Integrated Performance Report (IPR) Report: January 2023

December 2022 data unless stated otherwise

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

Section 1:

Introduction to the Trust strategy 2021-2026

Introduction to the Trust Strategy 2021-2026

Introduction to the Trust Strategy 2021-26

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

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

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

Key focus areas and Objective Key Results

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

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

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

Section 2:

‘At a Glance’ Performance and Trust Headlines;

An overview of performance relating to;

- National Oversight Framework
- Delivery of the strategic objective key results (OKRs)

Key risks, issues and highlights are provided by the Executive Managing Directors

‘**At a glance’ performance** – delivery of strategic objectives and NHS oversight framework

This page provides a ‘at a glance’ view of performance against the **5 key sections of this report**. Further detail relating to performance of each section can be found on the report pages shown below.

Report Section	# of metrics	# Targets achieved	Description	Report pages
NHS Oversight Framework (NOF)	8 (all have a target)	6	Overall performance is good, with the exception of the number of **inappropriate out of area placements (both Oxon and Bucks indicators).** Metrics dated June/July have not refreshed due to unavailability of data nationally following the clinical information systems outage.	Pages 9-10
Strategic Objectives – **Quality; Deliver the best possible care and outcomes**	18 (7 have a target)	3	We do not have up to date data for 2 of the 4 non-performing metrics due to the clinical information systems outage. Their last known performance, however, was non-compliant (**improved use of the Lester Tool in EIP and AMHTs)** The other 2 areas of non-compliance are; • **clinical supervision** • **evidence patients have been involved in their care and**	Pages 15-22
Strategic Objectives - **People; be a great place to work**	9 (8 have a target)	1	• **Agency usage, sickness rate, turnover, early turnover, vacancy rate, PDR compliance and Statutory and Mandatory training** are not yet achieving targets	Pages 23-30
Strategic Objectives - **Sustainability; make the best use of our resources and protect the environment**	4 excl. the NOF OKR (all have a target)	3	The **CIP plan** for the year is £7.9m with delivery profiled evenly over 12 months. £4.4m has been delivered at month 9 which is £1.5m adverse to plan due to limited resource time available to create and develop schemes.	Pages 31-33
Strategic Objectives – **Research & Development**	2 (no targets)	-	The Trust is ranked 6th Nationally for participants recruited to CRN Portfolio studies and 3rd Nationally for CRN Portfolio studies that recruited this FY	Page 34

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

Executive Director commentary: Grant MacDonald, Executive Managing Director, Mental Health, Learning Disabilities and Autism
Narrative updated: 17 January 2023
For reporting period ending: 30 December 2022

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Workforce challenges	Issue	The central recruitment team have recovered to support the services in ensuring there are a rolling campaign to fill vacancies alongside exploring creative approaches to attraction. Alongside this there are several 'new role' initiatives being pursued as well as opportunities for appropriate oversees recruitment; together with a range of organizational development activities to support retention. In particular, 32 training paces have been secured for Psychological Wellbeing Practitioners. Finally temporary staff are used to maintain service levels and the agency management work programme is aiming to reduce reliance on, and cost of temporary workers sourced in this way.
CIP programme	Risk	The primary focus this year is cost control and identifying agreed costs and associated budgets as part of H2 work and planning into FY24
Cost Control	Risk	Alongside the agency reduction programme and work to reduce out of area placements the key cost reduction work is aimed right sizing the requirements for additional staff to manage fluctuations in acuity.
Acute Out of Area Placements (OAPs)	Risk	The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control. There has been minimal use of inappropriate OAPs from April through to November however December and January levels have been relatively high following a significant spike in demand the associated activity and clinical complexity. This is also in part due to the reduction in commissioned beds (appropriate OAPs) from 21 to 4 or a monthly bed day reduction of circa 500 days.

Directorate highlights and escalations: Primary, Community and Dental Care

Executive Director commentary: Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care
Narrative updated: 17 January 2023
For reporting period ending: 31 December 2022

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
National Advanced IT Outage and Critical Incident Response	Issue and Risk	The roll-out of EMIS Web in an accelerated timescale was completed successfully in December in all non-ward-based community services (excluding District Nursing, which was completed in January). Feedback from staff has been positive and the clinical risks have been closely monitored through the harm review group and other quality reporting processes. The consensus is that this deployment has gone well with minimal disruption. A plan continues to progress with OUH partners to implement Cerner EPR into ward-based services, such as Community Hospitals and H@H. It is hoped this will roll-out early in the new year.
First Contact Care Service Pressures	Risk	During the November-December period, our urgent care services (especially urgent community response, out-of-hours GP and MIUs) saw a substantial increase in referrals and other patient activity. At peak the activity in our out-of-hours GP service was 60% above the average activity levels seen throughout the year, which unfortunately led to longer waiting times for some patients. This experience was mirrored by other providers and driven by surges in Group A Strep, influenza, covid and other respiratory conditions and a large increase was seen in children presenting to the service. Mutual Aid arrangements were put in place across the ICS and additional staff were deployed in the service to improve safety and help manage capacity challenges. In response to the Group A strep outbreaks, point-of-care testing was deployed into all our out-of-hours GP centres with good effect.
System and financial pressures	Risk	Due to ongoing system pressures we continue to face ongoing capacity issues in our preventive and planned care, children's services and first contact care pathways. This has put significant pressure on our financial plan, due to the requests from the system to increase staffing and capacity in response to ambulance handover delays, deteriorating Emergency Department performance and OPEL 4 status. We also continue to experience discharge delays in community hospitals and rehabilitation services due to limited availability of home care / reablement and are participating in a project with Adult Social Care (OCC) and OUHFT colleagues to develop a Transfer of Care team to facilitate more effective and timely hospital discharges.

Section 3:

NHS Oversight Framework performance

National objective: Compliance with the NHS Oversight Framework

This year, the NHS Oversight Framework indicators that have targets are;	Target	National position	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	65% (Dec)	88.8% (July)	↓
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	67.7% (June)	88.2% (June)	↑
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	54.2% (June)	94.3% (June)	↓
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	46.5% (June)	48.5% (June)	↑
(N5) IAPT - Percentage of people waiting six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	75%	89.0% (Oct)	99% (Aug)	↑
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.4% (Oct)	100% (Aug)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	171 (Dec)	↑
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	243 (Dec)	↑

Executive Summary: Martyn Ward, Director of Digital and Transformation
Narrative updated: 13 January 2023 for reporting period ending: **31 December 2022**

About: The NHS Oversight Framework replaced the provider Single Oversight Framework and the clinical commissioning group (CCG) Improvement and Assessment Framework (IAF) in 2019/20 and informs assessment of providers. It is intended as a focal point for joint work, support and dialogue between NHS England, Integrated Care Systems (ICS), and NHS providers. The table above shows the Trust's performance against the **targeted** indicators in the framework. Areas of non-compliance are explained overleaf. The Oversight metrics have changed for FY22/23, work is underway to review how best to report these in future board IPRs.

Performance: The Trust is compliant with the targets in the Framework, with the exception of the number of inappropriate out of area placements (OAPs). Please see overleaf for more information. Indicators dated June/July have not refreshed due to unavailability of data nationally following the clinical information systems outage therefore, no commentary is provided based on historical positions.

National Objective: areas of underperformance

NHS Oversight Framework Metric	Target	Actual
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Bucks)	0	171

NHS Oversight Framework Metric	Target	Actual
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Oxon)	0	243

Executive Director commentary: Martyn Ward, Director of Strategy and CIO
Narrative updated: 17 January 2023
For reporting period ending: 31 December 2022

The issue and cause
The use of Out of Area Placements increased in December and were relatively high compared to previous months. The reason for the increase was due to a significant spike in demand, the associated activity and clinical complexity.

The plan or mitigation
Following NHSE guidance the Trust has reviewed the use of OAPs and is assured that continuity of care principles are adhered to. Reporting from April 2021 reflects this change and please note this change when viewing performance against historical trends. **December 2022 locally reported total bed day usage was 414 days (171 inappropriate OAP bed days in Bucks, and 243 inappropriate OAP bed days in Oxon).**

Section 4:

South East Regional Performance including Provider Collaborative Performance

SE Regional Performance – Integrated Performance Report

Commentary by: Claire Page, Head of Performance and Information
Narrative updated: 12 January 2023
For reporting period ending: 16th December 2022 (latest SE Integrated Performance Report received)

Weekly data 29 weeks to 15 December 2022:

Bed occupancy comparison not included as OHFT data not available due to system outage.

Mental Health - No. of people awaiting admission:
The number of people awaiting admission to Oxford Health is low in the region, averaging 6 people over the past 29 weeks.
Across 8 providers the total number of people awaiting admission is 63 on average.

Inappropriate Out of Area Placements (OAPs): not included in regional reporting as OHFT data not available automatically due to system outage. The Trust is exploring if the information reported manually for internal Trust purposes can be flowed in the weekly national return.

Availability of 136 suite: 136 suite availability in Oxford Health is above the regional average of 37%, at 60% availability over 29 weeks as at the weekly snapshot position.

SE Regional Performance – Integrated Performance Report Provider Collaborative

Commentary by: Gillian Combe, Clinical Director, Thames Valley CAMHS Provider Collaborative
Narrative updated: 17.01.2023
For reporting period ending: 31 January 2023

Demand:

- Low numbers of cyp awaiting admission
- Inappropriate out of area bed use 5 children and young people (CYP)
- 2 delayed discharges

Initiatives:

- Hospital@Home for Eating Disorders now substantive and expanding to12 cyp caseload
- Hospital@Home for moderate to severe learning disabilities and autism consultant recruited and adverts for other posts out
- ALPINE guidelines for eating disorders continue to be rolled out across the Paediatric wards. Results of analysis show an additional impact of reduced admission to Paediatric wards as staff confidence in treating in the assessment unit has improved

Current pressures:

- Changes in leadership at Taplow Manor with enhanced support from PC
- Taplow media coverage continues with further report expected
- NHSE scrutiny of Taplow Manor work
- Staff shortages in the PC

Section 5:

Delivery of our four strategic objectives

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

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee
Reported period: December 2022 unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results (OKRs) are;	Target	Comm Services	Oxon & BSW	Bucks	LD	Forensics	Pharm	**Trust**	**Trust Trend**
(1a) Clinical supervision completion rate	95%	45%	68%	74%	73% (Specialisd Dir)			61%	↑
(1b) Staff trained in restorative just culture	TBC	-	-	-	-	-	-	28	↑
(1c) BAME representation across all pay bands including board level	19%	15%	19%	31%	11.3%	43.8%	25.4%	20.3% (Q3)	↑
(1d) Cases of preventable hospital acquired infections - YTD	<3	-	-	-	-	-	-	0** YTD	→
(1e) Reduction in use of prone restraint	TBC	-	12	3	-	43	-	58 uses	↓
(1f) Patient safety partners employed	2 YE	-	-	-	-	-	-	0	n/a
(1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP)	90%	-	88%	70%	-	-	-	81% (July*)	n/a*
(1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT	75%	-	66%	61%	-	-	-	64% (July*)	n/a*
(1g) Evidence patients have been involved in their care (clinical audits) reported bi-monthly	95%	97%	70%	85%	-	-	n/a	80% (n=348)	n/a
(1h) Clinical staff in non-learning disability services have completed internal eLearning on autism	-	-	-	-	-	-	-	See narrative	→

* Latest available data due to Carenotes outage.
** 1 MSSA on Wenrisc ward to still be reviewed by system meeting.

The arrows indicate the trend against the last reported position

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

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee
Reported period: **December 2022** unless otherwise indicated in brackets in the penultimate column

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

This year, our Objective Key Results (OKRs) are;	Target	Comm Services	Oxon & BSW	Bucks	LD	Forensic	**Trust**	**Trust Trend**
(1i) Numbers of Pressure Ulcers developed in service category 3 and grade 4	TBC	9	0	0	0	0	9	-
(1j) 48 hour follow up for those discharged from mental health wards	TBC	-	-	-	-	-	-	-
(1k) 72 hour follow up for those discharged from mental health wards	TBC (80% national)	-	-	-	-	-	73% (July*)	-
(1l) Inpatient Length of Stay (LOS) excl delay/leave – Mental Health Adult Acute	TBC		58 days	76 days			66 days (July*)	↑
(1m) Inpatient Length of Stay (LOS) – EMU	TBC	9 days	-	-	-	-	9 days (July*)	↓
(1n) Inpatient Length of Stay – Stroke	TBC	31 days	-	-	-	-	31 days (July*)	↑
(1o) Inpatient Length of Stay – Rehab	TBC	27 days	-	-	-	-	27 days (July*)	↓
(1p) Medically fit for discharge (MFFD) – Community	TBC	79	-	-	-	-	79 (July*)	↓

* Latest available data due to Carenotes outage.

The arrows indicate the trend against the last reported position.

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

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

Executive Summary: Marie Crofts, Chief Nurse
Narrative updated: 16th January 2023
For reporting period ending: 31st December 2023

Four OKRs which are underperforming year to date;

- Clinical supervision
- Completion of the Lester physical health tool for relevant patients on the AMHT caseloads
- Evidence patients have been involved in their care
- Staff training on Autism awareness and reasonable adjustments

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

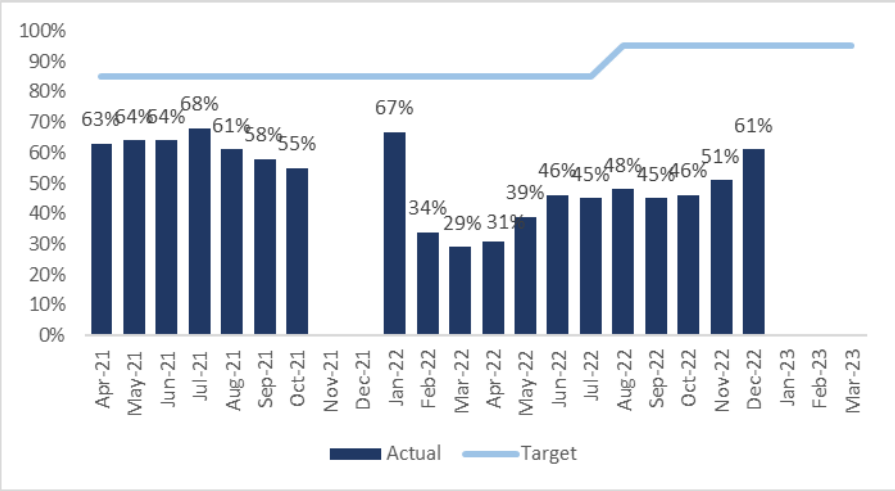
The review of the current Quality OKRs has been paused due to the attention needed to support the efforts around the IT outage which happened from early August 2022. This task is still needed so that the key indicators are monitored and reported here.

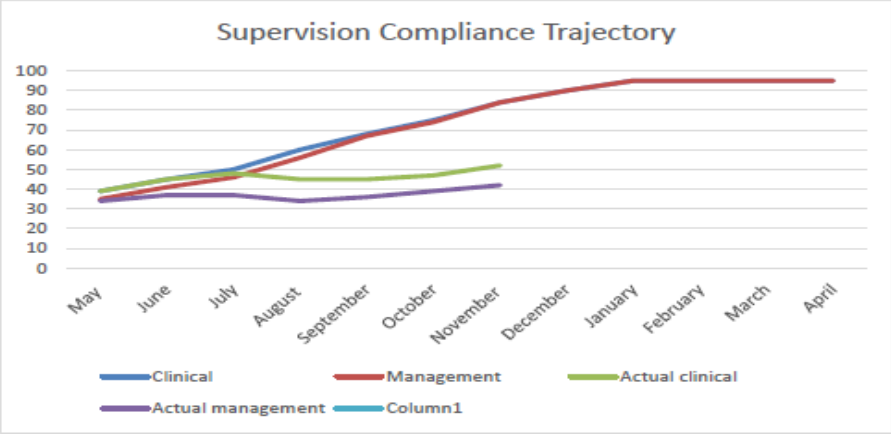
The Trust is carrying out Quality Improvement Projects in the following areas relevant to the Quality OKRs;

- Positive and Safe – reducing restrictive interventions including use of prone restraints
- Risk Assessment formulation and documentation
- Working with families and carers, alongside implementing the Carers, Friends and Family Strategy 2021-2024
- Improving co-production in care planning, which is a core part of the co-produced Patient Experience and Involvement Strategy being finalised Equality, Diversity and Inclusion programme

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	95%	61%





Executive Director commentary: Marie Crofts, Chief Nurse

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

The cause
Increased demand on clinical teams and issues with accuracy of reporting from OTR.

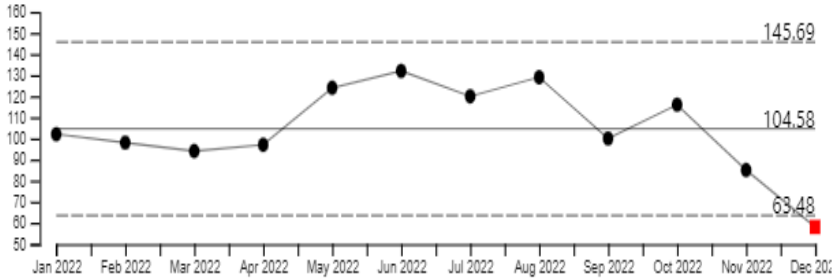
What is the plan or mitigation?
There has been an improvement across every Directorate in December however we are behind the trajectory.

A Supervision Steering Group meets monthly to lead on the recovery plan. Work is focused on; accuracy of reporting, developments to the OTR system for recording, training for supervisors and targeting services with the poorest rates.

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint	TBC	58

How many incidents involved prone restraint?



Executive Director commentary: Marie Crofts, Chief Nurse

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

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

What is the plan or mitigation?
The graph shows the use by month for all wards. There had been an increase in use from December 2021 relating to a single patient on a forensic ward who is very unwell and waiting placement in a higher secure environment. However more recently there has been a decrease.

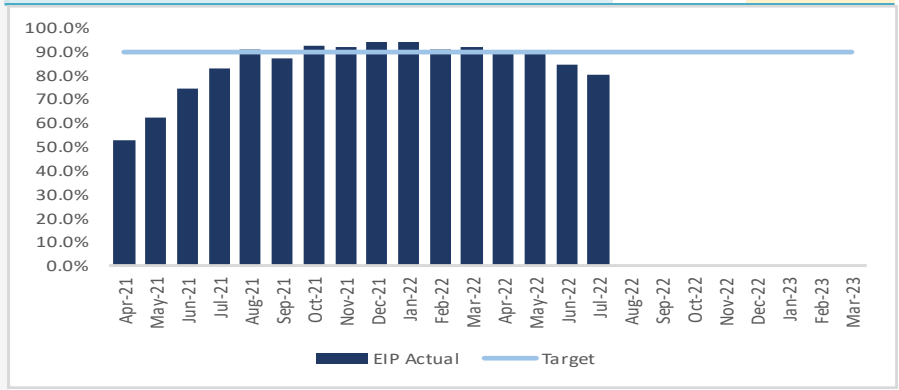
A large-scale QI programme is underway to reduce the use of restrictive interventions, including a project on reducing prone restraint. The Trust's Positive and Safe Committee is driving the work.

There are a series of tests of change/ actions being taken and we are seeing a reduction in the number and duration of prone restraint. Use is monitored by a Trust-wide group weekly and also through the individual QI projects on specific wards.

Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1fb) Improved completion of the Lester Tool for people with enduring serious mental illness (AMHTs for patients on CPA)	75%	64% (July)

Objective Key Result (OKR)	Target	Actual
(1fa) Improved completion of the Lester Tool for people with enduring serious mental illness (EIP teams for patients on CPA)	90%	81% (July)



Executive Director commentary: Marie Crofts, Chief Nurse

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

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

The plan or mitigation
We are unable to report on the completion rate for the Lester screening tool following the IT outage/ transition to RiO. Soft data from the directorates is there is an increase in clinical activities in terms of more physical health clinics being offered and new equipment has been purchased.

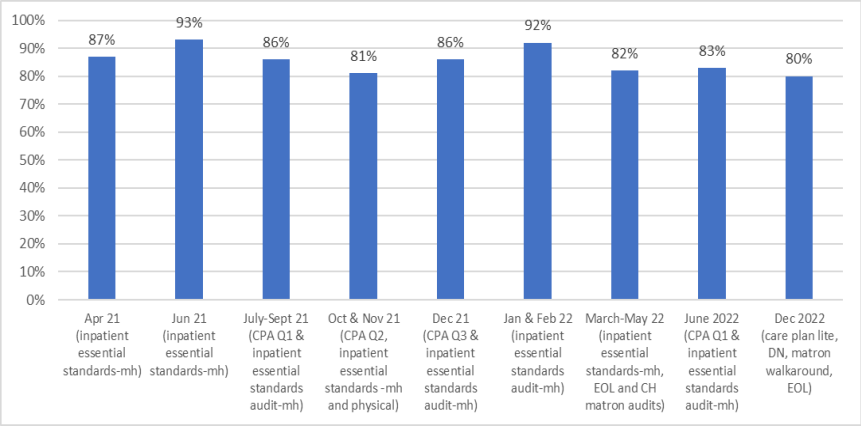
There is an improvement plan in place with 3 workstreams overseen by senior clinicians.

The focus in 2022/23 is:

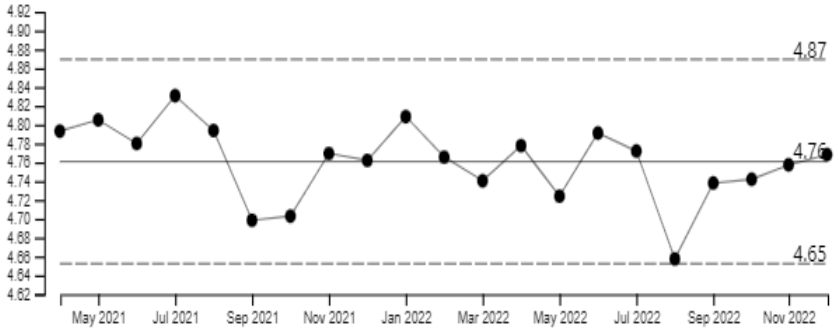
- Make changes to the physical health forms on the patient record
- Expand tobacco dependency long term plan goal
- Diabetes management on the wards
- Education and training for staff – physical health skills for wider team
- Develop patient information
- Enable patients to access own digital records e.g. health locker
- Increase the role of peer support workers and introduce community volunteer roles to promote screening
- Improve flexibility and mobility of testing to reduce DNA through mobile clinics and individual kits by nurse.

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1g) Evidence patients have been involved in their care (bi-monthly clinical audit)	95%	80%



Based on local patient and carer survey results;
The below graph shows the average score for the survey question- **were you involved as much as you wanted to be in your care and treatment?**



Executive Director commentary: Marie Crofts, Chief Nurse

The context

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

Our local survey data (IWGC) shows no substantial change in response to the question 'was someone involved as much as they wanted to be in their care'. Last 12 months ave. 4.75 out of 5, n=8,675.

The **national annual community mental health survey results for 2022** showed small improvements in this area from 2021;

- Patients feeling involved in deciding and planning care (Trust 7.3 against average 7.4)
- Patients feeling decision were made together when reviewing care (Trust 8.0 the same as the average 8.0)

The clinical audit results are based on a review of 348 records in Nov and Dec 2022.

The plan or mitigation

QI work
A number of quality improvements projects are underway with a focus on person centred care and care planning. Examples below;

Strategy
A co-produced Patient Experience and Involvement Strategy is in development, a central part of this is to improve personalised care.

Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1h) Clinical staff in non-learning disability services have completed internal eLearning on autism	TBC	See narrative

Executive Director commentary: Marie Crofts, Chief Nurse

The Context and plan

Local training

New internal training was developed by the Trust in 2021 and is available to staff to complete via the Trust's learning and development portal. The roll out of the training to make it mandatory for all staff was put on hold as pilots for the new national (Oliver McGowan) training started.

National training

The Trust was involved in the pilot of the new national training (Oliver McGowan) in 2021, which **125 staff attended**.

The **new national eLearning package for tier 1 (all staff) and 2 went live on 1st Nov 2022**. Staff only need to complete tier 1 OR tier 2. The Trust is making the elearning available on OTR for staff to be able to record completion. This will become mandatory training. The second part of both tier 1 and 2 of the training is being implemented at BOB ICS level as we need to have a cohort of train the trainers to facilitate the 1 hour interactive session (for tier 1) and the 1 day session (for tier 2) both completed after the elearning package. The train the trainers national package will not be available until early 2023.

Tier 3 training is already in place and available to staff.

Support and services

Below are some of the other activities we are doing to improve how we work with and support people with autism:

- The Reasonable Adjustment Service at the Trust is supporting mental health clinicians to better understand and support the needs of autistic individuals with reasonable adjustments and adaptions. The service is being expanded with additional funding and recruitment is underway. A Buckinghamshire lead has also been employed.
- Bespoke training sessions are being delivered to mental health wards and community teams, as well as regular support sessions for inpatient staff to discuss specific patients.
- Working with our autistic patients/ experts by experience we are developing an autism reasonable adjustment passport to support access to mental health services. This is being piloted.
- Resources have been developed to support clinical teams with making communication more autistic inclusive.
- We are also providing consultation and support from an adjustment perspective to individuals who do not meet the criteria for Learning Disability services but our mental health services are inaccessible.
- A new BOB wide ASD patient forum has been developed. The focus of the group will be on how to improve the experiences of autistic service users and their carers.

Objective 2: People – be a great place to work

Governance: Executive Director: Chief People Officer | **Responsible Committee**: People, Leadership and Culture Committee
Reported period: **December 2022** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results are;	Target	Bucks Mental Health	Comm Services	Corporate Services	Estates and Facilities	Research and Development	Oxon and Sw Mental Health	Lds Pathway	Forensic	Pharmacy	Trust	National comparator	Trust Trend
(2a) People Pulse Staff Engagement scoreQ2(2022)	>/=?	6.33↓	6.84↑	6.87↑	-	-	6.69↓	Only available at directorate level 6.81%↑ for Specialised Services			6.74	n/a	
(2b) Reduce agency usage to NHSE/I target Excludes covid spend	</ 7.9%	26.9%↑	9.2%↑	1.4%↑	9.0%↑	0.0%→	16.7%↑	8.2%↑	14.1%↑	0.0%↑	13.2%	ModHos 8.7%/ Peer 7.9%	↑
(2c) Reducing staff sickness to 3.5% over 2021/22	</=3.5%	7.3%↑	7.9%↑	4.2%↑	7.5%→	3.9%↑	5.2%↑	6.6%↑	8.8%↑	4.8%↓	6.6%	ModHos 5.2%/Peer 4.4%	↑
(2e) Reduction in % labour turnover	</=10%	17.7%↓	16.5%↑	11.6%↑	16.1%↑	23.2%↑	16.5%↑	19.2%↓	18.5%↓	13.7%↑	16.2%	ModHos 19.1 Peer 21.3%	↑
(2f) Reduction in % **Early** labour turnover	</=10%	20.1%↑	20.5%↑	12.3%↓	20.6%↑	23.3%↑	20.1%↑	0.0%→	27.6%↓	50.2%↑	19.4%	None	↑
(2g) Reduction in % vacancies	</=9%	17.2%↓	2.7%↑	-5.6%↓	19.8%↑	42.6%↓	20.2%↑	15.6%↓	23.2%↑	4.7%↑	12.2%	ModHos 10.5% Peer 11.2%	↓
(2h) PDR compliance	>=95%	48.8%↑	39.3%↑	35.0%↑	37.7%↑	28.6%↑	39.3%↑	56.0%↑	59.2%↑	28.0%→	41.4%	None	↑
(2i) S&MT (Stat and Mandatory training)	>=95%	83.6%↑	85.2%↑	82.9%↑	84.0%↓	73.9%↑	82.7%↑	81.1%↑	86.2%↑	72.4%↓	83.8%	None	↑
(2j) Number of Apprentices as % substantive employees	>=2.3%	6.8%↓	6.2%→	3.1%↓	0.0%→	0.0%→	4.8%↓	7.4%→	3.4%↑	0.0%→	5.1%	None	↓

Objective 2: People – be a great place to work

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

Executive Summary: Charmaine De Souza, Chief People Officer,
Narrative updated: January 2022
For reporting period ending: December 2022

The overall workforce position for the last period continues to be challenging and the recent weeks have seen nurses taking strike action in OHFT on two days in December in relation to fair pay. Approximately 220 nurses reported as striking on each day and the process to agree derogations of services took up significant time given the input required from corporate and clinical colleagues.

Headlines in relation to the OKRs below:

- The IQRA programme has now reset the plan for a 12 week period and refocused activity in relation to Retention and Recruitment with a view to resetting again in January for the second 12 week block. Significant amounts of resource across the Trust have been directed at the implementation of a new contract with NHS Professionals to manage our bank staffing - this is planned to go live in February 2023. The medical staffing workstream has gained pace and is progressing with the procurement process to engage a Master Vendor Contract which will enable the Trust to make immediate cost avoidance through direct engagement.

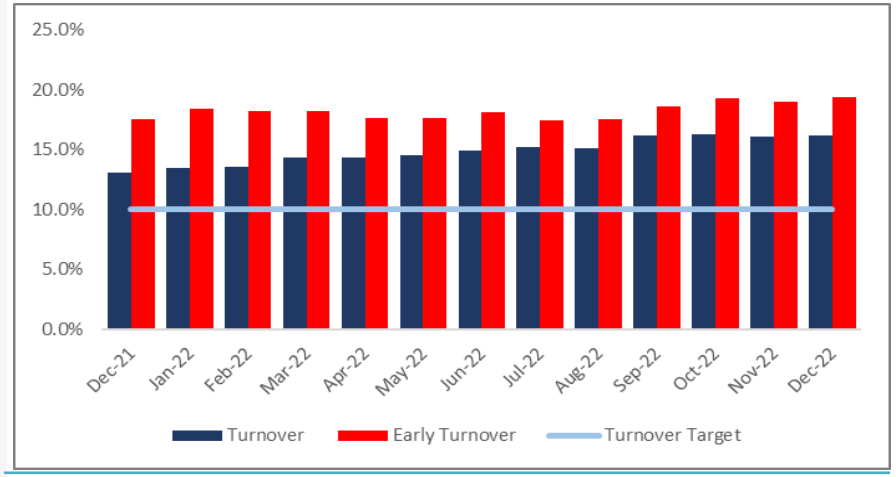
- Changes to systems to improve PDR is complete and completion rates have risen for the third month in a row and are higher for the first time since February 2022. Phase 2 of the improvement plan will commence in 2023 with the launch of e-learning packages ahead of a move to a PDR season where all PDRs will be expected to be completed between April and July. A communications campaign is planned for this.

- Improvements in the trajectory of compliance rates for Statutory & Mandatory training have stalled and work is being undertaken to understand what actions can be taken to reverse this – including improving the way that problems can be reported and more face-to-face training for Resus at key locations such as Aylesbury

- Absence has decreased only marginally and whilst there is targeted action in MH and Community directorates, we are already seeing an increase in absence in relation to winter illnesses and Covid.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<10%	16.17%
Early Turnover	<10%	19.39%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue

Staff turnover has increased from 16.1% to 16.2%. High levels of turnover will impact on vacancies, agency spend, quality of patient care and staff experience.

The cause

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

Executive Director commentary:
Charmaine De Souza, Chief People Officer

The plan or mitigation

The IQRA SRO has reviewed the Retention work programme and for the next 12 weeks the programme is focussed on:

- Retire and Return -(QI Stage – Discovery phase). Process mapping with HR, Recruitment, Systems, Pensions and Payroll has been completed and improvements to the current process are being implemented including better information and a dedicated policy
- PDR project. • (QI stage - Delivery Phase) A new PDR form was launched on the 1st November and a drive to compliance is underway. A new suite of training resources is on plan to be launched in January 2023. Compliance has started to increase.
- Onboarding project. (QI Stage – end of scoping phase) Month 3 data has been received and in-depth analysis has taken place by the OD team, with the results shared at a monthly review meeting (along with Exit survey data) to drive improvements based on the 'marginal gains' approach.
- Career Conversations. (QI Stage – end of Discovery phase) Scoping has taken place with a review of all the current offers and options for delivery with PNE to trial 48 hour stay conversation across 6 wards. A Questionnaire has been designed to survey all staff that have had a 'Career Conversation' in the last 12 months to assess the impact the conversation that was had.
- Work is continuing to ensure we are utilising the national high impact recommendations for the Nursing and Midwifery Retention Plan.
- The Head of OD attends the BOB Retention group, and the national actions are being implemented including Menopause network, career conversations, improved retire and return process and focus on apprenticeships,

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2h) PDR compliance	>/=95%	41.3%

Executive Director commentary:
Charmaine De Souza - Chief People Officer

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

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

Executive Director commentary:
Charmaine De Souza - Chief People Officer

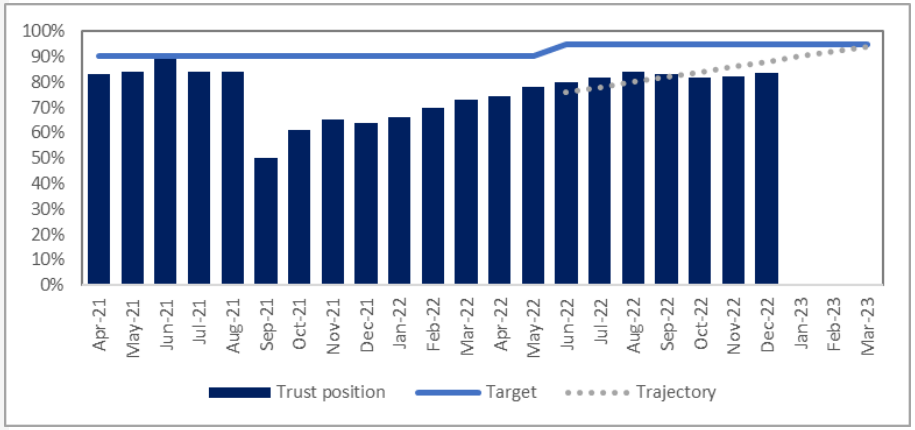
The plan or mitigation

The new PDR process was launched on the1 November with a drive to compliance to meet the intended trajectory by March 2023. The new 'PDR season' will start on the 1st April 2023. The new form and recording system has been well received across the organisation. Completion rates have risen for the third month in a row and are higher for the first time since February 2022. Despite this performance is 18% behind trajectory. The mitigation includes:

- Continuing to promote through HR teams at service meetings on the key message of ' If you have had a PDR within 12 months, Record it. If you have not had a PDR in the last 12 months, Book it' which has resulted in the highest PDR rate since Feb 2022
- Detailed dashboard showing compliance has been shared with Executives for cascade to their Teams and direct reports
- New training is due to be launched to support PDR's and communication plan is in development to map out the count down to the first PDR season ion April 2023.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2i) Statutory and Mandatory training	>/=95%	83.7%



Executive Director commentary: Charmaine De Souza - Chief People Officer

The risk or issue

The percentage of Statutory and Mandatory training reported at the end of Dec has slightly increased to 83.7% , falling 6% below the trajectory target of 90% for this month. Individuals who have not completed their training may not have the skills and knowledge to carry out their role safely.

The cause

Work on the L&D system continues to correct anomalies in job roles to ensure accurate training is allocated to each staff member as this remains greatest issue.

Service leads report high levels of sickness and annual leave as well as impact of strike action and winter pressures on recent ability for staff to complete and attend training which is reflected in continued DNA rates and static reporting.

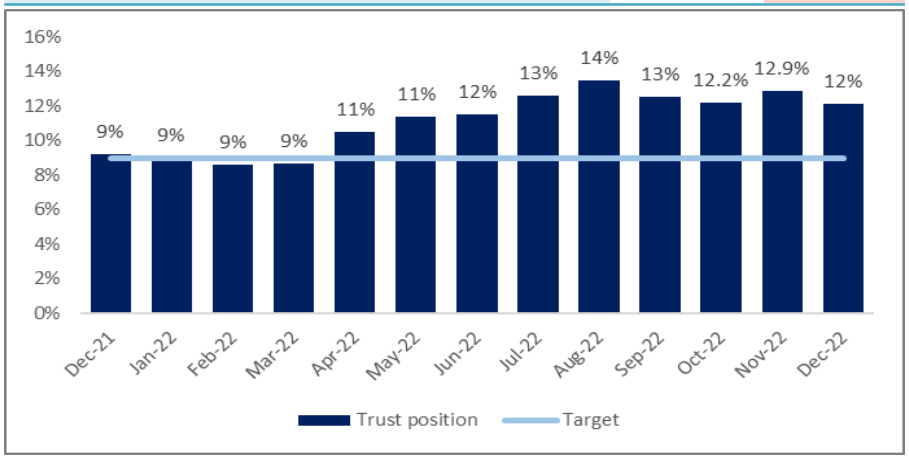
Executive Director commentary:
Charmaine De Souza - Chief People Officer

The plan or mitigation

- Queries regarding errors in the L&D system are now be reported by all staff through the HR Systems Service desk. There is a plan to to add L&D staff to this system by end of January to provide one central place for staff to rase L&D queries and providing a system which is easier to monitor and manage.
- New processes have been implemented to ensure that job roles and therefore the correct training matrices are correctly set up in ESR/L&D system for new starters. Improvements have already been measured as evidenced during recent Induction where staff reported these as accurate. This will continue to be monitored during registration process at Corporate Induction.
- A new process has been implemented to ensure staff have access to their online training records at the point at which they are booked on to Corporate Induction and can therefore attend the e-learning day 2. Improvements have already been measured as evidenced during recent Induction where fewer staff reported this as an issue. This will continue to be monitored during registration process at Corporate Induction.
- A Moving and Handling training steering group has been set up to agree and implement a plan to move training inhouse which should improve accessibility to training for staff which continues to be reported as an issue. This should be implemented by the end of March.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(**2g**) Reduction in % vacancies	</=9%	12.2%



The risk or issue
The vacancy rate has decreased from 12.9% to 12.2%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients. The long timescale that it is taking to hire an employee results in candidates withdrawing from recruitment process or securing roles in other organisations.

The cause
Hiring challenges due to low unemployment, talent market conditions and talent shortages in key areas such as nursing alongside the high cost-of-living and below inflation pay offer is impacting on staff recruitment.

The plan or mitigation
Following the TUPE of Staffing Solutions to NHSP the Resourcing Team will have an increased resource to support internal recruitment processes. This, with recent changes streamlining processes, should speed up employment checks for internal candidates.

Executive Director commentary:
Charmaine De Souza, Chief People Officer

As part of the IQRA Program a 12-week plan is in progress with a focus on:
1. Reducing time to hire (advertising to checks completed) – we have changed the way that this is now being reported, so it is now reported at Directorate level and fed back through the services via their SMT meetings with a breakdown for each area as to their longest waiting candidate. For December this was:
- Community – 32.8 days, Bucks – 39 days
- Specialist - 25.5 days. Corporate – 25 days
- Ox/SW CAMHS – 39.5 days. Ox/SW Adults - 35.6 days

Overall, our time to hire has decreased month-on-month since September 2022.

2. Proactive recruitment campaigns for the 5 key priority areas with the highest vacancy rates, risk and cost of agency. These are District Nursing, Forensic, Bucks Older Adults, South Older Adult and Out of Hours Services.

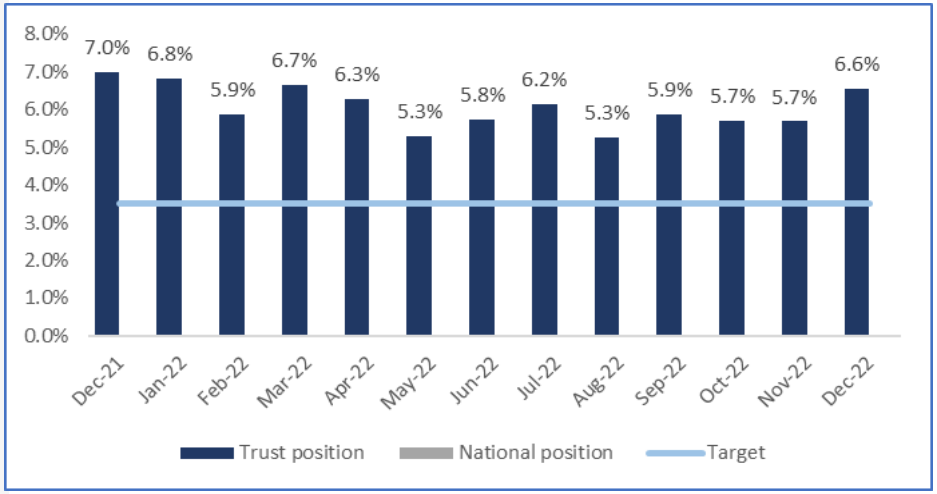
3. Trust wide campaigns including Return to Practice for Nurses and AHP's, and the re-launch of the Recommend a Friend initiative.

4. Developing a University/Student nurse recruitment strategy to focus on pre-engagement of student nurses at each year (1, 2 & 3). The aim is to increase the number of student nurses that join the Trust and increase the number of student nurses that join the Trust after placement.

5. Developing a consistent brand message and creating a visual career pathways for the areas of high vacancy rates / talent shortage. A Recruitment Marketing and Branding Agency Supplier is booked for 20th January with the aim of completing the project in Q1 2023.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=3.5%	6.55%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The sickness absence rate has increased from 5.69% to 6.55%. Excluding Covid absences the rate was 5.6% (4.9% last month)

The Cause
Sickness absence remains above target. The number of long-term sickness cases has slightly decreased in December whereas the Short term sickness has increased by 1%.
The top five reported causes of absence were Flu, Cough/Cold, Covid 19 confirmed, Other respiratory problems and Gastrointestinal.

Executive Director commentary:
Charmaine De Souza, Chief People Officer

The plan or mitigation
Work continues to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees. This is a key enabler to ensure that appropriate referrals are made, including signposting to the various support/assistance programmes that are available (e.g. our Employee Assistance Programme).

Furthermore, additional guidance and support for managers on using the full capability of the GoodShape system continues to be rolled out, via the absence team promoting live demonstrations to team and leadership meetings across the Trust.

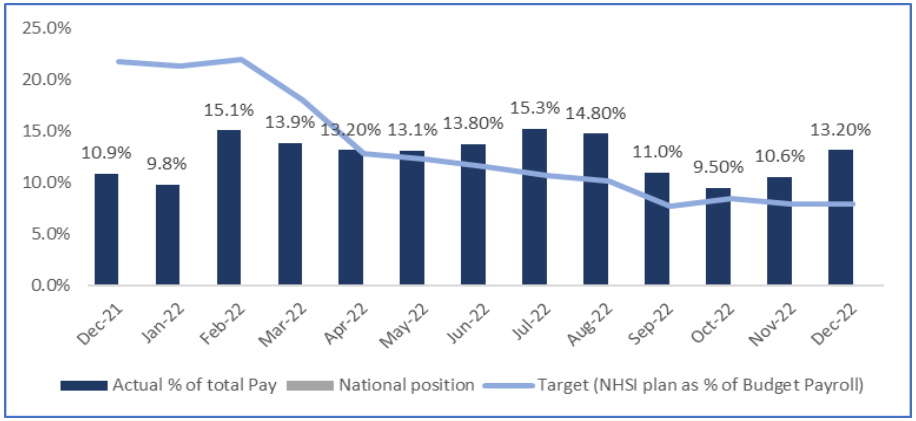
Further work is underway to understand the drivers for high volumes of absence in particular services and to ensure that there is consistent application of policy across the Trust. This will initially focus on service areas with the highest levels of absence, with bespoke interventions where necessary. The actions being prioritised within directorates are summarised below.

In Mental Health & Specialised directorates we have finalised a short developmental session focused on managing absence which will be targeted toward managers of areas where we know there is high absence. We also now have a HR Advisor in post who will support first level absence management as part of their role.

For Community Services we have a specific focus on top 10 teams with the highest absence , the Senior HR Advisors are working closely with the Managers in those areas to agree appropriate actions to address absences.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2b) Reduce Agency Usage to Target	</=7.9%	13.2%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

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

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

The plan or mitigation
The Improving Quality and Reducing Agency Programme has several workstreams which aim to improve the quality of our services whilst reducing agency spend.

Executive Director commentary:
Charmaine De Souza, Chief People Officer

The Improving Quality and Reducing Agency Programme has a number of workstreams which aim to improve the quality of our services whilst reducing agency spend.

The retention workstream has mapped the current retirement process with the pension, payroll, and HR teams. Insights from this process will be used to develop change ideas including the retire and return opportunities. The recruitment workstream has received marketing and branding proposals from 3 external organisations, these will be presented to the Trust on the 20th January. The e-rostering workstream has undertaken a data cleanse of staff who are owed hours, there were 2,000 in total and it has been recommended that they receive payment for these. The Safe Care sub-group has developed and implemented a project plan and planning for auto rostering is underway.

The international recruitment workstream has had 28 nurses (12 RMNs and 16 RNs) commence employment with the Trust, there are 6 nurses (5 RMN and 1 RNs) who are waiting for visas. There are 31 nurses (22 RMNs and 9 RNs) and 3 OTs currently going through the pre-employment check process. The medical staffing workstream has developed a proposal which will be presented at the next subgroup meeting to ensure that medical leaders have ownership of the workstream programme and that there is rapid progress with proposed improvements.

The agency management workstream has seen a further reduction of 8 red and 17 green lines of work. The Guaranteed Volume Contract has been awarded to TFS Healthcare and the Master Vendor Contract has been awarded to ID Medical with the implementation date planned for the 23rd January 2023. The implementation work for the staff bank transferring to NHSP is ongoing, although the key milestones have all been achieved, there has been a number of additional actions that have emerged as being required. Whilst all data has been successfully transferred, it has become apparent that end to end testing needs to take place as there is a risk post-transfer should the system integration not be robust. To allow sufficient time for full testing, the implementation date has been revised to the 13th February 2023.

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

This year, our Objective Key Results (OKRs) are;	Comm Services	Oxon & BSW	Bucks	LD	Forensics	Corporate & Trading	**Trust**	Trust Trend
(3a) **Favourable** performance against financial plan (YTD)	£5.9m adv ↓	£1.4m fav ↑	£1.2m adv →	£0.3m fav ↑	£0.7m adv ↓	£8.3m Fav ↑	£2.2m fav ↑	↑
(3b) Cost Improvement Plan (CIP) delivery (YTD)							£1.5m adv ↓	↓
(3c) **95%** of estate to achieve condition B rating by 2025 (75% in 2021)							75%	→
3d) Delivery of estates related NHS Carbon Footprint reduction target of 2879 tonnes by 2028 ,Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-2038. (25,550 C02t)	Work is now underway to carry out a six-facet survey to understand the current building condition ratings. This indicator will be updated once that work is complete.						6272 tonnes	→
(3e) **Achievement of all 8 targeted measures** in the NHS Oversight Framework (see section 2 of this report)	-	-	-	-		-	2 not achieved	

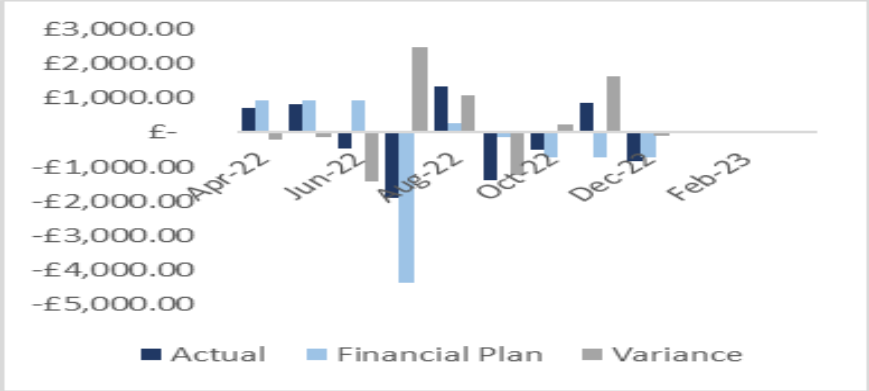
Governance
Executive Director: Heather Smith | **Responsible Committee**: Finance and Investment Committee | **Responsible reporters**: Alison Gordon/ Christina Foster

Executive Summary: Heather Smith, Chief Finance Officer
Narrative updated: January 2023
For reporting period ending: 31 December 2022

I&E £1.4m deficit, £2.2m favourable to plan. The Community directorate remains the area of concern with an adverse variance of £5.9m driven by Community Hospitals, GP Out of Hours and Continuing Healthcare. Other pressures include under delivery of CIP, high levels of Mental Health Out of Area Placements and high agency usage. These are mitigated by £5.6m of unspent Covid funding. The CIP plan for the year is £7.9m with delivery profiled evenly over 12 months. £4.4m has been delivered at month 9 which is £1.5m adverse to plan due to lack of engagement in developing CIP schemes. This CIP delivery includes £2.8m (£2.1m YTD) of Reserves budgets used to reduce this year's CIP target.

Objective 3: Sustainability – areas of underperformance

Objective Key Result (OKR)	Trust
(3a) Favourable performance against financial plan	£2.2m favourable



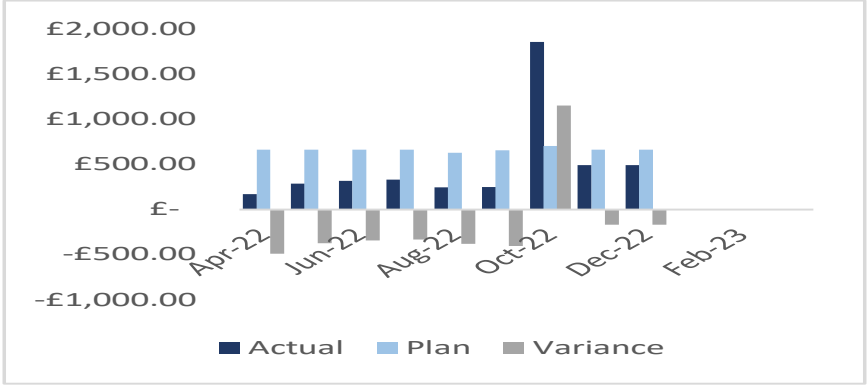
Executive Director commentary:
Heather Smith, Director of Finance

The risk or issue
Financial performance against plan is £2.2m favourable at month 9. However this includes non-recurrent Covid funding.

The cause
This is made up of overspends against clinical directorate budgets, notably Community £5.9m, offset with unallocated Covid-19 funding (£5.6m) and contingency reserves.

The plan or mitigation
Planning and budget setting for FY24 needs to include detailed CIP plans and plans to get services back into budget ,particularly in the Community Directorate. Finance have appointed two new Finance Business Partners and are recruiting to a new team structure in the Financial Management team to strengthen the financial support offered to services to help deliver on these plans.

Objective Key Result (OKR)	Trust
(3b) Cost Improvement Plan (CIP) Delivery	£1.9m adverse



Executive Director commentary:
Heather Smith, Director of Finance

The risk or issue
CIP Performance against plan is £1.5m adverse at month 9.

The cause
Lack of engagement with the CIP programme resulting in no significant schemes for this financial year.

The plan or mitigation
CIP targets have been devolved to Directorates to facilitate engagement and accountability. The Executive Team have agreed to use available reserves budget to offset some of this year's CIP targets (£2.8m) and this has been actioned in month 7 (this is the reason for high actuals in month 7). Budget setting will include developing CIP plans for FY24 to include delivery of the remaining FY23 target recurrently.

Objective 3: Sustainability – areas of underperformance

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

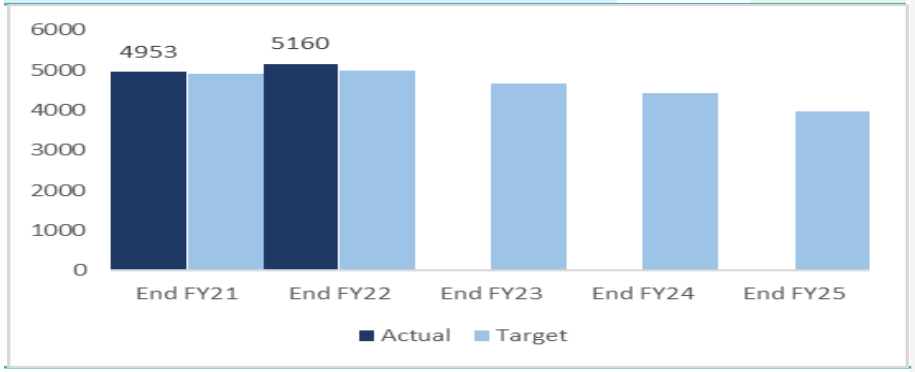
Executive Director commentary:
Martyn Ward – Executive Director: Digital & Transformation

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

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

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

Objective Key Result (OKR)	Target	Actual
(3e) (2e) Delivery of estates related CO2 reduction target of 2879 tonnes by 2028	2879	6,272



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

The risk or issue
In FY21, the Trust consumed 4,952 tonnes of Co2 (NHS Carbon Footprint only . The aim is to reduce consumption to 2879 by 2028. The improvement trajectory is shown on the graph above.
Total Carbon Emissions consumed (Supply Chain/Medicines) is 54,836

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

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

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

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

This year, our Objective Key Results are;	Previous FY	Community Services	Oxon & BSW	Bucks	Corporate Inc R&D	Trust	National comparator
Participants recruited to CRN Portfolio studies	2937 4th Nationally	75	70	20	1030	1195 6th Nationally	No.1 ranked Trust 5392
CRN Portfolio studies that recruited this FY	62 2nd Nationally	3	8	3	29	43 3rd Nationally	No. 1 ranked Trust 72

Executive Summary: Karl Marlowe, Chief Medical Officer
Data cut: 12 January 2023

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

Note: 1270 recruits for previous FY (43% of total recruited for the last FY) and 669 recruits for current FY (58% of total recruited for this FY) came from one study led by Prof Keith Hawton the "Oxford Monitoring System for attempted Suicide".

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