

# ANNUAL QUALITY ACCOUNT 2022 - 2023



*Working together to deliver the best for our communities, our people & the environment*

**| Caring | Safe | Excellent |**



**Outstanding care by an outstanding team**

1. What is a Quality Account? .....	3
2. About the Trust.....	3
3. Introduction from the Chief Executive .....	5
4. Our Focus to Continually Improve the Quality of Care .....	6
5. Key Achievements and Awards over the Year.....	7
6. Developments supported by the Oxford Health Charity.....	10
7. Progress Against the NHS Long-Term Plan and National Priorities .....	12
8. Research and Development Update: the Future of Healthcare.....	13
9. Quality Concerns .....	14
10. National and Key Quality Indicators – last 12 months .....	16
10.1 Our Performance against the NHS Oversight Framework.....	16
10.2 Follow up of patients within 72 hours of inpatient discharge (adults and older adults) .....	17
10.3 Care Quality Commission Visits and Inspections.....	17
10.4 Patient and Family Experiences and Involvement (including national survey results) .....	17
10.5 Complaints, Concerns and Compliments .....	24
10.6 The Learning Disability and Autism Improvement Standards .....	26
10.7 Patient Safety Incidents.....	28
10.8 National Enquiries – Our Response .....	30
10.9 Staff experiences (including national survey results).....	31
10.10 Clinical Audit.....	32
10.11 Data Quality and Information Governance .....	32
11. Strengthening our Safety Culture to empower staff to raise any concerns without fear.....	33
12. Learning from Deaths .....	35
13. Progress on Quality Objectives set for 2022/23.....	41
14. Our Quality Improvement Plan for 2023/24 .....	64
15. Statement of Directors responsibilities in respect of the Quality Account.....	66
16. Glossary of Acronyms used in this report .....	67
Appendix 1. National Clinical Audits.....	68
Appendix 2. The Trust’s Strategy at a glance .....	72
Appendix 3. Statements from our Partners on the Quality Account .....	73

## 1. What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year (2022/23) at achieving our goals. It also looks forward to the year ahead (2023/24) and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

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

If you require any further information about the 2022/23 Quality Account, please contact [Jane.Kershaw@oxfordhealth.nhs.uk](mailto:Jane.Kershaw@oxfordhealth.nhs.uk).

## 2. About the Trust

At Oxford Health we provide:

- **Mental health services** all ages in Buckinghamshire, Oxfordshire and predominantly children's services in Swindon, Wiltshire, Bath and North East Somerset.
- **Autism and learning disability services** in Oxfordshire.
- **Community physical health services**, such as district nursing, community dental services, podiatry, community hospitals, health visiting, school nursing, a homeless GP and urgent care services across Oxfordshire.

Our services are delivered at community bases, hospitals, clinics and in people's homes. We focus on delivering care as close to home as possible.

In everything we do, we strive to be caring, safe and excellent. The care we provide is rated overall as 'Good' by the Care Quality Commission (CQC).

We employ around **6,500 staff** who work across **150 Trust sites** and provide services to a population of **2.5 million people**.

We believe working in partnership with our patients, families, other care providers and academic institutes is the best way to achieve high quality care. There are many examples throughout the Account of how we do this.

We lead three NHS Provider Collaboratives in specialised mental health services, to manage whole pathways of care on regional footprints. As lead provider we take responsibility for the oversight of the delivery of services and encourage collaboration to provide the best possible care for patients. We have seen significant successes achieved by the collaboratives including the continued repatriation of patients closer to home, the lowest percentage of out of area placements for children in the Country, as well as developing a children's Hospital@Home service. The eating disorder team have been innovating and adapted CBT treatment into Integrated CBTE which has been shown to have positive outcomes for patients and won a national award.

The Collaboratives are;

- For Me, Thames Valley and Wessex Forensic Network (inpatient services), working with 8 providers
- Thames Valley Children and Adolescent Mental Health inpatient services, working with 3 providers
- HOPE<sup>1</sup> Adult inpatient Eating Disorder network (South East Region), working with 3 providers



Thames Valley Community Dental Services partnership. Community Dental Services provide dental care for people who are unable to access care from a general dental practitioner due to

<sup>1</sup> HOPE stands for Healthy Outcomes for People with Eating disorders

specific/complex needs. Over the past year the partnership has grown with numerous collaborative quality improvements and innovations taking place across all three NHS Trusts, we hope to formalize the agreement in 2023.



*Staff from the East Oxford Dental Clinic*

Integrated Care System (ICS) have been introduced across England as part of the NHS Long Term Plan. The Trust is part of the Buckinghamshire, Oxfordshire and Berkshire West ICS, and the Bath and North East Somerset, Swindon and Wiltshire Partnership ICS. ICSs have been established to add strength to partnerships between NHS organisations, local authorities, and the voluntary, community and social enterprise sector. We agree shared priorities and work together to resolve the most challenging issues.



In 2022/23, we launched the Buckinghamshire, Oxfordshire and Berkshire Mental Health Provider Collaborative with Berkshire Healthcare NHS Foundation Trust, in partnership with the Integrated Care Board (ICB). The aim of this provider collaborative is to lead the transformation of mental health services at scale in the ICS, focusing on improving quality of care and addressing health inequalities.



*Some examples of patients benefiting from the initiatives led by Oxford Health Arts Partnership*

### 3. Introduction from the Chief Executive

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

I am proud to introduce and share Oxford Health NHS Foundation Trust's 2022/23 Quality Account.

It has been quite a year! There have been extraordinary challenges including a major cyber incident that rendered some of our most important electronic systems inoperative for several months and alongside this we are managing increasing demand for services with limited resources. However despite this, we have continued to deliver services and care for thousands of patients whilst introducing many innovations and improvements to care. This is a considerable achievement and is as a result of our amazing staff who have shown dedication, ingenuity and kindness.

We are committed to reducing the number of staff vacancies and improving the well-being and support offered to our staff, shown through many examples in the Account and the quality objectives we set in 2022/23. We have introduced a range of awards to recognise and celebrate those who have gone the extra mile, some of these are shared in the report. We have a work programme focused on improving recruitment, retention and reducing agency use. The amount of activity around recruitment and the number of new staff appointed was higher in 2022/23 than the previous year however the number of vacancies is still high at 11% of roles. We will continue to work on this locally and also as part of a wider system.

It is our aim to keep patients and their families at the centre of what we do, and we have a dedicated section in the Account to share some of the work this year. We will keep building on this so that services are co-designed and co-produced.

Our 14 quality objectives for 2022/23 were ambitious and we have not fully achieved everything we set out to, although we have made progress against all and I am pleased to say for many of the objectives we have been able to demonstrate an impact on patient care and staff well-being.

I attach a great deal of importance to the culture of our Trust and ensuring that it is one that puts the patient first, is compassionate, inclusive, empowers and is always looking at ways to learn. Hence our focus throughout 2022/23 has been on

supporting staff, listening and embedding an ethos of continual quality improvement. On average we have around 100 active quality improvement initiatives happening at any time. Quite a few of the improvements and achievements we have made are detailed in the Account. We have also shared our progress on delivering the NHS national priorities to transform services.

With so many challenges ahead the role of research is absolutely key to the development of new treatments and interventions. Across the organisation there are an ever increasing number of examples of how we have been able to turn academic research into clinical practice. Such innovations have not only resulted in better care and treatment for our patients but also have resulted in our staff being able to work more efficiently and having higher job satisfaction. The Trust is ranked 3<sup>rd</sup> nationally for the number of National Institute for Health Research portfolio studies which people participated in, with 49 new studies being opened in 2022/23.

Good healthcare is dependent on good partnership working and collaboration. Very few, if any, of our patients just receive care from Oxford Health but instead are supported by professionals from a variety of different organisations. We are leading a number of provider collaboratives and see these alongside the Integrated Care Systems as essential to support and provide the leadership required to put services on a sustainable footing. As well as resolve the considerable difficulties we are now facing.

I hope you enjoy reading the Account and see the progress we have made in the last year. I am confident we will keep improving and developing the care we provide to patients and their families.



A handwritten signature in black ink, appearing to read 'Nick Broughton'.

**Dr Nick Broughton, Chief Executive**

#### 4. Our Focus to Continually Improve the Quality of Care



We are driving forward to make Quality Improvement ‘the way we always do things here’ so that we are continuously learning and improving to develop the care we provide.

The Trust has established the Oxford Healthcare Improvement Centre to provide; training and support for quality improvement projects, enable collaboration, sharing of outcomes and horizon scanning for future projects. Our aim is that improvements to patient care are always co-produced with patients and their families.

The Trust has a Quality Improvement Strategy with some of the key achievements in 2022/23 being;

- To build capability three levels of training have been developed and rolled out from level 1 on awareness to level 3 which provides simulation training to become a quality improvement coaches. The training is available to staff and patients/carers involved in quality improvement.
- Monthly QI cafes have been established as relaxed, informal space for staff to discuss ideas for change and any help needed.
- A series of podcasts have been recorded to share learning, as well as a Trust-wide QI conference in October 2022 involving staff and patients.
- We have also shared our learning and successes with other organisations at a number of external conferences and through five publications of our work including [Improving personality disorder care across mental health services: a system-wide approach](#)
- Creation of QI hubs in each directorate to bring together people to focus on QI activity within services. The hubs provide support and oversight of activity to embed our approach and sustain improvements.
- QI has gained significant momentum in the Trust over the year, with on average 100 QI projects open and active at any one time.

Below are some of the recent Quality Improvements projects we have undertaken. There are lots more examples of the improvements we have made to patient care throughout the Account. The majority of quality objectives in 2022/23 took a quality improvement approach.

- Reducing the use of restrictive practice – projects have occurred across a number of wards
- Increasing co-production in care planning – community mental health team
- Person-centred care in community hospitals
- Improving the standardisation and efficiency of occupational therapy initial contact and assessment within a mental health inpatient service
- Improving mealtimes for patients and staff within an eating disorder unit
- Bringing nature into CAMHS inpatient services: reflections for the implementation and integration of training into practice
- Improving sexual safety in mental health
- The use of simulation based learning to overcome barriers to Quality Improvement within NHS services
- Improving the uptake and quality of staff appraisals

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

- Inpatient ligature harm minimisation in the built environment
- Conducting therapeutic observations in mental health inpatient settings

We have received funding to carry out work on;

- Mapping trauma-informed practice at an integrated care system level: a realist synthesis
- A simulation-based education intervention for facilitating therapeutic meal support in the dining room of an adult inpatient eating disorders unit: a feasibility study

## 5. Key Achievements and Awards over the Year

There are many examples throughout the report of our achievements this year, however we also wanted to highlight the below.

Our pioneering use of enhanced [cognitive behaviour therapy \(CBT-E\)](#), developed with Oxford University, has reduced readmissions for people with anorexia by a remarkable 70% in a year. The HOPE Adult Eating Disorder Collaborative was named the national winner of the Excellence in Mental Health Award, NHS Parliamentary Awards 2022.

Hear Mollie's inspiring story of hope, a former patient who has had this treatment [see article](#)



Clinical team involved and *patient* who received the treatment and is helping us.

The Oxfordshire School Aged Immunisation Team have worked hard this year to increase the uptake of immunisations in those who either missed their vaccination due to the pandemic or who were eligible for their routine vaccinations during the academic year but for whom no consent form had been submitted by the parent/carer. To increase uptake text messaging to parents who had not submitted a consent form for the flu vaccination was introduced prior to the vaccination sessions in school and this has had a remarkable effect on increasing the number of consents received. In some schools this increased consent rates by over 50% and has now been introduced across all the school based immunisation programmes.

Buckinghamshire IAPT service (Improving Access to Psychological Therapies) has been working on increasing referrals and access to treatment through postal campaigns and radio marketing as well as closer working with the University including having a clinic within the University. The service to asylum seekers and refugees has been increased including working with the refugee hotels. The service has also worked with Berkshire, Oxfordshire and Milton Keynes NHS Talking Therapy services on a Staff Wellbeing Strategy to maintain good workplace wellbeing and support sustainable services for patients. The strategy has been designed by and for NHS Talking Therapy staff. The strategy has been successful and shared nationally for other services to model.

We have introduced ePMA (electronic prescribing and medicines administration) to replace paper drug charts with a system that supports prescribing and administration of all patient medication. As a Global Digital Exemplar site, Oxford Health has had the funding to invest in ePMA. Two mental health wards have gone live, and it has had an immediate impact on reducing missed and delayed doses of medicines, avoiding significant drug interactions and ensuring safe prescribing in patients with allergies. It has also significantly reduced the time for nurses to complete medicines rounds, releasing their time for care. ePMA will continue to be rolled out to other mental health wards, our community hospital wards and then to mental health community teams.

Oxfordshire Community Dental Services – going to the Witney dental clinic has been made a lot more relaxing following the addition of special LED ceiling screens that show either a soothing static image or can play a choice of nature themes films. They are designed to help relax and distract anxious patients enabling the dentist to examine them and carry out treatments. They have already been shown to reduce patient’s anxiety levels, particularly in children. These installations have been made possible with funding from the Oxford Health Charity.



The Buckinghamshire early intervention eating disorder service (FREED) is live, providing support for eating disorder patients between the ages of 18 – 25. Engagement with young people and their views of FREED was commissioned from Healthwatch. School nurses, GPs and Oxford health staff were trained on eating disorders by the charity BEAT. A review of adult eating disorder services has started.

Ofsted rated Oxford Health NHS Foundation Trust’s apprenticeship scheme as ‘Good’ across all five categories



Below is a selection of a few of our winners from the monthly exceptional people awards, the DAISY award (for nurses) and the BEE award (for allied health professionals) - all celebrated for going the extra mile.



## 6. Developments supported by the Oxford Health Charity

The Charity and Involvement team have continued to provide support to enhance the experience of patients, carers and staff in 2022/23 through Trust volunteering, the Oxford Health Charity (OHC), the Oxford Health Arts Partnership and informal community group engagement for the Trust. Some of the key areas we want to celebrate are described overleaf.

A big thank you to our **180 volunteers** and fundraisers.



*Annual football tournament to raise awareness and fundraise.*



*Nurses from the Community Children's Nursing team undertook a marathon walk to raise money for ROSY.*

The first Oxford Health Arts Partnership Strategy was launched in 2022 with the overall vision of 'Inspiring recovery, wellbeing and growth through creativity'. The [annual report](#) produced at the beginning of 2023 reflected on the significant achievements of the first year of this strategy with over 3200 participants joining the 473 arts sessions delivered through the year across services.



*A bespoke mural from a local artist, new flooring and toys transform the children's waiting area at Abingdon Minor Injury Unit. The artwork was funded by the Oxford Health Charity.*

# CHARITY & INVOLVEMENT ACHIEVEMENTS

The Charity & Involvement Team is responsible for the Oxford Health Charity, Trust volunteering, community engagement and the Oxford Health Arts Partnership (OHAP).



## FUNDRAISING & SUPPORT

In-person fundraising returned in 2022, following the reduction in COVID restrictions, and the team supported events at the Blenheim 7k, Oxford Half and a local football tournament. Over 300 requests for funding were received from teams across the Trust seeking to enhance patient, carer and staff experience.



## MAKE YOUR REST AREA SHINE

The Make Your Rest Area Shine programme was launched in early 2022 to support staff wellbeing. Over 60 teams requested support and OHC provided care packs, beanbags, activities and kitchenware to them over the following months.



## WILTSHIRE VOLUNTEERS

A successful bid to develop volunteering to support the waiting well through NHS England Volunteering Programme, has led to the introduction of volunteers in the Wiltshire Eating Disorder (ED) service - with roles supporting patient groups, individuals attending initial reviews and those on the waiting list.



## INSPIRING IMPROVEMENT

OHC hosted its first Inspiring Improvement Programme with Oxford Healthcare Improvement and received five strong projects for consideration from existing QI leads. Three of the projects related to green spaces developments, one to trialling a Long COVID support pilot and one to support individuals being discharged from long-term care.



## HEALTHFEST

HealthFest 2022/23 was delivered across four months, 47 hours were focused on staff wellbeing with overwhelmingly positive feedback. Sessions were held both in-person and online enabling engagement from across the Trust.



## VOLUNTEER TO CAREER

Following a successful bid to be one of 10 Trusts developing Volunteer to Career programmes with the support of Health Education England and Helpforce, we have introduced a new approach to support individuals seeking a way into the NHS through volunteering. The project is being piloted in Wiltshire ED services and will expand into other areas in 2023/24.



## APPEALS

Work started afresh with the Lucy's Room Appeal - bringing a music room to the Warneford, Oxford for adult mental health patients - with the building due to arrive Spring 2023. We also introduced the new Meadow Unit Appeal in support of developments in the new PICU for young people in Oxford.



## NHS CHARITIES TOGETHER

We continued to be part of the NHS Charities Together membership - receiving support, guidance and opportunities for grant funding through Stage 3 and Stage 4 COVID grants.



## IMPACT OF ART

The first OHAP Strategy was created and launched - aiming to increase delivery and impact of arts across the Trust for patient and staff wellbeing and recovery. Research projects to measure the impact of art on health have also been initiated to further evidence this impact.



## GREEN SPACES

The Oxford Health Charity projects to introduce an outdoor gym at Littlemore, increase the green spaces for staff and patients at Saffron House, Wycombe, develop a multi-use sports area at the Highfield, Oxford and introduce wellbeing pods to the garden at Cotswold House, Marlborough all came to fruition during the year with really positive results.

## 7. Progress Against the NHS Long-Term Plan and National Priorities

The NHS Long-term Plan from 2019-2029 and annual national priorities has and will continue to drive a number of major initiatives to transform services in 2022/23. More detail can be found here; <https://www.longtermplan.nhs.uk/> and [20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf \(england.nhs.uk\)](https://www.longtermplan.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf). This section should be read alongside our progress against the learning disability and autism national standards.



Our successes against the initiatives in the Long-Term Plan and National Priorities include;

- Enhancing the urgent community response (physical health services) to prevent unnecessary admissions and to speed up discharge. The services include; community response to someone's home within 2 hours for patients in a crisis, hospital at home 'virtual ward', and same day emergency care via the Emergency Multidisciplinary Units which might include admission. The services have been doing some focused work on increasing referrals from the ambulance service as part of 'call before you convey' work.
- In 2022/23 we have continued to increase vaccination capacity to provide the maximum level of immunity, as well as developing pathways for patients to access new antiviral treatments.
- Delivering a service jointly with Oxford University Hospitals NHS Foundation Trust for patients suffering from long COVID. Our post-COVID rehabilitation specialist took part in a Westminster Health Forum policy conference in January 2023 about the priorities for long COVID services, care and research (see photo above)
- Expanding hospital at home services to provide virtual wards to enable patients to stay at home whilst being treated.
- Introducing mental health support teams into education settings, we offer support to around 200 schools and this is due to expand further in 2023/24
- Specialist perinatal mental health services have been expanded.
- Developing primary care mental health teams with hubs in the community to improve timely access to mental health support and communication between GPs and mental health services. In Oxfordshire the teams are called Keystone mental health and wellbeing hubs. Frank Bruno opened one of the hub locations as a mental health champion in November 2022 (see photo above). In Buckinghamshire the model is around neighbourhoods based on local population needs - offering psychological support, signposting to specialist services and employment support. In 2023/24 the Buckinghamshire offer will include peer support and higher intensity outreach services for patients with a personality disorder.
- Increasing capacity of the Improving Access to Psychological Therapies (IAPT) in both counties including support for people with a long-term condition

- Developing individual placement and support services to help patients with a mental health secure and maintain employment, training or volunteering
- Expanding crisis resolution and home treatment teams for children and adults, as well as providing safe havens as an alternative to A&E for patients experiencing a mental health crisis
- Maintaining mental health crisis helplines 24/7 for both children and adults
- Mobilisation of the Thames Valley Complex Childrens programme this has involved the Trust working with RAW Potential (a social enterprise and charity) to employ community youth workers across Oxfordshire, Buckinghamshire and Berkshire to work as part of clinical teams to support and deliver co-produced interventions with young people with complex needs, with a focus on outreaching into the community.
- Joint working with our acute NHS partners in Oxfordshire and Buckinghamshire around better management and support of children with mental /social care needs who present to A&E
- Restoring our memory diagnostic services which were impacted by COVID-19, as well as increasing capacity through a change in service model and a project to increase the provision of assessments in nursing and care homes to support on-going care needs.
- Development of the mental health provider collaboratives, more details above under the section 'About the Trust'.

There is still lots of work to do to meet all aspects of the Long-Term Plan as we build on the changes above.

## 8. Research and Development Update: the Future of Healthcare

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

This year the Trust was ranked 3<sup>rd</sup> nationally for the number of National Institute for Health Research (NIHR) portfolio studies which people participated in. We were ranked 4<sup>th</sup> for the number of participants that we have recruited to our NIHR portfolio studies. 49 new studies have opened in 2022/23 compared to 47 opened in the previous year (2021/22), ranging from small projects to highly complex clinical trials of new medicines.

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

The Trust and the University of Oxford run a Biomedical Research Centre (BRC), one of two in the country focusing on Brain Health. This is dedicated to translating innovative research into better treatments for mental health disorders and dementia. In the summer of 2022, the Oxford Health BRC was renewed for a further five years starting in December 2022 and awarded £35.4 million in funds.



An example of the new BRC is the agreement to develop a world leading centre for the development, evaluation, and delivery of highly effective, accessible, and remote psychological interventions for children and young people that fills the gaps where current evidence is lacking, and current provision is not sufficiently effective. The aim is that this will provide both better access to clinical support and research for patients, and research-based evidence will allow the service development to be of maximal benefit for patients.

In the summer of 2022 the NIHR Oxford Cognitive Health Clinical Research Facility was renewed for a further five years starting in September 2022.

The Trust hosts the NIHR Applied Research Collaboration (ARC) Oxford and Thames Valley which carries out applied health research that will have a direct impact on patient health and wellbeing. An example of this is that research from NIHR ARC OxTV supported researchers was key in recent all-party government report evaluating government commitments on the digitisation of the NHS.

NIHR community Healthcare MedTech and In vitro Diagnostics Co-operative (MIC) to build expertise and capacity in the NHS to develop and evaluate new medical technologies and diagnostic tests. One of its key themes is around how to use points of contact devices to improve care for long term conditions, and one example of that working is a study that found only 1 in 4 people diagnosed with heart failure received a simple, recommended blood test that could have resulted in an earlier diagnosis at a more treatable stage. The Oxford MIC is currently in the process of applying for further funding to become a NIHR HealthTech Research Centre (HRC).

Oxford Health is now a part of the Oxford Joint Research Office (JRO), which includes teams from Oxford Health, Oxford Brookes University, the University of Oxford, and Oxford University Hospitals. The Oxford JRO now includes both of Oxford's NHS Foundation Trusts and both of its universities, promoting and facilitating greater collaborative working across and between the partner organisations in clinical research, for the benefit of the people they serve. The development of the Oxford JRO has been supported at the highest level in each organisation and by the Board of the Oxford Academic Health Partners, of which all four institutions are members.

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

## 9. Quality Concerns

The Trusts Quality Committee reviews and identifies the top-quality concerns at each meeting and these are also reviewed at the monthly Quality and Clinical Governance Sub-Committee and weekly Clinical Review Meeting to ensure the delivery of safe services and appropriate actions and mitigations are in place. Quality concerns are identified through some of the information sources shared in this Account, the Trust's Quality and Safety Dashboard and intelligence received from our staff and stakeholders.

Our five key areas of focus based on concerns highlighted are:

**Clinical Workforce Challenges.** Both mental health and physical health services are being affected by shortages of substantive staff due to high levels of vacancies alongside increased demand for care. This is having an impact on the quality of patient care and experience, our capacity to see patients timely and also increasing costs owing to the increased use of agency staff. Largely the vacancies are for nurses although there are significant difficulties with recruiting medics in some teams for example GP out of hours service, CAMHS community teams, adult acute mental health wards and within adult eating disorder services. There are also local and national shortages for podiatrists, speech and language therapists (SLT) and district nurses. We have a large scale programme of work led by the Chief Nurse called 'Improving Quality, Reducing Agency use'. This is a clinically led programme of work which has eight workstreams with a focus on how we retain and recruit staff, as well as reduce our reliance on using agency staff. This has included actions to centralise unregistered staff recruitment campaigns, targeted marketing and rebranding, reduced "time to hire" rates, virtual job fairs, co-creating jobs with candidates, continued expansion of apprenticeships and student placements, reviewing exit interview feedback and introducing international recruitment. We have seen a success in recruitment however turnover has remained high. An update on the work of Programme including trends on vacancies, turnover and agency use is regularly provided to Trust Board with the last update available in the public papers [here](#). Addressing these challenges is also a core part of our revised Nursing Strategy 2023-2026 with a focus on valuing and supporting nurses as well as creating a sustainable workforce.

**Loss of our electronic patient record systems.** The Trust had very reduced access to view information or use our three main patient record systems for an extended period from August to December 2022. This was due to a cyber-attack on our supplier which affected a number of NHS Trusts, with an investigation led at a national level involving the National Cyber Security Centre and the Information Commissioners Office. Locally we implemented business continuity plans and declared a critical incident to manage; operations, risks and mitigations, and to oversee a clinical harm review process throughout. As a result of the attack the majority of Trust services moved to new electronic systems from December 2022 which involved a huge piece of work to train and roll out new systems, which are still being embedded now. Our community hospital services plan to move to a new system in July 2023. It was an incredibly difficult time for staff managing increased risks to patient's safety as well as having a significant impact on team capacity to care and treat patients. This came at a time of increasing demand. Due to the dedication of staff and understanding from patients, no serious harm has been identified directly related to the issues created by the IT failure. However, we are still feeling the impact now (April 2023) for example we are unable to centrally report or monitor activity since the end of July 2022, some of our monitoring arrangements such as clinical audits had to be paused, and we have made limited progress against some of our quality improvements identified for 2022/23 because resource and attention had to be focused on day to day patient care.

**Timely Access to Services.** Waiting lists and access to some services are rising as a result of increased demand, higher patient acuity, pressures in the wider system and the aftermath of COVID-19. This potentially increases risk to patients and also means that we are not meeting national or local targets. Delayed access for an outpatient assessment and/ or treatment does not provide a good experience for patients, families and carers. Some services are struggling more with patients having to wait longer than expected- these include;

- District Nursing
- Podiatry services
- Children's therapy services
- Child and adolescent mental health services, including children with neurodevelopmental conditions
- GP out of hours service

Every service has processes in place to manage and regularly review anyone waiting. We conduct regular reviews to identify any clinical harm so this can be addressed quickly. Also a number of services have carried out what a perfect week would be like in 2022/23, to identify improvements that can be made. Lots of innovations are being tried to help manage demand exceeding capacity in many services, this includes working with the private and third sector as well as trying work across the BOB ICS.

**High use of inpatient out of area placements.** Unfortunately we have continued to rely on out of area placements due to sustained demand and not having sufficient bed capacity within our own wards. There has been a particular pressure on admissions for female patients. This often results in patients being further away from their home and family. Lengths of stay (duration of admission) can often be longer and there are additional costs. See below reporting on national indicators for more detail about the actions being taken.

**Staff health and wellbeing.** Ensuring Oxford Health is the best place to work is a strategic objective for the Trust. Research highlights the need to ensure colleagues feel valued and empowered and psychologically safe at work. Both the impact of Covid-19 and the continued high demand for services has had significant impact on our staff. The Trust has made this a high priority to keep a continued focus on supporting and listening to what staff need. We have a wide-ranging health and wellbeing offer delivered through a strategy and steering group. More on the work that has happened this year is captured in the reporting against quality objective L2 for 2022/23.

## 10. National and Key Quality Indicators – last 12 months

### 10.1 Our Performance against the NHS Oversight Framework

The NHS System Oversight Framework replaced the previous performance framework which informs the assessment of providers, more details can be found here [NHS England » NHS Oversight Framework 2022/23](#). The Trust monitors performance through a range of activity, quality and workforce measures in the monthly Integrated Performance Report presented to the Board of Directors.

Table 1 shows the Trust’s performance against the indicators in the NHS Oversight Framework.

Our ability to report on our up to date position against many of the national indicators has been affected by the cyber-attack from August 2022 described in detail on page 14. An indicator we can report on and have struggled to achieve the national target is the number of inappropriate out of area placements in both Oxfordshire and Buckinghamshire, further details are below.

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

National objective: Compliance with the NHS Oversight Framework				
This year, the NHS Oversight Framework indicators that have targets are;	Target	National position (England)	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	71.50% (Mar)	88.8% (July)	→
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	72% (Dec)	88.2% (June)	↑
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	71.4% (Nov)	94.3% (June)	↓
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	48.5% (Dec)	48.5% (Dec)	→
(N5) IAPT - Percentage of people waiting six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	75%	89.70% (Dec)	98.8% (Dec)	↓
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.2% (Dec)	100% (Dec)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	102 (Mar)	↑
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	182 (Mar)	↓

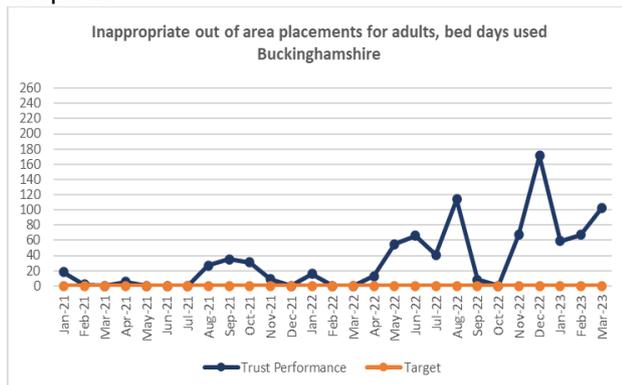
Source: Integrated Performance Report

#### Eliminating inappropriate adult acute out of area placements

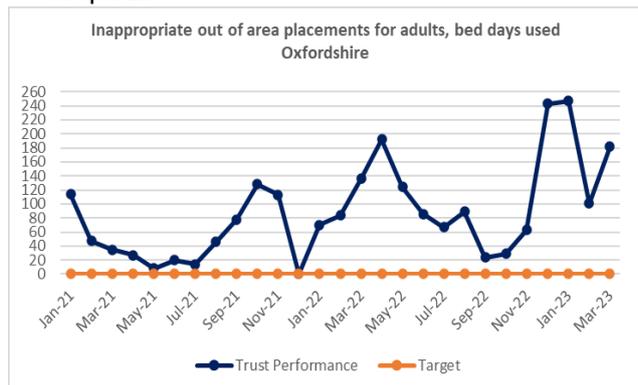
Out of area placements are when we admit someone to a ward outside the services provided by the Trust. An out of area placement is categorised as inappropriate if the rationale for placing the person relates to bed pressures or absence of community or social care support. The Trust is aiming to stop the use of out of area placements. However we have not achieved this consistently yet as the position by county shows in the graphs below.

The use of out of area placements varies month by month, we have seen a higher demand for specifically female beds than we have capacity. This remains a continued area of focus to manage patient flow and also to strengthen our crisis resolution and home treatment teams.

Graph 1.



Graph 2.



## Other national indicators and benchmarks

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

- 10.2 Follow up with patients within 72 hours of inpatient discharge
- 10.3 Care Quality Commission inspection rating
- 10.4 Patient and carer/ families experiences (including the national survey)
- 10.5 The Learning Disability and Autism Improvement Standards
- 10.6 Patient safety incidents
- 10.7 Staff experiences (including the national survey)
- 10.8 Clinical Audit
- 10.9 Data Quality and Information Governance

### **10.2 Follow up of patients within 72 hours of inpatient discharge (adults and older adults)**

This indicator is an important measure to the safety of care and evidence shows the importance to reducing suicides. See page 36 for our work on prevention of suicides. We are clear with our teams the importance of contacting and seeing patients soon after being discharged from a mental health ward. Our ability to report on this indicator has been affected by the cyber-attack from August 2022, however our performance between April to July 2022 was 81% against a national target of 80%. We continue to work on this as every patient should be followed up and supported in the first few days after being discharged from a ward.

### **10.3 Care Quality Commission Visits and Inspections**

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

Oxford Health NHS Foundation Trust is required to register with the CQC, and our current registration status is registered with no conditions. The CQC has not taken enforcement actions against the Trust in 2022/23.

Oxford Health NHS Foundation Trust is subject to periodic reviews of the quality of care by the CQC. Following our CQC inspection from July-September 2019 the Trust is rated as **Good** overall. The full report can be found at <https://www.cqc.org.uk/provider/RNU>. We have not had an inspection during 2022/23.

In 2022/23, 11 of our mental health wards received an unannounced visit by the CQC to review compliance with the legal requirements of the Mental Health Act for people who have been detained. This compares to 12 wards visited in 2021/22. The CQC carries out this specific type of visit for every mental health ward on a regular basis. During these visits the CQC reviewer will speak to patients and staff, review the environment, and review the quality of documentation in patients records. No serious concerns were raised and many examples of good practice were highlighted. The areas we continue to work on are around documenting the processes we follow around giving patients information about their rights and Section 17 leave, and further embedding individualised care plans.

### **10.4 Patient and Family Experiences and Involvement (including national survey results)**

#### **Strategy**

##### **10.4.1 Strategy**

The Trust has co-developed a new Experience and Involvement Strategy for the next 3 years (2023-2025) with patients, staff and local patient advocate organisations.

The key objectives of the strategy are;

- Working in partnership to co-produce care and services
- Listening to our patients and service users
- Using feedback to identify and make improvements to services

The Trust's Family, Friends and Carers Strategy 2021-2024, which is specifically aimed at carers and family members was published in 2021 and is available here; <https://www.oxfordhealth.nhs.uk/wp-content/uploads/2021/10/Family-Friends-and-Carers-Strategy-2021-24-FINAL-WEB.pdf>. An update on progress against the Strategy and our work with carers is provided under the quality objective E14.

The Trust's Experience and Involvement Forum is made up of patients, carers and staff and this group oversees our work to improve patients experiences and involvement. The forum meets bi-monthly (every other month) and has three co-chairs, two of whom are experts by experience.

## Involvement and Co-production

### 10.4.2 Co-production

Below are some examples of the work we have been doing with patients and carers in 2022/23. Embedding co-production into everything we do is a key focus of our new strategy.

**The Oxfordshire Primary, Community and Dental Services** have:

- Seen the amount of feedback double for their urgent care services as a result of using SMS texts sent to all eligible patients who attend the out of hours service, Minor Injury Units or the First Aid Unit.
- The Respiratory Service were the first service in the Directorate to test out the newly developed co-production training in February 2023. Staff fed back that it was motivational and have got the service thinking of ways of involving service users.
- The Community Voice group met for the first time in July 2022, to support services in identifying and designing changes to improve services.
- The Community Therapy Service hosted a virtual Allied Health Professionals work experience event for A-Level students. A patient spoke at the event about their use of the service.
- Experts by Experience helped to develop a patient information leaflet for the wearable technology and remote monitoring device trail in the Hospital at Home Service.
- The Oxfordshire system are developing a Transfer of Care (ToC) Hub and are aiming to improve discharge arrangements. To help shape this work, the system are using the perspectives and experiences of people and families. Experts by Experience are supporting the work.
- Creating with Care ran an arts focus groups in May 2022 at Didcot Community Hospital to co-design the next phase of the arts project for the ward.



*An example of some of the activities available on the community hospital wards*

**The Forensic Services** have:

- Co-produced improvement action plans around improving experiences and involvement in services with patients and their family/ friends. A patient involvement action group and families/friends action group meet regularly to oversee the delivery of actions.
- Six Peer Support Worker trainees have completed training and are nearing the end of their placements.
- The recovery and co-production session at Forensic Induction has been reviewed, with the participation of a Forensic CMHT service user.
- A new pattern of meetings has been developed for the Family and Friends monthly meet up. Family Champions have been supported in making sure family and carer contact details for their wards are up to date. The family & friends information leaflet for the wards has been redesigned. Resources to use when working with families and carers have been updated.

- Following previous work on promoting the importance of ward Community Meetings there is now a need to regularly review and audit how Community Meetings are going on each ward. This is in the early stages of development.
- A review of the Patient Council Rep role has been completed – the next stage is for this to be developed into more structured support for the role along with some co-produced and co-delivered training. A number of wards are now having their Patient Rep participate in part of their Senior Team meetings, rather than hold a separate Patient Council meeting. This is to be monitored and reviewed.
- Evenlode Voices group have worked with Rethink Mental illness as part of Rethinks project to improve experience and involvement across the Forensic Provider Collaborative. Following Rethink joining 3 meetings on Evenlode, Evenlode Voices have been asked to present the work they have done to a meeting which is open to all the services in the collaborative.

**The Learning Disability Services** continue to support their Governor representative. Experts by experience have interviewed for multiple posts within the Learning Disability service and for Trust-wide posts. A peer review has been carried out using an easy read version of the peer review paperwork. An expert by experience who has worked for CQC in the past participated in this first peer review and provided feedback on the process and paperwork.

**The Oxfordshire and Buckinghamshire Mental Health Services** have:

- The Oxfordshire and Buckinghamshire Our Voice patient groups are well established and embedding co-production across the Directorates. Members have been crucial in the following projects;
  - Co-produced care planning project across Oxfordshire adult and older adult community mental health teams
  - The new Warneford hospital development
  - The Trust-wide suicide prevention strategy
  - The Community Mental Health Framework workstreams
  - The development of the Keystone mental health and wellbeing hubs
  - The development of the service user involvement workstream across the Oxfordshire Mental Health Partnership
  - Peer review visits
  - The Directorate Quality Improvement hubs to oversee ensure a patients voice is in every QI project.
  - The introduction and trial of Oxevision – inpatient digital monitoring equipment to reduce the adverse impact on patients of routine observations
  - Multiple staff interviews
  - Develop a service user panel for the eating disorder service
  - Engaging with the crisis teams to recruit service users to feedback on the model and continuing work around engaging older adults.
  - The launch of the Berkshire, Oxfordshire, Buckinghamshire neurodivergent forum – ‘Thinking Neurodivergent’, which aims to give a voice to this patient group.
- A training package on putting co-production into practice has been developed, trialled and will be rolled out.



*The project team including experts by experience for the work on increasing co-production in care planning.*

### 10.4.3 Youth Boards

The Trust has been working with Unloc an organisation founded by young leaders and advocates to empower young people on a project to reach out to young people to listen to what they need and want from services.



Over 2,500 young people aged 12-25 took part in our initial survey, the top three things identified as having the biggest impact on their mental health was; negative thoughts and feelings, studying/exams and relationship problems. The surveys highlighted that the majority of young people lack confidence to ask for help (75% in Oxfordshire and 70% in Buckinghamshire) and are unsure what services are available to them.

Following the survey we recruited to Youth Boards in Oxfordshire and Buckinghamshire to enable ongoing engagement and involvement in specific projects. The work has galvanised young people across Oxfordshire and Buckinghamshire: receiving an incredible 70+ applications in Buckinghamshire and 50+ applications in Oxfordshire to join the respective Youth Boards. The Youth Board members have designed and held Mental Health Summits focused on wellbeing in Oxfordshire and Buckinghamshire in 2022/23. Youth Boards have also shaped the; CAMHS website, engagement strategy, membership strategy, emergency department project, the use of technology in promoting mental health, and have delivered online webinars.

### 10.4.4 Mental Health Peer Support Worker Programmes

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

At the Trust we have trained a total of 154 peer support workers since 2019. The peer support workers are embedded in various adult and older adult inpatient and community mental health teams across the Trust.

This year following feedback from a co-production event with our stakeholders, we changed the delivery/training model of the programme and are piloting a recruit to train model. We launched a new recruitment campaign in December 2022 and received a staggering 130 applications. We offered 4 'introduction to Peer Support' sessions, in order to set the expectations for the role and the application process, which were very well attended with 100 applicants. We had 3 days of interviews with 70 applicants and then eventually offered the programme to 19 candidates. The standard of applicants was very high and therefore competitive. The areas we have recruited to include primary care mental health teams, perinatal service, early intervention service and some of our mental health wards. The training will also be offered as a level 3 apprenticeship moving forward with a pilot in 2023, this will help to accredit the training and provide further development opportunities.



*Photo of the Forensic Peer Support Workers on the final training day*

#### 10.4.5 Individual Placement and Support (IPS) Service

This is an evidenced based programme to support people with mental health difficulties to return to employment and to support retention in work. Meaningful work and particularly paid employment for those who have been suffering with mental illness is crucial in their recovery and is a key plank within the Mental Health Long Term Plan. The service employs two peer support workers who have led the trailblazing team in offering peer support. In December 2022 the Buckinghamshire IPS team went through an external accreditation and was awarded IPS Grow Quality Mark. The Oxfordshire team will follow in May 2023.

In 2022/23 the service received 366 referrals and helped 77 patients back into paid work.



*IPS and Peer Support Team, this includes people with lived experiences.*

#### 10.4.6 Recovery Colleges



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

The forensic recovery college was selected as a finalist in the HSJ 2022 patient safety awards under the category of service user engagement and co-production award. The college is quite unique and one of only a handful of services in England working in forensic mental health services. It helps forensic patients manage their mental health and undertake their recovery journey in the same way as community patients. All the courses – on wellbeing, understanding mental illness, or living skills – are co-produced between tutors with lived experience, including forensic patients, and professional tutors. Courses are for forensic services staff too, who take part on an equal footing with patients. A great example of co-production by the colleges is the Library of life, here are some of the [videos](#) of college students' recovery journeys.

The model in Buckinghamshire is currently being reviewed with members to look at options of how to improve delivery.

## Feedback – what does it say?

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

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

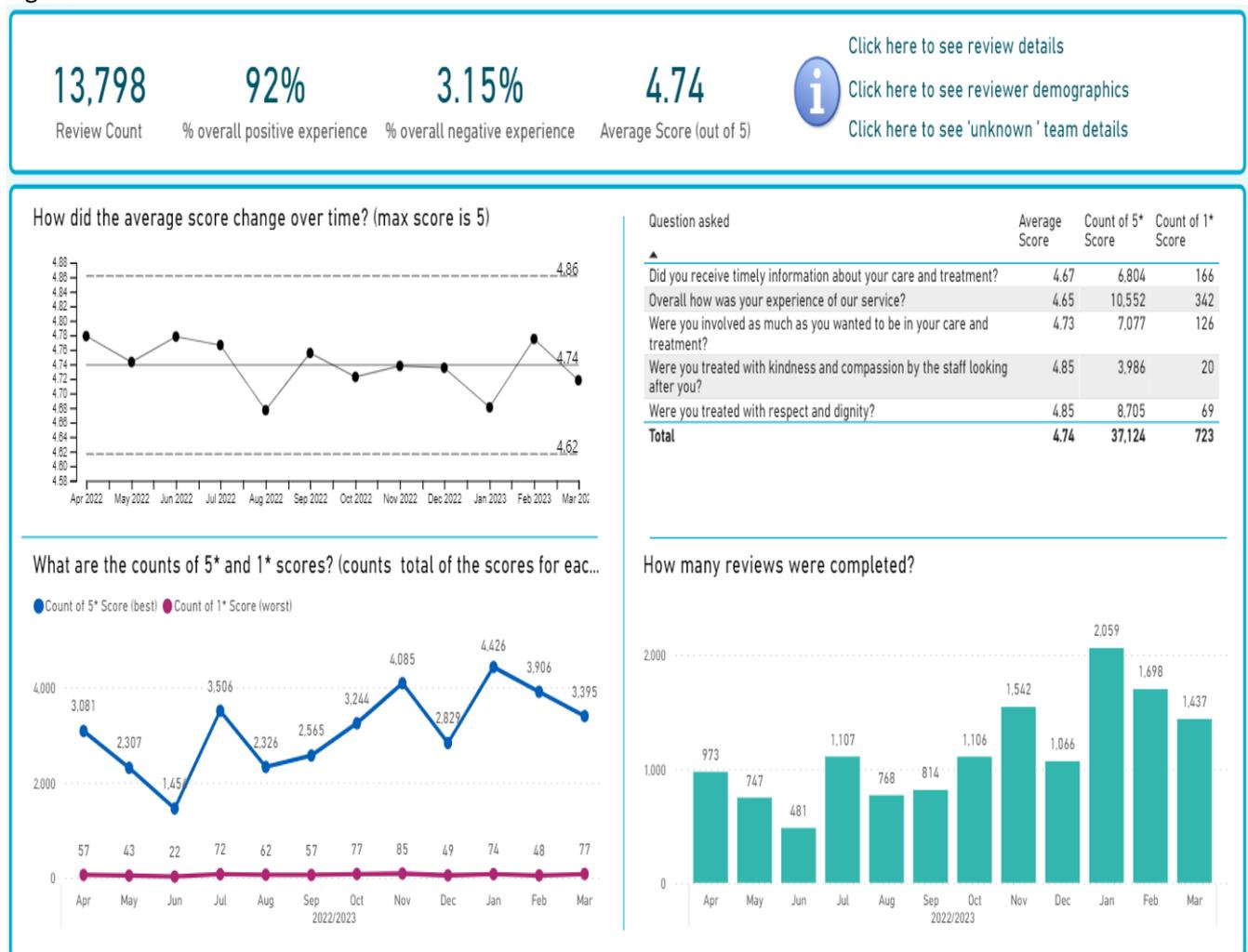
- Patient and family forums, groups and councils
- Concerns raised through PALS and complaints
- Volunteers collecting feedback
- Patient and family stories
- QI projects and facilitated focus groups
- Telephone surveys
- Feedback from Healthwatch
- Social media posts
- National surveys
- Feedback from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

### 10.4.7 Local Surveys

The Trust received 13,798 local surveys via IWGC in 2022/23, 4,000 more than the previous year (2021/22). The average score given by patients/ families was 4.74 out of a possible 5. The granular data is available at team level and is monitored by the Trust for improvement purposes.

Below is a Trust-wide summary of our feedback received in 2022/23, figure 1.

Figure 1.



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



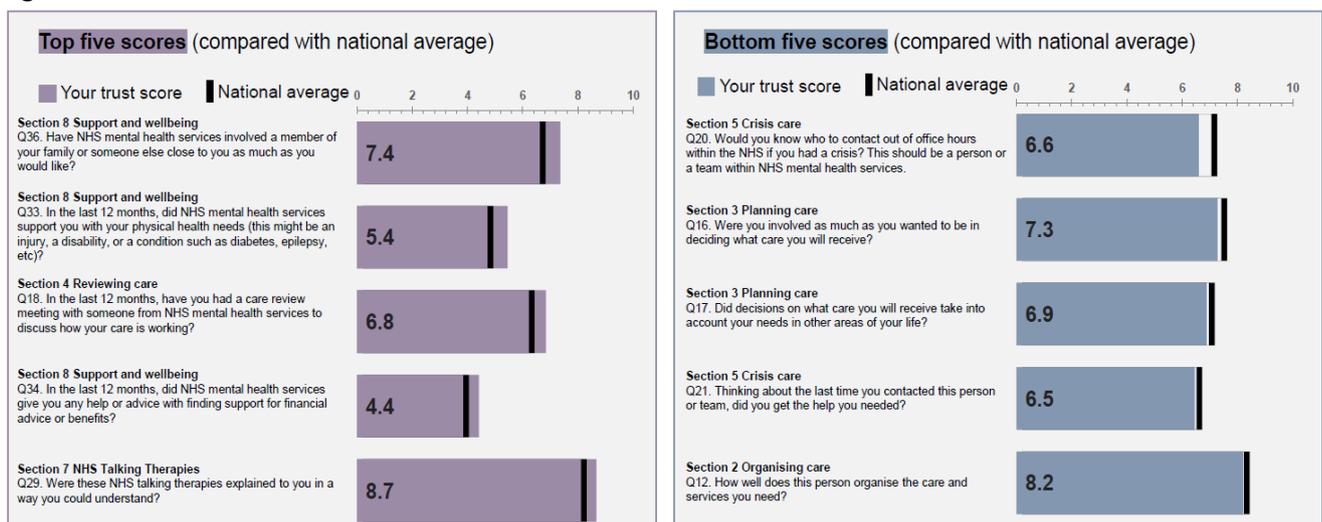
**About the survey and how it is scored.** The survey contained several questions organised across 12 sections. Responses to each question and section were converted into scores from 0 to 10 (10 representing the best response). Each score was then benchmarked against 53 other English providers of NHS mental health services, resulting in the Trust being given a rating for each question and section on a five-point scale ranging from “much better” to “much worse” than expected.

**Summary of Trust results.** The result to every question in the survey improved from 2021, with the change being statically significant for two questions. Two questions are better than expected compared to other NHS Trusts and improved from last year, however our performance against the majority of questions was similar to other NHS Trusts. We have performed better than the national average on; involving a family member, support with physical health needs, reviewing care in the last 12 months, supporting with financial advice, and explaining what are talking therapies. Areas we scored below average on; knowing who to contact in a crisis out of hours, getting the help needed when contacting the crisis number, feeling involved in care decisions and how well services/care were organised.

The Trust’s performance in relation to the national average are summarised below In figure 3.

The results have been shared with teams to identify any further actions that would have a positive impact.

Figure 3.



Source: CQC national report with the survey results

## 10.5 Complaints, Concerns and Compliments

We aim to ensure all service users and families get a good experience of using our services. At times we do fall short of our expected standards and need to work with patients and families to learn. We aim to resolve any concerns as soon as possible however sometimes these concerns escalate into a formal complaint. We welcome complaints in a positive way and recognise they give us a valuable insight and an opportunity to improve services.

In 2022/23 we received 200 complaints, all (100%) were acknowledged within 3 working days and 98%<sup>2</sup> of complaints were responded to within a timescale agreed and communicated with the complainant. Seven complaints were re-opened in the year. Graph 3 shows the number of complaints received year by year. The majority of complaints in 2022/23 were received from carers/family members and relate to our mental health services. The cyber-attack meant some investigations took longer to complete in 2022/23, but throughout we have kept complainants updated on progress. Overall the average response time was 50 days, this is much longer than we would want so we are taking a quality improvement approach to reduce this alongside introducing changes as a result of the new national NHS complaint standards.

<sup>2</sup> Two complaints were not responded to within a timescale agreed with the complainant.

The Parliamentary Health Service Ombudsman completed a national review of the NHS Complaints Standards in 2021 and 2022. The final standards were published at the end of 2022 and guidance published in early 2023. We have reviewed our position against the national standards and have started to identify where we need to make changes.

In addition to formal complaints, in 2022/23 the Trust responded to 130 MP enquiries where constituents had raised concerns with their local MP and we managed 784 more informal concerns raised by patients/families. Our teams also received 2,499 positive compliments.

The main reoccurring themes for improvement across the Trust are:

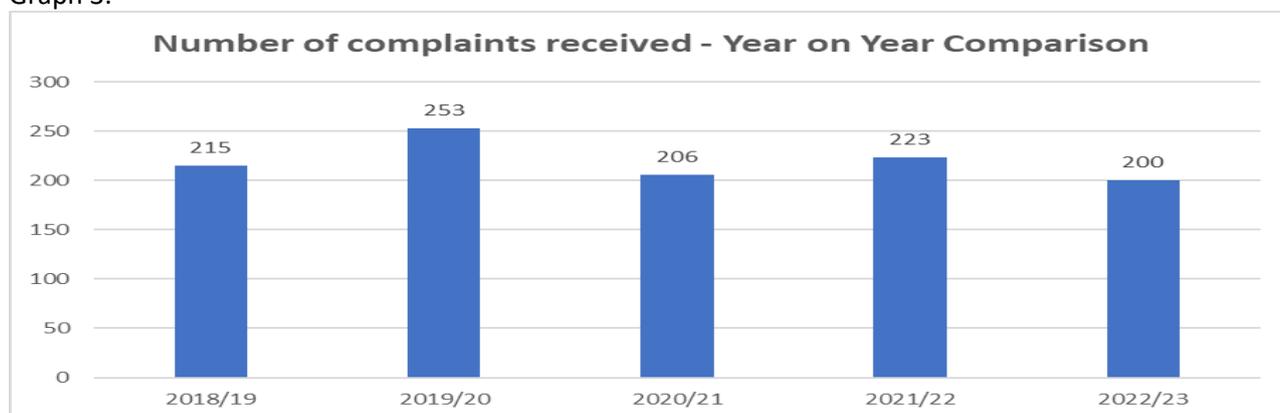
- ❖ How involved patients and families feel in decisions about their care, including related matters around confidentiality, information provided and communication from staff members. See quality objectives E13 (personalised care planning) and E14 (improve working with families) for the actions we have taken.
- ❖ Staff attitude and behaviour
- ❖ Poor sharing of information across teams, providers and agencies
- ❖ Waiting times and access to services

Examples of improvements have included:

- ❖ Implementation of training session with relatives if caring for patients at home. If patients are discharged home with family supporting care needs a training session is completed with the patient and their family on manual handling and personal care if applicable (Oxfordshire Stroke Rehabilitation Unit (OSRU))
- ❖ Continuing Healthcare Team have developed a letter to be sent out following the request for a retrospective assessment detailing the process and time frame to better manage expectations of patients and those involved with the request.
- ❖ To create a procedure for patients seeking support who are travelling outside of the UK regularly or live abroad (Improving Access to Psychological Therapies)
- ❖ The community eating disorder pathway did some work on personalised care planning.
- ❖ To implement a mandatory escalation/review whenever the patient reports a historic failed local anaesthetic or procedure. This should be implemented at the pre-operative stage (Podiatry)
- ❖ Developing a system to improve transfer/referral of patients when working across multiple teams. Patients and families should be given clear information about any changes, what the implications might be and what/if any alternative options there might be to consider (CAMHS)
- ❖ Improving documentation of conversations discussing consent to share information with family (Forensic ward)

The Trust's annual complaints report will be presented to the Board of Directors in May 2023 and published with the board papers at: <https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/>.

Graph 3.



Source: Trust's Complaint Database.

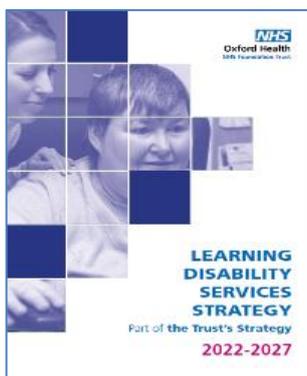
## 10.6 The Learning Disability and Autism Improvement Standards

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

The four standards are:

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

The full details about the standards can be found at [Improvement standards for people with a LD or Autism](#).



The Trust submits an annual self-assessment against the standards, which includes feedback from staff and patients at our Trust. Our focus in 2022/23 has linked with our new Learning Disabilities Service Strategy (2022-2027) to reduce health inequalities, increase life expectancy and quality of life. We have 8 workstreams working to deliver the aims of the Strategy.

The actions we have taken in 2022/23 include;

- Working with GPs to ensure every person has an annual health check (quality objective CE 10), as well as holding an event in June 2022 with primary care services and the third sector for people with a learning disability and their carers to find out what positive steps they can take to live well and be healthier.



- The Trust has rolled out the new national Tier 1 Oliver McGowan training to all staff, published in November 2022 (quality objective CE 10)
- Developed and published Accessible accessibility guides for our sites, available here [AccessAble](#)
- Developed the use of an environmental checklist for any new developments or changes to existing property, to consider the experience of those with autism.
- We continue to support and get huge value from having a person with a learning disability on our Council of Governors.
- Dynamic Support Registers for children and adults with a learning disability and autism are operational within Oxfordshire and have full system engagement. There is also a strong link around discussing children with complex needs in transition.
- The Trust is fully engaged with the medication safety programmes called STOMP and STAMP to ensure appropriate use of medicines and not over medicating.

- Extension of our Reasonable Adjustment Service which is also now fully recruited. This has enabled autistic people accessing mental health services to have the reasonable adjustments they require to access the treatment they need. The team are providing resources, training and advice to staff who are supporting people with autism.
- The Learning Disability Services has participated in a targeted trial around point of care testing for those with learning disability on anti-psychotic medications. We are also signed up to two further research projects; one supporting people with Down Syndrome to access a trial around potential medication; the other to support with alternative strategies to reduce instances of behaviours of concern.



*A patient enjoying some of the physical health activities encouraged and supported.*

## 10.7 Patient Safety Incidents

Everyone has a role in patient safety. Our focus is on creating a culture which is open, supportive and focused on learning, so staff feel able to raise concerns, incidents, risks and we can work together to make continual improvements.

### All Incidents

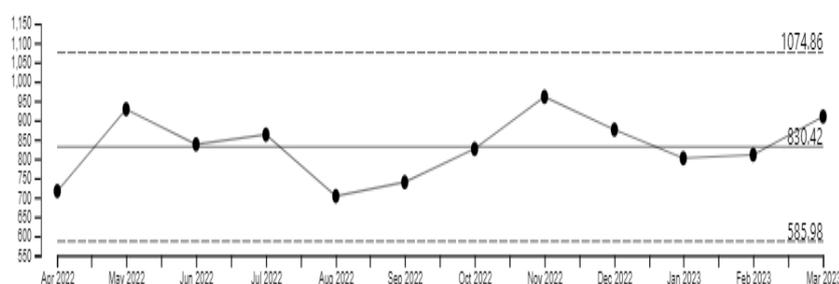
It is crucial that we use every incident and near miss as an opportunity to learn. The Trust reviews all incidents to identify any immediate actions and consider safeguards for patients. A group of senior clinicians review all incidents with moderate and above harm on a weekly basis and triangulate this with other quality information. On a quarterly basis we identify learning and more thematic areas for improvement.

In 2022/23 our staff reported 20,106 incidents and near misses to patients, demonstrating a positive culture for reporting and wanting to learn.

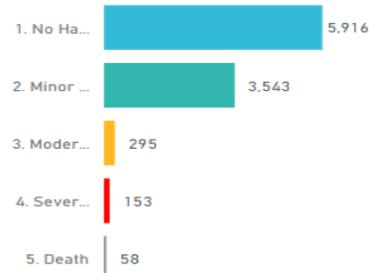
The Trust reports externally all unintended or unexpected incidents to patients which could or did lead to harm via the NHS National Reporting and Learning Service (NRLS). Graph 4 shows the number of incidents and level of harm of incidents reported to the NRLS for the last 12 months. 90% of the incidents resulted in no harm or minor harm and 211 incidents (2%) resulted in severe harm or death. Almost all of the deaths were suspected/confirmed suicides. The majority of incidents relate to self-harm (33%), followed by medication administration, delays in treatment, category 2 pressure ulcers<sup>3</sup> and then falls. This is generally in line with the themes from the national picture with the latest data last published for 2021/22.

Graph 4.

How many incidents were reported? (by date of incident)



Incidents by Actual Impact



Source: Trusts Incident Reporting System.

For details of the work and actions we have taken to reduce suspected/confirmed suicide and serious self-harm see the section on learning from deaths.

Pressure ulcers count for the area where we see most moderate and severe harm. This relates to category 3 and 4 ulcers developed in service but not necessarily where there were any issues with the care provided. In the last 12 months our teams have identified and treated 2,304 pressure ulcers (all categories), this is slightly lower than 2021/22. The majority of these patients had a pressure ulcer prior to entering our service (72%), most commonly a category 2 level, this is similar to 2021/22.

The focus in physical health services has been on reducing pressure ulcers within the district nursing services and community hospital wards. Despite these services being under extreme pressure due to increased demand and patient acuity there has been lots of work happening over the last year led by the pressure ulcer steering group. Every pressure ulcer developed in our care with harm to a patient is reviewed to identify if there were any lapses or issues in care so that we can learn and take action. We also use a

<sup>3</sup> Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are damage to the skin and underlying tissues caused by pressure or pressure and friction. They can range in severity from a red patch or blister to a complex open wound. Pressure ulcers are graded from 1 (superficial) to 4 (most severe).

safeguarding decision guide to look at whether a safeguarding alert should be raised. In 2022/23 we have carried out quarterly thematic reviews on pressure ulcers that developed due to a lapse in care to steer our actions, learning and to monitor change. Overall we have seen a reduction in the total number of category 3 and 4 ulcers developed whilst under our care and where we identified lapses (18 in 2021/22 compared to 12 in 2022/23). More details about our work are under quality objective S8.

### National Patient Safety Alerts

The NHS National Reporting and Learning Service issues a number of national patient safety alerts from reviewing incidents submitted by all NHS Trusts. In 2022/23, 11 national patient safety alerts were issued, of which five were relevant to services provided by the Trust. All actions for the five alerts were completed within the national deadlines set.

### Never Events

Never events are a sub-set of serious patient safety incidents and are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. The Trust has reported 0 never events in 2022/23.

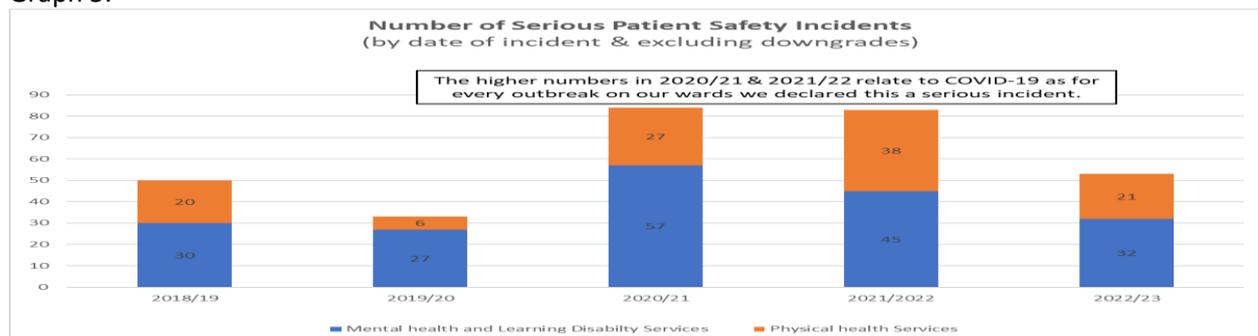
### Serious Patient Safety Incidents

In line with national guidance Serious Patient Safety Incidents are identified and reported where there has been significant harm to a patient and learning in the care provided. We have reported 53 in 2022/23 and each has had an in-depth investigation completed and shared with our commissioners. Most of our serious patient safety incidents relate to; self-inflicted harm such as suicide, unexpected deaths and pressure ulcers. We always aim to involve the patient/family in our investigation so that we are transparent with our findings and can maximise our learning. Graph 5 shows the number of Serious Patient Safety Incidents<sup>4</sup> reported by the Trust year on year.

Our key safety improvement areas identified from investigations in 2022/23 are;

- Pressure damage prevention (see quality objective S8)
- Engaging and sharing information with families (see quality objective E14)
- Staffing challenges impacting on access to timely treatment and care coordination (see section on quality concerns in the Account)
- Individualised risk management/ embedding safety planning co-produced with patients and their families (see quality objective S4 and our work on suicide prevention)
- Recognition and escalation of deteriorating patients, some local actions have been taken and this will be a focus in the 2023/24 objectives.
- How we adapt and make reasonable adjustments for people with autism (see quality objective CE10)
- Inpatient observation practice, local actions have and are being taken.
- Joint working/interface between teams and other organisations such as private care providers, GPs, substance misuse services and the Police, local actions have and are being taken.

Graph 5.



Source: Trust's Serious Patient Safety Incident Database

<sup>4</sup> Incidents downgraded by the commissioners are excluded.

As part of the NHS Patient Safety Strategy (2019) the Trust has been preparing and is now implementing our new approach to responding and learning from incidents in line with the national Patient Safety Incident Response Framework published in August 2022. This is a significant and welcome national change in policy to develop how we can improve the safety of patient care. We have received good support from our commissioners who have particularly helped to bring the care providers in the BOB ICS together to learn and share how we develop. We aim to transition to the framework by end of December 2023.

### Duty of Candour

Duty of candour is the act of being open and honest with patients and their families when something goes wrong during the provision of care, that appears to have caused, or could lead in the future, to significant harm. There is a legal and professional duty to comply with the legislation on duty of candour. Being candid with those affected by an incident or accident is also the right thing to do. The experiences and insights of patients/ families is a valuable source of learning and identifying opportunities for improvement.

The Trust has a Duty of Candour Policy that supports our culture of openness and wanting to learn when things go wrong. Our incident management system has been adapted to ask prompts and collect evidence of when duty of candour is required. Our Patient Safety Team also monitors incidents with serious harm to ensure duty of candour is always undertaken.

### **10.8 National Enquiries – Our Response**

There was a BBC Panorama documentary in September 2022 following an undercover journalist working at Edenfield Unit in Prestwich, an NHS forensic service that provides secure care to men and women. The footage made for incredibly distressing viewing, showing multiple examples of vulnerable patients being treated without dignity or respect, and subjected to physical, verbal, and emotional abuse. The ward environment appeared to lack appropriate boundaries, professionalism, purpose and compassion. There was also an inappropriate use of restrictive interventions.

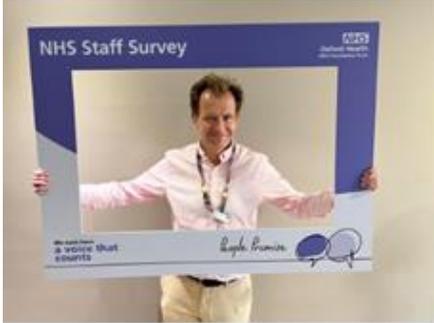
Following the documentary we carried out work across our forensic and mental health wards to look at the culture, compassion and clinical leadership to ensure it is one of respect and dignity that protects patients' human rights and prevents abuse. The outcome of our reviews (alongside information from external peer reviews, visits by the independent advocacy service and CQC Mental Health Act visits), found no evidence of unacceptable practices or abuse taking place in our services. Objective S6 details the work we have done this year on reducing the use of restrictive interventions, which we will continue.



However, we cannot afford to be complacent and need to prevent and uncover any abuse or unacceptable behaviours. It is therefore essential we continue to role model openness, curiosity and compassion, encouraging staff and patients to speak out if they have concerns, as well as maintaining a focus on fostering an open culture that is compassionate, has effective teamwork and strong values-driven leadership.

### 10.9 Staff experiences (including national survey results)

The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experiences, support and wellbeing. This is important as a positive staff experience plays an important role not only in staff welfare and morale, but also improving the quality of care for our patients.



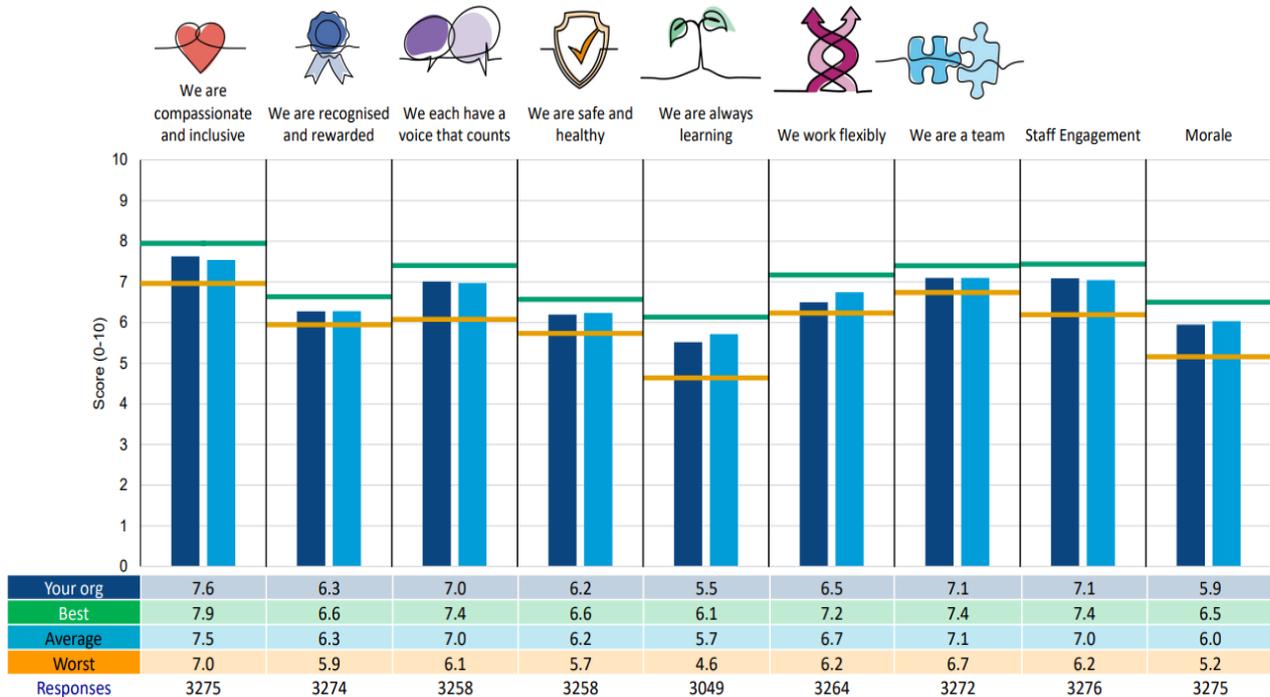
The Trust participated in the 2022 NHS National Staff Survey, 3,279 staff took part (53% of eligible staff). A summary of the results is below in figure 4 and the full results can be found here: [NHS Staff Survey Benchmark report 2022 \(nhsstaffsurveys.com\)](https://www.nhs.uk/staff-survey-benchmark-report-2022).

The overall staff engagement score was 7.1 out of 10, this is above the national average however slightly lower than in 2021. 69% of staff said they would be happy with the standard of care if their friend or relative needed treatment, against a national average of 64%.

We have much to be working on following the results. Key areas for development are: pay, staffing levels/workload and appraisals in keeping with the national picture. We saw an improvement in the areas we focused on in 2022 – work/life balance and job flexibility. The impact of our work on appraisals is most likely to be seen in the next survey results. Progress against the actions we take is monitored through quarterly internal staff surveys.

Figure 4.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



Source: National NHS Staff Survey report

### 10.10 Clinical Audit

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

In 2022-23 we participated in 12 national audits, we also partially participated in a further 3 national audits but unfortunately were not able to participate in 2 audits in relation to prescribing practice in mental health services<sup>5</sup> due to the cyber-attack. The audits and results are provided in Appendix 1. Alongside these we carried out locally identified clinical audits however the cyber-attack significantly impacted on the planned programme.

### 10.11 Data Quality and Information Governance

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

The Trust overall data quality score against across all relevant national datasets (CSDS, ECDS, QOP, MHSDS, APC and IAPT) was 82.2% as of July 2022, this is our last reported position prior to the cyber attacked and transition to new electronic patient record systems described more on page 14. The main areas for improvement are; recording of SNOMED diagnosis in our emergency care data set used by the GP out of hours service and recording of ethnicity across all data sets. We had been making some progress with improving the capture of ethnicity prior to the cyber-attack and this will need to be picked up with the new systems in 2023/24, as it is crucial to have this information to effectively plan and deliver services.

Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that we can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance. Oxford Health NHS Foundation Trust Data Security and Protection Toolkit overall score for 2021/22 was 'standards met'. The 2022/23 assessment has been submitted but we do not have the results yet. We have self-assessed that all standards have been met except for compliance with information governance training which as of 31<sup>st</sup> March 2023 was at 87.3% against a local target of 95%.

Oxford Health NHS Foundation Trust had a routine audit by the Information Commissioner in October 2021 and a follow up visit in December 2022 however no new inspections. The Information Commissioner is the independent regulator for enforcing and promoting compliance with data protection legislation<sup>6</sup>. The data protection audit report from 2021 is available at [ICO Audit Report 2021](#). The audit found reasonable assurance that processes and procedures are in place and are delivering data protection compliance. The follow up visit was to review the completed actions.

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<sup>5</sup> The two national audits we did not participate in were; valproate prescribing and anti-libidinal medication prescribing practice. We will be carrying out local audits in 2023/24 and reviewing the national findings.

<sup>6</sup> Legislation includes the UK General Data Protection Regulation and the Data Protection Act 2018.

## 11. Strengthening our Safety Culture to empower staff to raise any concerns without fear

We have continued work on developing an open, just and learning safety culture incorporating civility and respect and kindness into action. See the progress we have made against the quality objectives L1 and L2.

Staff are encouraged to raise any concerns about the quality of care, patient safety, poor behaviours or bullying and harassment – and we have developed a number of ways staff can speak up, described below.

In 2022/23 there were no cases of severe patient risk or harm raised or abuse similar to those seen at Mid Staffordshire following the enquiry in 2015. The most common concern raised has been about worker safety or wellbeing related to staff feeling stressed as a result of staff shortages, increased workloads/demands, lack of support from an immediate manager or poor communication. The annual 'Freedom to Speak up Guardian' report 2022 which provides more detail is available here [FTSUG-Annual-BOD-Report](#).

The 2022 staff survey results showed (n=3,279 responses);

- 79% would feel secure raising concerns about unsafe clinical practice, compared to the national average of 77%. We will continue to promote and enable every member of staff to feel safe to speak up and learn when things go wrong.
- 90% of staff felt encouraged to report errors/near misses and incidents, compared to the national average of 88%.
- 63% of staff said the Trust treats staff who are involved in an error, near miss or incident fairly, compared to the average of 60%

The Trust has developed five staff equality networks (listed below) and ten support groups to empower and inspire staff while nurturing a culture of belonging and inclusion. Total staff membership across all networks and support groups is more than 1,000. Four new staff support groups were set up in 2022/23 around Mental Health, Physical Disability and Health Conditions, Gypsy, Roma, & Traveller, and International Staff. These networks and groups are an important way to hear from under-represented people.



Example of staff celebrating Internal Nurses Day on 12<sup>th</sup> May 2022

Staff have opportunities to raise concerns through:

- A staff member's line manager to discuss what happened and how they would like to be supported.
- The dedicated Freedom to Speak Up Guardians provide independent and confidential support to all staff who wish to raise concerns and to promote a culture of openness. The resource has been expanded to 1.6 WTE from January 2023.
- The Trust has a Guardian of Safe Working for trainee doctors, who has a duty to advocate when concerns are raised by trainee doctors. The Trust also has a Trainee Doctors Forum which is another route trainees can raise concerns and issues to the Guardian.

- Regular leadership briefings each month which facilitate Q&As and routine monthly opportunities to meet 1:1 with Executive Directors – both allowing time for staff to speak up and be heard when they have concerns in addition to more informal routes.
- A number of nurses across our inpatients and community teams have successfully completed the Professional Nurse Advocates (PNA) programme. These nurses provide restorative supervision as an extra layer of support for staff. They also support the Advocating for Education and Quality Improvement model so that nurses can take forward their ideas and suggestions to improve the quality of care.
- The Human Resources Department, who also manage the whistleblowing process overseen by the Executive Team.
- Health and Wellbeing Team.
- Staff side representatives are available to offer advice and support. Representatives meet regularly with the Executive Directors. In 2022/23 there has been work to improve collaboration.
- Their directorates elected staff governor

The Trust regularly runs Schwartz Rounds, these are confidential forums for staff from all disciplines to come together to reflect on the emotional challenges of working in healthcare, to boost wellbeing and reduce stress and isolation. We use an evidence based approach to the rounds. We held 5 rounds in 2023/23.



### NHS Doctors in Training- Rota Gaps and Plans for Improvement

The Trust has a Guardian of Safe Working for trainee doctors, who has a duty to advocate when concerns are raised by trainee doctors. Each Guardian serves a term of 3 years and we had a change in Guardian in November 2022. The Guardian provides quarterly reports to the People, Leadership and Culture Committee and an annual report to the Trust Board.

The Guardian reviews and responds to exception reports raised by trainee doctors when work does not reflect the work agreed. In 2022/23 there have been on average 17 exception reports a month, based on the number of trainees, this is slightly lower compared to our neighbouring NHS Trusts. The exception reports primarily relate to late finishes for doctors working a shift on a ward, followed by missed educational opportunities and less than the minimum rest/break between ward shifts or on-call.

Plans for improving safe working are detailed in the quarterly reports for example;

- ❖ Working with specific wards where there have been exception reports to ensure adequate staffing levels
- ❖ Reviewing the delivery of CBT training to make it more accessible and so doctors do not have to stay late
- ❖ Identifying spaces for doctors to rest after working overnight

## 12. Learning from Deaths

The Trust takes our role and responsibilities very seriously around reviewing, learning and taking appropriate actions after a death. The Trust learning from deaths process reviews all patients against a national database to ensure we identify all deaths, including patients under our care at the time of their death and those who die within 12 months of their last contact. In most cases the deaths are expected but where a specific trigger is noted (as identified in our policy) we then review these deaths further. The level of review required will depend on various criteria such as age, the setting they died in and the circumstances surrounding their death. We always review the care provided to all patients who are aged under 18, had a learning disability, a diagnosis of autism, died on a mental health ward, whilst detained under the Mental Health Act, or died after we suspected they took their own life by suicide.

### Oversight and Governance

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

The Trust has a stepped approach to the review of patient deaths, described below;

- ❖ Stage 1. All known deaths receive an initial screening completed by at least two senior clinicians from the clinical team who knew the person, which includes speaking to the bereaved family where possible.
- ❖ Stage 2. The majority of deaths, particularly those meeting any of the criteria described above (aged under 18....) including all unexpected deaths will be reported onto the Trust's incident and mortality reporting system and reviewed through the weekly safety meetings.
- ❖ Stage 3. Depending on stage 2 a learning huddle or initial review maybe requested.
- ❖ Stage 4. Depending on stage 3 an in-depth investigation maybe started.

### Multi-agency and External Reviews

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

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

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

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

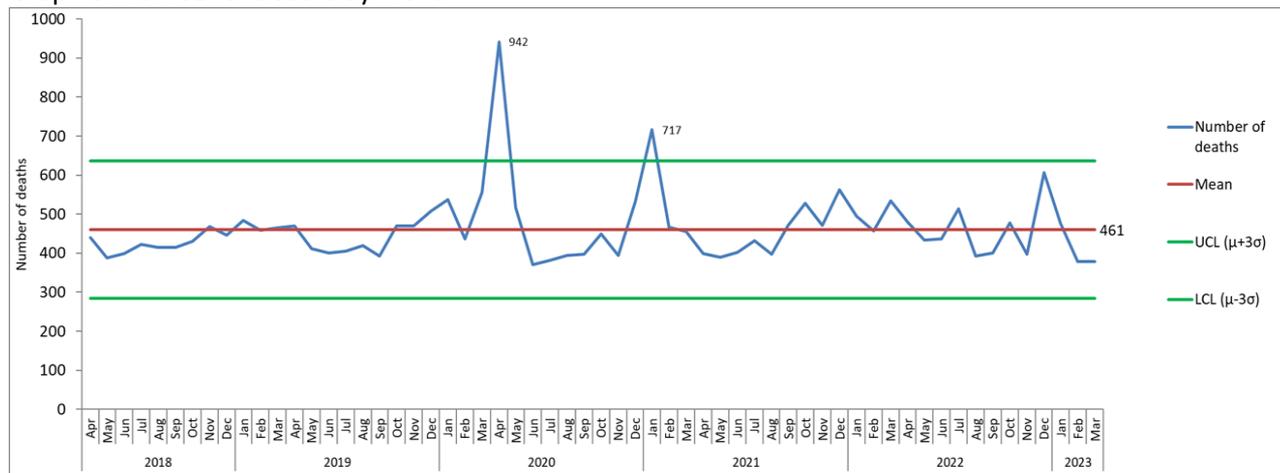
### Summary for 2022/23

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

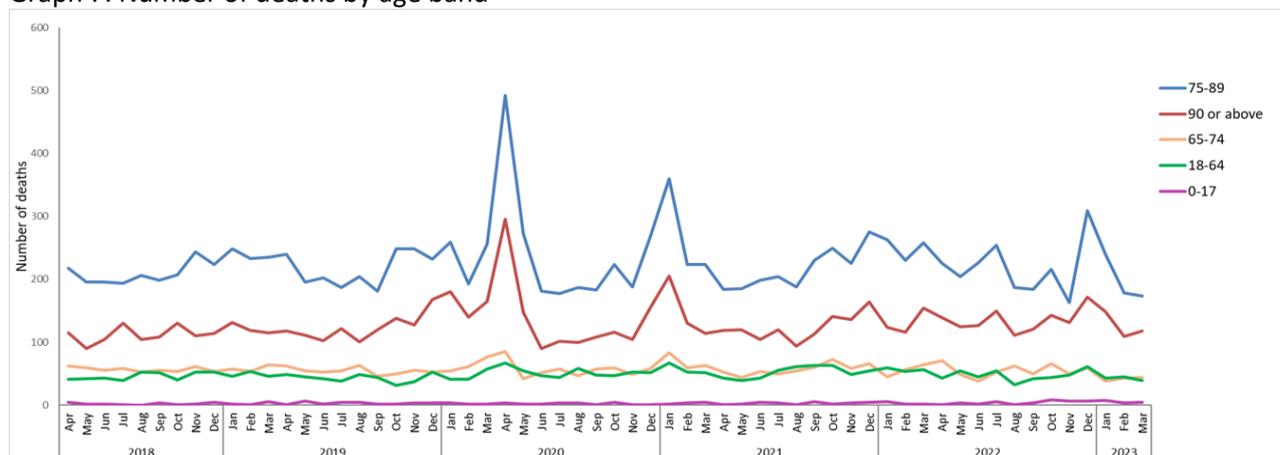
There has been little variance in the number of deaths over time, with most deaths for patients with an open referral (82%) aged 75 and over. Except for significant peaks in April 2020 (942 deaths) and January 2021 (717 deaths) relating to patients aged 75 and above, as a result of COVID-19.

The graphs below show the number of deaths by month and age band for the last 5 years. Our trend over time mirrors the national pattern, including the peaks in April and January. Most deaths are of people aged 75 and over. There has been a small increase in deaths across all directorates in January 2023 for patients aged 75 and over, which seems related to expected winter fluctuations.

Graph 6. Number of deaths by month



Graph 7. Number of deaths by age band



In 2022/23 there were 29 deaths for patients aged 17 and under compared to 32 in 2021/22. Almost all deaths were for patients open to services at the time of their death and most commonly last seen by the Health Visiting Service or Children’s Community Nursing Services. Two of the deaths were suspected suicides. All child deaths are reviewed through the multi-agency Child Death Overview Process (CDOP) led by the local Children’s Safeguarding Board and in some cases will also have a children’s serious partnership review or serious patient incident investigation. System-wide recent themes for learning have been in relation to co-sleeping on sofas, window safety and safety around open water.

The number of deaths in a community hospital ward have decreased year on year (58 deaths in 2022/23) reflecting the work with patients/families about choice on where someone dies and expansion of community-based end of life services. Nine of the deaths related to COVID-19, however this was not the primary cause of their death. We had no suicides in an inpatient setting.



### Suspected and Confirmed Suicides

We are conscious the next section is focused on our work around reducing suspected or confirmed suicides and may be distressing to read, so you might want to move onto the next section about our key learning from deaths we have reviewed. We acknowledge each and every suicide as a tragedy and the profound and lasting effect is unimaginable to families and loved ones.

In 2022/23 there were 59 suspected/confirmed suicides (compared to 69 in 2021/22) across all of the counties we provide services within, of which 36 of the suicides were a patient currently open and receiving care from the Trust. None of the suicides occurred in an inpatient setting. The majority of suicides have been by men (58%), in line with national figures. Most people were aged between 41-60 and White British. We have seen no significant change in the number of suicides over time which is in line with the national figures<sup>7</sup> which are relatively stable, although there has been a recent increase in March 2023 which we are exploring further. There were 10 people who died by suicide, including one prisoner receiving in-reach support. The number of suicides over the last 2 years, including people with an open referral and those discharged from services, is shown in graph 8.

The Trust's Suicide Prevention Strategy is taking a theory of change approach, influencing clinical practice and supporting improvement and innovation. The 2022-2025 strategy is overseen by a steering group, with specific workstreams established. Co-production is core with patients and carers being represented on the steering group and workstreams. The co-chair of the group is a family member bereaved by suicide.

The strategy is focused around four workstreams;

- ❖ Gender (risk to men, women with ASD and LGBTQ+)
- ❖ Substance misuse
- ❖ Access and inclusion
- ❖ Research, NICE guidance and training/communication. The research element includes mapping our current activity, promoting opportunities and supporting translation of research into practice. This includes working with the University of Oxford Department of Psychiatry as well as the Toronto University and the Toronto based Canada Addiction and Mental Health service working on developing a suicide prevention app.



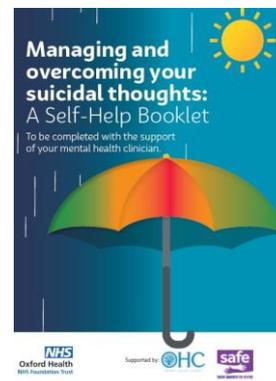
*The Trust visited Toronto in April 2022 and some of the team came to visit us this April 2023.*

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<sup>7</sup> The Annual National Confidential Inquiry of Suicides and Homicides published in 2023 looking at 10 years of data from 2010 to 2020 shows patient suicide numbers and rates in the UK are relatively stable.

Some of the actions we have taken this year around suicide prevention include;

- ❖ Embedding safety plans co-produced with patients and their families
- ❖ Trialling new roles located with our community teams to provide support in practice and training to staff around managing risks relating to suicide and serious self-harm
- ❖ Developing existing staff mandatory training on risk assessment and management to have a greater focus on risk formulation and meaningful safety planning, in line with new NICE guidance on self-harm
- ❖ Holding suicide awareness and prevention training for qualified staff, as well as training on psychosocial assessments following self-harm.
- ❖ Clinical researchers from Oxford University's Department of Psychiatry and Oxford Health NHS Foundation Trust, together with clinical colleagues and a service user have developed guidance to help clinicians identify and treat patients at risk of suicide. The new guidance is intended to reduce risk through a person-centred strategy in which assessment is regarded as a therapeutic process which is aimed at identifying interventions to enhance well-being, together with an individualised safety plan developed collaboratively with the patient.
- ❖ Improving support and involvement of families during and following mental health crises – a family connections model is being adopted (12 week course for parents/carers of people with emotionally unstable personality disorder or who struggle with emotional regulation and self-harm).
- ❖ Holding regular carer support groups and educational workshops around self-harm and suicidality
- ❖ We have developed a self-help booklet on managing and overcoming suicidal thoughts, for clinicians to work through with patients to explore early warning signs and recognise triggers and changes in their emotions. A variety of suggested coping strategies are highlighted and recommendations for who to contact during a crisis. The booklet was co-written by clinicians and experts by experience.

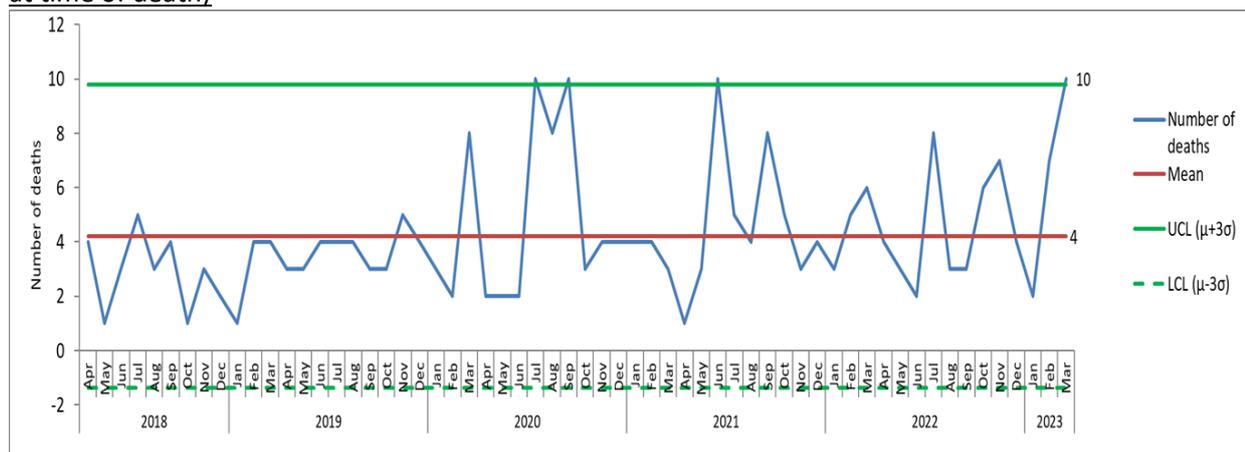


The Trust has an established Family Liaison Service which provides general bereavement support to adults, signposting to local and national support agencies for people bereaved by suicide, information/advice about processes and support to help families to raise concerns and questions. The service is not exclusively focused on support after suicide, but the majority of referrals are related to the death of a patient by suicide. In 2022/23 the service has received more than 50 referrals with 30 families accepting support, the support provided is tailored to each person. The Thames Valley area also has Amparo Listening Ear [www.amparo.org.uk](http://www.amparo.org.uk), this service provides emotional and practical support. Residents are referred to Amparo through the Thames Valley Suicide Real Time Surveillance Service. They can also self-refer, or the family liaison service can refer. In addition, Buckinghamshire has Survivors of Bereavement by Suicide peer support groups, and a similar group is being established in Oxfordshire. Buckinghamshire and Oxfordshire have specialist services to support children bereaved by suicide.

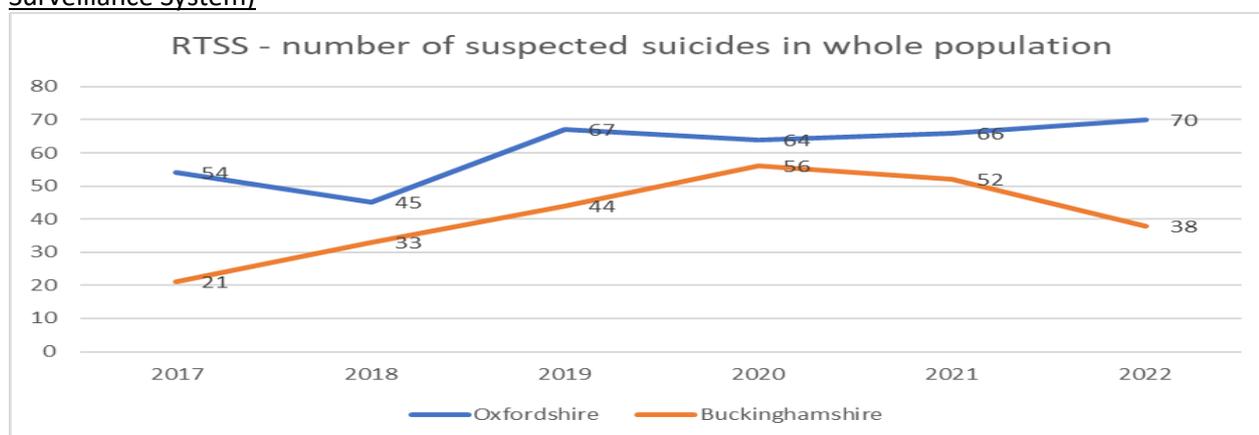
The Trust is an active partner in the Local Authority multi-agency suicide prevention groups in Oxfordshire and Buckinghamshire. The Trust is collaborating with organisations and providers across Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System to implement quality improvements to reduce suicides such as changes to the self-harm pathways by offering follow up to those who have self-harmed or attempted suicide but do not wish to fully engage with secondary mental health services.

As well as our own data we use the Thames Valley Real Time Surveillance System data coordinated by the Police, which includes all suicides for the whole populations in Oxfordshire and Buckinghamshire, shown in graph 9. Not all patients would have been known by mental health services. The information shows there has been a decrease in the number of suicides in Buckinghamshire in the calendar years of 2021 and 2022 and Oxfordshire is broadly the same. This information should be considered alongside population increases.

**Graph 8. Number of suspected/ confirmed suicides (Trust data – people open and discharged from services at time of death)**



**Graph 9. Number of suspected/ confirmed suicides (whole population information from the Real Time Surveillance System)**



**Key learning from our review of deaths**

Our key safety improvement areas identified from mortality reviews in 2022/23 are;

- Individualised risk management/ safety planning (see quality objective S4)
- Engaging with families – sharing information (see quality objective E14)
- Risk for babies of co-sleeping with parents, there has been a BOB wide project around safe sleeping linking in with the Perinatal Team. Fathers are also being made aware of safe sleeping advice.
- Completion of annual health checks and inclusion in health action planning for people with a learning disability, including reasonable adjustments to access national screening programmes (see quality objective CE10)
- Recognition and escalation of deteriorating patients, some local actions have been taken and this will be a focus in the 2023/24 objectives.

**Medical Examiner Role**

In line with the national programme we are working with the regional medical examiner offices hosted by our neighbouring acute NHS Trusts in Oxfordshire and Buckinghamshire to expand the roll out of the medical examiner role across our services. The role is to independently review deaths that are not referred to the Coroner to confirm the cause of death and to identify where there may be concerns which require further review.

The roll out was initially delayed by the Trust’s cyber-attack but there are now national delays due to capacity of the medical examiner offices to expand to community and primary care deaths. We continue to keep in regular contact with the medical examiner offices and are engaged in setting up a process to share

clinical information to support the medical examiner reviews. We are aiming for the medical examiner role to be introduced for deaths by April 2024.

#### Coroner Inquests

The Trust was involved and participated in 63 inquests in 2022/23.

The Trust has been issued with one Prevention of Future Death notice from the local Coroners in 2022/23 relating to a young person who took their own life whilst at home in 2022. Notices are made by Coroners to address concerns arising from inquests. In comparison the Trust received one notice in 2021/22. The concern being raised from the notice issued in 2022/23 is about how we can improve having an early coordinated approach between organisations for complex cases. We received the notice on 28<sup>th</sup> March so are still responding at the time of writing this Account.

### 13. Progress on Quality Objectives set for 2022/23

This section details the Trust's achievements against its quality objectives for 2022/23. We have made progress against all of the 14 objectives and for many we have seen an impact on patient care and staff well-being. Below is a summary of how we have self-assessed our achievement against each objective based on the aim we set in April 2022. For quite a few objectives we can demonstrate partial achievement but have not yet seen the full effect of our actions. A detailed breakdown by objective follows the summary.

Domain		Objective	Level Achieved (self-assessed)
Leadership	L1	Implement a Restorative, Just and Learning Culture	Achieved
	L2	Create a 'wellness' culture that supports and empowers staff to improve their health and wellbeing	Partially achieved
Safety	S3	Ensure staff receive high quality clinical supervision at least every 8 weeks	Partially achieved
	S4	Improve risk assessment, formulation and documentation	Partially achieved
	S5	Better support people with co-existing substance misuse being able to access interventions to reduce risk of suicide	Achieved
	S6	Reduce the use of restrictive interventions through the Positive and Safe work	Achieved
	S7	Improve sexual safety on our wards	Partially achieved
	S8	Reduce category 3 and 4 pressure ulcers which are identified as patient safety incidents (developed in service where there was learning in the care provided)	Achieved
	S9	Falls prevention, with a focus on reduction in harm from falls	Achieved
Clinical Effectiveness	CE10	Implement the improvements identified following the assessment against the national learning disability and autism standards, to include:  a. Roll out the Oliver McGowan tier 1 and tier 2 training programme b. Improve the % of annual reviews of health action plans	Partially achieved
	CE11	Improve the mental wellbeing of those undergoing stroke rehabilitation	Partially achieved
	CE12	Improve the physical health of people with serious mental illnesses	Partially achieved
Patient and Families Experiences	E13	Embed personalised care planning developed with patients to improve clinical outcomes	Partially achieved
	E14	Working with families, to include; a. Work against the carers, friends and family strategy b. QI work	Partially achieved

## Domain: Leadership

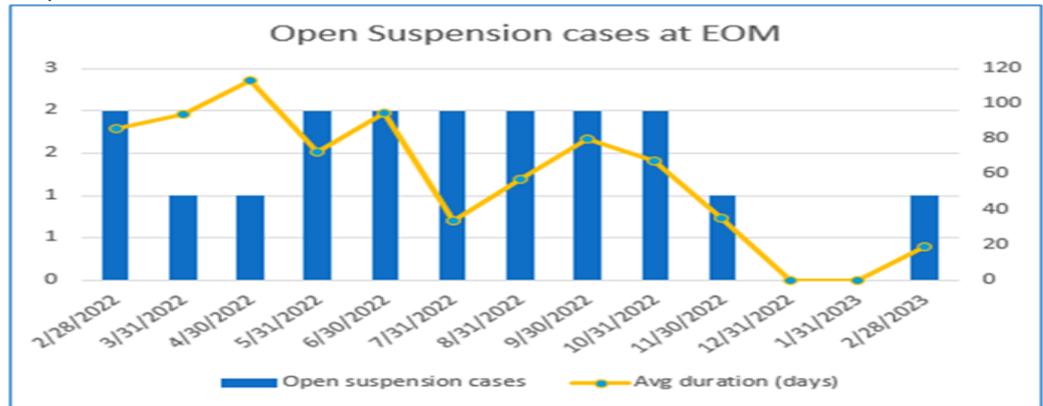
The objectives reported on are:

- ❖ L1. Implement a Restorative, Just and Learning Culture
- ❖ L2. Create a 'wellness' culture that supports and empowers staff to improve their health and wellbeing.

L1. Implement a Restorative, Just and Learning Culture	
Aim	Objectives achieved in year from implementation plan. Process measure; reduce number of staff suspensions
Self-assessment	<b>Achieved</b> – objectives for year completed and we have reduced the number of staff suspensions. The work will continue to keep developing the culture in the Trust.
Evidence of Progress	<p>Restorative Just and Learning Culture Project group was formed. The project was temporarily paused because of the cyber-attack from August-December 2022. During this time work happened to ensure the Restorative, Just and Learning Culture principles, Civility &amp; Respect Culture, and Kindness into Action are weaved together to form one joined up programme. Civility, respect and kindness are the foundations to achieving a Restorative, Just and Learning Culture and they are included as themes within training and corporate induction.</p> <p>The Trust is part of the NHSEI virtual community of practice for those trained in Restorative Just and Learning Culture to offer support and improve sharing. As well as the BOB ICS programme on Kindness into Action, a suite of elearning modules have been developed to introduce practical approaches to creating a kinder, safer culture where staff feel able to speak up safely.</p> <p>A rapid improvement group met to ensure the policy review process had elements of Restorative, Just and Learning Culture within its scope. A Restorative Just and Learning Culture 'checklist' was developed to ensure all HR polices have the correct approach, sentiment and language to align with the above programme.</p> <p>We have reviewed the suspension process and strengthened the decision-making process when a suspension is being considered by a manager to ensure this is just, fair and that alternative options such as redeployment have been reviewed.</p> <p>Work was carried out in 2022/23 to improve how we engage and support all those affected by a patient safety incident (staff, patients and families), using the principles of compassion and openness to create a positive learning culture. Further work is planned as part of the implementation of the new Patient Safety Incident Response Framework up to the end of 2023. The revised NHS Complaints Standards published in December 2022 will also require changes to ensure a restorative and compassionate approach – work is planned for 2023/24.</p> <p>We have introduced the initiative Trauma Risk Management (TRiM) which is a structured approach for staff to offer their peers support who have experienced a traumatic or potentially traumatic event. TRiM Practitioners are staff who have undergone specific training to spot signs of distress, carry out risk assessments, planning meetings and to signpost staff to support as required. So far there have been 5 training cohorts and 48 staff trained as TRiM. We have 5 initial pilot teams and 2 further teams identified. Training has been evaluated well, 93% of trainees felt confident in conducting one to one risk assessments after the training. Our aim is to review the impact on those staff supported over the next year.</p>
Measure of Impact	<p>Number of staff attended <u>formal training</u> on RJ&amp;L Culture: 28 staff trained –local target achieved.</p> <p>Reduction in the number of <u>suspensions</u>.</p>

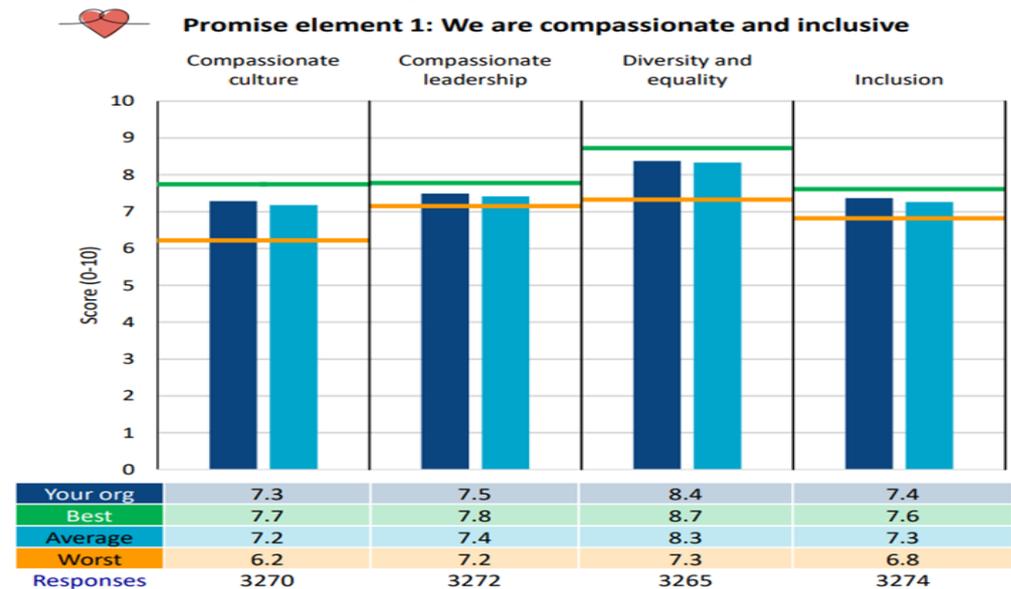
## L1. Implement a Restorative, Just and Learning Culture

Target to reduce has been achieved. The graph below shows the number and duration of suspension cases in the last year. During December 2022 and January 2023 we had 0 suspensions.



Annual national staff survey 2022 (n=3,279, 53%)

Below are the key questions related to culture. The Trust is just above the national average for all 4 measures although there is more work to do.



## L2. Create a 'wellness' culture that supports and empowers staff to improve their health and wellbeing

**Aim** Staff well-being part of everything we do, taking a holistic approach

**Self-assessment** **Partially achieved** – lots of work has happened however the impact is not yet evident in the measures



The Trust produces a monthly health and wellbeing matters newsletter for staff to help signpost and promote the activities happening. Health and Wellbeing is being woven into many of the Trust's change programmes including those on recruitment and retention.

The link between staff satisfaction/support, retention and an annual appraisal is well evidenced. Carrying out regular appraisals is also part of the Trust's strategic objective to be a great place to work. The 2021 staff survey identified appraisals as an area for improvement so a quality improvement project was started. From holding focus groups

## L2. Create a 'wellness' culture that supports and empowers staff to improve their health and wellbeing

with staff the main areas for improvement were identified as; streamlining the appraisal documentation, developing training/ resources to tackle inconsistencies, introducing an expectation to follow up on progress with objectives between annual reviews, and the timing of appraisals. In 2022/23 the appraisal documentation was reviewed and relaunched, elearning and resources have been developed, changes have been made to the recording system and an appraisal season was introduced from April 2023.

Following feedback from the 2021 staff survey we committed to developing our culture around flexible working, so people feel they can have an open discussion and explore what's possible. We hope this will improve retention of staff. A working group was set up to lead the work. A quality improvement approach has been taken, initially asking staff through workshops in May 2022 and a survey the best ways to improve how people can work more flexibly. The recommendations were accepted and put into an action plan to include work with e-roster colleagues to support managers to fully utilise flexible working practices on rotas, encourage managers to have discussions with staff in supervision, promoting trial flexible working requests and reviewing the current request form.

Other work this year has included:

- Employee Assistance Programme delivered by an external provider, available to staff 24/7 which provides a helpline to help staff to deal with personal problems that might adversely impact on their work, health and happiness.
- We have held five Schwartz Rounds in 2022/23, these are confidential forums for staff from all disciplines to come together to reflect on the emotional challenges of working in healthcare, to boost wellbeing and reduce stress and isolation.
- Wellbeing Conversations have been promoted with an increased uptake of REACT training to support these. OHFT lead the way across BOB in training via REACT. We now have invested in a REACT and TRiM trainer for one year.
- There has been work to increase the number of Health & Wellbeing Champions across the Trust with the aim of one per Team, currently there are 182 Health & Wellbeing champions in place.
- A menopause support group is now running, with OHFT signing up to become a Menopause Friendly Employer by July 2023.
- The Trust launched Gratitude Week in Oct 2022 with a focus on wellbeing, this included funding for teams to take time out for wellbeing, COVID Stars, Hampers, Bluelight Discount cards and a wellbeing annual leave day in 2022/23.
- Staff Awards have been restarted after the pandemic.
- A staff stress survey was carried out to help identify our next steps.
- The fifth annual HealthFest event was held from October 2022-January 2023. The theme for 2022 was Gratitude and Giving - offering a range of uplifting activities for staff to enjoy and have some much needed self-care.
- Due to the cost of living situation, work has been progressed over the summer to engage with staff side colleagues and staff to understand what measures would best support staff, and build on the work already done to ease financial pressures for staff. Some small gestures to help financially have included an increase in mileage expenses rate, free car parking on Trust sites and from January 2023 free supply of tea, coffee and milk.
- Two financial wellbeing seminars were held to help staff with the cost of living crisis are being put on by the Wellbeing Matters team and Money Charity.

### Measure of Impact

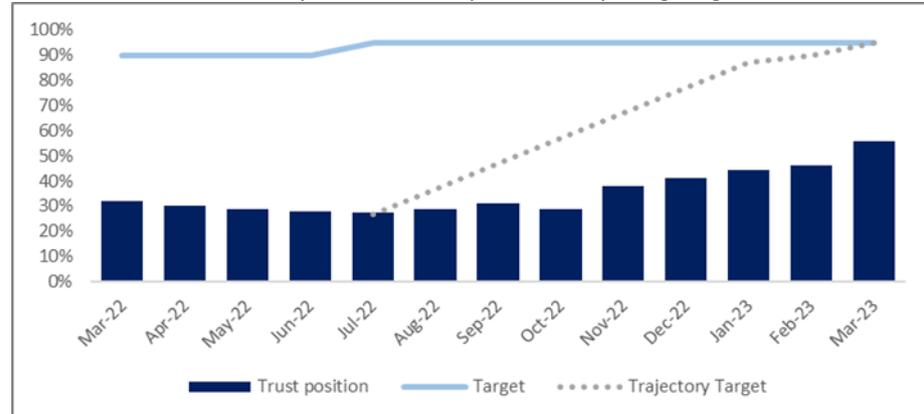
Employee Assistance Programme Service  
In 2022/23 there have been **717 calls**; 602 for counselling for anxiety/low mood and 115 for advice. Plus 2,276 hits on the portal/app to access support and signposting.

## L2. Create a 'wellness' culture that supports and empowers staff to improve their health and wellbeing

There has been good usage of the service month on month coupled with positive staff feedback (surveys and verbal feedback).

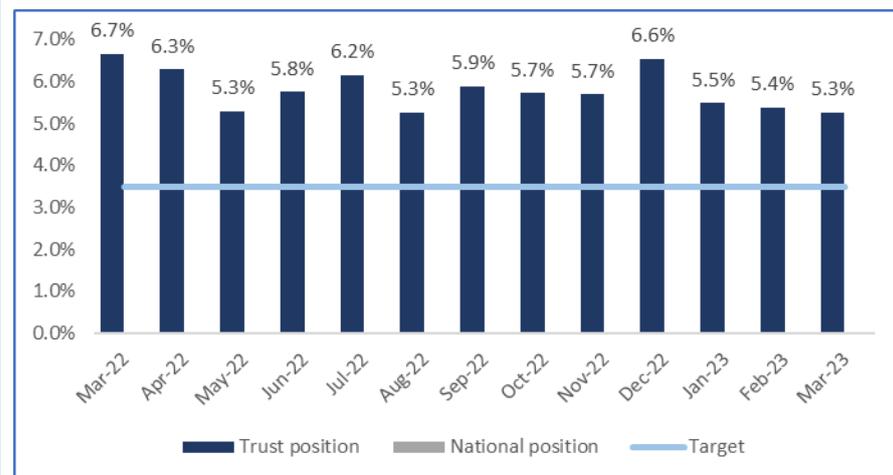
### Appraisals

Performance at the end of March 2023 was 56% against a local target of 95%. We have seen a slow improvement but we are below our local target. A number of changes have been made which we hope will have a positive impact going into 2023/24.



### Reduction in sickness

Rate in March 2023 at 5.3%. We have been above our local target of less than 3.5% throughout 2023/24. The top five reported causes of absence were Covid 19 confirmed, Cough/Cold, Gastrointestinal, headache/Migraine and Flu.



### Annual national staff survey 2022 (n=3,279, 53% of staff)

- The organisation takes positive action on health and wellbeing 67%, higher than national average 64% improved from 2021.
- My immediate manager takes a positive interest in my health and well-being 78.2% the same as 2021 and slightly higher than national average 77.9%
- 73% had an appraisal in the last 12 months, less than 2021 and below the national average 85% - many of the changes in 2022/23 did not take effect until after the survey was completed. The % who said their appraisal helped to improve how they did their job has slightly improved from 2021 to 2022 and is above the national average.
- Can approach immediate manager about flexible working 77% similar to 2021 and slightly below the national average 78%.
- 62% of staff said they were satisfied/very satisfied with opportunities for flexible working compared to a national average of 66%.

**Domain: Safety**

The objectives reported on are:

- ❖ S3. Ensure staff receive high quality clinical supervision at least every 8 weeks
- ❖ S4. Improve risk formulation/ assessment and management plan (Mental Health services)
- ❖ S5. Better support people with co-existing substance misuse being able to access interventions to reduce risk of suicide (Mental Health services)
- ❖ S6. Reduce the use of restrictive interventions through the Positive and Safe work (Mental Health services)
- ❖ S7. Improve sexual safety on our wards (Mental Health services)
- ❖ S8. Reduce category 3 and 4 pressure ulcers which are identified as serious patient safety incidents (Community S9. Nursing and Community Hospital inpatient services)
- ❖ S9. Falls prevention (Community Hospital inpatients)

S3. Ensure staff receive high quality clinical supervision at least every 8 weeks																																																																												
Aim	95% or above staff record having had supervision by March 2023																																																																											
Self-assessment	<b>Partially achieved</b> – changes have been made however aim not reached																																																																											
Evidence of Progress	<p>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.</p> <p>The actions taken include;</p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- Significant data quality exercise was completed to understand and ensure requirement was only for clinical staff, accuracy of data and report specifications.</li> <li>- Working alongside those teams with the poorest uptake</li> <li>- Delivering training for supervisors and supervisees, this continues to be evaluated and updated</li> <li>- Supervision guidance developed.</li> <li>- Spot checks by Associate Directors of Nursing/ Heads of Nursing to review practice and quality of supervision</li> </ul>																																																																											
Measure of Impact	<p>Position at the end of March 2023 was 57% below our local target set at 95%.</p> <table border="1"> <caption>Clinical Supervision Compliance Rate</caption> <thead> <tr> <th>Month</th> <th>Actual Compliance Rate</th> <th>Target Compliance Rate</th> </tr> </thead> <tbody> <tr><td>Apr-21</td><td>63%</td><td>85%</td></tr> <tr><td>May-21</td><td>64%</td><td>85%</td></tr> <tr><td>Jun-21</td><td>64%</td><td>85%</td></tr> <tr><td>Jul-21</td><td>68%</td><td>85%</td></tr> <tr><td>Aug-21</td><td>61%</td><td>85%</td></tr> <tr><td>Sep-21</td><td>58%</td><td>85%</td></tr> <tr><td>Oct-21</td><td>55%</td><td>85%</td></tr> <tr><td>Nov-21</td><td>0%</td><td>85%</td></tr> <tr><td>Dec-21</td><td>0%</td><td>85%</td></tr> <tr><td>Jan-22</td><td>67%</td><td>85%</td></tr> <tr><td>Feb-22</td><td>34%</td><td>85%</td></tr> <tr><td>Mar-22</td><td>29%</td><td>85%</td></tr> <tr><td>Apr-22</td><td>31%</td><td>85%</td></tr> <tr><td>May-22</td><td>39%</td><td>85%</td></tr> <tr><td>Jun-22</td><td>46%</td><td>85%</td></tr> <tr><td>Jul-22</td><td>45%</td><td>95%</td></tr> <tr><td>Aug-22</td><td>48%</td><td>95%</td></tr> <tr><td>Sep-22</td><td>45%</td><td>95%</td></tr> <tr><td>Oct-22</td><td>46%</td><td>95%</td></tr> <tr><td>Nov-22</td><td>52%</td><td>95%</td></tr> <tr><td>Dec-22</td><td>57%</td><td>95%</td></tr> <tr><td>Jan-23</td><td>57%</td><td>95%</td></tr> <tr><td>Feb-23</td><td>57%</td><td>95%</td></tr> <tr><td>Mar-23</td><td>57%</td><td>95%</td></tr> </tbody> </table>	Month	Actual Compliance Rate	Target Compliance Rate	Apr-21	63%	85%	May-21	64%	85%	Jun-21	64%	85%	Jul-21	68%	85%	Aug-21	61%	85%	Sep-21	58%	85%	Oct-21	55%	85%	Nov-21	0%	85%	Dec-21	0%	85%	Jan-22	67%	85%	Feb-22	34%	85%	Mar-22	29%	85%	Apr-22	31%	85%	May-22	39%	85%	Jun-22	46%	85%	Jul-22	45%	95%	Aug-22	48%	95%	Sep-22	45%	95%	Oct-22	46%	95%	Nov-22	52%	95%	Dec-22	57%	95%	Jan-23	57%	95%	Feb-23	57%	95%	Mar-23	57%	95%
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S4. Improve risk formulation/ assessment and management plan (Mental Health services)	
Aim	To identify changes that have a positive impact and to share this learning and changes across a wider range of teams.
Self-assessment	<b>Partially achieved</b> – diagnosis work completed and some changes made although impacted by the change in electronic patient record system
Evidence of Progress	<p>5 teams tested various changes in practice, detailed below.</p> <p>QI projects and aims;</p> <ul style="list-style-type: none"> <li>- Improve the co-production of and participation in risk assessments and safety plans in BSW CAMHS CRHT</li> <li>- Increase the rate of completed risk assessments on discharge from Oxfordshire Cherwell ward</li> <li>- Improve the quality of suicide risk assessments and risk formulation conducted by Buckinghamshire CRHT clinicians</li> <li>- Reduce missed appointments by improving handovers in Oxfordshire CRHT</li> <li>- Increase number of safety plans that are co-produced in Oxfordshire CAMHS</li> </ul> <p>The cyber-attack and then a transition to a new patient record system from December 2022 had a significant impact on progress with the quality improvement work and capacity within the teams. So the work was refocused in 2023 on;</p> <ul style="list-style-type: none"> <li>• Reviewing and updating the mandatory Clinical Risk Assessment and Management training for staff to include themes from Trust data, national guidance and emerging NICE best practice.</li> <li>• A focus on individual safety planning to support staff to work in collaboration with patients, carers and families to produce a meaningful, person centred, shared plan of care to inform interventions that promote recovery and support at times of distress/ crisis. Clinical audits of safety planning have been introduced recently to measure change.</li> <li>• A pilot of Clinical Practice Educators focused on suicide prevention who are working alongside teams in the context of their ward/service and patient group to strengthen risk assessment, formulation and documentation skills.</li> <li>• Development of recording on CareNotes and now this is being taken forward into the new electronic patient record system introduced from December 2022. Our aim is to support recording of information in a way that promotes the coproduction of patient’s safety, recovery and wellbeing plans that are easily accessible to those involved in care.</li> </ul>
Measure of Impact	<p>Quality improvement diagnosis work has been completed which helped to identify where work was needed.</p> <p>As of February 2023 the Clinical Risk Assessment and Management training figures for the Buckinghamshire mental health services is 84% and in Oxfordshire and BSW this is 80%. Compared to 57% in February 2022. Work continues to achieve our internal target of 95% as well as continuing to evolve the training. The plan in 2023/24 is to review the delivery model for training.</p> <p>The learning from our internal serious patient safety incident investigations completed in 2022/23 show continued work is needed around individualised risk management, alongside working with patient’s families to help manage and better understand risks. This is an extremely challenging and complex area, and is the most common theme for mental health providers. Both the Healthcare Safety Investigation Branch in their review of care delivery within community mental health teams (<a href="https://hsib.org.uk">Care delivery within community mental health teams (hsib.org.uk)</a> 2023) and the National Confidential Inquiry into Suicide and Safety in Mental Health (<a href="https://ncish.manchester.ac.uk">NCISH   Annual report 2023: UK patient and general population data 2010-2020 - NCISH (manchester.ac.uk)</a> 2023) recognise the complexities and challenges with getting this right.</p>

S5. Better support people with co-existing substance misuse being able to access interventions to reduce risk of suicide (Mental Health services)																																																	
Aim	Improve access to services to help with substance misuse for people who are in suicidal crisis (3-year goal)																																																
Self-assessment	<b>Achieved</b> – the work is in year 1 of 3																																																
Evidence of Progress	<p>This area is one workstream of the Trust’s suicide prevention strategy and steering group. About 12% of suspected suicides for people known to the Trust have a substance misuse diagnosis. A workshop was held in August 2022 as a deep dive into the trends and learning from reviews into suicides, with the aim to inform the work of each of the suicide strategy workstreams. There is more detail about our work on preventing suicides in section 11, learning from deaths of the Quality Account.</p> <p>This workstream is co-chaired by a member of staff and a person with lived experience and includes representatives from the externally provided specialist drug and alcohol services in each county. The work is being aligned with the actions for the Community Mental Health Framework on developing a dual diagnosis pathway. This workstream is concerned with addressing gaps in supporting people with substance misuse issues, including harmful and hazardous drinking. Work is progressing initially focused on strengthening staff training and resources. Staff webinars are planned and will be co-delivered with experts by experience, focusing on the impact and signs of substance misuse. The group has also been involved in developing the new risk assessment and management plan being developed for the new electronic patient record.</p>																																																
Measure of Impact	<p>Whilst the workstream is in year 1 of 3 the measure being shared is total suspected suicides.</p> <p>In 2022/23 there were 59 suspected/confirmed suicides (compared to 69 in 2021/22) across all of the counties we provide services within, of which 36 of the suicides were a patient currently open and receiving care from the Trust. We have seen no significant change in number of suicides month on month which is in line with the national figures which are relatively stable, although there has been a recent increase in March 2023 which we are exploring further.</p> <p><u>Number of suspected/ confirmed suicides (Trust data – people open and discharged from services at time of death)</u></p> <p><b>How many patient deaths were suspected or confirmed suicides?</b></p> <table border="1"> <caption>Data for 'How many patient deaths were suspected or confirmed suicides?'</caption> <thead> <tr> <th>Month</th> <th>Number of Suspected/Confirmed Suicides</th> </tr> </thead> <tbody> <tr><td>May 2021</td><td>2</td></tr> <tr><td>Jun 2021</td><td>5</td></tr> <tr><td>Jul 2021</td><td>9</td></tr> <tr><td>Aug 2021</td><td>7</td></tr> <tr><td>Sep 2021</td><td>5</td></tr> <tr><td>Oct 2021</td><td>7</td></tr> <tr><td>Nov 2021</td><td>8</td></tr> <tr><td>Dec 2021</td><td>3</td></tr> <tr><td>Jan 2022</td><td>6</td></tr> <tr><td>Feb 2022</td><td>4</td></tr> <tr><td>Mar 2022</td><td>6</td></tr> <tr><td>Apr 2022</td><td>7</td></tr> <tr><td>May 2022</td><td>4</td></tr> <tr><td>Jun 2022</td><td>3</td></tr> <tr><td>Jul 2022</td><td>9</td></tr> <tr><td>Aug 2022</td><td>3</td></tr> <tr><td>Sep 2022</td><td>3</td></tr> <tr><td>Oct 2022</td><td>5</td></tr> <tr><td>Nov 2022</td><td>10</td></tr> <tr><td>Dec 2022</td><td>6</td></tr> <tr><td>Jan 2023</td><td>9</td></tr> <tr><td>Feb 2023</td><td>8</td></tr> <tr><td>Mar 2023</td><td>13.17</td></tr> </tbody> </table>	Month	Number of Suspected/Confirmed Suicides	May 2021	2	Jun 2021	5	Jul 2021	9	Aug 2021	7	Sep 2021	5	Oct 2021	7	Nov 2021	8	Dec 2021	3	Jan 2022	6	Feb 2022	4	Mar 2022	6	Apr 2022	7	May 2022	4	Jun 2022	3	Jul 2022	9	Aug 2022	3	Sep 2022	3	Oct 2022	5	Nov 2022	10	Dec 2022	6	Jan 2023	9	Feb 2023	8	Mar 2023	13.17
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S6. Reduce the use of restrictive interventions through the Positive and Safe work (Mental Health services)	
Aim	Reduce use of prone restraint by 25% (this is year 2) Reduce use of seclusion by 15% (this is year 1)
Self-assessment	<b>Achieved</b> – national target reached and significant reduction made
Evidence of Progress	Restrictive practice is generally used when patients present a risk to themselves or others. We have been using a quality improvement approach to better anticipate and respond to risks and violence, with the aim of reducing the use of restrictive interventions. This is part of the national mental health patient safety programme and regional collaborative. The national aim is to make a 15% reduction in use of physical restraint, seclusion and rapid tranquilisation.

**S6. Reduce the use of restrictive interventions through the Positive and Safe work (Mental Health services)**

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.

Progress can be evidenced in our data with a reduction across all mental health wards of the use of physical restraint and also of the use of prone position. As well as a reduction in the use of seclusion.

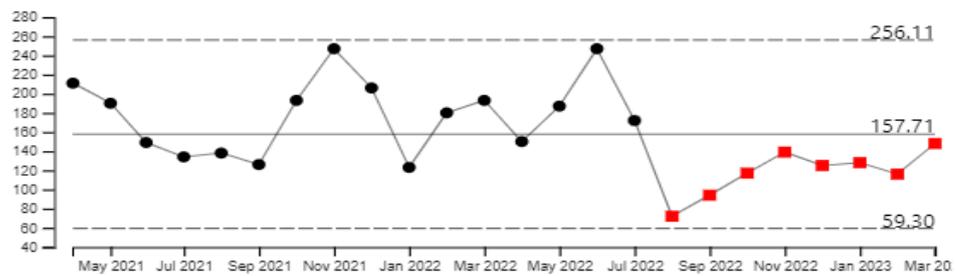
**Measure of Impact**

*We had one patient on a forensic mental health ward during 2022/23 who required a high level of restrictive practice for their own safety and the safety of staff. The patient had specific complex needs managed through a care plan while awaiting transfer to a high secure environment which occurred in early 2023. Due to the level of restrictions we had regular senior reviews and independent reviews into their care and treatment. For the purposes to look at any improvements made in reducing restrictive practice we have removed the data for this patient.*

All physical restraints

Reduction in use of physical restraint.

**How many incidents involved physical restraint?**

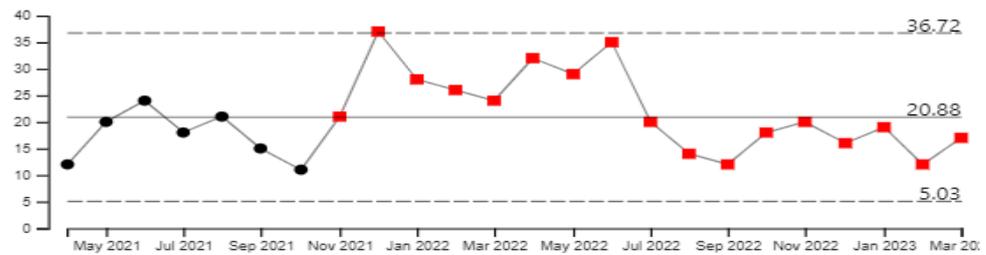


Use of Prone Restraint:

The number of overall uses of prone have reduced year on year. However the reduction has not quite been by the local target we were aiming for of 25%.

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

## S6. Reduce the use of restrictive interventions through the Positive and Safe work (Mental Health services)



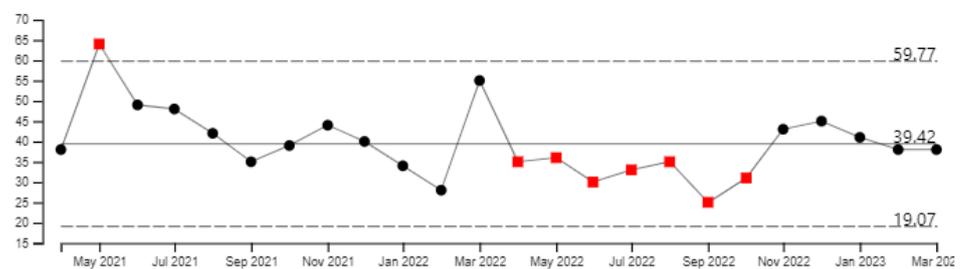
### Use of seclusion – number and duration

The number of uses of seclusion has reduced from last year and by more than our local target of 15%. The median duration of seclusion has increased slightly although this varies by ward.

We have some great examples of wards that have reduced their use of seclusion significantly. For example 1 forensic ward reduced the number of seclusions by 43% and the mean length of time by 59% over the last 6 months – the ward is showcasing the work they did both locally and nationally.

Year	Number of uses of seclusion	% change on number	Median length of time in seclusion
2021/22	516 episodes (210 patients)	Not applicable, baseline.	21 hours on average
2022/23	430 episodes (193 patients)	Year 1 – 17% reduction (from baseline)	25 hours on average

### How many incidents involved seclusion?



## S7. Improve sexual safety on our wards (Mental Health services)

Aim	Improve sexual safety in inpatient mental health services (impact on both patients and staff)
Self-assessment	<b>Partially achieved</b> – seen an increase in staff awareness and reporting as a result of the work started.
Evidence of Progress	<p>A quality improvement project was started and then paused alongside the national mental health patient safety programme. Some initial work has started whilst we wait to hear if the national collaborative work is going ahead. This has included raising awareness and encouraging reporting of incidents across the Trust.</p> <p>We completed some diagnosis work using a quality improvement approach and developed a driver diagram which identified 5 areas of focus;</p> <ul style="list-style-type: none"> <li>▪ Staff confidence, training and support</li> <li>▪ Partnership working with police and safeguarding</li> <li>▪ Sexual safety culture- awareness, are concerns raised, incidents and learning reported</li> <li>▪ Consistency of reporting and oversight</li> <li>▪ Improvements to ward environments</li> </ul>

**S7. Improve sexual safety on our wards (Mental Health services)**

	<p>Specific projects have started on;</p> <ul style="list-style-type: none"> <li>- CAMHS Marlborough House which has been working on increasing the % staff and patients that feel safe from sexual harm on the ward. Patients have reported an improvement in feeling safer.</li> <li>- Wenric forensic ward, this is at a fairly early stage but is gaining traction and the project group are meeting regularly. Learning is being shared with the other forensic wards.</li> </ul>																										
<p>Measure of Impact</p>	<p><u>Incident reporting levels</u></p> <p>We expected the number of incidents to increase when we started the work, as we believe there is underreporting, in line with national findings. The number of incidents increasing shows some of the positive affect of the work, with nearly all of the incidents resulting in no harm. The majority of incidents relate to inappropriate sexual comments from patients towards staff (118, 43%). Most of the incidents reported happened on our forensic inpatient wards (54%).</p> <table border="1"> <caption>Incident Reporting Levels (2022/23)</caption> <thead> <tr> <th>Month</th> <th>Number of Incidents</th> </tr> </thead> <tbody> <tr><td>Apr 2022</td><td>20</td></tr> <tr><td>May 2022</td><td>24</td></tr> <tr><td>Jun 2022</td><td>17</td></tr> <tr><td>Jul 2022</td><td>19</td></tr> <tr><td>Aug 2022</td><td>12</td></tr> <tr><td>Sep 2022</td><td>15</td></tr> <tr><td>Oct 2022</td><td>18</td></tr> <tr><td>Nov 2022</td><td>27</td></tr> <tr><td>Dec 2022</td><td>31</td></tr> <tr><td>Jan 2023</td><td>29</td></tr> <tr><td>Feb 2023</td><td>31</td></tr> <tr><td>Mar 2023</td><td>33.88</td></tr> </tbody> </table>	Month	Number of Incidents	Apr 2022	20	May 2022	24	Jun 2022	17	Jul 2022	19	Aug 2022	12	Sep 2022	15	Oct 2022	18	Nov 2022	27	Dec 2022	31	Jan 2023	29	Feb 2023	31	Mar 2023	33.88
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**S8. Reduce category 3 and 4 pressure ulcers which are identified as serious patient safety incidents (Community Nursing and Community Hospital inpatient services)**

<p>Aim</p>	<p>% reduction of pressure ulcers identified as serious patient safety incidents</p>
<p>Self-assessment</p>	<p><b>Achieved</b> – reduction in category 3 and 4 ulcers</p>
<p>Evidence of Progress</p>	<p>There has been lots of work happening over the last year led by the pressure ulcer steering group. Every pressure ulcer developed in our care with harm to a patient is reviewed to identify if there were any lapses or issues in care so that we can learn and take action. We also use a safeguarding decision guide to look at whether a safeguarding alert should be raised. In 2022/23 we have carried out quarterly thematic reviews on pressure ulcers that developed due to a lapse in care to steer our actions, learning and to monitor change. Overall we have seen a reduction in the total number of category 3 and 4 ulcers developed whilst under our care and where we identified lapses (18 in 2021/22 compared to 12 in 2022/23).</p> <p>The Trust developed a pressure ulcer improvement plan with 4 workstreams;</p> <ul style="list-style-type: none"> <li>• Workforce; recruitment, retention and skill mix developments</li> <li>• IT infrastructure and optimisation of access</li> <li>• Patient and public awareness and self-education</li> <li>• Training needs analysis and competency development</li> </ul> <p>Community Hospitals identified a focus on i) pressure ulcer risk assessments ensuring these are happening within 6 hours and ii) improving personalised care planning and actions to manage risks. They also choose to look at heel pressure ulcers with a focus on training around lower limb assessment and increasing the availability of equipment.</p> <p>The Community Nursing service has been in an escalation position, OPEL level 4 throughout 2022/23 due to increasing demand and lack of capacity. However they have been working on an improvement plan with a focus on recruitment, skill mix review, patient education and training. One element of this plan was the introduction of 6 senior clinical specialists with advanced skills to concentrate on patients with wounds and ensure they are on the correct evidence based pathways, as well as provide training within teams. The roles started in January 2023.</p>

**S8. Reduce category 3 and 4 pressure ulcers which are identified as serious patient safety incidents (Community Nursing and Community Hospital inpatient services)**

**Measure of Impact**

Most pressure ulcers are seen in the community while patients are in their home and under the treatment of the Community Nursing service (74%). The most common injury is a category 2 ulcer (low level of harm) which makes up 56% of all pressure damage, enabling prevention to more serious harm. We have seen a small increase in category 2 ulcers.

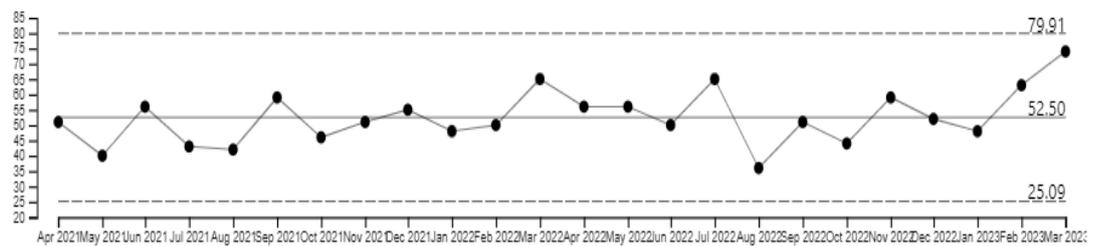
We have seen a reduction in the total number of category 3 and 4 ulcers developed whilst under our care (171 in 2021/22 compared to 151 in 2022/23) and also a reduction in category 3 and 4 ulcers developed in service where we identified learning/lapses in care, therefore meeting the criteria of a serious patient safety incident (18 in 2021/22 compared to 12 in 2022/23).

In relation to pressure ulcers by activity levels:

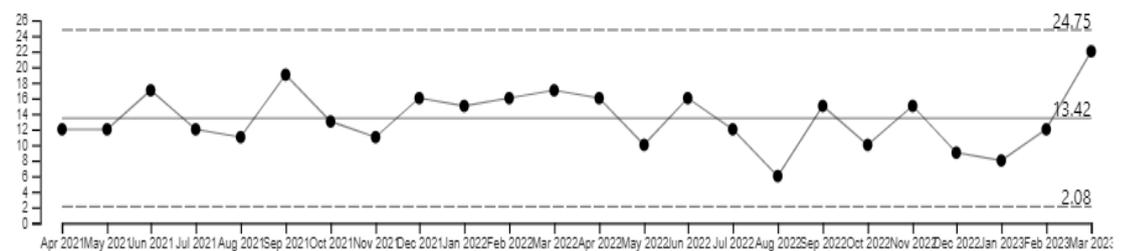
- Community Nursing service on average 0.5 incidents of pressure ulcers developed in service per every 1,000 appointments (based on activity April-July 2022). The rate in 2021/22 and 2022/23 is similar.
- Community Hospitals on average 0.8 incidents of pressure ulcers developed in service per every 1,000 occupied beds (based on activity April-July 2022). The rate in 2022/23 is slightly higher than 2021/22. There has been an increase in acuity of patients on the ward which may contribute to the predisposing factors and a patients ability to comply with using pressure relieving equipment.

The below graphs share the position month by month for the last 2 years.

All levels of Pressure Ulcers – developed in service (category 1, 2, 3, 4, deep tissue and unstageable), whether lapses in care identified or not



Number of Pressure Ulcers category 3 and 4 developed in service, whether lapses in care identified or not



Number of Pressures Ulcers meeting the Serious Patient Safety Incident criteria as lapses in care were identified

How many serious incidents were reported? (by date of incident)



S9. Falls prevention (Community Hospital inpatients)																																																			
Aim	Reduce falls from a patients bed.																																																		
Self-assessment	<b>Achieved</b> – reduction in falls from a bed by 30%																																																		
Evidence of Progress	<p>A quality improvement project started around embedding the completion of bed rail assessments within 12 hours (based on clinical decision making) and patient risk assessments. The discovery phase and baseline data was collected on 3 wards with initial good practice and gaps identified.</p> <p>The discovery phase identified a lack of training (specifically on bed rail assessments) and a need to revise our standards for the timescales to complete bed rail assessments. A bed rail awareness week was ran to engage staff. The Trust’s policy on safe use of bed rails was reviewed and amended in June 2022 to reflect the revised standards.</p> <p>Unfortunately some of the bed rails work planned has been impacted by the cyber-attack and subsequent reduced capacity on the wards to undertake quality improvement work. However, the work that was done and embedded has had an impact and we can demonstrate a reduction in falls from a patients bed.</p>																																																		
Measure of Impact	<p>There was a reduction in all falls from 2021/22 to 2022/23 across the community hospital wards (294 incidents in 2021/22 compared to 274 in 2022/23). In relation to our area of focus on patient falls from a bed there was also a reduction in the number of falls from 56 incidents in 2021/22 to 39 incidents in 2022/23.</p> <p>There has been a reduction in the overall number of falls as well as falls from a bed (both actual number and % of all falls) over the last 3 years. From the baseline in 2021/22 the number of falls from a patients bed have reduced by 30%.</p> <p><u>Patient falls from a bed</u></p> <table border="1"> <caption>Patient falls from a bed (Estimated Data)</caption> <thead> <tr> <th>Month</th> <th>Falls</th> </tr> </thead> <tbody> <tr><td>Apr 2021</td><td>6</td></tr> <tr><td>May 2021</td><td>4</td></tr> <tr><td>Jun 2021</td><td>5</td></tr> <tr><td>Jul 2021</td><td>2</td></tr> <tr><td>Aug 2021</td><td>7</td></tr> <tr><td>Sep 2021</td><td>5</td></tr> <tr><td>Oct 2021</td><td>2</td></tr> <tr><td>Nov 2021</td><td>2</td></tr> <tr><td>Dec 2021</td><td>10</td></tr> <tr><td>Jan 2022</td><td>4</td></tr> <tr><td>Feb 2022</td><td>6</td></tr> <tr><td>Mar 2022</td><td>3</td></tr> <tr><td>Apr 2022</td><td>3</td></tr> <tr><td>May 2022</td><td>4</td></tr> <tr><td>Jun 2022</td><td>2</td></tr> <tr><td>Jul 2022</td><td>2</td></tr> <tr><td>Aug 2022</td><td>2</td></tr> <tr><td>Sep 2022</td><td>3</td></tr> <tr><td>Oct 2022</td><td>7</td></tr> <tr><td>Nov 2022</td><td>5</td></tr> <tr><td>Dec 2022</td><td>3</td></tr> <tr><td>Jan 2023</td><td>6</td></tr> <tr><td>Feb 2023</td><td>2</td></tr> <tr><td>Mar 2023</td><td>0.5</td></tr> </tbody> </table>	Month	Falls	Apr 2021	6	May 2021	4	Jun 2021	5	Jul 2021	2	Aug 2021	7	Sep 2021	5	Oct 2021	2	Nov 2021	2	Dec 2021	10	Jan 2022	4	Feb 2022	6	Mar 2022	3	Apr 2022	3	May 2022	4	Jun 2022	2	Jul 2022	2	Aug 2022	2	Sep 2022	3	Oct 2022	7	Nov 2022	5	Dec 2022	3	Jan 2023	6	Feb 2023	2	Mar 2023	0.5
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**Domain: Clinical Effectiveness**

The objectives reported on are:

- ❖ CE10. Implement the improvements identified following the assessment against the national learning disability and autism standards, to include:
  - Roll out the Oliver McGowan national tier 1 and tier 2 training programme
  - Improve the % of annual health checks
- ❖ CE11. Improve the mental wellbeing of those undergoing stroke rehabilitation (Stroke inpatient service)
- ❖ CE12. Improve the physical health of people with serious mental illnesses (Mental Health services)

CE10. Implement the improvements identified following the assessment against the national learning disability and autism standards	
Aim	<p>a. 90% of staff complete Tier 1 of the national Oliver McGowan training by end of March 2023.</p> <p>b. Increase in health action plans for patients open to specialist learning disability community teams</p>

CE10. Implement the improvements identified following the assessment against the national learning disability and autism standards	
Self-assessment	<b>Partially achieved</b> – efforts made to achieve training however national launch delayed and increase in people with an annual health check and plan
Evidence of Progress	<p>The Trust submits an annual self-assessment against the standards, which includes feedback from staff and patients at our Trust. Our focus in 2022/23 has linked with our new Learning Disabilities Service Strategy (2022-2027) to reduce health inequalities, increase life expectancy and quality of life. We have 8 workstreams working to deliver the aims of the Strategy. The actions we have taken from the assessment are detailed in the body of the Account so this will focus on giving an update on progress with the roll out of training and improving the update of annual health checks.</p> <p><u>a. Training</u></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><u>b. Increase in health action plans</u></p> <p>We have been working with GPs and people with a learning disability to make annual health checks more accessible so that health conditions can be identified as early as possible for treatment. Research shows the average age at death of a person with a learning disability is 23 years younger for men and 27 years younger for women than the wider population. We held an event in June 2022 with primary care services and the third sector for people with a learning disability and their carers to find out what positive steps they can take to live well and be healthier.</p> <p>As of 31st March 2023 81.5% (2,466) of people in Oxfordshire aged 14 and over registered with their GP as having a learning disability have had an annual health check. This against a national target in the NHS Long Term Plan of 75%. Last years (March 2022) performance in Oxfordshire was at 74% so we have seen an improvement.</p> <p><u>Other activities happening</u></p> <p>Below are some of the other activities we are doing to improve how we work with and support people with autism:</p> <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ The Reasonable Adjustment Service at the Trust is supporting mental health clinicians to better understand and support the needs of autistic individuals</li> </ul>

**CE10. Implement the improvements identified following the assessment against the national learning disability and autism standards**

	<p>with reasonable adjustments and adaptations. 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.</p> <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ Resources have been developed to support clinical teams with making communication more autistic inclusive.</li> <li>○ 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.</li> <li>○ 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.</li> <li>○ 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.</li> <li>○ A new BOB ICS ASD patient forum has been developed to work on improving the experiences of people when they access services.</li> </ul>
Measure of Impact	See above information in description.

**CE11. Improve the mental wellbeing of those undergoing stroke rehabilitation (Stroke inpatient service)**

Aim	Improve how emotional changes are considered with patients to feed into care planning and provision of information.
Self-assessment	<b>Partially achieved</b> – training developed and delivered to more than half of the ward staff and clinical audit results improved
Evidence of Progress	<p>The stroke care pathway is a priority within the NHS Long Term Plan. The Trust provides a 20-bed inpatient service delivering intensive specialist rehabilitation for patients following an acute stroke. On average patients stay on the ward for 4-6 weeks. During this time, patients receive intensive rehabilitation from a multidisciplinary team (MDT). The team consists of nurses, doctors, physiotherapists, occupational therapists, speech and language therapists, and dietitians.</p> <p>In 2022/23 the ward team decided to focus on improving how they support patients/ families with psychological and emotional needs as part of working on personalised care planning. To support the work the ward secured funding to appoint a new permanent clinical psychologist, she started in July 2022. She has been supporting the whole MDT to think and support patients with psychological/ emotional effects commonly experienced after a stroke and providing psychology sessions to patients.</p> <p>The Team identified a series of actions they wanted to implement detailed below;</p> <ul style="list-style-type: none"> <li>▪ Staff training so the whole team is more aware around emotional changes after a stroke</li> <li>▪ Reviewing the mood screening tool used</li> <li>▪ Embedding what matters to me as part of improving personalised care</li> <li>▪ Looking at what information and signposting is given to patients/ families around emotional wellbeing.</li> </ul> <p>The team have not been able to progress all of the work as much as they would have liked due to the impact of the cyber-attack as the community hospital service which still continues to work in business continuity without an electronic patient system.</p>

## CE11. Improve the mental wellbeing of those undergoing stroke rehabilitation (Stroke inpatient service)

### Measure of Impact

#### Training

So far more than 42 staff on the ward have completed the training, which is over half. All staff have been sent the links to the training. This is to encourage the whole multi-disciplinary team to bring neuropsychological thinking into daily practice and care planning with patients. Prior to this none of the staff had received specific, tailored training around emotional changes.

#### National clinical audit results

We have participated in the national audit on stroke called SSNAP, the quarterly overall results for 2022-23 are below.

- Quarter 1 was B
- Quarter 2 was B
- Quarter 3 was C\*
- Quarter 4 was A (provisional to be confirmed in June 2023)

A total of 44 key indicators are included in the national audit chosen by the Intercollegiate Stroke Working Party as representing high quality stroke care. The indicators include looking at whether psychology was considered and offered to patients alongside physiotherapy, occupational therapy and speech and language therapy. The key indicators are grouped into 10 domains covering key aspects of stroke care. The performance is rated on a scale from A to E, with A being the highest compliance, 90% or above.

\*Audit compliance rating dropped to C in Quarter 3. This is across the same period as the cyber-attack to our supplier of the patient record system which meant all systems were unavailable from August 2022. So we believe the drop in performance is related to documentation rather than practice.

#### Feedback from patients/families

The response rate to surveys from patients on a stroke unit are expectedly low. We received 115 survey responses in 2022/23 and these showed overall;

- 4 patients gave a rating of 1 (lowest score)
- 9 patients a rating of 2
- 40 patients a rating of 3
- 73 patients a rating of 4
- 105 patients a top rating of 5 (highest score)

The average rating for the year was 4.44 out of 5, the ratings fluctuated slightly month by month, and did not show an improvement from the work to better support patients psychologically or emotionally. 110 out of 115 patients wrote responses in the open text comments, no-one specifically mentioned psychology but therapy was mentioned a number of times. A summary word cloud of the open text responses is below, the larger the text the more times it was mentioned, for example staff were mentioned 50 times. The colour of the word refers to the rating; a rating of 4 and 5 is green, a rating of 3 is yellow, a rating of 2 is orange and a rating of 1 is red. The reviews continue to be used to make positive changes on the ward.



CE12. Improve the physical health of people with serious mental illnesses (Mental Health services)	
Aim	<p>Improve the physical health for patients with a severe mental illness.</p> <p>We use a process measure, completion of annual physical healthcare reviews and acting on the actions identified; local targets are 90% of patients open to our Early Intervention Services and 75% of patients open to our Community Mental Health Teams.</p>
Self-assessment	<p><b>Partially achieved</b> – lots of work and changes have been made, some improvements in patient reported outcomes however we are been unable to see the impact on the completion of the Lester tool for a holistic physical health check.</p>
Evidence of Progress	<p>National statistics show that people with a serious mental illness are at a greater risk of poor physical health and have a higher premature mortality than the general population, often dying 15-20 years sooner from conditions like cardiovascular disease or cancers due to poor access to screening and physical health checks. To address this health inequality, we have committed to increase the number of patients with a serious mental illness open to our community mental health teams that have a full annual physical health check each year (using the Lester tool). The physical health check consists of reviewing seven parameters: Body Mass Index (BMI), systolic blood pressure, diastolic blood pressure, lipids, glucose, alcohol status and smoking status, and then identifying any actions in the person’s care plan or making a referral to specialist services as needed.</p> <p>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 and embedded into community mental health teams and wards, as well as the purchase of additional physical healthcare equipment.</p> <p>The focus has been on:</p> <ul style="list-style-type: none"> <li>• Diabetes management on the wards</li> <li>• Physical health skills training for community mental health teams</li> <li>• Developing patient information to support conversations and promote improving health</li> <li>• An inpatient referral pathway to embed a care treatment programme for tobacco dependency has been developed. The focus is on systematically identifying all active smokers on the wards and quickly offering nicotine replacement therapy, alternatives to smoking such as vapes and access to specialist 1:1 support throughout admission. Patients are then offered referral to community stop smoking services on discharge.</li> <li>• Increase the role of peer support workers to promote physical healthcare screening</li> <li>• Improve flexibility and mobility of testing through mobile clinics and point of care testing kits</li> <li>• We have also introduced new mental health practitioners to provide support to patients in primary care. 9 practitioners have so fare been recruited in Buckinghamshire.</li> <li>• Make changes to the physical health forms on the electronic patient record</li> </ul> <p>It will take time to really improve the healthcare of vulnerable people with a serious mental illness. Some patients will have neglected their health or not been able to access screening/support for decades. The Trust has committed to changing this and recognising the importance of our role in helping someone with their physical health as well as their mental health.</p>

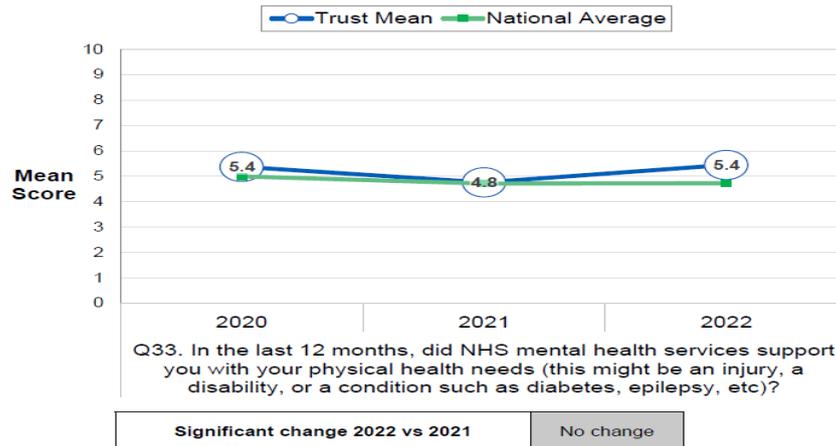
**CE12. Improve the physical health of people with serious mental illnesses (Mental Health services)**

**Measure of Impact**

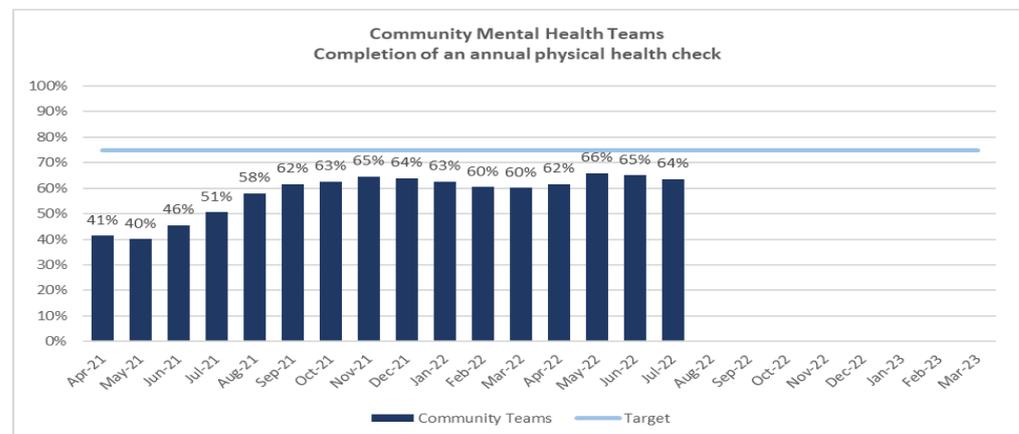
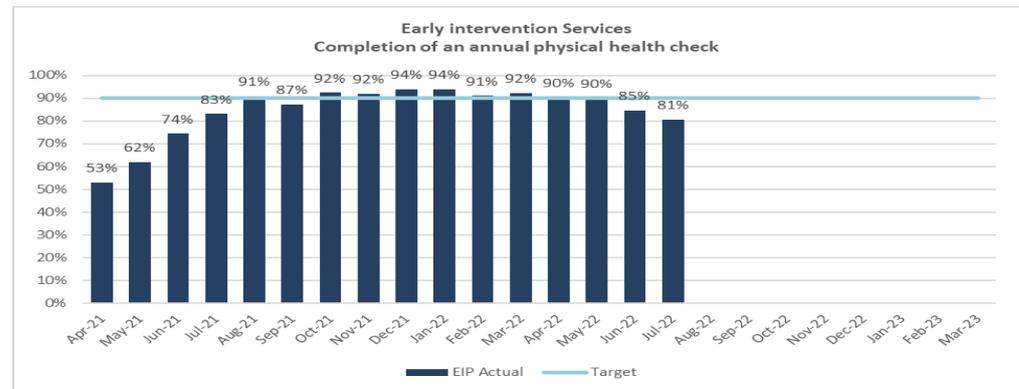
The measurement to demonstrate the impact of the changes has been hindered by the cyber-attack on the electronic patient system. The data we have on the completion of physical healthcare reviews is only available up to July 2022, this shows we did not achieve our local target in the first 4 months of 2022/23. 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.

National annual community mental health patient survey 2022 (n=266);

In the last 12 months have you been helped with physical health needs - 5.4 out of 10 against a national average of 4.7. Improvement from 2021.



Completion rate for the Lester screening tool is below our local target at the moment. However the data is only available to end of July 2022.



## Domain: Patient and Family Experiences

The objectives reported on are:

- ❖ E13. Embed personalised care planning developed with patients to improve clinical outcomes
- ❖ E14. Working with families;
  - a. Embed the Carers Trust's Triangle of Care standards (or equivalent) across all services aligned with the Trusts Family, Friends and Carers Strategy.
  - b. QI projects to improve working with families (Mental Health services)

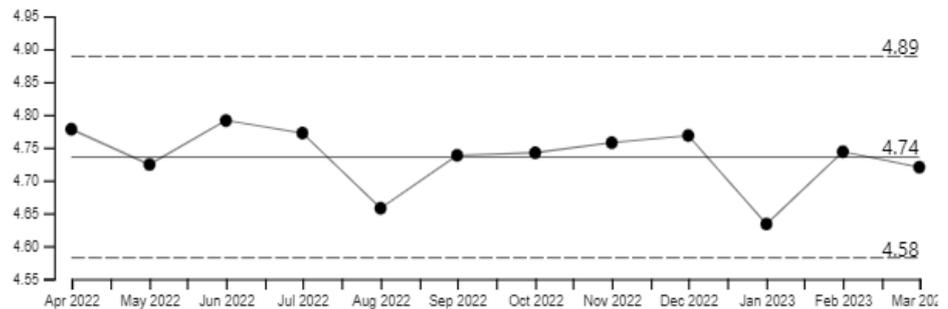
E13. Embed personalised care planning developed with patients to improve clinical outcomes	
Aim	Improve feedback from patients about having a co-produced personalised care plan/ plan of care.
Self-assessment	<b>Partially achieved</b> – lots of work has happened, some small improvements can be evidenced
Evidence of Progress	<p>A number of quality improvement projects are underway with a focus on person centred care and care planning.</p> <p>Some examples of the projects this year include;</p> <ul style="list-style-type: none"> <li>- Forensic inpatient services have focused on needs led care planning in collaboration with patients.</li> <li>- 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.</li> <li>- 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.</li> <li>- The community dental services have introduced the Patient Bridge from Nov 2022, 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. A quality improvement approach was taken from the start in April which meant changes were made as we introduced and used the system based on feedback from patients and staff. Moving forward we hope to use the portal to share more information and to make it more interactive so we have closer working with patients.</li> <li>- The Urgent Community Response team has been trialling joint visits with the care team from Oxford University Hospitals NHS Foundation Trust 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 providers and enables the patient to stay at home with on-going care needs after treatment has commenced.</li> <li>- Children We Care for have been developing a personalised physical health summary for their clients just before they turn 18 years old. Clients are asked to provide feedback on what would be helpful to include in the health summary, what does not need to be included and whether anything else should be considered. A three-month trial is underway for the service with plans to expand in other services if successful.</li> </ul> <p>The Trust has a co-produced a new Patient Experience and Involvement Strategy in 2022/23, building on the previous Strategy, which is in the final stages of being approved, a central part of this is to improve personalised care.</p> <p>The national annual community mental health survey results for 2022 showed small improvements in this area from 2021, although our local survey results and evidence in clinical records (via clinical audits) shows this has remained quite static.</p>

### E13. Embed personalised care planning developed with patients to improve clinical outcomes

#### Measure of Impact

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.

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



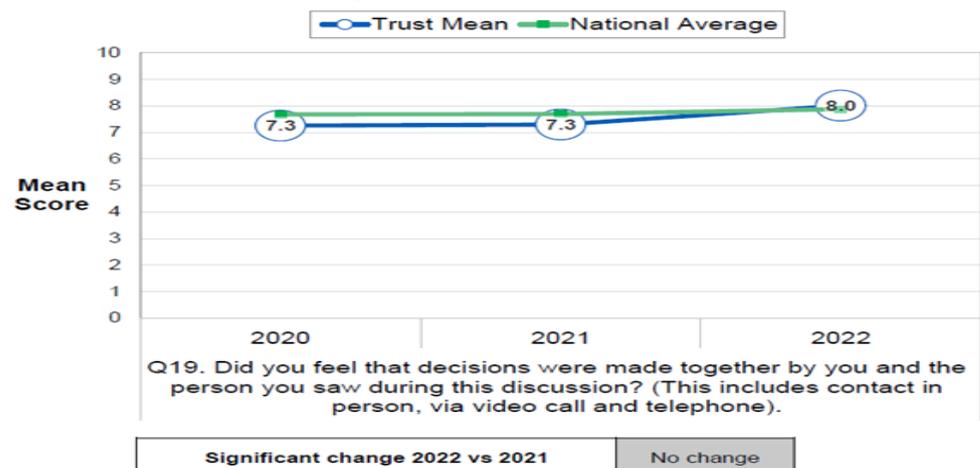
What are the counts of 5\* and 1\* scores? (counts total of the scores for each month)



National annual community mental health patient survey in 2022 (n=266);

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

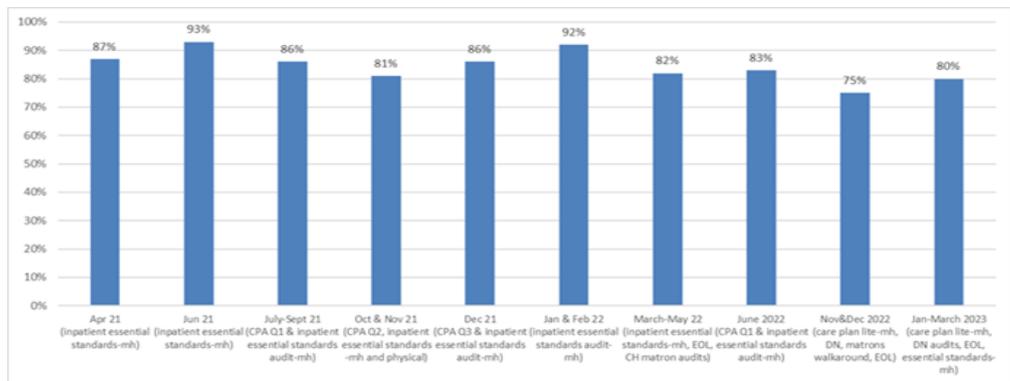
- Patients feeling involved in deciding and planning care (Trust 7.3 against average 7.4)
- Patients feeling decision were made together when reviewing care (Trust 8.0 the same as the average 8.0)



**E13. Embed personalised care planning developed with patients to improve clinical outcomes**

Evidence in Patients Records (Clinical Audit Results)

Across 6 different clinical audits that review patient involvement in care planning, these are care plan lite for community mental health services, essential standards for mental health wards, community hospital matrons walkaround and Community Nursing service audits on documentation, pressure ulcer prevention and end of life care.



**E14. Working with families**

**Aim**

- a. To work in partnership with carers:
  - 85% of carers and families will report feeling involved as part of their loved ones' care by June 2024. (Y1 2022/23 61%)
  - 75% of carers and families will report feeling listened to as part of their loved ones' care by June 2024. (Y1 2022/23 45%)
- b. The overall aim of this project is to improve family and carer involvement and experiences.

**Self-assessment**

**Partially achieved** – we have retained the triangle of care accreditation, seen an improvement in the patient and carer survey results, completed many of the strategy actions and undertaking a number of QI projects.

**Evidence of Progress**

- a. Trust Family, Friends and Carers Strategy 2021-2024 in place with 7 primary drivers:
    - Build on staff awareness and training about carers
    - Increase support and signposting available to carers
    - Better communication with carers
    - Develop and improve resources about services for patients and carers to access in different formats
    - Build on involvement work with carers
    - Identify carers who are accessing our services with the service user
    - Build on equality and inclusion
- Implementation plan set out for year 1 - 2022/23. Annual survey has been repeated to measure impact of Strategy, see below a snapshot of the results.



The Trust was re-assessed by the Carers Trust in Sept 2022 in relation to the Triangle of Care membership scheme, the result was we retained our accreditation of 2 stars. The Triangle of Care describes a therapeutic relationship between the patient, staff member and carer that promotes safety, supports communication and sustains wellbeing. The membership demonstrates our commitment to becoming more carer inclusive. We hope at the end of completing the Strategy we will have achieved all 3 stars across all of our services. At the moment only 2 other NHS Trusts have achieved 2 stars.

As part of the Strategy in 2022/23 we have;

## E14. Working with families

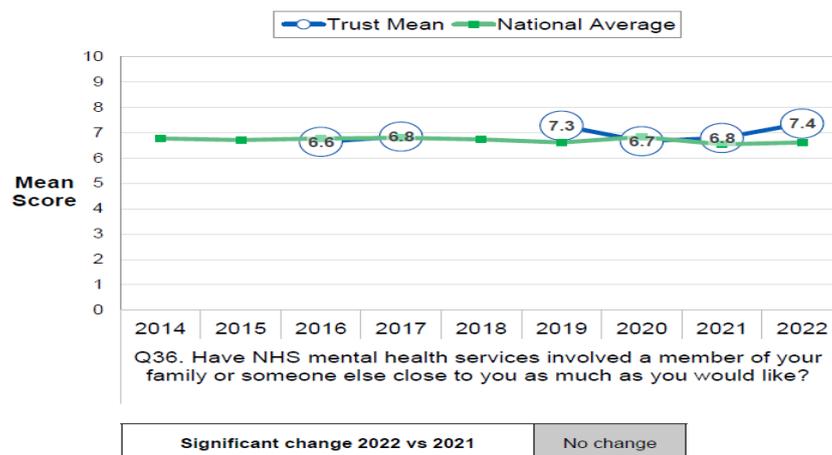
- Provided education sessions for carers, developed with and co-facilitated covering topics such as understanding psychosis, bipolar, depression,, drug and alcohol addiction, suicide and self-harm, and personality disorder
- Facilitated carer support groups for the majority of mental health service areas
- Provided a family and carers support line. This is available to carers should they feel they need someone to talk to and/or want to find out about support available to them.
- Updated the carers support leaflet for Buckinghamshire and Oxfordshire mental health services. A more detailed handbook for mental health services has also been co-produced with carers and is in its final stages before being published.
- Co-facilitated training with a carer on a course on the Buckinghamshire Recovery College called Carers Matter
- Delivered face to face carer awareness sessions across the Trust and developed an e-learning module available to all staff.
- Family Interventions training is being developed in liaison with an external provider with a planned train the trainer roll out for directorates in 2023/24.

b. There are individual team projects underway across Buckinghamshire and Oxfordshire mental health services. The diagnostic phases have been completed. The driver diagram identified 3 primary drivers; identification of carers, communication and involving carers. A series of tests of change were started including;

- Creating carer information boards
- Creation of family surgeries, due to be rolled out across all mental health wards
- Re-introducing pre-ward rounds meetings to support patients/ families to be involved. Increasing carer attendance to ward rounds and clinical review meetings.
- Developing an inpatient introduction letter and pack for carers when their loved one is admitted
- Simulation training for staff on sharing information, confidentiality and effective communication with families
- Information on involving families added to our staff induction pack.
- Family involvement becoming a standing item on team meeting agendas

### Measure of Impact

National annual community mental health patient survey in 2022 (n=266); Patients reported - above average for involvement of a family member, scored 7.4 against the national average of 6.6. Improvement from 2021.



The Trusts local surveys completed by carers, friends and family survey are detailed below which helps measure the impact of the Carers Strategy. The measures show some progress however feedback shows this is inconsistent as many carers responded saying they felt involved or felt listened to only sometimes and not every time.

## E14. Working with families

	Starting Point		Year One of Strategy–2022/23	
	Actual	Target	Actual	
			Annual carers survey 2022 N=68	IWGC carers survey for 2022 N=202 (majority of responses from the community hospital wards)
% of family, friends and carers felt involved	51%	61%	Yes - 35 (51.5%) Sometimes – 21 (30.9%) No – 12 (17.7%)	Totally - 134 (66%) Not at all - 3
% of family, friends and carers felt listened to	36%	45%	Yes – 23 (34%) Sometimes – 22 (32%) No – 23 (34%)	Totally - 152 (75%) Not at all - 10

The learning from serious patient safety incidents in 2022/23 shows family involvement is still an area for improvement, coming up as a theme in about 40% of the reviews we complete across our mental health services. Although we have also seen an increase in good practice examples within reviews of very good engagement with families.

### Complaints (majority are received from carers/ family members)

From May to December 2022 we had a reduction in the number of complaints received, compared to the previous year. However in Jan and Feb 2023 this returned to average levels and in March 2023 the number increased.

#### 14. Our Quality Improvement Plan for 2023/24

We have identified the following 13 quality objectives for 2023/24, showing our commitment to continually make improvements to the quality of care. These are summarised on the following page.

In addition to the quality objectives, we will also continue to develop our Quality Improvement Strategy and delivering the programmes on Improving Race Equality in the Workforce and Improving Quality Reducing Agency use (focused on recruitment and retention of staff).

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

The objectives were identified after a:

- Review of progress against the 2022/23 objectives
- Conversations with our staff and key stakeholders
- Analysis of themes from quality information over the last 12 months
- Review of the Trust's top risks to quality of care
- Evaluation of the quality improvement projects
- Review of national drivers and strategies for the NHS including the NHS Long-Term Plan and CQUIN<sup>8</sup> goals for 2023/24

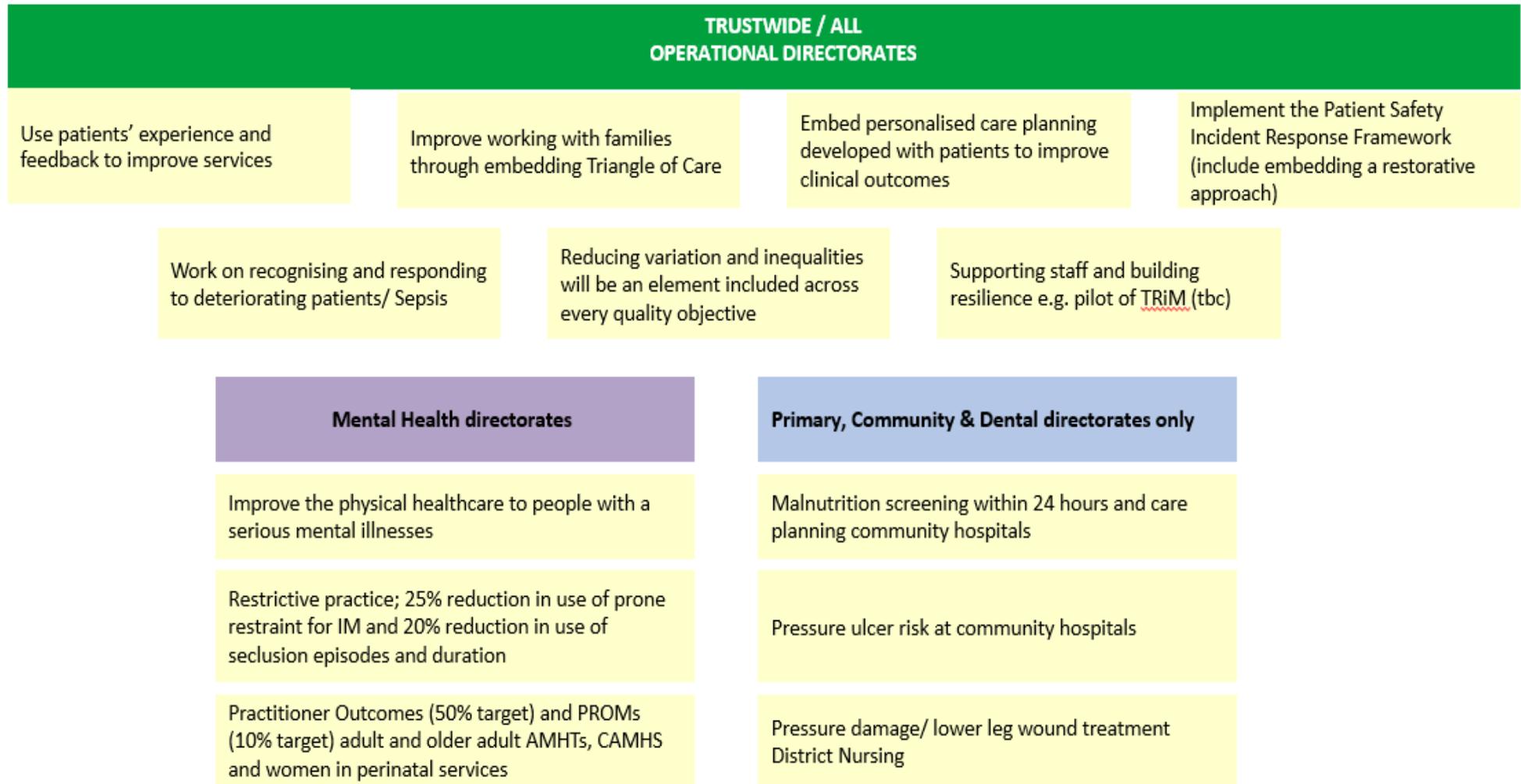
The objectives support the delivery of the priorities in the Trust's 5 year Strategy 2021-2026, see appendix 2.

Each of the objectives will be broken down to identify key milestones, measures and what is expected to be achieved by 31st March 2024. The Trust's Quality Committee will monitor progress against the objective milestones quarterly. The Trust will publish our progress against each objective in our Quality Account next year.

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<sup>8</sup> *The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to link a proportion of providers' income to the achievement of quality improvement goals*

Summary of the Trust's 2023/24 quality objectives.



TRiM = Trauma Risk Management, this is a structured approach for staff to offer their peers support who have experienced a traumatic or potentially traumatic event.

## 15. Statement of Directors responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out by NHS England, available here [NHS England » Quality Accounts requirements](#)
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2022 to March 2023
  - papers relating to quality reported to the Board over the period April 2022 to March 2023
  - feedback from commissioners dated 26<sup>th</sup> June 2023
  - feedback from governors dated 12<sup>th</sup> June 2023
  - feedback from local Healthwatch organisations dated 14<sup>th</sup> June 2023
  - feedback from Overview and Scrutiny Committees dated 15<sup>th</sup> June 2023
  - the Trust's annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2022 national patient survey
  - the 2022 national staff survey
  - the Head of Internal Audit's annual opinion of the Trust's control environment
  - Any CQC inspection reports
  - the Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
  - the performance information reported in the Quality Account is reliable and accurate
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
  - the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
  - the Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.



**27<sup>th</sup> June 2023 - David Walker, Chairman**



**27<sup>th</sup> June 2023 - Dr Nick Broughton, Chief Executive**

## 16. Glossary of Acronyms used in this report

Acronym	Full Name
BAME	Black, Asian and minority ethnic
BRC	Biomedical Research Centre
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death and Overview Process
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
ePMA	Electronic Prescribing and Medicines Administration
FFT	Friends and Family Test
GP OOH	General Practitioner Out of Hours service
HOPE	Healthy Outcomes for People with Eating Disorders
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System. When BOB ICS is used this is the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.
IPS	Individual Placement and Support
IWGC	I Want Great Care
JRO	Oxford Joint Research Office
LeDeR	Learning from lives and deaths – People with a learning disability and autistic people
MDT	Multidisciplinary team
MHSDS	Mental Health Services Data Set
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning Service
OAP	Out of Area Placements
PALS	Patient Advice and Liaison Services
PNA	Professional Nurse Advocates
POMH-UK	Prescribing Observatory for Mental Health- UK
PSI	Serious Patient Safety Incidents
QI	Quality Improvement
SCAS	South Central Ambulance Service
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both
TRiM	Trauma Risk Management

## Appendix 1. National Clinical Audits

Name of Audit	Audit Scope	Status	Results and Actions
National Audit of Inpatient Falls	Mental health wards and Community Hospitals	Continuous data collection	The national team had not allocated the Trust any cases for us to audit we think this is due to the recording on the hip fracture database and are working with Oxford University Hospitals NHS Foundation Trust to try and resolve this.
UK Parkinson's Audit	Speech and Language Therapy service and Physical Disability Physiotherapy Service	Snapshot	<p>Speech and Language Therapy were unable to participate due to the systems outage. A local audit will be undertaken in 2023-24.</p> <p>The Physical Disability Physiotherapy Service team entered 29 cases before the cyber-attack. Improvement was evidenced from the previous audit around outcome measurement and advice provided on exercise.</p> <p>There were no concerns regarding the operational or organisational data collected and analysed.</p>
Serious Hazards of Transfusion	Emergency Multidisciplinary units	Continuous data collection	Data inclusion to the Serious Hazards of Transfusion Database is part of the post incident review of incidents relating to blood transfusion process and therefore this project is not a clinical audit but a registry. Learning and actions were tracked as part of the incident review process.
National Audit of Diabetes Footcare	Community services Podiatry	Continuous data collection	<p>National deadline for the 2022/23 audit is July 2023. At the time of writing the Account we have so far audited 163 cases.</p> <p>Due to capacity within the podiatry service we do not meet the target of assessing patients within 2 working days from referral. The risk is mitigated by:</p> <ul style="list-style-type: none"> <li>• The service has a triage protocol in place.</li> <li>• Providing education and outreach to colleagues e.g., GP, Nursing, allied health professionals etc.</li> <li>• Information is provided to patients.</li> </ul> <p>Interim analysis (March 2023) shows follow up and outcome measures remain consistent with previous years.</p> <ul style="list-style-type: none"> <li>• Low lost to follow up rate (2.5%)</li> <li>• Ulcer free at 12 weeks (58.3%)</li> </ul>
Core National Diabetes Audit; Structured Education Element only	Community services Diabetes	Continuous data collection	<p>Waiting for the national results.</p> <p>Service provides structured education to type 2 diabetes patients, this is well evaluated and externally accredited.</p>

Name of Audit	Audit Scope	Status	Results and Actions
National Asthma and COPD Audit Programme: Pulmonary rehab service (1 audit) and in-reach service into inpatient wards at the Oxford University Hospitals NHS Foundation Trust (2 x audits)	Respiratory service	Continuous data collection	<p>National deadline for 2022-23 is August 2023. However we know access times to assessment are not being met due to staff capacity not being able to meet demand.</p> <p>The 2022-23 Quarter 1 and 2 interim results showed:</p> <ul style="list-style-type: none"> <li>• Appropriate referrals into service (further supported by a triage process on receipt).</li> <li>• Once assessed patients commence pulmonary rehabilitation in an average of 9 days.</li> <li>• Patients who received an exercise plan on discharge improved to 87% (from 23.3% in previous 6 months).</li> <li>• Patients saw an important difference (positive outcomes to quality of life): <ul style="list-style-type: none"> <li>○ 14% saw improvement measured via MRC.</li> <li>○ 48% saw improvement measured via walking assessments.</li> <li>○ 69% saw improvement measured by COPD Assessment Test.</li> </ul> </li> </ul>
National Audit of Care at the End of Life	Community Hospitals	Snapshot	<p>Oxford Health undertook the following elements of the national audit:</p> <ul style="list-style-type: none"> <li>• Organisational</li> <li>• Case note</li> <li>• Staff reported measures.</li> </ul> <p>The Trust did not participate in the families and carers survey as we believe the survey is poorly designed and could be upsetting to families.</p> <p>The 2022-23 results highlighted:</p> <ul style="list-style-type: none"> <li>• Communication with the dying person could be improved.</li> <li>• Communication with families and others was 100% in 5 of the 6 measured elements.</li> <li>• Involvement in decision making (the dying person) was either 100% or there was a recorded rationale as to why they weren't.</li> <li>• Individualised care was 100%, or had a recorded rationale, in 28 of the 29 measured elements.</li> <li>• Workforce/specialist palliative care complied with 6 of the 7 measures.</li> <li>• Staff confidence could be further improved (support had improved from last year).</li> </ul>
National Clinical Audit of Psychosis	Early Intervention in Psychosis Services	Snapshot	<p>The audit ran a reduced data set in 2022-23 due to the cyber-attack. It focused on effective treatment, physical monitoring and whether outcome assessments were undertaken.</p> <p>The audit highlighted evidence of increased conversations with patients around:</p> <ul style="list-style-type: none"> <li>• commencing CBTp</li> <li>• commencing supported education programme</li> </ul>

Name of Audit	Audit Scope	Status	Results and Actions
			<ul style="list-style-type: none"> <li>• commencing a family intervention course</li> <li>• documenting supporting family member/friend/carer</li> </ul> <p>Physical health checks being recorded declined slightly;</p> <ul style="list-style-type: none"> <li>• Number of current smokers is smaller than last year. 61.4% of current smokers declined intervention.</li> <li>• Patients did not want to disclose alcohol and/or substance and the patients who did reveal often declined intervention.</li> <li>• BMI recording dropped slightly. 75% of our patients who flagged as having a BMI over 25 had interventions made.</li> <li>• Blood pressure recording dropped slightly. 94% of patients who flagged as having abnormal Blood Pressure had an intervention made.</li> <li>• Glucose recording dropped slightly. 100% of patients who flagged with abnormal glucose had interventions made.</li> <li>• Cholesterol recording dropped slightly. 100% of patients that triggered had interventions.</li> </ul> <p>It has been identified that the systems outage meant that the normal prompts on the electronic system did not occur.</p> <p>The outcome assessments showed the same consistency of completion as the last audit.</p> <p>Actions are currently being developed but will focus on:</p> <ul style="list-style-type: none"> <li>• Continue to build on the improvement in having effective conversations with patients,</li> <li>• Clinical system development to add physical health assessment and prompts.</li> </ul>
Prescribing Observatory for Mental Health (POMH-UK) - The use of Melatonin (21a)	CAMHS mental health community teams and wards, as well as the learning disability teams	Snapshot – 150 patients who have and active prescription of melatonin.	<p>Actions are currently being created but will focus on the following recommendations:</p> <ul style="list-style-type: none"> <li>• Review what evidence-based, non-pharmacological interventions are being tried before melatonin is prescribed.</li> <li>• Produce a brief melatonin guideline for CAMHS prescribers. This should include a recommendation to use non-pharmacological interventions first. The guideline should include the Trust's choice of formulation (according to the formulary), dosing, and monitoring recommendations (efficacy/side effects). There should be a recommendation to provide verbal and written information about off-label/unlicensed use (where appropriate) – including links to available leaflets. Include recommendations about what should be documented (and where) in the</li> </ul>

Name of Audit	Audit Scope	Status	Results and Actions
			patient's notes at each review to ensure a consistent approach (consider the use of a proforma). Link this guidance to the existing shared care protocols.
Prescribing Observatory for Mental Health (POMH-UK) - Valproate prescribing in adult mental health services (20b)	Adult mental health services	Snapshot	Due to the cyber attack this audit could not be participated in.  It should be noted there were national alerts regarding the use of valproate which we acted on. We are also piloting a valproate registry in Buckinghamshire with the acute NHS Trust and primary care. A local audit will be undertaken in 2023-24.
Prescribing Observatory for Mental Health (POMH-UK) - Monitoring of patients prescribed lithium (7g)	Adult mental health services	Snapshot	Waiting for the national results.
Prescribing Observatory for Mental Health (POMH-UK) - National clinical audit of anti-libidinal medication prescribing practice	Men under adult mental health forensic services prescribed medications for anti-libidinal	Snapshot	Due to the systems outage this audit could not be participated in. A local audit will be undertaken in 2023-24.
Sentinel Stroke National Audit programme	Oxfordshire Stroke Rehabilitation Unit	Continuous data collection	Key results from the audit in 2022/23; <ul style="list-style-type: none"> <li>• Occupational Therapy and Physiotherapy consistently achieved an 'A' grade across the year</li> <li>• Speech and Language Therapy performance improved during the year from E to D, reflecting some improvement in staff recruitment.</li> <li>• The service consistently performs poorly in the discharge processes sub-section, due to lack of specialist stroke rehabilitation services available for patients on discharge.</li> </ul>
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Transition of young people with complex chronic conditions from child to adult health services	Mental health wards, Community Hospitals and community teams	Snapshot	We provided records on request for the national confidential enquiry. However due to the cyber attack we were not able to participate in the clinical questionnaires. The Trust will review our performance against national recommendations when published.

The full strategy with more detail about each of the four strategic priorities and objectives can be read at [Our strategy - Oxford Health NHS Foundation Trust](#).



# Our strategy: At a glance

## 2021-2026

### Our four strategic objectives:

- ### 1 Quality



**Deliver the best possible care and health outcomes**

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



**Be a great place to work**

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



**Make the best use of our resources and protect the environment**

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



**Be a leader in healthcare research and education**

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



**Mission**

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



**Vision**

**Outstanding** care delivered by an **outstanding** team



**Values**

Caring ● Safe ● Excellent

### Council of Governors

#### Annual Quality Account 2022-23 – Lead Governor's statement for the Council of Governors

The Annual Quality Account for 2022-23 sets out admirably the many quality developments achieved by the Trust in what, post-pandemic, was still a difficult year for the NHS.

The Account is an interesting and informative document - reflecting the Trust's achievements in the face of significant continuing challenges including increased demand, commissioning disparities, and inadequate funding. The evidence of focused quality improvements is welcome.

It is right however that the Account acknowledges the significant challenges to providing quality services which the Trust has faced in 2022-23 including the loss of electronic patient records resulting from a cyber attack, staff recruitment and retention, providing timely access to services, recourse to mental health service out of area placements, concerns about staff health and wellbeing, and performance against a number of national benchmark indicators.

The quality objectives for 2023-24, while openly repeating some previous objectives, are relevant and urgent.

The Council of Governors will continue to support the Board to address and achieve the aims and objectives for improving the quality of care for patients and their carers, the experience of Trust staff, and effective collaboration with key partners.

**Mike Hobbs, Lead Governor, June 2023**

### Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Dr Nick Broughton  
Chief Executive Officer  
Oxford Health NHS Foundation Trust

Sent via email to:  
[Nick.Broughton@oxfordhealth.nhs.uk](mailto:Nick.Broughton@oxfordhealth.nhs.uk)

  
**Buckinghamshire, Oxfordshire  
and Berkshire West**  
Integrated Care Board  
Sandford Gate, Second Floor  
East Point Business Park  
Oxford  
OX4 6LB  
[rachael.corser@nhs.net](mailto:rachael.corser@nhs.net)

26 June 2023

Dear Nick

**RE: OHFT Quality Account Response BOB ICB**

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) has reviewed the Oxford Health NHS Foundation Trust (OHFT) Quality Account and believe that it is accurate and meets the requirements of a Quality Account.

Achievement against the Trust's quality priorities for 2022-3 is described in detail in section 13 of the Quality Account. Of the 14 priorities sent for 2022/23 five have been fully achieved with the remaining nine partially achieved.

Focussed work on falls and pressure ulcers has delivered measurable improvements to patients. This is a real step forward for this important safety area when compared with 2021-2022. We would encourage the Trust to create a whole trust wound care strategy/action plan to report to their Pressure Ulcer Prevention Group and to link with the system wide wound care collaborative work.

There has been improvement in the performance on annual health checks for people with a learning disability (LD). This is an important step to addressing the inequality in health and outcomes for this population. The LD and autism improvement standards are a set of indicators to ensure the needs of people with a learning disability and autistic people are being met. Training is essential to ensure that staff can make the necessary reasonable adjustments. We would welcome the Trust building on this work to ensure that people with a learning disability and/or autism with more specialist needs are able to receive high quality care within the Trust and do not have to receive care at a distance from where they live.

The broad range of partnerships and community connections is clear throughout the account. The Trust's work to reduce restrictive practice has had a real and measurable effect on the quality of patient care. It was very positive to have the lessons from this work shared within the ICB to support learning across our local system.

The Trust's work to reduce the placement of children out of area is to be commended. The ICB would like to congratulate the Trust on now having the best performance in the country and will support the effort to reduce the occurrence of these placements out of area to zero.

For the new priorities there is a clear focus on putting patients and their families at the centre to ensure care is personalised. The ICB welcomes the Trust's employment of family members as experts by experience to advise the Trust staff on areas such as Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder.

Workforce is the single greatest challenge for the system. There is a clear correlation between areas which are short staffed and the patient safety incidents. The Trust's ongoing efforts to recruit, retain and support staff are important and we welcome the continued focus in this area.

The loss of the patient information system as a result of a cyber attack in August 2022 has added further pressure to an already stretched workforce. The resultant lack of data has presented a challenge in terms of understanding the Trust's performance and quality. There remains a programme of work to recover clinical systems. The ICB will continue to work with the Trust to gain assurance on quality and to request proportionate information in light of the challenges.

The National Quality Board has refreshed the definition of quality in its *Shared Commitment to Quality*, adding 'well led' 'sustainable' and 'equitable' to the established domains of safe effective and with a positive experience. The BOB ICS is committed to understanding and reducing variation and inequalities. The OH priority of reducing inequality and variation across all the quality improvement areas is a welcome step toward this aim.

The new NHS Patient Safety Strategy represents a significant change to the way the NHS understands and learns from incidents. The Patient Safety Incident Response Framework (PSIRF) sets out a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The focus is on improving patient safety with an emphasis on how incidents happen and the factors which contribute to them. The Trust has had a real focus on developing a culture of quality improvement and this is an excellent foundation for PSIRF. The strong link with Quality Improvement within the Trust will mean that safety incidents will lead to real and sustained changes in practice. The ICB has been working closely with the Trust on this hugely positive change to the way in which we understand patient safety. PSIRF also aims to better support those affected by patient safety incidents. The Trust's priority of empowering patients is in line with the aims of PSIRF and should support those affected by a patient safety incident. It could be further strengthened by factoring in the role of patient safety partners and the guidance on Involving Patients in Patient Safety.

The OHFT Quality Account is an accurate description of the Trust's activity and the quality of its services. We recognise the considerable challenges of the last 12-months, and value the close and evolving working relationship that OHFT and the ICB have enjoyed over this time. Provider collaboratives represent a new balance in the relationships between, and responsibilities for, commissioning and improving the quality of whole pathways of care. We look forward to the further collaboration over the coming year as we increasingly work as a part of the BOB system as well as integrating services locally to improve the outcomes for the populations we serve.

Yours sincerely



Rachael Corser  
Chief Nursing Officer

#### Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NHS Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) welcome the opportunity to review and comment on the Oxford Health Quality Account for 2022/ 2023. It is the view of BSW ICB that the Quality Account reflects Oxford Health's on-going commitment to quality improvement and addressing key issues in a focused and innovative way, and the key achievements of the Quality Improvement Strategy in 2022/23 demonstrate this. The ICB notes the progress and improvements achieved against the trusts quality objectives for 2022/23 and the improvements in patient care as a result are evident from the detailed breakdown provided. It is also noted that the trust has highlighted clinical workforce challenges as one of the five key areas of focus. The ICB acknowledges the challenges the trust has faced around workforce and supports the trusts' commitment to supporting, retaining and recruiting staff. We look forward to seeing progress with quality priorities identified in this Quality Account in conjunction with the continued transition to the Patient Safety Incident Response Framework and the formulation of the organisations Patient Safety Incident Response Plans (PSIRPs). We would encourage alignment to focus improvement in key areas.

BSW ICB are committed to sustaining strong working relationships with Oxford Health, and together with wider stakeholders, will continue to work collaboratively to achieve our shared priorities as the Integrated Care System further develops in 2023/24.



Gill May - Chief Nurse Officer

15 June 2023

Dear Jane,

Many thanks to Oxford Health, and specifically Britta Klinck and Rose Hombo, for attending our Committee on 08 June and presenting to us a very comprehensive, clear and accessible report – including a glossary of acronyms. HOSC has been emphasising the importance of accessible reporting throughout the year we are grateful that this report is a good practice example.

I and the Committee continue to recognise the continuing pressures on staff at OH over the past year and to emphasise the appreciation the Committee has for the commitment shown to deliver its services amidst such a challenging context. We remain acutely aware of the pressures on you and your teams and the impacts which this has had on workloads and on physical and mental health across OH.

The following are comments made by the Committee at its meeting : -

Issue	Commentary
EPRS (Electronic Patient Record System) Downtime	The challenges on staff of having to learn new processes to mitigate the EPRS downtime, and the difficulties of sourcing patient data in new ways is liable to have increased stress on staff, and by extension reduced capacity – likely impairing patient outcomes. The Committee welcomes the Trust’s response in reviewing its critical incident response and encourages that the learning be shared with other system partners owing to the potential for this situation to be experienced elsewhere in the system. It is critical that members of the public can trust in the safety of their data and the response if there is an incident and the proliferation of this learning will support that. The Committee particularly encourages the review to include the impact and effectiveness of mitigations taken to support staff wellbeing as part of this critical incident review. The Committee would value seeing the outcomes of the Trust’s thematic review concerning patient safety at a forthcoming meeting when available
Eating Disorders	Having previously considered this issue on the basis of it being an area of concern, the HOSC particularly welcomes the significant progress made by the Trust in reducing the number of referrals for eating disorders, particularly when set against the national context in this area.
Physical Health for those with Mental Health	The Committee has long perceived a need for improving this area of provision and welcomes the Trust’s prioritisation of this area. The Committee will be keen to see how this is taken forward.
Frank Bruno Centre	The Committee recognises that for mental health provision it is important that there be multiple points of access to allow support across the diversity of people needing mental health support. Nevertheless, when patient data is available the Committee would endorse the quantitative monitoring of this service’s effectiveness. The Committee is cautious that links into boxing are not pressed with undue force or to individuals for whom it would be inappropriate.
Staffing levels and recruitment	Whilst the Trust can evidence progress made in recruitment, the Committee also notes that staff morale in the Trust is very low, and turnover is very high. More people have left the Trust than joined over the last year. Given that it has some hesitancy over international recruitment owing to the detrimental impact on the healthcare systems of countries recruited from, as recently reported in the national media, the Committee suggests that staff retention is an equally if not more important part of this equation. The Committee

Issue	Commentary
	<p>would value any suggestions from the Trust as to how it could convey the value and appreciation the Trust's staff are held in.</p> <p>Notwithstanding the comprehensive work elsewhere in this area, the Committee questions whether the data and monitoring around staff recruitment and retention is given the prominence it needs within the Quality Account, given the priority it holds for the entire work of the Trust. The Committee would encourage recruitment rates, turnover rates, percentages of permanent staff and staff satisfaction to be displayed, with historic trends, as a minimum to be included prominently within the report.</p>
Focus of priorities	<p>To a degree the Committee queries whether some of the Trust's priorities for the forthcoming year are too narrowly focused. Specifically, its work around malnutrition screening and pressure sores. It is possible malnutrition issues may be linked with the contracting out of catering. This is an issue which could be relevant in other settings also. Likewise, with the move towards greater care at home, pressure sore prevention is an issue with relevance beyond the Trust's current priority as stated.</p>
Overall comments	<p>HOSC wishes to praise the Trust for the comprehensiveness of its report. It is clear much work has gone into it.</p> <p>The work of the Trust, and particularly its staff, who have continued to work in an extremely challenging environment on multiple fronts, is particularly noted.</p>

Subject to the observations above, I and the Committee are very supportive of your priorities for 2023/24 and we remain very keen to continue to support OH and the wider health and social care system in the coming year. As referenced, there are clear issues which the Committee would like to be kept abreast of over the coming year, such as the outcomes of the thematic review of patient safety arising from the loss of EPRS and the work to support the physical health of mental health patients. We also look forward to hearing OH's views on the other issues which should fill out our work programme in the coming year, and OH are welcome to put forward any other proposals as they arise if there are other matters on which the Committee's input would be useful.

Yours sincerely

**Clr Jane Hanna OBE**

Chair, Oxfordshire Joint Health Overview and Scrutiny Committee

[Jane.hanna@oxfordshire.gov.uk](mailto:Jane.hanna@oxfordshire.gov.uk)

Contact: Tom Hudson, Scrutiny Manager

[tom.hudson@oxfordshire.gov.uk](mailto:tom.hudson@oxfordshire.gov.uk)

### Joint response from Healthwatch Buckinghamshire and Healthwatch Oxfordshire

14<sup>th</sup> June 2023

Thank you for letting Healthwatch Bucks and Healthwatch Oxfordshire have sight of the Oxford Health NHS Foundation Trust Quality Account for 2022/23 prior to publication and giving us the opportunity to comment. We are the independent local health and social care champions for Oxfordshire and Buckinghamshire residents. As the Trust delivers services across both Oxfordshire and Buckinghamshire areas, we have jointly reviewed the account with this focus.

We would like to congratulate the Trust and all staff for their resilience and commitment to patient care, service delivery and improvement during a challenging year.

The pro-active approach the Trust has to eliciting patient feedback and using learning from Complaints, Concerns and Compliments comes through in the report, and is welcome. In the past year, Healthwatch Bucks has been commissioned by the Trust to seek feedback from young people on an early intervention model; First Episode Rapid Early Intervention for Eating Disorders (FREED) and, as part of the Community Mental Health Framework rollout for Buckinghamshire, a project gathering feedback on from people who may experience barriers to access to mental health services. We look forward to seeing how the recommendations from these reports are actioned and implemented over the coming year.

In relation to the demographic and patient experience data from the 'I Want Great Care' surveys, it would be helpful to see this breakdown against individual services. In addition, the data of service experience and use from diverse and multi-ethnic communities is currently categorised using the aggregate term 'BAME' - a term not now widely favoured. As you recognise, improved capture of data relating to ethnicity is crucial to support delivery and planning of services and to tackle inequalities. If data was broken down to indicate ethnicity, it would better highlight any inequalities of experience and outcome within different communities across Buckinghamshire and Oxfordshire. For instance, more negative feedback from one particular community would provide a starting point in helping to understand the issues and address them. In addition, we would welcome more indication of the work you are doing to effectively engage diverse and multi-ethnic communities in service development.

It is positive to see the highest proportion of feedback coming from the 0-18 age group but the next age range indicated is broad - noted as ages 19-65. Again, this will not enable understanding of specific issues, or differences in patient experience within this category and should be further broken down. For example, we are not able to tell if people moving from child to adult services might be experiencing issues with the transition.

We would like to see more emphasis on how service feedback has been reflected back to those who gave their views, and how it has driven change.

Whilst we understand the challenges faced by the impact of the cyber attack on data and patient record keeping, we are pleased to see progress towards this being reinstated. However, information and data for example on pressing issues such as CAMHS waiting times is key, and important not only for families, but for the system as a whole. We would like to note Healthwatch Oxfordshire's specific comments on last year's quality accounts (2021-2) (point 1 - around reducing waits for children) – which still stands, and progress on which are clearly impacted by this lack of clear data. Clear communication from the Trust to families and those impacted by waiting times is key.

We ask you to pass on to all staff and volunteers at the Trust our thanks for their ongoing commitment to serving the people of Oxfordshire and Buckinghamshire, and congratulate you and your team on being award winners, and leaders in their field.

**Zoe McIntosh, Chief Executive, Healthwatch Bucks**  
**Dr. Veronica Barry, Executive Director, Healthwatch Oxfordshire**