Integrated Performance Report (IPR) Report: July 2023

May 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 areas of non-compliance are; • **clinical supervision** • **evidence patients have been involved in their care** • **Reduction in the use of prone restraint and** • **% staff have completed the national autism/LD training**	Pages 15-23
Strategic Objectives - **People; be a great place to work**	9 (8 have a target)	7	22%	• **Agency usage, 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)	1	25%	The **CIP plan** at month 2 is £0.4m adverse	Pages 30-32
Strategic Objectives – **Research & Development**	2 (no targets)	-	-	The Trust is ranked 2nd Nationally for participants recruited to CRN Portfolio studies and 6th 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, Chief Executive Officer
Narrative updated: 11 July 2023
For reporting period ending: May 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.
Inappropriate 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 Q1 23/24 the use of inappropriate OAPs has reduced from the demand peak in December and January and there were 174 bed days used in June 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: 11 July 2023

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Operational Update	Issue and Risk	EMIS roll-out has been completed across in-patient and ICC pathways- excellent support from the IT team CHC transfer completed end June- some data transfer issues ongoing 0-19 bid submitted Local Area SEND Inspection 4-21st July Significant pressures remain in OOHs/ Podiatry and District Nursing Winter planning has started at pace!
First Contact Care Service Pressures	Risk	There continues to be little change in issues relating to our First Contact Care Pathway. Significant demand pressures continue to impact across both OOHs and MIUS. 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. Leadership team robustness continues to develop. We are doing some work to review established staffing models in both services.
System and financial pressures	Risk	Sustained improvement 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, this success has been maintained. 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.

Section 3:

NHS Oversight Framework performance

National objective: Compliance with the NHS Oversight Framework

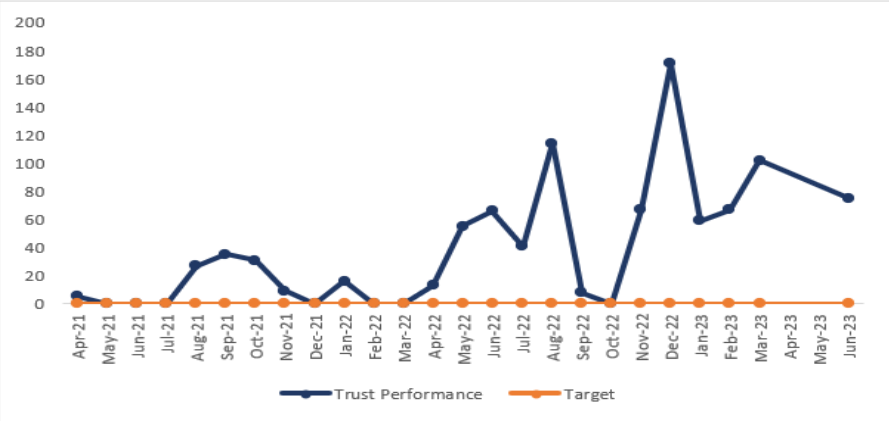
This year, the NHS Oversight Framework indicators that have targets are;	Target	National position (England)	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	74% (May)	91.6% (May)*	↓
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	72% (Dec)	88.2% (June 22)	
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	75.1% (Jan)	96.0% (July 22)	
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	48.1% (Mar)	54.2% (Mar)	→
(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%	90.2% (Mar)	99% (Mar)	→
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.4% (Mar)	100% (Mar)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	75 (June)	↑
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	99 (June)	↑

Executive Summary: Amélie Bages, Executive Director of Strategy and Partnerships
Narrative updated: 04 July 2023 for reporting period ending: **30 June 2023**

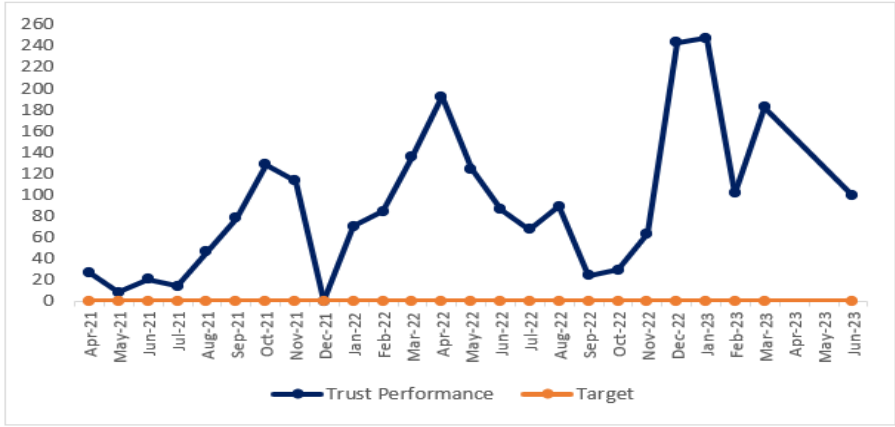
About: The NHS Oversight Framework replaced the provider Single Oversight Framework and the clinical commissioning group (CCG) Improvement and Assessment Framework (IAF) in 2019/20 and informs assessment of providers. It is intended as a focal point for joint work, support and dialogue between NHS England, 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. IAPT and MIU attendance wait time are both slightly below target and these are being monitored in operational services but are not considered a risk. *the figure provided is a local Trust figure owing to technical issues with the national submission. Indicators greyed out 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	75



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	99



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

The issue and cause
The use of Out of Area Placements decreased in Q1 in comparison to Q4 as a result of continued focus by Directorates on reducing the use of OAPs. Nonetheless demand remains extremely 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. **In June 2023 locally reported total bed day usage was 174 days (75 inappropriate OAP bed days in Bucks, and 99 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: May 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%	56.7%	68.2%	76%	72%	76.2%	46.8%	64.8% (June 23)	↑
(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%	19.7% (Q4)***	↑
(1d) Cases of preventable hospital acquired infections	<3 YE	-	-	-	-	-	-	0* YE	→
(1e) Reduction in use of prone restraint by 25% from 2022/23	183 YTD	-	22	11	-	4	-	37 uses against YTD target of 30	↓ improving
(1f) Patient/carer safety partners	2 YE	-	-	-	-	-	-	2 YE	n/a
(1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP)	95%	-	88%	70%	-	-	-	81% (July 22**)	n/a**
(1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT	95%	-	66%	61%	-	-	-	64% (July 22**)	n/a**
(1g) Evidence patients have been involved in their care (clinical audit result) reported bi-monthly	95%	No breakdown						80% (Q4)	→
(1h) % staff have completed the national autism/learning disabilities training	95%	35.7%	33%	41.2%	40.2%	49.5%	-	36.5%	↑

* Next health economy review meeting held quarterly
** Latest available data due to Carenotes outage.
*** Representation is quite varied when viewed by pay band

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: **May 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)	TBC	15	0	0	0	0	15 in month (28 YTD)	→
(1j) 48 hour follow up for those discharged from mental health wards	TBC	-	60%	78%	-	-	67% (July 2022* n=47/70)	-
(1k) 72 hour follow up for those discharged from mental health wards	80% national	-	60%	78%	-	-	67% (July 2022* n=47/70)	-
(1l) Inpatient Length of Stay (LOS) excl delay/leave – Mental Health Adult Acute	TBC		58 days	76 days			66 days (July 2022*)	-
(1m) Inpatient Length of Stay (LOS) – EMU	TBC	9 days	-	-	-	-	9 days (July 2022*)	-
(1n) Inpatient Length of Stay – Stroke	TBC	31 days	-	-	-	-	31 days (July 2022*)	-
(1o) Inpatient Length of Stay – Rehab	TBC	27 days	-	-	-	-	27 days (July 2022*)	-
(1p) Medically fit for discharge (MFFD) – Community	TBC	79	-	-	-	-	79 (July 2022*)	-

* 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: 26 June 2023
For reporting period ending: 31 May 2023

Four OKRs are underperforming YTD, although positive improvement 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.

Two OKRs are not RAG rated as there has been no data available to measure performance since July 2022 due to the IT outage and change in electronic patient health record. An exception slide is provided to share the work that is still continuing although it is harder to measure the change at the moment. Clinical audit results are being used to help steer the actions.

As part of the national patient safety strategy and to further our work to improve safety we have interviewed and offered 2 new patient/carer safety partner roles who will support and ensure co-production in safety improvement initiatives.

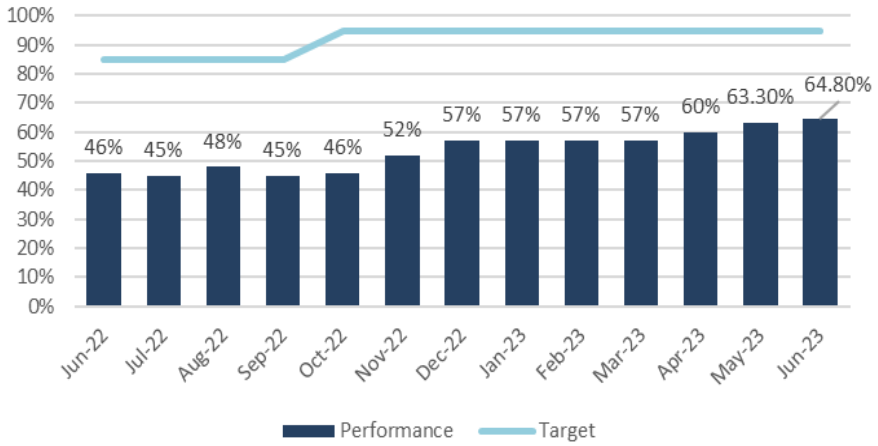
The Trust is carrying out Quality Improvement Projects in the following areas relevant to the Quality OKRs;

- 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 in the annual Quality Account, however further work and agreement is needed to reflect them within this report.

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	95%	64.8%



Executive Director commentary: Marie Crofts, Chief Nurse
Month narrative relates to: May 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 rate has improved this month for each of the clinical directorates. The Corporate services are currently the lowest for clinical supervision at 38%.

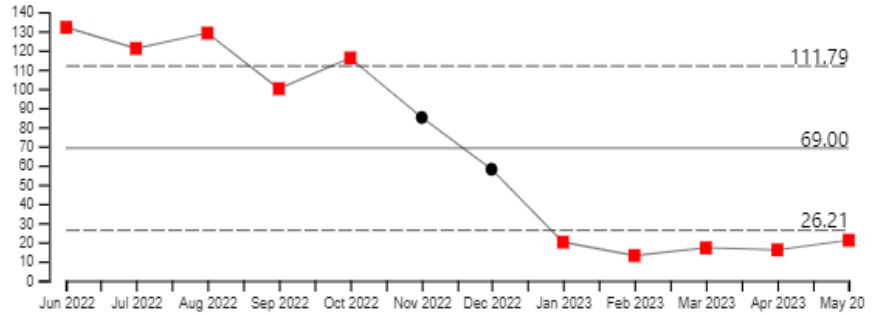
The actions taken include;

- Continued development of the recording system to improve ease of recording and accuracy. To include data quality work as identified.
- Working alongside those teams with the poorest uptake
- Delivering training for supervisors and supervisees, this continues to be evaluated and updated
- Supervision guidance developed and policy revised.
- Spot checks by Associate Directors of Nursing/ Heads of Nursing to review practice and quality of supervision
- Communication campaign about importance, including a focused supervision week in July 2023.

Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint	25% reduction from 2022/23 (183 YTD)	37 uses against YTD target of 30

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: May 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.

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.

For 2023/24 we have reset the target and baseline to focus on a 25% reduction in use from last year (2022/23).

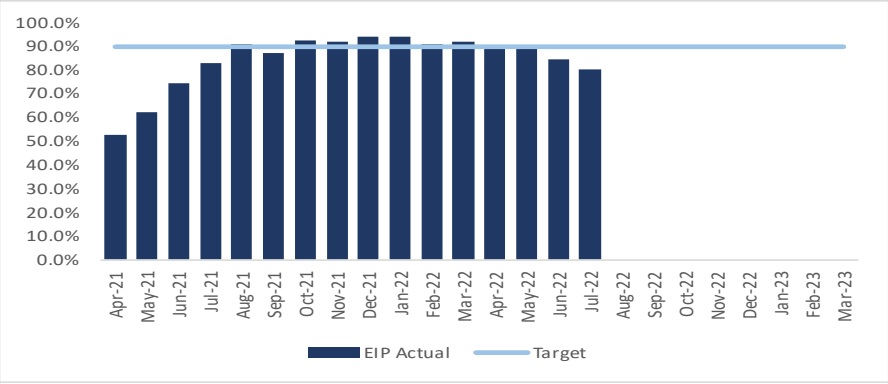
As well as individual ward projects the Trust has been rolling out the following actions across all wards;

- 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)	95%	64% (July 2022)

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)	95%	81% (July 2022)



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

Please note performance is not RAG rated because the last data available is from July 2022. An exception slide is provided to describe the work that is happening. In 2022/23 the target was 90% for EIP and 75% for AMHTs. The revised target for 2023/24 is 95%.

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. Clinical audits are supporting where to focus improvement work. We have some patient reported outcomes which show patients reporting feeling more supported with managing their physical healthcare.

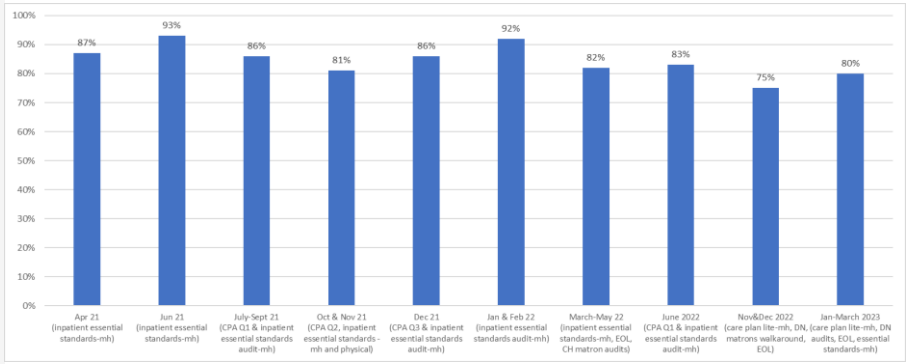
The focus in 2023 is on:

- Purchase of additional physical healthcare equipment.
- Diabetes management on the wards
- Physical health skills training for community mental health teams/ ward staff
- 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. Supported by employment of 4 WTE tobacco dependency advisors.
- 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.

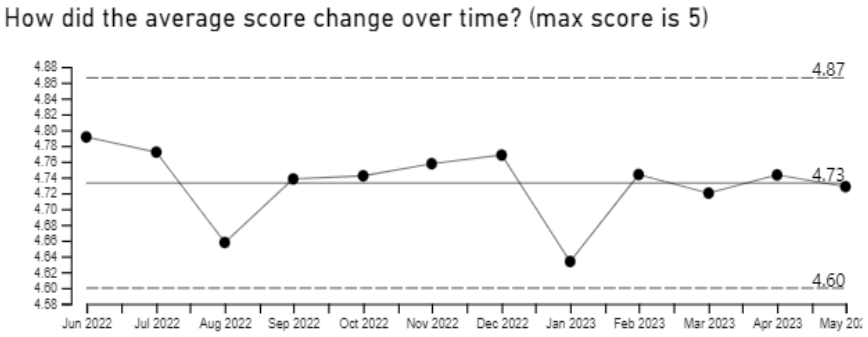
Objective 1: Quality; areas of underperformance

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.



Executive Director commentary: Marie Crofts, Chief Nurse
Month narrative relates to: May 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 for the question 'were you involved as much as you wanted to be in your care'. In May 2023 there were 1,652 responses from patients/families. The graph below shows the average score per month over the last year out of a maximum score of 5.

The plan or mitigation
Ensuring care is always co-produced is a primary objective of the new Experience and Involvement Strategy 2023-2025.

A number of quality improvement projects are underway with a focus on person centred care planning, 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) % staff have completed the national autism/learning disabilities training	95%	36.5%

Executive Director commentary: Marie Crofts, Chief Nurse
Month narrative relates to: May 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 new national training has now been released and all staff are expected to complete the training. The performance reported here is based on completion of part 1 of the national training provided on-line. Part 2 of the training is being developed with partners in the BOB ICS as it requires the provision of face to face teaching.

Performance against the national training is improving (5% in May 2023) and currently at 36.5% after being available to staff for the last 6 weeks.

Other activities happening
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.

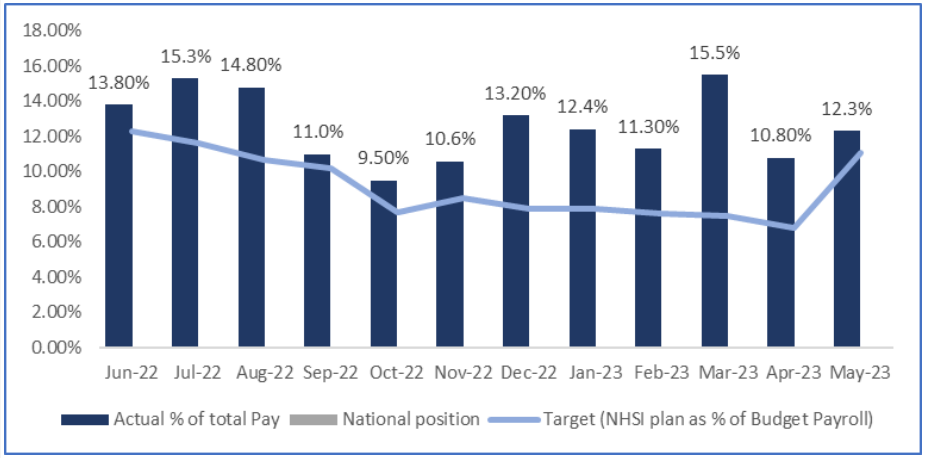
Objective 2: People – be a great place to work

Governance: Executive Director: Chief People Officer | **Responsible Committee**: People, Leadership and Culture Committee
Reported period: **May 2023** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results are;	Target	Buckinghamshire Mental Health	Community Services	Corporate	Forensic Services	Learning Disabilities	Oxford Pharmacy Store	Oxfordshire & BSW Mental Health	Provider Collaborative Commissioning	Research & Development	Trust	National comparator	Trust Trend
(2a) Staff Survey- Staff Engagement scoreQ4(2022)	>/=?	6.7↓	7.2→	7.3↑	7.5↑	7.1↓	7.5↑	7.1↓	6.1↓	7.3→	7.1↓	Best 7.4 Average 7.0 Worst 6.2	↓
(2b) Reduce agency usage to NHSE/ target	</ 10.4%	22.9%↑	7.9%↑	1.3%↑	14.8%↑	11.5%	0.0%	17.5%↑	0.0%→	0.0%→	12.3%	ModHos Peer Avg 7.8% - National Value 6.5 %	↑
(2c) Reducing staff sickness to 4.5%	</=4.5%	4.7%↑	6.2%↑	3.3%↑	5.9%↑	8.3%↑	3.6%→	5.1%↑	0.7↑%	1.9%→	5.1%	ModHos Peer Avg 4.9% - National Value 5 %	↑
(2e) Reduction in % labour turnover	</=14%	17.2%↓	17.4%↓	11.8%↑	17.0%↓	20.0%↓	21.9%→	16.5%↑	4.6%→	21.4%↑	16.0%	ModHos Peer Avg 19.9% - National Value 18.5%	↓
(2f) Reduction in % **Early** labour turnover	</=14%	18.0%↓	24.1%↑	12.7%↑	27.8%↓	16.9%↓	37.6%→	19.8%↑	9.8%→	10.0%→	19.6%	None	↓
(2g) Reduction in % vacancies	</=9%	16.0%↑	8.9%↑	1.8%↑	23.9%↓	12.0%↓	39.0%→	20.3%↑	-53.8%	40.6%↓	13.6%	ModHos Peer Avg 9.7% - National Value 9.1%	↑
(2h) PDR compliance	>=95%	32.3%↑	32.5%↑	31.5%↑	40.5%↑	21.3%↑	15.0%↑	26.7%↑	40.0%↑	17.5%↑	31.0%	None	↑
(2i) S&MT (Stat and Mandatory training)	>=95%	88.3%↑	88.4%↑	84.5%↓	90.9%↑	88.1%↑	90.5%↑	85.3%→	89.9%↑	84.3%↑	87.1%	None	↑
(2j) Number of Apprentices as % substantive employees	>=2.3%	6.9%↓	6.4%↑	2.2%↓	3.6%↑	4.3%→	0.0%→	4.7%↑	0.0%→	2.4%↑	5.0%	None	→

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2b) Reduce Agency Usage to Target	</=10.4%	12.3%



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 recruitment workstream has implemented Page Tiger a platform that makes it easier for staff to join to the Trust and complete the required pre-employment documentation. The recruitment team are now developing the onboarding documents and a recruitment brochure. The workstream has also implemented Horsefly Talent Insights which provides analytics data to inform future recruitment campaigns.

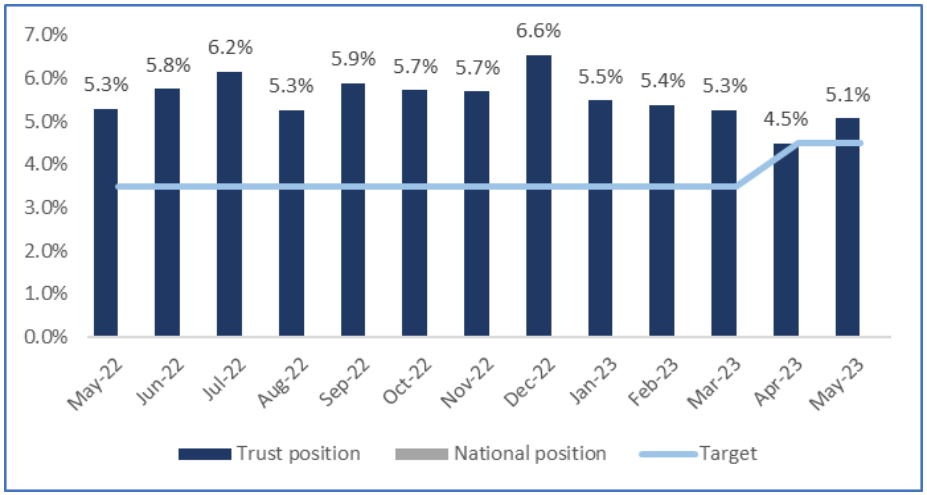
The international recruitment workstream has had 55 nurses (30 RMNs and 28 RNs) commence employment with the Trust. There is 1 RMN due to arrive this month, 1 RMN who is waiting for their visa and 5 nurses (1 RMNs and 4 RNs) ging through pre-employment checks. There are 3 international OTs who have commenced employment with the Trust and 6 OTs going through the pre-employment check process.

The medical workforce workstream is continuing to work with finance colleagues to clarify the medical workforce establishment baseline. The workstream is currently finalising the medical workforce recruitment strategy and priority work plan.

Use of the Patchwork system to manage Junior Doctor Bank Workers went live on the 26th June. The Master Vendor Agency Contract for the Medical and Dental workforce is due to go live on the 31st July.

Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=4.5%	5.1%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The sickness absence increase from 4.5% to 5.1% and has remained above target. Excluding Covid absences the rate was 4.5% (3.9% last month). High sickness absence rates result in increased temporary staffing use and pressure on colleagues.

The Cause
Whilst sickness absence remains above target.

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

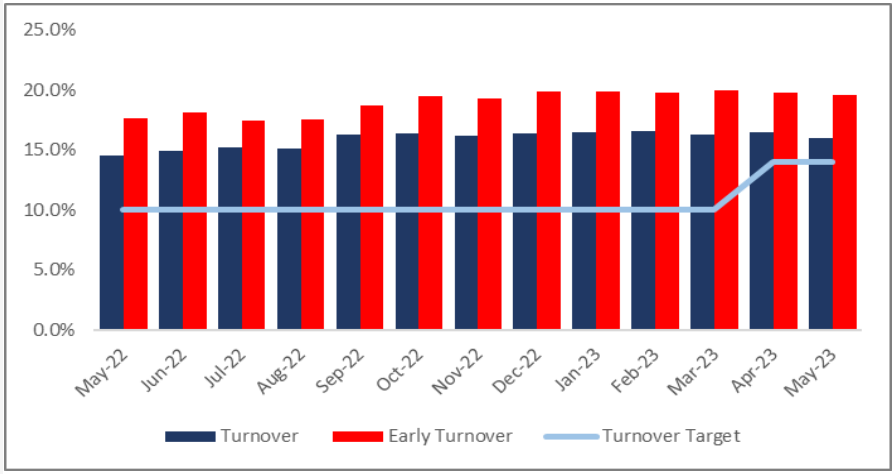
Work continues to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees. This is a key enabler to ensure that appropriate referrals are made, including signposting to the various support/assistance programmes that are available (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. We are also reviewing our contract with GoodShape which runs out in September 2023. 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. 34 cases are being actively managed by the team, overall absence levels continue to drop. . 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%	16.0%
Early Turnover	<14%	19.6%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Staff turnover decreased to 16.0%. Early labour turnover has slightly decreased to 19.6%. 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

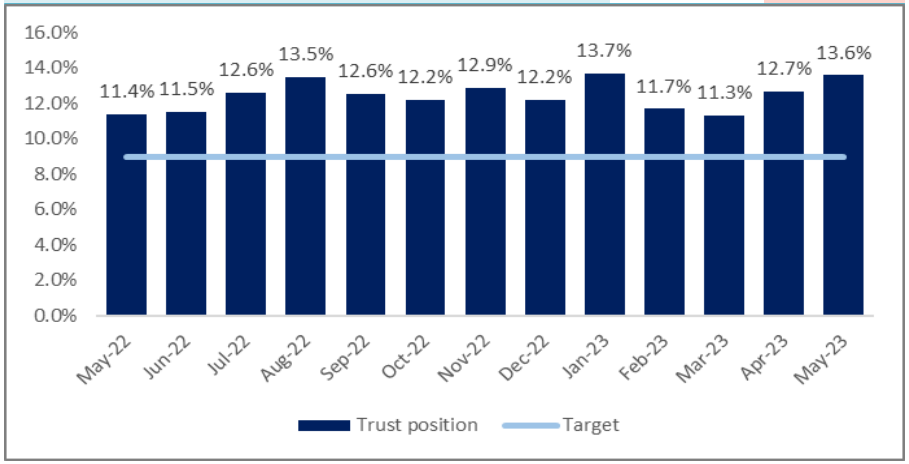
The plan or mitigation

The Retention Team started on the 1st May and have commenced the work programme in line with the national best practice recommendations :

- Retire and Return (QI Stage – Delivery). The process has been streamlined and the information much more accessible to staff. A policy needs to be completed and then the project will be complete for this stage. The next PDSA cycle will be linking in with the Systems workstreams as there are still issues there.
- PDR project (QI stage - Delivery Phase) The first PDR season launched on the 1st April 2023 and at time of writing compliance is at 52% with 4 weeks to go. The next PDSA cycle will start in July 2023.
- Onboarding project (QI Stage – Design) Month 7 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 – Delivery) New process set up with L&D and Retention working in partnership.
- Talent Management (Discovery) a new QI workstream is being set up which will focus on talent management and career progression.
- 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%	13.6%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The vacancy rate has increased from 12.7% to 13.6%; 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, talent and skills 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
A Recruitment and Onboarding Manager has been appointed and started with an initial focus on further streamlining recruitment processes, upskilling the recruitment team to become advisors and experts on the recruitment process and improving the candidate journey to reduce the number of candidates that 'drop out' during the recruitment process.

New KPIs have been identified which are across both qualitative and quantitative metrics.

A focus on improving the candidate experience, will result in improving Oxford Health's employer brand and in turn will support candidate attraction and long-term retention.

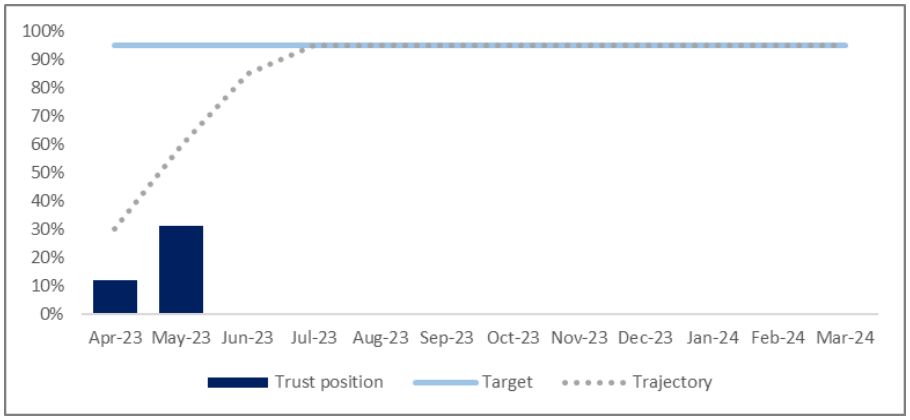
The PICU Recruitment program is in progress, now having completed 2 successful open days, held at the Highfield Unit, on 25th February and 13th May 2023. The project team have confirmed 2x virtual events for July with a focus on B5 nursing recruitment as this is the highest area of risk.

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 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. A recruitment branding project plan is being created to ensure buy-in from colleagues across the Trust and to ensure the brand represents our communities
3. 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%	31% (May)



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. Individuals who do not receive a PDR may not be supported to access professional and personal development opportunities which maybe a risk to retention. The NHS Staff Survey shows that our staff do not find PDRs valuable or useful.

The cause
Several historical factors have contributed 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. These have been resolved through the Quality Improvement Programme and it is now important to change the culture regarding the value in completing PDRs.

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.

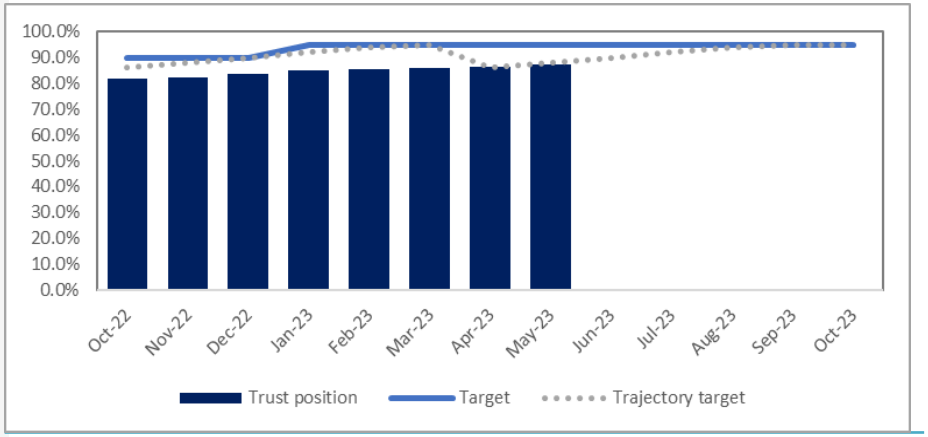
Posters have been distributed across all inpatient & community sites to raise awareness of the PDR campaign and remind staff to get their booked in.

As of the 3rd July the Trust is currently at 52.5% compliance which is below 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%	87.1%



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 June has decreased from 87.1 to 85.5%. 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 decrease in the overall compliance rates, which can be attributed to the required changes made to the resus audiences to enable the Trust to return staff to a F2F model for all resus training. 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

- Forensic Service and Oxford Pharmacy Store are leading the way having achieved more than 90% compliance. The Trust average is being lowered by compliance levels below 86% in Corporate Services, Research and Development and Oxfordshire & BSW Mental Health.
- Queries regarding errors in the L&D system continue to be reported by all staff through the HR Systems Service desk. Most recently work has focused attention on our out of hours GP's to ensure that they have access to the correct training required to meet CQC standards.
- Focused work on Resus continues with weekly reporting being sent to the Chief Nurse. Staff who are out of date being targeted and booked by L&D admin onto available spaces. Resus trainers reporting improvements in attendance rates more recently.
- Successful roll out of new streamlined IPC training removing unnecessary levels of training and providing more accessible training for all staff.
- Staff reporting some issues with e-learning not signing off after completion – HR systems team working with system provider to ensure this is not a wider issue.
- 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;	Trust	Trust Trend
(3a) **Favourable** performance against financial plan (YTD)	£0.2m Fav	↑
(3b) Cost Improvement Plan (CIP) delivery (YTD)	£0.4m 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)	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

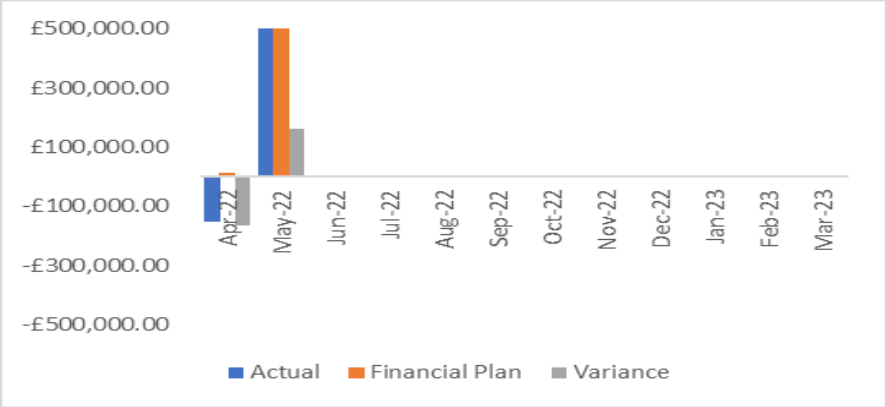
Executive Summary: Heather Smith, Chief Finance Officer
Narrative updated: July 2023
For reporting period ending: 31 May 2023

I&E £0.7m surplus, £0.2m favourable to plan. The Clinical Directorates are all reporting adverse to plan positions at month 2 which need to be addressed for the Trust to meet its overall plan for the year.

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 £4.8m has been delivered -£1m from the temporary staffing team following the NHSP transfer and £3.8m 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 favourable



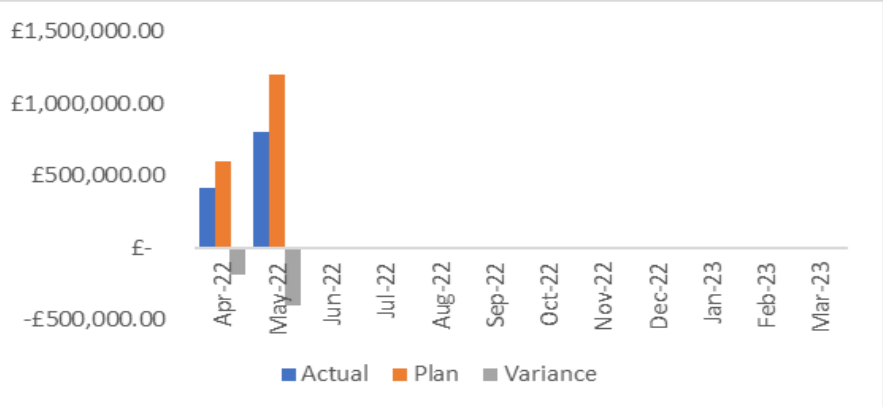
Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
Financial performance is £0.2m favourable to plan at month 2, but there are overspends in all of the clinical directorates.

The cause
Agency spend is the driver of many of the overspends in clinical directorates.

The plan or mitigation
Agency control panels to start at the end of July.
Directorate Management teams to take action to bring directorates back into budget.

Objective Key Result (OKR)	Trust
(3b) Cost Improvement Plan (CIP) Delivery	£0.4m adverse



Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
CIP Performance against plan is £0.4m adverse at month 2.

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

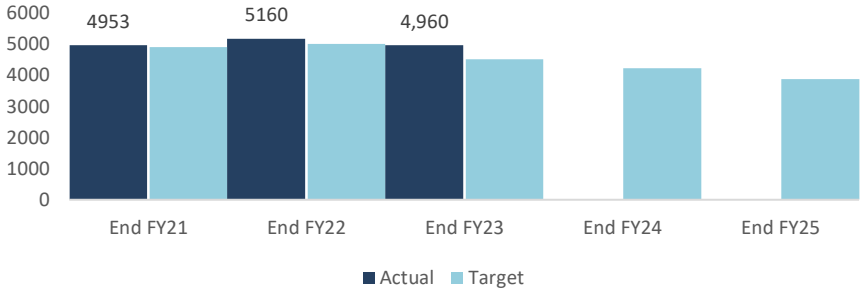
Executive Director commentary:
Heather Smith, Chief Finance Officer

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 has been commissioned and completed. An overarching report based on these survey documents is to be produced, accompanied by a 5 year investment plan for presentation and discussion at Green Task Force and CPSC .

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 ,	2028	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) . Which translates to 19% reduction in NHS Direct Carbon Footprint when 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 tonnes.

The cause
Staff Business mileage increased by 533,996 miles, increasing the travel related carbon footprint by 17% (147 tCO2e)

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. Report with recommendations to be completed in July following outcome of staff travel survey .

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	9	3	Community Services 3 Oxon & BSW 5 Bucks 4 Corporate inc. R&D 12 TOTAL 24	OHFT 2nd nationally – 24 studies 1st Trust – 40 studies	OHFT 4th nationally – 46 studies 1st Trust – 72 studies
Non-Portfolio Student	4 3	3 2	4 5	n/a	n/a

	FY24 - TD		FY23 for reference
	Recruited participants to the above studies	National comparator	
CRN Portfolio	Community Services 15 Oxon & BSW 11 Bucks 18 Corporate inc. R&D 59 Oxford Monitoring System for attempted Suicide 207 TOTAL 310	OHFT 6th nationally – 310 participants 1st Trust – 1030 participants	OHFT 5th nationally – 1789 participants 1st Trust – 6598 participants
Non-Portfolio Student	21 50	n/a	n/a

Executive Summary: Karl Marlowe, Chief Medical Officer \ Vanessa Raymont, R&D Director **Data cut:** 27 June 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)