Integrated Performance Report (IPR) Report: March 2023

February 2023 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 (updated bi-monthly)

'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 not achieved	% OKRs achieved	Description	Report pages
NHS Oversight Framework (NOF)	8 (all have a target)	2	80%	Overall performance is good, with the exception of the number of **inappropriate out of area placements (both Oxon and Bucks indicators).**	Pages 9-10
Strategic Objectives – **Quality; Deliver the best possible care and outcomes**	18 (8 have a target)	6	20%	We do not have up to date data for 2 of the 6 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** • **Reduction in the use of prone restraint and** • **Patient safety partners employed**	Pages 15-22
Strategic Objectives - **People; be a great place to work**	9 (8 have a target)	7	13%	• **Agency usage, sickness rate, turnover, early turnover, vacancy rate, PDR compliance and Statutory and Mandatory training** are not yet achieving targets	Pages 23-29
Strategic Objectives - **Sustainability; make the best use of our resources and protect the environment**	4 excl. the NOF OKR (all have a target)	1	75%	The **CIP plan** for the year is £7.9m with delivery profiled evenly over 12 months. The plan is currently £1.9m adverse due to limited resource time available to create and develop schemes.	Pages 30-32
Strategic Objectives – **Research & Development**	2 (no targets)	-	-	The Trust is ranked 5th Nationally for participants recruited to CRN Portfolio studies and 3rd Nationally for CRN Portfolio studies that recruited this FY	Page 33

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: 22 March 2023
For reporting period ending: February 2023

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. However, February has seen a significant reduction to 168 bed days. Nonetheless demand remains volatile.

Directorate highlights and escalations: Primary, Community and Dental Care

Executive Director commentary: Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care (March narrative provided by Emma Leaver , Service Director)
Narrative updated: 21/03/2023
For reporting period ending: February 2023

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
EPR Update	Issue and Risk	The basic EMIS functionality deployed across the Directorate has been received positively. We have a robust infrastructure set up to effectively manage the development of EMIS such that it becomes a system that adds value to our patients and staff. This includes an Operational group that has strong clinical and operational leadership and a Board that meets regularly to provide oversight. We have agreed a set of developments that will enhance the system for all services and then will work on specific requests once we get the maximum benefit for all set up. We do not yet have agreement on a system for our Community Hospital wards and this is problematic. We took a step back from implementing Cerner to consider fully our options. Channel 3, an external and independent consultancy are just completing some work to support our decision making around this- the scope of their work included our SDECs (Same Day Emergency Centres) Hospital and Home and Urgent community Response as we focus on patient pathways and interfaces with other providers/ teams.
First Contact Care Service Pressures	Risk	Significant demand pressures continue to impact across all areas of our First Contact Care Pathway. This particularly includes our Minor Injury Units, and our GP Out Of Hours service. Despite some effective recruitment into GP roles in the OOHs service we are consistently seeing demand far higher than the established capacity we have to manage it. This is consistent with our partners in the BOB ICS footprint and driven by a range of issues including the pressure day time primary care are under.
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. This system position has improved slightly. The Transfer of Care Hub continues to develop and there has been a reduction in our delays. We have focussed efforts on Community Rehabilitation and First Contact Care pathways in terms of financial management and have seen a significant reduction in agency spend in Community Rehab pathway.

Section 3:

NHS Oversight Framework performance

National objective: Compliance with the NHS Oversight Framework

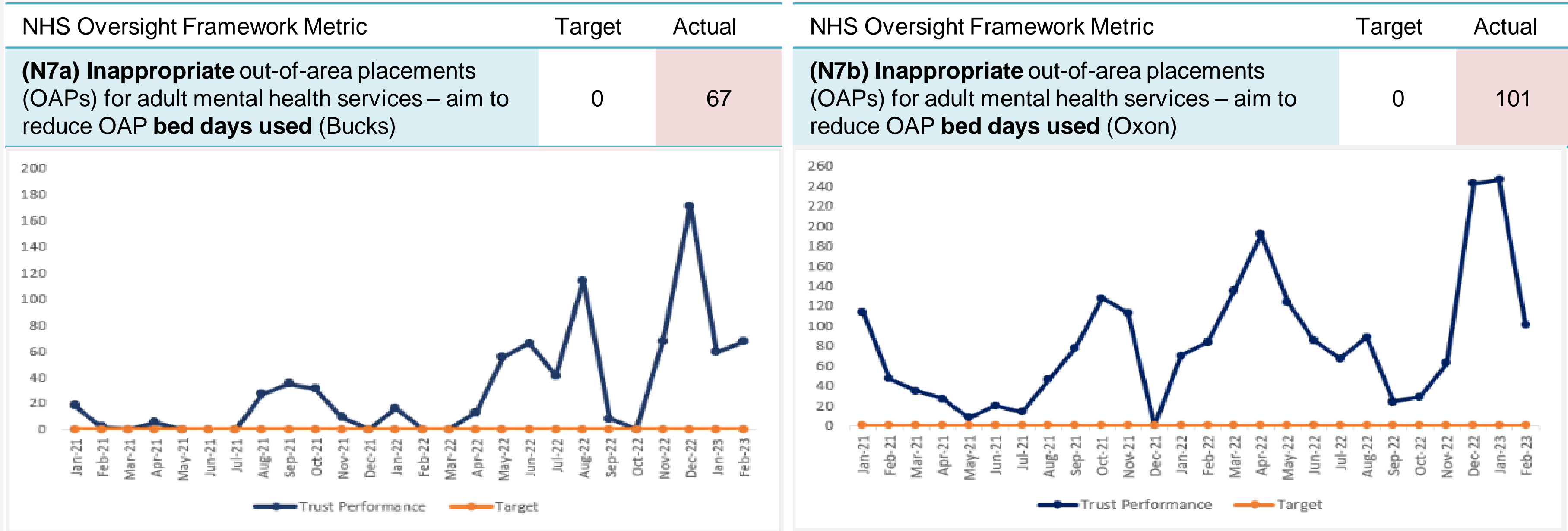
This year, the NHS Oversight Framework indicators that have targets are;	Target	National position (England)	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	71.50% (Feb)	88.8% (July)	→
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	72% (Dec)	88.2% (June)	↑
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	71.4% (Nov)	94.3% (June)	↓
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	48.5% (Dec)	48.5% (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%	89.70% (Dec)	98.8% (Dec)	↓
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.2% (Dec)	100% (Dec)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	67 (Feb)	↑
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	101 (Feb)	↓

Executive Summary: Amélie Bages, Executive Director of Strategy and Partnerships
Narrative updated: 16 March 2023 for reporting period ending: **28 February 2023**

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.

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	67

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	101

Executive Director commentary: Grant MacDonald, Executive Managing Director, Mental Health, Learning Disabilities and Autism
Narrative updated: 16 March 2023
For reporting period ending: 28 February 2023

The issue and cause

The use of Out of Area Placements decreased in February as a result of continued focused by Directorates on reducing the use of OAPs. Nonetheless demand remains volatile.

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. **February 2023 locally reported total bed day usage was 168 days (67 inappropriate OAP bed days in Bucks, and 101 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: 20 March 2023
For reporting period ending:

The South East Integrated Performance Report has not been received by the Trust since 3rd February. The Performance and Information are following up with ICB.

SE Regional Performance – Integrated Performance Report Provider Collaborative

Commentary by: Gillian Combe, Clinical Director, Thames Valley CAMHS Provider Collaborative
Narrative updated: 17.02.2023
For reporting period ending: 28 February 2023

Demand:

- Low numbers of CYP awaiting admission
- Inappropriate out of area bed use 4 children and young people (CYP)
- Increase in delayed discharges due to lack of social care placements

Initiatives:

- Hospital@Home for Eating Disorders now substantive and expanding to 12 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. Collaborating with author on ALPINE 2.0

Current pressures:

- Changes in leadership at Taplow Manor with enhanced support from PC
- Taplow media coverage impacting on willingness of families to accept an offer of a bed there
- NHSE scrutiny of Taplow Manor work
- Impact of media coverage at Taplow Manor on recruitment and retention

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: February 2023 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%	48%	64%	64%	65% (Specialisd Dir)			57%	→
(1b) Staff trained in restorative just culture	-	-	-	-	-	-	-	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	<3 YE	-	-	-	-	-	-	0* YTD	→
(1e) Reduction in use of prone restraint	<208 YE	-	173	28	-	57	-	258 uses YTD	↓
(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 audit result) reported bi-monthly	95%	97%	70%	85%	-	-	n/a	80% (Dec) (n=348)	n/a
(1h) Clinical staff in non-learning disability services have completed internal eLearning on autism	-	-	-	-	-	-	-	See narrative	→

* Next health economy review meeting in April, held quarterly
** Latest available data due to Carenotes outage.

The arrows indicate the trend against the last reported position and the colour is the RAG status against the target

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

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee
Reported period: **February 2023** unless otherwise indicated in brackets in the penultimate column

These indicators are relatively new and 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	11	0	0	0	0	11 in month (127 YTD with 7 being PSII)	➔
(1j) 48 hour follow up for those discharged from mental health wards	TBC	-	60%	78%	-	-	67% (July* n=47/70)	-
(1k) 72 hour follow up for those discharged from mental health wards	TBC (80% national)	-	60%	78%	-	-	67% (July* n=47/70)	-
(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 and the colour is the RAG status against the target.

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: 20th March
For reporting period ending: 28th February 2023

Five OKRs are underperforming year to date;

- Clinical supervision
- Reduction in use of prone restraint
- Completion of the Lester physical health tool for relevant patients on the AMHT and EIP caseloads (two OKRs)
- Evidence patients have been involved in their care

Please see overleaf for more information by measure on the cause of the underperformance and the plans to mitigate and improve performance. There is also an update on our progress with rolling out the national Oliver McGowan training around autism and learning disabilities.

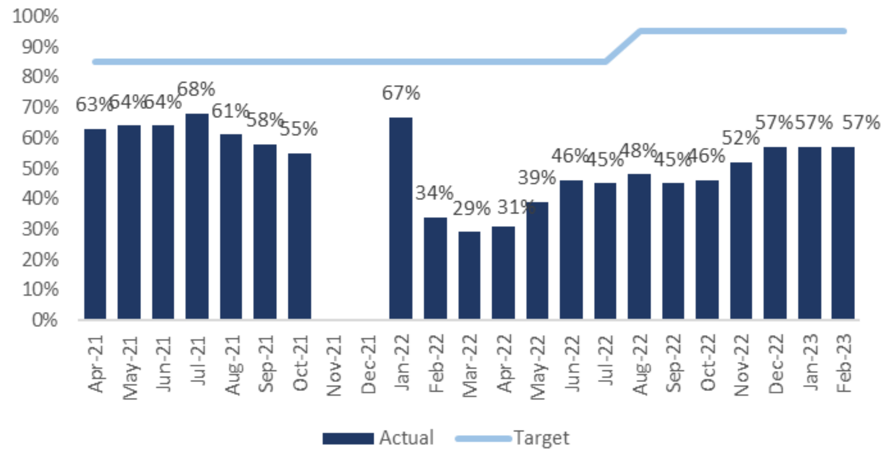
There is a review of the current Quality OKRs underway, linked to the annual planning process and setting the quality priorities for 2023/24.

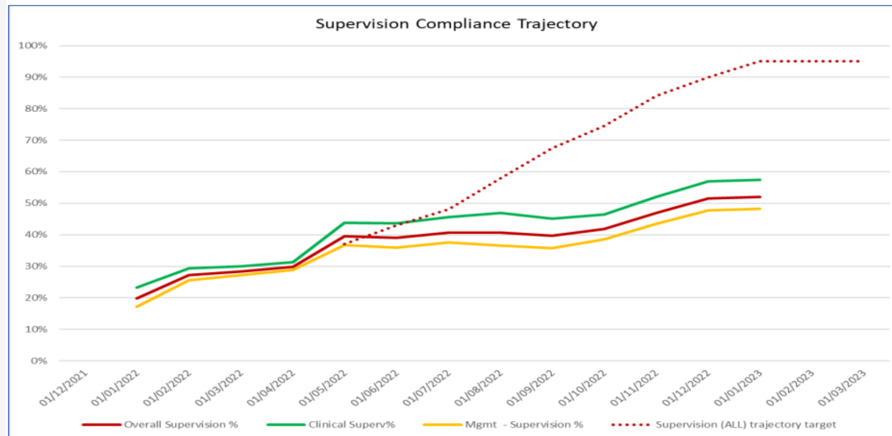
The Trust is carrying out Quality Improvement Projects in the following areas relevant to the Quality OKRs;

- 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%	57%





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, lack of central recording and issues with accuracy of reporting.

What is the plan or mitigation?
The current position is behind the trajectory and target.

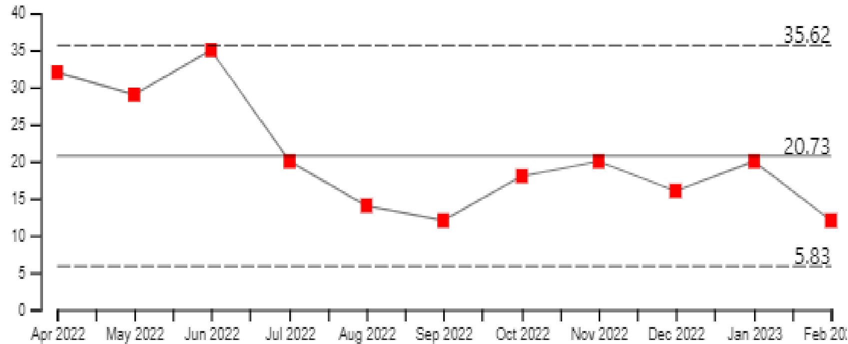
A Supervision Steering Group has been meeting monthly throughout the year to lead on the recovery plan. The group has developed a QI driver diagram setting out the actions planned.

- Doctors/dentists now removed from supervision requirements. Further data cleansing to be completed by end March '23.
- Plan to reach 95% and address quality of supervision by working with directorates and services when the system is optimised.
- System team completing final changes to the supervision recording functionality to include the ability for both admin and managers to record staff supervision for teams as well as the ability to record group supervision on multiple user accounts. This change will be ready to launch mid-March and will address the biggest concerns raised by Service leads.
- Supervision guidance to be added to the Manager and staff guidance.

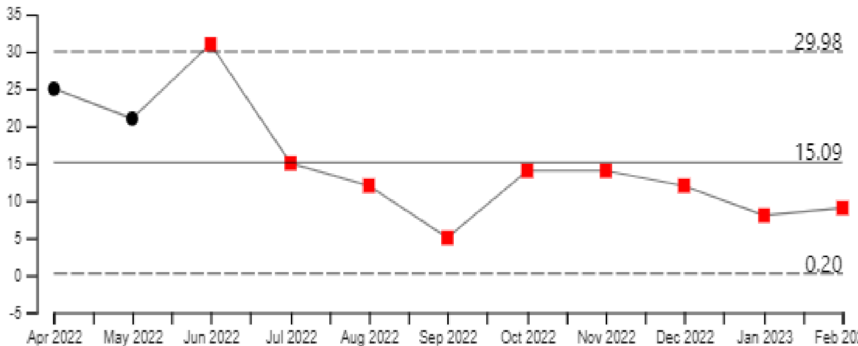
Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint	208 YE, 25% reduction	258 uses YTD

Graph 1



Graph 2



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?

Graph 1 shows the use of prone by month for all wards.

Use of prone remained high for a single patient on an individualised care plan being nursed in long term seclusion awaiting placement in a high secure environment. The use for this single patient is removed from the graphs shown.

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.

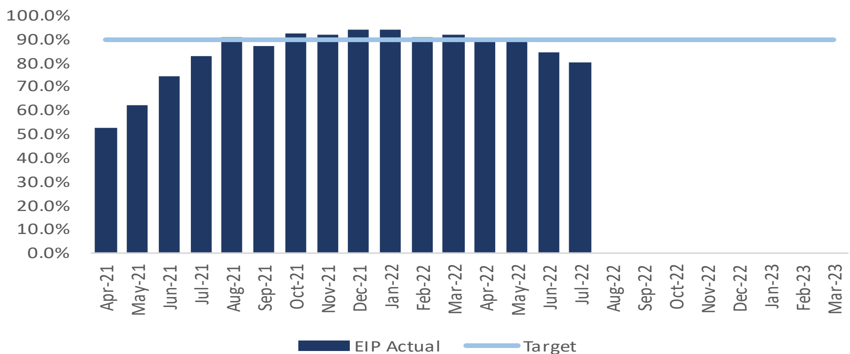
There are a series of tests of change/ actions being taken and we are seeing a reduction in the number and duration of prone restraint however not as much as the target we set. All use of prone are monitored by a Trust-wide group weekly and also through the individual QI projects on specific wards.

Graph 2 shows the use of prone for immediate IM only which has been the focus of much of the QI work to look at alternative medication sites and the roll out of the use of safety pods. There has been a reduction in use of prone restraint.

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 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 and 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.

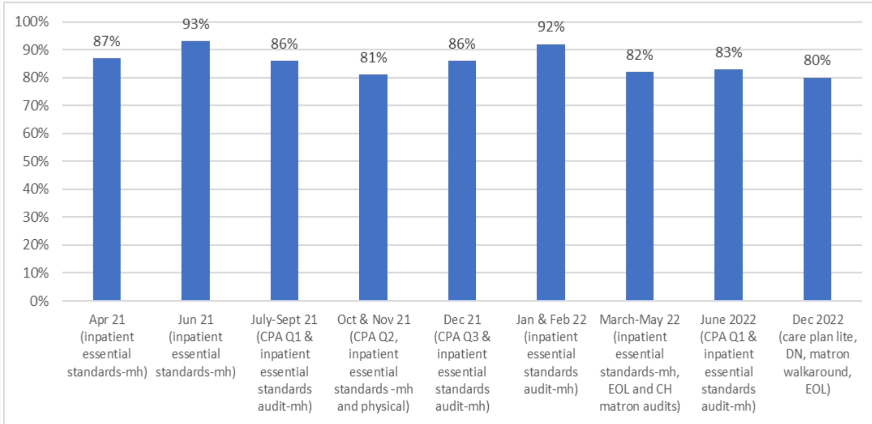
There is an improvement plan in place with 3 workstreams overseen by senior clinicians.

The focus in 2022/23 is:

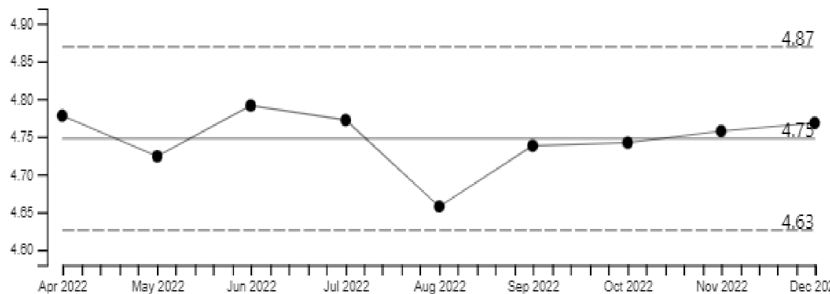
- Make changes to the physical health forms on the patient record (changes were made and now these need to be made on RiO)
- Expand tobacco dependency long term plan goal
- Diabetes management on the wards
- Education and training for staff – physical health skills for wider team
- Develop patient information
- 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%



<u>Based on local patient and carer survey results;</u>
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 indicator is reported on bi-monthly.

The plan or mitigation
<u>QI work</u>
A number of quality improvements projects are underway with a focus on person centred care and care planning. Examples below;

<u>Strategy</u>
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

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 in 2022 was put on hold as pilots for the new national (Oliver McGowan) training started. The Trust was involved in the pilot of the new national tier 1 training (Oliver McGowan), which 125 staff attended.

The new national eLearning package for tier 1 (all staff) and 2 went live on 1st November 2022. Staff only need to complete tier 1 or tier 2. The Trust made the tier 1 elearning training available on OTR for all staff in March 2023. However to fully complete the training staff need to complete part 1 on-line and part 2 which is face to face training. Currently the part 2 face to face element of the training is not available and there are significant financial and logistical challenges to rolling this out which have been fed back to the national team. The BOB ICS is trying to identify some different solutions but this will take time. The current plan is to start rolling out the on-line part 1 training element to key service areas, senior leaders and new starters.

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 Green light Toolkit has been completed across the Bucks wards, with actions focusing on establishing autism champions in teams, training and sensory surveys of the ward environments. The audits in the community teams are planned to be completed by March 2023.
- 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 in Oxon and Bucks is being expanded with additional funding.
- Bespoke training sessions are being delivered to mental health wards and community teams, as well as regular support sessions.
- 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 to work on improving the experiences of people when they access services.

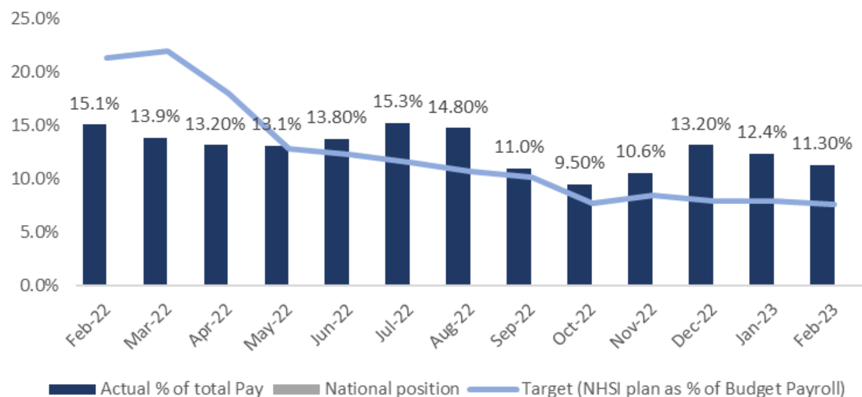
Objective 2: People – be a great place to work

Governance: Executive Director: Chief People Officer | **Responsible Committee**: People, Leadership and Culture Committee
Reported period: **February 2023** 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	</ 7.6%	19.2%↓	6.2%↓	1.0%↓	4.5%↑	0.0%→	17.3%↑	12.5%↑	13.6%↓	0.0%→	11.3%	ModHos Peer 8.0% / National 7.3%	↓
(2c) Reducing staff sickness to 3.5% over 2021/22	</=3.5%	5.2%↓	6.4%↓	3.3%→	5.3%↑	3.8%↑	4.9%↑	4.3%↓	7.5%↑	5.9%↑	5.4%	ModHos Peer 5.1% / National 5.6%	↓
(2e) Reduction in % labour turnover	</=10%	17.9%↑	17.0%↑	11.7%↓	14.8%↓	21.5%↑	16.7%↓	18.7%↓	18.9%↓	15.9%↑	16.4%	ModHos Peer 20% / National 19.2%	→
(2f) Reduction in % **Early** labour turnover	</=10%	18.7%↑	22.5%↑	12.2%↓	19.8%↓	9.8%↑	19.1%↓	2.9%↑	30.9%↓	52.3%↑	19.4%↓	None	↓
(2g) Reduction in % vacancies	</=9%	15.9%↓	1.9%↑	-4.9%↑	19.7%↓	29.0%↓	20.3%↓	18.5%↑	24.1%↑	5.1%↑	11.7%	None	↓
(2h) PDR compliance	>=95%	52.2%↑	44.6%↑	40.7%↑	41.2%↑	40.6%↑	43.7%↑	62.2%↑	64.7%↑	34.0%↑	46.3%	None	↑
(2i) S&MT (Stat and Mandatory training)	>=95%	84.8%↑	86.7%↑	83.7%↑	84.3%↑	78.3%↑	84.2%↑	84.9%↑	88.0%↑	76.8%↑	85.2%↑	None	↑
(2j) Number of Apprentices as % substantive employees	>=2.3%	7.0%↓	6.2%↓	3.0%→	0.0%→	0.0%→	4.8%→	4.3%→	3.5%→	0.0%→	5.0%↓	None	↓

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2b) Reduce Agency Usage to Target	</=7.5%	11.3%



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 a number of workstreams which aim to improve the quality of our services whilst reducing agency spend.

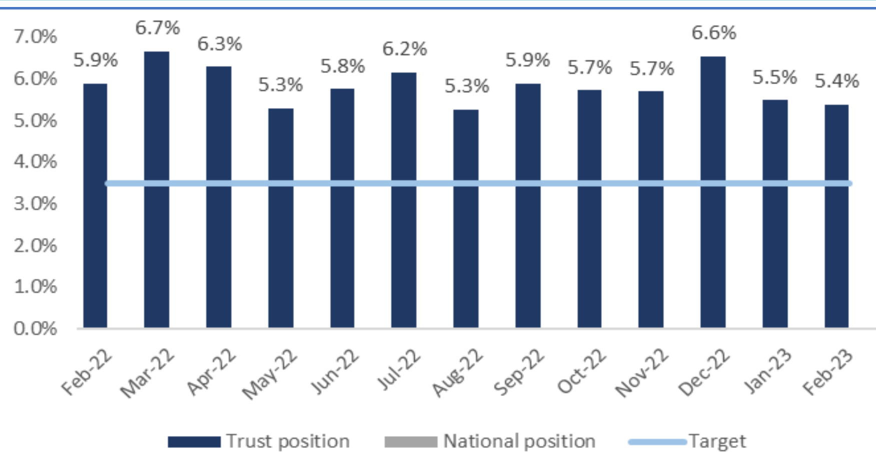
The retention workstream has launched the communications campaign around the PDR season beginning on the 1st April until the 31st July 2023. Appointments have been made to the Retention Programme Manager and Project Support Officer roles, start dates to be confirmed. The recruitment workstream has developed a student nurse recruitment plan that includes engagement with the students and universities throughout their placements with the Trust. The recruitment plan and deliverables for first 12 weeks to ne presented to IQRA programme Board in March. The e-rostering workstream is currently undertaking work regarding finalisation of the rotas.

The international recruitment workstream has had 34 nurses (15 RMNs and 19 RNs) commence employment with the Trust. There are 3 RMNs due to arrive this month, 7 nurses (4 RMNs and 3 RNs) who are waiting for visas and 24 nurses (17 RMNs and 7 RNs) ging through pre-employment checks. There are 2 international OTs who have commenced employment with the Trust and 1 OT who will be arriving in May 2023.
Implementation of the Master Vendor Contract with ID Medical went live on the 13th February, due to interface challenges with NHSP there had been a delay with the Trust benefiting form the revised agency cascade model. A procurement exercise is currently being undertaken for a Medical and Dental Master Vendor Contract; this is due to end on the 24th March. Implementation of an internal medical bank with Patchwork is underway.

The incident that occurred following the transition to NHSP on the 13th February has significantly improved, although there are a small number of operational issues that are still required to be worked through. The Trust is now in a position where the incident escalation response can be closed down and the service can be managed effectively through a BAU model.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=3.5%	5.4%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The sickness absence rate has decreased from 5.5% to 5.4%. Excluding Covid absences the rate was 4.7% (4.8% last month)

The Cause
Sickness absence remains above target. The number of long-term sickness cases has slightly decreased in January as well as the Short term sickness. The top five reported causes of absence were Cough/Cold, Flu, Covid 19 confirmed, headache/Migraine and Anx/Dep/psych-P non-work-related

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).

Additional guidance and support for managers on the full capability of the GoodShape system continues to be rolled out; with a working group to support development of manager guidance to improve consistency to be established, in partnership with union colleagues. Colleagues from GoodShape are offering support and guidance on making reporting available to managers user friendly and easy to understand, with additional insights.

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. Cases of Long Covid are now being actively supported and managed in accordance with national guidance.

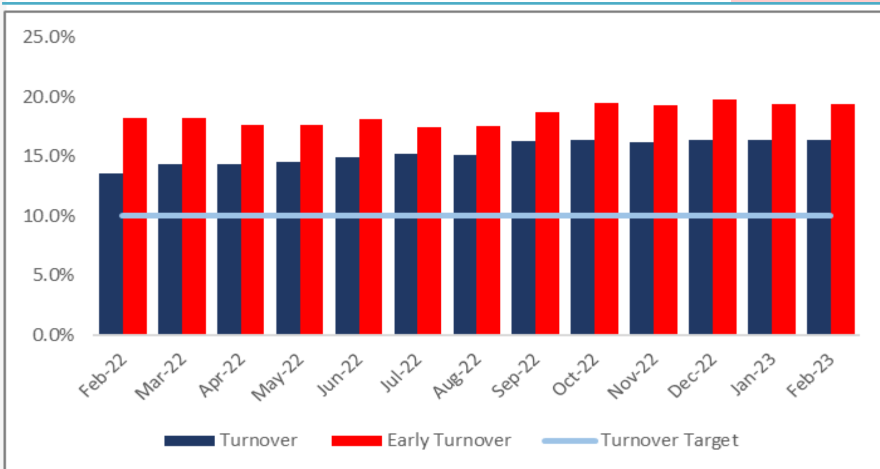
In Mental Health & Specialised directorates we are running manager briefings to support knowledge increase in management of absence. There is also a HR Advisor substantively in post who is providing dedicated support to first level absence management. Around 30 cases re being actively managed by the team.

For Community Services there is a specific focus on the top 10 teams with the highest absence; Senior HR Advisors are working closely with the Managers in those areas to agree appropriate actions to address absences. Around 30 cases are being actively managed by the team, covering both short and long term absence.

The absence target is being reviewed in readiness for the new financial year. It is anticipated to be within the range of 3-4% based on ESR data, aligning with the approach taken by organisations within BOB ICB. As we report using Goodshape data which due to using a different calculation method reports absence consistently as 0.9% higher than ESR the target is likely to be adjusted to reflect this.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<10%	16.4%
Early Turnover	<10%	19.4%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Staff turnover remained at 16.4%. 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.

The plan or mitigation

A Retention Team has been successfully recruited and are being cleared to start as soon as possible. A work programme has been designed with the IQRA SRO to guide their work with clear links to the retention KPI. Work continues are part of the Retention work:

- Retire and Return -(QI Stage – Design). The outputs of the consultation of the 1995 scheme are being reviewed and in essence this will remove a lot of barriers to staff retire and returning.
- PDR project. • (QI stage - Delivery Phase) The first PDR season begins on the 1st April 2023 and the communications plan is in its final phase with weekly comms going out.
- Onboarding project. (QI Stage – end of scoping phase) Month 4 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) At the end of the discovery phase it has become apparent that a much bigger piece of work around talent management, career pathways and promotion needs to take place. The work stream is getting ready for the arrival of the Retention Team who will drive this forward.
- 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,
- **The labour turnover target has been reviewed and agreed at 14% for 2023/24.**

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2g) Reduction in % vacancies	</=9%	11.7%

Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The vacancy rate has decreased from 13.7% to 11.7%; 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, increased vacancy rates, 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
The TUPE of Staffing Solutions to NHSP has provided the Resourcing Team with increased resource to support internal recruitment processes, This had been delayed due to the deferral in the outsourcing of Staffing Solutions. The team has now restructured with additional support for internal recruitment.

This additional resource focusing on internal recruitment along with streamlining of processes and upskilling of hiring managers will speed up the recruitment process and clearance of employment checks for internal candidates.

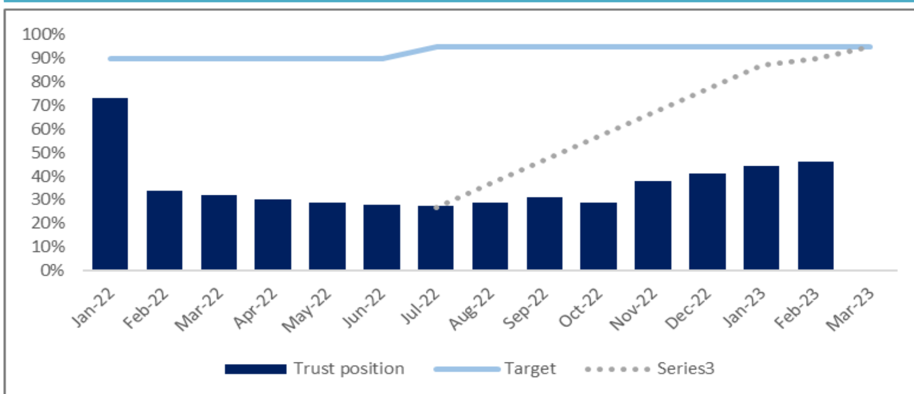
The PICU Recruitment program is in progress, with a successful open day held at the Highfield Unit on 25th February 2023. Phase 2 of this project will include another face-to-face open day, a virtual open day, a national advertising campaign with Indeed, a national, paid social media campaign across TikTok, Instagram and Facebook, with the support of an external creative advertising and branding supplier.

The next 12-week phase of the IQRA Program is in progress (ending 31st March 2023) with a focus on:

1. Hotspot areas | Proactive recruitment campaigns for priority areas including Littlemore Forensic units, Bucks Older Adult, Oxford City, the new PICU, Podiatry and Corporate Estates. Hotspot areas are identified using a combination of high vacancy rate and high agency usage data.
2. 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.
3. 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 review took place on the 20th January, a business case is to be prepared to appoint the preferred supplier. The preferred supplier are currently working on the PICU campaign.
4. An outline for a QI project to look at internal talent mobility is being presented to the IQRA Board in March to identify how the Trust can retain more staff by ensuring internal opportunities are available and more easily accessible to all staff.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2h) PDR compliance	>/=95%	46.3%



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 until November 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.

The plan or mitigation

The PDR season launches on the 1st April 2023 and all recorded PDRs will turn 'red' on the Learning & Development System. The Trust will then look to focus on PDR's for the next 16 weeks to ensure the 95% target is met.

Weekly updates will be sent to Executive and Operational Leads with progress against target, with updates regularly sent to EMC and OMT so progress is monitored.

The Communications team will publish the weekly performance against the compliance target on their webpage and include it in the bulletin, exec briefing and other avenues of engagement.

Posters have been designed and will be distributed across all inpatient & community sites to raise awareness of the PDR campaign and remind staff to get their booked in.

A PDSA cycle 2 begins in July to review the first PDR season and take the learning forward with full write to be taken

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2i) Statutory and Mandatory training	>/=95%	85.2%

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 February has increased to 85.2% , 9% below the trajectory target of 94% 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
There continues to be high rates of non-attendance to face to face skills-based courses; moving and handling, fire response and resus with Resus frequently running at less than 50% attendance. Staff report that due to ongoing staffing pressures, they are not being released to attend. Work continues to correct anomalies in job roles to ensure accurate training is allocated to each staff member as this remains an issue.

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. The process to add all L&D staff to this system is complete, which will provide one central place for staff to rase L&D queries and providing a system which is easier to monitor and manage. L&D are also
- L&D are working with team leads to work through concerns raised around S&M training including more training to be planned in wider locations such as M&H and fire response in Bucks, training for managers on how to run reports and planning full days of recert training to support easier planning for rotas.
- Plan to review Resus provision including team structure, resources and current training delivery with Chief Nurse Marie Crofts. The intention is to introduce a new Band 7 role into the team to mitigate the risk of only having one member of staff who can play the role course director for the ILS courses. Scheduling of all courses has also been completed up to June '23 to cover the period of recruitment for to the Senior Resus Officer post.
- Service report the need for exemption functionality for staff that may be exempt for short periods of time such as short-term injury within L&D system – this has been added to project plan.

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	Other	**Trust**	Trust Trend
(3a) **Favourable** performance against financial plan (YTD)	£5.5m Adv →	£0.2m fav ↑	£1.8m adv ↓	£0.1m fav ↑	£0.9m Adv ↑	£11.1m Fav ↑	£3.2m fav ↑	↑
(3b) Cost Improvement Plan (CIP) delivery (YTD)							£1.9m 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.						5160 tonnes	→
(3e) **Achievement of all 8 targeted measures** in the NHS Oversight Framework (see section 2 of this report)	-	-	-	-		-	2 not achieved	

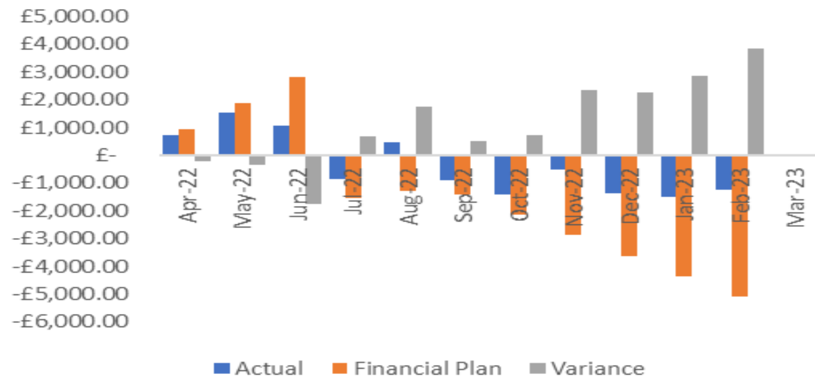
Governance
Executive Director: Heather Smith | **Responsible Committee**: Finance and Investment Committee | **Responsible reporters**: Alison Gordon/ Christina Foster

Executive Summary: Heather Smith, Chief Finance Officer
Narrative updated: March 2023
For reporting period ending: 28 February 2023

I&E £1.2m deficit YTD, £3.9m favourable to plan. The Community directorate remains the area of concern with an adverse variance of £5.5m 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 £6.5m of unspent Covid funding. The CIP plan for the year is £7.9m with delivery profiled evenly over 12 months. £5.4m has been delivered at month 11 which is £1.9m adverse to plan due to lack of engagement in developing CIP schemes. This CIP delivery includes £2.8m (£2.6m 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	£3.2m favourable



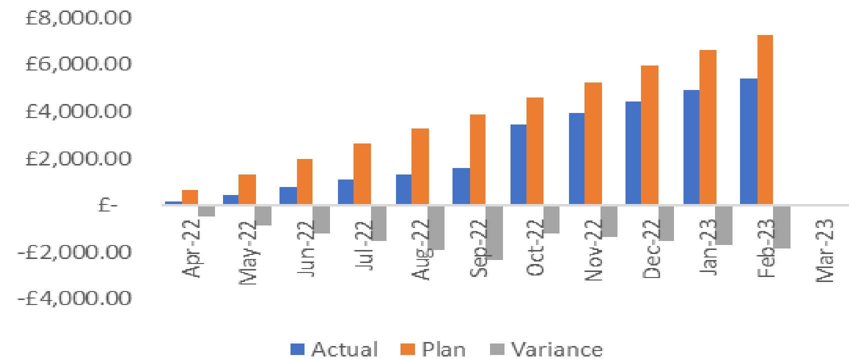
Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
Financial performance against plan is £3.2m favourable at month 11. However this includes non-recurrent Covid funding.

The cause
This is made up of overspends against clinical directorate budgets, notably Community £5.5m, offset with unallocated Covid-19 funding (£6.5m) 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, Chief Finance Officer

The risk or issue
CIP Performance against plan is £1.9m adverse at month 11.

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

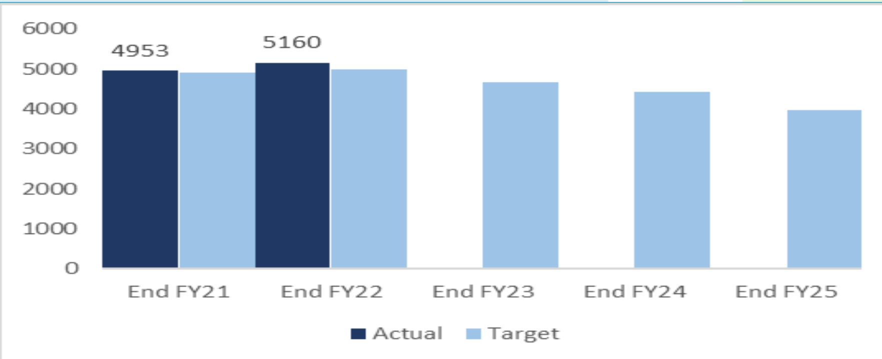
Executive Director commentary:
Heather Smith, Chief Finance Officer

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	5,160



Executive Director commentary:
Heather Smith, Chief Finance Officer

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 , becoming a net zero 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 ‘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	91	75	27	1448	1641 5th Nationally	No.1 ranked Trust 6050
CRN Portfolio studies that recruited this FY	62 2nd Nationally	3	9	4	30	46 3rd Nationally	No. 1 ranked Trust 77

Executive Summary: Karl Marlowe, Chief Medical Officer \ R&D Director Vanessa Raymont
Data cut: 14 March 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 1034 recruits for current FY (63% of total recruited for this FY) came from one study led by Prof Keith Hawton the "Oxford Monitoring System for attempted Suicide".

Impact of limited Electronic Health Records access
Being unable to review patient records is delaying 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. Following discussion at the last IMG meeting and with the Trust Risk Manager this is in the process of being added to the Trust Risk Register

The Trust host the following National Institute for Health Research (NIHR) Infrastructure awards

- Oxford Health Biomedical Research Centre (BRC) Director, Prof John Geddes
- Oxford Clinical Research Facility (CRF) Director Prof Andrea Cipriani, Co-Director Dr Cathy Henshall
- Oxford Applied Research Collaboration Oxford and Thames Valley (ARC) Director, Prof Richard Hobbs
- NIHR Community Healthcare MedTech and IVD Co-operative (MIC) Director, Professor Gail Hayward