Integrated Performance Report (IPR) Report: May 2023

April 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 (9 have a target)	6	33%	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 15-23
Strategic Objectives - **People; be a great place to work**	9 (8 have a target)	6	25%	• **Sickness rate, turnover, early turnover, vacancy rate, PDR compliance and Statutory and Mandatory training** are not yet achieving targets	Pages 24-39
Strategic Objectives - **Sustainability; make the best use of our resources and protect the environment**	4 excl. the NOF OKR (all have a target)	2	50%	The **CIP plan** at month 1 is £0.2m and **financial performance against plan** is also £0.2m adverse .	Pages 30-32
Strategic Objectives – **Research & Development**	2 (no targets)	-	-	The Trust is ranked 5th Nationally for participants recruited to CRN Portfolio studies and 5th 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: 16 May 2023
For reporting period ending: April 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 are supporting the services in ensuring there is 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 on cost control therefore the directorates have worked successfully to minimise the CIP programme as part of financial planning for the year ahead.
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. During Q4 the use of inappropriate OAPs has reduced and there were circa 4 people in OAPs in April due to clinical demand and acuity.

Directorate highlights and escalations: Primary, Community and Dental Care

Executive Director commentary: Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care (May narrative provided by Emma Leaver , Service Director)
Narrative updated: 16/05/23 **For reporting period ending:** April 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. The infrastructure described in the last report to manage the implementation and maximisation of EMIS is developing well with strong service engagement both operational and clinical. Good progress has been made relating to data sharing agreements with our Primary care colleagues with about two thirds having signed up to this and patient and staff benefit being released as a result. We have now agreed on EMIS as the system for our Community Hospital wards, this decision has had a mixed response from system partners- Primary Care being especially pleased.
First Contact Care Service Pressures	Risk	There has been little change in our operational issues relating to our First Contact Care Pathway. 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. The challenge of several bank holidays increases the pressure. We have made significant changes to the leadership team in this pathway and are seeing some early green shoots of improvement.
System and financial pressures	Risk	We are witnessing improvements across the system in terms of demand and capacity with less occasions when OPEL 4 is the position of our acute partner. Nonetheless we are continuing to see high demand in planned and preventative care services. The Transfer of Care Hub continues to have positive impact and we have seen a further reduction in our delayed patients. We continue to focus 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. NHSP operational issues continue to be problematic to services across the Directorate.
0-19 competitive procurement process.	Risk	The Council Public Health Department are competitively tendering the 0-19 services. They have combined 5 current contracts into one large contract with a range of staggered start dates due to the fact all 5 current contracts expire at different times. OHFT currently provide 3 of the 5 contracts in the tender, FNP/ Health Visiting and School health Nursing. We are currently working on a financial analysis to consider the viability of the contract.

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%	74.60% (Mar)	94.2% (Apr)	↑
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	72% (Dec)	88.2% (June)	↓
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	79% (Dec)	96.0% (July)	→
(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%	90.3% (Feb)	99.5% (Feb)	↑
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.4% (Feb)	100% (Feb)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	35 (Apr)	↓
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	90 (Apr)	↓

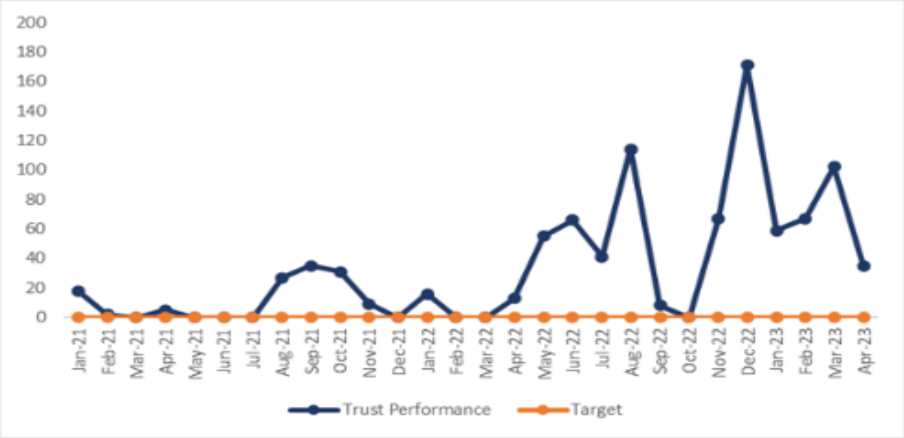
Executive Summary: Amélie Bages, Executive Director of Strategy and Partnerships
Narrative updated: 15 May 2023 for reporting period ending: **30 April 2023**

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. MIU attendance wait time slightly below target, monitored in operational services.

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	35



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	90

Executive Director commentary: Grant MacDonald, Executive Managing Director, Mental Health, Learning Disabilities and Autism
Narrative updated: 11 May 2023
For reporting period ending: 30 April 2023

The issue and cause
The use of Out of Area Placements decreased in April as a result of continued focus 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. **April 2023 locally reported total bed day usage was 125 days (35 inappropriate OAP bed days in Bucks, and 90 inappropriate OAP bed days in Oxon).**

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: April 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%	53%	63%	69%	69%	68%	29%	59.6%	↑
(1b) Staff trained in restorative just culture	20	-	-	-	-	-	-	28	→
(1c) BAME representation across all pay bands including board level	19%	15.3%	18.8%	30.5%	11.6%	43.9%	26.8%	20.7% (Q4)	↑
(1d) Cases of preventable hospital acquired infections	<3 YE	-	-	-	-	-	-	0* YE	→
(1e) Reduction in use of prone restraint	25% reduction (target tbc)	-	11	3	-	2	-	16 uses YTD	↓ positive
(1f) Patient safety partners employed	2 YE	-	-	-	-	-	-	0 YE	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%	No breakdown						80% (Q4, n=561)	→
(1h) Clinical staff in non-learning disability services have completed internal eLearning on autism	-	-	-	-	-	-	-	See narrative	→

* Next health economy review meeting 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: **April 2023** unless otherwise indicated in brackets in the penultimate column

These indicators are relatively new and need further development/ 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 (includes cases with and without lapses in care)	16	21	0	0	0	0	16 in month	↓ positive
(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: 15 May
For reporting period ending: 30 April 2023

Six OKRs are underperforming at year end, although progress is being made against all indicators.

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.

The adverts for the new patient/carer safety roles are live which will support co-production in improving patient safety alongside the involvement and volunteer opportunities already available.

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
- 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

The Quality Objectives for 2023/24 have been finalised and are provided overleaf.

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: 15th May
For reporting period ending: 30th April 2023

The Quality Objectives for 2023/24;

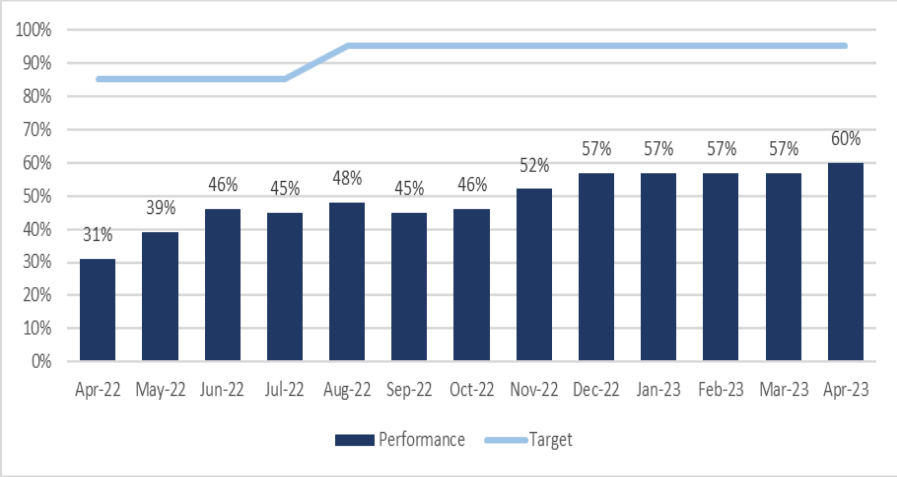
TRUSTWIDE / ALL OPERATIONAL DIRECTORATES

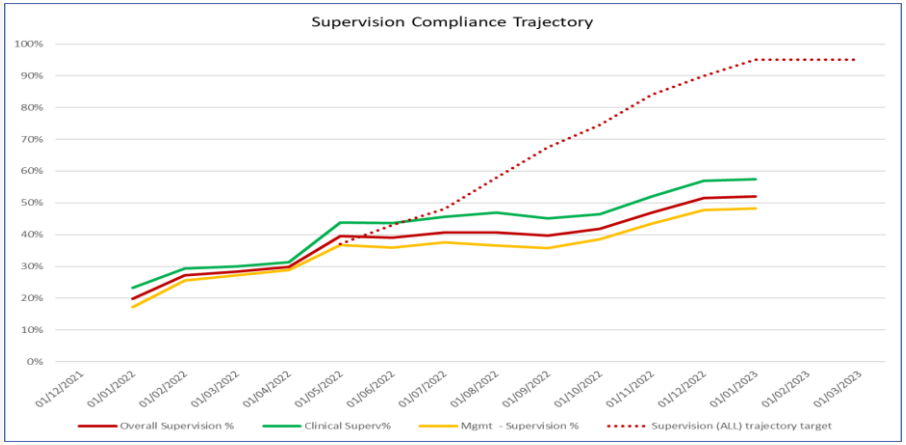
- Use patients' experience and feedback to improve services
- Improve working with families through embedding Triangle of Care
- Embed personalised care planning developed with patients to improve clinical outcomes
- Implement the Patient Safety Incident Response Framework (include embedding a restorative approach)
- Work on recognising and responding to deteriorating patients/ Sepsis
- Reducing variation and inequalities will be an element included across every quality objective
- Supporting staff and building resilience e.g. pilot of TRiM (tbc)

Mental Health directorates	Primary, Community & Dental directorates only
Improve the physical healthcare to people with a serious mental illnesses	Malnutrition screening within 24 hours and care planning community hospitals
Restrictive practice; 25% reduction in use of prone restraint for IM and 20% reduction in use of seclusion episodes and duration	Pressure ulcer risk at community hospitals
Practitioner Outcomes (50% target) and PROMs (10% target) adult and older adult AMHTs, CAMHS and women in perinatal services	Pressure damage/ lower leg wound treatment District Nursing

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	95%	59.6%





Executive Director commentary: Marie Crofts, Chief Nurse
Month narrative relates to: April 2023

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?
A Supervision Steering Group has been meeting monthly throughout the year to lead on the recovery plan. The group has taken a quality improvement approach to work with staff about how to improve uptake.

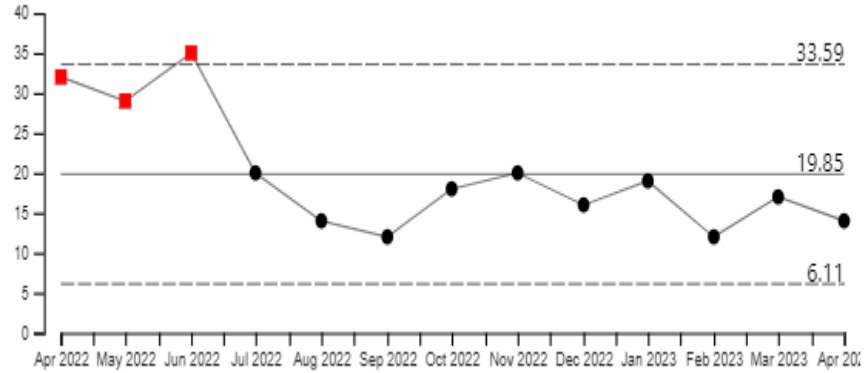
The actions taken include;

- Development of the recording system to improve ease of recording and accuracy. Final changes to the 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 last change was made in March 2023.
- Significant data quality exercise was completed to understand and ensure requirement was only for clinical staff, accuracy of data and report specifications.
- Working alongside those teams with the poorest uptake
- Delivering training for supervisors and supervisees, this continues to be evaluated and updated
- Supervision guidance developed.
- Spot checks by Associate Directors of Nursing/ Heads of Nursing to review practice and quality of supervision

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint	25% reduction – YE target TBC	16 uses YTD

Graph 1



Year	Number of uses of prone restraint	% change	Number of patients involved
2020/21	286 (of which 177 for rapid tranquilisation by intramuscular injection)	Not applicable, baseline.	135
2021/22	257 (of which 166 for rapid tranquilisation by intramuscular injection)	Year 1 - 10% reduction (from baseline)	128
2022/23	244 (of which 175 for rapid tranquilisation by intramuscular injection)	Year 2 – 15% reduction (from baseline)	119

Executive Director commentary: Marie Crofts, Chief Nurse
Month narrative relates to: April 2023

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?
Progress can be evidenced in our data with a reduction year on year across the Trust on the use of physical restraint and also the use of the prone position. As well as a reduction in the use of seclusion.

*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 figures shown.

Graph 1 shows the use of prone by month for all wards and the table shows the position across the last 3 years, demonstrating a 15% reduction in use of prone restraint from our baseline in 2020/21.

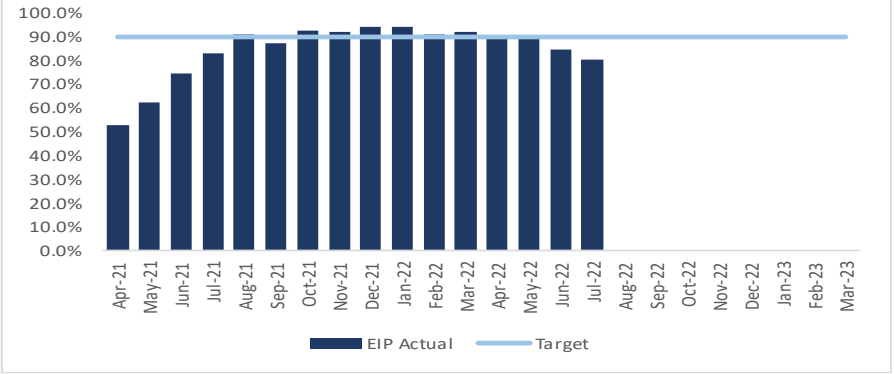
As well as individual ward projects the Trust has been rolling out the following actions across all wards;

- Robust measurement and regular scrutiny of data
- Training and resources for using alternative intramuscular injection sites, to reduce use of prone position during physical restraint
- Use of safety pods. These were new to the Trust so training, videos and resources were also developed.
- Work to develop a rapid tranquilisation prescription chart to support the use of alternative injection sites.

Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1fb) Improved completion of the Lester Tool for people with enduring serious mental illness (AMHTs for patients on CPA)	75%	64% (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
Month narrative relates to: April 2023

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. Local intelligence from teams is there has been an increase in reviews and availability of physical health clinics. We have some patient reported outcomes which show patients reporting feeling more supported with managing their physical healthcare.

Throughout 2022/23 there has been an improvement plan in place with 3 workstreams. Lots of work and funding has been put into improving the physical healthcare of patients accessing mental health services, including new physical healthcare roles and tobacco dependency advisor roles being appointed within community mental health teams and wards, as well as the purchase of additional physical healthcare equipment.

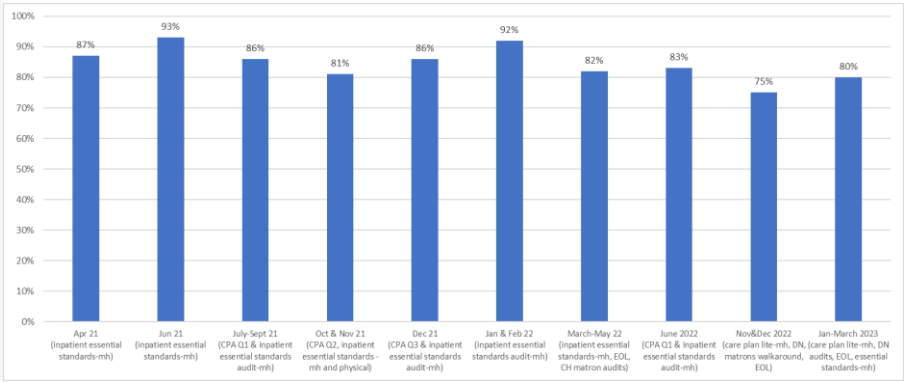
The focus has been on:

- Diabetes management on the wards
- Physical health skills training for community mental health teams
- Developing patient information to support conversations and promote improving health
- An inpatient referral pathway to embed a care treatment programme for tobacco dependency has been developed.
- Improve flexibility and mobility of testing through mobile clinics and point of care testing kits
- Make changes to the physical health forms on the electronic patient record.

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%

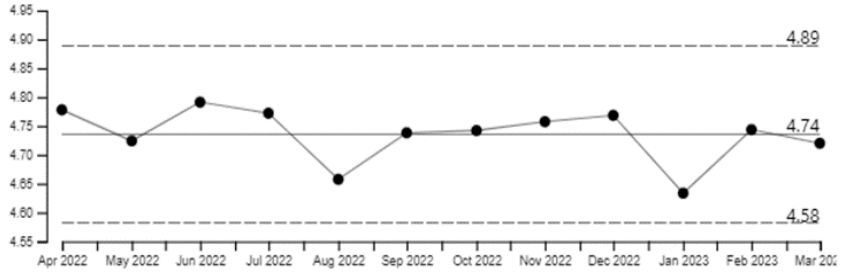
Clinical audit results n=561



Patient/carer Surveys (IWGC);

The below graph shows the scores for the survey questions around being involved in care - **2022/23 n=8,044**

How did the average score change over time? (max score is 5)



Executive Director commentary: Marie Crofts, Chief Nurse
Month narrative relates to: April 2023

The context

The most recent national annual community mental health survey results(n=266) showed small improvements in patients feeling involved in care planning and making decisions together when reviewing care, although our local survey results via IWGC and evidence in clinical records (via audits) shows our performance around consistently involving a patient in their care planning remains quite static.

Our local patient survey data through IWGC shows an average score of 4.73 (n=8,416 patients) for the question 'were you involved as much as you wanted to be in your care' in 2021/22 compared to 4.78 in 2022/23 (n=8,044 patients) so this is similar. The graph below shows the average score per month in 2022/23, out of a maximum score of 5.

The plan or mitigation

A number of quality improvement projects are underway with a focus on this including;

- Forensic inpatient services have focused on needs led care planning in collaboration with patients.
- A community hospital ward completed a quality improvement project to better involve their patients in care planning and the use of patient boards. The positive outcome of the work is now being spread across the other community hospital wards.
- An adult community mental health team used an appreciate inquiry model to engage staff and patients to co-design a new care plan format which could better improve coproduction in care planning. The pilot has been successful and the learning is being shared across teams.
- The community dental services have introduced the Patient Bridge, a cloud-based platform which has a patient portal so that our patients, parents and carers can complete their pre-assessment forms before attending their appointment. We can also send messages to patients through the portal to improve communication.
- The Urgent Community Response team has been trialing joint visits with the care team from Oxford University Hospitals so that a patient can be assessed for reablement at the same time as a patient receives treatment. This supports better coordinated care planning between provider.

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
Month narrative relates to: April 2023

The Context and plan
The Trust participated in the pilot of the new national training on autism and learning disabilities (Oliver McGowan) to help shape the content, which 125 staff attended. The Trust also developed internal short training videos as an interim while waiting for the national training to be released.

Tier 1 of the national training was available from 1st November 2022. The e-learning has been made available on the Trust's training portal for all staff to complete alongside a communication campaign. The training will become mandatory over the coming months. The Trust is working with BOB ICS partners to develop and delivery the second part of the training which will involve face to face teaching.

As the national training was delayed in being released, we have not been able to achieve our local target of 90% of staff completing the training by the end of 2022/23. As of March 2023 282 staff (5%) have completed the new national training. This work will continue and be mandatory for all staff. The compliance with all mandatory training is overseen by the Executive Team. See information below about the Reasonable Adjustment Service which has provided in addition bespoke training for teams and support working with patients.

<u>Other activities happening</u>
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 Buckinghamshire mental health wards, with actions focusing on establishing autism champions in teams and sensory surveys of the ward environments. The audits are underway across the community teams.
- 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 Oxfordshire and Buckinghamshire is being expanded. Bespoke training sessions have been delivered to mental health wards and community teams, as well as regular support sessions.
- Working with our autistic patients/ experts by experience we have developed and piloted an autism reasonable adjustment passport in Oxfordshire to support access to mental health services.
- 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.
- Buckinghamshire has implemented a new service providing support to over 20 young people with significant mental health and learning disability or autism needs. One innovation for the service is to follow the wider trend of using a new social prescribing role this seeks to support young people to access and participate in community activities that add value to their recovery and to the mental health services they receive.
- The Disability Equality Staff Network marked 'Neurodiversity Celebration Week' in March 2023 with a live Teams event for the first time which was attended by 80 people.
- A new BOB ICS ASD patient forum has been developed to work on improving the experiences of people when they access services.

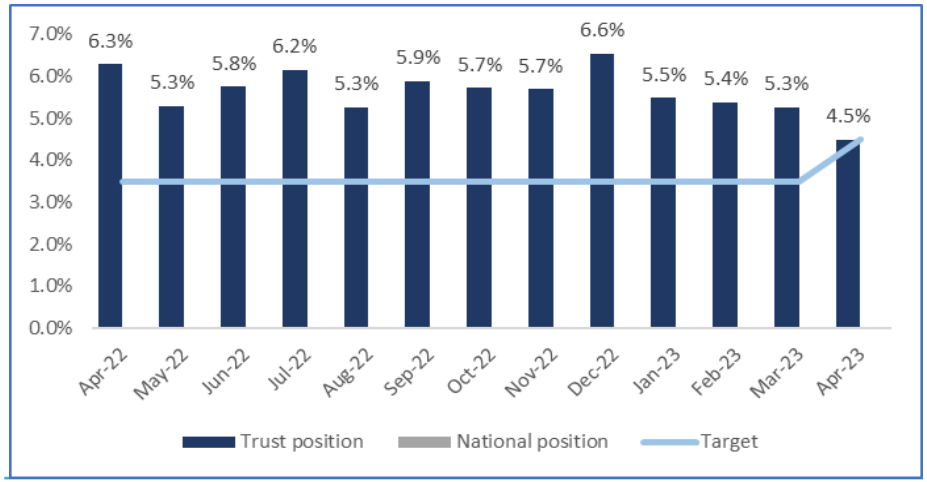
Objective 2: People – be a great place to work

Governance: Executive Director: Chief People Officer | **Responsible Committee**: People, Leadership and Culture Committee
Reported period: **April 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) Staff Survey-Staff Engagement scoreQ4(2022)	>/=?	6.7↓	7.2→	7.3↑	6.8↑	7.3→	7.1↓	7.5↑	7.1↓	6.1↓	7.1	Best 7.4 Average 7.0 Worst 6.2	↓
(2b) Reduce agency usage to NHSE/I target	</= 11.1%	20.4%↓	7.1%↓	0.7%	2.4%↓	0.0%	14.4%↓	12.3%	13.1%↓	0.0%→	10.8%	ModHos Peer Avg 7.8% - National Value 6.5 %	↓
(2c) Reducing staff sickness to 4.5% over 2023/24	</=4.5%	4.5%↓	5.2%↓	3.2%↓	5.2%↑	1.6%↓	4.3%↓	4.7%↑	4.8%↓	4.1%↓	4.5%	ModHos Peer Avg 4.9% - National Value 5 %	↓
(2e) Reduction in % labour turnover	</=14%	18.1%↑	17.5%↑	11.1%↓	14.9%↑	19.0%→	16.4%↑	22.0%↑	17.3%↑	21.3%↑	16.3%	ModHos Peer Avg 19.9% - National Value 18.5%	↑
(2f) Reduction in % **Early** labour turnover	</=14%	20.7%↓	22.8%↓	11.3%↓	21.0%↑	10.0%→	19.0%↑	17.1%↑	28.5%↑	75.1%↑	19.7%	None	↑
(2g) Reduction in % vacancies	</=9%	13.2%↓	8.6%↑	-4.9%↓	19.5%↑	45.0%↑	17.7%↓	12.7%↓	24.0%↓	6.2%↑	12.7%	ModHos Peer Avg 9.7% - National Value 9.1%	↑
(2h) PDR compliance	>=95%	11.7%↓	12.6%↓	10.0%↓	18.7%↓	1.6%↓	9.7%↓	10.5%↓	18.0%↓	4.3%↓	11.8%	None	↓
(2i) S&MT (Stat and Mandatory training)	>=95%	86.9%↑	87.3%↑	84.7%↑	82.6%↓	83.5%↑	85.3%↑	87.8%↑	90.7%↑	78.8%↑	86.4%	None	↑
(2j) Number of Apprentices as % substantive employees	>=2.3%	7.0%→	6.3%→	3.0%↑	0.0%→	0.0%→	4.6%↓	4.3%↑	3.5%→	0.0%→	5.0%	None	→

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=4.5%	4.5%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The sickness absence rate whilst decreasing from 5.3% to 4.5%, has remained above target. Excluding Covid absences the rate was 3.9% (4.6% last month). High sickness absence rates result in increased temporary staffing use and pressure on colleagues.

The Cause
Whilst sickness absence remains above target, it has decreased to the lowest rate seen over the previous 12 months at 4.5%.

The proportion of long term v short term cases remains broadly consistent with the previous month. The most common reasons for absence continue to be Covid, Cough/Cold, Flu, and Gastrointestinal issues.

The plan or mitigation

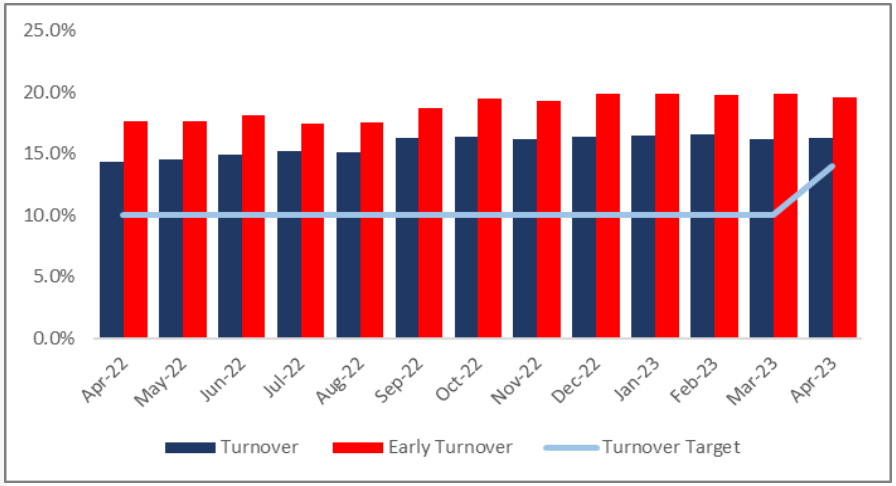
Work continues to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees. This is a key enabler to ensure that appropriate referrals are made, including signposting to the various support/assistance programmes that are available (e.g. our Employee Assistance Programme). The internal GoodShape working group is progressing the development of manager guidance, in partnership with union colleagues, and supported by GoodShape. The work led by the GoodShape working group will support our efforts to ensure that there is consistent application of policy across the Trust. Cases of Long Covid continue to be actively supported and managed in accordance with national guidance.

In Mental Health & Specialised directorates manager briefings continue to be rolled out to support knowledge increase in management of absence, coupled with an HR Advisor who is providing dedicated support to first level absence management. Around 30-40 cases are 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 continue to work closely with managers in those areas to agree appropriate actions to address absences. Around 30-40 cases are being actively managed by the team, covering both short and long term absence.

The sickness target for 23/24 has been reviewed and set at 4.5%, which is within the range of targets (broadly 3.5% to 4.5%) set across comparable (Community and Mental Health) Trusts within England. During 22/23 it became clear that there was a difference in the way sickness percentages are calculated between Goodshape and ESR. This meant that whilst this appears to be a significant increase in the target level, the calculation method and ways of reporting in reality means that this target is asking for a performance broadly consistent with that which was asked for with the previous target of 3.5% and previous calculation method.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<14%	16.3%
Early Turnover	<14%	19.7%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Staff turnover increased to 16.3%. Early labour turnover decreased to 19.7%. 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. Staff are still leaving based on promotion in different Trusts, work life balance and access to flexible working

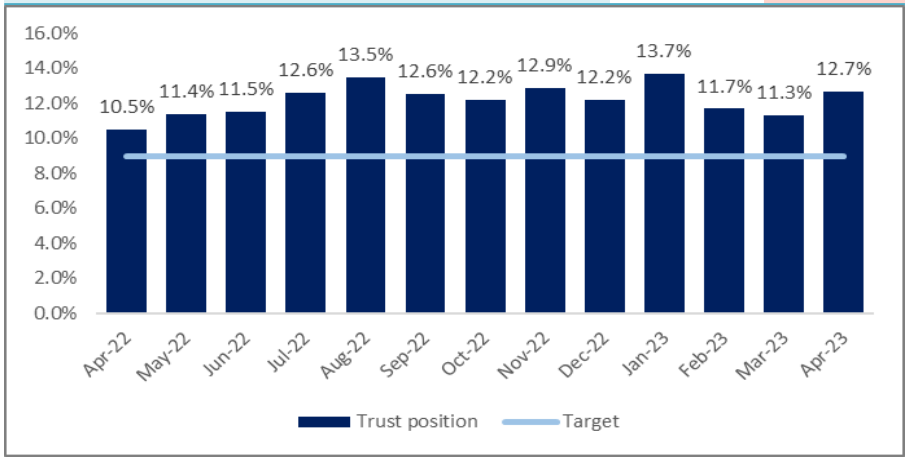
The plan or mitigation

The Retention Team started on the 1st May and have commenced the work programme:

- 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 launched on the 1st April 2023 and will drive uptake of PDR to ensure every member of staff has a career development, wellbeing and flexible working discussion with their manager (The top 3 reasons given for leaving the Trust)
- Onboarding project (QI Stage – end of scoping phase) Month 6 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) It has become apparent that a much bigger piece of work around talent management, career pathways and promotion needs to take place.
- The Retention team are conducting exit interviews with staff who are leaving and are setting up the process for Stay conversations and career conversations for those staff who are ready for the next step.
- A Retention Hub is in development which managers can access once they hear staff are planning to leave which will enable the retention team to have early proactive conversations about supporting people to stay
- 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%	12.7%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The vacancy rate has increased from 11.3% to 12.7%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients. The lengthy time 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 resourcing team has now appointed a Recruitment and Onboarding Manager who will focus on further streamlining of recruitment processes, upskilling of the recruitment team, developing KPIs and SOPs to speed up the recruitment process and clearance of employment checks for all candidates. This will also improve the candidate experience, improving Oxford Health's employer brand which will in turn support candidate attraction.

The PICU Recruitment program is in progress, now having completed 2 successful open days, held at the Highfield Unit, on 25th February and 13th May 2023. The project team will regroup to review the outcomes and plan the next step, depending on the number of vacancies still available, this may include a further open day focusing on nursing recruitment only and a virtual open day for all roles.

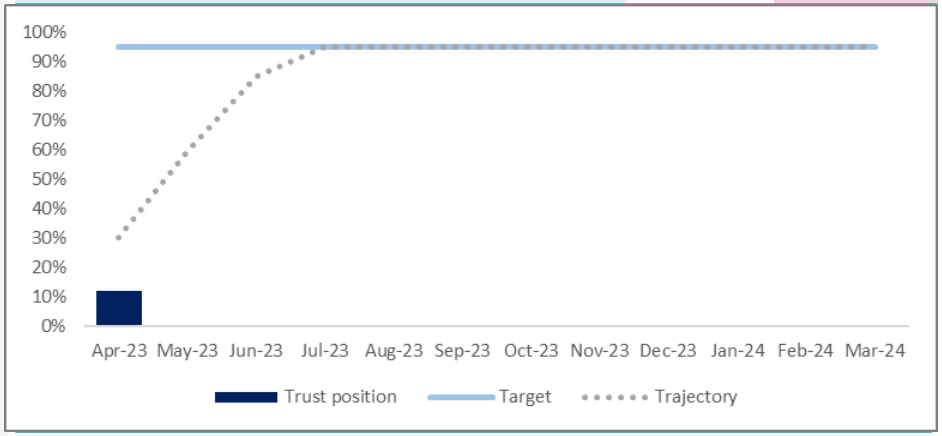
The project group will also review the national advertising campaign with Indeed, across social media platforms and on radio.

The next 12-week phase of the IQRA Programme is to be defined; the focus has been 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%	12%



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 launched on the 1st April 2023 when all recorded PDRs turned 'red' on the Learning & Development System. The Trust is focusing on the completion of PDR's for the next 16 weeks to ensure the 95% target is met.

Weekly updates are being sent to Executive and Operational Leads with progress against target. Updates are also regularly sent to EMC and OMT so progress is monitored. The operational teams will drive compliance in their teams with support from L&D and OD where needed.

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

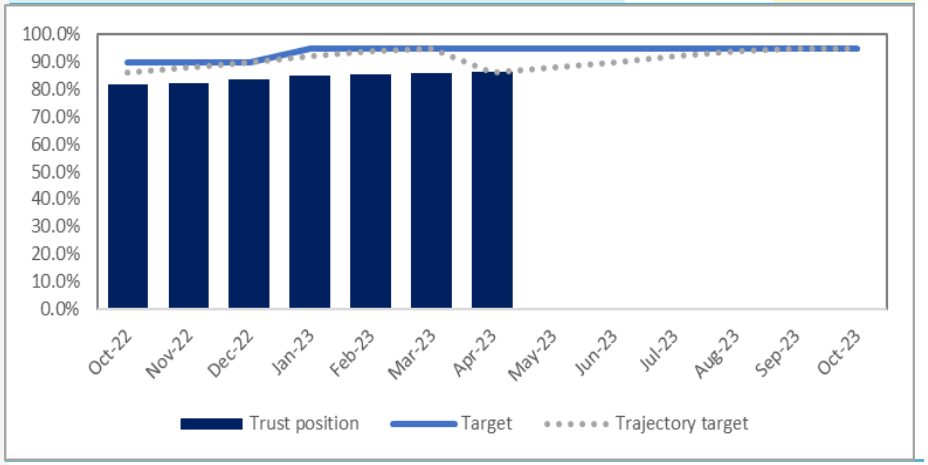
Posters have been distributed across all inpatient & community sites to raise awareness of the PDR campaign and remind staff to get their booked in.

As of the 12 May the Trust is currently at 11.5% compliance which is slightly being the forecast, but assurance has been given from the operational teams that PDRs are being booked in for all staff.

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%	86.4%



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 April has increased to 86.4% , 0.4% above the trajectory target of 86% 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 is a small increase to the compliance rates overall, but 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 continue to be reported by all staff through the HR Systems Service desk, and this process is becoming more efficient with one central place to report queries.
- New starter process for getting onto the system is being reviewed to ensure that all new starters can access L&D system to complete mandatory training in their induction, building on the improvement in staff compliance in mandatory training in their induction
- Compliance figures are being impacted by staff going out of date whilst having mitigations such as injury preventing practical training Services could previously exempt individuals in the short term to mitigate this, and this functionality is now available and can be requested via the helpdesk
- A QI project to be commenced to determine the rationale for non-attendance at resus courses and whether this can be improved.
- Work continues to define audiences for safeguarding training levels, and a final position will be determined by the end of May
- PDR season between April and July should also impact positively on mandatory training compliance rates as this is reviewed as part of the process with each staff member. This will also highlight anomalies in matrices

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)	Directorate positions are not reported at month 1 as budget adjustments are not all complete						£0.2m Adv ↓	↓
(3b) Cost Improvement Plan (CIP) delivery (YTD)							£0.2m 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	

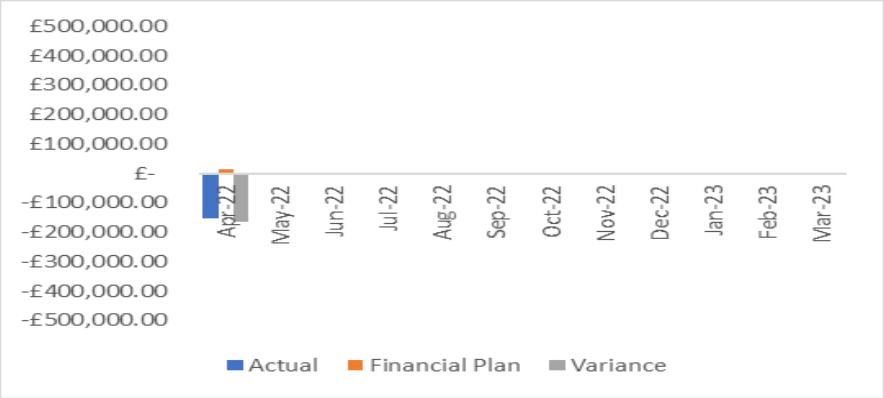
Governance
Executive Director: Heather Smith | **Responsible Committee**: Finance and Investment Committee | **Responsible reporters**: Alison Gordon/ Christina Foster

Executive Summary: Heather Smith, Chief Finance Officer
Narrative updated: May 2023
For reporting period ending: 30 April 2023

I&E £0.1m deficit, £0.2m adverse to plan. This includes £857k of one-off spend in April.
The CIP target allocated to directorates for FY24 is £7.2m, made up of £5.1m for FY24 and £2.1m unmet from FY23, So far £5.0m: £1m from the temporary staffing team following the NHSP transfer and £4.0m from clinical directorates through the planning of new investment.

Objective 3: Sustainability – areas of underperformance

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



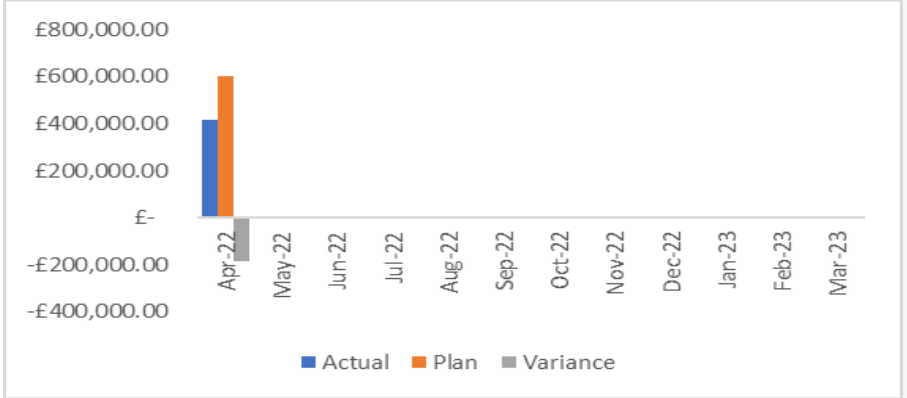
Executive Director commentary:
Heather Smith, Chief Finance Officer

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

The cause
The month 1 position includes £857k of one-off spend.

The plan or mitigation
Directorate positions against budget will be reported from month 2. Directorates which are overspent will need to take action to ensure that they can stay within their budgets by the end of the year.

Objective Key Result (OKR)	Trust
(3b) Cost Improvement Plan (CIP) Delivery	£0.2m adverse



Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
CIP Performance against plan is £0.2m adverse at month 1

The cause
CIP schemes have not been developed yet for the full CIP target, particularly within Corporate directorates.

The plan or mitigation
Finance will work with directorates over the next few months to identify schemes for the remaining CIP target.

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

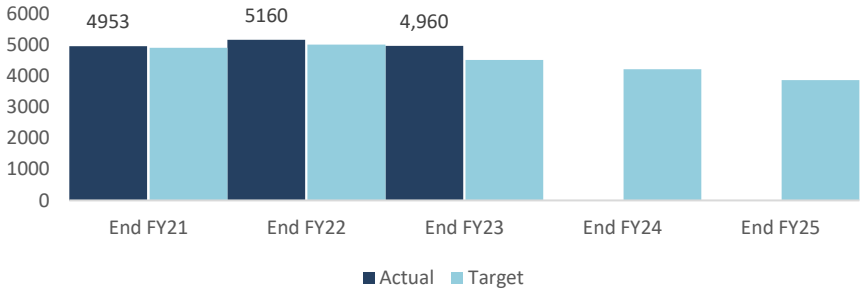
Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
It had been several years since the Trust completed a condition rating survey. Work to maintain a safe estate has been regularly carried out

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?
An updated 6 facet survey of the estate as been commissioned and completed. An overarching report based on these survey documents is to be produced, accompanied by a 5 year investment plan by mid-June 2023 for presentation and discussion to the Trusts Executive Committee.

Objective Key Result (OKR)	Target	Actual
(3e) (2e) Delivery of NHS Direct carbon footprint of 47% reduction by 2028 compared to 2019-20 baseline year ,	2328	4,960



Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
In FY23, the Trust consumed 4,960 tonnes of Co2 (NHS Carbon Direct Footprint only) . In FY23 we have achieved 4% reduction in the NHS Direct Carbon Footprint and 19% reduction compared to the 2019 baseline year. The actual consumption falls short of the annual 5% target for South East region to meet Net Zero by 2040. Total Carbon Emissions consumed (Supply Chain/Medicines) is 54,836

The cause
Staff Business mileage increased by 500,00 miles,increasing travel related carbon footprint by 15%

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. A key objective for FY24 to review modal shift to more sustainable travel.

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

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

	FY24 - TD				FY23 for reference
Studies	Opened	Closed	Studies that recruited	National comparator	
CRN Portfolio	4	3	Community Services 1 Oxon & BSW 2 Bucks 3 Corporate inc. R&D 6 TOTAL 12	OHFT 5th nationally – 12 studies 1st Trust – 24 studies	OHFT 3rd nationally – 49 studies 1st Trust – 84 studies
Non-Portfolio Student	2 1	2 1	2 1	n/a	n/a

	FY24 - TD		FY23 for reference
	Recruited participants to the above studies	National comparator	
CRN Portfolio	Community Services 5 Oxon & BSW 3 Bucks 8 Corporate inc. R&D 13 Oxford Monitoring System for attempted Suicide 91 TOTAL 120	OHFT 5th nationally – 120 participants 1st Trust – 986 participants	OHFT 5th nationally – 1806 participants 1st Trust – 6808 participants
Non-Portfolio Student	9 10	n/a	n/a

Executive Summary: Karl Marlowe, Chief Medical Officer \ Vanessa Raymont, R&D Director **Data cut:** 10 May 2023

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

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.

The Trust hosts the National Institute for Health Research (NIHR), Oxford Health Biomedical Research Centre (BRC), Oxford Clinical Research Facility (CRF), Oxford Applied Research Collaboration Oxford and Thames Valley (ARC) and NIHR Community Healthcare MedTech and IVD Co-operative (MIC)