NHS
Oxford Health
NHS Foundation Trust

ANNUAL QUALITY ACCOUNT 2021 - 2022

CARING, SAFE, EXCELLENT






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1. What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Throughout the document we have used the terms patients, families, and carers to mean any person who has used or will use our services.

If you require any further information about the 2021/22 Quality Account, please contact Jane.Kershaw@oxfordhealth.nhs.uk.

2. About the Trust

Oxford Health NHS Foundation Trust delivers mental health and community-based physical health services to approximately two million people. On average we care and treat more than 185,000 people a year.

The Trust provides comprehensive mental health services for people of all ages across Oxfordshire and Buckinghamshire, and mental health services for children and young people and for adults with eating disorders across Wiltshire, Swindon, Bath and North East Somerset.

In Oxfordshire, the Trust is the main provider of community-based physical health services delivering these in people's homes and a range of community and inpatient settings including community hospitals. Most recently from December 2021 we started to provide palliative inpatient care for patients requiring end of life services in close partnership with the charity Sue Ryder Care. Also in Oxfordshire, the Trust provides services for adults with learning disabilities and autism, and support to their families.

We employ around 6,500 staff who operate from a number of Trust sites as well as in people's homes and in various community settings.

The care we provide is rated overall as 'Good' by the Care Quality Commission (CQC). There is further detail about the CQCs assessment of the Trust in the Account.

We believe working in partnership with our patients, families, other care providers and academic institutes is the best way to achieve high quality care. Over the years we have developed close partnerships with other care providers to improve care, some examples are;

- The Oxfordshire Mental Health Partnership involving Oxford Health and five third sector organisations
- Richmond Fellowship (helping with employment), Relate (providing therapy) and Buckinghamshire Healthcare Trust (obesity management) with Healthy Minds in Buckinghamshire
- Close working with a number of charities/ third sector organisations such as Barnardo's and MIND, to provide a range of effective interventions as part of children and adolescent mental health services. As well as working with companies such as Healios and Kooth providing on-line assessments and psychological interventions.
- Active member of the Oxford Academic Health Partners involving the University of Oxford, this includes running the Clinical Research Facility that provides innovative research with the potential to develop new treatments and clinical applications.
- Working with Age UK Oxfordshire, Parkinsons.Me and Parkinson's UK as part of the Physical Disability Physiotherapy Service.

We have developed and implemented three NHS-led Provider Collaboratives in 2021/22, as the lead provider, to manage whole pathways of care on regional footprints. As lead provider we take responsibility for the oversight of the delivery of services with the intention of improving access, developing community alternatives to admission and where admission is clinically appropriate, ensuring community support post-discharge.

The Collaboratives we are leading on are:

- Thames Valley and Wessex Adult Low and Medium Secure inpatient services (Forensic mental health services)
- Thames Valley Children and Adolescent Mental Health inpatient services
- Adult inpatient Eating Disorder services, South East Region

Integrated Care System (ICS) have been introduced across England as part of the NHS Long Term Plan. The Trust is part of the Buckinghamshire, Oxfordshire and Berkshire West ICS, and the Bath and North East Somerset, Swindon and Wiltshire Partnership ICS. ICSs have been established to add strength to partnerships between NHS organisations, local authorities, and the voluntary, community and social enterprise sector. The organisations in each ICS agree shared priorities for health and social care to meet the needs of local people to improve their quality of life and outcomes. The ICS are set to become new statutory bodies from July 2022.

Another partnership we are developing is the Thames Valley community dental services provider collaborative. Community dental services provide dental care for people who are unable to access care from a general dental practitioner due to specific needs. The development of the collaborative is still at an early stage but we hope to see the benefits of working more closely with our two neighbouring NHS Trusts (Berkshire Healthcare and Central and North West London) to deliver the best services possible by sharing resources and combining our efforts around making quality improvements.

The Trust set up three national NHS Mass Vaccination Centres and a number of pop-up centres as well a 'health on the move' bus to administer the vaccines for communities in Berkshire, Buckinghamshire and Oxfordshire to help the fight against COVID-19. The vaccine team has just reached million jabs which is an enormous achievement in only 14 months.

Our Chief Executive celebrating with the vaccination team when more than a million vaccinations had been delivered.

3. Introduction from the Chief Executive

Our vision is: outstanding care, delivered by an outstanding team.

I am pleased to introduce Oxford Health NHS Foundation Trust's 2021/22 Quality Account.

All of our services across Oxford Health continue to face significant pressures. Many teams were experiencing challenges, with increasing demand, limited resources and vacancies, before the onset of the COVID-19 pandemic and this has only served to make these worse. We also expect that the pandemic will have a 'long tail' that will impact on both people's physical and mental health for some considerable time. The scale of the challenges we are facing serves to highlight the importance of service transformation and finding new ways to support and treat patients, particularly ways in which health problems can be prevented and both physical and mental health maintained.

I attach a great deal of importance to the culture of our Trust and ensuring that it is one that is compassionate, inclusive, empowers people and encourages continual learning. As part of this we have been embedding a quality improvement approach at every level. We are also increasing the engagement and support to staff to help them make the changes needed. If we can achieve and maintain this, I am confident that we will also be able to deliver great care to our patients and service users and effectively manage the demands for services using what resources we have available efficiently.

The culture of every organisation is driven by its values. We certainly have the right values of caring, safe and excellence and I would like to think that these influence and indeed drive the behaviour of us all. The ongoing challenges we are facing and the understandable stresses these are causing again only serve to highlight the importance of focusing on the health and wellbeing of our staff so that we can deliver outstanding care.

The Trust has made it a priority to reduce our reliance on agency staff and increase our activity around recruitment as well as developing homegrown talent through our successful nurse cadets programme and apprenticeships.

We have also been focusing on strengthening the patient/ family voice throughout the Trust with a genuine commitment to co-production, this is essential to the success of the Trust.

With so many challenges ahead the role of research is absolutely key to the development of new treatments and interventions. Across the organisation there are an ever increasing number of examples of how we have been able to turn academic research into clinical practice. Such innovations have not only resulted in better care and treatment for our patients but also have resulted in our staff being able to work more efficiently and having higher job satisfaction.

Good healthcare is typically dependent on good partnership working and collaboration. Very few, if any, of our patients just receive care from Oxford Health but instead are supported by professionals from a variety of different organisations. We are committed to putting patients at the centre of our thinking and working more closely with colleagues from different organisations. There are examples of how we are doing this throughout the Account. The ongoing development of Integrated Care Systems, such as the one covering Buckinghamshire, Oxfordshire and Berkshire West (BOB) is all about trying to put in place the conditions for organisations that support people to work more closely and therefore, more effectively. As we look to the future it is vital that we strengthen these relationships and develop a true ethos of collaboration.

I hope you enjoy reading about the progress we have made in the last year and our quality objectives going forward.

Dr Nick Broughton, Chief Executive

This Account has been approved by the Board of Directors.

4. Our Focus to Continually Improve the Quality of Care

We are driving forwards to make Quality Improvement 'the way we always do things here' to continuously improve the quality of care and outcomes for patients, carers and families.

The Trust has established the Oxford Healthcare Improvement Centre to provide; training and support to lead quality improvement projects, to enable collaboration and horizon scanning for future projects. To find out more go to https://www.oxfordhealth.nhs.uk/ohi/

The Trust has developed a Quality Improvement (QI) Strategy and below are some of the key achievements this year:

- Development and support of a significant number of quality improvement projects across the Trust in each directorate
- Engagement in national and regional QI collaborations
- QI hubs have been established in each clinical directorate to identify new local QI projects, as well as to support, monitor progress and share learning. The hubs report into the Trust's overall Quality Improvement and Learning Group.
- A training model has been implemented based on three levels to provide staff and patients/ experts by experience with the skills and confidence to run a QI project and apply QI methodology. All staff now receive level 1 QI awareness training on induction. The training model is developing a network of staff to undertake and support QI projects.
- QI cafes are being used to offer support and to troubleshoot any QI issues
- Podcasts have been developed to share and spread skills, experience and learning.
- The LifeQI system has been introduced to record the Trust's QI projects , as well as support the sharing of learning.

A QI approach works when we don't know what the solutions are, and several changes might be needed for success and the best results will be achieved from staff working in partnership with patients and carers.

Below are some of the current Quality Improvements projects that are in progress:

- Improving Sexual Safety in Marlborough House (National collaborative)
- Improving behaviours in the dining room at Cotswold House
- Mental Health Act Assessment Response Times
- Person-centered care - Didcot Hospital
- Evaluation of Peer Support Workers
- Positive & Safe Collaborative - Reducing Restrictive Interventions (National collaborative)
- Nature based intervention
- Risk Assessment/Formulation & Documentation
- Working with families and carers
- Trauma informed practice

We are also involved in the following regional and national collaborative QI work:

- Inpatient Ligature Harm Minimisation
- Suicide prevention across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System
- Inpatient observation practice

The quality objectives identified for 2022/23 will take a quality improvement approach to: understand the problem, identify and test possible changes ideas, measure the impact of changes and sustain successful changes.

5. Key Achievements and Awards

In addition to the many quality improvement projects you will read about in the report, below are a few of the achievements we are particularly proud of from 2021-22.

We have recruited over 90 international nurses and podiatrists, of which 45 have started work at the time of writing this report. This is a significant achievement, led by our programme to 'improve quality and reduce agency use ' which will help with continuity and safety of care. Key planks of this work are recruitment and retention of high-quality clinical staff.

In December 2021 around 600 native trees were planted on the Littlemore site as part of the Tiny Forest initiative. A "tiny forest" is defined as a dense fast-growing native woodland which is based on a forest management method. The Trust is collaborating with MINI Electric and Earth Watch Europe in this endeavour in order to help boost biodiversity and create an accessible green space for our local communities to reconnect with nature. Over the next two years Earth Watch will use this area of woodland as a classroom to monitor and collect data on carbon collection, flood mitigation, thermal comfort, solar shading, biodiversity and the social and wellbeing benefits of having this new green space.

The work of Oxford Health's Charity and our 170 volunteers has been incredible in 2021/22. The impact they have had on staff well-being and patient care is detailed in the annual report that went to Board in November 2021 available here https://www.oxfordhealth.nhs.uk/papers/november-30-2021/. The team are leading on the Unloc project which is very exciting reaching out to thousands of young people to listen to what they need and want from services, and also developing new Youth Boards (more detail below). They have also increased access to creative arts to aid recovery and improve our environments through the creation of Oxford Health Arts Partnership which has won national awards for bringing art into the Community Hospital wards.

The team from Vaughan Thomas ward in Oxfordshire were winners in two Health Service Journal Awards categories; the Most Effective Contribution to Patient Safety and Health Technology Partnership of the year. The first award was shared with colleagues from Coventry and Warwickshire Partnership NHS Trust, the South London and Maudsley NHS Foundation Trust and the technology company Oxehealth. Both awards were in relation to the deployment of the Oxevision observation platform on Vaughan Thomas ward. This platform has been developed in collaboration with Oxehealth and enables staff to remotely observe the physical wellbeing of inpatients in their bedrooms, as appropriate to reduce interruptions particularly at night.

In addition, the Trust's integrated multi-disciplinary respiratory team won the Health Service Journal 'Best Pharmaceutical Partnership Award' for its work in conjunction with the Boehringer Ingelheim Pharmaceutical Company to improve the care of patients across Oxfordshire suffering from chronic respiratory disease.

At the Oxfordshire Health & Social Care Awards 2021, Luther Street Medical Centre was named GP Practice of the Year. Plus the 24/7 Mental Health Helpline for Buckinghamshire & Oxfordshire won the Mental Health category.

The Trust continues to operate in a system that is highly challenged from a demand and capacity perspective. Our services continue to work hard to support system flow and ensure patients are cared for as close to their own homes as possible. One of our directorates led a system day aimed to prevent conveyance to hospital and instead help patients to stay at home safely. 'Call before you Convey' involved paramedics contacting a Single Point of Access to consider if an alternative plan could be made to keep the patient at home. The day was a huge success and allowed us to see our own potential. We have been asked to share this good practice at several external events.

Our Community Diabetes service has been accredited for a further three years, the training they have developed and deliver to people with Type 2 Diabetes has achieved national standards in defining good practice in self-management education. The service along with partners also won the Health Service Journal Value Award in 2021 for their entry on using data to improve the care of people with diabetes across Oxfordshire.

We have added to the Trust's library on short films on mental health. In November a film was added about the anti-depressant medication Fluoxetine, also known as Prozac. This film goes alongside 10 other films about; depression, anxiety, psychosis, self-harm, personality disorders, neurodiversity, suicide prevention, good mental health, digital mental health and post-traumatic stress disorder. Each film is developed with the input of young people. The films are available to watch here https://www.youtube.com/playlist?list=PLKw7kjGJdcXAYVCP4lhoLzVOeBol1vqfU

We welcomed 11 new nursing cadets in September. This is the second year of the programme as part of the Trust developing and growing the workforce of the future. The scheme is based on the Trust employing local Year 11s on a senior healthcare worker apprenticeship whereby the cadets spent 18-20 months studying and working in front line roles to achieve a level 3 health and social care qualification. On completion of the course cadets have a number of career opportunities in the NHS. We very much hope the cadets will continue to work with us.

The new nurse cadets which started in September 2021.

6. Progress Against the NHS Long-Term Plan

The NHS Long-term Plan from 2019-2029 and associated Mental Health Implementation Plan has and will continue to drive a number of major initiatives to transform services. More detail can be found here; https://www.longtermplan.nhs.uk/

For physical health services this includes;

- Enhancing community care response teams to prevent unnecessary admissions (see quality objectives CE2) and to speed up discharge as well as to improve access via a single point for people needing urgent care in the community
- Enhancing care for people living in care homes, particularly out of hours support
- Delivering care in partnership through Primacy Care Networks to enable people to age well

The Long-Term Mental Health Implementation Plan has seen a number of changes and developments , such as:

- Introducing mental health support teams into education settings, we offer support to around 200 schools and this is due to expand further
- Specialist perinatal mental health services have been implemented
- Increasing capacity of the Improving Access to Psychological Therapies (IAPT) in both counties including support for people with a long-term condition
- Improving the physical health of adults with a severe mental illness in the community
- Developing individual placement and support services (more detail in the Experience and Involvement section below)
- Introducing crisis resolution and home treatment teams for children and adults
- Introducing mental health crisis helplines 24/7 for both children and adults
- Opening two safe havens in each county, Oxfordshire and Buckinghamshire, to provide an alternative to traditional crisis care
- Establishing a Family Liaison Service for those impacted by suicide

There is still lots of work to do to meet all aspects of the Long-Term Plan for Mental Health including;

- Elimination of inappropriate out of area placements (more detail is below)
- Fully restore memory diagnostic services which were impacted by COVID-19, to improve diagnostics and support afterwards. There is some detail in the Research and Development section about innovative work happening in relation to the Brain Health Centre.
- Continuing to improve physical healthcare access for adults with a severe mental illness (see quality objective S5)
- Increase the capacity and treatment options in mental health services for children and young people
- We need to work on our data quality particularly the recording of ethnicity identified as an enabler of the developments and to help to tackle some of the health inequalities experienced by patients.

7. Research and Development – the Future of Healthcare

Clinical Involvement in clinical research is one way that we demonstrate our commitment to actively improving the clinical assessments, treatments, care, and outcomes for our patients. Our aim is for all patients to have access to research opportunities which are relevant to them.

This year we ranked 2nd nationally for the number of National Institute for Health Research (NIHR) portfolio studies which people participated in. We ranked 5th for the number of participants that we have recruited to our NIHR portfolio studies. 47 new studies have opened in 2021/22 compared to 46 opened last year, ranging from small projects to highly complex clinical trials of new medicines.

The COVID-19 pandemic has impacted research locally and nationally in many ways, with many studies being put on hold at different points in time. However, it has also driven research and we are running the following COVID-19 specific studies;

- Novavax vaccine trial and follow up studies
- PRINCIPLE - a priority one urgent public health COVID-19 trial to evaluate treatments that can be delivered at home for COVID-19
- Virus Watch study- immunity subset

The *Count me in,* an 'opt-out' initiative for informing patients about research relevant to their care was launched in August 2021. It is a 12-month implementation study, which aims to promote inclusivity for research, by enabling greater equity of information provision about research opportunities to patients.

We would not be able to achieve what we have without the following collaborations;

- The Trust and the University of Oxford run a Biomedical Research Centre, one of two in the country. This is dedicated to translating innovative research into better treatments for mental health disorders and dementia.
    - An example of the work is gameChange VR program led by the university, health and industry experts including Oxford University spin-out: OxfordVR, creators of immersive technology for mental health. It tackles a problem that is common in people diagnosed with psychosis: intense fears about being outside in everyday situations. For many patients, these fears develop into a severe agoraphobia that means they avoid leaving the home, severely disrupting relationships with family and friends, their education, and careers. GameChange will lead to a transformation in the digital provision of evidence-based psychological therapy.
- The NIHR Oxford Cognitive Health Clinical Research Facility is hosted by Oxford University Hospitals NHS Foundation Trust in partnership with us. The Facility has been successful to achieving funding to continue for a further five years from September 2022.
    - An example of the work, with the Biomedical Research Centre, is Brain Health Centre clinics. This project aims to develop enhanced, standardised radiology reports, which compare an individual patient's results to normative data from a large number of healthy brains. The enhanced reports used for patients attending the clinics provide clinicians with more measures of brain health that facilitate accurate and earlier diagnosis of memory problems.
- The Trust hosts the NIHR Applied Research Collaboration Oxford and Thames Valley which carries out applied health research that will have a direct impact on patient health and wellbeing.
- NIHR community Healthcare MedTech and In vitro Diagnostics Co-operative to build expertise and capacity in the NHS to develop and evaluate new medical technologies and diagnostic tests.
- Oxford Institute of Nursing, Midwifery and Allied Health Research aim is to produce world-class translational research that will impact upon health and social care delivery and clinical practice.
- A partnership between the Trust, the University of Oxford, the University of Toronto and the Centre for Addiction and Mental Health. This partnership helps realise the benefits of the complementary capabilities of the organisations. More information can be found here https://www.oxfordhealth.nhs.uk/news/new-transatlantic-partnership-to-transform-research-and-clinical-landscapes-in-mental-health/

Our website at https://www.oxfordhealth.nhs.uk/research/about/ details much more on our research activities and how we are supporting more staff to get involved.

8. Quality Concerns

The Trust Board reviews and identifies the top-quality concerns at each Quality Committee meeting through a range of indicators, including a detailed Quality and Safety dashboard. Quality concerns and issues are reviewed weekly and monthly through different forums to ensure delivery of safe services and appropriate actions and mitigations are in place. Quality concerns are identified through some of the information sources provided in this account alongside any other intelligence received from performance reports, our staff, and stakeholders.

Our main areas of focus based on concerns highlighted are:

Clinical Workforce Challenges. Both mental health and physical health services are being affected by shortages of substantive staff due to high levels of vacancies and sickness. This is having an impact on the quality of patient care and experience as well as increasing our costs owing to the increased use of temporary staff. Inpatient wards, community nursing services (District Nursing), child and adolescent mental health services and some of our adult community mental health teams are experiencing significant staff shortages alongside increased demand for care. We have a significant programme of work led by the Chief Nurse, which seeks to 'Improve Quality, Reducing Agency use'. This is a clinically led programme of work which has eight workstreams with a focus on how we retain and recruit staff. This has included actions to centralise unregistered staff recruitment campaigns, targeted marketing and rebranding, virtual job fairs, co-creating jobs with candidates, continued expansion of apprenticeships, re-introducing a standard survey when staff leave and introducing international recruitment. We have been very successful with international recruitment with around 90 nurses and podiatrists recruited of which 45 have commenced employment at the time of writing this report.

Timely Access to Services: Waiting lists and access to some services are rising and this has been significantly impacted by COVID-19. This potentially increases risk to patients and also means that we are not meeting national or local targets. Delayed access for an outpatient assessment and/ or treatment does not provide a good experience for patients, families and carers. Some services are struggling more with patients having to wait longer than expected- these include;

- Community nursing services (District Nursing)
- Podiatry services
- Children's therapy services
- Speech and language services for children and adults
- Child and adolescent mental health services, including children with neurodevelopmental conditions
- Community adult eating disorder services.

Every service has processes in place to manage and regularly review anyone waiting. We also conduct regular reviews to identify any clinical harm so this can be addressed quickly.

There is a range of reasons for such access challenges including increased demand through Covid-19; staff vacancies, and current funding. We are working with partners such as GPs and our other NHS colleagues to address some of the issues. Waiting lists are routinely monitored closely by senior clinicians and managers with progress reported monthly to the Board of Directors. Action plans and programmes of work are being taken forward with system partners to ensure innovation and improved patient experience.

Access rates in Oxfordshire and Buckinghamshire to our Child and Adolescent Mental Health Services (CAMHS) are higher than the national average by 20-20% (but lower by 5% than average in Bath and North East Somerset, Swindon and Wiltshire) resulting in high waiting times for certain treatments. The Trust is part of a national waiting time pilot identifying solutions and efficiencies to reduce waiting times. Some of the solutions implemented include giving support to parents to help manage young people while they are waiting. We continue to deliver services in partnership with a variety of organisations and Third Sector providers to enhance and offer a wider range of treatment options. We are also part of the BOB ICS improvement streams to develop solutions to long waits in the neuro developmental conditions pathway. Reducing waits for children is a priority of the ICS in Buckinghamshire, Oxfordshire and Berkshire West.

We are working with Oxford University Hospitals NHS Foundation Trust around podiatry services. Through improved collaboration our two organisations are working to focus on shared recruitment, workforce

development, training and also developing the clinical pathway to ensure that patients are seen at the most appropriate place defined by clinical need, regardless of which organisation employs the staff or delivers that part of the pathway. The added bonus to this work will be the development of a podiatry apprenticeship programme which as individual providers we would not have been able to deliver. Together we can!

High use of inpatient out of area placements. Unfortunately we have continued to reply on out of area placements due to sustained demand and not having sufficient bed capacity within our own wards. There has been a particular pressure on admissions for female patients. . This often results in patients being further away from their home and family. Lengths of stay (duration of admission) can often be longer and there are additional costs. An improvement plan is in place to reduce reliance on out of area placements through reducing overall inpatient length of stay and increasing support in the community. Our aim, as before COVID-19, is to eliminate the use of out of area placements. See below reporting on national indicators for more detail.

Staff health and wellbeing. Ensuring Oxford Health is the best place to work is a strategic objective for the Trust. Much research highlights the crucial objective to ensure colleagues feel valued and empowered and psychologically safe at work. Both the impact of Covid-19 and the continued high demand for services has had significant impact on our staff. The Trust has made this a high priority to keep a continued focus on supporting and listening to what staff need. We have a wide-ranging health and wellbeing offer delivered through a strategy and steering group.

More on the work that has happened this year is captured in the reporting against quality objective L3 for 2021/22.

Young People at the Highfield Unit created a new mosaic to hang over the entrance to the building.

Creating with Care artwork funded by the League of Friends to bring sun to the garden at Didot Community Hospital all year round.

9. National and Key Quality Indicators – last 12 months

9.1 Our Performance against the NHS Oversight Framework

The NHS System Oversight Framework replaced the previous performance framework which informs the assessment of providers, more details can be found here https://www.england.nhs.uk/nhs-system-oversight-framework-2021-22/. The Trust monitors performance through a range of activity, quality and workforce measures in the monthly Integrated Performance Report presented to the Board of Directors.

Table 1 shows the Trust's performance against the indicators in the framework.

Overall our performance is positive with the majority of indicators consistently achieved over the past 12 months. The exception is the number of inappropriate out of area placements in both Oxfordshire and Buckinghamshire, further details are below.

Table 1. Trust performance against the indicators in the Single Oversight Framework

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%	71.6% (Mar)	91.5% (Mar)	↓
(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%	76.3% (Dec)	97% (Dec)	↓
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	46.9% (Mar)	50.5% (Dec)	↑
(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	0 (Mar)	→
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	136 (Mar)	↑

Source: Integrated Performance Report

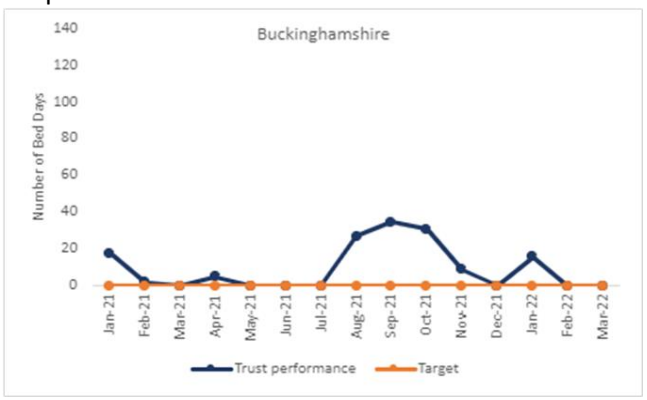
Eliminating inappropriate adult acute out of area placements

Out of area placements are when we admit someone to a ward outside the services provided by the Trust. An out of area placement is categorised as inappropriate if the rationale for placing the person relates to bed pressures or absence of community or social care support.

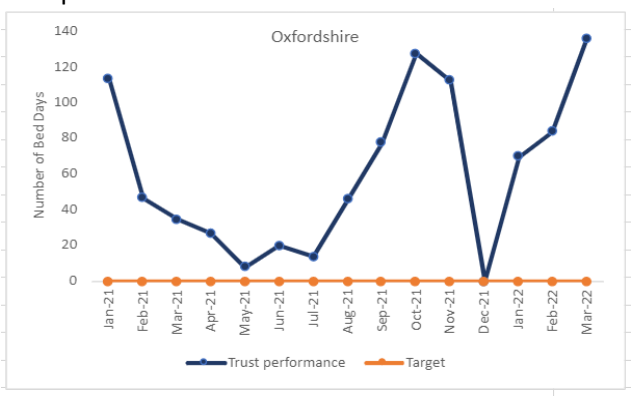
COVID-19 has had an impact on our aim to eliminate inappropriate out of area placements because by introducing essential infection, prevention and control measures this has meant the Trust has been operating throughout the year with reduced inpatient bed capacity. Our wards within the Oxfordshire directorate have been particularly affected owing to the environmental factors older buildings have presented. The interim closure of beds to manage inpatient isolations and social distancing has resulted in additional out of area placements which the Trust has managed by purchasing a block contract of beds with an independent sector provider. The block contract has enabled us to ensure better continuity of care and closer oversight of quality by the Trust.

The position by county is in the graphs below.

Graph 1.



Graph 2.



Source: Patient record system called CareNotes.

Other national indicators

In this section we will report on the following national quality indicators:

9.2 Follow up with patients within 72 hours of inpatient discharge
9.3 Care Quality Commission inspection rating
9.4 Patient and carer/ families experiences (including the national survey)
9.5 The Learning Disability and Autism Improvement Standards
9.6 Patient safety incidents and Serious Incidents
9.7 Staff experiences (including the national survey)
9.8 Clinical Audit
9.9 Data Quality and Information Governance

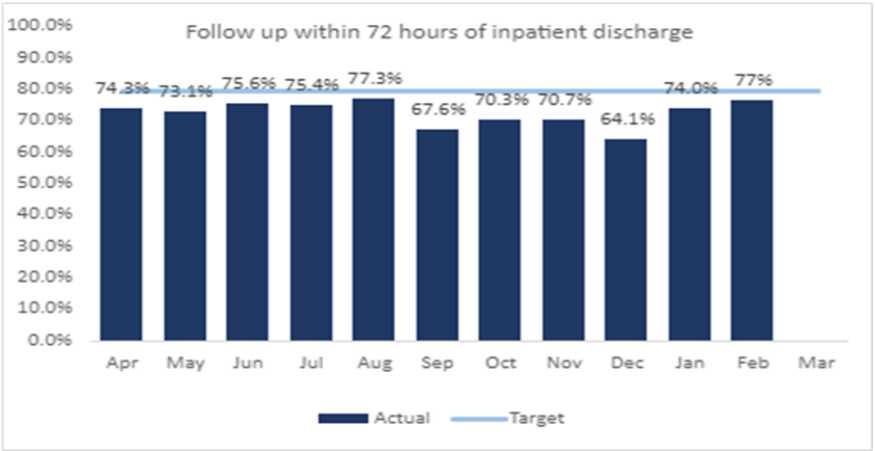
9.2 Follow up with patients within 72 hours of inpatient discharge (adults and older adults)

This indication has shown to be significant with regards to suicide prevention following discharge from inpatient services. The latest information is shared below, with performance being fairly consistent across both Buckinghamshire and Oxfordshire mental health services. Any discharges not followed up within 72 hours are reviewed each month to identify learning.

The most common reasons for non-compliance are:

- Patient was seen same day as discharge which cannot be included in the national reporting specification requirements
- Patient was on agreed leave from the ward as part of preparing for discharge. They were visited in the community during leave but then when the patient was discharged as the leave was successful they were not visited again within 72 hours
- Attempts by the team to contact the patient were not successful or the patient was not available to be visited within 72 hours
- In a few cases the team saw the patient outside of the 72 hours but within a short timeframe.

Graph 3.



Source: Patient record system called CareNotes.

9.3 Care Quality Commission Visits and Inspections

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with high quality safe, effective, responsive and caring, treatment and support. The CQC monitors and inspects these services and then publishes its findings and ratings to help people make choices about their care.

Oxford Health NHS Foundation Trust is required to register with the CQC, and our current registration status is registered with no conditions. The CQC has not taken enforcement actions against the Trust.

Oxford Health NHS Foundation Trust is subject to periodic reviews of the quality of care by the CQC. Following our CQC inspection from July-September 2019 the Trust is rated as **Good** overall. The full report can be found at https://www.cqc.org.uk/provider/RNU. We have not had an inspection during 2021/22. The CQC detailed the following one action the Trust MUST take to improve as well as 22 SHOULD actions. An action plan was submitted to the CQC against all 23 actions.

The one MUST action related to the ward for people with a learning disability or autism. The action was to:

- Ensure that staff follow good practice guidance when secluding patients and include a rationale in records for the clinical decision to seclude a patient. Patients must also be secluded for the shortest time possible. Patients in seclusion must be offered an appropriate level of privacy.

A full review of seclusion and clinical decision making has taken place. A further plan regarding environmental changes was submitted and all work has been completed except for the relocation of the seclusion room. Work has started to build a new seclusion room but this has been delayed due to a number of factors, including site challenges, the COVID-19 pandemic and some supply issues. There are mitigating actions in place while the work is being completed. Progress is reviewed monthly at Executive Team level.

In 2021/22 - 12 of our mental health wards have received an unannounced visit by the CQC to review compliance with the legal requirements of the Mental Health Act for people who have been detained. The CQC carries out this specific type of visit for every mental health ward on a regular basis. During these visits the CQC reviewer will speak to patients and staff, review the environment, and review the quality of documentation in patients records.

The key improvement themes we are taking action around are:

- Ensuring all patients are aware of their rights and there are regular conversations to discuss this throughout a patients stay
- To improve our links with the independent Mental Health Advocacy to ensure patients always have timely access to this help, even throughout the Covid pandemic
- To embed individualised care plans and ensure care is personalised

Oxford Health NHS Foundation Trust has also participated in the following special system-wide review by the CQC during 2021/22:

- Provider collaboration review of mental health care of children and young people during the COVID-19 pandemic. Seven integrated care system areas were included. More details are available here https://www.cqc.org.uk/publications/themed-work/provider-collaboration-review-mental-health

9.4 Patient and Family Experiences and Involvement (including national survey results)

Strategy

The Trust is co-developing a new Experience and Involvement Strategy for the next 3 years, as the period related to the previous Strategy has now finished. It is paramount this important strategy is co-produced and to that end significant engagement work has taken place with patients, staff, the voluntary sector and patient advocate groups such as Healthwatch to describe where we want to be in 3 years' time and what we need to do to get there.

A key focus of the new strategy will be:

- improving how we work more in partnership when identifying and delivering people's care needs
- ensuring a strong voice in decision-making, co-production in quality improvements,
- and equality of access to services.

The Trust's Family, Friends and Carers Strategy 2021-2024, which is specifically aimed at carers and family members and was published last year is available here; https://www.oxfordhealth.nhs.uk/wp-content/uploads/2021/10/Family-Friends-and-Carers-Strategy-2021-24-FINAL-WEB.pdf

The Trust's Experience and Involvement Forum is made up of patients and carers known as Experts by Experience and staff and this group oversees our work to improve patients experiences and involvement. The forum meets every other month and is co-chaired by the Chief Nurse and two Experts by Experience.

Involvement and Engagement

Co-production

We know we still have a lot to do regarding development of embedded co-production at all levels within the organisation. Our new strategy will help us achieve that. However, 2020/21 has seen some innovation across all services. Below are some examples of the projects we have been working on with patients, carers and family members to improve the care and services we provide.

The Oxfordshire Primary, Community and Dental Health services Directorate have:

- Seen the amount of feedback double for their urgent care services as a result of trialling the use of SMS texts sent to all eligible patients who attend the out of hours service, Minor Injury Units or the First Aid Unit.
- The Directorate have also been gathering a library of patient stories which are shared with staff at meetings and in training.
- The children's services launched 'Chat Health' in February 2022 a new service for parents and young people in Oxfordshire to text health visitors and school health nurses for advice and support.
- A catering focus group was set up from January 2022 to work together on improving the quality of food and drink across the community hospital wards.
- After the success of the Family Nurse Partnership patient experience video, the service is creating a video for promoting the service to potential patients, and has been recruiting young fathers to share their experiences which will be feedback to the team for service improvements.
- Patients have recently been involved in developing information leaflets for the wearable remote monitoring devices pilot for Urgent Community Response.
- Wallingford community hospital are planning a co-produced film with experts by experience so that patients/ families can share their voices and help design staff training around end of life conversations.

The Forensic services have:

- Co-produced improvement action plans around improving experiences and involvement in services with patients and their family/ friends. There are two monthly action groups overseeing the work. The Evenlode Voice Group are currently working on an easy read version of the improvement action plans.
- The patient involvement action group has been developing an experience questionnaire to ask all patients, producing an involvement bulletin to promote opportunities to patients, assisting with the introduction of the new peer support worker programme and introducing best practice guidance for ward community meetings.
- The family and friends action group has been reviewing current information leaflets with a plan to create a welcome pack that is sent to every carer/ family member across the service, reviewing how 'welcome meetings' for families work on some of the wards to share good practice, relaunching the friends and family monthly meet up, raising the profile of the family champions in each team, and clarifying the process/ paperwork about the expectation that families will be invited to be involved in the Care Programme Approach (CPA) process.

The Learning Disability services continue to support their Governor representative and recently shared a patient story at the Council of Governors meeting. A group of patients/ experts by experience continue to support the development of easy read materials across the Trust. The Leading Together group are working with South Central Ambulance service to improve how they communicate with people with a learning disability.

The Oxfordshire and Buckinghamshire Mental Health Directorates have:

- Representation from patients/ experts by experience on their Quality Improvement (QI) hubs to ensure a patients voice is in every QI project.
- The Oxfordshire and Buckinghamshire Our Voice patient groups are well established and embedding co-production across the Directorates. The team are leading on one of the workstreams in the improving working with families project and have started engaging a group of carer experts to identify what actions to take.
- We have also been working with the Oxfordshire Mental Health Partnership group to create a sub-group of patients/ experts by experience solely focused on involvement and co-production.
- A project has started with carers to refresh the family, friends and carers handbook about adult and older adult mental health services.
- A QI project has commenced with Oxfordshire adult and older adult community mental health teams around improving collaborative care planning. The team are supporting patients/ experts by experience to be involved in the inpatient digital monitoring project to reduce the impact of routine observations when appropriate, which has included developing a poster to go into all patient bedrooms.
- Recruitment has started of patients/ experts by experience to be involved in the workstreams leading the delivery of the suicide prevention strategy, as well as staff training films being developed with experts on risk assessment and management.

Oxfordshire Child and Adolescent Mental Health Services (CAMHS) and Oxford University Hospital NHS Foundation Trust are planning a joint project on gathering feedback from young people on the reasons for choosing to attend the emergency department rather than other courses of support. Young people will be involved in developing the questions and hopefully asking these to other young people. The CAMHS Neuro Developmental Conditions Pathway have been looking at ways to increase the amount and quality of feedback. From a thorough review of feedback the following actions were identified; to better understand what information parents would find helpful at point of referral, and they have reviewed the letter sent to parents following acceptance of referral and improved the format and resources included. There is also a range of work happening to reduce waiting lists across CAMHS teams and expand the support available to parents while they are waiting.

Cotswold House Eating Disorder services have completed a Quality Improvement Project around reducing distracting behaviours at dinner time which has since been published and the work disseminated nationally and are just starting a new project around waiting times.

<u>Youth Boards</u>

The Trust has been working with Unloc founded by young leaders and advocates to empower young people. The work consists of:

- A survey programme to gain a representative picture of mental health experiences of 12-25 year olds
- Setting up a youth board so that we can hear feedback and enable young people to lead on improvements
- Holding roadshows to engage a wider pool of young people about how to address the findings from the surveys and to identify priorities for improvement, taken forward by the youth board

The Oxfordshire survey received 1,450 responses with the top three things identified as having the biggest impact in their mental health being; negative thoughts and feelings, studying and exams and relationship problems. The Youth Board is made up of 19 members and has met four times, the board is thinking about whether to nominate 1 or 2 members to became a Trust Governor. The format and topic of the roadshows is in development for the Summer.

The Buckinghamshire survey received 1,172 responses and the results are currently being analysed. The deadline for applications to join the Youth Board is 25th April 2022.

The aim is to start a survey in Bath and North East Somerset, Swindon and Wiltshire in the next year.

Mental Health Peer Support Worker Programmes

Peer support is when people with lived experience of mental health, support others with their own mental health challenges. Peer support workers aim to foster a sense of hope, focusing on people's strengths and mutuality. The value of peer support is internationally recognised and is promoted by the World Health Organisation and also forms an important part of the transformation agenda for the future of mental healthcare services, providing an opportunity to increase capability and skill mix.

At the Trust we have trained a total of 86 peer support workers since 2019 and just recruited 12 people for a new forensic peer support cohort, with training due to start in the autumn 2022. In 2021/22 we have trained and supported 41 workers. The peer support workers are embedded in various adult and older adult inpatient and community mental health teams across the Trust.

Individual Placement and Support (IPS) Service

This is an evidenced based programme to support people with mental health difficulties to return to employment, as well as supporting and advising employers. Meaningful work and particularly paid employment for those who have been suffering with mental illness is crucial in their recovery and is a key plank within the Mental Health Long Term Plan. The service employs two peer support workers who have led the trailblazing team in offering peer support.

In 2021/22 the service received:

- 377 referrals,
- supported 347 people and
- helped 113 people to achieve their outcome to gain employment.

The service is so important and showed true innovation through the pandemic. This year the service will be creating new specialist posts to support retention (keeping people in work) and will be going for an external accreditation. The most recent fidelity review (which is nationally prescribed) awarded **exceptional status** for quality of services provided.

Below is an example of the feedback received about the service:

"The practical support is very useful and motivating, finding present work opportunities, and sending them on to me and motivating me in the independent search for work. It is also very helpful to know that there is a regular catch-up session, where concerns and difficulties can be discussed and worked through. The IPS worker was able to understand my work history and needs, as well as the needs and circumstances of my personal life. They were able to pick up and use this information to help me in my employment journey from the very start. The search for work has been very successful. My IPS worker was able to secure me a job interview very quickly in our journey, which I was lucky enough to get some work through. They have also been able to identify other work opportunities that may suit me. As well, they have been able to check over job applications and offer encouragement and feedback, as well as celebrate successes on my employment journey with me. It has been great to have that support"

Recovery Colleges

We have well established recovery colleges in Oxfordshire and Buckinghamshire as well as a Forensic spoke of the Oxfordshire college. The colleges take an educational approach to recovery, on the basis that the more we learn about ourselves, a diagnosis or tried and tested strategies the more we can look after ourselves and each other. Everything is designed and delivered at the colleges together using co-production, drawing on professional expertise and lived experience. The colleges are open to everyone, people experiencing mental health challenges, carers/ families, staff and volunteers to learn together. More details can be found at https://oxfordshirerecoverycollege.org.uk/ and https://www.oxfordhealth.nhs.uk/bucksrecoverycollege/.

Feedback – what does it say?

Patients, service users and families experiences are a key marker of providing high quality care, alongside clinical effectiveness and safe services.

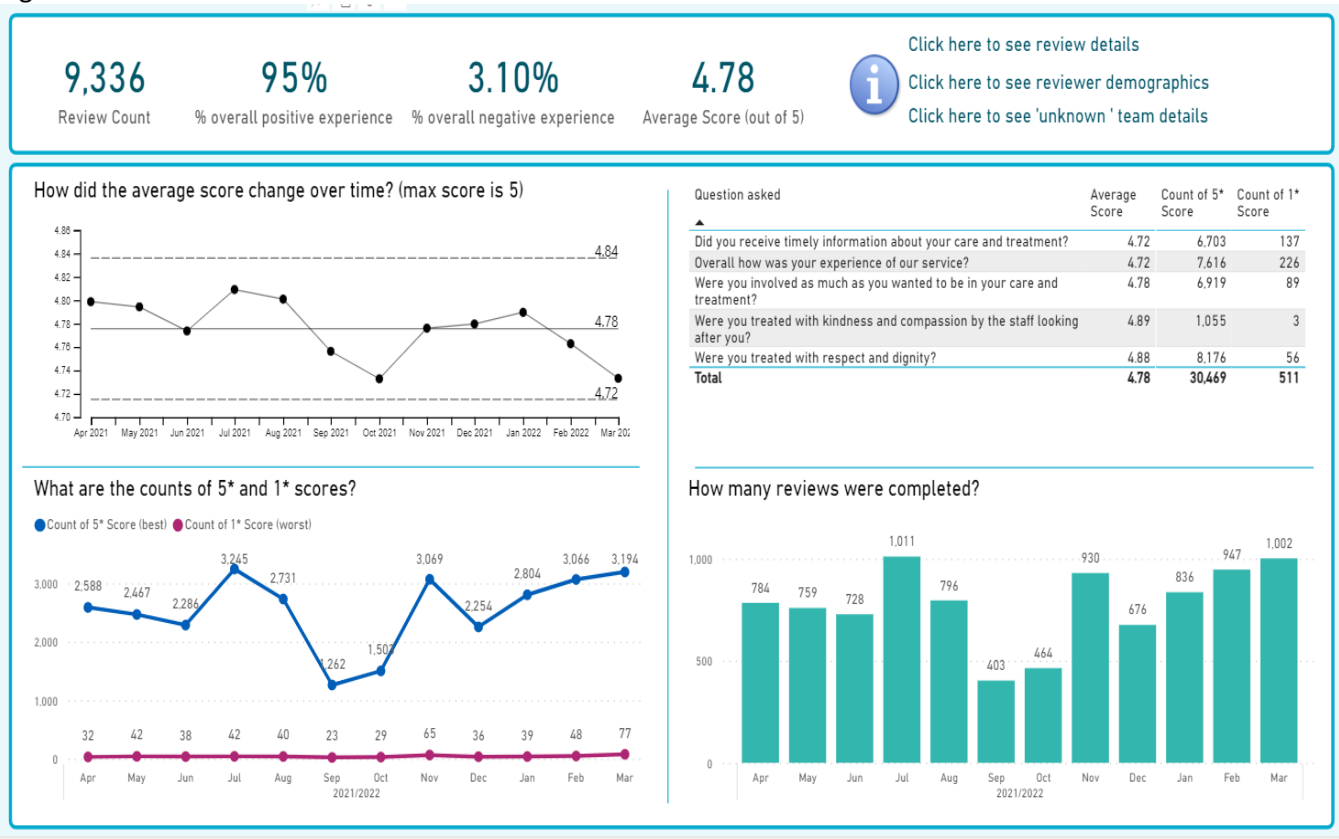
We use several ways to gather feedback from patients and their families- to hear about their experiences and to use this to make improvements. Some of the ways we gather feedback include:

- Patient and family forums, groups and councils
- Concerns raised through PALS and complaints
- Volunteers collecting feedback
- Patient and family stories
- QI projects and facilitated focus groups
- Telephone surveys
- Feedback from Healthwatch
- Social media posts
- National surveys
- Feedback from peer review visits
- Our local standardised paper and electronic survey provided by an external company, I Want Great Care (IWGC).

Local Surveys

The Trust received 9,336 local surveys via IWGC in 2021/22. The average score given by patients/ families was 4.78 out of a possible 5. Data at team level from IWGC surveys is available to all staff.
Below is a Trust-wide summary in figure 1.

Figure 1.



Source: Trust's on-line Business Intelligence Platform, primary source IWGC.

Demographics:

- Patients have given the most feedback.
- In relation to age range the feedback spans the age ranges, with 22% aged 0-18, 32% aged 19-65, 34% aged 65 and over, and 12% responders did not declare.
- 56% of responders identified as female, 38% male and 6% said they would prefer not to say.
- Only 7% of responders identified as being from a BAME background and 19% of people did not respond to this question. For context, based on modelling from the 2011 census, 16% of the Oxfordshire population are from ethnically diverse backgrounds and 14% of the Buckinghamshire population are from ethnically diverse backgrounds. We do need to ensure we engage those using our services from diverse backgrounds in giving us feedback in order for us to improve.

Below is a word cloud including all open text responses received in 2021/22 to the question, what was the experience of care provided?

Figure 2.

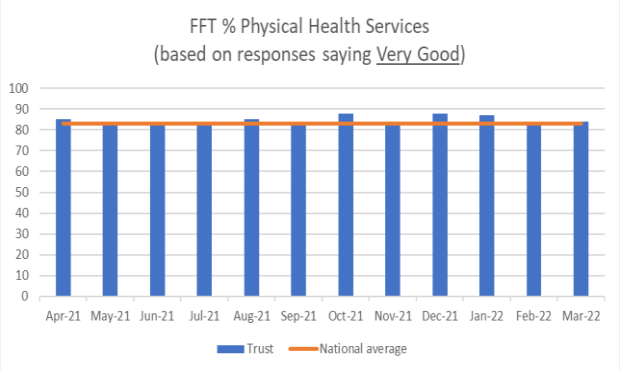
Source: Trust's on-line Business Intelligence Platform, primary source IWGC.

<u>Friends and Family Test (FFT) Results</u>

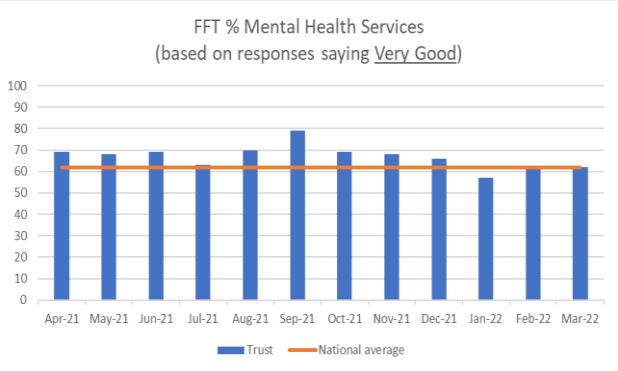
We submit the national Friends and Family Test (FFT) results monthly, shown below. The % of patients responding that overall the care was <u>very good</u> has not significantly changed month on month in 2021/22,

- Physical health services on average achieve 85% of patients who respond care is very good against a national average of 83%.
- Mental health services on average achieve 67% of patients who respond care is very good against a national average of 62%.

Graph 4.



Graph 5.



Source: National returns for the Friends and Family Test.

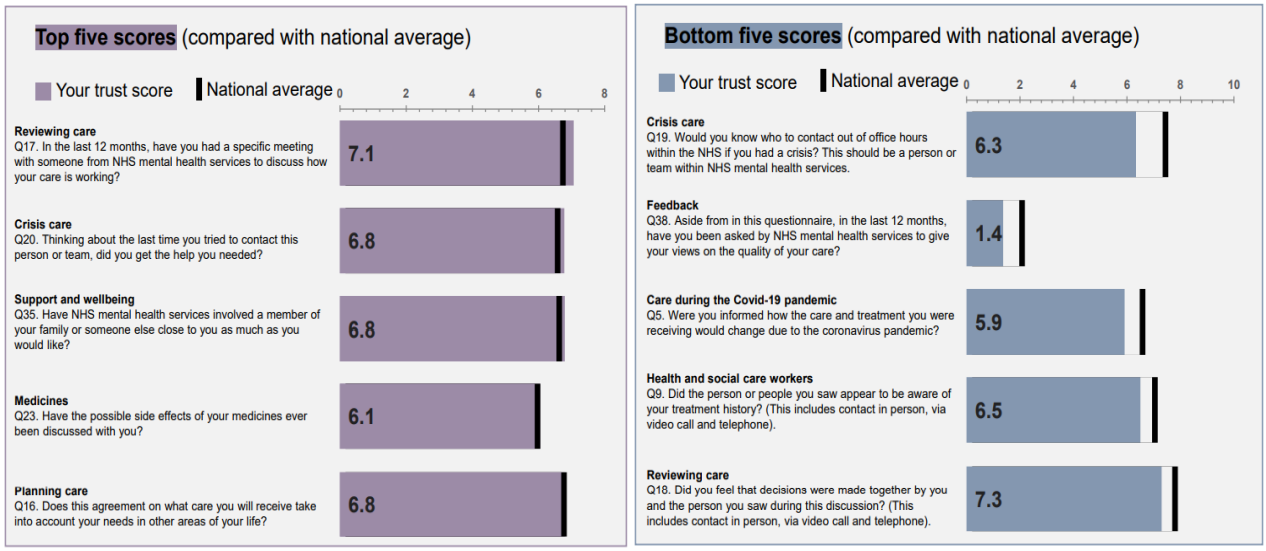
<u>National Survey Adult and Older Adult Community Mental Health Patient Survey</u>

The results of the national postal patient survey for 2021 were published in December 2021. Below is a summary of the Trust's results, the full report is available here https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2021/.

The Trust received 347 responses, giving a response rate of 28% against the national average of 26%. The majority of responses by question were about the same as other Trusts.

The top and bottom 5 questions compared to the national average are detailed below in figure 3.

Figure 3.



Source: CQC national report with the survey results

The open text comments received from patients identify areas for improvement around:

- Communication and involvement of patients and their families in care
- Waiting times and difficulties with accessing the care they need.

The impact of the actions from the last survey have been reviewed with two areas seeing small improvements (involvement in care and support with employment) and two areas seeing a decline (people being asked for their feedback and support with physical health needs).

Actions are underway regarding;

- Improving the involvement and engagement of families in care (quality objective for 2022/23)
- Improving the physical health of people with serious mental illnesses (quality objective for 2022/23)
- Developing how/ when we ask for feedback
- Expanding the Individual Placement and Support Service to support more people with findings and retaining employment
- Improving access and information on where to get help in a crisis.

We have also volunteered to be part of the below national surveys:

- **Inpatient adult mental health survey**. Survey closes in April 2022. 12 other Mental Health Trusts are also participating in the survey.
- **Community mental health survey** to pilot the use of text and on-line surveys for the annual mandated survey. Our response rate was higher for on-line responses over postal responses.

<u>Healthwatch Studies</u>

We work with our local Healthwatch organisations. An example of this is the Oxfordshire Healthwatch report published in 2022 on 'using interpreters to access health and social care support'. In response . we have taken steps to improve the accessibility of information on the Trust's website and to better promote ReachDeck software. This is software we use on our website so a person can translate any of the material into their chosen language or increase the size of text or have the information read aloud. The Trust's lead for Inclusion meets with our three main interpreting service providers on a quarterly basis to monitor usage, quality assurance and to identify any issues.

Complaints

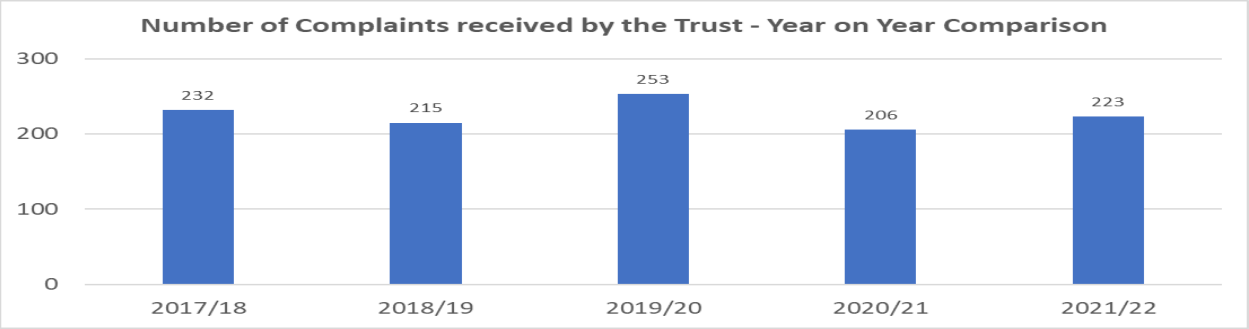
We aim to ensure all service users and families get a good experience of using our services. At times we do fall short of an expected standard and need to work with patients and families to learn. We aim to resolve any concerns as soon as possible however sometimes these concerns escalate into a formal complaint.

The Trust has continued to respond to and learn from complaints and compliments during the year. Graph 6 shows the number of complaints received year by year. In 2021/22 we received 223 complaints, all (100%) were acknowledged within 3 working days and all (100%) were responded to within a timescale agreed and communicated with the complainant. The pandemic has seen us take extended times to complete a complaint investigation which we have communicated to service users / families. The average number of days to respond to a complaint in 2021/22 was 50 days. The majority of complaints were received about our mental health services.

The main reoccurring themes for improvement across the Trust are: how involved patients and families feel in decisions about their care, including related matters around confidentiality, information provided and communication from staff members. A Quality Improvement programme, led by a senior clinician is in progress to address and improve how we work better with families. We are also exploring customer service simulation training.

The Trust's annual complaints report will be presented to the Board of Directors in May 2022 and published with the board papers at: https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/.

Graph 6.



Source: Trust's Complaint Database.

A national review of the NHS Complaints Standards has been undertaken by the Parliamentary Health Service Ombudsman on how NHS services should approach complaints handling. The draft Standards were published in 2021 and will be refined and introduced across the NHS in 2022/23. The Trust has reviewed our position against the draft national standards and we have started to make improvements, including a focus on more timely contact by the investigating officer or senior clinicians when a complaint is first received to try and resolve issues more quickly, to improve access to raising a concern, and to improve how learning is disseminated from complaints so actions are not only taken in one team. We are working with experts by experience in this work.

9.5 The Learning Disability and Autism Improvement Standards

The improvement standards have been developed to help all NHS Trusts to measure the quality of care they provide to people with learning disabilities and/or autism. Most standards relate to non-learning disability services (i.e. acute/mental health services) to ensure people with a learning disability and autistic people can access healthcare appropriately. They contain a number of measurable outcomes developed by people with learning disabilities and/ or autism and their families, which clearly state what is expected from the NHS in this area.

The four standards are:

- Respecting and protecting rights
- Inclusion and engagement
- Workforce
- Specialist learning disability services standard

The full details about the standards can be found at Improvement standards for people with a LD or Autism.

The Trust submits an annual self-assessment against the standards, which includes feedback from staff and patients at our Trust. Our focus for 2022/23 will link to the aims of our Learning Disabilities Service Strategy (2022-2027) to reduce health inequalities, increase life expectancy and quality of life. The actions (which will be across all our services) include;

- Working with GPs to ensure every person has an annual health check
- Introducing apps to develop person-centred care planning, with visual support, signposting and prompts that are developed with each person
- Rolling out autism awareness training more widely across the Trust (quality objective E4 below for more information)
- Continued work to reduce inequalities for people accessing services

9.6 Safety Incidents and Serious Incidents

All Incidents

It is crucial that we learn from every incident and near miss that happens to address concerns and continually learn. The Trust reviews all incidents to take immediate any actions identified and consider safeguards for patients. Alongside senior clinicians reviewing incidents on a weekly basis, on a quarterly basis we identify learning and more thematic areas for improvement. Further detail about how we are learning from deaths is in the below section.

The Trust reports externally all unintended or unexpected incidents which could or did lead to harm via the NHS National Reporting and Learning Service. Graph 7 shows the number of incidents and incidents by level of harm for the last 12 months. In 2021/22 our staff reported 9,575 incidents and near misses, 95% resulting in no harm (58%) or minor harm (37%). This is generally in line with the national picture in which 56% of community health incidents and 61% of mental health incidents were graded as no harm. The majority of incidents relate to self-harm (33%), followed by patients resisting treatment, medication administration, pressure ulcers[1] and falls.

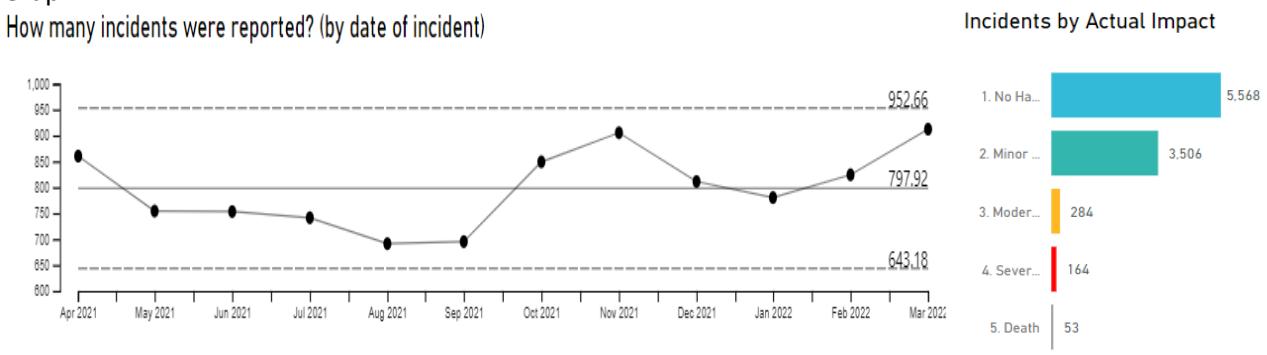
Pressure ulcers count for the area where we see most moderate harm. This relates to category 3 or 4 ulcers developed in service. Our work on reducing pressure ulcers is detailed below under the quality objective S4. In the last 12 months our teams have identified and treated 2,339 pressure ulcers (all categories). The majority of these were patients where the pressure ulcer had already been formed prior to entering the service (74%). The number of incidents is slightly raised when compared to 2020/21 (2,176 pressure ulcers) and we have also seen an increase in the number of patients with a pre-existing ulcer, 74% in 2021/22 compared to 67% in 2020/21.

The focus in physical health services has been on reducing pressure ulcers within the community nursing services. The community nursing services have been under particular pressure since the start of the pandemic due to both capacity issues with high vacancies and sickness as well as increasing demand, with many patients more acutely unwell and requiring more intensive support. As well as developing a specific, targeted recruitment campaign for the service, there has been work on improving documentation and improving patient education. See progress against quality objective S4 below.

We know there is more work to do and to this end we will continue to focus on this objective during 2022/23.

[1] Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are damage to the skin and underlying tissues caused by pressure or pressure and friction. They can range in severity from a red patch or blister to a complex open wound. Pressure ulcers are graded from 1 (superficial) to 4 (most severe).

Graph 7.



Source: Trusts Incident Reporting System.

National Patient Safety Alerts

The NHS National Reporting and Learning Service issues a number of national patient safety alerts from reviewing incidents submitted by all NHS Trusts. In 2021/22, 11 national patient safety alerts were issued, of which 8 were relevant to services provided by the Trust. The actions for the 8 alerts have been completed within the national deadlines set.

Never Events

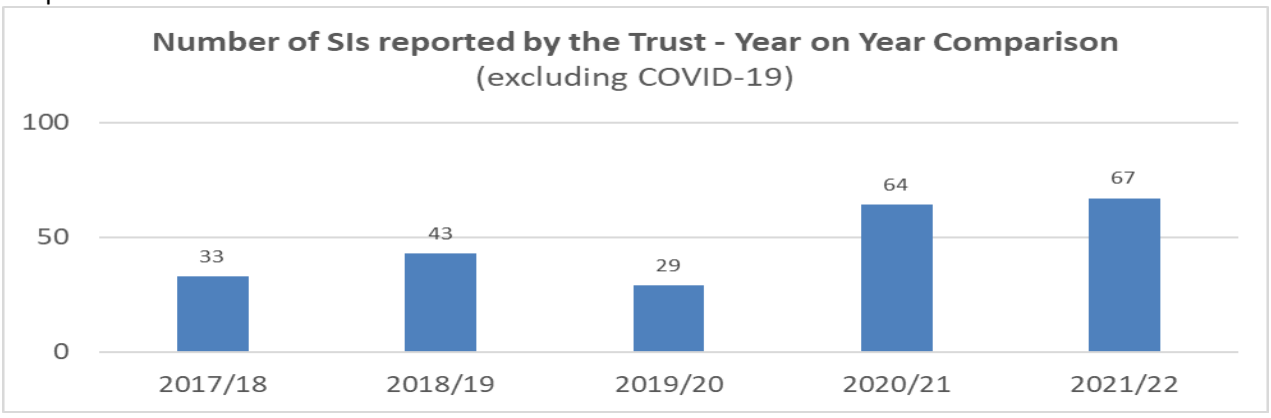
Never events are a sub-set of Serious Incidents and are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. The Trust has reported 0 never events in 2021/22.

Serious Incidents

In line with national guidance Serious Incidents (SI's) are reported and an in-depth investigations completed to identify our learning and any actions. Every investigation is shared with our commissioner for review.

Graph 8 below shows the annual number of Serious Incidents reported by the Trust in comparison with the previous financial years. A total of 88 incidents were originally reported as serious incidents (excluding COVID-19 ward outbreaks) by the Trust in 2021/22. At the time of writing this report, 21 of these incidents have been downgraded by our commissioner so the total number of serious incidents for 2021/22 is 67. The main causes for serious incidents and where we have seen an increase in 2020/21 and 2021/22 are in; self-inflicted harm such as suicide, unexpected deaths and pressure ulcers.

Graph 8.



Source: Trust's Serious Incident Database

34 (51%) of serious incidents reported in 2021/22 were related to a death, of which 23 were suspected suicides. This compares to 35 (55%) in 2020/21 and 21 suspected suicides.

We are conscious this part of the report is reporting on suspected or confirmed suicides and we acknowledge each and every death as a tragedy and has a profound and lasting effect on families and friends of those who have died by suicide.

As well as our own data we use the Thames Valley Real Time Surveillance System data coordinated by the Police, which includes all suicides by County. Some of the patients will not be known to our mental health services. The data for the calendar year 2021 shows the number of suspected suicides was similar in Oxfordshire in 2021 (n=66 suicides) compared to 2020 and 2019, although there were increases in June and July 2021 and a decrease in March 2021. In Buckinghamshire the number of suspected suicides reduced in 2021 (n=48 suicides) and was nearer to the level in 2019. The Trust is collaborating with organisations and providers across Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System to implement quality improvements to reduce suicides such as changes to the self-harm pathways by offering follow up to those who have self-harmed or attempted suicide but do not wish to fully engage with secondary mental health services.

The latest Public Health information available on suicide profiles, with data up to 2017-19, reports the suicide rate in Oxfordshire as 8.9 per 100,000, slightly reduced over the last 10 years. This compares to the South East region rate of 9.6 per 100,000 and England as a whole 10.1 per 100,000. Buckinghamshire did not submit data for 2017-19 but the 2016-18 data shows a rate of 8.0 per 100,000.

In response to thematic analysis, learning and requirements for improvement identified from serious incident investigations there has been significant patient safety activity across the Trust.

Across mental health services our focus in 2021/22 has been on two Quality Improvement projects to improve;

- Communication and involvement of family members during care
- Risk assessment and formulation including documentation

Our focus will continue in these areas in 2022/23 and both have been identified as new quality objectives. In line with this we are developing during 2022/23 a Suicide Prevention strategy which will have key themes based on national, regional and local data.

As part of the NHS Patient Safety Strategy (2019) and planned changes to the management of serious incidents, the Trust has been strengthening our processes to improve the timeliness of initial reviews and learning with increased early engagement of professionals and patients/ families using a restorative just and learning culture approach. Initial feedback from colleagues has been extremely positive. .

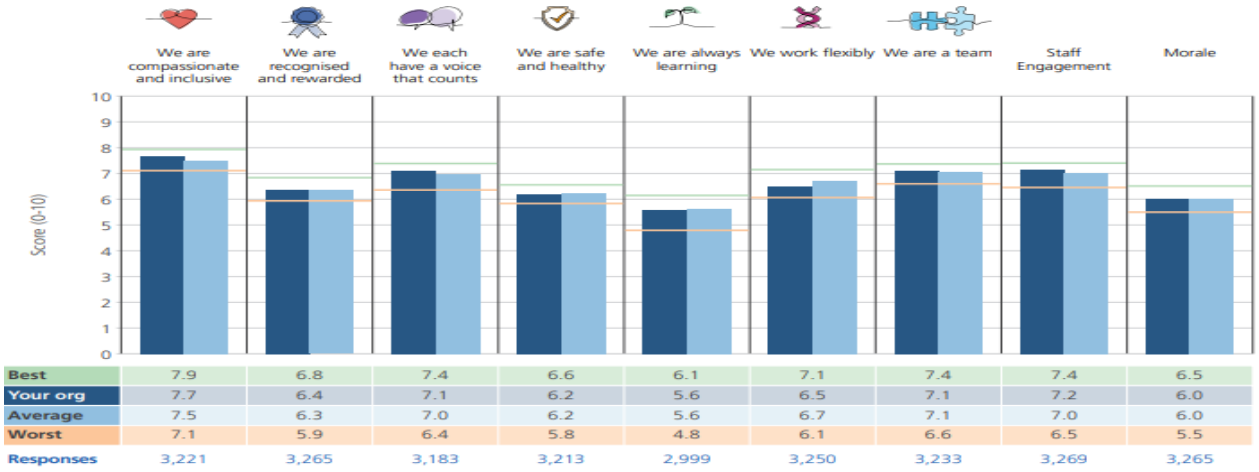
9.7 Staff experiences (including national survey results)

The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experiences, support and wellbeing. This is important as a positive staff experience plays an important role not only in staff welfare and morale, but also in helping to maintain and improve patient safety and experiences.

The Trust participated in the 2021 NHS National Staff Survey, 3,299 staff took part (55% of eligible staff). A summary of the results is below in figure 4 and the full results can be found here: https://cms.nhsstaffsurveys.com/app/reports/2021/RNU-benchmark-2021.pdf .

The overall staff engagement score has remained at 7.2, however is now above the average which has fallen across other NHS Trusts.

Figure 4.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
Your org	7.7	6.4	7.1	6.2	5.6	6.5	7.1	7.2	6.0
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5
Responses	3,221	3,265	3,183	3,213	2,999	3,250	3,233	3,269	3,265

Source: National NHS Staff Survey report

We scored higher than the average for 3 out of 7 elements, with staff saying:

- We are compassionate and inclusive (83% of staff think care of patients is the organisation's top priority, above the national average of 78%)
- We are recognised and rewarded
- We each have a voice that counts

We scored average on;

- We are safe and healthy
- We are a team
- We are always learning

We were below average in;

- We work flexibly

From previous surveys we took actions to improve staff wellbeing and reduce stress including the procurement of an Employee Assistance Programme[2], the introduction of a Restorative Just and Learning approach (Quality Objective L1) and the introduction of Schwartz Rounds[3].
The areas of focus from the 2021 survey will be;

- **Capacity**: Staff feel that they have insufficient capacity to do their jobs well with the response rate to the question "There are enough staff at the Trust to do my job" falling by nine per cent since the last survey. 'Able to meet conflicting demands' and 'have realistic time pressures', also fall into the lowest scoring questions. The Improving Quality, Reducing Agency (and vacancies) programme is leading the actions to support teams to build their capacity.
- **Personal Development Reviews:** PDR and appraisal value and quality scored low in terms of how respondents perceive it helps them do their role (21 per cent) and helped them to agree clear objectives (33 per cent). This is broadly in line with the national average. We will be identifying and working on how to improve the quality of PDRs.
- **Flexible Working:** How we work flexibly was also highlighted as an area for development with the *we work flexibly* theme of the People Promise scoring below the national average. Staff have been invited to workshops to help identify the best ways to improve and embed flexible working.

Progress against the actions we take will be monitored through quarterly internal staff surveys.

[2] The Employee Assistance Programme is delivered by an external provider which provides a helpline staffed by counsellors to help staff to deal with personal problems that might adversely impact on their work, health and happiness.
[3] Schwartz Rounds are confidential forums for staff from all disciplines to come together to reflect on the emotional challenges of working in healthcare, to boost wellbeing and reduce stress and isolation.

9.8 Clinical Audit

Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust takes actions to improve the care provided.

In 2021-22 we participated in 12 national audits, listed below in table 2 relevant to the services we provide. Alongside these we carried out locally identified clinical audits.

We also continued to participate in three national confidentiality enquiries::

- Learning disabilities mortality review programme
- National child mortality database
- National confidential inquiry into suicide and homicide.

Further details about our learning from deaths is in the below section.

9.9 Data Quality and Information Governance

It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning.

The Trust overall data quality score against across all relevant national datasets (CSDS, ECDS, QOP, MHSDS, APC and IAPT) was 82% as of November 2021, the latest reported position. The main area for improvement is the recording of ethnicity. The Trust's Data Quality Delivery Group oversees and is leading actions to make improvements. We understand ensuring we capture the ethnicity of those wo use our services is crucial in order to plan and deliver services in an appropriate and relevant way to all of the population.

Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that we can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance.

Oxford Health NHS Foundation Trust Data Security and Protection Toolkit overall score for 2020/21 was 'standards met'. The 2021/22 assessment has been submitted but we do not have the results yet.

Oxford Health NHS Foundation Trust had a routine audit by the Information Commissioner in October 2021. The Information Commissioner is the independent regulator for enforcing and promoting compliance with data protection legislation[4]. The data protection audit report is available at ICO Audit Report 2021. The audit found reasonable assurance that processed and procedures are in place and are delivering data protection compliance. There were some areas for improvement identified which the Trust has taken action around.

[4] Legislation includes the UK General Data Protection Regulation and the Data Protection Act 2018.

Table 2. National Clinical Audits

Name of Audit	Audit Scope	Status	Actions being taken
National Audit of Inpatient Falls	Mental health wards and Community Hospitals	Continuous data collection	Waiting for annual report.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Transition of young people with complex chronic conditions from child to adult health services	Mental health wards, Community Hospitals and community teams	Data submitted in February 2022	Waiting for results.
National Audit of Dementia	Memory Clinic Services	Data submitted in January 2022	Waiting for results.
Serious Hazards of Transfusion	Urgent and ambulatory care	Continuous data collection	Waiting for annual report.
National Audit of Diabetes Footcare Core National Diabetes Audit	Community Podiatry services Community Diabetes services	Continuous data collection Data submitted in May 2021.	Waiting for annual report Waiting for annual report
National Asthma and COPD Audit Programme	Respiratory service – pulmonary rehabilitation	Continuous data collection	Waiting for annual report.
National Audit of Care at the End of Life	Mental health wards and Community Hospitals	Data submitted in October 2021.	Embedding an individualised plan of care and consistent documentation of discussions regarding spiritual and practical needs. See details under quality objective CE1 for 2021-22.
National Clinical Audit of Psychosis	Spotlight on physical health & employment-Community mental health services Early Intervention in Psychosis Services	Data submitted in May 2021. Data submitted in November 2021.	Improvements needed to the recording and monitoring of physical health monitoring. See details under quality objective S5 for 2021-22. Waiting for results.
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for substance misuse: alcohol detoxification (14c)	Mental health wards	Data submitted in May 2021.	Actions around improving documented assessment of history and intake, as well as taking blood tests. Amendment to be made to the inpatient admission checklist and induction for junior doctors. Work to raise awareness with all relevant staff about guidelines on management of acute alcohol detox on our wards.
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for depression in adult mental health services (19b)	Mental health wards and community teams	Data submitted in November 2021.	Waiting for results.
Sentinel Stroke National Audit programme	Oxfordshire Stroke Rehabilitation Unit	Continuous data collection	Waiting for annual report.

10. Supporting Staff to Raise Any Concerns

To enable a more open and supportive culture that encourages staff to raise any concerns over the quality of care, patient safety or bullying and harassment we have developed a number of ways staff can speak up and to ensure those who do speak up do not suffer repercussions.

In 2021/22 there have been no concerns reported of abuse similar to those seen at Mid Staffordshire following the enquiry in 2015. The most common concerns raised have been about bullying, worker safety (due to increased demand, complexity of work and challenges of remote working), staff wellbeing for example stress and lack of communication. A common theme across the concerns is the level of demand and work pressures. The annual 'Freedom to Speak up Guardian' report provides more detail, it is available here https://www.oxfordhealth.nhs.uk/papers/november-30-2021/.

In the 2021 staff survey results 82% of staff felt able to raise concerns about unsafe clinical practice, a small improvement from last year and above the national average (80%). However we will continue to promote and enable every member of staff to feel safe to speak up and learn when things go wrong.

We started two significant programmes of work in 2021/22 to develop the culture of the organisation including implementing the approach of a Restorative Just and Learning Culture (quality objective L1) and improving Race Equality in the Workforce (quality objective L2).

The Trust has developed five staff equality networks (listed below) and five support groups to empower and inspire staff while nurturing a culture of belonging and inclusion. These networks and groups are an important way to hear from under-represented people.

Staff have opportunities to raise concerns through:

- A staff member's line manager to discuss what happened and how they would like to be supported.
- The Freedom to Speak Up Guardians provide independent and confidential support to all staff who wish to raise concerns and to promote a culture of openness.
- The Trust has appointed a Guardian of Safe Working for trainee doctors, who has a duty to advocate for safe working hours for trainee doctors and to hold the Board to account for ensuring this. The Guardian presented an annual report to the Board in November 2021. The Guardian oversees and reports on 'exception reports' from trainee doctors when work does not reflect the work agreed, for example working too many hours, or when safety aspects are breached. Feedback shows the system of cover continues to work and any gaps are covered quickly. The Trust has a Trainee Doctors Forum which is another route trainees can raise concerns and issues to the Guardian.
- We have introduced the role of Professional Nurse Advocates (PNA) from December 2021, with over 30 trained advocates and more to commence their training. The training programme is focused on restorative supervision and ensuring that nurses voices are heard and that they feel empowered to speak up especially regarding issues of patient safety. The roles are embedded across services with an aim that every team has a PNA.
- The Human Resources Department, who also manage the whistleblowing process overseen by the Executive Team.
- Fair treatment at work facilitators, this innovative role has been introduced across the Trust led by the Head of Inclusion. This is a service made up of more than 14 staff to provide one-to-one support to staff who have experiences or have concerns about bullying and harassment in the workplace. The facilitators have received specialist training by the Advisory, Conciliation and Arbitration Service.
- Staff side representatives are available to offer advice and support. Representatives meet regularly with the Executive Directors and work has been done to improve relationships.

11. Learning from Deaths

For some people, sadly, death whilst under the care of the NHS is an inevitable outcome. In the majority of instances people receive excellent care in the months or years leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. The purpose of mortality reviews is to identify any problems in care, to learn and take actions.

The Trust learning from deaths process reviews all patients we have seen checked who subsequently died against a national database, including patients under our care at the time of their death and those who die within 12 months of being discharged and their last contact. In most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further. The level of review required will depend on various criteria such as age, the setting they died in and the circumstances surrounding their death. We always review the care provided to all patients who had a learning disability, aged under 18 or died after we suspected they took their own life by suicide.

The information below includes all deaths for patients past and present known to any of our services. All of the graphs are based on data from the Trust's incident and mortality reporting system, the Trust's patient record system and the national information on disclosure of death registration information.

Oversight and Governance

The Chief Medical Officer is the lead Executive Director responsible for how the Trust learns from deaths and chairs the Trust's Mortality Review Group, which meets at least quarterly and includes representatives from our Trust Governors. Every meeting involves each clinical directorate reporting back on key learning and actions following reviews into patient deaths.

The Trust has a stepped approach to the review of patient deaths, this includes:

- An initial screening completed by at least two senior clinicians from the clinical team, which includes speaking to the bereaved family where possible
- Review of care and the patient's record, followed by a clinical group discussion outside the team
- The following types of deaths always receive further scrutiny - all unexpected deaths, suspected suicides, expected deaths where any care concerns are identified, all deaths involving a person with a learning disability, all mental health inpatient deaths, all COVID-19 inpatient deaths and all deaths of a patient detained under the Mental Health Act
- An in-depth investigation and/ or declaration as a serious incident may then be declared

In relation to the number of deaths reported onto Ulysses for further review this varies by type of service depending on the patients being cared for and treated.

External Scrutiny

Members of the Trust are also involved in the following external multi-agency review processes to look into the deaths of our patients and to maximise learning:

- Child Death and Overview Process (CDOP)
- Learning from lives and deaths of people with a learning disability and autistic people (LeDeR).
- Children's Serious Partnership Reviews
- Adult Safeguarding Adult Reviews
- Domestic Homicide Reviews
- Mental Health Homicide Reviews
- Coroner Inquests
- Oxfordshire system vulnerable adults mortality forum
- Oxfordshire system homeless mortality review process
- Regional Oxford Academic Health Science Network Mortality Review Group
- A joint Mortality and Morbidity forum with Oxford University Hospitals NHS Foundation Trust

We also submit information to the following national confidential enquiries to aid national learning:

- Learning disabilities and autistic people mortality review programme
- National child mortality database
- National confidential inquiry into suicide and homicide.

National Inquiries

In the last year we have reviewed the findings and recommendations from the below national inquiries, to identify how we can learn from these:

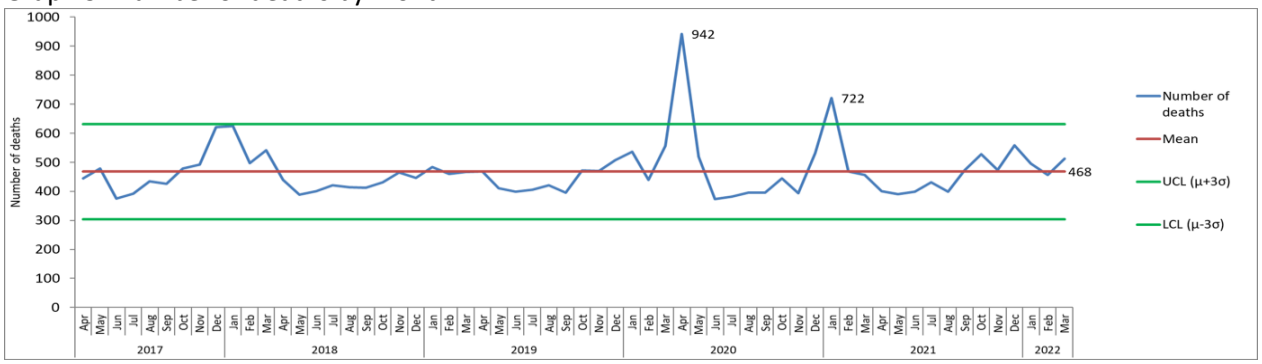
- Mr Pascoe's recommendation from 2nd stage public investigation in 2021 related to Southern Health NHS FT, deaths of patients from 2011-2015
- Ockenden review of maternity services at Shrewsbury and Telford NHS Trust 2022, related to serious harm and deaths of children and mothers

Summary for 2021/22

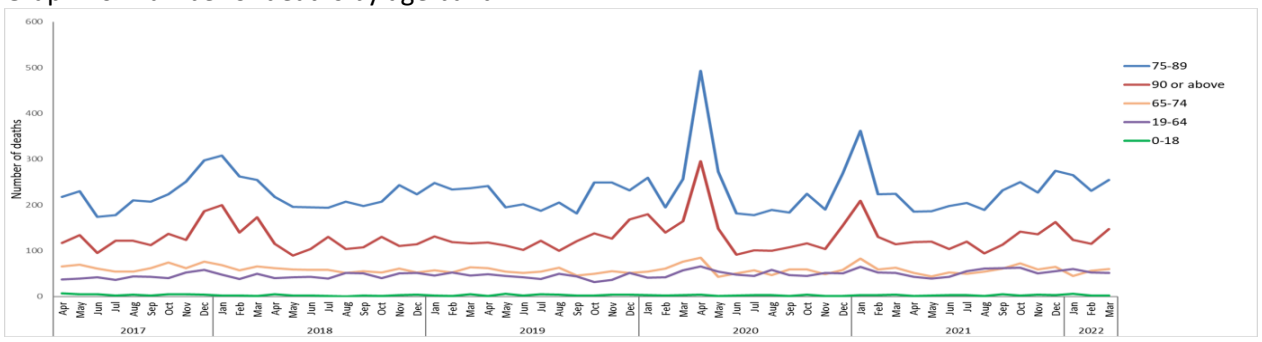
There has been little variance in the number of deaths over time, with most deaths for patients with an open referral (82%) aged 75 and over. Except for significant peaks in April 2020 (892 deaths) and January 2021 (686 deaths) for patients aged 75 and above with an open referral, related to deaths from COVID-19.

The graphs below show the number of deaths by month and number of deaths by age band. Our trend over time mirrors the national pattern, including the peaks in April and January. In the Trust the peak in April 2020 was followed by a lower-than-average number of deaths June to Sept 2020.

Graph 9. Number of deaths by month



Graph 10. Number of deaths by age band



In 2021/22 there were 34 deaths for patients aged under 18 compared to 27 in 2020/21. Most deaths were for patients open to services at the time of their death and most commonly last seen by the Health Visiting Service or Children's Community Nursing Services. All child deaths are reviewed through the multi-agency Child Death Overview Process (CDOP) led by the local Children's Safeguarding Board and in some cases will also have a children's serious partnership review/ serious incident investigation. System-wide recent themes for learning have been in relation to co-sleeping on sofas, window safety and safety around open water.

There were 93 inpatient deaths in 2021/22 including patients who recently died after discharge, this compares to 107 in 2020/21. Most inpatient deaths occur in the community hospital wards (90 deaths) for patients aged over 80 and the death has been expected. In five of the inpatient deaths the person had been positive with COVID-19 however this was not the primary cause of their death. We had three deaths of people on our mental health wards, two related to physical health reasons and one person died from suspected suicide whilst on leave from the ward. Overall the number of inpatient deaths has declined over the last 4 years.

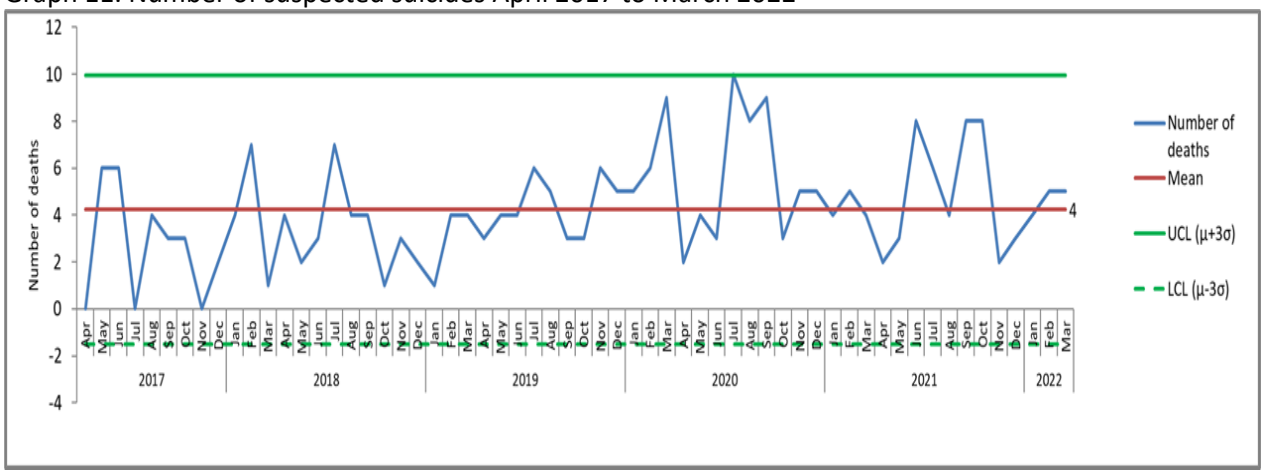
The effect when someone sadly takes their own life is unimaginable to families and loved ones. The graph below shows the number of suspected and confirmed suicides. In 2021/22 there have been 58 suspected or confirmed suicides, of which 33 patients had an open referral at the time of their death. The majority of suicides have been by men. The Trust has been focused on actions around:

- Embedding safety plans co-produced with patients and their families,
- Development of suicide prevention champions within teams and
- Additional staff training and seminars to improve skills

The Trust is an active partner in multi-agency work in each County to prevent and reduce suicides. Information was provided above which showed the rates of suicide in Oxfordshire and Buckinghamshire are below the average in the South East region and England.

The Trust established a Family Liaison Service to provide compassionate support, signposting, practical advice and advocacy to families and carers who have been bereaved by the suicide of a loved one. The service started around a year ago and so far has provided support for 34 family members or carers. Support has varied in terms of length of time, with some families wanting just one or two meetings and others remaining open for longer.

Graph 11. Number of suspected suicides April 2017 to March 2022



Key learning

We identified two main issues from our reviews of patient deaths for additional focus in 2021/22 and we are making progress against these, the areas are:

- Communication and involvement of family members during care,
- Risk assessment and formulation including documentation.

To ensure the actions we take address the issues and can be sustained we have taken a quality improvement approach. Work will need to continue into 2022/23.

The Trust has been issued with one Prevention of Future Death notice from the local Coroners in 2021/22 relating to an inpatient suicide in 2019. Notices are made by Coroners to address concerns arising from inquests. The Trust received two notices in 2020/21. The timing of a notice from the Coroner relates to the completion of the inquest rather than the year the person has died. The concerns being addressed from the notice issued in 2021/22 are:

- Using a monitor screen for close observations
- Searching bedrooms on the ward for prohibited items

Actions have been identified for each area of concern which have been shared with the Coroner, CQC and local commissioner.

12. Progress on Quality Objectives set for 2021/22

This section details the Trust's achievements against its quality objectives for 2021/22.

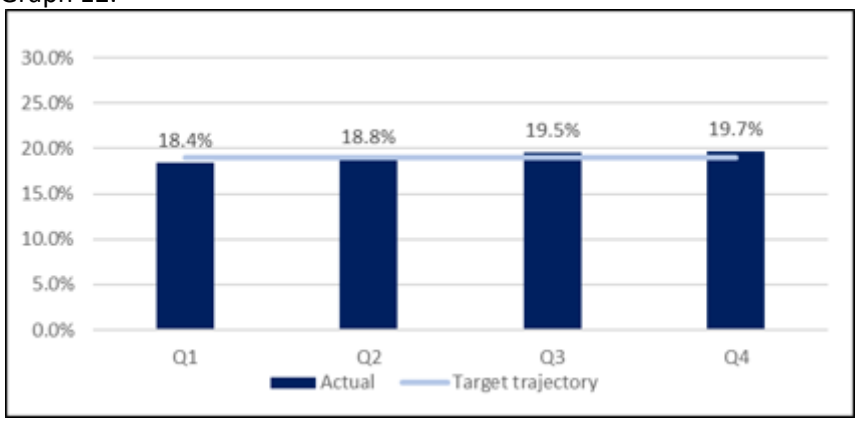
Below is a summary of how we have self-assessed our achievement against each objective. The full detail then follows for each objective.

Domain	Objective	Level Achieved (self-assessed)
Leadership	L1. Develop and embed the use of a Restorative Just & Learning Culture approach	Achieved.
	L2. Achievement of the Race Equality Framework for Change – 5-year programme	Achieved.
	L3. Continue to support and improve staff wellbeing	Achieved.
Safety	S1. Minimise nosocomial infections (hospital acquired)	Achieved.
	S2. Reduce restrictive practice through introducing a Positive and Safe approach (part of national project)	Partially achieved.
	S3. Improve sexual safety in mental health inpatient settings (part of national project)	Not achieved.
	S4. Improve tissue viability and reduce avoidable harm in pressure ulcers	Not achieved.
	S5. Continue work to improve physical healthcare for patients with a severe mental health illness	Partially achieved.
Experience	E1. Ensure we have strong patient/ family voices as part of developing and improving services	Achieved.
	E2. Continue our focus on improving personalised care planning	Partially achieved.
	E3. Develop easy read versions of publicly available quality papers	Achieved.
	E4. Develop and launch a new e-learning course for staff on an introduction to autism	Partially achieved.
Clinical Effectiveness	CE1. Improve personalised care planning for patients at end of life	Partially achieved.
	CE2. Support the delivery of initiatives within the Ageing Well work	Achieved.
	CE3. Develop the consistency and application of clinical supervision	Not achieved.
	CE4. Improve clinical documentation and practice in relation to the Mental Capacity Act	Achieved.

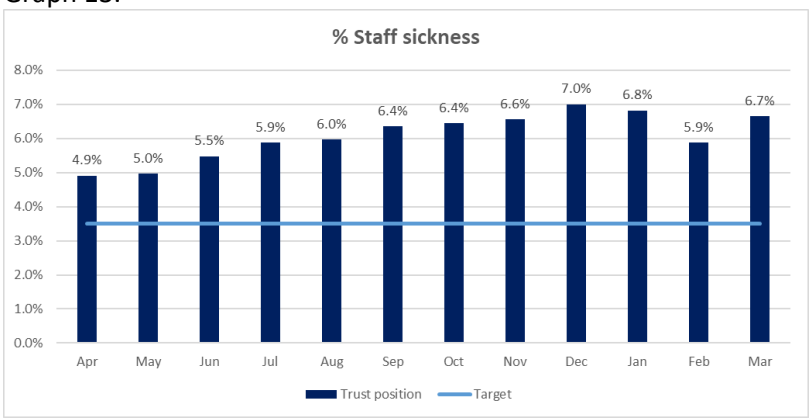
Domain: Leadership

L1. Develop and embed the use of a Restorative Just & Learning Culture approach	
Self-assessment	Achieved Year 1 goal around staff training. Year 2 goal identified in the 2022/23 quality objectives.
Evidence of Progress	26 Trust staff have attended formal 6-day training on Transforming Organisational Culture: Principles and Practice of Restorative Just & Learning Culture, provided by Mersey Care NHS Foundation Trust and the University of Northumbria. Embedding this new approach and cultural change will take a number of years to complete, however work has started. A Restorative Just & Learning Culture Steering group as well as a Civility & Respect sub-group have been set up to lead and oversee the changes. A BOB Integrated Care System 'community of practice' has also been set up for everyone who has been trained – a number of sessions have been held to share learning across organisations on embedding the approach. Changes are being make to the management of HR casework, Trust-wide work around acceptable behaviours has started and also work has started to minimise harm to staff involved in patient safety incident investigations.
Measure of Impact	26 staff trained against a local target set of 25 in Year 1. There has been a reduction in the number of staff suspended, the numbers are small but a reduction is evident. 2021 staff survey results; staff rated the compassion of the culture as 7.4 against a national average of 7.2.

L2. Achievement of the Race Equality Framework for Change – 5-year programme	
Self-assessment	Achieved Year 1 goal to establish a programme of work and take some initial actions to increase representation from staff from Black, Asian and minority ethnic (BAME) backgrounds.
Evidence of Progress	At year end **19.7%** of staff in substantive roles (clinical, non-clinical and medical/ dental staff) are from BAME backgrounds. Overall the national target for NHS Trusts is 19%. This compares to a national average position of 22.4% of staff working in NHS Trusts were from a BAME background on 31st March 2021 (data source Workforce Race Equality Standard 2021). We know we want to do more and achieve at least this target in every directorate and in every pay band. The target is not being met in all of the clinical directorates and there is also an underrepresentation across the Trust at higher pay bands. 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. There is an Integrated Care System level action plan to improve the race disparity ratio and meet the six national Equality, Diversity and Inclusion actions. The Trust has developed a Race Equality 'Framework for Change' Strategy being led by the Chief Nurse with the support of the Equality, Diversity and Inclusion Steering Group and Race Equality network. Some of the workstreams are being led by self-nominated volunteers from the Race Equality Network who are using this work experience as part of their professional development.
Measure of Impact	Below is the % representation of BAME staff across all pay bands including board level.

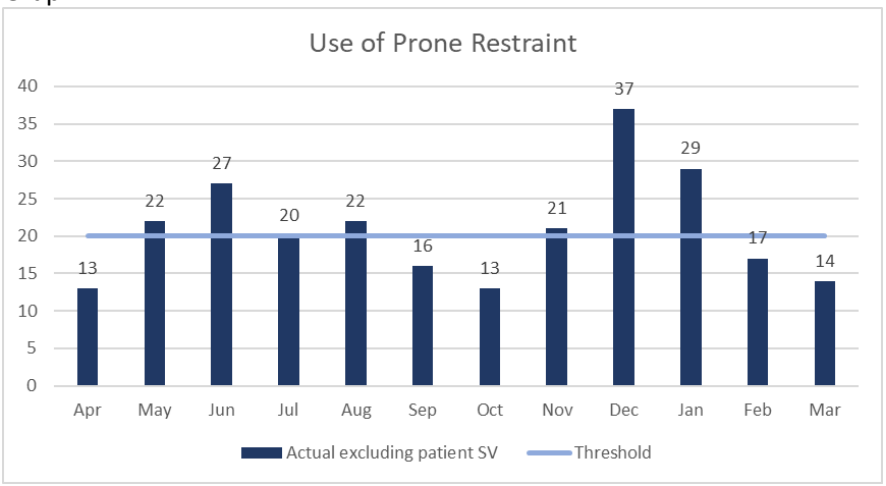
L2. Achievement of the Race Equality Framework for Change – 5-year programme	
	Graph 12.  Source: Trust's staff records database. The NHS Workforce Race Equality Standard Report 2021 highlights some areas where the Trust has improved from last year, including: • An overall increase in the proportion of BAME staff • An increase in the % of BAME staff believing the Trust provides equal career opportunities for career progression or promotion • An increase in the proportion of BAME applicants more likely to be appointed from shortlisting compared to White applicants, and considerably ahead of the national benchmark

L3. Continue to support and improve staff wellbeing	
Self-assessment	Achieved objectives set in year. Remains an important area with a new objective for 2022/23.
Evidence of Progress	There has been a strong focus on supporting staff wellbeing, with a clear emphasis on a preventative and proactive approach to the implementation of a wellness culture. Some of the key actions/ initiatives include: • Establishment and support of Health and Wellbeing Champions – to promote health and wellbeing, local activities and share news within your team • Introducing personal wellbeing plans, encouraging regular conversations between line managers and employees • Launch of REACT training to help managers be aware and to start wellbeing conversations. • TRiM courses (supporting staff through trauma risk management) • Monthly Health and Wellbeing newsletter and dedicated pages on the staff intranet, to summarise the support and help available. • Setting up and supporting five staff equality networks and five support groups to empower and inspire staff while nurturing a culture of belonging and inclusion. These networks and groups are an important way to hear from under-represented people. The latest network group is for people going through and experiencing the symptoms related to Menopause. • Leading the delivery of a Mental Health & Wellbeing hub 'You Matter' offering psychological support to staff • Staff training and introduction of restorative just and learning culture, including civility and respect • Use of Schwartz rounds for reflection • Exit interview process relaunched • Innovation 'Recovery and renewal' days offered to staff

L3. Continue to support and improve staff wellbeing	
	• We set up a stress reduction steering group in partnership with staff side. Focus groups and surveys have been completed to identify and guide the actions. • The Employee Assistance Programme is available to staff 24/7 and having a positive impact offering counselling and advice. • Ongoing staff focus groups through the year to identify what other support would be helpful • We have continued with our staff Exceptional People Awards each month, and have also introduced from May 2021 a new award called The Daisy Award, to recognise the contribution of nurses who go above and beyond to help patients. Five nurses have received awards to date.
Measure of Impact	2021 staff survey results; the overall staff engagement score has remained at 7.2, however now above the average as this has fallen across other NHS Trusts. The results to the individual survey questions around well-being showed an improvement, with staff feeling the Trust has taken more positive action on health and well-being (66% and above the national average) and their line manager has taken a positive interest in their health and well-being (78% and above the national average). Sickness rate; The sickness absence rate by month for 2021/22 is shown below – 6.7% in March 2022. Excluding Covid absences the rate reduces to 4.35% (same as last month) and 0.85% above the local target of 3.5%. The national average across the NHS is 9.1%. The Trust has sickness policies and processes, as well as its Occupational Health Department, to support staff with health conditions. The GoodShape service (formerly known as First Care) provides first line advice through its team of qualified nurses working to the same standards as NHS 111 and this service offers guidance to employees about managing their health condition. Anxiety, stress, depression & other psychiatric conditions continue to be a significant cause of absence as well as COVID-19. Graph 13.  Source: Trust's staff records database. There continues to be good use of the Employee Assistance Programme with consistent evidence of reduced presenteeism (3.5 to 2.8) and work distress (2.6 to 2.2) coupled with increased work engagement and life satisfaction following therapy. In the calendar year of 2021 the service received 890 calls, both advice and counselling. Anxiety is the highest reason for contacts.

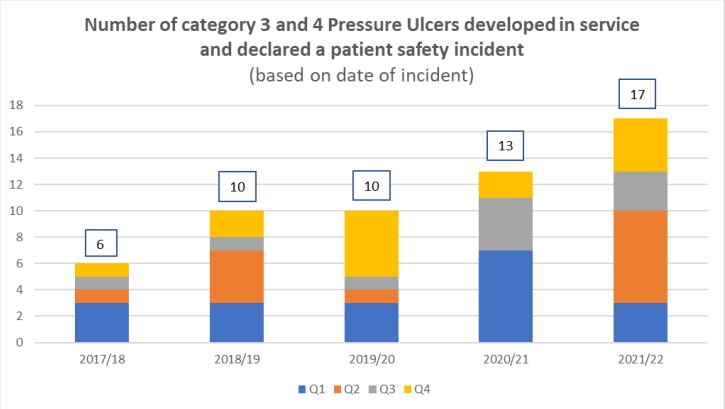
Domain: Safety

S1. Minimise nosocomial infections (hospital acquired)	
Self-assessment	Achieved
Evidence of Progress	In 2021/22 the Trust had 0 cases.
Measure of Impact	0 cases against a reduction local target of less than 3 baselined from 2020/21.

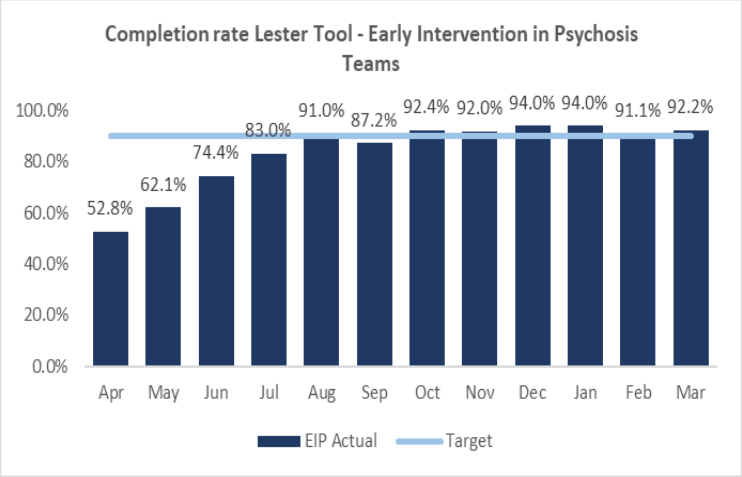
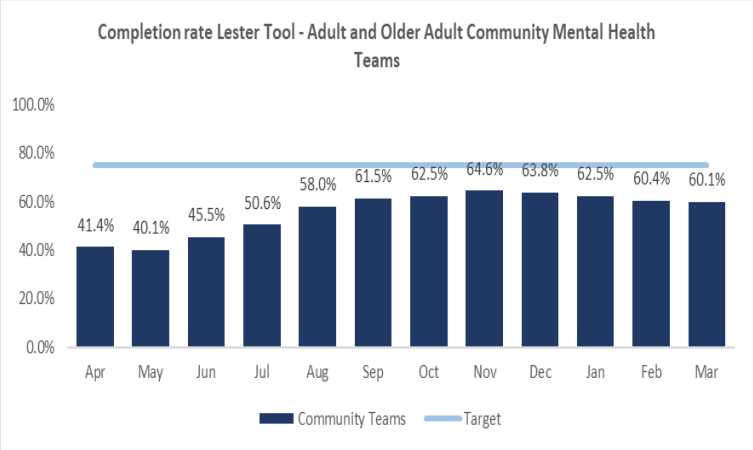
S2. Reduce restrictive practice through introducing a Positive and Safe approach	
Self-assessment	Partially achieved. Continued work identified as part of quality objective for 2022/23 to reduce restrictive interventions.
Evidence of Progress	The use of prone restraint carries increased risks for patients and should be avoided and only used for the shortest possible time. A large-scale quality improvement (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. The training we provide to staff around the use of restrictive interventions achieved external accreditation in June 2021. 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 minutes are reviewed by a Head of Nursing (In 2021/22 there were 20 cases last lasted longer than 5 minutes).
Measure of Impact	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. Graph 14.  Source: Trust's incident reporting system.

S3. Improve sexual safety in mental health inpatient settings	
Self-assessment	Not achieved. This is a continued area for focus and included within the 2022/23 objectives.
Evidence of Progress	The national mental health Quality Improvement (QI) workstream has been delayed because of a national decision to focus on the workstreams of restrictive interventions and prevention of suicides initially. Locally we have started preparatory work around; increasing awareness and improving reporting to gather baseline information to identify what improvements to make. Proposed workstreams will be; data capture and improve learning from themes, person-centred care and staff training.
Measure of Impact	From initial actions we have seen a small increase of incident reports from an average of 20 incidents a month in 2020/21 to 25 a month in 2021/22. This is as a result of raising the profile and improving some of the ways staff can report incidents. In line with national findings we suspect that sexual safety incidents are still under-reported and expect numbers may rise with a more accurate reporting going forward. We are not at a stage yet to measure staff and patient safety and if this has improved.

S4. Improve tissue viability and reduce avoidable harm in pressure ulcers	
Self-assessment	Not achieved. This is a continued area for focus and included within the 2022/23 objectives.
Evidence of Progress	In 2021/22 there were **17** category 3 and 4 pressure ulcers developed in service (based on date of incident) where we identified learning. This is 4 more cases than in 2020/21 (when there were 13 cases), therefore there was no reduction which was our local target. In the last 12 months our teams have identified and treated 2,339 pressure ulcers (all categories), the majority of which patients had prior to referral into our services (74%). The number of incidents is slightly higher than in 2020/21 (2,176 pressure ulcers) and we have also seen an increase in the number of patients with a pre-existing ulcer, 74% in 2021/22 compared to 67% in 2020/21. In relation to activity the District Nursing Service carried out broadly the same number of appointments in the years 2020/21 and 2021/22 (271,800 appointments in 2021/22), and the average number of appointments per care episode (14) was also similar. However, the District Nursing Service has been under significant pressure from August 2021 due to increased demand combined with patients having greater and more complex care needs, and the service having staffing challenges (managing a 11% vacancy rate through the year). The service has been operating at an 'Amber' escalation level for most of 2021 and moved into 'Red' level status from December 2021, equivalent to OPEL 4. This has meant that care delivery has been prioritised and significant numbers of visits have been delayed or rescheduled. Plans are in place for each team with mitigations and actions to reduce the potential for harm to patients, and workload pressure is managed through a daily countywide capacity planning calls. Quarterly pressure ulcer thematic reviews are carried out and the learning identifies the following areas for improvement; staffing levels, poor functioning of IT, chronic excessive workload which has led directly to a lack of effective care planning and continuity of care in some cases. There are long-term actions being implemented with oversight by the Pressure Ulcer Steering Group attended by frontline staff and our commissioners. The actions include introducing a newly procured electronic patient record system for community nursing in 2022.

S4. Improve tissue viability and reduce avoidable harm in pressure ulcers	
	It's been a very challenging year for the District Nursing Service, which has meant many of the improvements they have wanted to make have not been possible. The following actions have been taken to keep the service safe: • redeployment of staff from other teams • increased use of consistent agency staff in the short term to stabilise the service • more information given to patients about self-care and deterioration signs to support earlier trigger to the District Nursing Services • a bespoke recruitment campaign which included extensive advertising in public spaces and recruiting experienced international nurses. • upskilling clinical support workers on wound care and nurses have received phlebotomy training, to help manage the demand and capacity in the service.
Measure of Impact	The below graph shows the number of category 3 and 4 pressure ulcers developed in service and declared a patient safety incident, as there was learning identified. The information is by quarter and year. In 2021/22 most incidents happened in Q2 between July-September 2021. 15 out of the 17 cases related to patients under the care of the District Nursing Service, spread across the different locality teams in Oxfordshire. Graph 15.  Source: Trust's incident reporting system.

S5. Continue work to improve physical healthcare for patients with a severe mental health illness	
Self-assessment	Partially achieved. This is a continued area for focus and included within the 2022/23 objectives.
Evidence of Progress	The indicator is based on the completion and at least 12-monthly review of the comprehensive Lester physical health assessment tool for patients with a serious mental illness. The tool covers eight elements including smoking status, lifestyle, BMI, blood pressure, glucose and cholesterol, and the associated interventions. Actions in 2021/22 have been overseen by a task and finish group led by a senior clinician. Key actions have included; • Recruiting physical health leads, embedded in clinical teams • Improving the consistency across the physical health clinics • Ensuring teams have the appropriate monitoring equipment available • A new physical assessment form was introduced on the patient record system The Early Intervention in Psychosis teams have **achieved** and sustained performance above the local target. The Adult and Older Adult community mental health teams have improved their performance but not achieved the local target.

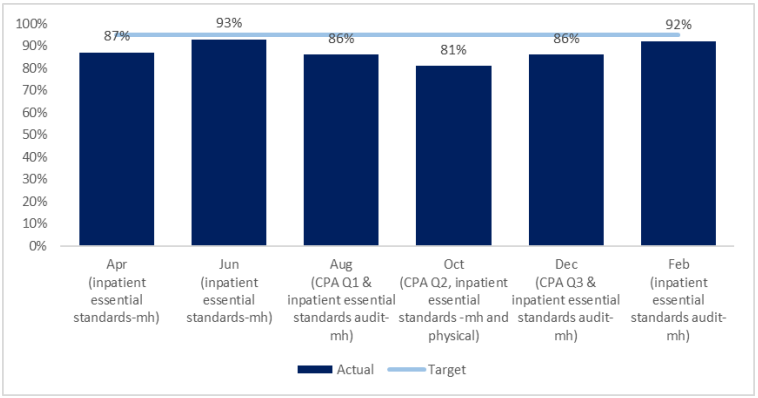
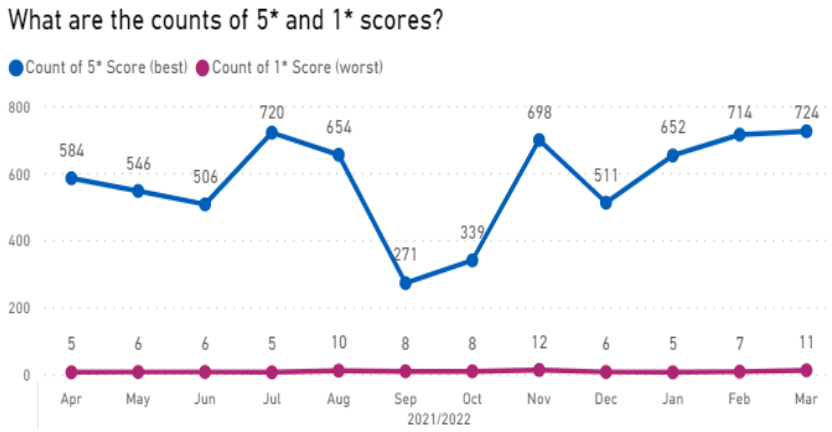
S5. Continue work to improve physical healthcare for patients with a severe mental health illness	
Measure of Impact	At the end of March 2022 the results were as follows; 92% Early Intervention in Psychosis teams against a local target of 90%. This was achieved and performance maintained. 60% Adult and Older Adult community mental health teams against a local target of 75%. This was not achieved. Graph 16.  Graph 17.  Source: Patient record system called CareNotes.

Domain: Patient and Family Experiences

E1. Ensure we have strong patient/ family voices as part of developing and improving services	
Self-assessment	Achieved. However, we will continue to embed co-production and engagement in everything we do, so this is always our approach.
Evidence of Progress	Having the patient voice as part of everything we do is improving. Work has been completed with the service change team to ensure project managers are held accountable to involve patients and/ or families in all applicable projects. In 2021/22 – 17 out of 22 new projects started engaged and involved patients. This is an improvement however we need to be achieving 100% going forward. An example of the engagement is a project which started in September 2021 in Buckinghamshire working with Healthwatch Bucks to help engage with vulnerable groups that are less represented. To find out their needs, views on mental health and barriers to service access, so we can develop future models of care to make community mental health services accessible.

E1. Ensure we have strong patient/ family voices as part of developing and improving services	
	The patient voice is also a key part of our Quality Improvement (QI) approach and programmes. Each QI project is involving and engaging with patients/ experts by experience in different ways. The other ways we are ensuring there is strong engagement is: • Local patient, parent and carer forums at team and ward level. As well as a Trust-wide Experience & Involvement Forum, co-chaired by experts with experience. • Patients/ experts by experience being members of Trust QI Hubs and being trained alongside staff in QI approach. • Patients/ experts by experience are part of our peer review visits to teams. 10 people have completed training in 2021/22 and started to join visits to speak to patients about their experiences, to identify improvements. • Routinely patient stories are presented at every Board of Directors meeting, as well as other groups and staff training. • Expansion of peer support workers and we have achieved external provider status to deliver peer support worker training. • Development of Youth Boards. • Development and recruitment of new paid roles for people with lived experiences of mental illness. • Involving patients/ experts by experience on staff recruitment panels. • Identifying champions in every team to lead on engagement and involvement. Supported by the central Experience and Involvement Team to provide leadership, support and training. See above section in Account on Patient and Family Experiences and Involvement which details a number of ways we have involved and worked alongside patients, families and carers to improve services and the care we provide.
Measure of Impact	See description above.

E2. Continue our focus on improving personalised care planning	
Self-assessment	Partially achieved. This is a continued area for focus and included within the 2022/23 objectives.
Evidence of Progress	The feedback we receive and the clinical audit information, detailed below, tells us patients are not always and consistently being involved in care planning. We have several examples of successful quality improvements focused on improving personalised care planning, shared in the body of the Account under the section on Patient and Family Experiences and Involvement. Some additional examples are provided below: 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.
Measure of Impact	Based on clinical audit results we have not achieved a sustained improvement or our local target of 95%.

E2. Continue our focus on improving personalised care planning	
	Graph 18.  Source: Clinical audit results Based on local patient and carer survey results; Out of 8,044 responses in 2021/22 patients/ carers rated their involvement in their care and treatment as 4.78 out of 5. This was a small improvement from 2020/21, when the average was 4.74. 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? Graph 19.  Source: IWGC.

E3. Develop easy read versions of publicly available quality papers	
Self-assessment	Achieved.
Evidence of Progress	The Trust has developed the information available in easy read, this includes easy read papers going to the following meetings in 2021/22; • Board of Directors • Council of Governors • Annual General Meeting Sept 2021 A person with a learning disability was elected as a Governor for the Trust who is supporting and helping the Trust to make information more accessible for all.
Measure of Impact	See description above.

E4. Develop and launch a new e-learning course for staff on an introduction to autism	
Self-assessment	Partially achieved. This is a continued area for focus and included within the 2022/23 objectives.
Evidence of Progress	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. • 6 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.
Measure of Impact	See description above.

Domain: Clinical Effectiveness

CE1. Improve personalised care planning for patients at end of life	
Self-assessment	Partially achieved. Continued work will be included in the 2022/23 objectives under improve holistic personalised care plans developed with patients.
Evidence of Progress	The End of Life and Palliative Care Steering group oversees the improvements we are making, they also review all incidents/ mortality reviews and complaints related to end of life care. The key areas for learning are; pressure ulcers related to skin changes at life's end and medication incidents both prescription and administration. All learning is fed into the end of life link nurse meetings. National Audit of Care at the End of Life is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental

CE1. Improve personalised care planning for patients at end of life	
	health inpatient wards. The aim is to improve the quality of care of people at the end of life and monitors progress against the *five priorities for care* set out in *One Chance To Get It Right, 2014* and *NICE Guideline (NG31) and Quality Standards (QS13 and QS144).* The last National Audit of Care at the End of Life in 2020 showed the Trust was performing above the national average for identifying when patients were at the end of life and working with families. There was also an improvement in use of an individualised care plan (Trust 7.4/10 compared to the national average 7.2). Our work was considered best practice and was presented at the Community Hospitals Association. Although we have more work to do so that every person has a personalised care plan which they and/ or their family have been involved in developing. The Trust participated in the 2021 audit however the sample size was small as the number of deaths on the wards was low which meant the analysis is limited. The Trust carries out a local audit on quality of end of life care completed by the District Nursing Services and Community Hospital wards, the most recent results show the use of the personalised care plan is not fully embedded (about 80% completeness) and instead many clinicians are using the note section to capture patients/ families wishes and needs. Identifying a patients spiritual/religious preferences also remains an area to work on. Resources based around the HOPE spiritual needs assessment tool have been shared across teams. The community hospital wards are going to be working with the 'Creating with Care' team, using theatre techniques to work with patients and their families to identify wishes and needs at end of life. Unfortunately the local target of 100% of patients at end of life having a personalised care plan has not been achieved. Oxfordshire system-wide work, as part of the national ReSPECT[5] document - treatment escalation plans are being implemented to bring together information in relation to a patient's Do Not Resuscitate (DNR) status and advance care planning based on the patient's wishes. The Oxfordshire health and social care system is working on making the ReSPECT document digital although this will not be available until late 2022. In the interim, separate Do Not Resuscitate and advance care planning documents are in use, and a Do not Resuscitate teaching package has been developed by Oxford University Hospitals NHS Foundation Trust on behalf of the system and will be rolled out to staff across the Trust. Good progress is also being made with the EARLY project which is aimed at increasing the proportion of people on GP palliative care registers with a personalised end of life care plans. In December 2021 the Trust opened two beds to provide palliative inpatient care for patients requiring end of life services in close partnership with the charity Sue Ryder Care. Over 10 patients have been cared for in the beds so far. An evaluation has shown the service has been extremely well received by patients and their families.
Measure of Impact	See description above.

CE2. Support the delivery of initiatives within the Ageing Well work	
Self-assessment	Achieved New 2-hour and 2-day response service introduced. This is being enhanced further by more recent close working with Age UK Oxfordshire.
Evidence of Progress	Urgent community response is the collective name for services that improve the quality and capacity of care for people through the delivery of urgent, crisis response care within two-hours and or reablement care responses within two-days.

[5] Recommended Summary Plan for Emergency Treatment and Care

CE2. Support the delivery of initiatives within the Ageing Well work	
	The Trust is an accelerator site to implement a new urgent community response service, along with the other providers in the BOB Integrated Care System. The work is 3 years of transformation and 2021/22 is year 2. Year 3 with be a transition phase to set out the service model and funding needed long term. <u>2-hour response performance</u> *(crisis response due to urgent need and person at risk of admission to hospital. Involves assessment and short-term interventions)* Average number of patients seen per day is 14 against a local target of 20 per day. This trajectory has been amended for the next financial year (2022/23) to 13 per day due to funding limits that have been imposed. 78% of patients have been seen within the 2 hours against a local target of 80%. Call before you convey day; was a very successful initiative with South Central Ambulance Service (SCAS) and we have had national interest in this initiative, presented results and learning at a national conference. Future work: • Continued work with SCAS and Primary Care to increase referrals. • Medical model agreed with our acute partners. Recruitment to medical cover in progress. • Ongoing review of new service to ensure the pathway meets new national guidance <u>2-day response performance</u> *(fast access to reablement care for patients not being discharged from hospital to maximize independence. Intervention usually less than 6 weeks)* This part of the service was started from July 2021. Average number of patients seen per day is 12. 73% of patients have been seen in 2 days against a local target of 80% Future work: • Started an audit to improve performance. • Work with partners within BOB Integrated Care System to share learning. • Still waiting for national guidance to be released: national focus has been mainly on the 2-hour response. In addition, Age UK Oxfordshire have started working with us from January 2022 to further help improve the outcomes for patients in the community. This trial will run for 15 month, until March 2023. The community link networkers (Age UK Oxfordshire) work closely with the urgent community response service to support people to live well in their community. Age UK Oxfordshire have received 5 referrals since January 2022.
Measure of Impact	See above measures of number of patients seen per day and of these the % responded to within 2-hours and 2-days.

CE3. Develop the consistency and application of clinical supervision	
Self-assessment	Not achieved. This is a continued area for focus and included within the 2022/23 objectives.
Evidence of Progress	Our performance is below our local target of 85%. This has not been achieved due to operational pressures and issues with accurate reporting/ being able to capture the information on our central system. The accuracy of reporting has been an issue since the Trust moved to a new solution in September 2021. We are not confident with our central reporting of data at the moment and this is being tested. 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 supervision The actions that have been taken include: • A new Trust clinical supervision lead started in August 2021 to help embed supervision structures and to develop the quality of sessions. • NHSE/I are funding Professional Nurse Advocates and we have a range of nurses on these courses which will support embedding Restorative Supervision across our Trust. • Clinical supervision training for supervisors was re-launched in November 2021. • The "supervision toolkit" has been updated, this will reflect the changes to recording supervision and provide refreshed templates. • Communication campaign around the importance of supervision. • We have been taking a QI approach to understand barriers to low compliance and recording challenges on the central system.
Measure of Impact	See description above.

CE4. Improve clinical documentation and practice in relation to the Mental Capacity Act (MCA)	
Self-assessment	Achieved.
Evidence of Progress	Community Hospitals made changes to strengthen their processes to improve oversight and management of the Deprivation of Liberty Safeguards. The position in relation to any patients on Deprivation of Liberty Safeguards is reviewed at a senior Trust-wide clinical meeting weekly. Any patients waiting for authorisation by the Local Authority are monitored closely and waiting times have reduced in the last year as a result of monthly liaison meetings with Social Care and Advocacy Providers. This has also improved patients having more timely access to Independent Mental Capacity Advocates. Changes were made to the patient record systems used by teams to improve the recording and ease of finding information on a patients' mental capacity. Clinical audits have shown an improvement in documentation. Additional staff have been supported to undertake Best Interests Assessor Training. As part of improving practice around the Mental Capacity Act we have been preparing for the implementation of the new national Liberty Protection Safeguards and revised code of practice on the Mental Capacity Act 2005. The changes will mean greater responsibilities for health providers and were scheduled to be introduced from April 2022 but this has been delayed.
Measure of Impact	See description above.

13. Our Quality Improvement Plan for 2022/23

We have identified the following 14 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. A driver diagram[6] is a tool used to help organise change ideas/ improvement projects when dealing with complex change. To achieve our aim we have identified 6 main areas for change, known as drivers, and then identified the quality objectives under these.

In addition to the quality objectives, we will also continue developing our Quality Improvement Strategy and delivering the programmes on Improving Race Equality in the Workforce and Improving Quality Reducing Agency use (and vacancies).

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

The objectives were identified after a:

- Review of progress against the 2021/22 objectives
- Conversations with our staff and key stakeholders
- Analysis of themes from quality information over the last 12 months
- Review of the Trust's top risks to quality of care
- Evaluation of the quality improvement projects and national programmes that have recently started and need focus on in the next 12 months
- Review of national drivers and strategies for the NHS including the NHS Long-Term Plan and CQUIN[7] goals for 2022/23

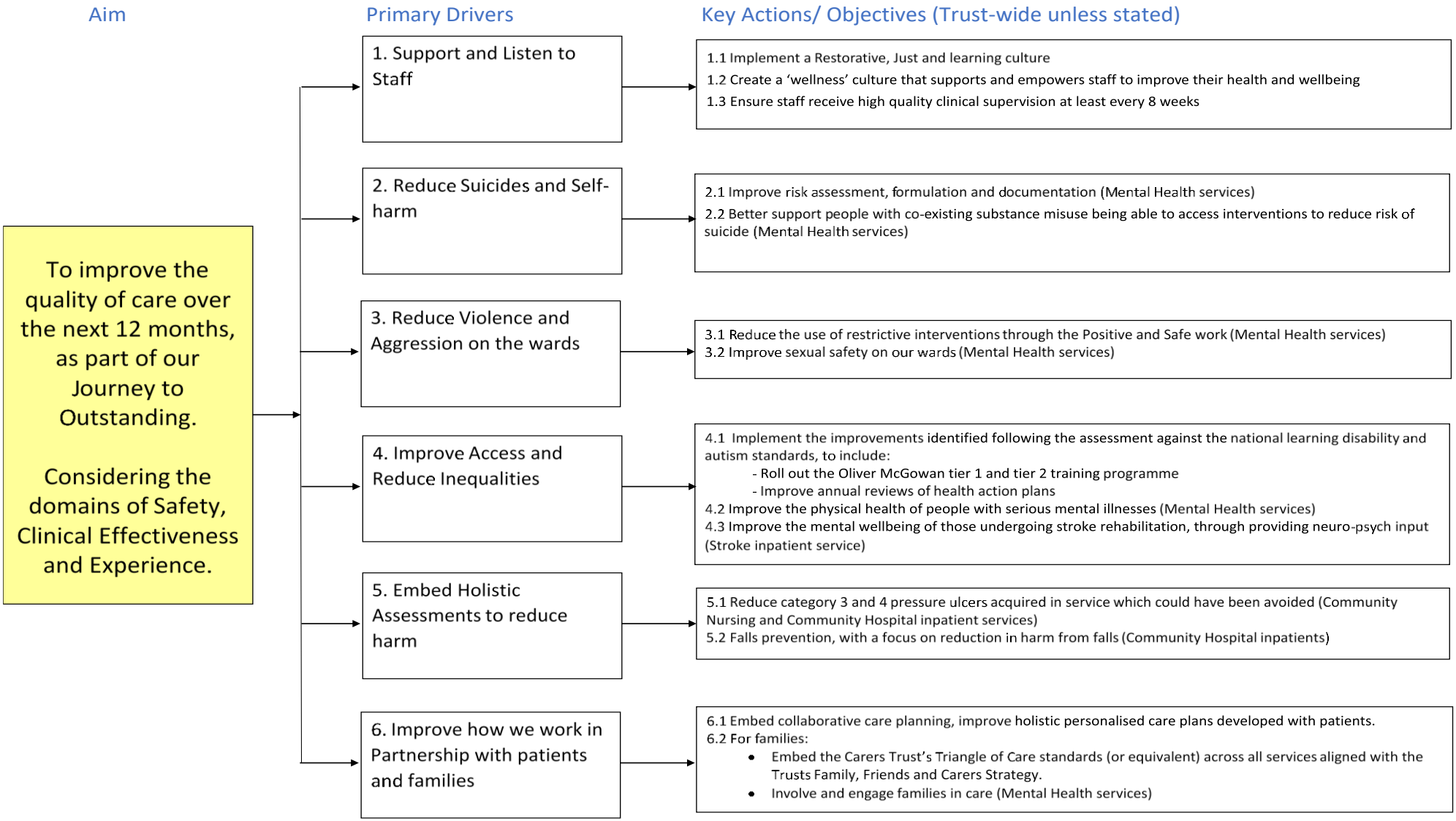
The objectives support the delivery of the goals in the Trust's Strategy 2021-2026, see appendix 1.

Each of the objectives will be broken down to identify key milestones, measures and what is expected to be achieved by 31st March 2023. The Trust's Quality Committee will monitor progress against the objective milestones quarterly. The Trust will publish our progress against each objective in our Quality Account next year.

[6] To find out more information about using driver diagrams https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-driver-diagrams.pdf

[7] The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to link a proportion of providers' income to the achievement of quality improvement goals

Driver Diagram identifying the Trust's 2022/23 quality objectives.



14. Glossary of Acronyms used in this report

In order of appearing in the document.

Acronym	Full Name
CQC	Care Quality Commission
ICS	Integrated Care System. When BOB ICS is used this is the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.
QI	Quality Improvement
IAPT	Improving Access to Psychological Therapies
NIHR	National Institute for Health Research
CAMHS	Child and Adolescent Mental Health Services
MHSDS	Mental Health Services Data Set
OAP	Out of Area Placements
CPA	Care Programme Approach
CAMHS	Child and Adolescent Mental Health Services
IPS	Individual Placement and Support
IWGC	I Want Great Care
FFT	Friends and Family Test
SI	Serious Incidents
POMH-UK	Prescribing Observatory for Mental Health- UK
PNA	Professional Nurse Advocates
CDOP	Child Death and Overview Process
LeDeR	Learning from lives and deaths – People with a learning disability and autistic people
BAME	Black, Asian and minority ethnic
SCAS	South Central Ambulance Service
CQUIN	Commissioning for Quality and Innovation

Appendix 1. The Trust's Strategy at a glance

NHS
Oxford Health
NHS Foundation Trust

Our strategy: At a glance

2021-2026

Our **four** strategic objectives:

1 Quality

Deliver the best possible care and health outcomes

To maintain and continually improve the quality of our mental health and community services to provide the best possible care and health outcomes. To promote healthier lifestyles, identify and intervene in ill-health earlier, address health inequalities, and support people's independence, and to collaborate with partner services in this work.

2 People

Be a great place to work

To maintain, support and develop a high-quality workforce and compassionate culture where the health, safety and wellbeing of our workforce is paramount. To actively promote and enhance our culture of equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment.

3 Sustainability

Make the best use of our resources and protect the environment

To make the best use of our resources and data to maximise efficiency and financial stability and inform decision-making, focusing these on the health needs of the populations we serve, and reduce our environmental impact.

4 Research

Be a leader in healthcare research and education

To be a recognised leader in healthcare research and education by developing a strong research culture across all services and increase opportunities for staff to become involved in research, skills and professional qualifications.

Mission

To be the **best Trust of our kind** in the country

Vision

Outstanding care delivered by an **outstanding** team

Values

Caring ● Safe ● Excellent

Appendix 2. Statements from our Partners on the Quality Account

Council of Governors

The year 2021-22 was challenging for Oxford Health FT, in common with the NHS more widely. Constraints imposed by the Covid pandemic impacted on services and staff, and exposed the inadequacies of funding which preceded it and which continue despite a welcome small recent uplift. The Council of Governors recognises that the Trust achieved some significant successes during the year, and Governors share the Board's concerns about a number of unresolved challenges.

On the positive front, the Trust established mass Covid vaccination services across the Thames Valley which delivered a highly impressive number of vaccinations. Oxford Health has been appointed lead provider Trust in a number of Provider Collaboratives (inpatient services for children and adolescents, adult eating disorders services, and secure services) which provide services more efficiently and effectively across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and wider geographical area. Innovative community services have been developed in Oxfordshire to reduce the need for hospital admission, particularly of older and vulnerable people with a range of physical health conditions. Collaboration with the Oxford University Hospitals Trust led to establishment of local provider collaboratives to deliver more effective urgent care, end of life, and podiatry services in the county.

The perinatal mental health teams in Buckinghamshire and Oxfordshire are proving highly effective for a critical population. A Youth Board has been established in Oxfordshire, and actions initiated to set up Youth Boards both in Buckinghamshire and the Swindon, Wiltshire, Bath and North East Somerset area. Other notable services are the Individual Placement and Support Service and the Recovery Colleges. Patient and carer feedback has been largely positive, but some significant criticisms still require action including listening to and engaging patients and families in their care.

Another mark of progress has been the Trust's recruitment of a number of Executive and Non-Executive Directors who bring wide and complementary experience and skills to the Board. The Trust's commitment to research has enabled marked achievements, reflected in the strength of the Trust's bid in conjunction with the University of Oxford for renewed funding for the prestigious Biomedical Research Centre.

The Council of Governors recognises and celebrates the Trust's achievements, but has shared concerns with the Board about a number of continuing performance issues. These include unacceptable waiting times for a number of services (especially physical and mental health services for children and young people), high numbers of Oxfordshire adult out of area mental health placements, physical restraints of patients, expensive reliance on agency staff in many wards and community teams, and (of great concern) staff recruitment, supervision and retention.

Governors have generally supported, but when necessary challenged, the remedial actions which the Trust has put in place to tackle these concerns. Governors recognise that many of the Trust's challenges result from the pandemic, but also from historic inadequacies of funding and national policies such as Brexit. The Council of Governors welcomes the Trust's Quality Improvement Plan for 2022-23, and will continue to work alongside the Trust Board, senior staff and partner organisations to ensure that the services provided for patients, and the experience of Trust staff and volunteers and the staff of partner organisations, are the best it is possible to achieve.

Mike Hobbs, Lead Governor, June 2022

NHS Oxfordshire Clinical Commissioning Group (OCCG) and NHS Buckinghamshire CCG (BCCG) have reviewed the Oxford Health NHS Foundation Trust (OHFT) Quality Account and believe that it is accurate and meets the requirements of a Quality Account.

The Trust quality priorities are described in detail in section 12 of the quality account. The Trust has demonstrated achievement of several of the priorities. The Safety domain has seen the greatest challenges with achievement, affecting both community and mental health directorates. The avoidable harm from pressure ulcers is referenced throughout the report and the Trust has agreed to develop a whole trust Pressure Ulcer Prevention Strategy.

The priorities that were not achieved in full, or at all, have comprehensive mitigating descriptions around actions taken and achievement. Some of these remain priorities within the new trust priorities for 2022/23. The priorities not achieved affect both community and mental health services, as well as ongoing staff supervision and support.
In the quality account, OHFT have outlined their Quality Improvement Plan for 2022/23.

The objectives reflect priorities not achieved in 21/22, and the new additions appear to have a sound basis for inclusion. The priorities reflect new themes, such as reducing violence and aggression; as well as some existing challenges, such as suicide risk assessment and support planning, management of pressure ulcers and working in partnership with patients and families across all care settings. The new priorities outlined are supported by OCCG and BCCG.

Within the account, OHFT describes achievement against the NHS Oversight Framework indicators; the report highlights either similar performance to national peers, or better performance when benchmarked. The account identifies areas for improvement in out-of-area placements in particular. This is more of a challenge within Oxfordshire than Buckinghamshire. The conclusions and mitigations in this section seem a fair reflection on the Trust's performance and challenges.

The Trust has outlined several key headlines within the account. Provider collaboratives represent a new balance in the relationships between, and responsibilities for, commissioning and improving the quality of whole pathways of care. OHFT has also effectively mobilised, staffed and delivered a significant proportion of the vaccination programme against COVID-19, through a Mass Vaccination Centre, pop-up centres and other routes – this has been key to the success of the vaccination programme locally.
The Quality Improvement (QI) Strategy has been rolled out, with several valuable projects listed. This approach will be integral to overcoming some of the challenges the organisation faces with avoidable harm associated with staffing shortages across services such as District Nursing and Podiatry. These services are clearly staffed with many dedicated and caring people; a QI approach will support sustainable improvements across the Trust.

The Trust has a highly committed and compassionate workforce; there are too many achievements to list individually, especially given the context of working within the COVID-19 pandemic. It is clear that the Trust has many reasons to be proud of the achievements of its staff.

Looking to 2022/23 – the organisation is within a healthcare system forming into an Integrated Care Board (ICB). There is an opportunity to improve the way providers and commissioners work, with a far greater focus on joining forces for common goals. We look forward to the positive impact on quality this integration will bring. We are keen to see improvements to patient safety in both community and mental health services. In community service, avoidable harms in Podiatry are undoubtedly affected by staffing. We are

confident that the improved cross-organisational work with Oxford University Hospitals NHS Foundation Trust (OUHFT) and OCCG will lead to sustainable improvements for patients and staff.

The District Nursing service experiences a high level of demand alongside staff challenges which are a national issue. The avoidable harms from pressure damage is the most significant result of the challenges within the service. The CCGs are keen to support digital improvements in patient care, risk assessment and record keeping to support a skilled workforce use their time as effectively as possible.

Within the mental health services there is evidence of improved cross-organisational working. The report highlights general improvements in reducing incidents of patient self-harm. The organisation has identified risk assessment, safety and care plan formulation, and the involvement of patients and family as areas for improvement. We support this focus and believe that it offers an opportunity for the Trust to make a real difference to patient care and safety.

The Trust partially achieved an objective to implement an e-learning course for staff on an introduction to Autism; the Reasonable Adjustment Service is being expanded; OCCG & BCCG both advocate additional training and monitoring on the implementation of reasonable adjustments.

We look forward to working with Oxford Health in 2022/23.
NHS Oxfordshire CCG & NHS Buckinghamshire CCG

Diane Hedges
Deputy Chief Executive
Oxfordshire CCG

OXFORDSHIRE COUNTY COUNCIL

Cllr Jane Hanna OBE

Chair, Health Overview and Scrutiny Committee

Jane Kershaw
Head of Quality Governance
Oxford Health NHS FT

13 June 2022

Dear Jane

Re: Oxford Health's (OH's) Draft Quality Account 2021/22 and Priorities for 22/23 – Response from the Health Overview and Scrutiny Committee (HOSC)

Many thanks for attending Committee on 10 June and presenting to us a very clear and accessible report – including a glossary of acronyms. HOSC has been emphasising the importance of accessible reporting throughout the year and this report is a good practice example.

I and the Committee continue to recognise the significant impact of Covid-19 on OH's work over the past year. We remain acutely aware of the pressures on you and your teams and the impacts which this has had on workloads and on physical and mental health across OH. As such, this Committee remains very grateful for the work which OH does and for your time in bringing details of it before the Committee.

The Committee also wish to note the Trust's overall rating of Good by the CQC and that it has received a number of national awards during the year as well as being ranked second for a number of research studies. The Committee also wishes to welcome the emphasis on culture and values at OH and that the Trust has maintained engagement of staff within the national feedback survey.

Points raised and responded to Committee, and additional points raised after the meeting : -

1. Staffing – The Committee recognised the serious challenges faced by the Trust in respect of sickness absence and workforce shortages. It is hoped that the Trust will embrace agile working and additional flexibility to staff to drive recruitment and retention. This of course has to be balanced with the delivery of a quality service. We welcome the Trust's efforts in relation to international recruitment but question the long term sustainability and ethics of it.

2. Consistency and Application of Clinical Supervision – we note this was not achieved but it included as a key action for next year.

3. Child and Adolescent Mental Health Services (CAMHS) – Access issues were highlighted on page 11. We welcomed OH to HOSC on 10 March to outline current service pressures and opportunities for service improvement. We noted the whole system prevention agenda in this space and since then, HOSC has closely followed the development of the emotional health and wellbeing service for children and young people. We hope that future strategies of the Trust and the Integrated Care Board prioritise such funding.

4. Out of Area (OOA) Placements – We note the high cost and high impact on families and carers that OOA placements have. The Trust will note that the Clive Treacy report is applicable in this space, and not just for service users with a learning disability.

5. Physical Heath Improvements – The Committee were concerned about the way in which the Trust implements such health checks and that targets have not been achieved. The Committee has highlighted this in previous years.

6. Next Year's Objectives – We would have welcomed a little more detail on the future objectives but look forward to working with you over a longer timescale next year to support a richer conversation at HOSC.

7. Engaging with Oxfordshire's Diverse Communities – We note that only 6% of respondents to feedback are from a BAME background, against a total population of 16% (page 19). We would wish for OH to do more work with the BAME communities to draw out their feedback and influence priorities and service delivery.

I and the Committee are very supportive of your priorities for 2022/23 and we remain very keen to continue to support OH and the wider health and social care system in the coming year. We have a challenging work programme ahead of us this year; we mentioned the topic of serious mental illness at Committee and you were supportive of the Committee's interests. Whilst we are busy, this must not prevent OH coming to talk to HOSC if there are matters or proposals which OH would like the Committee's engagement on.

Yours sincerely
Cllr Jane Hanna OBE
Chair, Oxfordshire Joint Health Overview and Scrutiny Committee

Jane.hanna@oxfordshire.gov.uk

Contact: Helen Mitchell, Interim Health Scrutiny Officer
Helen.mitchell@oxfordshire.gov.uk

13th June 2022

Dear Dr Broughton,

Oxford Health Quality Account Statement 2021-22

Thank you for letting Healthwatch Oxfordshire have an opportunity to comment on the Quality Account statement prior to publication. We received the document at a very late stage and so have restricted our comments to areas that resound with Healthwatch responsibilities, specifically hearing the patient voice and those that impact on patent experiences of services.

1. Reducing waits for children – a Trust priority (page 11). Healthwatch Oxfordshire knows that the quality of patient experience of a service starts from the point of referral. There is nothing in the quality account that shows what the Trust has done in 2021-22 to reduce waiting times for children and families other than support parents whilst they wait. What harm reviews does the Trust carry out for those on waiting lists? The quality priorities for 2022-23 do not appear to address this either. Primary Driver 4 could include a Key Action / Objective to reduce waiting times for children with specific actions included.
2. National objects eliminating inappropriate adult acute out of area placements (page 13). We note that Oxfordshire has an increasing number of these placements 'which the Trust has managed by purchasing a block contract of beds with an independent sector provider'. We would be assured that this approach was improving the quality of patient care and experience of care to know if this provider is located in the county or if not how far away. This impacts not only on continuity of care and closer oversight of quality but also on the quality of experience of patients and impacts on family's ability to support patients.
3. We are assured to read about the initiatives the Trust has implemented and planned for regarding involvement and engagement of patients over the past year. In next year's Quality Report we would like to see the impact these have had on patient experience and delivery / design of services.
4. We are pleased that the Healthwatch Oxfordshire report on using interpreters to access health and social care has had an immediate impact the Trusts website. (Page 21). We hope that this is not the end, and that staff will continue to be reminded to offer interpreter support for all services; together with wide promotion of the right of patients to have an interpreter at all appointments. Would urge the Trust to actively engage community members in developing communications with communities about this.
5. Interesting that the Trusts review of community services in Oxfordshire is not mentioned. Would like to see from the Trust how this review will improve quality of care in community services, a commitment to involving patients in service design and development, and a priority for 2022-23.

Finally can I ask that you pass onto all staff and volunteers at the Trust our thanks for their ongoing commitment to serving the population of Oxfordshire and congratulate you and your teams on being award winners, and leaders in their field.

Yours sincerely,

Rosalind Pearce, Executive Director