# Integrated Performance Report (IPR) Report: September 2022

July/August 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
Updated: 23 September 2022

| 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 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. In particular, 32 training paces have been secured for Psychological Wellbeing Practitioners. Finally temporary staff are used to maintain service levels and the agency management work programme is aiming to reduce reliance on, and cost of temporary workers sourced in this way. |
| CIP programme | Risk | Initial progress has been made in identifying cost improvements in the directorates with limited success. However, the primary focus this year is cost control and identifying agreed costs and associated budgets as part of H2 work and planning into FY24 |
| 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 (OAPs) | Risk | The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control. There has been an increase in inappropriate OAPs which is in part due to operational pressures but is mainly as a result of the planned transition from/reduction in contracted appropriate OAPs from 21 to 5 during this financial year |

# Directorate highlights and escalations: Primary, Community and Dental Care

**Executive Director commentary:**
Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care
Updated: 20 September 2022

| Headline | Risk, Issue or Highlight? | Description (including action plan where applicable and please quote performance/data where applicable) |
|---|---|---|
| National Advanced IT Outage and Critical Incident Response | Issue and Risk | The Advanced IT outage in August impacted significantly on all of our urgent care, primary care and community services, with a lesser impact on non-urgent dentistry services, resulting in a Trust-wide critical incident being declared. As a result, other development and project work in the Directorate had to be suspended during August, as staff and resources were urgently redeployed to manage the incident as a patient safety priority. This included immediate action to instigate the emergency business continuity measures and processes were put in place to actively monitor and respond to any risks and incidents. Through these processes it became evident that continuing these measures for a prolonged period at peak periods of service activity posed a risk for our out-of-hours GP service in particular and an alternative solution would be required for the August bank holiday weekend. Senior Trust staff (IT Clinical and Operational colleagues) worked incredibly hard with EMIS, supported by the ICB and other OOH service provider partners, to rapidly roll-out a version of EMIS Web in time for the August bank holiday. This has enabled the team to provide a significantly safer and more reliable service, benefitting thousands of patients.<br><br>Whilst this interim measure significantly mitigated immediate clinical and operational risks, the EMIS system in place was set up for rapid deployment, not long-term use. Ongoing work is required to link it in the most effective way with the 111 referral systems (also affected by the outage) and to tailor it for the Oxfordshire service environment. Following a period of testing, we received confirmation that Ad Astra was ready to be reactivated and our clinical and operational leads recommended that this system was reactivated in mid-September for dentistry, minor injuries and GP out-of-hours services. This was judged to be the lowest risk solution for patients and staff for those specific services.<br><br>Over the coming weeks, we will focus on implementing EMIS Web into the community services that are still on business continuity measures, for which this system has been deliberately procured. This roll-out will take a similar risk-based approach, considering wider aspects of patient and staff safety. This deployment work will benefit greatly from the efforts and learning from the OOH team's experience and we will continue to regularly update the Board as these plans develop. |

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% | 71% (July) | 88.8% (July) | ↓ |
| (N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly) | 56% | 68.2% (Mar) | 88.2% (June) | ↑ |
| (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% | 46.5% (June) | 48.5% (June) | ↑ |
| (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% | 88.9% (June) | 99% (June) | ↑ |
| (N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT | 95% | 98.5% (June) | 100% (June) | → |
| (N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures | 0 | n/a | 114 (Aug) | ↑ |
| (N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures | 0 | n/a | 89 (Aug) | ↑ |

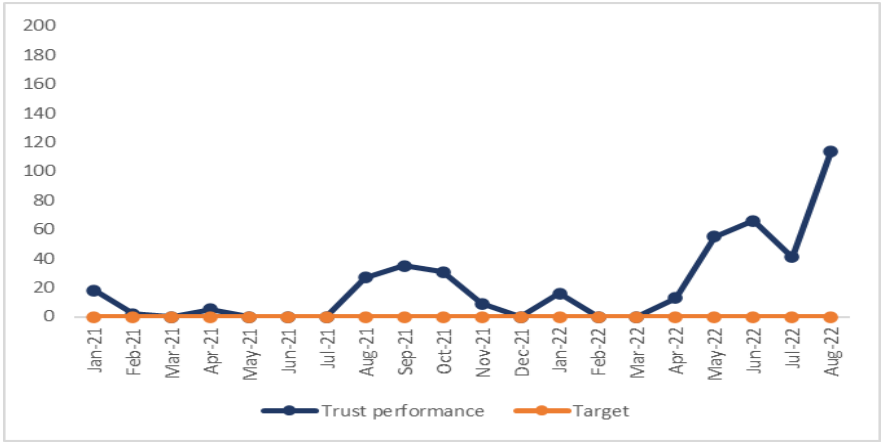
**Executive Summary:** Martyn Ward, Director of Digital and Transformation
**Narrative updated**: 15 September 2022

**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.

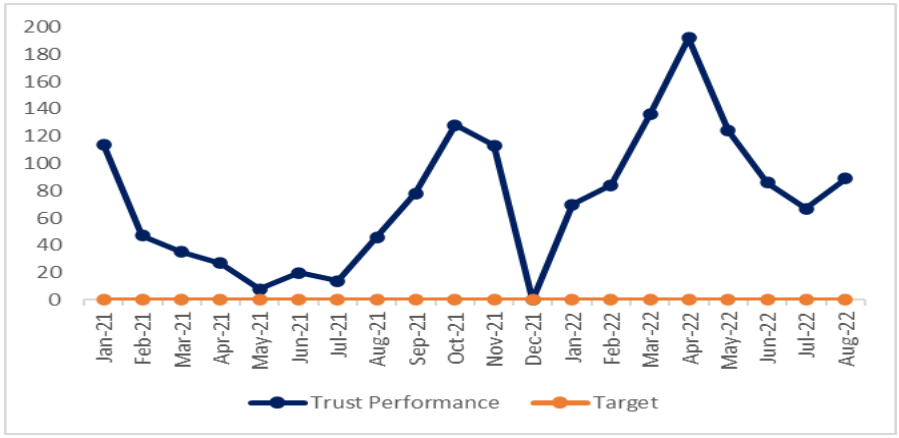
**Performance:** Overall performance is good, with the exception of the number of inappropriate out of area placements, MIU 4 hour performance and IAPT. Please see overleaf for more information on OAPs. MIU performance is due to increased activity levels this year, increased appointment times due to patient complexity and staffing issues. The position is being monitored and action taken as appropriate. IAPT performance is being monitored but is not currently a cause for concern.

# 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 | 114 |




| 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 | 89 |




**Executive Director commentary:** Martyn Ward, Director of Strategy and CIO
**Narrative updated**: 12 September 2022

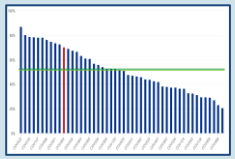
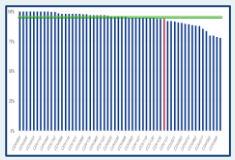
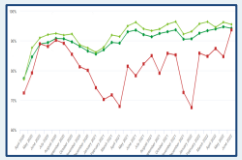
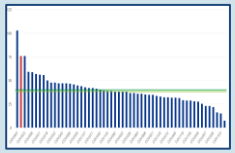
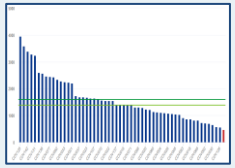
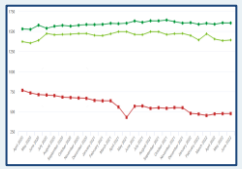
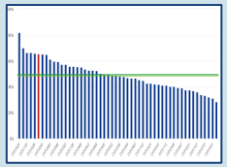
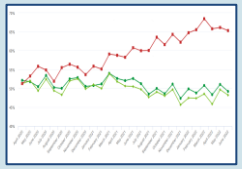
**The issue and cause**
The use of Out of Area Placements is due to demand outstripping capacity for inpatient beds.

**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. **August 2022 locally reported total bed day usage was 203 days (114 inappropriate OAP bed days in Bucks, and 89 inappropriate OAP bed days in Oxon).** In April, changes to IPC guidance have allowed 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 OAP capacity. The Trust has an agreed trajectory to reduce the number of block purchased beds, with the aim to be down to 3 beds from 9th December 2022.

Section 4a:

# Comparative/Benchmarking Data

# How do we benchmark (June 22* MH & LD Covid-19 Benchmarking) *latest data available. Published quarterly

| Service Area / Currency | Latest Trust Position<br>OHFT Red bar, other Trusts in blue | Trust Trend<br>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 |  |  | 70.31% | 52.14% | Higher | In June admissions under the MHA were higher than the national average. With May and June both higher than 70%, levels not experienced since December 2020. The draft 21/22 annual benchmarking indicates that the Trust admissions under the MHA in the highest quartile nationally. |
| Adult Acute Bed Occupancy (%) |  |  | 93.69% | 94.22% | Lower | OHFT bed occupancy has increased in recent months with June being at 93.69% which is in line with national averages. In the draft 21/22 annual benchmarking for the same measure the Trust was below the national average. |
| Adult Acute Mean LOS (exc leave) in Days |  |  | 76.00 | 40.08 | Higher | OHFT LOS in June 22 was higher than national average. There were some patients with high LOS impacting on the averaging including 1 patient discharged with a LOS of 1,585 days. Operational services continue to explore ways of reducing LOS. In the draft 21/22 annual benchmarking for the same measure the Trust was one of the highest nationally |
| Adult CMHTs Total number of patients on caseload at month end per 100,000 reg pop |  |  | 472.58 | 1602.00 | Lower | This monthly benchmarking exercise only counts as being on caseload where there are two face to face contacts delivered. A full mapping review of teams in scope is being undertaken to ensure all teams are being appropriately included. If required a refreshed data submission will be made following the review. Liaison with another provider identified that their services may hold people open on caseload who are not regularly being seen (see indicator below which demonstrates OHFT engagement levels with patients on caseloads). |
| Adult CMHTs % of caseload at month end who had a clinical contact during the month (%) |  |  | 65.31 | 49.19 | Higher | The number of Adult CMHT caseload who were open to services at the end of the month and who had a clinical contact in month is higher than the national average. Again the mapping exercise may identify the need to refresh the data. |

Section 4b:

# **SE Regional Performance** including Provider Collaborative Performance

# Regional Performance – South East Integrated Performance Report - 2 September 2022

**Bed Occupancy** comparison not included as OHFT data not available for full rolling 12 week period due to system outage.

**Mental Health No. of People Awaiting Admission:**

The number of people awaiting admission to Oxford Health is low in the region, averaging 0 people over the past 12 weeks.

- Across 7 providers the total number of people awaiting admission is 83 on average.

**Inappropriate Out of Area Placements (OAPs):**

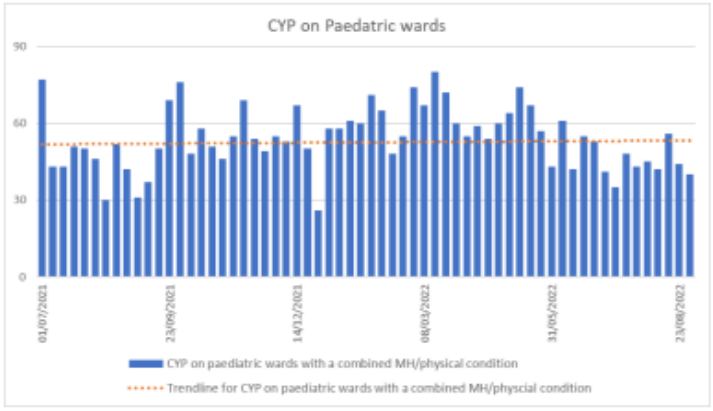
- Oxford Health had a higher number of inappropriate OAPs compared to other providers; the average of last 12 weeks was 9.
- Across 8 providers the average number of inappropriate OAPs was 50, driven in the main by one provider.

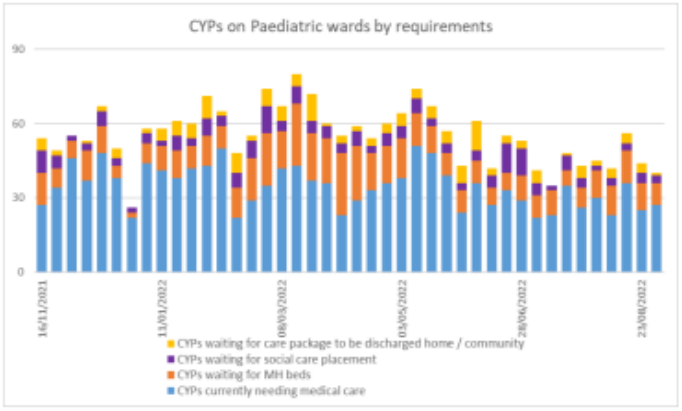
**Availability of 136 suite:**

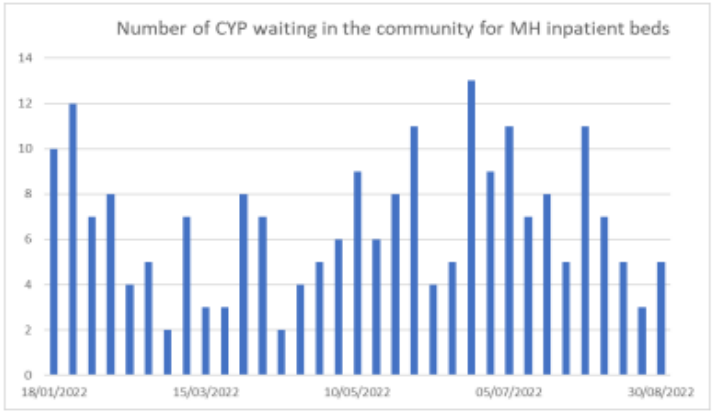
- 136 suite availability in Oxford Health is one of the highest in the region averaging 40% availability over 12 weeks as at the weekly snapshot position compared to the regional average of 30%.

**Bed Occupancy** comparison not included as OHFT data not available for full rolling 12 week period due to system outage.

## CYP on acute paediatric wards




**As at 30.08.2022**

**Number of CYPs on Paediatric wards: 40**
CYPs currently needing medical care: 27
CYPs waiting for transfer to MH bed: 9
CYPs waiting for social care placement: 3
CYPs waiting for MH community care package to be discharged home: 1

**Number of CYPs currently waiting/admitted to s.136 suite or waiting in A&E: 3**

**Number of CYPs waiting in the community for MH bed: 5**

# Regional Performance – South East Integrated Performance Report Provider Collaborative – 2 Sept 2022

**Commentary by:**
Gillian Combe, Clinical Directory, Thames Valley CAMHS Provider Collaborative

**Demand:**

- Referrals are slightly down compared to last year. Inappropriate out of area bed use is at its lowest at only 5 cyp
- Wait for transfer from Paediatric beds is slightly down compared to last year but still high and a priority area
- Several cyp who were delayed discharges have been successfully discharged

**Initiatives:**

- Hospital@Home for Eating Disorders will be made part of our service following a very successful pilot and will increase from treating 6 to 12 patients at any time, the equivalent of an additional ward
- Hospital@Home for moderate to severe learning disabilities and autism will launch soon. Adverts are out for members of the team
- ALPINE guidelines for eating disorders continue to be rolled out across the Paediatric wards. The pilot was in Salisbury District Hospital and their Children's Ward won Team of the Year for this work. Results show a positive impact for young people and reduced referrals to Tier 4

**Current pressures:**

- Quality improvement work at Taplow Manor (formerly Huntercombe Maidenhead). CQC recently rated Requires Improvement
- Lack of social care provision impacting on Tier 4 referrals and discharges
- Workforce pressure due to lack of trained staff across most disciplines

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 August 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 | 95% | 32% | 56% | 64% | 66% | | | 48% | ↓ |
| (1b) Staff trained in restorative just culture | TBC | - | - | - | - | - | - | 26 (Q4) | → |
| (1c) BAME representation across all pay bands including board level | 19% | 14% | 18% | 30% | 38% | | | 19.6% | → |
| (1d) Cases of preventable hospital acquired infections - YTD | <3 | - | - | - | - | - | - | 0 YTD | → |
| (1e) Reduction in use of prone restraint | TBC | - | - | - | - | - | - | 128 uses | See slide |
| (1f) Patient safety partners employed | 2 | - | - | - | - | - | - | 0 | n/a |
| (1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP) | 90% | - | 88% | 70% | - | - | - | 81% (July*) | ↓ |
| (1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT | 75% | - | 66% | 61% | - | - | - | 64% (July*) | ↓ |
| (1g) Evidence patients have been involved in their care (clinical audits) reported bi-monthly | 95% | No relevant audits | 83% (n=222) | 80% (n=114) | - | 86% (n=58) | - | 83% (June) | → |
| (1h) Clinical staff in non-learning disability services have completed internal eLearning on autism | TBC | - | - | - | - | - | - | See narrative | → |

* Latest available data due to Carenotes outage.

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
All data relates to August unless otherwise indicated in brackets in the penultimate column

These are the new indicators introduced which need further development and targets to be agreed.

| 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 | 8 | 0 | 0 | 0 | 0 | 8 | ↓ |
| (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% (national) | - | 66% (27/41) | 92% (12/13) | - | - | 72% (June*) | ↓ |
| (1l) Inpatient Length of Stay (LOS) excl delay/leave – Mental Health Adult Acute | TBC | | 58 days | 76 days | | | 66 days (July*) | ↑ |
| (1m) Inpatient Length of Stay (LOS) – EMU | TBC | 9 days | - | - | - | - | 9 days (July*) | ↓ |
| (1n) Inpatient Length of Stay – Stroke | TBC | 31 days | - | - | - | - | 31 days (July*) | ↑ |
| (1o) Inpatient Length of Stay – Rehab | TBC | 27 days | - | - | - | - | 27 days (July*) | ↓ |
| (1p) Medically fit for discharge (MFFD) – Community | TBC | 79 | - | - | - | - | 79 (July*) | ↓ |

* Latest available data due to Carenotes outage.

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**: Sept 2022

Three OKRs which are underperforming:

- Clinical supervision
- Completion of the Lester physical health tool for relevant patients on the AMHT caseloads
- Staff training on Autism awareness and reasonable adjustments

Please see overleaf for more information by measure on the cause of the underperformance and the plans to mitigate and improve performance. We are also reporting on the position on the use of prone restraint and patients are being involved in their care.

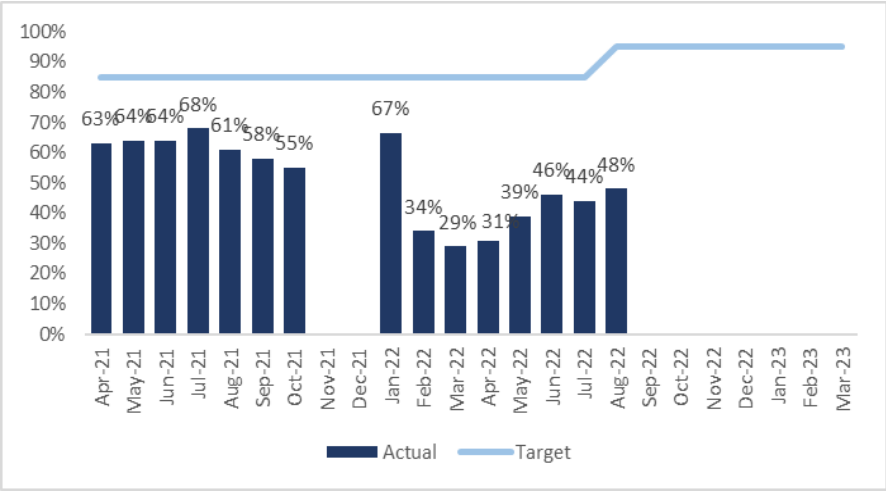
The Chief Medical Officer and Chief Nurse are reviewing the current Quality OKRs in line with the quality objectives approved for 2022/23 which are published in the Quality Account.

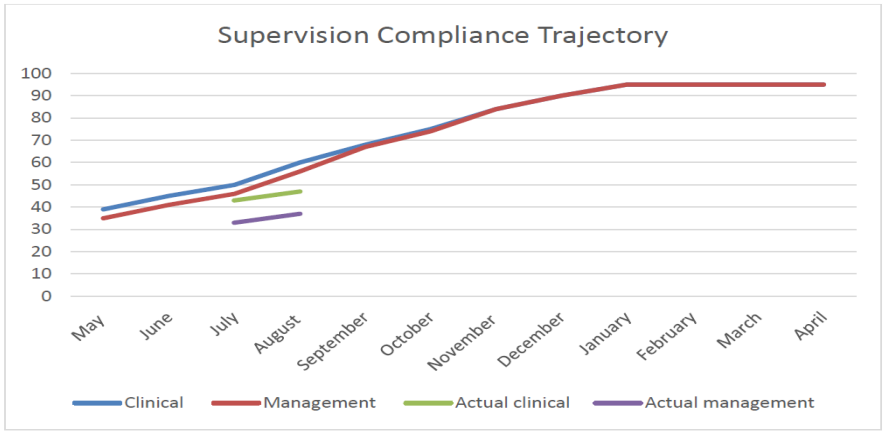
The Trust is carrying out Quality Improvement Projects in the following areas relevant to the Quality OKRs:

- Positive and Safe – reduction in restrictive practice
- Risk Assessment formulation and documentation
- Working with families and carers, alongside implementing the Carers, Friends and Family Strategy 2021-2024
- Improving co-production in care planning, which is a core part of the co-produced Patient Experience and Involvement Strategy (being finalised at the moment)
- Equality, Diversity and Inclusion programme

# Objective 1: Quality; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (1a) Clinical supervision completion rate | 95% | 48% |




**Executive Director commentary:** Marie Crofts, Chief Nurse

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

**The cause**
Increased demand and issues with accuracy of reporting from OTR.

**What is the plan or mitigation?**
Recovery plan in place with a focus on;

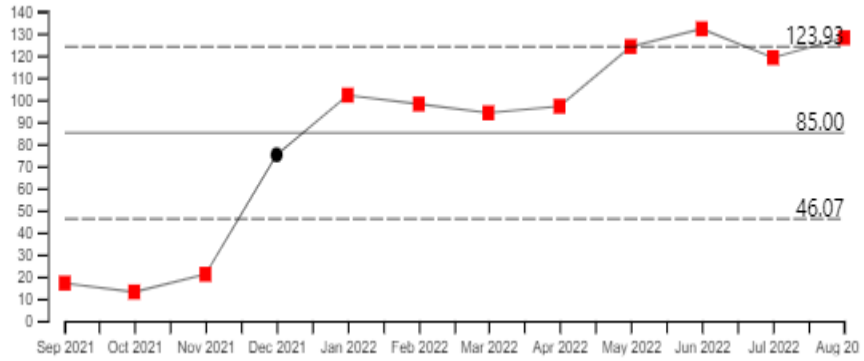
- Accuracy of supervision requirement attached to each staff member
- Targeting services with the poorest rates
- Work with HR systems Team to address the issues raised about recording
- Staff training
- Spot checks by HoN to ensure supervision is taking place

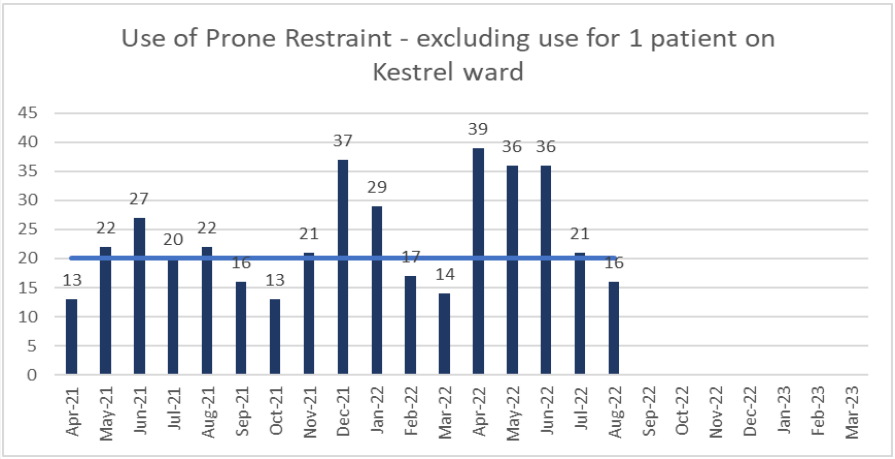
A Supervision Steering Group meets monthly to lead on the recovery plan led by the Deputy Chief Nurse.

# Objective 1: Quality; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (1e) Reduction in use of prone restraint | Less than 20 uses per month | 128 (Aug) |

Number of uses of Prone Restraint all wards




**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**
The most common cause for this type of restraint is violence, followed by self-harm. The position is used mostly as part of a seclusion procedure, planned care or to administer immediate IM.

**What is the plan or mitigation?**
The first SPC chart shows the use by month for all wards, since December 2021 the use of prone has increased. The increase relates to a particular patient on a forensic ward who is very unwell and waiting placement in a high secure environment, the use of prone is part of an individualised care plan.

The second graph shows the information excluding this one patient to give a better view of the position against target (in 7 of the last 12 months the target has been achieved). The use and duration of prone restraint is reviewed Trust-wide weekly.

A large-scale QI programme is underway to reduce the use of restrictive interventions, including prone restraint. This is part of the national mental health patient safety programme.

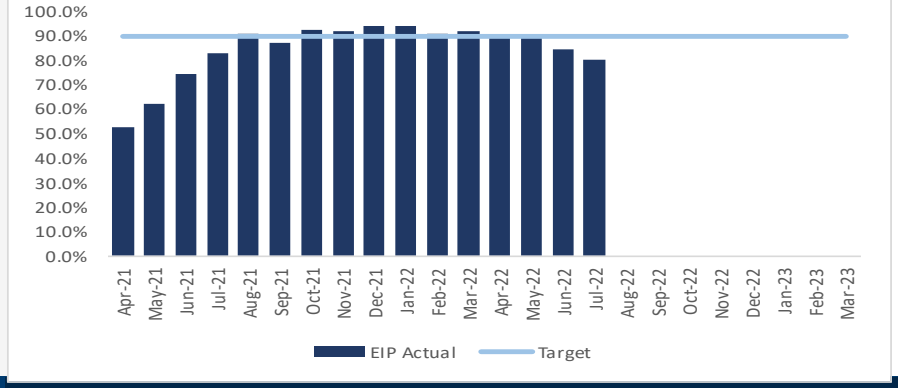
Actions;

- Alternative IM medication site training is being rolled out and safety pods are in situ on every ward, remaining wards have ordered.
- Videos have been developed to support coaches going forward.
- Techniques have been signed off by independent assessor and have now been added to the re-cert training.
- Training for use of safety pods has been scheduled and embedded in the PEACE training programme.
- Training for withdrawal from seclusion using safety pod is in progress.
- Work to develop a rapid tranq prescription chart to support the use of alternative injection sites.

# 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% | 64% |


| 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% | 81% |




**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**

People with severe mental illness (SMI) die on average 15-20 years sooner than the general population. They are dying from physical health causes, mostly commonly respiratory, circulatory diseases and cancers

**The plan or mitigation**

Data is up to July 2022 only.

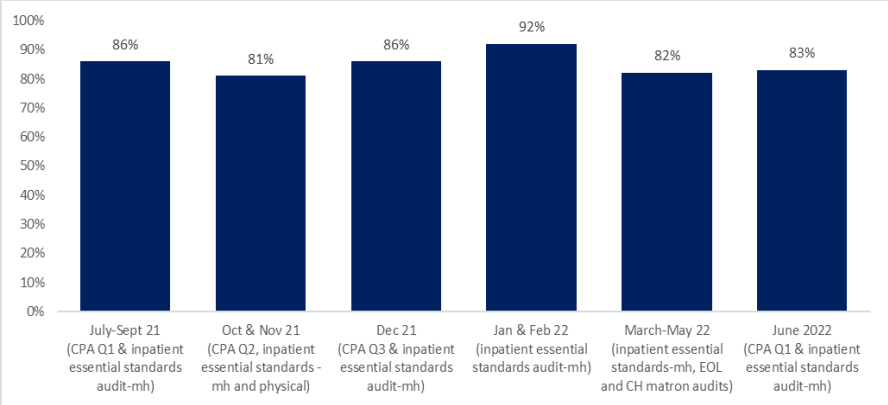
There is an improvement plan in place for 3 workstreams.

The focus in 2022/23 is;

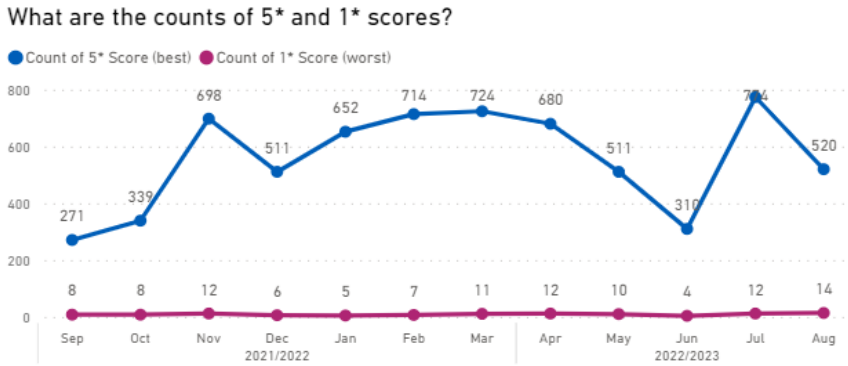
- Make changes to the physical health forms on CareNotes
- Expand at pace smoking cessation work
- Education and training for staff – physical health skills for wider team
- Develop patient information
- Increase the role of peer support workers to promote screening
- Improve flexibility and mobility of testing to reduce DNA through mobile clinics and individual kits by nurse.

# Objective 1: Quality; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (1g) Evidence patients have been involved in their care (bi-monthly clinical audit) | 95% | 83% (June) |




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**
The feedback we receive and the clinical audit information, detailed below, tells us patients are not always and consistently being involved in their care or care planning. This affects a patient's experience, the outcomes they can achieve and their safety.

**The plan or mitigation**
A number of quality improvements projects are underway with a focus on person centred care and care planning.

There is a QI programme on better involving and engaging friends, families and carers which is linked to the implementation of the Friends, Family and Carers Strategy 2021-2024.

We are developing a new co-produced Patient Experience and Involvement Strategy to include an implementation plan for the next 3 years. More than 65 patients, service users and experts by experience have supported the development of the Strategy to date and we hope to share a draft for public consultation shortly ready to be finalised in November 2022. A central part of the Strategy will be to improve personalised care.

# 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 | TBC | See narrative |

**Executive Director commentary:** Marie Crofts, Chief Nurse

**The Context and plan**

Local training
New internal training was developed by the Trust in 2021 and 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.

National training
The Trust was involved in the pilot of the new national training (Oliver McGowan) in 2021, which 125 staff attended. The new 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 available from Oct 2022, this has been delayed. The platform for delivery is being agreed at BOB ICS level. Tier 2 will then follow.

Initial plan was for Tier 1 awareness training to be made mandatory, although this needs to be confirmed since the recent review of mandatory courses.

Support and services
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. A Buckinghamshire lead has also been employed.
- 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 **August 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 scoreQ2(2022) | >/=? | 6.84↑ | 6.69↓ | 6.33↓ | Only available at directorate level 6.81%↑ for Specialised Services | | | 6.87↑ | 6.74 | n/a | ↑ |
| (2b) Reduce agency usage to NHSE/I target Excludes covid spend | </=10.2% | 11.7%↑ | 20.0% ↓ | 27.1%→ | 0.0%↑ | 17.1%↑ | 5.5%→ | 1.4%↓ | 14.8% | ModHos 8.3%/ Peer 8.2% | ↓ |
| (2c) Reducing staff sickness to 3.5% over 2021/22 | </=3.5% | 6.0%↓ | 4.0%↓ | 6.2%↓ | 3.5%↓ | 7.1%↓ | 4.7%↑ | 4.4%↑ | 5.3% | ModHos 4.5%/ Peer 3.9% | ↓ |
| (2e) Reduction in % labour turnover | </=10% | 14.9%↓ | 14.8%↑ | 16.4%↑ | 21.3%↓ | 20.6%↑ | 9.2%↑ | 12.6%↑ | 14.9% | ModHos 19.4% Peer 20.2% | ↓ |
| (2f) Reduction in % Early labour turnover | </=10% | 17.4%↓ | 18.3%↓ | 19.9%↑ | 0.0%→ | 29.8%↑ | 20.0%↑ | 9.7%↓ | 17.1% | None | ↓ |
| (2g) Reduction in % vacancies | </=9% | 4.1%↑ | 20.2%↑ | 20.0%↑ | 21.5%↓ | 21.2%↓ | 2.1%↑ | 9.8%↓ | 13.5% | ModHos 10.8%Peer 11.1% | ↑ |
| (2h) PDR compliance | >=95% | 27%↑ | 28%↑ | 34%↑ | 29%↑ | 43%↑ | 17%↓ | 26%→ | 29% | None | ↑ |
| (2i) PPST (Stat and Mandatory training) | >=95% | 84%↑ | 81%↑ | 84%↑ | 83%→ | 86%↑ | 84%↓ | 86%↑ | 84% | None | ↑ |
| (2j) Number of Apprentices as % substantive employees | >=2.3% | 6.4% → | 2.6% ↓ | 8.6% ↑ | 3.4%↓ | 5.8% ↑ | 0.0% → | 2.2% ↓ | 5.5% | 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**: August 2022

The senior HR leadership team have defined the priorities for the next 18 months until the end of FY23/4 which will form the HR People Plan and this was agreed at the PLC on the 7 July 2022. Three cross cutting themes of work have been identified to address the most pressing priorities: upskilling line managers to lead teams and increase engagement; a focus on new joiners – from advert to the 12 months to support attraction and retention and lastly strengthening our data and systems to free up clinicians time maximise self service capabilities. All of the key priorities require a collective effort across the specialisms within HR with cross team working. There is activity across all areas with specific focus on deliverables that support the attraction and retention of staff which corresponds directly to our highest workforce risk – this work takes different forms e.g. improving recruitment blockages; getting the right structure in place to support recruitment of bank staff; corporate induction redesign; PDR redesign; agreeing definition of statutory and mandatory training and agreeing creative ways to reward staff with cash and non cash benefits.

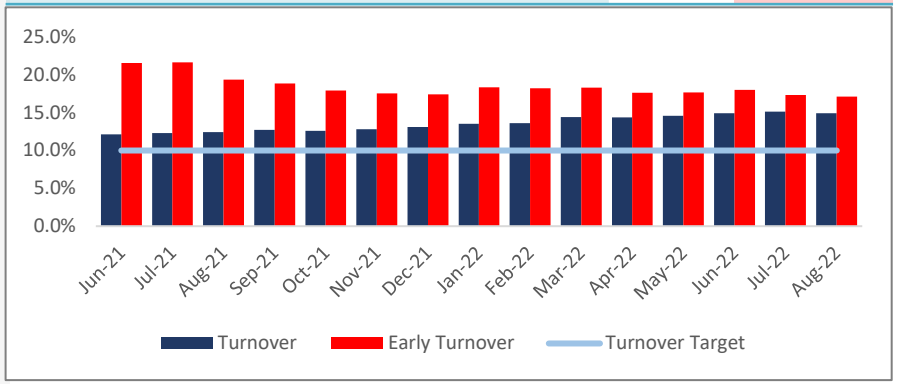
The over-riding risk that will permeate the 12 months ahead is the pressure of cost of living increases – we have already taken some action to reward staff with one off payments; covering cost of Blue Light discount cards; temporary uplifts in mileage rates, permanent suspension of car parking and additional annual leave but there is more to do on financial wellbeing as we move into the autumn and winter period with particular focus do all we can to support staff with fuel costs. We need to work closely with Trust partners across the system and local authorities to support staff given our wide geographical spread. We have engaged with staffside colleagues who have provided constructive feedback in relation to where they feel their members will have most need.

The HR Systems Strategic Review is led by an external consultancy is almost complete. An Outline Business Case detailing options to develop our HR Systems will be presented to the Executive Management Committee for initial consideration on 10 October. This will inform the direction of the work to deliver the People Plan priority of strengthening our data and systems to free up clinicians time maximise self service capabilities. As an interim development a new process has been developed enabling a line manager to request equipment and access to systems for new starters by the completion of one form. This will free up time for managers and resolves a recommendation and risk raised in the Employee IT Data Record Audit conducted in 2020/21.

The HR team have been supporting the organisation in response to the cyber security attack on patient record systems, looking at methods to deliver more staff into First Contact Care and additional administrative and clerical staff across affected services. Actions taken include consideration of additional payments for excess hours worked during the outage, additional use of bank staff and redeployment of staff from across the organisation especially from corporate services, and advancement of expense payments where staff are unable to identify patient visits to claim expenses.

# Objective 2: People; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (2e/f) Reduction in % labour turnover | <10% | 14.9% |




**Executive Director commentary:** Charmaine De Souza, Chief People Officer

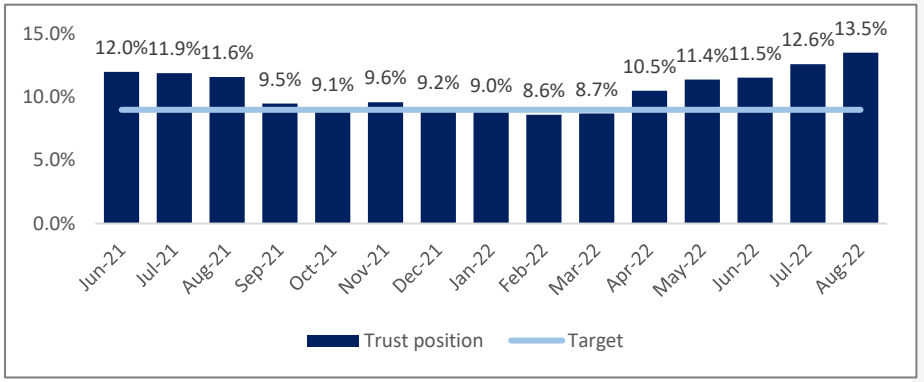
**The risk or issue**
Staff turnover has decreased from 15.1% to 14.9%. High levels of turnover will impact on vacancies, agency spend, quality of patient care and staff experience.

**The cause**
Whilst the reduction is welcome in August the cost-of-living crisis and the below inflation pay offer is impacting on staff retention (especially in the lower bands) with wage increases in other sectors increasing rapidly.

**The plan or mitigation**

- A Retire and Return working group s being set up to ensure the route to retire and return is as simple and quick as possible so that we continue to retain our most experienced staff
- Practice Nurse Educators (PNE) are starting in the Trust as part of a national programme to work directly with clinical teams to support them to develop their clinical careers within the Trust
- A Workforce Planning Manager has started who will be working directly with services to support them to ensure they have the right staff in post
- Cost of living and reward options are being developed by the Head of HR Policy, Reward and Projects
- A New starter experience group has developed 6 surveys to track the experience of our new starters. Their feedback will inform e the Recruitment and Retention groups enabling them to make changes to give staff the best new starter and hopefully retain them within the organisation for several years.

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| **(2g)** Reduction in % vacancies | </=9% | 13.5% |




**Executive Director commentary:** Charmaine De Souza, Chief People Officer

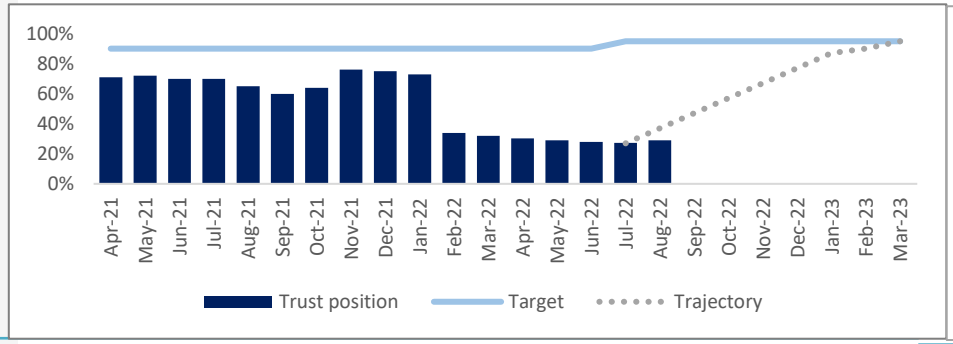
**The risk or issue**
The vacancy rate has increased from 12.6% to 13.5%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients.

**The cause**
The number of vacancies in progress via the TRAC Recruitment system has increased month by month over the past six (6) months, August - 1806 vacancies.
This is putting increased pressure on the Recruitment Onboarding team to complete background checks for an increased volume of candidates.
As a result the 'time to hire' metric has moved back up to 91.5 days (from a low of 85 days in May 2022).
The Recruitment Onboarding team continue to be short-staffed due to long-term sick leave and vacancies (internal HR transfers).

**The plan or mitigation**
The Recruitment team have appointed to all but 1 vacancy, with two (2) experienced new starters joining the team in October 2022, this includes an additional part time resource to support the Community team to support with increased volumes.
Absence has been managed closely for the two staff members on long-term sick leave, one has now had their contract terminated within the probation policy, the other is now on maternity leave, this takes maternity leave to 3 WFE within the team. The team are recruiting to replace 1x Band 3.
The Recruitment campaigns team are developing proactive recruitment campaigns for areas of high vacancy and agency spend, to reduce vacancy rates in the most difficult areas.

# Objective 2: People; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (2h) PDR compliance | >/=95% | 29% |




**Executive Director commentary:** Charmaine De Souza - Chief People Officer

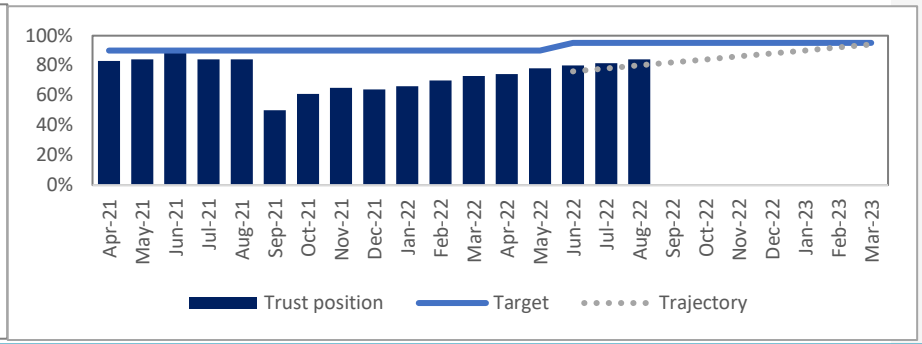
**The risk or Issue**
The percentage of staff receiving a PDR in the past 12 months has remained static at a very low percentage. Individuals who do not receive a PDR may not be supported to access professional and personal development opportunities which maybe a risk to retention. There is no reliable way to corroborate the report that PDRs are occurring but not being recorded.

**The cause**
Several factors are contributing to this including Learning & Development (L&D) system issues, a lack of trust in and knowledge of using the L&D system which may have led to individuals not recording PDR's centrally and the PDR form being time consuming to complete.

**The plan or mitigation**
The PDR process has been reviewed with a T&F group including OD and L&D staff using the Quality Improvement methodology. A proposal will be presented to the Exec Board on 19 September for approval to introduce a series of actions to address the poor recording rate including:

- Moving to a yearly PDR 'season' and away from PDR's being conducted on an employee's increment date,
- Closing the PDR form on Learning & Development System (LDS) and using the system to record only the date of PDR
- Rolling out a refreshed PDR form with focus on career development, wellbeing and flexible working.
- Removing the requirement of a PDR on the L&D system for individuals where this is managed elsewhere or not required, such as students and Medics.

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (2i) Statutory and Mandatory training | >/=95% | 84% |




**Executive Director commentary:** Charmaine De Souza - Chief People Officer

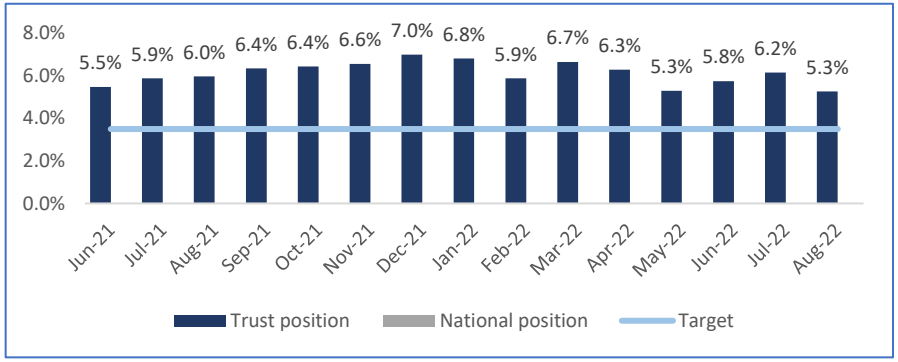
**The risk or issue**
The percentage of Statutory and Mandatory training completed on 13 September shows a further increase to 83.5%, although it does not meet Trust compliance target of 95%. Individuals who have not completed their training may not have the skills and knowledge to carry out their role safely

**The cause**
There are still a few underlying system and reporting fixes that need to be made. The reporting does not yet reflect the new 11 nationally agreed stat and mandatory training categories. Despite recent improvements there are still several staff who cancel or do not attend training.

**The plan or mitigation**
Work has already been completed by the HR System and Reporting team to correct errors in data as well as a full review of mandatory training provision. The true compliance picture based on the revised definition of Statutory & Mandatory training will only be known once this work is complete. T&F groups for resus and moving and handling are set up to address the more in-depth requirements of these provisions. A new delivery of the Trust Corporate induction will begin in November, this includes an e learning day which will enable improved compliance with e learning from an earlier date. ~~All work on Statutory and Mandatory training in the L&D system will be complete by the end of September except for training for Flexible Workers and resus and moving and handling which requires more in-depth analysis~~. New mandatory training for Autism awareness at varying levels, needs to be introduced into the requirements for all staff.

# Objective 2: People; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| (**2c**) Reducing staff sickness to 3.5% | </=3.5% | 5.3% |



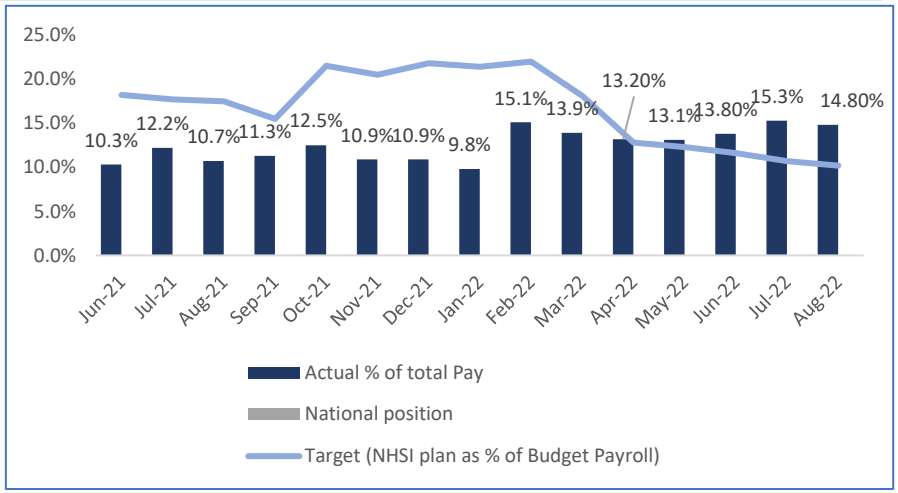

**Executive Director commentary:** Charmaine De Souza, Chief People Officer

**The risk or issue**
The sickness absence rate has decreased in August from 6.2% to 5.3%. Excluding Covid absences the rate was 4.2% (4.3% last month)
**The Cause**
Whilst sickness absence remains above target, it is pleasing to see a reduction in overall absence levels in August. Despite this, there has been an increase in the number of long term sickness cases. The top five reported causes of absence were Covid Confirmed, Special Leave, Headache/Migraine, Gastrointestinal, & Cough/Cold.
**The plan or mitigation**
Work is ongoing to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees. This will ensure appropriate referrals are made and signposting to the various support/assistance programmes that are available. Additional analysis will be undertaken to identify service areas which are particular hotspots.

Further work will be undertaken to understand the drivers for high volumes of absence in particular services and to ensure that there is consistent application of policy across the Trust, This will initially focus on service areas with the highest levels of absence, with bespoke interventions where necessary.
We are currently reviewing the sickness absence target in view of a different method of absence calculation (GoodShape rather than ESR) and it having not been reviewed for many years.

# Objective 2: People; areas of underperformance

| Objective Key Result (OKR) | Target | Actual |
|---|---|---|
| **(2b)** Reduce Agency Usage to Target | </=10.2% | 14.8% |




**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.

**Executive Director commentary:**
Charmaine De Souza, Chief People Officer

**The plan or mitigation**

The Improving Quality and Reducing Agency Programme has several workstreams which aim to improve the quality of our services whilst reducing agency spend. The retention workstream has started a subgroup to look specifically at the retire and return process and options available to our staff including national best practice guidelines. The recruitment workstream has established a new starter feedback group and has completed an initial mapping of revised recruitment timelines and KPIs, to be presented to the IQRA Programme Board on the 16th September.

The e-rostering workstream has completed the upskilling sessions with 28 out of the 32 inpatient units, this will be completed by the end of September. The agency management workstream has finalised the data reports for the inpatient units, this is now sent out weekly. The number of red lines of work has reduced from 56 to 48.

The international recruitment workstream has had 2 RMNs commence employment with the Trust, there are 2 RMNs with start dates confirmed for September and there are 31 nurses (23 RMN and 8 RN) going through the pre-employment check process. The Trust has been successful in securing funding from NHSEI to deliver an international recruitment programme to recruit 20 OTs between now and the 31st March 2022.

A full review of all workstreams has been undertaken to create more focus on achievable actions in 12 week blocks until the 31st March 2023. Due to the ongoing critical incident the e-rostering and medical staffing workstream meetings were stood down in August.

# 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) **Favourable** performance against financial plan (YTD) | £4.0m adv ↓ | £0.3m adv ↓ | £1.4m adv ↓ | £0.3m fav → | £1.3m adv ↑ | £0.1m adv → | £8.6m fav ↑ | £1.8m fav ↑ | → |
| (3b) Cost Improvement Plan (CIP) delivery (YTD) | | | | | | | | £3.1m 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) | - | - | - | - | | | - | 5 achieved | |

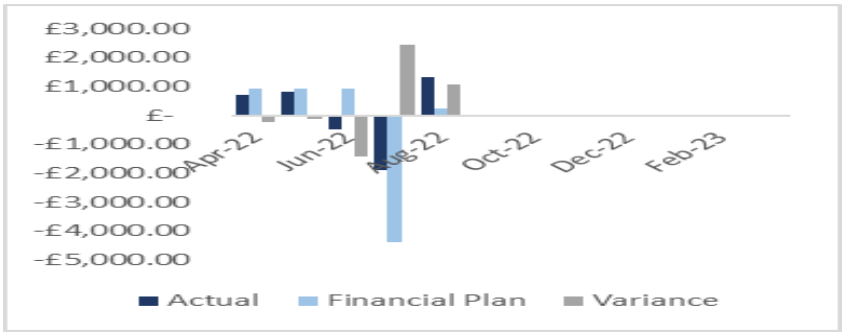
**Governance**
**Executive Director**: Heather Smith | **Responsible Committee**: Finance and Investment Committee | **Responsible reporters**: Paul Pattison/ Christina Foster | All data relates to the position as at end of August unless indicated in the penultimate column

**Executive Summary:** Heather Smith, Director of Finance
**Narrative updated**: end of August 2022

I&E £0.5m surplus, £1.8m favourable to plan. Financial pressures are under delivery of CIP, continuation of high level of agency and contracted OAPS both reported as Covid spend in FY22 mitigated by release of covid funding in expectation of the tapering down of these expenditure items and release of reserves and deferred income. The CIP plan for the year is £7.9m with delivery profiled evenly over 12 months. £1.8m has been delivered at month 5, this is £3.1m 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 |
|---|---|
| **(3a) Adverse** performance against financial plan | £1.8m favourable |



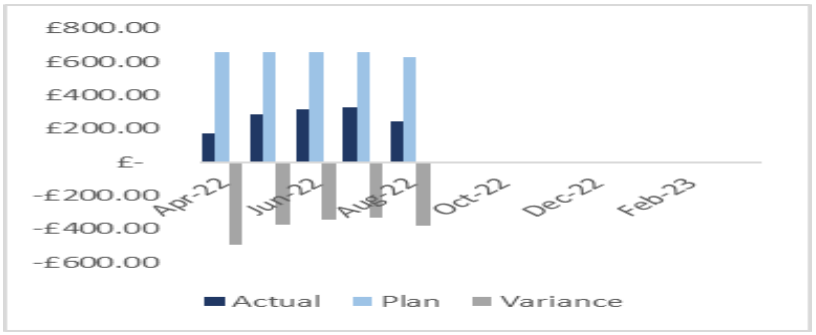

**Executive Director commentary:**
Heather Smith, Director of Finance

**The risk or issue**
Financial performance against plan is £1.8m favourable at month 5.

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

**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 |
|---|---|
| **(3b)** Cost Improvement Plan (CIP) Delivery | £3.1m adverse |




**Executive Director commentary:**
Heather Smith, Director of Finance

**The risk or issue**
CIP Performance against plan is £3.1m adverse at month 5.

**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<br>4th Nationally | 19 | 29 | 16 | 708 | 772<br>2nd Nationally | No.1 ranked Trust 3277 |
| CRN Portfolio studies running as at month end | 72<br>2nd Nationally | 1 | 7 | 2 | 31 | 41<br>4rth Nationally | No. 1 ranked Trust 82 |

**Executive Summary:** Karl Marlowe, Chief Medical Officer
**Narrative updated**: September 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 and 459 recruits for current FY came from one study led by Prof Keith Hawton the "Oxford Monitoring System for attempted Suicide".

CARENOTE OUTAGE IMPACT
Being unable to review patient records will delay or prevent recruitment of patients to clinical studies. The impact of this will be, reputational, if we fail to meet national deadlines and financially, if will fail to recruit to funded studies and where the recover excess treatment costs are based on patient recruitment .

Section 6:

# Patient activity and demand - Areas of concern

# 6. Patient Activity and Demand – areas of concern

## 2. Section content

**Referral levels, appointment activity, number of admissions and length of stay** are routinely monitored by the Performance and Information Team using statistic process control (SPC) charts which indicate whether activity is outside of 'usual/expected' levels (or 'norms').

This section reports on **areas of concern**. Areas of concern are determined by (1) the Performance and Information Team highlighting activity outside of normal levels to services which is then (2) investigated by the services who confirm if it is a genuine area of concern.

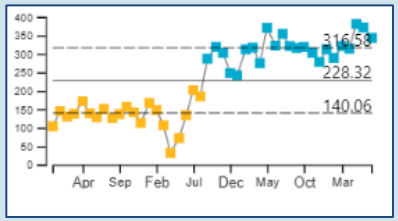
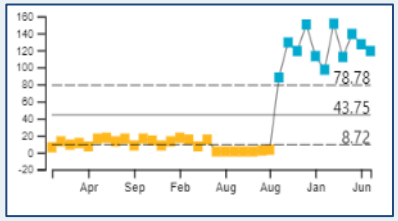
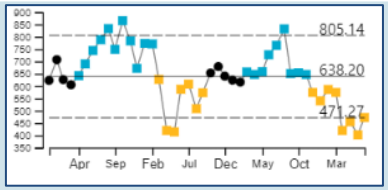
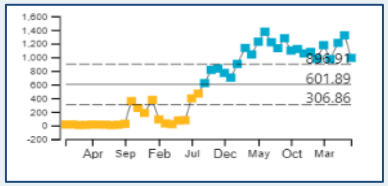
**Headlines**

- There are currently 12 areas of concern – see table below
- 5 are experiencing higher levels of demand or activity and 7 are experiencing lower levels
- Further information is provided overleaf for each area

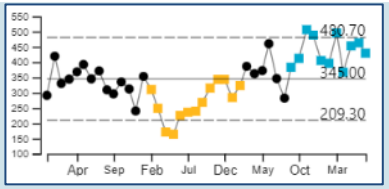
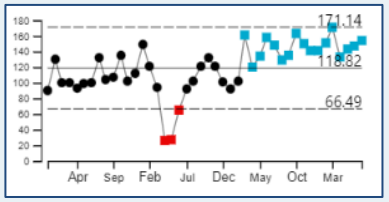
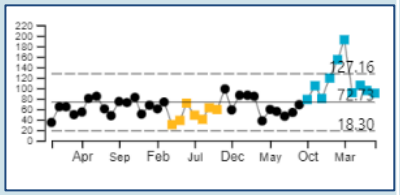
| Directorate | No. areas of concern | Areas of concern | Currency of concern | Is activity higher or lower than usual |
|---|---|---|---|---|
| Community | 5 | Care Home Support Service<br>Tissue Viability<br>Speech and Language Therapy | Referrals and appointments<br>Emergency referrals and appointments<br>Appointments | Higher<br>Higher<br>Lower |
| Oxon & BSW Mental Health | 5 | Memory Assessment Service CAMHS<br>BSW In-reach<br>Oxon CAMHS Forensic (CABS, Forensic & Specialist Housing)<br>Oxon CAMHS Perinatal<br>BSW CAMHS Swindon Community | Referrals<br>Appointments<br>Appointments<br><br>Appointments<br>Appointments | Higher<br>Lower<br>Lower<br><br>Lower<br>Lower |
| Bucks Mental Health | 2 | ADHD and Autism<br>Memory Service | Appointments<br>Appointments | Higher<br>Higher |

Please refer to the IPR supporting report for further information relating to demand and activity that is **not of concern**.

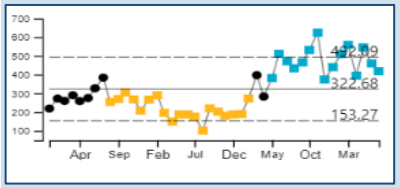
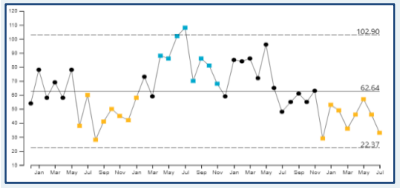
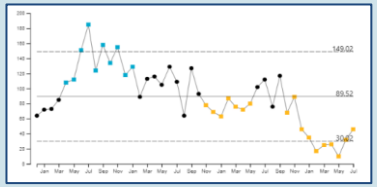
# Patient Activity and Demand: **Community Services** Noteworthy exceptions

| Specialty / Directorate | Currency / Service Line | Trend over time | Activity in month | SPC Analysis Variation | Commentary |
|---|---|---|---|---|---|
| Community Services Care Home Support Service | Referrals: Care Home Support Service |  | **343** |  | Is performance within usual levels? No. Since Sept 2020 referral numbers have been increasing to above average and on or near the UCL.<br>Is it expected? Yes, during COVID there was limited access to Care Homes. The service now receiving far higher volumes of referrals than pre pandemic levels. Development of new care homes has also placed additional pressures on the service.<br>It is a problem? Yes, the staffing levels have not increased in line with this increased demand.<br>Is any action required? Yes, the service is seeking to develop a business case to reflect this increased demand. |
| Community Services Tissue Viability | Emergency Referrals: Tissue Viability |  | **119** |  | Is performance within usual levels? No referral numbers for Emergency referrals for the last 11 months above the UCL. Urgent referrals have been above average for last 10 months. Routine referral volumes have decreased and have been below average for the last 11 months.<br>Is it expected? Yes, the service has been responding to higher levels of activity to support the DN service which is currently on Red Level 1 escalation due to capacity concerns vs demand/complexity.<br>It is a problem? Yes, across all DN and community nursing service lines a review of contacts/service specifications and negotiation with CCG is required.<br>Is any action required? Yes, review as above has commenced. A wound care recovery plan is being agreed for the DN service. |
| Community Services, Adult Speech & Language | Appointments |  | **472** |  | Is performance within usual levels No appointment numbers since December 21 have been below average and at times below the LCL.<br>Is it expected? Yes, the reduction in activity is partly driven by sickness and vacancies. In addition to recruitment a review is underway of the triage process and allocation to help maximise clinical capacity.<br>Is it a problem? Yes<br>Any action required? As outlined above |
| Community Services Care Home Support Service | Appointments: Care Home Support Service |  | **990** |  | Is performance within usual levels? No appointment numbers have been above average since September 20 and since March 21 have been above the UCL.<br>Is it expected? Yes, during COVID there was limited access to Care Homes. The service is now returning to business as usual. Additionally since Sept 2020 the service has been more accurately capturing all activity volumes<br>Is it a problem? Yes, the staffing levels have not increased in line with this increased demand.<br>Is any action required? Yes, the service is seeking to develop a business case to reflect this increased demand. |

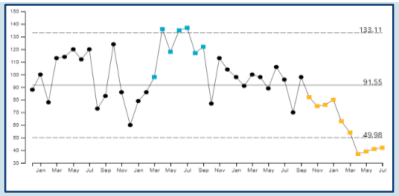
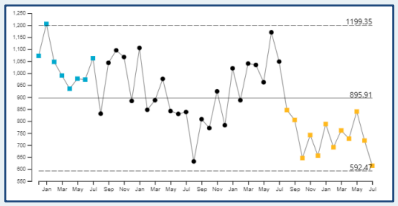
# Patient Activity and Demand: **Community Services** Noteworthy exceptions

| Specialty / Directorate | Currency / Service Line | Trend over time | Activity in month | SPC Analysis Variation | Commentary |
|---|---|---|---|---|---|
| Community Services, Tissue Viability | Appointments: Tissue Viability |  | **429** |  | Is performance within usual levels No appointment numbers since September 21 have been above average.<br>Is it expected? Yes, the service has been responding to higher levels of activity to support the DN service which is currently on Red Level 1 escalation due to capacity concerns vs demand/complexity.<br>Is it a problem? Yes, across all DN and community nursing service lines a review of contacts/service specifications and negotiation with CCG is required.<br>Any action required? Yes, review as above has commenced. A wound care recovery plan is being agreed for the DN service. |
| Oxon & BSW Older Adults | Referrals (All): Memory Assessment Services |  | **154** |  | Is performance within usual levels: No, since March 2020 referral volumes have been above average.<br>Is it expected? Yes, during the first wave of Covid there was a reduction in referrals made for memory assessments.<br>It is a problem? Yes capacity issues within CMHTs to meet the demand. This is a capacity gap since removal of S75 and lack of investment in service over a significant time frame.<br>Is any action required? SBARD completed to increase resources across the CMHTs unfortunately no additional funding is available |
| Bucks Community ADHD& Autism service | Appointments: ADHD & Autism |  | **90** |  | Is performance within usual levels? No since October 2021 appointment numbers have been above average<br>Is it expected? Yes, activity is higher than in the previous years due to the ASD/ADHD waiting list initiative<br>It is a problem? Yes Referrals to the service are much higher than the commissioned resource which leads to a large number of patients with long waits.<br>Is any action required? Ongoing monitoring |

# Patient Activity and Demand: **Community Services** Noteworthy exceptions

| Specialty / Directorate | Currency / Service Line | Trend over time | Activity in month | SPC Analysis Variation | Commentary |
|---|---|---|---|---|---|
| Bucks Older Adult MH Memory Services | Appointments: Memory Services |  | **418** |  | Is performance within usual levels? No appointment numbers for the last 13 months have been above average with some months above or on UCL.<br>Is it expected? Yes, the south teams have been delivery activity above commissioned levels to support reducing the wait for memory assessments. The service delivery model has changed to increase telephone and digital consultations resulting in delivery of higher volume of appointments.<br>It is a problem? Yes, there is a potential impact on the quality of appointments via telephone consultations. Additionally, patients have chosen to wait longer as they did not want to have a digital consultation.<br>Is any action required? The service are encouraging more face to face and digital appointments so the position may reduce in coming months. The service are exploring the model of delivery for memory services to support assessments in a timely manner and speed up provision of treatment |
| Oxon & BSW CAMHS BSW In-Reach | Appointments: CAMHS BSW In-Reach |  | **33** |  | Is performance within usual levels? No appointment numbers for the last 12 months have been below average.<br>Is it expected? Yes, there is an increase in demand coming both internally and from children's social care. There is also increased demand that is not reported on Carenotes due to limitations of the care record system.<br>It is a problem? Yes, it has come at a time of vacancies within the team. This will need to be monitored carefully. The vacancies are impacting on the volume of appointments delivered despite the increase in demand.<br>Is any action required? Ongoing monitoring |
| Oxon & BSW CAMHS O Forensic | Appointments: CAMHs O Forensic (CABS, Forensic & Specialist Housing) |  | **46** |  | Is performance within usual levels? No appointment numbers for the last 2 months have been below the LCL<br>Is it expected? Yes, these are small teams with low numbers of staff. There have been significant vacancies and long term sickness within all the teams leading to an impact of a reduction in activity.<br>It is a problem? Yes, long term sickness staff have now returned at end of June but there are ongoing recruitment needs<br>Is any action required? Yes, recruited plans in place for all vacancies. |

# Patient Activity and Demand: **Community Services** Noteworthy exceptions

| Specialty / Directorate | Currency / Service Line | Trend over time | Activity in month | SPC Analysis Variation | Commentary |
|---|---|---|---|---|---|
| Oxon & BSW CAMHS O Perinatal | Appointments: Oxon CAMHS O Perinatal |  | **42** |  Service concern | Is performance within usual levels? No since October 2021 appointment numbers have been below average, with last 4 below LCL.<br>Is it expected? Yes - Some sickness in team and some vacancy / Data quality issues; clinicians not recording all appts – mainly indirect / Ineffective processes within service pathway – now reviewed clarified and improved.<br>It is a problem? Yes<br>Is any action required? Yes – see below<br>• Consistent standardised case management<br>• Office manager supporting admin to improve<br>• Deep dive into care notes to ensure accurate and up to date<br>• Improved focus on wait and throughput |
| Oxon & BSW CAMHS Swindon Community | Appointments: BSW CAMHS Swindon Community |  | **614** |  Service concern | Is performance within usual levels? No since August 2021 appointment numbers have been below average.<br>Is it expected? It reflects national trends in eating disorders since the pandemic<br>It is a problem? Yes<br>Is any action required? The Swindon service is subject to business recovery measures |
| | | | | | |
| | | | | | |