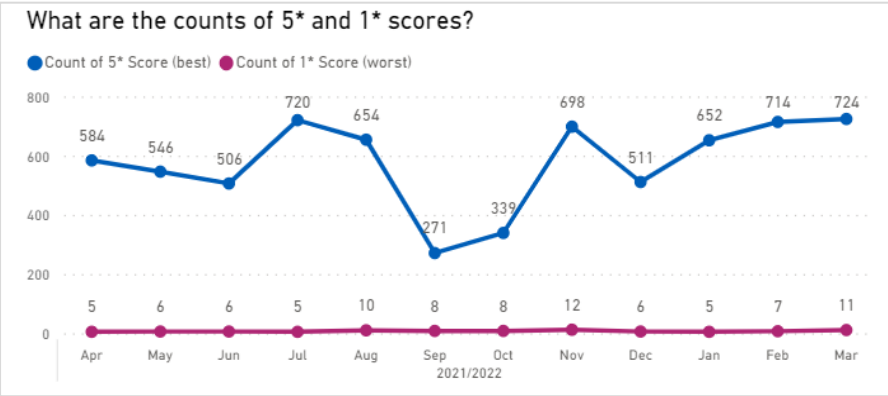
<u>The EIP teams have achieved and sustained the target for 7 months</u>.

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1g) Evidence patients have been involved in creating their care plan (bi-monthly clinical audit)	95%	92%



Based on local patient and carer survey results;
The below graph shows the number of scores of 5 (best) and 1 (worst) by month against the survey question-were you involved as much as you wanted to be in your care and treatment?



Executive Director commentary: Marie Crofts, Chief Nurse

The context and plan
The feedback we receive and the clinical audit information, detailed below, tells us patients are not always and consistently being involved in care planning.

Quality improvements are being carried out with a focus on improving personalised care planning, for example;

A QI project was completed to improve person-centred are in the community hospital wards. The key change introduced was patient boards with 'what matters to me' with the expectation that they are populated within 48 hours of admission. The boards were introduced after speaking to inpatients and staff and carrying out a process map of the admission steps. Alongside the board guidance and person-centred care training were provided. Local leadership was also important. Inpatients have reported an improvement in feeling involved in their care.

Luther Street Medical Centre, providing healthcare to people experiencing homelessness in Oxford City, launched a social prescribing service from September to help patients identify what matters to them and assist in achieving these goals.

In 2021/22 we also worked and had successes on strengthening patient/ family voices as part of developing and improving services. This work will continue.

Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1h) 30% of clinical staff in non-learning disability services have completed internal eLearning on autism	30% year end	See narrative

Executive Director commentary: Marie Crofts, Chief Nurse

The Context and plan

New internal training was developed to support staff with communicating effectively with people with Autism and making the adjustments needed to support with access to health care. The training is available to staff to complete via the Trust's learning and development portal. The roll out of the training to make it mandatory for all staff was put on hold as pilots for the new national (Oliver McGowan) training started. Therefore, we have not achieved our local target of 30% of staff trained from outside the Learning Disability and Autism services.

The Trust was involved in the pilot of the new national training, which 125 staff attended. The national training will be organised into tiers; Tier 1 awareness training for all staff, Tier 2 for champions identified in teams and, Tier 3 training for staff working within Autism services (this is in place now). Tier 1 awareness training should be made available in 2022/23.

As the internal training has been put on hold. Below are some of the other activities we are doing to improve how we work with and support people with autism:

- The Reasonable Adjustment Service at the Trust is supporting mental health clinicians to better understand and support the needs of autistic individuals with reasonable adjustments and adaptions. The service is being expanded with additional funding and recruitment is underway.
- Autism webinars were delivered for staff and recorded for people to watch later (around 45 staff attended the live sessions).
- Bespoke training sessions are being delivered to mental health wards and community teams, as well as regular support sessions for inpatient staff to discuss specific patients.
- Working with our autistic patients/ experts by experience we are developing an autism reasonable adjustment passport to support access to mental health services. This is being piloted.
- Resources have been developed to support clinical teams with making communication more autistic inclusive.
- We are also providing consultation and support from an adjustment perspective to individuals who do not meet the criteria for Learning Disability services but our mental health services are inaccessible.
- There has also been work from an employee perspective, for example setting up an employee dyslexia support group and autism support group.

Objective 2: People – be a great place to work

Governance: Executive Director: Chief People Officer | **Responsible Committee**: People, Leadership and Culture Committee
All data relates to **April 22** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results are;	Target	Comm Services	Oxon & BSW	Bucks	LD	Forensic	Pharm	Corporate & Trading	Trust	National comparator	Trust Trend
(2a) People Pulse Staff Engagement scoreQ1(2022)	>/=?	6.76↓	6.85↓	6.44↑	Only available at directorate level 6.71%↓ for Specialised Services			6.75↓	6.73	n/a	↓
(2b) Reduce agency usage to NHSE/I target Excludes covid spend	</=?	11.1%↓	16.6% ↓	23.6%↑	3.6%↑	16.6%↑	4.7%↓	1.6%↓	13.2%	ModHos 7.7%/ Peer 11.8%	↓
(2c) Reducing staff sickness to 3.5% over 2021/22	</=3.5%	7.2%↓	6.0%↓	7.1%↑	3.5%↓	8.0%↓	4.1%↓	4.3%↓	6.2%	ModHos 5.4%/ Peer 5.2%	↓
(2e) Reduction in % labour turnover	</=10%	14.3%↓	14.1%↓	14.6%↓	23.8%↑	16.9%↓	4.6%↓	12.2%↓	14.1%	ModHos 18.8% Peer 18.6%	↓
(2f) Reduction in % Early labour turnover		18.5%↓	19.9%↓	17.3%↓	21.0%↓	21.0%↓	0.0%→	12.2%↓	17.4%	None	↓
(2g) Reduction in % vacancies	</=9%	3.0%↑	17.2%↑	10.3%↓	20.6%↑	20.7%↑	-1.9%↑	8.8%↓	10.5%	ModHoss 8.9%Peer 12.7%	↑
(2h) PDR compliance	>=90%	29%↓	30%↓	33%↓	28%↓	29%↓	22%↓	31%→	28%	None	↓
(2i) PPST compliance	>=90%	75%→	72%↑	74%↑	71%↑	79%↑	76%↓	74%↑	77%	None	↑
(2j) Number of Apprentices as % substantive employees	>=2.3%	6.0% ↑	2.5% ↓	9.5% ↑	2.4% ↑	1.8% →	0.0% →	2.2% ↓	5.10%	None	↓

Objective 2: People – be a great place to work

Governance
Executive Director: Chief People Officer | **Responsible Committee**: People, Leadership and Culture Committee

Executive Summary: Charmaine De Souza, Chief People Officer,
Narrative updated: May 2022

There are now dedicated programmes of work set up to tackle the OKRs which are underperforming. This has been a result of a re-focus of the HR activity to align work with the most pressing priorities.

- **Reduction in Turnover**: A working group has been set up as part of the IQRA programme to focus on **retention**; the group have begun examining how we collect exit data from staff and how we act when staff indicate they wish to resign; there will also be a focus on the EDI aspects given that BAME staff are more likely to leave in the first 12 months when compared to other staff. In Q2 we will have additional senior capacity in the HR team to look at our overall Reward package and how we articulate this to staff to both attract and retain staff.

- **Reduction in vacancies**: We have focused for the last period on addressing the structural and **capacity** issues in the recruitment team and clearing backlogs. This has now been complete. There is still work to be done to understand if our flexible working team are correctly configured to meet the objectives set for a greater amount of work to be filled by bank (rather than agency) and that is planned for late June- Aug of this year. Targets have been set as part of the IQRA programme to reduce vacancy rates.

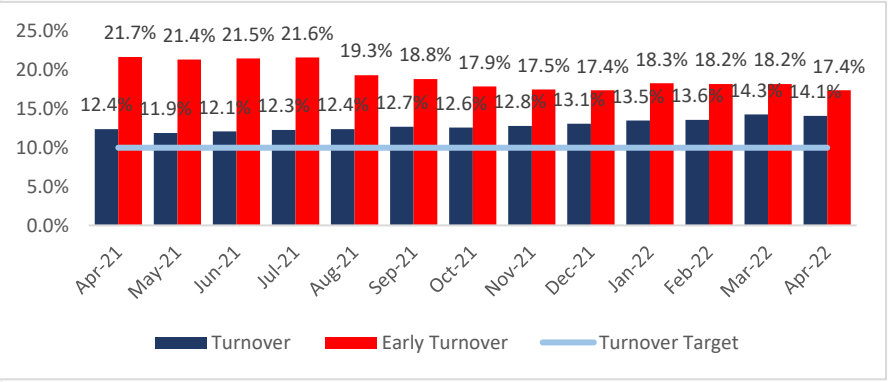
- **PDR Compliance** : A dedicated working group has been set up by the Head of OD to improve PDR compliance. We are reviewing the PDR **process and documentation** to understand the barriers to completion; we have launched the Pay Progression Policy in April of this year which makes clear that pay progression is linked to satisfactory completion of annual PDRs; and we are doing focused activity with the staff grades with the lowest compliance rates. Work is underway now to resolve the technical issue related to the OTR, and oversight of this has been transferred to the Head of Workforce systems, new resource has been brought into the team to complete this.

- **PPST Compliance**: A task and finish group has been set up under the new L&D leadership to tackle the different issues that are contributing to the lower than expected compliance rates – this includes resolving the technical system issues (see above); putting controls in place on any new training matrices; continuing to reduce the overall number of matrices and identifying whether a "digital by default" approach to learning requirements is sensible.

- **Agency spend** – The IQRA programme is now gaining momentum; key pieces of work for the next period involve agency volume contracts and review of e-rostering within inpatient units; together with recruitment to the vacancies that have now been established as result of the workforce planning review.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<10%	14.1%



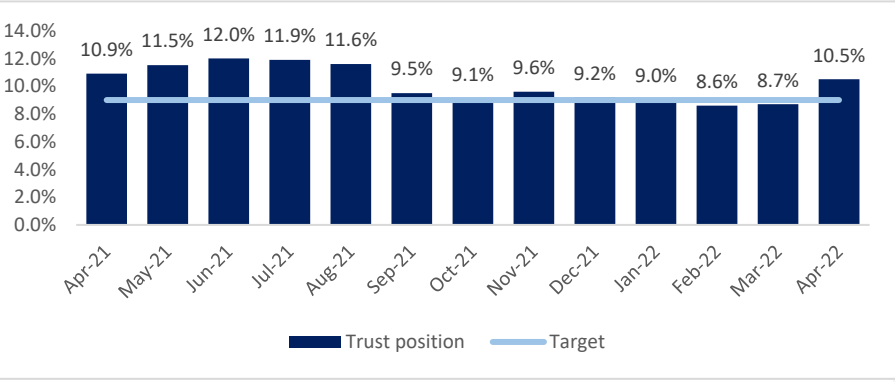
Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Staff turnover has decreased to by 0.2% to 14.1%. High levels of turnover will impact on vacancies, agency spend, quality of patient care and staff experience.

The cause
Work / life balance is reported as the highest reason for staff voluntarily leaving the Trust (besides unknown). Triangulation of information from the leavers data and exit questionnaire (now leavers survey) suggests the need to distinguish between whether the work / life balance reason for leaving being cited is due primarily to workload pressures OR opportunities to work flexibly.

The plan or mitigation
Action to date includes redesigning the current exit questionnaire to provide more detailed information as to why people leave. We have also repositioned how this leavers survey fits into the exit process to increase completion rates and provide greater opportunity to discuss with staff options for staying in the Trust's employment. The onboarding process is to be process mapped in May. Focus groups with recent joiners are planned to take place in June. Whilst we will promote these focus groups to all new joiners, we will pay particular attention on promoting them in areas where early turnover is high.
The data has shown that BAME staff are more likely to leave within 12 months so the EDI and OD team are working with specific teams (such as Oxen & BSW) and the Networks to discovery the reasons for this and implement mitigations

Objective Key Result (OKR)	Target	Actual
(**2g**) Reduction in % vacancies	</=9%	10.5%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

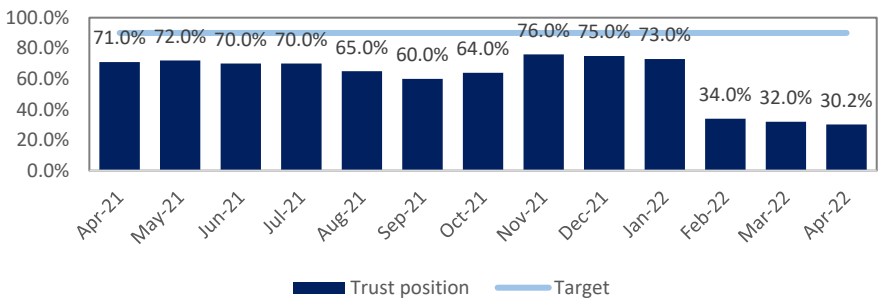
The risk or issue
The vacancy rate has increased from 8.7% in March to 10.5% in April; high vacancy rates will impact staff wellbeing and retention, agency spend, and the quality of care provided to patients.

The cause
This significant increase of 1.8% in one month is due to an increase in budget of 105 WTE.and a decrease in 15WTE staff. There were an additional 175WTE in the O&SW Mental Health Directorate. In addition to this the General Recruitment team, was understaffed between January and March due to sick leave, resignations and role changes. This was exacerbated by team members taking annual leave at the end of the financial year increasing the recruitment backlog.

The plan or mitigation
The Recruitment team have heavily recruited, now with almost all vacancies filled. Sickness absence is being managed closely and this has now reduced to 1 staff member on long-term sick leave. Role changes have now been integrated into the team and the team has stabilised. New team members have all completed initial training and are working to full capacity. The recruitment backlog has been cleared and new staff members to the Trust are being onboarded in a timely manner.
We expect to see a steady decrease in vacancy rates over the coming months.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2h) PDR compliance	>/=90%	30.2%



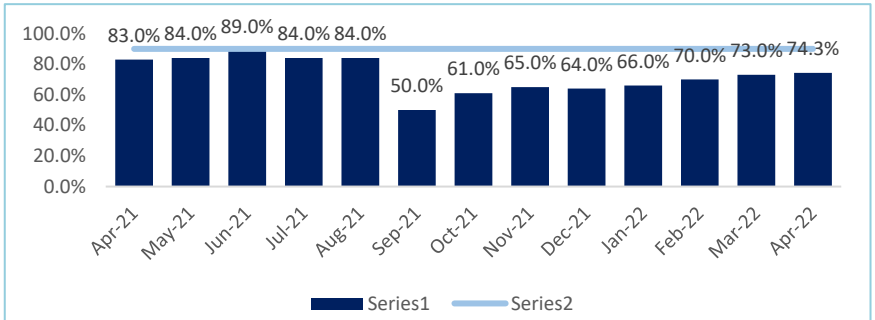
Executive Director commentary:
Charmaine De Souza - Chief People Officer

The risk or Issue
The percentage of staff receiving a PDR in the past 12 months has decreased further in March. Individuals who do not receive a PDR may not be supported to access professional and personal development opportunities which maybe a risk to retention.

The cause
It is thought that several factors are contributing to this including systems issues such as user accounts not reflecting actual staffing, previous data inaccuracies which have been rectified resulting in as sudden dip in performance in February and a lack of trust and knowledge in using the OTR system which may have led to individuals not recording PDR's centrally. It is likely that the number of PDR's completed dropped during the pandemic due to service pressures The recording method on OTR has been updated and despite guidance being issued, has caused some reticence to use the online system

The plan or mitigation
The PDR process is being reviewed with input from operational staff to ensure it meets the needs of the organization. Work is also being undertaken to ensure that data in the On Line Training Record system is accurate and that the process of recording PDR's is simple. In the interim, support during the deep dives (see PPST plan) will be provided to ensure recording is accurate.

Objective Key Result (OKR)	Target	Actual
(2i) PPST compliance	>/=90%	74.3%



Executive Director commentary:
Charmaine De Souza - Chief People Officer

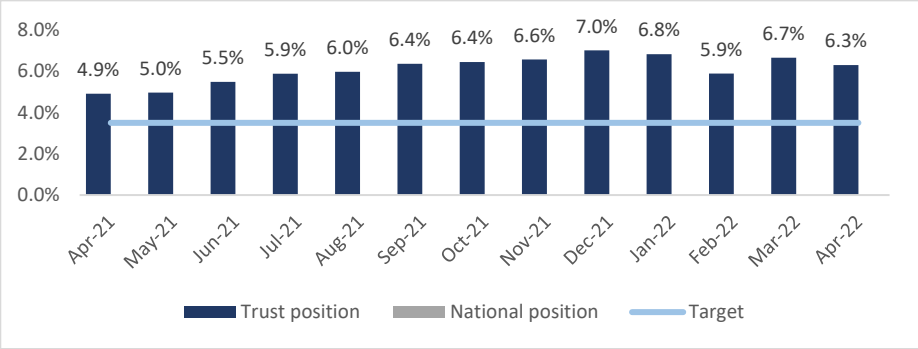
The risk or issue
The percentage of PPST (Personal, patient safety training) completed in April has increased by 1.3% to 74.3% but still does not meet Trust compliance target of 90%. Individuals who have not completed their PPST training may not have the skills and knowledge to carry out their role safely.

The cause
It is thought that several factors are contributing to this including systems issues such as user accounts not reflecting actual staffing, correct training matrices not being attached to staff and inaccuracies in the recording of training. It is believed that there are sufficient training spaces available although it can be challenging to book onto some courses. In addition to this a significant number of staff do not attend or cancel training at short notice due to staff pressures

The plan or mitigation
A task and finish group is being established to identify and address all issues impacting on compliance with mandatory training targets. This group includes members from L&D, Operations, Nursing and Clinical governance and HR Systems. Deep dive meeting are being held with services to ascertain reasons for levels of low compliance to inform this group. Management of the OTR system has moved to HR Systems and Reporting and a project is underway to resolve the system issues.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=3.5%	6.3%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

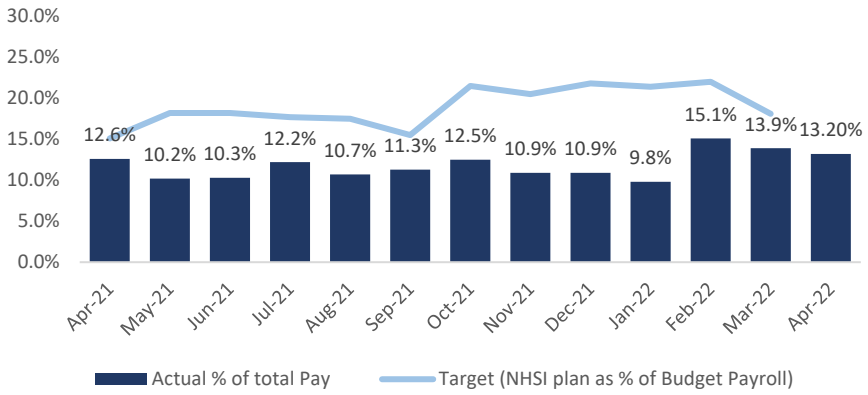
The risk or issue
The sickness absence rate has decreased in April from 6.7% to 6.3%. Excluding Covid absences the rate was 4.52% (4.35% last month) or 1.0% above the target

The cause
COVID confirmed remained the top cause of absence in April, with the second highest absence reason being gastrointestinal and the third headache-migraine. In April there was a significant decrease in the number of COVID confirmed absence spells with 279 cases in April compared to 506 in March and 223 in Feb. There has been a slight increase in the number of staff off on long term absence, with 173 employees being absent for >4 weeks in April compared with 158 in March.

The plan or mitigation
Further work is also taking place to ensure that RTW/Wellbeing conversations are taking place after every absence event, this will ensure appropriate referrals are made and signposting to our various support/assistance programmes.
In services where absence levels are high, additional support is being provided to ensure appropriate measures are in place to address both short and long term absences.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(**2b)** Reduce Agency Usage to Target	</=?	13.2%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Agency use in the Trust is extremely high which increases costs and impacts quality and safety of patient care and staff wellbeing.

The cause
The causes are multifaceted and are being addressed by the Improving Quality Reducing Agency programme which has several workstreams and aims to improve the quality of our services whilst reducing agency spend.

The plan or mitigation
Workforce requirements have been mapped out for next 5-7 years for inpatient units, this will support future workforce planning decisions. This workforce tool considers current committed workforce education programmes such as nurse associate training, top up degrees and advanced clinical practice. The funded establishment review has been completed and budgets have been realigned from month 1 to reflect an additional investment of £711,584 for community hospitals and £1,209,035 for mental health services, this review has resulted in additional nurse vacancies for the inpatient teams.

66 nurses have started through the international recruitment programme which has resulted in zero Band 5 nurse vacancies in community hospitals and 23 agency lines of work being ended. The KPIs for recruitment, retention and agency reduction have been agreed for 2022-2023.
A tender process for an agency guaranteed volume contract (GVC) across the Littlemore site will start in August with the contact being awarded at the end of August with a contract start date of no later than the 1 October. The agency management workstream has a target of reducing ad hoc agency use by 70% by the end of November and to stop agency grade swaps by the end of June.

The e-rostering workstream has a target of improving the overall management of rosters by the end of December, improved medium term workforce planning, including the regular review of budgets, will take place over the financial year 2022/2023.

Objective 3: Sustainability; make the best use of our resources and protect the environment

This year, our Objective Key Results (OKRs) are;	Comm Services	Oxon & BSW	Bucks	LD	Forensics	Pharm	Corporate & Trading	**Trust**	Trust Trend
(3a) **Adverse** performance against financial plan (YTD)	£1.0m adv ↑	£0.5m adv ↑	£0.4m adv ↓	£0.1m fav ↑	£0.3m adv ↑	£0.0m fav ↓	£1.9m fav ↑	£0.2m adv ↓	↓
(3b) Cost Improvement Plan (CIP) delivery (YTD)								£0.4m adv	↓
(3c) **95%** of estate to achieve condition B rating by 2025 (75% in 2021)								75%	→
(3d) Delivery of estates related CO2 reduction target of 1623 tonnes by 2025 (**10,862** in 2021)	-	-	-	-			-	10,862 tonnes	→
(3e) **Achievement of all 8 targeted measures** in the NHS Oversight Framework (see section 2 of this report)	-	-	-	-			-	7/8 achieved	

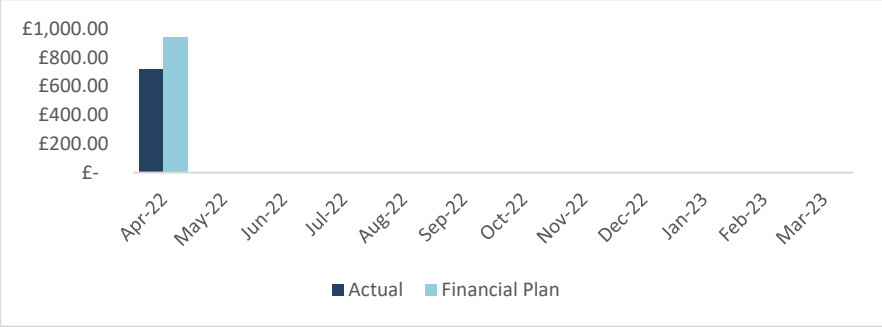
Governance
Executive Director: Director of Finance | **Responsible Committee**: Finance and Investment Committee | **Responsible reporters**: Paul Pattison/ Christina Foster | All data relates to the position as at **end of April** unless indicated in the penultimate column

Executive Summary: Mike McEnaney, Director of Finance
Narrative updated: end of April 2022

I&E is £0.2m adverse to plan driven by under delivery of CIP £0.4m, continuation of high level of agency and contracted OAPS (c.£1.6m) both reported as Covid spend in FY22 partially mitigated by release of covid funding c.£0.6m in expectation of the tapering down of these expenditure items and release of reserves and deferred income, c.£1.2m. The CIP plan for the year is £7.9m with delivery profiled evenly over 12 months. £0.3m has been delivered at month 1, this is £0.4m adverse to plan due to delay in CIP engagement as a result of Covid-19.

Objective 3: Sustainability – areas of underperformance

Objective Key Result (OKR)	Trust
(3b) Adverse performance against financial plan	£0.2m adverse



Executive Director commentary:
Mike McEnaney, Director of Finance

The risk or issue
Financial performance against plan is £0.2m adverse at month 1.

The cause
Overspends in all 4 clinical directorates due to under delivery of CIP, continuation of high level of agency and contracted OAPS.

The plan or mitigation
Reliance on the Trust's programme to improve quality, reduce agency and CIP will be crucial to delivering the FY23 plan. Finance will continue to work with directorates with emphasis on Directorate forecasts: focusing on drivers of overspends, directorate plans to address them, the impact on service delivery and monitoring and challenge where plans are failing, at a Directorate and Executive level. The process will be supported by consideration of contracted activities and the associated unit costs as a means of controlling cost and measuring productivity.

Objective Key Result (OKR)	Trust
(3c) Cost Improvement Plan (CIP) Delivery	£0.4m adverse

Executive Director commentary:
Mike McEnaney, Director of Finance

The risk or issue
CIP Performance against plan is £0.4m adverse at month 1.

The cause
Engagement with the CIP Programme and the main scheme of reducing agency have been delayed due to Covid-19

The plan or mitigation
International Recruitment programme and other plans as part of the Improving Quality, Reducing Agency programme to reduce agency spend.
CIP targets devolved to Directorates to facilitate engagement and accountability.

Objective 3: Sustainability – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(3d) 100% of estate to achieve condition B rating by 2025	75%	TBC

Executive Director commentary:
Martyn Ward – Executive Director: Digital & Transformation

The risk or issue
It has now been several years since the Trust completed a condition rating survey. Although work to maintain a safe estate has been regularly carried out, there is a risk that some buildings may now be classified as condition rating C or D.

The cause
Limited investment, shortages in skilled workforce and competing priorities. This, along with difficulties maintaining sites during COVID has resulted in a backlog/shortfall of maintenance and repair.

What is the plan or mitigation?
Work is now underway to carry out a six-facet survey to understand the current building condition ratings. This indicator will be updated once that work is complete.

Objective Key Result (OKR)	Target	Actual
(3e) Delivery of estates related Co2 reduction target of 1623 tonnes by 2025	10,862	10,862

Executive Director commentary:
Martyn Ward – Executive Director: Digital & Transformation

The risk or issue
In FY21, the Trust consumed 10,862 tonnes of Co2. The aim is to reduce consumption to 9030 by 2025. The improvement trajectory is shown on the graph above.

The cause
The Trust has an obligation under Statute and the NHS Contract to reduce carbon emissions generally, becoming a net carbon organisation by 2045. This objective relates only to plans to reduce carbon emissions linked to the estate

What is the plan or mitigation?
The estates department has an action plan describing potential schemes and a new 'Green Plan' has been produced for the Trust.

Objective 4: Become a leader in healthcare research and education (Research & Education)

Governance: Executive Director: Chief Medical Officer | **Responsible Committee**:

This year, our Objective Key Results are;	Previous FY	Community Services	Oxon & BSW	Bucks	Corporate Inc R&D	Trust	National comparator
Participants recruited to CRN Portfolio studies	2254 4th Nationally	0	17	3	65	85 10th Nationally	No.1 ranked Trust 630
CRN Portfolio studies running as at month end	72 2nd Nationally	1	8	2	27	38 4th Nationally	No. 1 ranked Trust 66

Executive Summary: Karl Marlowe, Chief Medical Officer
Narrative updated: May 2022

The National ranking compares research active Mental Health Trusts. In some Trusts this will include Community based and non-mental Health studies.

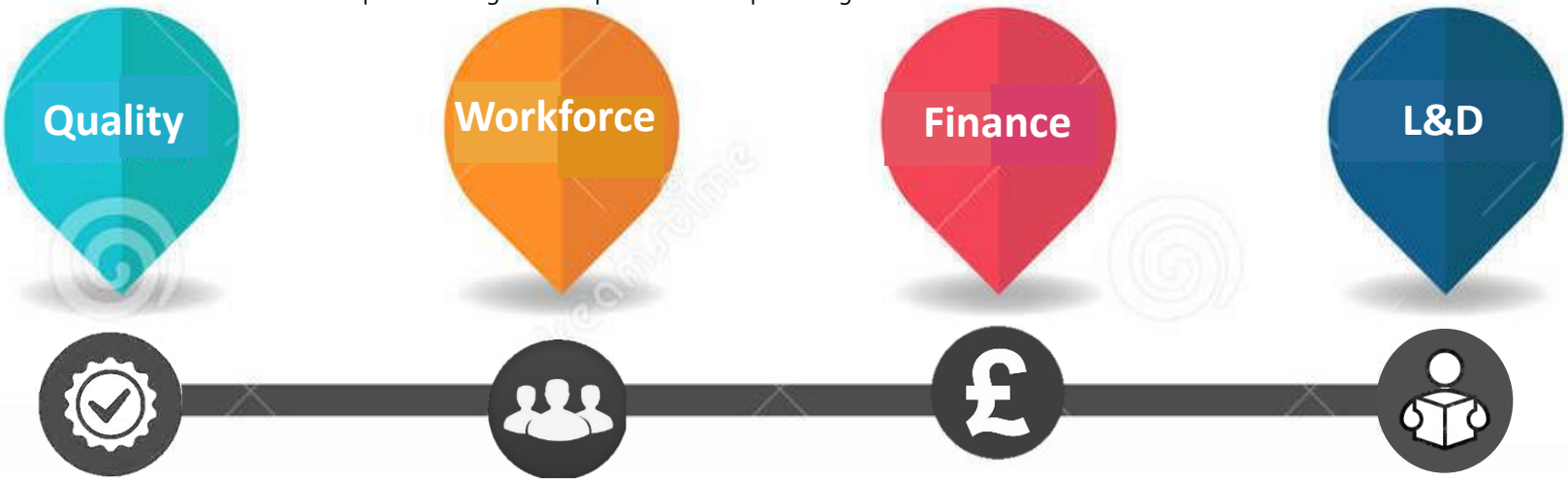
Note: 1270 recruits for previous FY came from one study led by Prof Keith Hawton the "Oxford Monitoring System for attempted Suicide".

Section 6:

Did you know?

Facts and figures for your information

The arrows indicate whether the trend is up or down against the previous last reported figure



PSIs, Complaints & Feedback

🡻 **9 PSIs** reported to STEIS in April (of which 1 COVID-19 outbreak). Average of 7 per month. In 2021/22- 89 PSIs reported excl. downgrades (19 COVID outbreaks). Compared to 86 in 2020/21.

🡹 **23 Formal Complaints** received in April. Average of 19 per month. 2021/22- 223 complaints. Compared to 206 in 2020/21.

➔ **FFT patient feedback** – Overall in 2021/22, physical health services 85% of patients responded care is very good against a national ave of 83%. Mental health services 67% of patients responded care is very good against a national ave of 62%.

New starters, Leavers & HR mgmt. cases resolved

🡹 **100 new starters** in April**,** 13 higher than last month (87) and 27% higher than the 2019/20 monthly average of 79

🡻 **58 leavers** in April, 45 lower than last month (103) and 8% lower than the 2019/20 monthly average of 63

🡻 **15 HR management cases resolved** in April.10 lower than last month (25) and 38% lower than the 2019/20 monthly average of 24

Finance

🡹 **£646k** spent on **Out of Area Placements** in month 1. +3% higher than the 2021/22 monthly average of £622k and less than month 12 FY22 (£494k).

🡹 **£5,572k** spent on **Agency Staff** in month 1. +6% higher than the 2021/22 monthly average of £5,264k, and less than month 12 FY22 (£6,350k).

🡻**£23k** spent on **travel claims.** - 82% lower than the 2021/22monthly average (£129k) and less than month 12 FY22 (£116k)

Appraisals, Supervision & Training

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classroom) increase on the previous month of February 2022

Data under review and will not be available until further notice

Patient Activity and Demand – Exceptions updated bi-monthly for month's with Board meeting

Introduction and Headlines – as at April 2022

The following activity levels are monitored using statistic process control (SPC) charts which indicate whether activity is outside of 'usual/expected' levels. This month's activity is compared to the pre-COVID 2019/20 monthly average (which is the Trust's current benchmark of 'normal' activity levels (unless specified otherwise).

- Referrals received
- Appointments delivered
- Admissions
- Inpatient length of stay
- Bed occupancy

Headlines:

- There are **25 services/teams that have HIGHER than usual/expected activity levels**; 6 in community services, 7 in Bucks Mental Health, 10 in Oxon and BSW Mental Health and 2 in Specialist Services. Please see the following two slides which provides the list of services and levels of activity above the Trust's benchmark or 'normal' activity.

- There are **20 services/teams that have LOWER than usual/expected activity levels**; 6 in community services, 4 in Bucks Mental Health, 10 in Oxon and BSW Mental Health. Please see the following slides which provides the list of services and levels of activity below the Trust's benchmark or 'normal' activity.

For detailed information, please refer to the IPR Supporting Report. Commentary for each of the service lines is provided that states whether this level of activity is expected, is a problem and whether any action is required.

Activity Exceptions April 2022: High compared to 19/20 levels (normal)

The following services/teams have higher levels of activity than pre-pandemic levels

Directorate	Service	Currency	Activity this month compared to 19/20 monthly average	No. this month /19/20 monthly ave
Community	Children's Community Nursing	All referrals	**+185%**	57 / 20
Community	Respiratory	Emergency referrals	**+957%**	74 / 7
Community	District Nursing	All referrals	**+9%**	2634 / 2409
Community	Childrens Integrated Therapies	Urgent referrals	**+312%**	103 / 25
Community	Tissue Viability	Emergency referrals	**+762%**	112 / 13
Community	Care Home Support Service	Appointments	**+415%**	958 / 113
Bucks Mental Health	ADHD and Autism Service	All referrals	**+100%**	86 / 43
Bucks Mental Health	Memory Assessment Service	All referrals	**+7%**	153 / 143
Bucks Mental Health	ADHD and Autism Service	Appointments	**+178%**	89 / 32
Bucks Mental Health	Crisis Teams	Appointments	**+182%**	1127 / 400
Bucks Mental Health	OSCA	Appointments	**+65%**	316 / 192
Bucks Mental Health	Reconnect	Appointments	**+81%**	94 / 52
Bucks Mental Health	CAMHS SPA	Appointments	**+9%**	127 / 116
Oxon & BSW Mental Health	ADHD	Routine referrals	**+391%**	113 / 23
Oxon & BSW Mental Health	SCAS Triage	All referrals	**+807%**	381 / 42

Activity Exceptions April 2022: High compared to 2019/20 levels (normal)

The following services/teams have higher levels of activity than pre-pandemic levels

Directorate	Service	Currency	Activity compared to 19/20 monthly average	No. this month / 19/20 monthly average
Oxon & BSW Mental Health	Memory Assessment Services	All referrals	**+19%**	134 / 113
Oxon & BSW Mental Health	CAMHS Youth Liaison and Diversion	All referrals	**+243%**	24 / 7
Oxon & BSW Mental Health	CAMHS Wiltshire SPA	All referrals	**+16%**	150 / 129
Oxon & BSW Mental Health	SCAS Triage	Appointments	**+205%**	354 / 116
Oxon & BSW Mental Health	CAMHS O Perinatal	Appointments	**+6%**	36 / 34
Oxon & BSW Mental Health	CAMHS O SPA	Appointments	**+606%**	240 / 34
Oxon & BSW Mental Health	BSW In-Reach	Appointments	**+29%**	44 / 34
Oxon & BSW Mental Health	CAMHS BaNes Community	Appointments	**+63%**	444 / 272
Specialist Services	Pathfinder Team	Appointments	**+7500%**	95 / 1
Specialist Services	FIND Team	Appointments	**+88%**	30 / 16

Activity Exceptions April 2022: Low compared 2019/20 activity levels (normal)

The following services/teams have lower levels of activity than pre-pandemic levels

Directorate	Service	Currency	Activity in month compared to 19/20 monthly average	No. this month / 19/20 monthly average
Community	Community Therapy Service	Emergency referrals	-94%	5 / 84
Community	Nutrition and Dietetics	All referrals	-9%	158 / 174
Community	Phlebotomy	All referrals	-29%	99 / 139
Community	SPA	Routine referrals	-42%	81 / 139
Community	Diabetes	Appointments	-21%	462 / 582
Community	Adult Speech and Language	Appointments	-46%	404 / 745
Bucks Mental Health	Older Adult CMHT	Appointments	-10%	1271 / 1407
Bucks Mental Health	Memory Services	Appointments	-9%	391 / 430
Bucks Mental Health	CAMHS Learning Disabilities	Appointments	-44%	66 / 118
Bucks Mental Health	Sapphire Ward	Average Length of Stay	-51%	29 / 59
Oxon & BSW Mental Health	Older Adult CMHTs	Urgent referrals	-12%	36 / 41
Oxon & BSW Mental Health	CAMHS W Melksham Community	All referrals	-17%	79 / 95
Oxon & BSW Mental Health	CAMHS Wiltshire Risk	All referrals	-90%	2 / 21
Oxon & BSW Mental Health	Complex Needs	Appointments	-85%	38 / 257
Oxon & BSW Mental Health	Getting Help Teams	Appointments	-42%	368 / 639
Oxon & BSW Mental Health	CAMHS Swindon Community	Appointments	-33%	653 / 975

Activity Exceptions April 2022: Low levels compared to 2019/20 levels (normal)

The following services/teams have lower levels of activity than pre-pandemic levels

Directorate	Service	Currency	Activity compared to 19/20 monthly average	No thi month / 19/20 monthly average
Oxon & BSW Mental Health	CAMHS Wiltshire Risk	Appointments	-83%	72 / 429
Oxon & BSW Mental Health	ED Cotswold House Oxford	Admissions	-25%	3 / 4
Oxon & BSW Mental Health	Allen Ward	Average LOS	-17%	35 / 42
Oxon & BSW Mental Health	Phoenix Ward	Average LOS	-30%	35 / 50