

PUBLIC

Please notify attendance and send questions to Georgia Denegri, Associate Director of Corporate Affairs, on Georgia.Denegri@oxfordhealth.nhs.uk



BOARD OF DIRECTORS' MEETING

Wednesday, 24 July 2024
10:30¹ – 14:10

**Whiteleaf Centre (Conference Room), Bierton Road,
Aylesbury HP20 1EG**

Agenda

<u>INTRODUCTORY ITEMS</u>	Purpose	Lead	Indicative Time
1. #Hellomynameis and apologies for absence ²	Welcome	Chair	10:30
2. Patient Journey – Specialised Services, Forensic Learning Disability ward	Discussion	Chief Nurse	
3. Staff Story – Staff Side and Wallingford Community Hospital	Discussion	Chief People Officer	10:45
4. Declarations and Register of Directors' Interests	Update	Chair	11:00
5. Minutes and Matters Arising of the meetings held on 22 May and 26 June 2024	Approval	Chair	
<u>STRATEGIC, REGULATORY & SYSTEM</u>			
6. BOB Transformation Board Chair of Berkshire NHS FT and Chair of BOB Transformation Board	Discussion	Martin Earwicker	11:10
7. Trust Chair's report	Discussion	Chair	11:30
8. Chief Executive's report (supporting access to the Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB) Board papers: https://www.bucksoxonberkswh.icb.nhs.uk/about-us/board-meetings/board-papers/)	Discussion	CEO	11:40
9. Corporate Affairs report including updates on: a. Legal, Regulatory and Policy; and b. Board Assurance Framework (strategic risks)	Information & Assurance	AD of Corp Affairs	11:55

¹ Meeting is preceded by Board site visits at the Whiteleaf Centre

² Apologies: Amélie Bages, Executive Director of Strategy & Partnerships (on maternity leave); Rob Bale, Executive Managing Director for Mental Health, Learning Disabilities and Autism; and Mohinder Sawhney, Non-Executive Director

PERFORMANCE & SUSTAINABILITY

10. Integrated performance and sustainability reporting: a. Integrated Performance Report (IPR); b. Safety & Quality Dashboard; and c. Finance report	Information & Assurance	Exec Team	12:10

Lunch break (30 minutes) 12:30

11. Board Committees' update reports and recommendations from recent meetings: a. 3As reports (matters for Alert, Advice and Assurance) from the Audit Committee and the People, Leadership & Culture Committee (see Reading Room for supporting Committee minutes and agendas; no 3As report expected from the Charity Committee which has not met since the last 3As report presented to the May Board and verbal updates from the Quality Committee meeting on 16 July 2024 and the Finance & Investment Committee meeting on 23 July 2024)	Discussion	C'ttee Chairs	13:00

RESEARCH & EDUCATION

12. NMAHPP ³ Research Capacity & Capability Development Programme	Approval	Professor of Rehabilitation/ Chief Medical Officer	13:10
13. Research & Innovation report	Information	Chief Medical Officer	

PEOPLE & QUALITY

14. Equality, Diversity & Inclusion report (WRES & WDES ⁴)	Assurance	Chief People Officer	13:30
15. Patient Safety Incidents (PSI) report	Assurance	Chief Nurse	13:40

GOVERNANCE & REGULATORY

16. Board Committees' annual reports ⁵	Receipt and Assurance	AD of Corp Affairs	13:50
17. Modern Slavery Act Transparency Statement	Approval	AD of Corp Affairs	

CONCLUSION & RESOLUTION TO CONDUCT PRIVATE BUSINESS

³ Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacists and Psychologists (NMAHPP)

⁴ Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES)

⁵ Committee Terms of Reference and Workplans to follow in September 2024

18. Any Other Business	-	Chair	14:00
19. Questions from the public and any governors or staff attending	-	Chair	
20. Review of the Meeting	-	Chair	
21. Resolution by the Board to exclude the public and conduct its business in private for confidential matters which may be prejudicial to the public interest if conducted in public or for other reasons	Approval	Chair	

Meeting Close

14:10

Next meeting in public: 25 September 2024

READING ROOM/APPENDIX

- supporting reports to be taken as read to prompt discussion and decisions as required -

22. Appendix to the Chief Executive's report:

- a. access to the Buckinghamshire, Oxfordshire & Berkshire West (**BOB**) Integrated Care Board (**ICB**) Board papers: <https://www.bucksoxonberksw.icb.nhs.uk/about-us/board-meetings/board-papers/>

23. Supporting information to the Corporate Affairs update report:

- a. Board Assurance Framework (strategic risks)

24. Minutes, agendas and supporting information from Committees:

- a. Audit Committee on 23 April and 19 June 2024
- b. Charity Committee on 07 May 2024
- c. Finance & Investment Committee on 09 May and 23 July 2024
- d. Mental Health & Law Committee on 13 May and 16 July 2024
- e. People, Leadership & Culture Committee on 10 July 2024
- f. Quality Committee on 02 May and 16 July 2024

25. Committee annual reports for FY24:

- a. Audit Committee
- b. Charity Committee
- c. Mental Health & Law Committee
- d. People, Leadership & Culture Committee
- e. Quality Committee
- f. Warneford Park Programme Board

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

24 July 2024

For Information

Specialised Services – Forensic learning Disability ward

"A decade long journey on Evenlode"

Summary of the story

This story contains a mother's reflections on what has gone well and what could have been better during her son's decade long admission to Evenlode. During her son's admission the unit changed from being run by Southern Heath NHS Trust to being run by Oxford Health NHS Trust.

There are references to very practical things within the story such as the information families receive when their loved one is admitted, the laundry system and what you can and cannot give someone who is a patient on an inpatient ward. The anxiety of entering the world of forensic healthcare is also touched upon as this family had not had any previous experience of these types of systems. Through exploring the story, it became clear that the development of the Family carer lead role on the ward had made a huge difference to this families experience and so this is focused on towards the end. Though recording this story, we have also identified several possible actions that could be taken to improve families experience and these are shown at the end.

About the service

Evenlode is a medium secure ward for gentlemen with a learning disability. The ward take a person centered approach to the care they provide and utilize positive behavioral support, sensory approaches and other evidence based approaches to working with this patient group.

About the service users

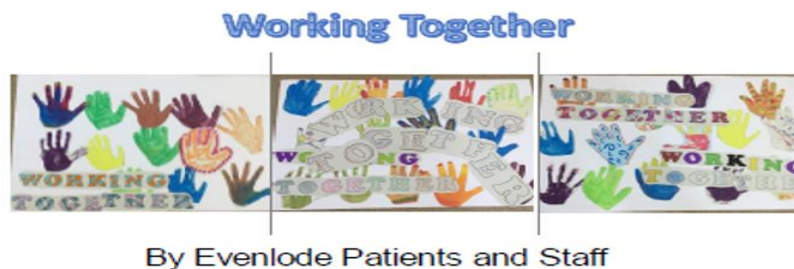
The patients on Evenlode all have a learning disability. Communication approaches often need to be adapted for this patient group including using easy read information, creating easy read care plans. In addition to their learning disability many of the patients have additional diagnoses of autism or other mental health problems. All the patients are detained under the Mental Health act.

Service delivery.

Evenlode provides 24-hour inpatient care to up to 10 patients on Evenlode ward within the Oxford Clinic. Evenlode is staffed by learning disability and mental health nurses and health care support worker. The ward also has a multidisciplinary team including Psychiatry, Psychology, Occupational Therapy, Speech and Language Therapy and Social Work. Evenlode currently has one patient with very high needs.

The ward environment offers a sensory room, and the ward routine is designed to help people to gain daily living and social skills in preparation for discharge to the community.

The staff and Patients on Evenlode Value working together, and this is reflected in the Poster they created for the Provider collaborative poster competition last year which won a Pizza supper for the ward.



Service challenges.

Providing care to people with a learning disability requires specific skills which can provide challenges in terms of staffing. Evenlode has developed specific training for new staff to help them to develop their skills and tries to use bank staff who are familiar with Evenlode whenever possible.

One of the biggest challenges for Evenlode is the identification of suitable placements for the gentlemen to move to when they are ready for discharge.

Author and Title: Rachel Miller - Patient Experience Lead for Learning Disability Services,

Lead Executive Director: Britta Klinck – Chief Nursing Officer (CNO)

A decade long journey.....



My son was admitted to Evenlode



- This was all very new to us.....
- I remember being very confused....I wasn't given any information , or phone numbers.
- I didn't know the names of the staff or the Doctors or who was who.
- I came to visit Evenlode, but it took me ages to find it, the signposts were very confusing, and I had gone in the wrong Littlemore entrance.
- I became anxious as I kept asking people who could not help me.
- A site map for relatives/ carers, would be very helpful.





- It would have been good to have a photo of what is the other side of the door.
- The first 2 years my son was here I could visit him on the ward.
- Then Oxford Health took over and suddenly I couldn't I could only see him in the family room.
- I would find it very difficult if I didn't have some idea of what the ward looked like.
- I wonder if families could at least see it once, so they know where their family member is and the facilities, they have available.

Things I didn't know.....



- I didn't know what seclusion was it was all very scary. It would be good to have information to explain this to families.

- After 2 years I became aware staff recorded my visits, I felt I was being judged and observed . This made me feel physically sick and I left never wanting to go back, but of course, I wanted to see my son.



- I think staff should explain to families that some records will be kept but this is to help their loved one and record if they become sad or anxious during a visit, so that all staff are aware and that it is not a judgement on their parenting skills.

Things it would be good to know.



- It would be good if staff introduced themselves when they escort my son to see me.

- I was asked to get some shorts for my son for Summer. I brought 4 pairs.



- When I took them to the unit, I was told only 1 pair was ok, the others were too short and were returned to me. Why did no one explain the rules about shorts if they wanted me to buy him some?
- I had lost the receipt, so that was £75 lost.
- It would be good to have a leaflet explaining what people can and can't have on the ward.

Finance



- Initially ,staff used to call just before I would visit to say he needed some money, then I would have to get to a cash point before I visited to ensure he had enough money.
- Now there are very few places you can get cash out.
- It was 4 or 5 years before I was told my son could have an account at Patient Finance that I could pay money into for him.
- It works well as I can pay money in by bank transfer online and he can take money out at Patient finance when he needs it.
- The only problem is I don't get statements. I got one , it was great, but I haven't had one since.
- It would help me see if his account needs topping up. He has missed out on having a takeaway when he hasn't had enough money, and this is something he enjoys.

laundry



- I have brought my son 100's of socks while he has been on Evenlode, but they just disappear.
- When he moved out, he had just 5 pairs.
- Sometimes when I have visited, he is in clothes that I know are not his.
- The laundry system just doesn't seem to work, I think they need a procedure, so everyone knows what to do. All the staff explain it differently.
- The Washer and dryer seem very temperamental!

Legal frameworks and medication



- I didn't have any understanding of the legal frameworks and what everything means it would be good to have a guide for carers to explain it all.



- I don't know anything about medication, and I understand it is my son's decision if he is happy for information to be shared with me.
- However, it would be good if there was some information leaflets with the main information about the medication for families if patient happy for information to be shared.

Life Changing.....



- The Summer BBQ's and Christmas quiz have been life changing.



- It was good to see the staff from the unit interacting with my son and other patients.



- It's so good to put a face to a name of the people my son talks about. Staff and patients.

Kathy Carers Lead role



- It is very useful to have a named person you can go to who is a familiar face and has a specific role to support families.
- It is so difficult when you speak to different staff each time and need to explain things from the beginning again.
- Kathy is perfect for the role, she can relate to families and is open, giving of herself, kind, thoughtful.
- Kathy just gets it, she is easy to talk to , build a rapport with and she gets things done.
- I wish she had been in post when my son first came to Evenlode as I think it would have helped a lot.



Kathy's Carer lead role continued..



- My heart lifts when I see that is Kathy,
or

A member of Staff I know who is supporting my son, when I see him.



- However, I do fear Kathy could become overwhelmed with work, as she is so helpful, and you know she will make things happen.

Brief video of Cathy and Celia talking about carer role.



An update.....



- My son is now happily living in the community.



- Evenlode staff are continuing to visit him and will do so and will continue to do so until he is settled.

Actions from Sharing Experiences.



1. Evenlode Voices video for new patients to be made available to families if they would like as has photos of ward and Oxford clinic as well as onsite facilities.
2. Reinforce to staff the importance of introducing themselves to family members.
3. List of things you can/can't give as gifts e.g. no china mugs, pictures with glass in or living plants.
4. Provide guidance that the food you bring in needs to be shop brought and in date and not homemade.
5. To adapt the carers information leaflet for Evenlode Families.



**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 3

24 July 2024

Staff Story

For: Discussion

Executive Summary

We have chosen this staff story to come from one of our Staff Side (Unison) colleagues, Andy Armsby. It is timely to hear from Andy, as we reflect on and look towards potential future changes from a Labour government. We are mindful that we continue working in the context of junior doctor industrial action, and that the election further delayed the pay deal for Agenda for Change staff. Whilst Unison did not have a mandate to take industrial action over pay in this Trust in 22/23, we recognise their ongoing dissatisfaction with current pay levels for many of their members. We are proud of our constructive working relationship with staff side colleagues, and look forward to the Board hearing directly from Andy.

Andy works as a Ward Manager on St Leonard's Ward within Wallington Community Hospital. Andy has worked for the Trust in a variety of nursing roles for over 25 years.

Furthermore, Andy was recently elected as Vice Chair of OHFT's staff side, further to his longstanding role as a Unison convenor. This, when coupled with his management experience, enables Andy to bring a varied perspective to his staff story, both as a manager, and a union representative.

Andy is also an active member of our LGBTQIA+ staff equality network.

Recommendation

The Board is asked to receive this report, and take the opportunity to hear directly from Andy during the Board meeting.

Author and Title: Alison Bourne, Head of HR Policy, Reward and Projects

Lead Executive Director: Charmaine de Souza, Chief People Officer

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** – *this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust*
 - 1) *Quality - Deliver the best possible care and health outcomes*
 - 2) *People - Be a great place to work*

REGISTER OF DIRECTORS' INTERESTS

July 2024

PART A – CURRENT BOARD MEMBERS

PART B - FORMER BOARD MEMBERS DURING 2023/24

Oxford Health NHS Foundation Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish this Register of Interests which draws together Declarations of Interest made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests on items on the agenda.

DECLARATION OF INTERESTS
PART A – CURRENT BOARD MEMBERS

Name	Role	Interests Declared
Amélie Bages	Executive Director of Strategy & Partnerships ¹	Husband is the Chief of Staff for the Chief Operating Officer of NHS England .
Rob Bale	Interim Executive Managing Director for Mental Health, Learning Disability & Autism Services ²	Director of Little Magic Train Ltd - a multi-sensory resource for early years educators, teachers and parents which is sold to a range of settings, in the UK and abroad, including the commercial sector and local authorities.
David Clark	Non-Executive Director – Nominee of The University of Oxford	University of Oxford: • Emeritus Professor of Experimental Psychology. • Emeritus Fellow, Magdalen College; • Member of the Board of Calvea Research Centre, Magdalen College; • Member of Project Board for the Life & Mind Building; and • Co-Director, Oxford Centre for Anxiety Disorders & Trauma NHS England: • National Clinical and Informatics Advisor for the NHS Talking Therapies for Anxiety Disorders & Depression programme; • Member of Mental Health Currencies for Mood & Anxiety Disorders Working Group; • Member of Community Mental Health Outcomes Task & Finish Group; and • Member of PROMS (Patient Reported Outcome Measures) for Community Mental Health Services Expert Reference Group Co-developer of internet cognitive therapies for social anxiety disorder and PTSD (post-traumatic stress disorder) further to research at the University of Oxford; these may become licensed and made available to the NHS, further to recommendation by NICE, for use in NHS Talking Therapy for Anxiety and Depression services. Clinical Advisor to Anxiety UK. Fellowships of the British Academy, Academy of Medical Sciences, Academy of Social Sciences, Kings College London and London School of Economics. Honorary Fellowships of the British Psychological Society and British Association of

¹ On maternity leave March 2024 – September 2024)

² Interim since October 2023.

		Behavioural and Cognitive Psychotherapies. Various International Fellowships, Memberships and Honorary Memberships of learned societies and professional organisations, and member of the editorial boards of numerous academic journals.
Geraldine Cumberbatch	Non-Executive Director	Director of Croydon Business Venture Ltd – locally-based business involved in facilitating support for small local businesses. Trustee of Start Up Croydon - the locally-based charity/initiative of Croydon Business Venture Ltd which supports start-up businesses. Dispute Resolution and Public Law Solicitor for the Port of London Authority (PLA) – responsible for handling dispute and regulatory matters on behalf of the PLA, a statutory port trust, who are the custodians of the River Thames. Partner is employed by NHS England as a Clinical Network Senior Clinical Programme Manager for the London Clinical Networks.
Charmaine De Souza	Chief People Officer	Board member for Hightown Housing , a charitable housing association covering Hemel Hempstead and the surrounding area and counties of Hertfordshire, Buckinghamshire, Bedfordshire and Berkshire.
Chris Hurst	Non-Executive Director	Non-Executive Director and Audit Chair at Coventry & Warwickshire Integrated Care Board (remunerated) from 03 June 2024. Executive coach and mentor – past clients have included senior staff in NHS organisations, local and national government, and in the private sector. Formerly Managing Director & Owner, Dorian3d Ltd – a consultancy business providing support to public sector clients (including the NHS, local authorities and governments) and independent advice to the private sector. Dorian3d Ltd closed on 31 December 2022. Partner is Regional Delivery Director with the Strategic Estates Planning team of NHS England, Midlands region.
Britta Klinck	Chief Nurse	No interests to declare.
Grant Macdonald	Interim Chief Executive Officer ³	No interests to declare.
Karl Marlowe	Chief Medical Officer	Educational Supervisor, Clinical Studies, Oxford University Medical School (from Sept 2023). Chairman of The Social Interest Group Board (charity partnership working for marginalised populations). Includes directorships of: Penrose Options; Equinox Care; Pathways to Independence; Safe Ground; and SIG Investments (all unremunerated). Advisor to UNTANGLE GRIEF, digital peer support platform, and Tasting Colours, digital wellbeing service (both unremunerated). Wife is founder of 'Jump in puddles' a social purpose consultancy working with various innovation health companies and charities.

³ Interim since 01 July 2023. Formerly Executive Managing Director for Mental Health, Learning Disability & Autism Services

Ben Riley	Executive Managing Director for Primary, Community & Dental Care	Former GP Partner (left the practice in September 2021) at Dr C Kenyon & Partners, Beaumont Street Surgery, Oxford. The practice partnership holds shares in two of the four GP federations in Oxfordshire: OxFed Health & Care Ltd and Principal Medical Ltd. Formerly linked to OxFed Health & Care Ltd (non-profit trading company of OxFed, one of the four GP federations in Oxfordshire): until 01 May 2020 - Chair and Director; until 31 May 2020 - Director (retired); and until 30 September 2020 - Clinical Partnership Officer (part-time employee and not a board or director position)
Philip Rutnam	Non-Executive Director	Chair, National Institute of Economic and Social Research which is an independent and politically impartial institution that seeks to improve economic policy through research and advice. Chair, National Churches Trust. This is the national charity for churches, chapels and meeting houses. It provides grants, advice and support and advocacy, including supporting the use of the buildings for community benefit which may be relevant to health care. Council Member, University of Surrey, and Lay Member of Governing Body of the University of Surrey. The University is a partner in the Oxford Health Biomedical Research Centre and has active research and teaching programmes in health care. Non-Executive Director, Innovate Surrey Limited (ISL). ISL is the innovation and enterprise arm of the University, supporting business development, spin outs and growth. Chair, Advisory Board, WA Communications. WA is a strategy and communications consultancy active in a number of sectors including energy, transport, financial services, education and health care. Senior Adviser, Civil Service College. CSC is a not-for-profit entity separate from Government which provides training, consultancy and development services for mainly public sector entities in the UK and abroad. Assistant Churchwarden and Parish Council Member, Parish of Barnsbury, Diocese of London.
Mohinder (Mindy) Sawhney	Non-Executive Director	Non-Executive Director at Hampshire and Isle of Wight Integrated Care Board (remunerated) from 01 December 2023. Managing Director of root+branch ltd (management consultancy). Has previously undertaken engagements with related bodies including the General Medical Council, health charities and suppliers to the NHS. Husband was Chief Customer Officer at NHS Test and Trace - secondment ended 01 June 2021. Husband commenced as Chief Operating Officer at the Bank of England in January 2022.
Heather Smith	Chief Finance Officer	Non-Executive and unremunerated Member of the Board and Trustee of Arts at the Old Fire Station (AOFS), a charity. AOFS shares the Old Fire Station building in Oxford with the homelessness charity Crisis and encourages people from all backgrounds to understand and shape the world in which we live through stories, creativity and the arts, and by connecting with others. Family member is General Manager at Latis Scientific Limited, who deliver water testing services to various NHS organisations both directly and via 3rd parties. Latis provide laboratory testing and technical consultancy services including advice on water systems such

		as management of microbiological risk. Latis Scientific is a subsidiary of SUEZ which is a consortium owned multinational company based in France specialising in water and waste services.
Richard (Rick) Trainor	Non-Executive Director	Exeter College, University of Oxford: Professor Sir Richard Trainor - Rector (Head) of Exeter College; Chair of the Governing Body and various college committees; Trustee of the affiliated Michael Cohen Trust; and Director of companies related to the College including Checker Hall Company Limited, Collexoncotoo Limited and Exeter College Trading Limited. University of Oxford (central functions): Pro Vice Chancellor without portfolio (presiding at ceremonies and chairing/serving on appointment boards for professors and other senior posts); member of the Audit & Scrutiny Committee; member of the Divisional Board, Social Sciences Division; and member of the History Faculty. Vice President & Trustee of the Economic History Society, Chair of the Scholarship Committee of the Jardine Foundation, Fellow and Emeritus Professor of Social History at King's College London, Chair of the Academic Panel of the Museum of London, Governor and Member of the Gift Acceptance Committee of the Royal Academy of Music (ending summer 2022) and member of the Council of Reference, Westminster Abbey Institute, Westminster Abbey. Various honorary affiliations including to: City of London; Institute of Historical Research, University of London; Merton College, Oxford; Rosalind Franklin University of Medicine and Science; Royal Academy of Music; Royal Society of Arts; Trinity Laban (Trinity College of Music); US/UK Fulbright Commission; University of Glasgow; University of Greenwich; University of Kent; and the Worshipful Company of Educators. Spouse has honorary affiliations to the University of Glasgow and to Wolfson College, Cambridge.
David Walker	Trust Chair	Miscellaneous journalism, lecturing and writing. Partner is a member of the NHS Assembly - created 2019 to advise NHS England on delivery of improvements in health and care, potential to influence NHS policy affecting the Trust.
Lucy Weston	Non-Executive Director	Chair of Red Kite Community Housing (charitable housing association in Buckinghamshire). Formerly Chair of Soha Housing (stepped down in September 2023) and Director of SIB Property Ltd (subsidiary of Soha). Self-employed - Lucy Weston Consulting.
Andrea Young	Non-Executive Director	Board Governor at University of West of England (second term running July 2023 – July 2026) and member of its Audit Committee. The University is the trainer and supplier of Allied Health Professionals and Nurses in the West of England, which may be relevant to contracts/services in the Bath, Swindon and Wiltshire area. Member of the Independent Reconfiguration Panel, providing independent advice to Ministers on changes to health services (4-year appointment starting 18 March 2024).

		Self-employed independent coach/mentor and member of the Critical Coaching Group, a professional body for independent coaches and mentors. Partner owns/runs Wantage Natural Therapy Centre and is a practicing chiropractor with referrals from Oxfordshire GPs. Listening volunteer with the Samaritans (starting June 2024).

DECLARATION OF INTERESTS
PART B - FORMER BOARD MEMBERS DURING 2023/24

Name	Role	Interests Declared
Nick Broughton	Chief Executive (until 30 June 2023)	Partner Member for Mental Health of the Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB). From 01 July 2022, the BOB ICB gained the commissioning responsibilities of the BOB area's three former Clinical Commissioning Groups together with national functions including pharmacy, optometry and dentistry. Board Member - Oxford Academic Health Partners (formerly the Oxford Academic Health Science Centre). Board Member – Oxford Academic Health Science Network (AHSN). Honorary Fellow of the Department of Psychiatry, University of Oxford (3-year term, ending 30 June 2023). Member - Oxfordshire Health & Wellbeing Board. Member – Buckinghamshire Health & Wellbeing Board. Member – Thames Valley Academic Health Science Network. Trustee - Charlie Waller Memorial Trust. Patron of Action for Families Enduring Criminal Trauma (AFFECT). Member – Unloc Advisory Board for 2023 – working alongside industry professionals to apply knowledge and experience to advise Unloc (an education non-profit helping schools, colleges and organisations inspire and empower young people through programmes in entrepreneurship, leadership, career pathways and student voice). Not a remunerated position. Will not be part of commissioning decisions involving the Trust procuring any work or services from Unloc whilst a member of their Advisory Board.
Marie Crofts	Chief Nurse (until December 2023)	No current interests to declare (formerly, until September 2020 Trustee of PAPYRUS, prevention of young suicide charity).
Anna Christina (Kia) Nobre	Non-Executive Director – nominee of the University of Oxford (until June 2023)	University of Oxford: • Chair in Translational Cognitive Neuroscience; • Head of Department of Experimental Psychology; • Director of the Oxford Centre for Human Brain Activity; • Chair of the Oxford Neuroscience Strategy Committee; • member of the University Council, serving on its research, innovation and education committees; • Professorial fellow at St Catherine's College; and • Head of the Brain & Cognition Lab Collaborator with the Mesulam Centre for Cognitive Neurology and Alzheimer's Disease as an adjunct professor at Northwestern University in Chicago, USA. Serves as an advisor to various advisory bodies to scientific institutions as well as holding roles on multiple editorial, funding, programme and prize-awarding boards. Fellow of the British Academy, a member of the Academia Europaea, and an international fellow of the National Academy of Sciences.

Kerry Rogers	Director of Corporate Affairs & Company Secretary (until May 2024)	Trustee - Age UK Oxfordshire. Non-executive director of Cristal Health Ltd trading as Akrivia Health (appointment made by the Trust and transferred from the former Director of Finance with effect from 01 September 2022). Cristal Health Ltd was created in 2019 to develop UK-CRIS further, to provide ongoing search capability (of pseudonymised electronic medical records) to the trusts already signed up, to recruit more trusts to the programme and to develop commercial capability from the Intellectual Property (IP). The Trust has a 10% shareholding in Cristal Health Ltd, which it holds on behalf of NIHR and the NHS, representing the 10% share in the IP. As a “Founder”, an initial shareholder, the Trust is entitled to appoint a non-executive director to the board of Cristal Health Ltd.

Meeting of the Oxford Health NHS Foundation Trust Board of Directors

Minutes of a meeting held on 22 May 2024 at 09:00 Microsoft Teams virtual meeting

Present:¹

David Walker	Trust Chair (the Chair) (DW)
Grant Macdonald	Chief Executive Officer (GM)
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (RB)
David Clark	Non-Executive Director appointee of the University of Oxford (DC)
Geraldine Cumberbatch	Non-Executive Director (GC)
Georgia Denegri	Associate Director of Corporate Affairs (GD)* ²
Charmaine De Souza	Chief People Officer (CDS)
Chris Hurst	Non-Executive Director (CMH)
Britta Klinck	Chief Nurse (BK)
Karl Marlowe	Chief Medical Officer (KM)
Ben Riley	Executive Managing Director for Primary, Community & Dental Care (BR)
Philip Rutnam	Non-Executive Director (PR)
Mohinder Sawhney	Non-Executive Director (MS)
Heather Smith	Chief Finance Officer (HeS)
Rick Trainor	Non-Executive Director (RT)
Lucy Weston	Non-Executive Director (LW)
Andrea Young	Non-Executive Director (AY)

In attendance³:

Attendees/observers from Oxford Health NHS FT

Jane Appleton	Associate Director of Communications & Engagement
Lianne Bowes	Freedom to Speak Up Guardian – <i>part meeting</i>
Rita Bundhoo-Swift	Freedom to Speak Up Guardian – <i>part meeting</i>
Laura Carter	Head of Strategy - Performance
Vicky Drew	Deputy Head of Learning & Development
Rachel Garnett	Senior Project Manager
Alison Gordon	Head of Financial Management
Susan Halliwell	Registered Nursing Associate – <i>part meeting</i>
Di Hilson	Carers' Lead – <i>part meeting</i>
Rose Hombo	Deputy Director of Quality & Clinical Standards
Elaine Jones	Executive Officer
Jo Lazarus	Strategic Programme Management Office (PMO) Manager
Sue Marriott	Executive Assistant
Hannah Smith	Assistant Trust Secretary (HaS) (Minutes)
Priya Thompson	Head of Strategy - PMO (PT)

¹ Quorum is 2/3 of the whole number of members of the Board (including at least 1 NED and 1 Executive) i.e., where voting members of the Board are 16 (from March 2023), quorum of 2/3 with a vote is 11

² * = non-voting

³ An officer in attendance for an Executive but without formal acting up status will not count towards the quorum – Standing Orders 3.12.2

BOD 38/24	Apologies for Absence	
a	Apologies for absence were received from Amélie Bages, Executive Director of Strategy & Partnerships.	
BOD 39/24	Patient and Carer Story - Buckinghamshire Adult Mental Health Services	
a	The Carers' Lead presented the report and introduced the Carer to the meeting. The Carer described their adult son's experiences with the Trust over two episodes of care separated by nine years, both of which had been frustrating and characterised by feeling disconnected with the system and not being listened to. The Carer wanted to be able to help the Trust but was also exhausted from dealing with a life-long caring role, feeling that their voice had not been heard and seeing their son deteriorate, be hospitalised and put on medication to which he was drug-resistant despite trying to inform the treating team. The Carer singled out their son's key worker for praise as the key worker had been supportive and done what they had said they would do.	
b	The Chief Executive, the Trust Chair and the Chief Nurse apologised on behalf of the Trust and emphasised the importance of learning from this experience and ensuring that this would not be replicated for another family. The Chief Nurse noted that there was learning to be had on achieving consistency during a patient's journey through various services including community, inpatient and Crisis teams.	
c	In discussion with Non-Executive Directors, the Carer explained that: • their son's experiences in hospital and reactions to medication could have been avoided and he may have been able to leave hospital sooner and more stable if the Carer had been listened to and if support after hospitalisation had been available; • they had felt impeded by poor communication between clinical teams and a sense of hierarchy that had prevented them from being able to discuss directly with the consultant; and • it had been helpful to attend a Carers' support group during the pandemic and it would help if such groups could be more available, especially to support Carers and prevent them from deteriorating under the pressure.	
d	The Carers' Lead presented slides setting out the actions the Trust was taking to learn from this and other patient and carer experiences, including: • adoption of the Triangle of Care (a therapeutic alliance between carers, service users and healthcare professionals); • family surgeries on wards to provide dedicated time for families and carers; • development of a Carer's Handbook; and • reinforcing a 'working with families' ethos with regular working groups to monitor this, training for new joiners so that this was recognised as a priority and emphasis upon consistency with embedding this throughout the culture of teams.	
e	The Trust Chair asked the Chief Nurse to provide an update to the next meeting on reflections from the Carer's story and changes which may be required or already in train. He also invited the Carer to get back in contact with him and the Chief Nurse if needed.	BK
f	The Board thanked the Carer for sharing their experiences and acknowledged the need for improvement in response. <i>The Carers' Lead and the Carer left the meeting.</i>	
BOD 40/24	Staff Story - Apprenticeship Programme, Abingdon Community Hospital	
a	The Chief People Officer introduced the Registered Nursing Associate and the Deputy Head of Learning & Development to the meeting. The Registered Nursing Associate	

b	recounted their positive experiences of being supported through Apprenticeships by the Trust and the opportunities which had been made available for them, with support from Learning & Development. The Chief Nurse noted how heartening it was to hear that the Trust was successfully providing alternative routes into the nursing profession. The Board noted the Staff Story and thanked the Registered Nursing Associate. <i>The Registered Nursing Associate left the meeting.</i>	
BOD 41/24 a	Register of Directors' Interests No interests were declared pertinent to matters on the agenda.	
BOD 42/24 a	Minutes of the Meeting held on 27 March 2024 The Minutes of the meeting were approved as a true and accurate record and the actions due that meeting were noted as complete, with remaining actions not yet due.	
BOD 43/24 a b c	Trust Chair's Report and system update The Trust Chair took his report as read and added that: - work was taking place to deepen relations with the voluntary and social enterprise sector, starting with a meeting with the sector connected to mental health but hopefully expanding to voluntary organisations connected to community services. He invited input from the wider Board as this was a complex sector which could have a positive impact upon the wellbeing of patients and carers; and - the reference to the conference for psychiatrists in his report should also be read as having extended to other medical leaders such as GPs and dentists. Non-Executive Directors discussed feedback they had received from voluntary sector colleagues, in particular around the manner and timeliness of communication with the Trust, management of contracts and behaviours below director level and the importance of the middle level of management. The Board noted the report.	
BOD 44/24 a b c d	Chief Executive's Report The Chief Executive presented his report and drew the Board's attention to the link in the agenda which provided access to the Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB) Board papers and the annual system financial planning process. He commented upon the challenges which the system had faced last year, the central financial support it had received (which had reduced the system outturn to a £53 million deficit) and this year's system position which was a £92 million deficit. The Chief Medical Officer referred to the report and congratulated the winners and shortlisted finalists of the Royal College of Psychiatry awards. He also congratulated the Director of Research and Development, Vanessa Raymont, on having been conferred the title of Associate Professor by the University of Oxford's Medical Sciences Division. Non-Executive Directors commented upon the report and praised the Administrative & Clerical staff conference in April and the Trust's support for Mental Health First Aiders. The Board noted the report.	

BOD 45/24	Corporate Affairs update report	
a	The Associate Director of Corporate Affairs presented the new format of the report and the recent legal and regulatory guidance relevant to the work of the Trust, with the Trust's initial responses and ownership through the governance framework and key meetings. She highlighted: • the NHS priorities and operational planning guidance FY25; • the new mandatory NHS Volunteers data collection; • the Care Quality Commission's guidance on visiting hospitals, which may be of particular relevance further to the Carer Story discussed at item BOD 39/24 above; and • the Department of Health & Social Care consultation on the NHS Constitution.	
b	The Trust Chair commented upon the volume of recent policy and regulatory activity and the challenge to ensure that staff, especially frontline staff, were made appropriately aware of the relevant information. The Associate Director of Corporate Affairs and the Chief Executive noted that this would feed into the work taking place around mapping responsibilities for Executive leads. Non-Executive Directors praised the new format of the report and the links to oversight by Committees and groups, commending the clarity which this brought to understanding whether new developments were for information or action. Hyperlinks to existing summaries of new developments may help to further condense the report.	
c	The Board noted the report.	
BOD 46/24	Annual Plan and Financial Plan/Budget Update 2024/25	RB
a	The Chief Finance Officer and the Head of Strategy for the PMO presented the report, highlighting: (i) the changes made to the Annual Plan since the last Board meeting on 27 March 2024 and as summarised in the covering report; (ii) arrangements for monitoring and review of progress against the Annual Plan through the Executive, the Finance & Investment Committee (FIC) and the Board; and (iii) that the Financial Plan submission had been made to NHS England on 02 May 2024 for a planned deficit of £4.3 million, further to the Trust's contribution towards improving the overall system financial position from the £92 million system deficit which the Chief Executive had referred to at item BOD 44/24(a) above.	
b	David Clark expressed concern that patients may be recording data on outcome measures but services may not be utilising that data sufficiently. The Executive Managing Director for Mental Health, Learning Disabilities and Autism agreed to consider how the strategic programme on outcome measures ensured that the Trust used measures that impacted on individuals' clinical care and outcomes across services.	
c	The Board discussed: • the importance of communicating the core messages in the Annual Plan for staff and bringing them to life as staff support and engagement would be crucial to achievement of an ambitious plan, especially at times of operational and financial pressures which may otherwise consume staff attention. Staff support and engagement would be as key to success as additional monitoring arrangements; • communicating the financial messages in ways which were relatable and achievable for staff, as well as consistent with the operational ambitions reflected in the Annual Plan; • developing a longer-term 3-5 year view to sit below the high level strategy and potentially release some of the burden from the Annual Plan itself. This could help to articulate targets which may need to sit outside of an Annual Plan framework, for example agency reduction over an 18-month period;	

	- getting used to challenging itself on how its stated priorities would help to address, ameliorate or improve the patient, carer and staff experiences which it received at the start of Board meetings, especially in light of the Carer Story at item BOD 39/24 above; and - how tackling health inequalities was a golden thread running through various strands of work in directorates, the Patient & Carer Race Equality Framework and the focus on physical health checks in mental health services. The Chief Medical Officer to circulate NHS Providers' recent publication on 'United against health inequalities' after the meeting.	KM
d	Further to discussion with the Associate Director of Corporate Affairs, the Head of Strategy for the PMO agreed to review the frequency of planned reporting on progress against the Annual Plan to the Board.	PT
e	The Chair summarised that there was support for the 2024/25 Annual Plan and Financial Plan although the timeliness and frequency of planned reporting would need to be clarified and, as discussed above, consideration would need to be given to communicating the Annual Plan and financial context to patients, carers and staff in such a way as to be relevant for their experiences and to help them to understand the causal relationships to the services provided.	
f	The Board APPROVED the 2024/25 Annual Plan and Financial Plan, giving retrospective approval for the Financial Plan submission made to NHS England on 02 May 2024 and noting that change control would be applied by the Executive if further changes were required as part of the ICS's planning settlement and these would be escalated to the Board if necessary. <i>The meeting took a break for 10 minutes and resumed at 10:50.</i>	
BOD 47/24	Integrated Performance, Quality and Sustainability Reporting	
a	The Chief Executive explained that work was ongoing to revise and enhance the Integrated Performance Report and reset reporting timelines; the revised format of reporting would be socialised in advance with Committee Chairs. In the interim, data from March 2024 was presented which should already be familiar from discussion in Committee meetings and he therefore invited questions or discussion. The Trust Chair welcomed the work taking place to radically revise reporting on performance. <i>Integrated Performance Report</i>	
b	The Trust continued to perform well against the NHS National Oversight Framework metrics with the ongoing exception of inappropriate Out of Area Placements (OAPs) and Minor Injuries Unit 4-hour performance targets. The use of inappropriate OAPs remained lower than the previous year however numbers continued to fluctuate based on clinical demand and acuity. In response to questions from Lucy Weston, the Chief Executive and the Executive Managing Director for Mental Health, Learning Disabilities and Autism explained that the challenge was to ensure that high quality OAPs were available, relatively close to patients' homes and supported by adequately staffed community resources. It was difficult to discharge patients and safely support them in the community if the right community resources were not available.	
c	The report also included an update on the project to support the recovery of reporting in response to the clinical systems outage. Work continued on re-flowing national datasets and the re-launch of the Trust's intelligence platform for staff. Recovery work would continue into FY25. However, the Trust would continue to have gaps in its data as: the clinical systems outage had resulted in data not being recorded in systems; and	

	ii. the new systems had reduced functionality due to the pace at which they had needed to be implemented, although this gap would be closed as the new systems were optimised. The estimated data gap due to system functionality remained approximately 10%.	
d	Lucy Weston referred to the ongoing impact of the clinical systems outage and the reported use of paper records by part of the Oxfordshire Community Directorate; she asked about the current position and projected timeline to resolve any remaining issues. The Executive Managing Director for Primary, Community & Dental Care replied that it was not possible to provide a timescale for removal of all the paper notes used by District Nurses as these were part of a shared folder in patients' homes which could be referred to by carers/the patient/other professionals when needed; their use also pre-dated the clinical systems outage. Moving away from this paper notes/folder system would depend upon other partner organisations implementing digital systems which were interoperable with the Trust's digital systems. This work was not one of the Trust's IT development priorities for FY25 and not currently identified as a significant risk by system partners; it was therefore unlikely to be subject to a timescale for the foreseeable future. The Chief Executive added that, in relation to the project on recovery of reporting, core recovery had taken place but not yet a total rebuild whilst priority areas were focused on instead. Quality & Safety Dashboard	
e	The Board discussed the information now available through the Quality & Safety Dashboard on waiting times and the ongoing impact of the clinical systems outage. In response to Non-Executive Director questions on the reliability and trajectory for waiting times reporting, the Chief Nurse acknowledged that it was work in progress which had been hampered by the clinical systems outage. However, harm minimisation plans to safeguard patients waiting to be treated were in place for every service and vacancies were being appropriately filled with temporary staffing. The aim was for waiting times reporting to be comparative and able to provide a trajectory but this was just the start of the reporting. The Executive Managing Director for Mental Health, Learning Disabilities and Autism added that performance teams were working with operational teams on data quality and ensuring that demographics were being appropriately registered and recorded. The Chief Executive gave the Board assurance that the underlying data to support reporting on waiting times was being checked and built into formal reporting for the Board but for this month, interim reporting from the available data was presented. David Clark, Philip Rutnam and Mohinder Sawhney thanked the Chief Executive and the team for the waiting times reporting, noting that Non-Executive Directors appreciated seeing the work in progress rather than waiting longer for fuller reporting.	
f	The Board discussed future reporting on waiting times being able to report according to protected characteristics. The Chief Finance Officer confirmed that this was a goal and also supported by the Patient & Carer Race Equality Framework. David Clark noted that it was already possible to download national reporting on waiting lists for Talking Therapies services by ethnic group and other protected characteristics. The Executive Managing Director for Mental Health, Learning Disabilities and Autism added that work was being led in Buckinghamshire around health inequalities to develop a dashboard reporting around postcode data, services offered and local challenges. Finance and Sustainability	
g	The Chief Finance Officer presented the Month 12 Finance Report, reminding the meeting that the annual data was still subject to formal External Audit and an outstanding accounting prior period adjustment. All key indicators were green-rated, Income & Expenditure and Cash had all performed better than plan but Capital Expenditure was	

	underspent against funded capital allocation; slippage in Estates projects would be taken into account in ensuring that the Capital Plan for FY25 remained sustainable.	
h	The Board noted the report and that the format of the Integrated Performance Report would be revised.	
BOD 48/24	Board Committees' update reports – matters for Alert, Advice & Assurance (3As)	
a	The Board took as read the 3As reports from the Audit Committee, Charity Committee, FIC, People, Leadership & Culture (PLC) Committee and the Quality Committee.	
b	Mohinder Sawhney highlighted from the PLC Committee 3As report: (i) significant recruitment activity and the intention to develop segmented recruitment strategies by place, profession and targeted audience for recruitment; and (ii) the development of performance assurance through the new 'People dashboard' to enable early identification of hotspots.	
c	In relation to the Quality Committee's 3As report: - the Chief Nurse and the Executive Managing Director for Primary, Community & Dental Care issued a correction and noted that the District Nursing service had a vacancy rate of 5.17%, not over 30%. Andrea Young agreed; and - in relation to Board Assurance Framework (BAF) risk 1.1 (utilising digital, data and technology to drive quality, efficiency, economy, research and innovation), the Chief Finance Officer took an action to set up a meeting with the Chairs of the Quality Committee and the FIC to discuss respective Committee ownership/monitoring of BAF 1.1.	HeS
d	Committee recommendations The Board reviewed the following, as recommended by the Quality Committee: - the Director of Infection Prevention & Control annual report; - the Complaints annual report; and - the Research & Development policy. Further to a request from David Clark, the Chief Medical Officer agreed to review reference to duplication of previous work in research being unethical, as replication could be an important principle in medical science and research.	KM
e	The Trust Chair commended the work of the Infection, Prevention & Control team in relation to antimicrobial resistance, noting the national importance as part of the wider health system.	
f	The Chief Medical Officer presented the Guardian of Safe Working (GoSW) and Medical Education reports, which had been recommended by the PLC Committee, and agreed: - to expand upon the process of discharging of the GoSW function and how information was acted upon; and - in future Medical Education reporting to consider providing comparative data for the previous year on feedback on clinical placements, fill rate for posts and any data on trainees' onward destinations.	KM
g	The Board APPROVED: the Director of Infection Prevention & Control annual report; the Complaints annual report; and, subject to the comments and review above, the Research & Development policy, as recommended by the Quality Committee.	
h	The Board received the Guardian of Safe Working and Medical Education reports, as recommended by the PLC Committee and noted the 3As updates from the Committees, with supporting minutes and agendas in the Reading Room.	

BOD 49/24	Freedom to Speak Up Guardians' annual report	
a	The Freedom to Speak Up Guardians joined the meeting and presented their annual report; they also thanked Andrea Young for her support as Non-Executive Director Champion for Speaking Up. They highlighted: the launch of the Freedom to Speak Up policy; the development of guidelines on tackling detriment; and inaugural reporting on numbers of cases by protected characteristics, now included in the annual report.	
b	The Board discussed: - the need to build a wider data picture especially as although the data from the local Pulse survey potentially indicated areas for development, such as around fear of detriment acting as a barrier to speaking up, the local Pulse survey was answered by fewer people than the Staff Survey; - the positive impact of investment in Freedom to Speak Up which had supported an increase in the number of people speaking up; - cultural and leadership development and modelling of behaviours which was still needed, especially in light of Patient and Carer Stories such as that at the start of the meeting at BOD 39/24 above where there had evidently not been improvement between two different episodes of care separated by a nine year period; - the ongoing challenge for the organisation to both listen and then respond appropriately in order to identify and resolve issues, without breaching confidentiality or privacy.	
c	The Board noted the report and was assured by the Freedom to Speak Up work taking place.	
BOD 50/24	Patient Safety Incidents (PSI) report	
a	The Chief Nurse reported on learning identified from 11 PSI reviews completed in March-April 2024 and wider learning from the local incident response plan for the national Patient Safety Incident Response Framework (PSIRF). There had been 22 reviews under PSIRF from December 2023 which took various learning response forms (including thematic reviews, incident learning huddles, observational audits, system reviews, in-depth investigations and work using the Triangle of Care) and enabled quicker identification and learning under the new PSIRF. Feedback from staff had been that the learning was of a higher quality than previously and more focused upon supporting staff to operate safely and minimise risk. There had also been progress in agreeing a new process across the BOB ICS in how to approach investigations which involved various partners. Some system reviews had also taken place involving successful liaison between the Trust and ambulance and emergency services.	
b	The Board noted the report.	
BOD 51/24	Corporate Registers: receipt of gifts and hospitality	
a	The Associate Director of Corporate Affairs presented the report which concluded investigations into breaches of policy and guidance on acceptance of gifts.	
b	The Board noted the outcome of the investigations and ratified the breaches of policy.	
BOD 52/24	Any Other Business	
a	The Trust Chair commented upon the moving Patient and Carer Story and the relevance of the action to reflect on it and changes which may be required.	

Public

BOD 53/24 a	Review of the meeting No comments received.	
BOD 54/24 a	Board resolution to conduct further business in private The Board resolved to exclude the public and conduct its business in private for confidential matters which may be prejudicial to the public interest if conducted in public or for other commercial or financial reasons. The Trust Chair explained that any such private decisions taken would become public knowledge in due course and when appropriate and he would as usual provide an update to the Lead Governor afterwards.	
	The meeting was closed at: 12:26	

Extraordinary Meeting of the Oxford Health NHS Foundation Trust Board of Directors

Minutes of an extraordinary meeting held on 26 June 2024 at 09:00 Microsoft Teams virtual meeting

Present:¹

David Walker	Trust Chair (the Chair) (DW)
Grant Macdonald	Chief Executive Officer (GM)
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (RB)
David Clark	Non-Executive Director appointee of the University of Oxford (DC)
Geraldine Cumberbatch	Non-Executive Director (GC)
Georgia Denegri	Associate Director of Corporate Affairs (GD)* ²
Charmaine De Souza	Chief People Officer (CDS)
Chris Hurst	Non-Executive Director (CMH)
Britta Klinck	Chief Nurse (BK)
Ben Riley	Executive Managing Director for Primary, Community & Dental Care (BR)
Philip Rutnam	Non-Executive Director (PR)
Mohinder Sawhney	Non-Executive Director (MS)
Heather Smith	Chief Finance Officer (HeS)
Rick Trainor	Non-Executive Director (RT)
Lucy Weston	Non-Executive Director (LW)
Andrea Young	Non-Executive Director (AY)

In attendance³:

Attendees/observers from Oxford Health NHS FT

Jane Appleton	Associate Director of Communications & Engagement
Ben Cahill	Deputy Director of Corporate Affairs
Peter Milliken	Director of Finance
Hannah Smith	Assistant Trust Secretary (Minutes) (HaS)
Mark Underwood	Head of Information Governance – <i>part meeting</i>
Michael Williams	Financial Controller

¹ Quorum is 2/3 of the whole number of members of the Board (including at least 1 NED and 1 Executive) i.e., where voting members of the Board are 16 (from March 2023), quorum of 2/3 with a vote is 11

² * = non-voting

³ An officer in attendance for an Executive but without formal acting up status will not count towards the quorum – Standing Orders 3.12.2

BOD 55/24 a	Apologies for Absence Apologies for absence were received from: Karl Marlowe, Chief Medical Officer; and (noted as on maternity leave) Amélie Bages, Executive Director of Strategy & Partnerships.	
BOD 56/24 a	Register of Directors' Interests The following recorded additions to their declared interests which would be reflected in the next version of the Register of Directors' Interests: - Chris Hurst, Non-Executive Director, as Non-Executive Director and Audit Chair at Coventry & Warwickshire Integrated Care Board; and - Philip Rutnam, Non-Executive Director, as Chair of the National Institute of Economic and Social Research.	HaS/ GD
BOD 57/24 a b	Trust Chair's Report The Trust Chair explained that this meeting was focused upon receipt and, if appropriate, approval of the financial year-end reports, being the Annual Report and Accounts and supporting documents. The Trust Chair took his report as read. The Board noted the report.	
BOD 58/24 a b c	Audit Committee's recommendation on the Annual Report & Accounts Chris Hurst gave a presentation and reminded the Board of its role and responsibilities in approving the Annual Report & Accounts, whilst also noting the general increase in oversight requirements for NHS organisations with the new Fit & Proper Person annual submission which was also on the agenda for the meeting. He took the Board through the timetable for approval and submission of the Annual Report & Accounts to NHS England and set out the position at the time of review by the Audit Committee at its meeting on 19 June 2024. He reported that the External Audit had been nearing completion (the External Audit Letter of Representation was not yet available at that time), the Trust had adjusted for the majority of the audit findings and corrected for disclosure errors/omissions, there were a very small number of minor issues under discussion, the review of the Remuneration Report was substantially complete, the Value For Money assessment had been substantially completed (subject to final written sign-off) and no significant weaknesses had been identified. Compared to the previous year, there were no estates valuation issues delaying progress but instead focus had been given to the accounting treatment of the Private Finance Initiative (PFI) exit. Subject to any material matters arising from the External Audit, the Audit Committee had recommended the Annual Report & Accounts to the Board for final approval and submission to NHS England. The Board noted the recommendation from the Audit Committee.	
BOD 59/24 a b	Financial Statements & Accounts 2023/24 (including Letter of Representation) The audited financial statements were presented to the Board, having been reviewed and recommended by the Audit Committee at its meeting on 19 June 2024. The Chief Finance Officer highlighted: despite an overall positive External Audit process this year, the audit was not yet fully complete and a draft Audit Results Report had been provided together with a draft Letter of Representation;	

c d e	- the adjusted surplus had exceeded the original forecast agreed with the Integrated Care System by £0.7 million. This improvement had been communicated to the Integrated Care Board (ICB) and should help to reduce the amount of deficit the system as a whole would be required to repay in future years; and - the PFI accounting treatment and implications detailed in the supporting PFI accounting paper. The Director of Finance took the Board through the summary of the main changes from the draft financial statements to the audited financial statements. The changes made since the Audit Committee meeting all related to accounting notes and disclosures rather than movement in the underlying financial data. He explained the detail of the PFI accounting treatment as agreed with External Audit and notified to NHS England. He set out the overall improvement in adjusted financial performance after adjustments for updated agency accruals and reductions in impairments and interest charges. In response to a question from Lucy Weston on ongoing work indicated in the draft Audit Results Report, Chris Hurst replied that the report had been drafted originally for the Audit Committee and the status of the audit had now substantially moved on although the final written opinion was not yet available. The Chief Finance Officer reported that the majority of the audit work had been completed but there had been a delay in receiving the final report in the absence of the relationship partner earlier in the week. However, the Annual Report & Accounts would not be signed without the final and complete Audit Results Report. The Chief Finance Officer also confirmed that there were no outstanding issues around estates valuation or PFI accounting treatment. The Board: APPROVED the audited 2023/24 Financial Statements & Accounts and delegated authority for any final adjustments to be agreed by the Chief Executive, the Chief Finance Officer and the Chair of the Audit Committee but if there were any material changes required by the External Audit then these would be brought back to the Board; and APPROVED the Letter of Representation which related to the Financial Statements be prepared on an appropriate Trust letterhead and sent to the Trust's auditors.	
BOD 60/24 a b	Trust Annual Report 2023/24 The Associate Director of Corporate Affairs presented the paper which set out the text of the Trust's Annual Report and explained that the near-final Annual Report was also subject to completion of the External Audit. She thanked the Deputy Director of Corporate Affairs for his work in developing the text to follow more closely the guidance from the Annual Reporting Manual. She highlighted: - the Annual Governance Statement and confirmed that it had been reviewed twice by the Audit Committee and there were no significant control weaknesses to highlight; it was also supported by the Head of Internal Audit Opinion which was one of significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control; and - updates in the Remuneration Report in relation to adjusted staffing figures, as discussed and agreed with External Audit. David Clark and Lucy Weston referred to omissions in the text of the Annual Report in relation to: (i) the work of the Biomedical Research Centre; and (ii) meeting attendance to be included. Philip Rutnam also commented that he would send through a mark-up with typographical errors to amend. Further to a suggestion from Lucy Weston, the Chief	BC

c	Executive supported including more reflection upon the experiences and challenges for the public in being able to access mental health treatment and more reference to the Board listening to patient and carer experiences. Subject to the comments and inclusions referred to above, the Board: • APPROVED the Trust Annual Report 2023/24 to enable submission to NHS England by 28 June 2024 and subsequent laying before Parliament of the Trust's Annual Report & Accounts 2023/24; and • noted that for completion of Board records, the final document including the final External Audit Results Report and certificate of audit completion would be circulated separately over email.	
BOD 61/24	Quality Account 2023/24	
a	The Chief Nurse presented the near final draft Quality Account, on the quality of care provided by the Trust and a range of quality improvement, research and innovation activities. She confirmed that it had been consulted on with stakeholders including governors, ICB commissioners, Healthwatch organisations in Oxfordshire and Buckinghamshire and the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC). She reported that the Trust was on track in responding to the recommendations from the HOSC, as listed in the covering report.	
b	The Board commented upon the Quality Account and commended it for being comprehensive and setting out a clear roadmap of the various services which the Trust provided. Andrea Young reminded the Board that NHS organisations now had more freedom to design and develop a Quality Account. Although this version was very comprehensive, it may be useful if in future years it developed to be more focused upon specific quality themes. David Clark recommended including timelines for the integration between the True Colours and Rio systems, especially as delayed integration was cited as a reason for not having achieved quality objectives to capture outcomes in mental health services. The Chief Executive supported this.	BK
c	The Chief Executive suggested using some of the graphics in the Quality Account for the Annual Report.	BC
d	Subject to the comments above, the Board APPROVED the Quality Account for publication by 30 June 2024. <i>The Head of Information Governance joined the meeting.</i>	
BOD 62/24	Data Security and Protection Toolkit (DSPT)	
a	The Associate Director of Corporate Affairs presented the report from the Information Management Group on the DSPT annual submission and confirmed that the Internal Audit review had achieved significant assurance	
b	Lucy Weston commented upon the DSPT as an important part of Board assurance, especially in the context of the previous clinical systems outage, and asked about progress to conclude the two red-rated assertions in relation to: (i) publication of the independent audit into the DSPT; and (ii) penetration testing requiring review at a very senior level. The Head of Information Governance explained that: (i) it was Internal Audit's responsibility to publish their independent audit and although that had been awaited at the time of writing of the report, that had now been done; and (ii) penetration testing had also been completed. Therefore, there were no red-rated assertions still outstanding and the DSPT was ready for publication.	
c	The Board commented on the useful assurance provided by the report but noted that cyber security remained a matter of national concern and strategic interest across the	

d	NHS, especially given the impact upon NHS organisations of cyber incidents suffered by third party suppliers. The Trust needed to continue to be alert to this and to monitor the situation through its strategic Board Assurance Framework risk at 3.10 on Information Governance & Cyber Security and develop its mitigations and recovery plans accordingly. The Board noted the report and the pending DSPT submission which provided a broad range of assurance on data protection, cyber security, information management governance arrangements and data quality.	
BOD 63/24 a b	Fit & Proper Person Regulation (FPPR) annual submission report The Associate Director of Corporate Affairs presented the report and explained that the FPPR annual submission was a new requirement and that, further to the appropriate review of Board Director declarations, appraisals and Disclosure & Barring Service checks, all current Board Directors were compliant for 2023/24. She thanked the Chief People Officer and her team and noted that there would be ongoing work to improve and streamline processes further. The Board noted the report and was assured that processes were in place to ensure that Board Directors met the requirements of the FPPR and that all current Board Directors were compliant for 2023/24.	
BOD 64/24 a	Any Other Business/Questions None.	
BOD 65/24 a	Review of the meeting The Trust Chair commented upon the timeliness of the financial year-end reports and supporting documents and opportunities to make further improvements to the process.	
	The meeting was closed at: 10:14	

Summary of Actions from the Board meetings on 22 May and 26 June 2024

Relevant Item	Action	Responsibility:
BOD 39/24 (e)	Patient and Carer Story The Chief Nurse to provide an update to the next meeting on reflections from the Carer's story and changes which may be required or already in train. Status: <i>verbal update for the Board meeting in July</i>	BK
BOD 46/24 (b)	Annual Plan – strategic programme on outcome measures The Executive Managing Director for Mental Health, Learning Disabilities and Autism agreed to consider how the strategic programme on outcome measures ensured that the Trust used measures that impacted on individuals' clinical care and outcomes across services. Status: complete: 1. <i>Overview of current situation presented at board development day on 28th June by Bill Tiplady</i> 2. <i>Steering group meeting on 14th August to agree work plan over next year</i> 3. <i>True Colours:</i> a) <i>CAMHS re-launched with a pilot team CAMHS O MHST South in May 2024, and CAMHS-wide rollout by end of August 2024.</i> b) <i>ReQoL, Dialog, GBOs, Co-Produced Cate Plan built on True Colours to be rollout out to pilot teams on 16th July 2024. Pilot will be run for an initial period of 6 months</i>	RB
BOD 46/24 (c)	Health inequalities The Chief Medical Officer to circulate NHS Providers' recent publication on 'United against health inequalities' after the meeting. Status: complete - <i>circulated to the Board on 22 May 2024.</i>	KM

BOD 46/24 (d)	Annual Plan - reporting To review the frequency of planned reporting on progress against the Annual Plan to the Board. <i>Status: verbal update for the Board meeting on 24 July (further to report to the Finance & Investment Committee meeting on 23 July).</i>	PT/HeS
BOD 48/24 (c)	BAF risk 1.1 (utilising digital, data and technology to drive quality, efficiency, economy, research and innovation) The Chief Finance Officer took an action to set up a meeting with the Chairs of the Quality Committee and the FIC to discuss respective Committee ownership/monitoring of BAF 1.1. <i>Status: in progress – meeting with the Chairs of the Quality Committee and FIC being arranged for the end of August.</i>	AC/HeS
BOD 48/24 (d)	Research & Development policy The Chief Medical Officer agreed to review reference to duplication of previous work in research being unethical, as replication could be an important principle in medical science and research. <i>Status: complete and discussed with the Director of R&D</i>	KM
BOD 48/24 (f)	Guardian of Safe Working (GoSW) and Medical Education reports - GoSW reporting - to expand upon the process of discharging of the GoSW function and how information was acted upon; and - in future Medical Education reporting to consider providing comparative data for the previous year on feedback on clinical placements, fill rate for posts and any data on trainees' onward destinations. <i>Status: complete - diagram of the GoSW process pathway which sets out how information is acted upon to potentially rectify non-contractual or unsafe working conditions circulated to the Board on 22 May 2024 (with confirmation that the GoSW is satisfied that processes are in place to raise and escalate issues). Comments for future Medical Education reporting noted and being considered by Alastair Reed and Executives for future reports.</i>	KM

BOD 56/24 (a)	Register of Directors' Interests Updates to the Register of Directors' Interests: - Chris Hurst, Non-Executive Director, as Non-Executive Director and Audit Chair at Coventry & Warwickshire Integrated Care Board; and - Philip Rutnam, Non-Executive Director, as Chair of the National Institute of Economic and Social Research. <i>Status: complete and on the agenda</i>	HaS/GD
BOD 60/24 (b) and 61/24 (c)	Annual Report Amendments in relation to: - the work of the Biomedical Research Centre; - meeting attendance for David Clark and Lucy Weston; - typographical amendments; - inclusion of more reflection upon the experiences and challenges for the public in being able to access mental health treatment and more reference to the Board listening to patient and carer experiences; and - using some of the graphics in the Quality Account for the Annual Report. <i>Status: complete</i>	BC
BOD 61/24 (b)	Quality Account To include timelines for the integration between the True Colours and Rio systems, especially as delayed integration was cited as a reason for not having achieved quality objectives to capture outcomes in mental health services. <i>Status: verbal update for the Board meeting in July</i>	BK
Actions from the meeting on 27 March 2024		
BOD 24/24 (d)	BAF risk 1.1 (utilising digital, data and technology to drive quality, efficiency, economy, research and innovation)	HeS

	Although its future monitoring may be shared by both the Finance & Investment Committee and the Quality Committee, a decision on this would need to be made and documented. Status: in progress – meeting with the Chairs of the Quality Committee and FIC being arranged for the end of August.	
BOD 27/24 (d)	Research & Innovation reporting To include research clinic work on Virtual Reality in future reporting. Status: complete – included in Research & Innovation report for July 2024.	VR/KM
ACTIONS NOT YET DUE from the meeting on 27 March 2024		
BOD 31/24 (c)	Patient Safety Incident Response Framework (PSIRF) In Q4 FY25 or Q1 FY26 the Board should hold a workshop on the national Patient Safety Incident Response Framework once it had had a year to operate. Status: not yet due/scheduled – for private Board Workshop in February or April 2025 or Board Seminar in May 2025.	HaS/BK

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

24 July 2024

Trust Chair's report

For: Information/ Discussion

Agenda item: 7

Executive Summary

The general election dramatically changed parliamentary representation in our area and we welcomed returning and new MPs. We look forward to their visiting wards and teams and – for the new members - getting to know Oxford Health as they settle in. At the recent opening of our latest mental health and wellbeing hub in the shopping centre in Wantage I welcomed the town's mayor Dr Angela Dunford. Her party, the Liberal Democrats, are now Oxford's most significant political grouping.

The wider consequences of the change of government are unfolding and last week's King's Speech promised a mental health bill, which will pick up legislation pending under the last parliament and bring into law recommendations on patient rights from Sir Simon Wessely's independent review of aspects of the mental health acts. The NHS Confederation played a key role in informing Sir Simon's work. The mental health lead for the Confed, Sean Duggan, has just retired and I would like to record my thanks to him. All the best as he moves to chair the Sussex Partnership NHS FT.

Detained patients and those on community treatment orders lose some dimensions of their liberty but not their civil rights. Among them is access to independent advocates. Arrangements for these have recently changed – they are appointed by the local authority – and we look forward to working with the various charities involved. I would like to pay tribute to the work of the associate hospital

managers through whom patients have a right of appeal against detention and, on our side, the work of Paula Courtney, Mental Health Act Service Manager, and Mark Underwood, Head of Information Governance, in organising and sustaining them, and to Nicolette Habgood, Associate Hospital Manager, for chairing their group. Their statutory role has been queried and there is an overlap between them and the formal tribunals to which detained patients have access. But they remain a formidable voluntary resource, adding eyes and ears to the supervision of vulnerable people in our care.

One consequence of the election has been to delay confirmation of NHS appointments as ministers go and come. Our main integrated care system, Buckinghamshire, Oxfordshire and Berkshire West still lacks both a substantive chair and chief executive and on the appointments to those roles depends our forward movement on the chief executive role at Oxford Health. A fellow chair in our area observed that these sign offs may not be near the top of the new secretary of state's in-tray.

The Board will not meet again until September and many colleagues will have the chance to take a break. But our services are 365/24/7 so other colleagues will hold the fort: they have our recognition and thanks.

Recommendation

The Board is asked to note the report.

Author and Title: David Walker, Trust Chair

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **Strategic Objectives/Priorities** – *this report relates to the following Strategic Objective(s)/Priority(ies) of the Trust:*
 - 1) *Quality - Deliver the best possible care and health outcomes*
Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).
 - 2) *People - Be a great place to work*
Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.
 - 3) *Sustainability – Make best use of our resources and protect the environment*

Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects

**Report to the Meeting of the
Oxford Health NHS Foundation Trust
Board of Directors
24 July 2024**

Agenda item: 8

Chief Executive's Report

New governors

From the beginning of June, the Trust had a number of new governors following the close of the governor election period in late May. Governors have a key role in representing the membership of the Trust, staff, and the public the Trust serves, and in holding directors to account for the performance of the board. I'd like to welcome the following new governors to the Trust's council of governors – Bernice Hewson (public constituency, Buckinghamshire); James Campbell and Juliet Hunter (both public constituency, Oxfordshire); Maude Bvumbe (public constituency, Rest of England & Wales); and Dilshad Alam and Julie Timbrell (both staff constituency). I'd also like to welcome Cllr Zahir Mohammed who is the recently appointed governor for Buckinghamshire Council.

I was able to meet some of the new governors at the 12th June Council of Governors meeting (held in Aylesbury at the Whiteleaf Centre) and I look forward to meeting more and to continue working with returning and existing governors.

Annual staff awards

The annual staff award ceremony was held on 19th June in Thame, with sixteen award categories for teams and individuals. It was a pleasure to attend this event, meet so many staff, and be inspired by the continuing commitment and expertise of staff. A special mention to Debbie Walton who won an award retiring after 37 years in the NHS. I've included at the end of this report a list of all the staff award winners – my congratulations to them all and to all those nominated.

Pride month

June was Pride month and across the Trust there were a range of events and awareness campaigns to support and celebrate the LGBTQIA+ community, including the Trust having a stall at the 8th June Oxford city Pride celebration. The 'Pride Progress' flag was flown at key Trust locations to signal its ongoing support and allyship to the LGBTQIA+ community. My thanks to all the staff volunteers for organising the events over the month and to great work of the LGBTQIA+ Equality Staff Network. Also over June, the Romani flag was flown at Trust sites to mark Gypsy, Roma & Traveller History Month.

Service user network symposium

Earlier in June, I attended a symposium - hosted in Buckinghamshire - that brought together the growing number of service user networks (SUN) across the country. The service user network is an easy to access peer support programme where members can gain support and help others by sharing their experiences in a group setting. The groups are for people with personality disorder symptoms or complex emotional needs, formal diagnosis is not required. I found the symposium an inspiring and informative event with over one hundred people attending from across the NHS and voluntary, community and social enterprise sector. There were discussions and presentations on the role of volunteers in service user networks, outcomes achieved to date, and on the experience of using the network. I look forward to similar future events and the continued development of service user networks.

Community Mental Health Framework – celebration event

On the 20th June organisations from across Buckinghamshire, Oxfordshire and Berkshire showcased developments achieved over the last 3 years across the integrated care system as part of the community mental health framework (CMHF). 160 people attended the event and there were presentations from NHS services, primary care and the voluntary sector. A major theme of the event was the acknowledgement of the impact of working collaboratively on shared opportunities and challenges. There was also recognition that there is still more to do but the partnership-working and networking opportunities available were very encouraging.

Oxford Biomedical Research Centre – annual open day

The Oxford Biomedical Research Centre (BRC) held its annual open day on 30th May at Oxford's Westgate, showcasing the research that takes place in Oxford. It was a well-attended event and was a valuable demonstration of the BRC's work.

Health inequalities funding – showcase event

Last year the Trust received investment from the integrated care board to be used to improve health inequalities for people at greater risk of poor mental health. From the outset the Trust partnered with the voluntary and community sector to do this work. Voluntary, community and social enterprise (VCSE) organisations submitted proposals with an eventual 5 organisations securing investment – Wycombe MIND, Lindengate, Elmore, Bucks MIND and Chiltern Music Therapy. On the 4th July 2024, Lindengate - a

horticultural mental health charity based in Weston Turville (Buckinghamshire) - hosted an event where the organisations showcased their progress including work on wellness events for carers of people with a mental illness, targeted peer support groups for specific community groups, and examples of outreach to raise awareness. Learning from these projects using the non-recurrent funding has been valuable and has the opportunity to inform the work of wider services in addressing health inequalities

Kidlington Keystone hub

I am pleased see that a further Keystone mental health hub was opened in Kidlington town centre (north of Oxford) at a special event that brought together staff who will be working at the site and colleagues from partner organisations. The objective of the Keystone hubs is to enable adults experience mental health challenges to draw access support from NHS mental health professional and peer support workers who have their own experience of mental health challenges. The Kidlington hub is one of a number recently launched in Oxfordshire, after people said they would like to see more specialist care available at local level and improved communication between GPs and mental health services. Hubs are already open in Banbury, Abingdon, and on the Cowley Road in Oxford. Plans are underway for a further hub to open in Wantage mid-July 2024.

Learning Disabilities week

The 17th-23rd June was Learning Disabilities week – this year's theme was 'Do you see me?'. The Trust marked the week with a number of activities and events including the development of a therapeutic outdoor space by people with a learning disability on the Evenlode ward at the Oxford Clinic (Littlemore Mental Health Centre); a focused Thames Valley collaborative discussion on support for young people with a learning disability attended by the Trust's Child & Adolescent Mental Health Learning Disability and Autism Hospital at Home team; and the 'Have a Go' Festival – a sports day offering adults with learning disabilities to try a range of sports, meet new people and to get active. Also over the week, the Association of Chartered Physiotherapists for People with Learning Disabilities published an animation with ideas on how to support practitioners provided care to people with a learning disability.

Visit of Secretary of State for Health & Social Care

In late May, the then Secretary of State for Health and Social Care, Victoria Atkins, visited Oxford University Hospitals, and asked to meet with some of our health visiting team. Bethany Boddy, Karen Bisp and Christina Collins met with Ms Atkins and were able to discuss the health visiting service, the universal offer and targeted and specialist support. They were able to share the plans for Oxfordshire and the four-year review, talked about school readiness, and health promotion.

Annual report and accounts

The Trust's 2023/24 annual report and accounts were finalised over late June and submitted to NHS England. My thanks to the teams working on these and to our external auditors for our their work. The final annual report and accounts will be presented to the Trust's Annual General Meeting and Annual Members Meeting on the 10th September.

Oxford Health Charity

The Trust's charity – Oxford Health Charity – has had an active summer to date with events including the ROSY Great Estates Walk (raising over £12,500 for the ROSY appeal), runners and walkers taking part in the Blenheim events (raising over £1700 for a variety of appeals), cyclists taking on the Bike Oxford event (raising over £1000) and individual fundraising across the country. The NHS Big Tea took place on the 5th July and focused on fundraising in support of the NHS. Recently charity funding approvals included support for Carers Week activities, service user activities and events, and enhancements to the Trust environment.

Volunteering

The Trust's new Volunteer Programme Management System (Assemble) went fully live at the beginning of July and will now enable all engagement with volunteers to be managed in one place. The system will also enable data management to meet the new NHS England requirements for data returns on the numbers, diversity and level of actively of volunteer roles. New volunteers roles currently are being developed across the Trust including the Melksham Mental Health Support and Child & Adolescent Mental Health teams, the Bucks Recovery College, and the Oxford Stroke Recovery Unit. The volunteering team also supported the new Keystone hubs with volunteering roles open for recruitment at all locations now. Lastly, the volunteer of the year award was announced at the previously mentioned staff awards – congratulations to Steve Cook for all his time and commitment in supporting patients.

The Oxford Health Arts Partnership team presented to the Society for Academic Primary Care on their 'Didcot's Brilliant' project – demonstrating the impact of creativity of recovery, engagement and community. They have continued to develop community links with public art project planning taking place in Didcot and Wallingford as well as links with social enterprise, Yellow Submarine, in Witney and ongoing work with the Recovery Colleges in both Buckinghamshire and Oxfordshire.

Grant Macdonald, Chief Executive

Staff award winners

Inclusion award - Hannah Robinson, Peer Support Worker, Abingdon Keystone Mental Health & Wellbeing Hub

Living the values award - Wendy Corner, Modern Matron and Clinical Development Lead at Abingdon Emergency Multi-disciplinary Assessment Unit

Delivering care award - Lizzie King, Allied Health Professional Clinical Lead for Adult Speech Therapy

Safe award - Louise Tohill, Clinical Nurse lead for the Oxfordshire Child and Adolescents Mental Health Service Community Services

Wellbeing award - Kaye Thorne, Admin Officer for Oxfordshire Learning Disability Office

Recognising excellent and innovation award - Debbie Walton, Associate Director of Adult Mental Health in Oxfordshire

Preceptorship award - Mpofu Thokozile, Senior Care Coordinator with the Adult Mental Health Assessment and Treatment Team City in Oxfordshire

Teamwork award (Clinical) - Cherwell Ward, City Community Hospital, Sandford Ward (Fulbrook Centre)

Teamwork award (Non-clinical) - Buckinghamshire Health Inequalities Working Group

Inspiring team award - Mental Health and Learning Disabilities Directorate: Evenlode Ward, Littlemore Mental Health Centre

Inspiring team award - Primary, Community and Dental Care Directorate: Oxfordshire District Nursing Team

Flexible team award (Clinical) - School Age Immunisation Service South Team

Flexible team award (Non-clinical) - Psychological Wellbeing Practitioner Apprenticeship Programme Team

Volunteer of the year award (As voted by patients, public and colleagues) - Steve Cook, Volunteer at Oxfordshire Stroke Rehabilitation Centre (OSRU)

Co-production award - Personalised Patient rehabilitation

Improving patient experience award - Adele Smith, Trainee Clinical Psychologist with the Child and Adolescent Mental Health Service's Community Services in Oxfordshire

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

24 July 2024

Agenda item: 9

Corporate Affairs Update Report

For: Awareness and Assurance

Introduction

This is the regular report to the Board providing updates on:

- a. Regulatory and good practice guidance relating to the work of the Trust;
- b. Board Assurance Framework (strategic risks);

Key communications and engagement and charity and involvement activity updates are now included in the Chief Executive's report.

The regulatory and good practice guidance, relevant to the work of the Trust, published from 15 May to 10 July 2024, is presented in Appendix 1. Its purpose is to inform the Board of the guidance issued and what action(s) are being taken by the Trust.

The format has been developed further following Board's feedback at the last meeting.

The regular Board Assurance Framework report is presented in Appendix 2. The Board has already agreed that the BAF will be refreshed in the coming months.

Governance Route/Approval Process

This is a routine report with direct relevance to the Board and its committees.

Recommendation

The Board of Directors is asked to note the report.

Author and Title:

Georgia Denegri, Interim Associate Director of Corporate Affairs (regulatory guidance)
Hannah Smith, Assistant Trust Secretary (BAF)

Lead Exec: Georgia Denegri, Interim Associate Director of Corporate Affairs

PUBLIC

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. ***Strategic Objectives/Priorities*** – *this report relates to or provides assurance and evidence against all aspects of each of the Strategic Objectives/Priorities of the Trust*

Appendix 1

Regulatory and good practice guidance published 15 May to 10 July 2024 (NHSE, CQC, NHS Employers, NHS Providers, DHSC)

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	NHS England				
1.	Safeguarding accountability and assurance framework NHSE's updated framework sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and commissioning organisations. It includes content on national, regional, and local safeguarding; the fit and proper person test; and duty of candour. Link to website/document: NHS England » Safeguarding children, young people and adults at risk in the NHS	24 June 2024	Safeguarding children and adults	Britta Klinck, Chief Nurse	The safeguarding team are reviewing the updated framework to determine the nature and the extent of any changes that may be needed to the Trust's accountability and assurance framework. Regarding section 10 – parallel investigations, the safeguarding team are already working with patient safety colleagues to encourage more consistent participation of partners (particular LAs) in our reviews where there is a safeguarding element to the incident/ event.
2.	Autumn/Winter flu and COVID-19 seasonal campaign NHSE's letter about how services should prepare for the Autumn/Winter 2024/25 flu and COVID-19 seasonal campaign. It includes information about a new procurement process.	30 May 2024	Flu and COVID vaccination programme	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	Regular annual seasonal campaign.

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	Link to website/document: NHS England » Preparations for an Autumn/Winter 2024/25 flu and COVID-19 seasonal campaign				
3.	2024/25 flu vaccination programme Sanofi has confirmed the recombinant quadrivalent influenza vaccine (QIVr) will not be available for the vaccination programme. Providers are responsible for securing alternative supplies of vaccine and should order first line vaccines where possible. Link to website/document: An amendment to the National flu immunisation programme 2024-2025 letter sets out alternative vaccines based on JCVI recommendations.	17 June 2024	Flu vaccination programme	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	As above
4.	Introduction of new NHS vaccination programmes against Respiratory Syncytial Virus (RSV) Following advice from the Joint Committee on Vaccination and Immunisation (JCVI), from Sunday 1 September, two vaccination programmes will target older adults 75 to 79 years old and pregnant women to protect infants. The letter confirms that all adults turning 75 years old, on or after 1 September, will be eligible for	24 June 2024	Vaccination programme	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	Vaccination programme

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	the routine programme and should be offered a single dose of the RSV vaccine, and advises that women who are at least 28 weeks pregnant should also be offered vaccination. Link to website/document: 2 vaccination programmes will target older adults and pregnant women to protect infants.				
5.	Patient initiated follow-up (PIFU) campaign assets NHS England's (East of England) team have developed a range of resources and assets to promote and explain patient initiated follow-up (PIFU) to clinicians and patients. These assets have been produced in close collaboration with the national Outpatient Recovery and Transformation team and can therefore be used by teams across the country, alongside the national PIFU campaign toolkit. Link to website/document: PIFU campaign assets for providers	15 May 2024	Outpatient appointments	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care/ Rob Bale, Chief Operating Officer for Mental Health and Learning Disabilities	For information
6.	Consultants pay reform deal: revenue finance and contracting This NHSE guidance advises how commissioner allocations will be recurrently adjusted in 2024/25 to fund the impact of the consultants pay reform	16 May 2024	Finance	Heather Smith, Chief Finance Officer	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	deal, sets out the expected impact on the cost uplift factor (CUF) in the NHS Payment Scheme (NHSPS), and provides information on payment and contracts; financial reporting instructions for NHS organisations; and cash management. Link to website/document: pay implementation guidance				
7.	NHS Universal Family Programme toolkit NHSE's Universal Family Programme toolkit shares learning from organisations and provides a step-by-step guide for ICBs on delivering a successful programme that meets the needs of care leavers in recruitment, training, mentoring, support, and career planning. It explains how organisations can assess the needs of care leavers, develop tailored support and services, and implement effective strategies to achieve the intended outcomes. These communications resources on FutureNHS help to promote the programme locally. For further information email england.nhsworkforcesupply@nhs.net. Link to website/document: NHS England » NHS Universal Family Programme: quick-guide	16 May 2024	Workforce	Charmaine De Souza, Chief People Officer	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
8.	Research demand signalling: mental health nursing Aimed at research funders and the academic research community, NHSE's mental health demand signalling report outlines the key questions that researchers can assist NHSE in addressing within mental health nursing. It details NHSE's approach; provides content on prevention and population health; and describes overarching themes across 3 priority areas. Supporting information includes a methodology and priority topics ranked by theme. Link to website/document: mental health demand signalling report	16 May 2024	Mental health nursing research	Britta Klinck, Chief Nurse	For information
9.	Policy book for primary dental services NHSE's updated policy book for primary dental services and supporting appendices provides commissioners with the information and tools to commission and manage dental contracts. This includes information on excellence in commissioning; contract types and variations; financial recovery; and provision of occupational health services. Link to website/document: NHS England » Policy book for primary dental services	28 May 2024	Dental services	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
10.	NHS Education Funding Agreement 2024-27 The NHS Education Funding Agreement replaces the 2021/24 NHS Education Contract, covering both education and placement providers from 1 April 2024 until 31 March 2027. The funding agreement supports non-competitive, equitable activities listed in the DHSC education and training tariff guidance and NHS Education funding guidance for: • education and placements funding • salary support funding • education and training grants for programmes published by NHS England Link to website/document: funding agreement	03 June 2024	Education funding	Charmaine De Souza, Chief People Officer	For information Learning and Development manage this contract with support from Finance in accordance with 2024-2027 Funding Agreement.
11.	Primary care and general practice IT funding guidance NHSE guidance detailing the funding available in 2024/25 and includes information about how it should be spent and managed. It provides additional information about dental and eye health and community pharmacy PCN roles. Appendix 1 details the allocations by ICB. Link to website/document: primary care service development guidance	10 June 2024		Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
12.	Speaking up support scheme (formerly known as Whistleblowers Support Scheme) The scheme is for past and present NHS workers who have experienced a significant adverse impact on both their professional and personal lives following a formal speaking up process. It provides a programme of support which includes one-to-one psychological wellbeing support and career coaching. Applications are open until Monday 5 August. Link to website/document: Speaking up support scheme For further information email england.speakingupscheme@nhs.net. The Evaluation of the 2022/23 scheme includes learning outcomes for leaders to improve speaking up processes.		Workforce	Charmaine De Souza, Chief People Officer	For information. We are aware of this scheme and promote it through our FTSUGs. Trust employees have accessed this support in the past.
13.	National Quarterly Pulse Survey (NQPS) The Q1 2024/25 NQPS data release was delayed due to the pre-election period. The data will be released following the general election on the NQPS website. Trusts should collect their Q2 NQPS data between	17 June 2024	Workforce	Charmaine De Souza, Chief People Officer	The July People Pulse Survey is currently live, and has been promoted by the Communications team, including sending diary slots to all staff as reminders to complete.

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	1 to 31 July. The People Pulse is the easiest way to collect and submit data. Trusts not using the People Pulse should submit their data by 11.59pm on Thursday 8 August on the SDCS portal for NQPS. Link to website: document: For further information visit the NQPS website or email england.quarterlyss@nhs.net				
14.	NHS Parliamentary Awards Due to the general election, the NHS Parliamentary Awards Ceremony will now take place on Monday 14 October. The national shortlist for the awards will be announced on Thursday 5 September. Link to website/document: For further information email nhs.stakeholderengagement@nhs.net.	17 June 2024			For information
15.	Health and care passports NHSE guidance and template support ICSs to review existing arrangements for health and care passports (hospital passports) following recommendations by the Health Services Safety Investigations Body, and to improve health	24 June 2024	Learning disabilities	Rob Bale, Chief Operating Officer Mental Health & Learning Disabilities	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	outcomes for people with a learning disability and autistic people. It includes a plain English and easy-read guide. Link to website/document: guidance and template support ICSs to review existing arrangements for health and care passports (hospital passports)				
16.	Allied Health Professional (AHP) learning disability videos Videos designed to raise the profile of AHP roles in services that care for people with a learning disability and autistic people. They highlight the impact of AHPs providing care and in improving health outcomes. Link to website/document: Watch these films, designed to raise the profile of AHP roles		Learning disabilities / AHP	Rob Bale, Chief Operating Officer Mental Health & Learning Disabilities	For information
NHS Employers					
17.	Apprenticeship pay guidance and FAQs	13 June 2024	Workforce	Charmaine De Souza, Chief People Officer	The Trust complies with this new guidance.

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	NHS Employers' guidance, FAQs and pay scenarios support the changes to apprenticeship pay, which came into force from Monday 1 July 2024. Link to website/document: FAQs and pay scenarios support the changes to apprenticeship pay				
18.	Supporting the psychological safety of staff NHS Employers' guidance to create a psychologically safe workplace that improves staff experience and wellbeing. It includes top tips and a recording of a webinar on psychological safety. Link to website/document: Top tips for supporting the psychological safety of staff NHS Employers	24 May 2024	Workforce	Charmaine De Souza, Chief People Officer	The Trust has a wide range of wellbeing measures in place to support staff including a recently enhanced psychological service for staff which is part of our Occupational Health team, and are currently focused on embedding a Restorative, Just and Learning Culture across the Trust. We have recently piloted TRiM to provide additional support to staff who may potentially have witnessed trauma.
19.	Recruitment toolkit NHS Employers' guidance providing best practice on planning, preparing, implementing, and evaluating recruitment activity. Link to website/document:	28 May 2024	Workforce	Charmaine De Souza, Chief People Officer	This is being reviewed as part of the recruitment process QI project.

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	Read NHS Employers' updated 'Inspire, attract and recruit' toolkit.				
20.	International retention toolkit NHS Employers' updated international retention toolkit helps line managers and employers to support international staff by improving their experience at work. It provides good practice examples to assist employers in retaining colleagues. Link to website/document: updated international retention toolkit	15 May 2024	Workforce	Charmaine De Souza, Chief People Officer	For information. HR is reviewing all our recruitment and other practices in relation to international staff and will be using this toolkit as part of the review.
21.	International recruitment toolkit NHS Employers has updated the toolkit to reflect recent changes in international recruitment and links to new tools and resources including a guide on the medical training initiative scheme and a case study on collaborating across an ICS. Link to website/document: toolkit to reflect recent changes in international recruitment	24 June 2024	Workforce	Charmaine De Souza, Chief People Officer	For information. As above.

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
22.	Diversity in health and care partners programme Applications are open for NHS Employers' diversity in health and care partners programme. The initiative offers a comprehensive organisational development programme which helps organisations advance equality, diversity and inclusion (EDI) in the workplace. Delivered through a year-long series of events, it includes a virtual session for board members on the strategic business case for EDI, four face-to-face interactive modules and specialist virtual masterclasses. Link to website/document: Applications are open for NHS Employers diversity in health and care partners programme.	14 May 2024	Training for board members		To be offered to all board members
NHS Providers					
23.	Digital ICS briefing: Keeping your integrated care system safer from cyber attacks In the latest insights briefing from their Digital ICS programme, which is delivered in partnership with NHS Confederation and Public Digital, NHS Providers share five top tips and pose a series of	10 July	ICS Cyber security	Heather Smith, Chief Finance Officer	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	questions to help ICS leaders ensure they are prepared and able to respond to cyber threats. Link to website/document: digital-ics-insights-briefing-july-2024.pdf (nhsproviders.org)				
24.	NHS Providers briefing on NHS pay This briefing outlines the importance of prioritising the announcement of the 2024/25 pay award for NHS staff and explains the pay review process in England, with an overview of the: ○ NHS Pay Review Body (NHSPRB), covering most NHS staff. ○ Doctors' and Dentists' Remuneration Body (DDRB). ○ Senior Salaries Review Body (SSRB), covering very senior public sector managers, including in the NHS. Link to website/document: pay-briefing-for-new-mps.pdf (nhsproviders.org)	09 July 2024	Workforce/pay	Charmaine De Souza, Chief People Officer	For information
25.	System working in the NHS: How trusts work in partnership to improve care and outcomes for people	09 July 2024	System working / partnerships	All	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	This resource looks at the role of system working in the NHS and how trusts can work in partnerships to improve outcomes. Link to website/document: systems-explainer-briefing-july-2024.pdf (nhsproviders.org)				
26.	Making sense of health inequalities This resource, produced as part of our Health Inequalities programme, looks at the current state of the nation in relation to health inequalities and the role that NHS trusts have to play in addressing them. Link to website/document: making-sense-of-health-inequalities.pdf (nhsproviders.org)	04 July 2024	Health inequalities	Karl Marlowe, Chief Medical Officer	For information
27.	10 facts about the NHS workforce The NHS is the single largest employer in the UK. Although the size of its workforce is rising, the level of growth is not sufficient to meet the increasing demand for healthcare and complexity or level of patient need. Increases in staff numbers are not consistent across roles, and the service faces high numbers of vacancies overall.	02 July 2024	Workforce	Charmaine De Souza, Chief People Officer	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	This briefing presents 10 facts outlining the current state of the NHS workforce. Link to website/document: 10-facts-about-the-nhs-workforce.pdf (nhsproviders.org)				
28.	Providers Deliver: achieving value for money The tenth report in the publication series which explores how trusts across all sectors have been identifying innovative solutions to improve their productivity and continue delivering on the priorities of their local populations. Link to website/document: Providers Deliver: Achieving value for money (nhsproviders.org)	June 2024	Finance/value for money	Heather Smith, Chief Finance Officer	For information.
Care Quality Commission					
29.	CQC has published three inspection reports during this reporting period. Link to website/documents: CQC publishes reports on services run by University Hospitals of Leicester NHS Trust - Care Quality Commission	14 June 2024	Regulation/inspection reports	Britta Klinck, Chief Nurse	For information. No implication for OHFT

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
	Birmingham GP practice is rated inadequate and placed in special measures by CQC CQC takes enforcement action over inadequate maternity services at Bedfordshire Hospitals NHS Foundation Trust	05 July 2024 05 July 2024			
Department of Health and Social Care					
30.	New medical certificate of cause of death (MCCD) DHSC has published updated guidance on how organisations can get the new MCCD. The reforms to death certification and the introduction of medical examiners will start on Monday 9 September. Link to website/document: updated guidance on how organisations can get the new MCCD Please check that your organisation is on the MCCD distribution list .	25 June 2024	Medical certificate of cause of death	Karl Marlowe, Chief Medical Officer	The Patient Safety team are up to date on the Medical Examiner's roll out, and working closely with our ICS partners.
Office for Health Improvement and Disparities					

	Publication, summary, and link	Publication date	Area	Executive Lead(s)	Trust action(s)
31.	Addressing health inequalities across allied health professional services OHID's new guide supports the planning, implementation and evaluation of actions to reduce health inequalities in allied health professional services. It is for system leaders working across regions, ICSs, local authorities and provider organisations. Link to website/document: new guide supports the planning, implementation and evaluation of actions to reduce health inequalities in allied health professional services	9 May 2024	Health inequalities in Allied Health Professional Services	Karl Marlowe, Chief Medical Officer	For information

Appendix 2

Risk Management

The Code of Governance for NHS provider Trusts replicates Provision 28, UK Corporate Governance Code (July 2024) and states that *“the board should carry out a robust assessment of the company’s emerging and principal risks. The board should confirm in the annual report that it has completed this assessment, including a description of its principal risks, what procedures are in place to identify emerging risks, and an explanation of how these are being managed or mitigated.”*

Included in the Reading Room is the latest iteration of the Board Assurance Framework to ensure Board members continue to have a universal view of the Trust’s strategic risk profile and its committees’ assessment of the supporting control environment. This is the July 2024 edition of the BAF.

The Trust’s risks at a strategic level on the Board Assurance Framework (**BAF**), and at an operational level on the Trust Risk Register (**TRR**), are considered in more detail through the work of: (i) the Executive Team and Extended Leadership Team meetings; and (ii) Board Committees in particular the Finance & Investment Committee (**FIC**), the People, Leadership & Culture (**PLC**) Committee and the Quality Committee (**QC**) which have monitoring oversight of specific risks. Further oversight is provided through the work of the Audit Committee which is responsible for reviewing the content, processes and format of the BAF and TRR to seek assurance as regards risk management processes.

Since last reporting to the Board, the Executive Team meetings on 28 May, 24 June and 22 July 2024 reviewed updates on the BAF, whilst the Extended Leadership Team meeting on 03 June and 01 July 2024 reviewed updates on the TRR and Directorate Risk Registers including progress on migrating Directorate Risk Registers onto the same platform as the TRR. The Extended Leadership Team meeting, which is also attended by senior managers from Directorates, will approve changes to TRR risks and the removal of TRR risks, as part of their oversight of operational risks.

Board Committees also received their regular updates on BAF and TRR risks and undertook deep dives into selected risks through meetings of the Audit Committee on 19 June 2024, the PLC Committee on 10 July 2024 and the QC on 16 July 2024.

Updates and changes to highlight since previous Board reporting at the end of May 2024 are:

- BAF 3.4 on *Delivery of the financial plan and maintaining financial sustainability* was subject to a deep dive at the Audit Committee meeting on 19 June 2024, further to discussion and review at the FIC meeting on 09 May 2024 (previously reported). Although the Current Risk Rating remain unchanged, the content of the risk has been updated and is available in the latest iteration of the BAF in the Reading Room. BAF 3.4 highlights gaps in controls and assurances in relation to: funding pressures and system shortfalls; agency spend; and the Cost Improvement Plans process;
- although there have been significant updates to the contents of BAF 2.3 on *Succession*, BAF 2.4 on *Culture* and BAF 2.5 on *Retention* (available in the Reading Room), there are not yet changes to the Current Risk Ratings. Controls and sources of assurance have been increased to include investment in the Affina Team journey (an all-in one assessment and development tool for team leaders), a six weekly compliance reporting board within Learning & Development to monitor training compliance and feedback from the Education Strategy Group; and

- BAF 3.1 on *System planning and partnerships* was subject to a deep dive at the QC meeting on 16 July 2024. Although the Current Risk Rating remains unchanged, the content of the risk has been updated and is available in the Reading Room. Actions are progressing to agree performance reporting at System, Place and Trust levels aligned with the internal planning process, to work with place-based and local partners, to engage in funding dialogues with integrated care systems for system clinical and financial planning and to develop Provider Collaborative transformation programmes. Embedded resources are now in place within operational Directorates and the role of Associate Director of Mental Health leading on the Buckinghamshire, Oxfordshire and Berkshire West Mental Health Provider Collaborative has been recruited to and commenced.

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 10

24 July 2024

**Integrated Performance Report (IPR)
For: Information & Assurance**

Executive Summary

The Integrated Performance Report (IPR) report provides the Board of Directors with an integrated view of the strategic domains of Operational Performance, Quality and People.

The Integrated Performance Report (IPR) has been re-designed for an improved alignment with Trust strategic ambitions, national and local reporting performance requirements. The Board is receiving IPR containing May 2024 data unless stated otherwise. The report continues to be developed further to provide a comprehensive and reassuring oversight of Trust performance measures.

As part of this development the Board reviewed the first draft of this format at a development day at the end of June and has made suggestions for improvement that will be incorporated over the coming months, including – an average column on the pages before run charts, including clinical outcome information, greater indication of performance in community health, dentistry and primary care services, Forensic Services and Learning disability services. Alongside this we will ensure the supplementary reports on finance and Quality provide a complete picture and ensure the prominence of Quality reporting in the board.

IPR - Performance Summary

(1) Delivery of the NHS National Oversight Framework (NOF)

The Trust continues to perform well against the reportable targeted NOF metrics with the exception of Inappropriate Out of Area Placement (OAP) bed days.

In May 2024 locally reported total bed day usage was 152 days (25 inappropriate OAP bed days in Buckinghamshire, and 127 inappropriate OAP bed days in Oxfordshire) – a reduction of 18 bed days compared to April 2024. The directorates continue their focus on reducing the use of OAPs to improve the quality of patient care and improve cost control. The use of inappropriate OAPs remains lower than the previous year, however numbers continue to fluctuate based on clinical demand and acuity.

NHS England is currently reviewing the NHS Oversight and Assessment Framework with the view to publish and implement the new framework later in 2024. As a result of this, the currently reported NOF metrics to the Board may change accordingly.

(2) Clinical performance

The Trust has developed a new set of metrics to monitor clinical performance derived from nationally reportable metrics, national objectives and locally agreed metrics. Reporting against some of the metrics is still in development and will be introduced to the Board on a phased approach – detailed information can be found in summary dashboard throughout of the IPR.

Service area	Total number of indicators	Total number of indicators reported in May 2024	Total number of indicators with reporting mechanism in development	Comments
Child and Adolescent Mental Health Services (CAMHS)	7	3	4	Four week wait (interim metric – one meaningful contact within episode) – Buckinghamshire CAMHS above national target (61%) with 77.92% in May 2024 whilst Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire CAMHS services under national average with 56.42% and 51.23% respectively.
Talking Therapies	15	12	3	All reported metrics have met target apart from one – Buckinghamshire reported 65.91% of patients who have completed a course of treatment, have reported an improvement; the target is 66%.
Adult and Older Adult Community Mental Health Services	12	2	10	Four week wait (interim metric – two contact within episode) – Buckinghamshire services under national average (32%) with 28.10% in May 2024 while Oxfordshire services at 41.03%.
Mental Health Urgent Care Services	6	6	0	Both Oxfordshire and Buckinghamshire services performing significantly better than the national average (62%) against the 1 hour face to face response from Psychiatric Liaison service metric with 93.40% and 87.16% respectively. 24 hour response time for urgent

				referrals below national average across both Oxfordshire and Buckinghamshire.
Adult and Older Adult acute/inpatient services	31	26	5	% of Adult acute and psychiatric intensive care unit admissions with no prior contact with mental health services appears to be higher than national average (13%) in Buckinghamshire (13.73%) and Oxfordshire (15.29%). Adult and Older Adult wards in Oxfordshire were unable to follow up 80% of their patients within 72 hours of discharged in May 2024 and have followed up 69.23% and 72 73% respectively. There is a selection of indicators that are being baselined with a view to either set a target or a trajectory after a few months of monitoring within this IPR sub-section.
Community Health Services, Dentistry and Primary Care services	7	4	3	89.65% of patients attending Minor Injury Units have been seen within 4 hours (national target – 76%).

(3) Delivery of Strategic Objectives

The Trust has 40 strategic metrics to track performance against set strategic objectives and ambitions. Strategic Dashboard inclusive of all strategic metrics will be reported to the Board on a six-monthly basis with the first detailed report to be expected in November 2024.

- Quality – 19 strategic metrics (11 have targets, 8 – baselining or target to be confirmed). Those strategic metrics that are reportable monthly, are added to the relevant sections within the IPR (Clinical performance for Information only or Quality section for narrative). In addition to the strategic metrics, there are an additional 7 quality metrics monitored on a monthly basis.
- People - 9 strategic metrics (5 have targets, 1 – target to be confirmed, 3 are process measures). Five of the strategic metrics are reportable monthly in the People's section within the IPR. Additionally, there are an extra 11 People's metrics monitored monthly.
- Sustainability – 7 strategic metrics (5 have targets, 2 are process measures). All to be reported to the Board on a six-monthly basis.
- Research & Education – 5 strategic metrics (none are targeted). All to be reported to the Board on a six-monthly basis.

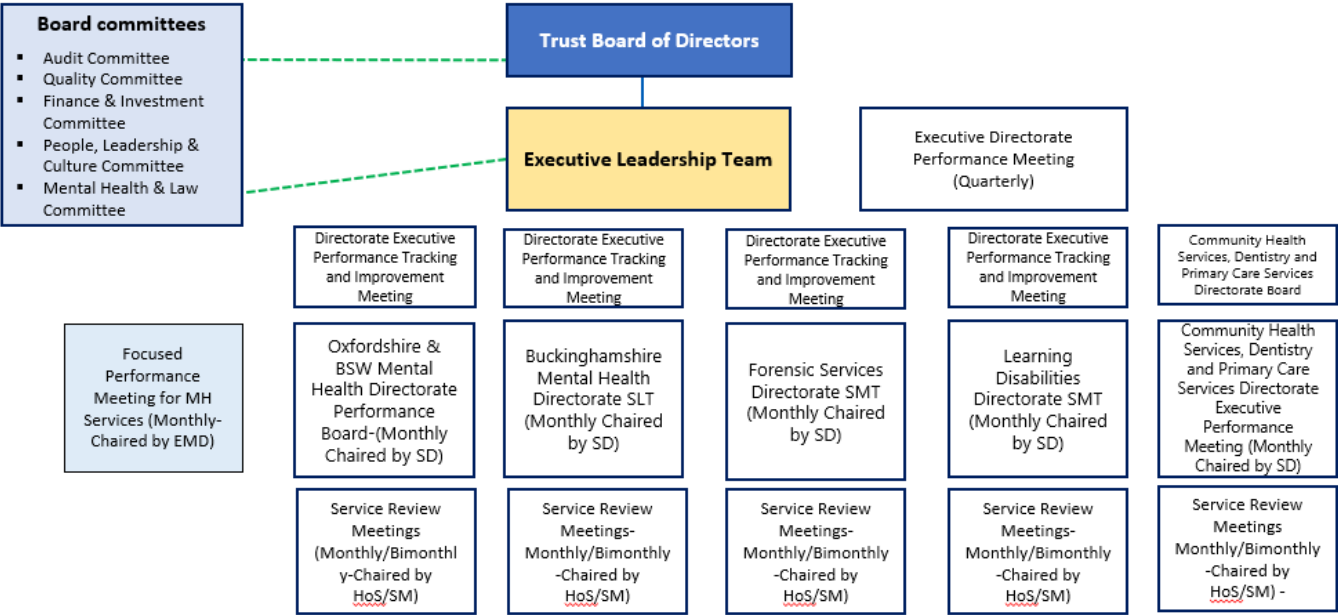
Trust's Performance Management

The primary purpose of the Performance Management Framework is to give the Trust a structure supporting systematic and continuous improvements to performance enabling achievement of its objectives.

The Performance Management Framework is part of the Trust’s wider governance framework. The performance framework should be used as an engagement tool to demonstrate ownership of performance at every level of the organisation from ward to board. If all individuals and teams consistently operate and perform to the best of their ability, the organisation will then experience positive outcomes and substantial benefits.

Performance management should be at the centre of what we do to enable continuous improvement in delivering quality, efficient and patient-focused services. Performance measurement, monitoring and management should always be directly linked to achieving the Trusts strategic objectives to ensure that we plan and deliver effectively and for continuous improvement to be an embedded way of working. The Performance Management Framework will be reviewed each year to ensure its effectiveness.

The structure of performance management governance is detailed below:

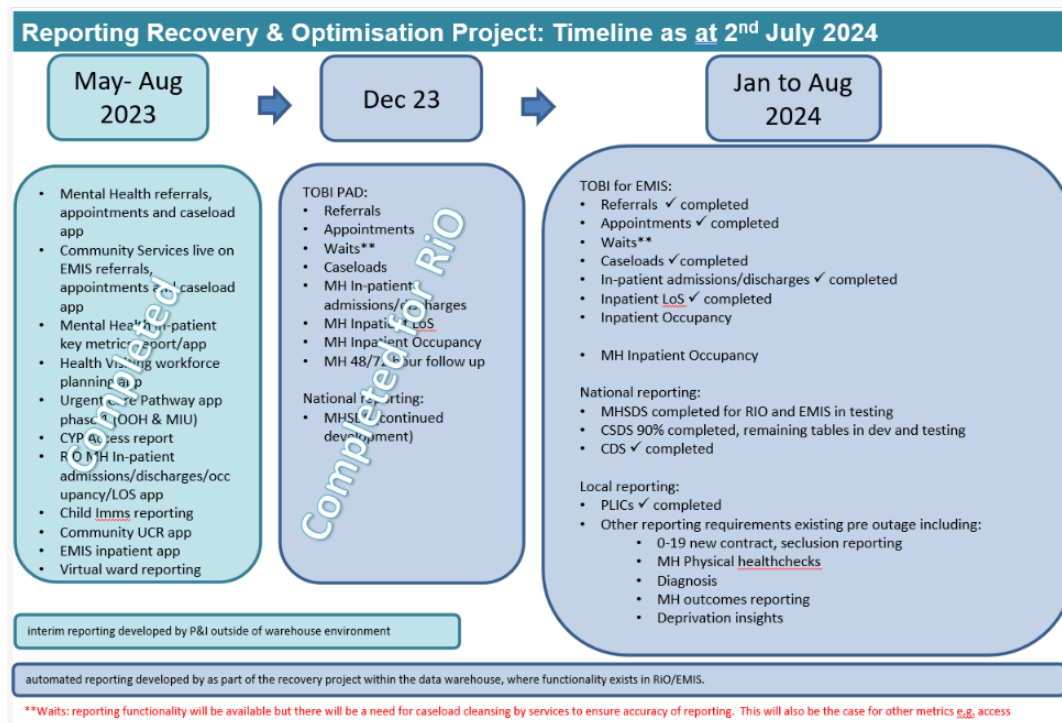


Patient Activity and Demand and Recovery of Reporting:

The core clinical information systems for the Trusts community and mental health services were replaced at the start of 2023 following a malicious cyber-attack in August 2022.

The scale of the work to recover and transition the reporting to the new systems (RiO and EMIS) is significant. Concept Analytics were the chosen partner and work commenced in May 2023. Work has progressed well and is nearing completion. The last phase of the project is due to complete in August 2024.

Overleaf is a high-level summary of what has been completed to date and the remaining items:



The reporting recovery work will report on the data that is recordable/available in the new systems as well as data that has been migrated from Carenotes, however, the Trust has, and will continue to have, gaps in its data for two reasons:

- **Data Gap 1 (Outage period).** The capture of data by services during the outage was inconsistent both in terms of method and completeness. Some services were able to retrospectively enter data in the new clinical systems once available, whereas other services were not able to or took the decision not to. Therefore, anything that was not retrospectively entered into RiO/EMIS/Adastra relating to the outage period is not reportable and there is a gap in the data.
- **Data Gap 2 (system functionality).** Data can only be reported if it is recorded in the clinical system. If the new clinical information systems do not have the functionality yet to enable the data to be recorded, the corresponding reporting does not exist.

With the exception of the two data gaps above, all other data items that were reportable before the outage will be reportable again by end of August when the project concludes. It should be noted that the data gaps are minimal (estimated to be c5% of data items).

It should also be noted that additional reporting has continued to be developed alongside the reporting recovery project and therefore information that was not available before the outage is now available, or will be available, from the end August 2024. Overall, the reporting capability and outputs of the Trust will be better than before the outage.

Recommendation

The Board of Directors are asked to note the contents of this report and provide further feedback for continuous development.

Author and Title: Vicki Bull
Head of Business Services

Lead Executive Director: Grant Macdonald
Chief Executive

Integrated Performance Report (IPR): July 2024

May 2024 data unless stated otherwise



- Guide to the Integrated Performance report
- Section 1.1 – Clinical Performance (Mental Health Services)
- Section 1.2 – Clinical Performance (Community Health services, Dentistry and Primary Care services)
- Section 2 – Quality and People (inc. In-Year Strategic metrics)
- Section 3 – Strategic Dashboard
- Appendices

Guide to the Integrated Performance Report



Oxford Health
NHS Foundation Trust

The Integrated Performance report (IPR) provides an overview of the performance of the Trust. The report is designed to give the Board a comprehensive summary of the Trust's performance, areas of celebration & challenge and the key actions being taken to address these challenges in the areas of quality, sustainability, people and operational management.

The report monitors performance against the key targets the organisation has set in line with strategic and clinical objectives. The IPR will be used at all levels of the organisation to ensure that we are consistently tracking performance from Ward to Board. The report can be produced at Board, business unit and service level to support performance discussions across the Trust.

The Key Performance Indicators included in the IPR are divided into two categories - [strategic](#) and [clinical](#) metrics.

Strategic - these are aligned to the Trust's Strategic Objectives and have been selected as the highest priority to the Trust.

- [Strategic Dashboard](#) – set of overarching strategic measures supporting the delivery of the Trust strategy to 2026. Grouped into four themes – Quality, People, Sustainability, and Research & Education. Progress against the Dashboard will be assessed on a 6-monthly basis in Section 3 of the IPR
- [In-year strategic metrics](#) – strategic measures allowing focused and/or more frequent evaluation of specific aspects tied to strategic dashboard. Metrics reported on a monthly basis, where possible, for information only in Section 2.

Clinical - these acknowledge business as usual activities to maintain performance. These are monitored against set thresholds, which will determine when further action should be taken. Reported on a monthly basis where applicable in Sections 1.1 and 1.2 of the IPR.

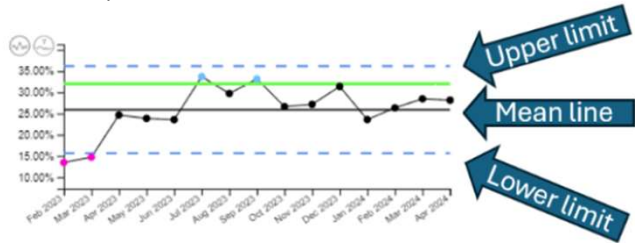
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Guide to the Integrated Performance Report

The below legends explain Variation and Assurance icons and Statistical Process Charts (SPCs) used throughout this IPR.

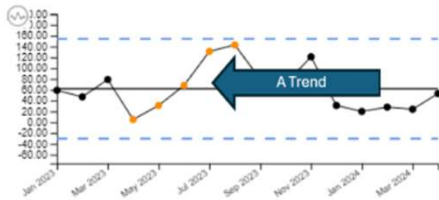
Statistical Process Charts (SPC) is an analytical technique that plots data over time. Such charts help identify variation i.e. what is 'different' and what is the 'norm'. Using these charts can help understand where focus might be needed to make a difference.

The SPC chart has three lines on it: central line (mean line; black) is the average of data and blue are upper and lower control limits. If data points are within the control limits, it indicates that the activity is within normal range. If the data points are outside of these control units, it indicates that the activity is out of control.

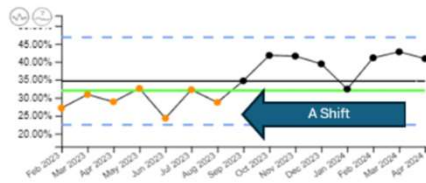


Green is the metric target line – only added to those graphs where target is applicable. Data points highlighted in pink are noted to be statistically different from the rest of the points (outside of the upper and lower control limits).

A Trend is defined as five or more consecutive data points all going up or all going down – orange indicates a deteriorating trend and blue indicates an improving trend.



A Shift is defined as seven or more consecutive data points all above or all below the centre (mean) line. Orange indicates a deteriorating shift and blue indicates an improving shift



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: orange indicates concerning special cause variation requiring action; blue indicates where improvement appears to lie, and grey indicates no significant change (common cause variation).

Assurance icons: Blue indicates that you would consistently expect to achieve a target. Orange indicates that you would consistently expect to miss the target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

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Section 1.1

Clinical performance

(National Mental Health Standards)

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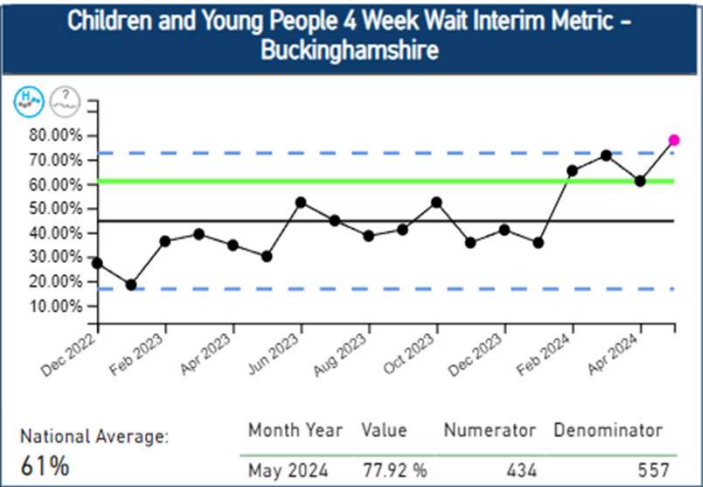
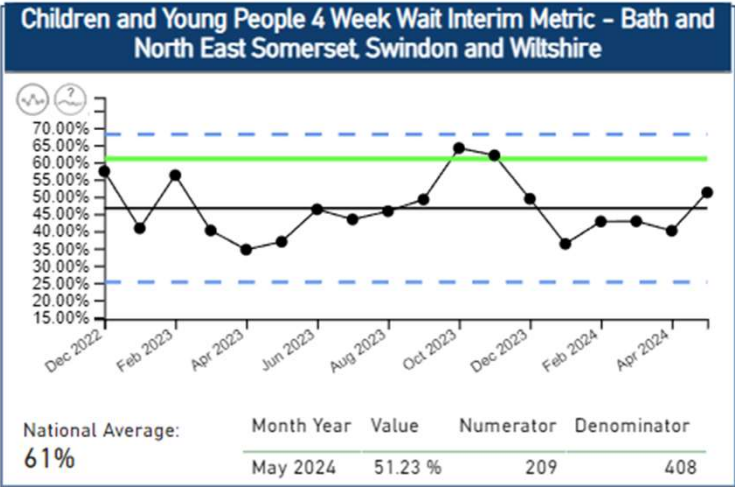
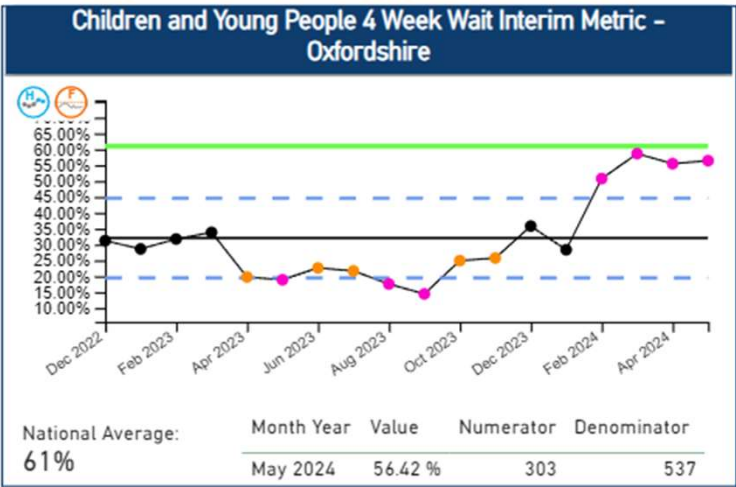
Mental Health services – Child and Adolescent Mental Health Services – Summary dashboard

Narrative provided only for metrics under target or national average (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous month	Better is
Child and Adolescent Mental Health Services (CAMHS)						
National measure	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)	<i>In development (estimated completion – June/July 2024. Status: technical development in testing)</i>				
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Buckinghamshire	61% National average	May-24	77.92%	↑	↑
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Oxfordshire	61% National average	May-24	56.42%	↑	↑
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Bath & North East Somerset, Swindon and Wiltshire	61% National average	May-24	51.23%	↑	↑
National Objective	Waiting time standard for a meaningful contact & outcome measure	<i>In development (estimated completion – FY25. Status: technical development initiated; operational action needed to record in Electronic Patient Records)</i>				
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks	<i>In development (estimated completion – June/July 2024. Status: technical development in testing)</i>				
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days	<i>In development (estimated completion – June/July 2024. Status: technical development in testing)</i>				

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Mental Health services – Child and Adolescent Mental Health Services



Summary

This is an interim metric, which measures one meaningful contact* within a care episode within the four (4) week period. Following on from the national 4 week wait pilots and the clinically led review of mental health standards, new non-urgent waiting time standards are being introduced for Child and Adolescent Mental Health Services (CAMHS). The Trust will be working to align existing models of care where possible to the new standards during this financial year, reporting will be updated in line with national changes to include the full metric (one contact, SNOMED** intervention or care plan, and baseline outcome measure recorded within the CAMHS pathway within the four (4) week period). There are currently no national targets set and the trust will be baselining against the national average position. Buckinghamshire CAMHS achieved national average in May2024 whilst Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire CAMHS are still working towards achieving national average.

*Meaningful contact is one that informs assessment and intervention, that is related to the identified/coded problem and is intended to assess or change feelings, thoughts, behaviour, or physical/bodily state. This may involve advice, support, or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment. These may be delivered through direct or indirect work where there is a referral.
**SNOMED is a structured clinical vocabulary for use in an electronic health record.

Actions

- Data recording guidance being rolled out across teams with the aim of improving data input and quality;
- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Reporting will be updated in line with national full metric during this financial year.

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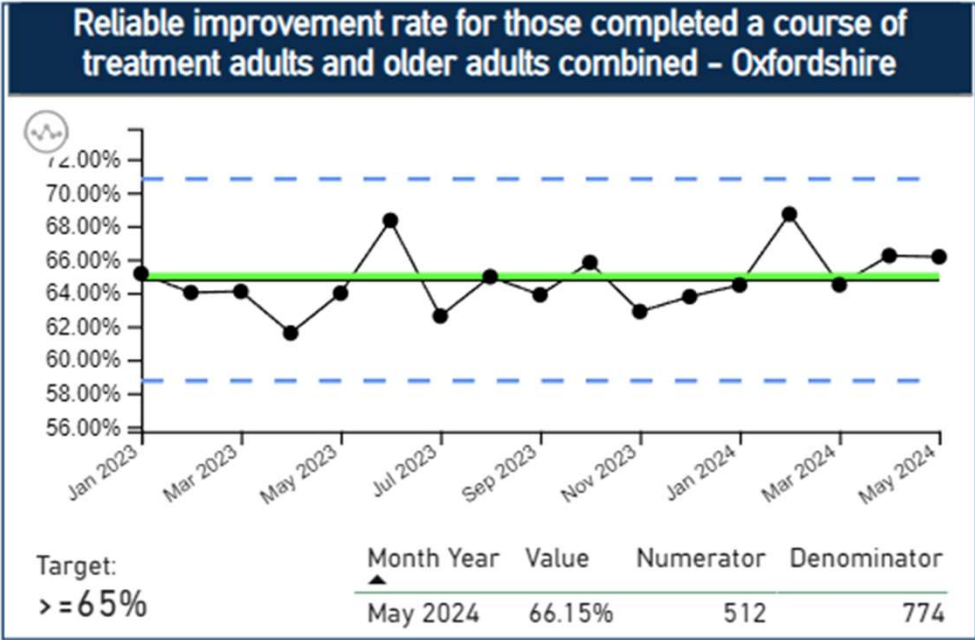
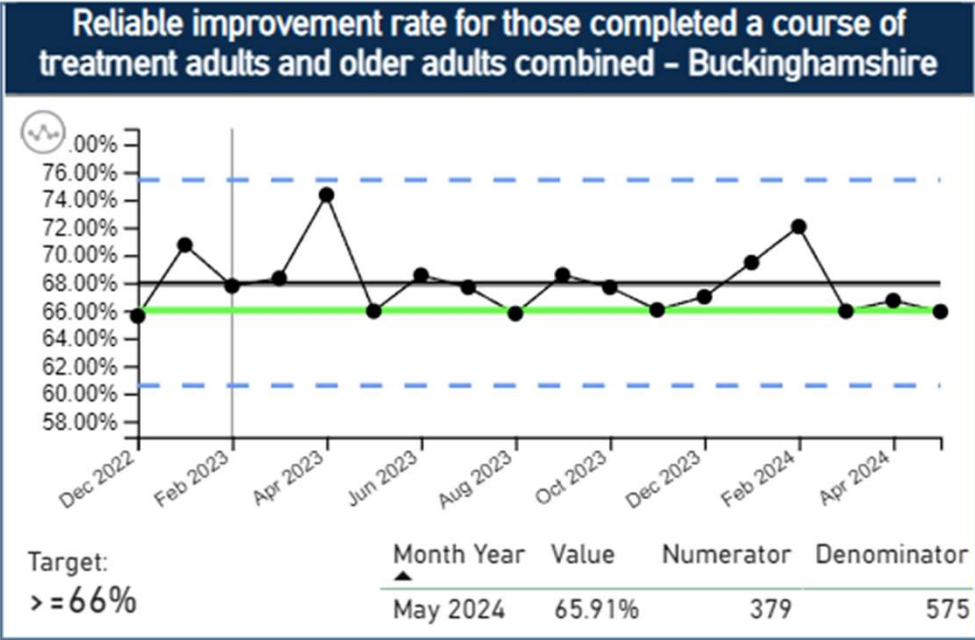
Mental Health services – Talking Therapies – Summary dashboard

Narrative provided only for metrics under target (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous month	Better is
Talking Therapies						
National Objective	Increase the number of adults and older adults accessing Talking Therapies treatment	In development for Q1 FY25				
National Objective	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000	In development for Q1 FY25				
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	48%	May-24	48.57%	↑	↑
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	46%	May-24	49.13%	↑	↑
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	66%	May-24	65.91%	↓	↑
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	65%	May-24	66.15%	↓	↑
National Objective	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	75%	May-24	99.13%	↑	↑
National Objective	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	75%	May-24	100%	↑	↑
National Objective	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	95%	May-24	100%	↑	↑
National Objective	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	95%	May-24	100%	→	↑
National Objective	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Buckinghamshire	10%	May-24	1.64%	↓	↓
National Objective	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	10%	May-24	3.98%	↑	↓
National Objective	Meet and maintain at least 50% Talking Therapies recovery rate with improvement to 52% by end of Financial Year 24-25 - Buckinghamshire	50%	May-24	51.62%	↑	↑
National Objective	Meet and maintain at least 50% Talking Therapies recovery rate with improvement to 52% by end of Financial Year 24-25 - Oxfordshire	50%	May-24	52.60%	↓	↑
National Objective	Meet and maintain Talking Therapies standards - 52% Talking Therapies recovery rate - continue progress to reduce the gap in recovery of all ethnicity groups relative to White British recovery rates	In development for Q1 FY25				

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Mental Health services – Talking Therapies



Summary

Reliable improvement rate measure significant improvement in patients condition following a course of treatment, measured by the difference between their first and last scores on questionnaires tailored to their specific condition. In May 2024, Talking Therapies in Oxfordshire saw 66.15% of their patients reporting improvement (above target of 65%). Buckinghamshire Talking Therapies achieved 65.91% against target of 66%.

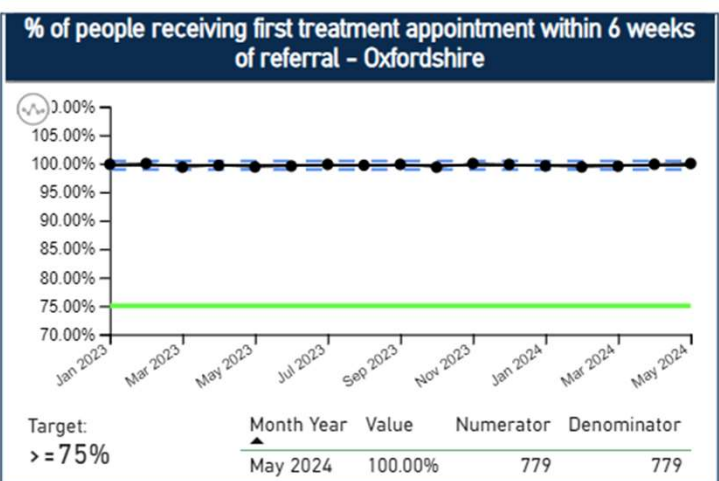
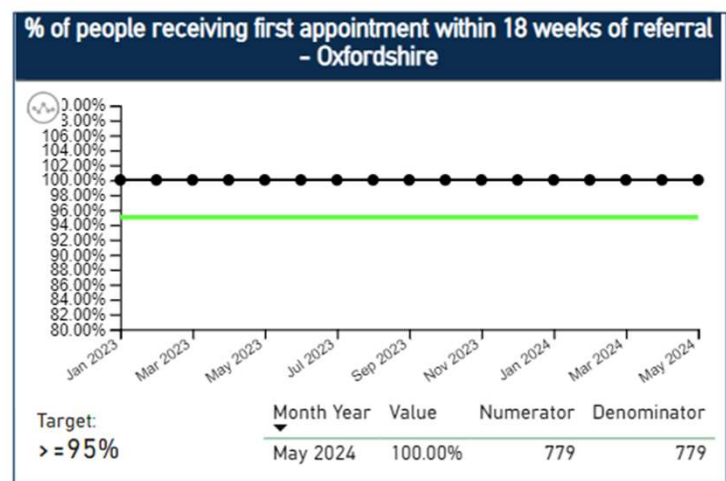
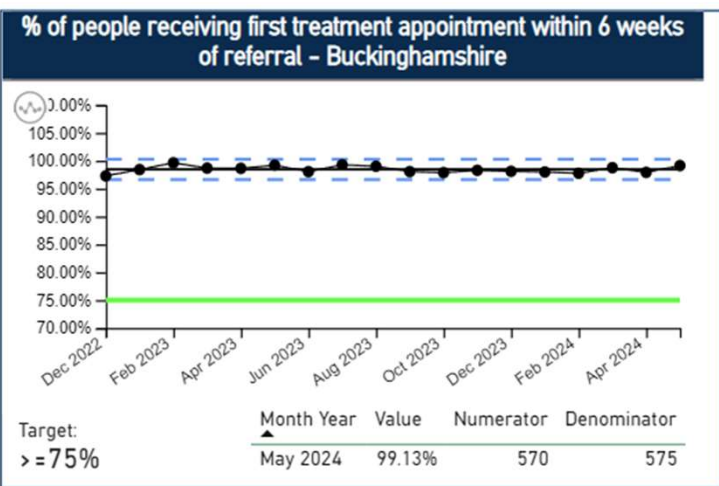
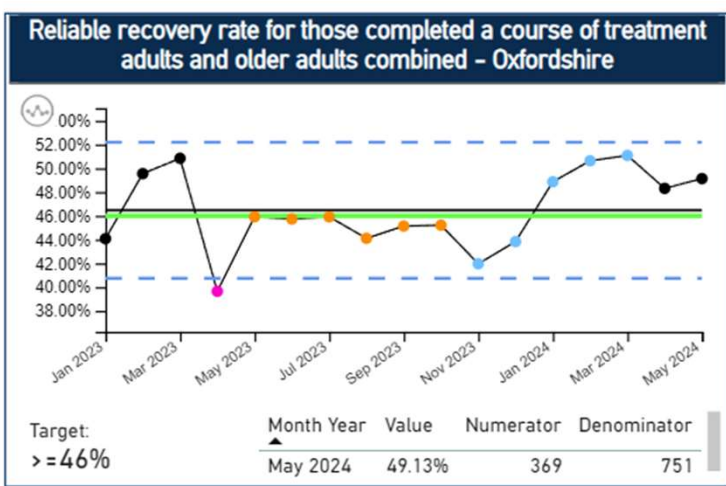
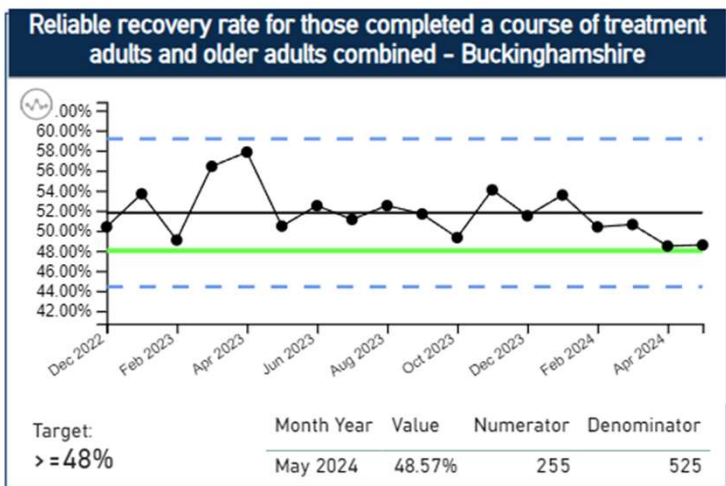
Actions

- To continue monitoring activity levels and performance at internal performance meetings

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Mental Health services – Talking Therapies

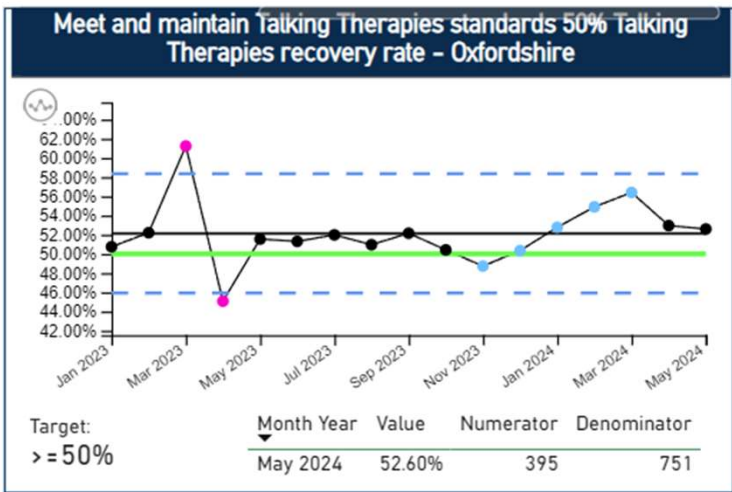
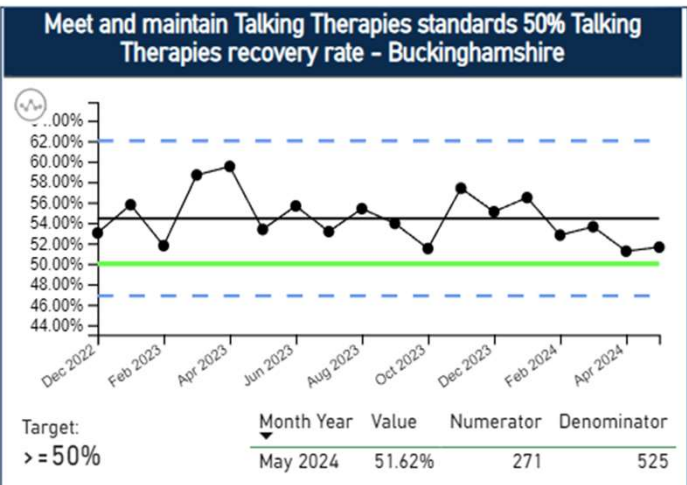
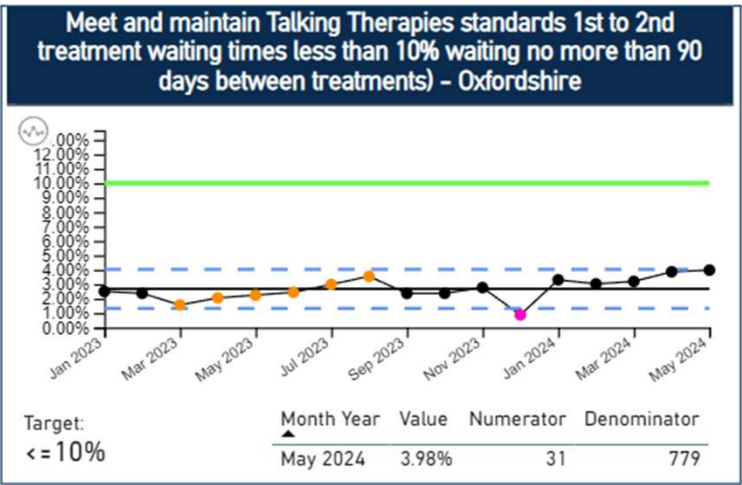
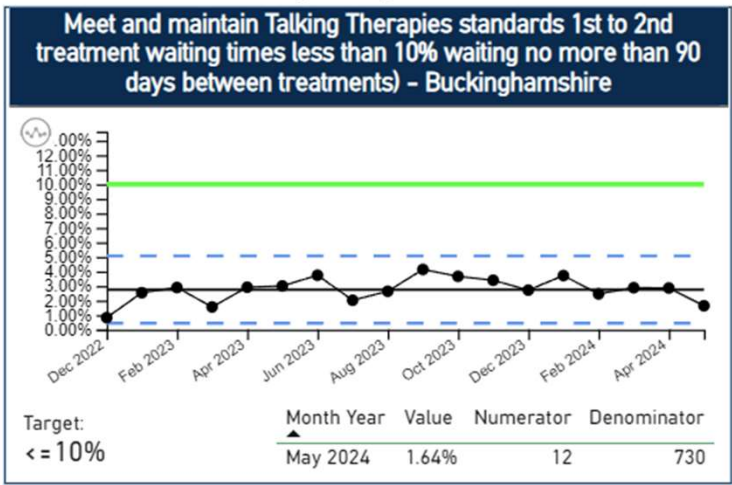
Metrics meeting target:



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Mental Health services – Talking Therapies

Metrics meeting target:



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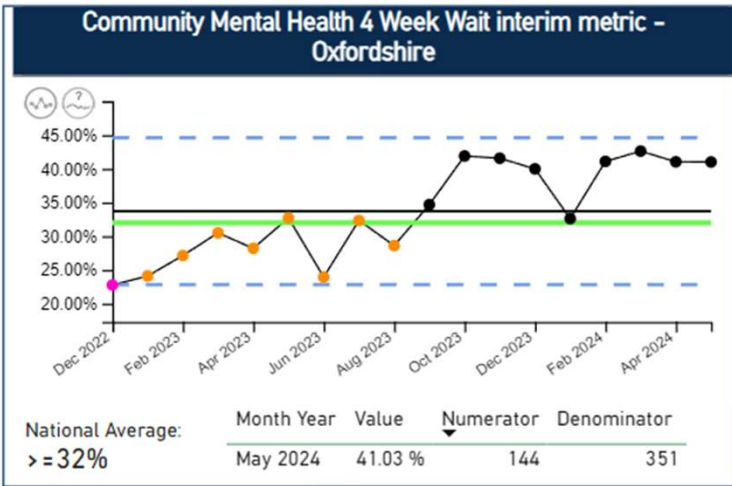
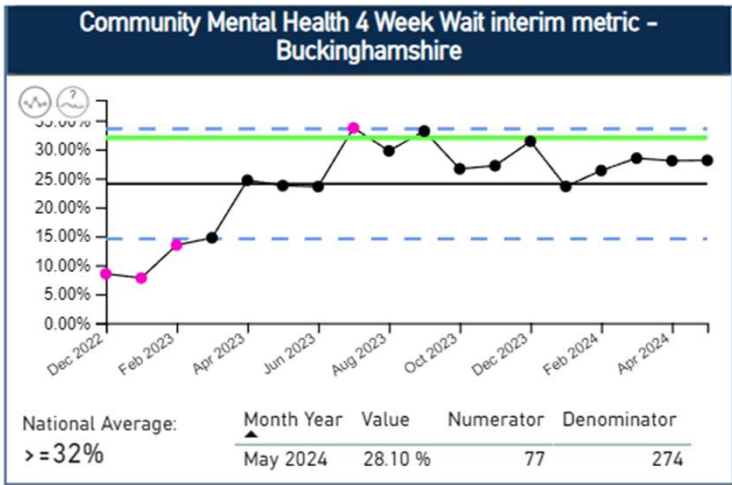
Mental Health services – Adult and Older Adult community – Summary dashboard

Narrative provided only for metrics under target or national average (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous month	Better is
Adult and Older Adult Community						
National measure	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	In development (estimated completion – July 2024. Status: technical development in testing)				
National Objective	4 week wait (28 days) standard (interim metric - two contacts within episode) - Buckinghamshire	32% National average	May-24	28.10%	↓	↑
National Objective	4 week wait (28 days) standard (interim metric - two contacts within episode)- Oxfordshire	32% National average	May-24	41.03%	↑	↑
National Objective Strategic Metric - Quality	Waiting time standard, care plan, outcome measure	In development (estimated completion - FY25. Status: technical development initiated; operational action needed to record in Electronic Patient Records)				
National Objective	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Buckinghamshire)	Quarterly measure - Q1 performance will be reported when published nationally				
National Objective	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Oxfordshire)					
National measure	Improve access to perinatal mental health services	In development (estimated completion – July 2024. Status: technical development in testing)				
National measure	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	Further technical development required – estimated completion August 2024.				
National Objective	Number of people accessing IPS	In development (estimated completion – July 2024. Status: technical development in testing)				
National measure	Recover dementia diagnosis rate (System measure - Buckinghamshire)	Monthly measure - April & May 2024 performance will be reported when published nationally				
National measure	Recover dementia diagnosis rate (System measure - Oxfordshire)					

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Mental Health services – Adult & Older Adult Community



Summary

This is an interim metric, which measures two (2) meaningful* contacts within a care episode within the four (4) weeks period. Following on from the national clinically led review of mental health standards, new non urgent waiting time standards are being introduced for Adult Mental Health Services. The Trust will be working to align existing models of care where possible to the new standards during this financial year, reporting will be updated in line with national changes to include the full metric (one meaningful contact, SNOMED** assessment, SNOMED intervention or care plan, baseline outcome measure). There are currently no national targets set and the trust will be baselining against the national average position.

Oxfordshire Adult and Older adult Community services achieved national average in May 2024 whilst Buckinghamshire Adult and Older Adult Community services are still working towards achieving national average.

**Meaningful contact is one that informs assessment and intervention, that is related to the identified/coded problem and is intended to assess or change feelings, thoughts, behaviour, or physical/bodily state. This may involve advice, support, or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment. These may be delivered through direct or indirect work where there is a referral.*

*** SNOMED is a structured clinical vocabulary for use in an electronic health record.*

Actions

- Data recording guidance being rolled out across teams with the aim of improving data input and quality;
- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Reporting will be updated in line with national full metric during this financial year.
- Introduction of Gateway (Buckinghamshire) services is anticipated to have a positive impact on reducing waiting times into Adult Mental Health teams. Gateway is a specialist, multi-disciplinary team providing advice and guidance to professional to help them meet the needs of service users within Primary Care.

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Mental Health services – Urgent Care – Summary dashboard

Narrative provided only for metrics under national average (value coloured in red below)

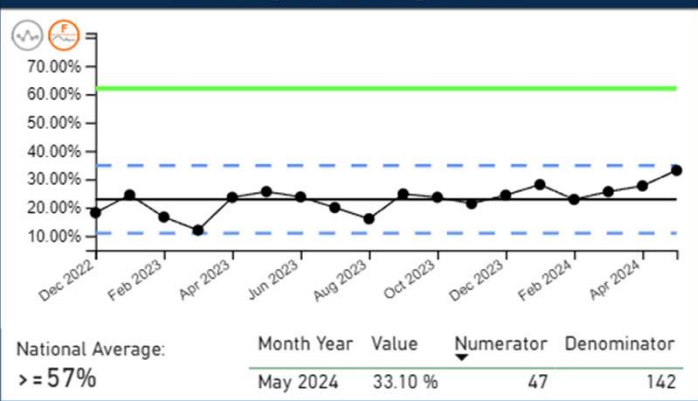
Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous month	Better is
Urgent Care						
National Objective	Face to Face response from MH Psychiatric Liaison within 1 hour - Buckinghamshire	62% National average	May-24	93.40%	↓	↑
National Objective	Face to Face response from MH Psychiatric Liaison within 1 hour - Oxfordshire	62% National average	May-24	87.16%	↓	↑
National Objective	Face to Face response from MH Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	69% National average	May-24	n/a	n/a	↑
National Objective	Face to Face response from MH Crisis Service within 4 hours (Very Urgent) - Oxfordshire	69% National average	May-24	n/a	n/a	↑
National Objective	Face to Face response from MH Crisis Service within 24 hours (Urgent) - Buckinghamshire	57% National average	May-24	33.10%	↑	↑
National Objective	Face to Face response from MH Crisis Service within 24 hours (Urgent) - Oxfordshire	57% National average	May-24	33.33%	↓	↑

* National average over April – December 2023

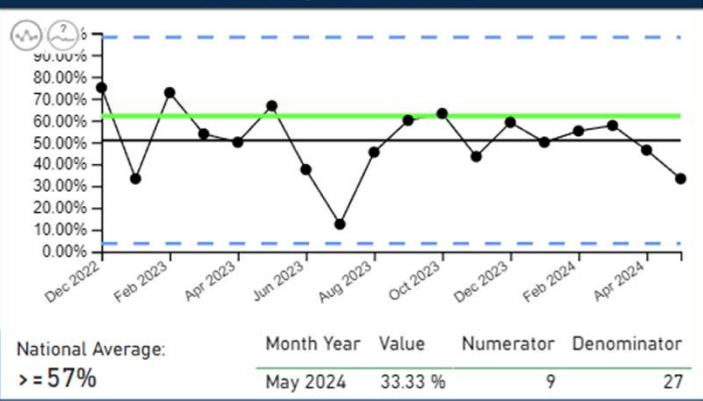
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Mental Health services – Urgent Care

Face to Face response from Mental Health Crisis Service within 24 hours (urgent) – Buckinghamshire



Face to Face response from Mental Health Crisis Service within 24 hours (urgent) – Oxfordshire



Summary

New standards are being introduced for Mental Health Urgent Care Services. The trust will be working to align existing models of care where possible to the new standards during this financial year, reporting will be updated in line with national changes. There are currently no national targets set and the trust will be baselining against the national average position. Both Oxfordshire and Buckinghamshire Mental Health Crisis services responded to 33.33% and 33.10% of urgent referrals within 24 hours against the national average of 57%.

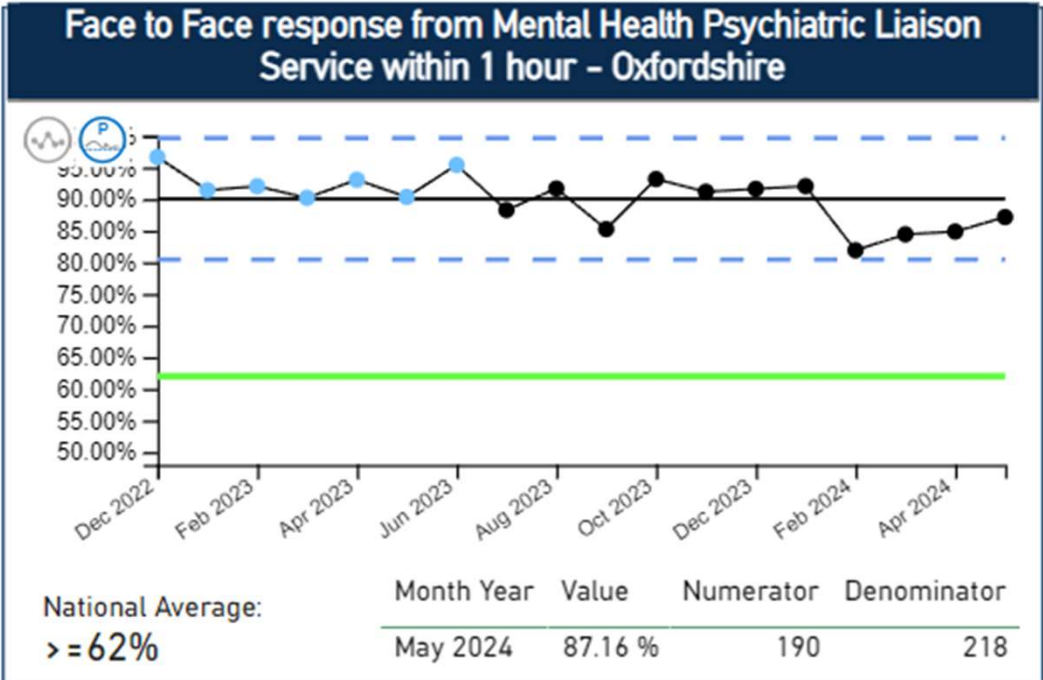
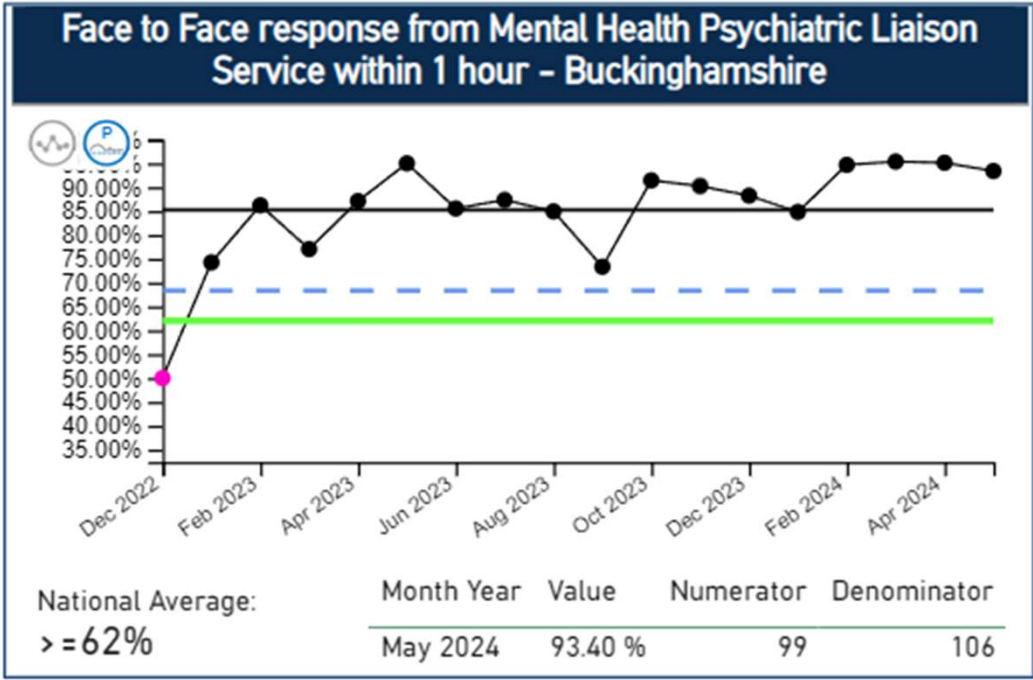
Actions

- Data recording guidance being rolled out across teams with the aim of improving data input and quality;
- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Focused data/recording meetings to address potential data recording practices.

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Mental Health services – Urgent Care

Metrics meeting national average:



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Mental Health services – Acute / In-patients (Adults & Older Adults) – Summary dashboard (1/2)

Narrative provided for metrics under target (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous month	Better is
Acute / In-patients (Adults & Older Adults)						
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact (all inpatients) - rolling quarter	<i>In development (estimated completion – July 2024. Status: technical development in testing)</i>				
	% of acute admissions with no prior contact - Adult (acute & Psychiatric Intensive Care Units) - Buckinghamshire	13% National average	May-24	13.73%	↑	↓
	% of acute admissions with no prior contact - Adult (acute & Psychiatric Intensive Care Units) - Oxfordshire	13% National average	May-24	15.29%	↑	↓
	% of acute admissions with no prior contact - Older Adult - Buckinghamshire	13% National average	May-24	12.00%	↓	↓
	% of acute admissions with no prior contact - Older Adult - Oxfordshire	13% National average	May-24	6.90%	↓	↓
National Objective NOF	Rate per 100,000 population in adult acute beds with a length of stay over 60 days - Buckinghamshire	<i>In development (estimated completion – July 2024. Status: technical development in testing)</i>				
National Objective NOF	Rate per 100,000 population in adult acute beds with a length of stay over 60 days - Oxfordshire	<i>In development (estimated completion – July 2024. Status: technical development in testing)</i>				
National Objective NOF	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days - Buckinghamshire	<i>In development (estimated completion – July 2024. Status: technical development in testing)</i>				
National Objective NOF	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days - Oxfordshire	<i>In development (estimated completion – July 2024. Status: technical development in testing)</i>				
National Objective	72 hour follow up for those discharged from mental health wards - Adults - Buckinghamshire	80%	May-24	90.48%	↑	↑
National Objective	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	80%	May-24	69.23%	↓	↑
National Objective	72 hour follow up for those discharged from mental health wards - Older Adults - Buckinghamshire	80%	May-24	91.67%	↑	↑
National Objective	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	80%	May-24	72.73%	↓	↑
	% adult readmission within 30 days for mental health - Buckinghamshire	n/a	May-24	0%	→	↓
	% adult readmission within 30 days for mental health - Oxfordshire	n/a	May-24	0%	↓	↓
	% older adult readmission within 30 days for mental health - Buckinghamshire	n/a	May-24	0%	→	↓
	% older adult readmission within 30 days for mental health - Oxfordshire	n/a	May-24	0%	→	↓
	Average number of clinically ready for discharge patients per day - Buckinghamshire	n/a	May-24	12	↑	↓
	Average number of clinically ready for discharge patients per day - Oxfordshire	n/a	May-24	6	→	↓

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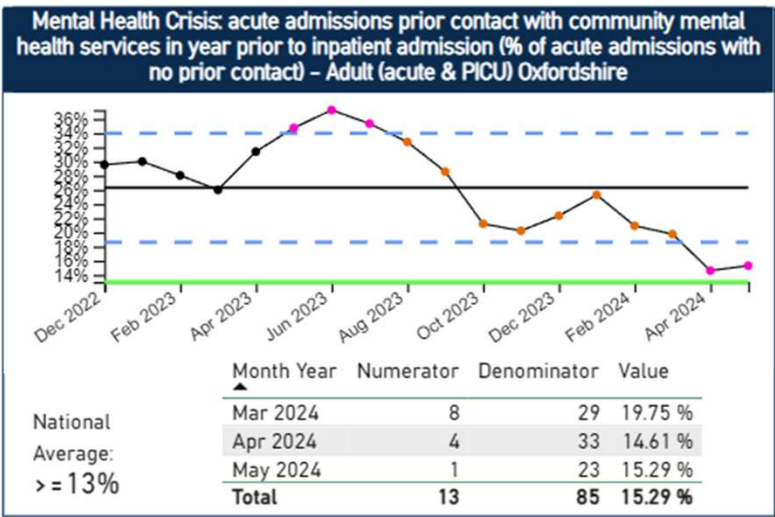
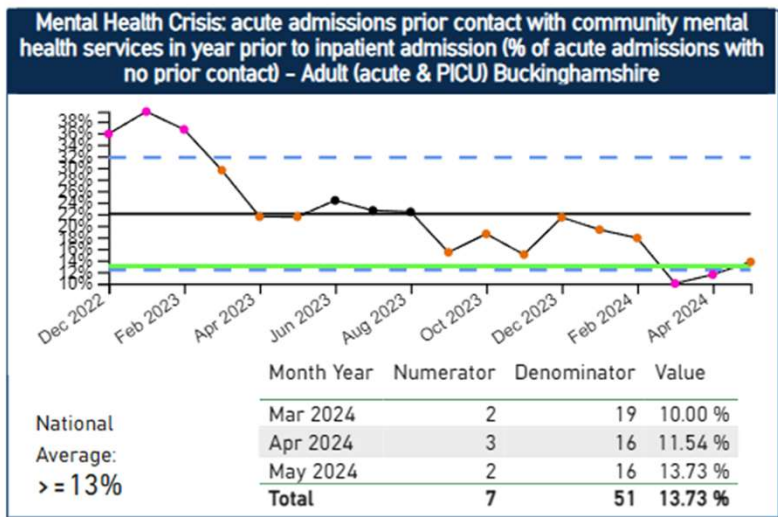
Mental Health services – Acute / In-patients (Adults & Older Adults) – Summary dashboard (2/2)

Narrative provided for metrics under target (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous month	Better is
Acute / In-patients (Adults & Older Adults)						
	Inappropriate adult acute mental health out of area placements - snapshot last day month - Buckinghamshire	3	May-24	0	↓	↓
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Buckinghamshire			0	→	↓
	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Buckinghamshire			0	→	↓
	Inappropriate adult acute mental health out of area placements - snapshot last day month - Oxfordshire	5	May-24	3	↓	↓
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire			0	→	↓
	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire			0	→	↓
NOF	Inappropriate adult acute mental health out of area placements - beds days in month - Buckinghamshire	n/a	May-24	25	↓	↓
NOF	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Buckinghamshire	n/a	May-24	0	→	↓
NOF	Inappropriate older adult acute mental health out of area placements - beds days in month - Buckinghamshire	n/a	May-24	0	→	↓
NOF	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	n/a	May-24	127	↑	↓
NOF	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	n/a	May-24	0	↓	↓
NOF	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	n/a	May-24	0	→	↓

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Mental Health services – Acute / In-patients (Adults & Older Adults)



Summary

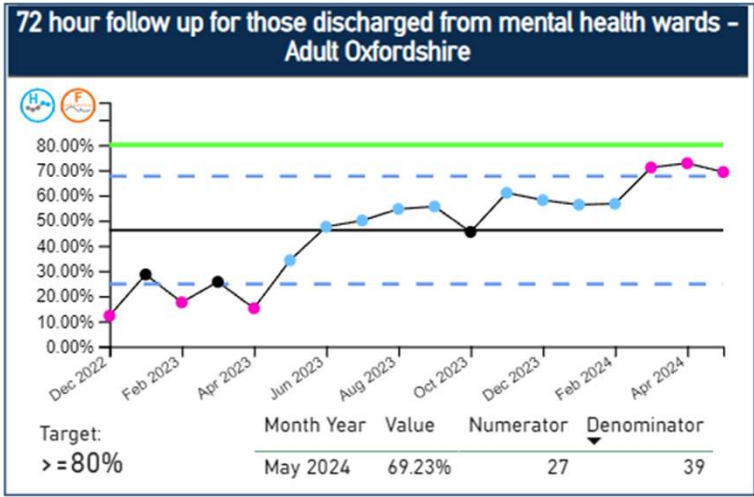
In May 2024, 13.73% of inpatient admissions in Oxfordshire and 15.29% in Buckinghamshire were of those patients who have not had a prior contact with mental health services within the last year. While there is no target set for this metric, the Trust monitors themselves against the national performance average of 13%. Admissions to acute in-patient mental health services should be appropriate, purposeful, therapeutic and safe, and be part of patients Recovery plan. Monitoring of this metrics provides a better understanding and insight into acute admissions.

Actions

- Data recording guidance being rolled out across teams with the aim of improving data input and quality;
- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Patient Flow teams continue reviewing purpose of admissions, estimated discharge dates and communicate plans with service users. Patient Flow teams are completing triages for all new admissions indicating Power of Attorney.

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Mental Health services – Acute / In-patients (Adults & Older Adults)



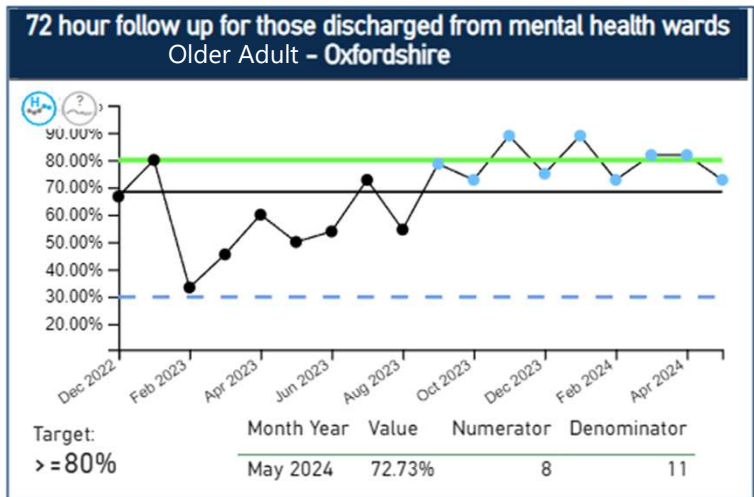
Summary

69.23% of adult patients and 72.73% of older adult patients discharged from mental health wards in Oxfordshire have had a follow up within 72 hours of discharge; target is 80% of discharged patients to be followed up within 72 hours to mitigate risk of dying by suicide following an inpatients stay.

Compliance is measured in days (not hours) and starts the day after the person is discharged from hospital (e.g. if someone is discharged on 1st January, they could be followed up on 2nd, 3rd or 4th January to comply with the 72-hour time period.

Actions

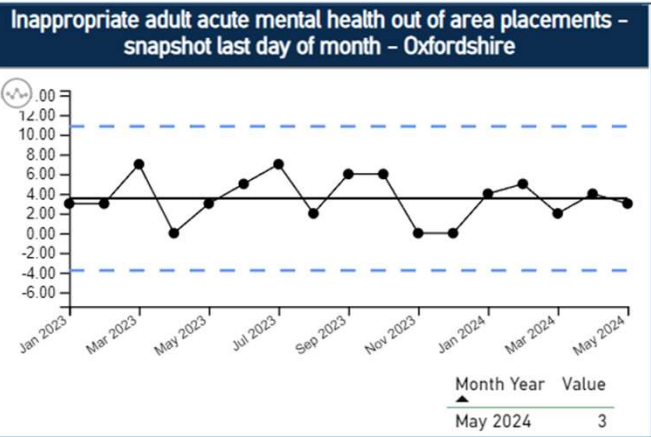
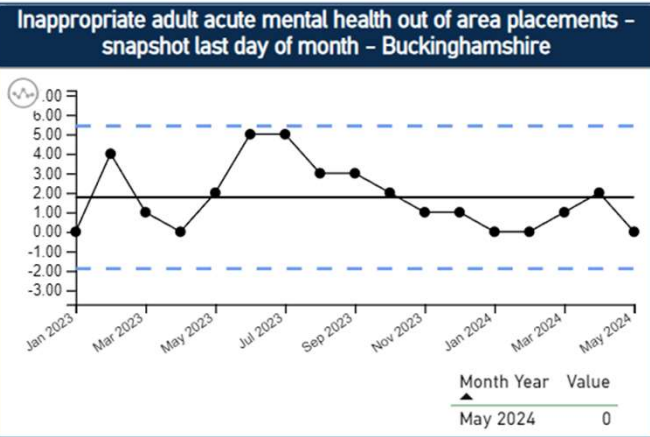
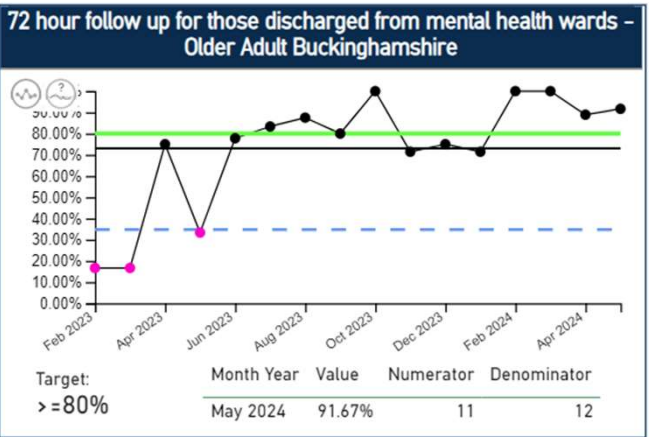
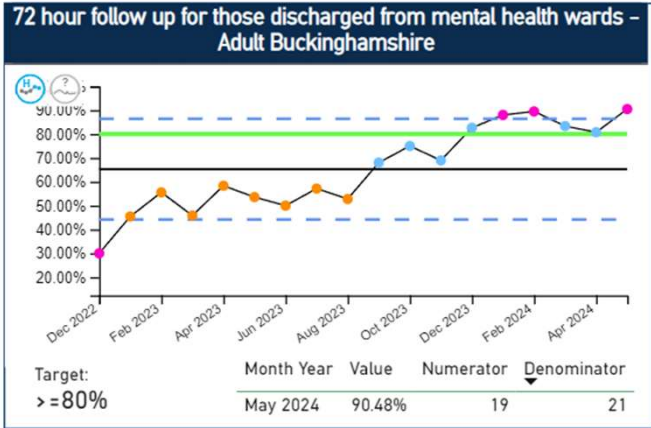
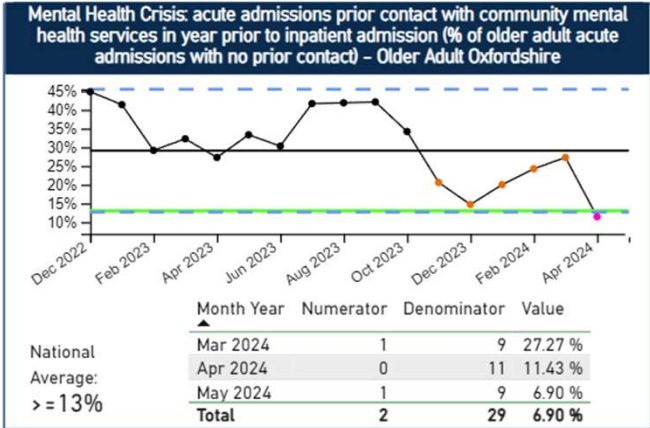
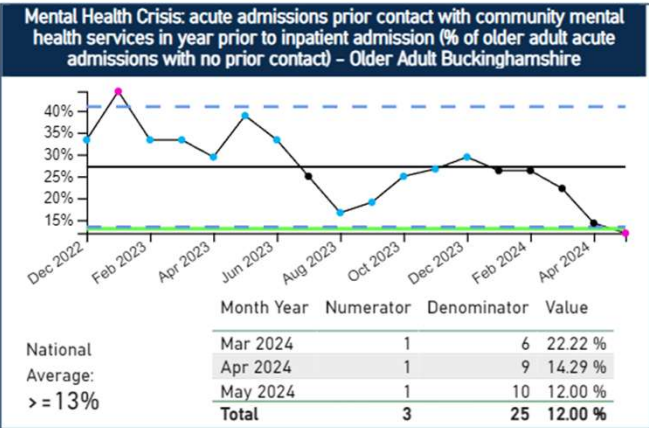
- Data recording guidance being rolled out across teams with the aim of improving data input and quality;
- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;



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Mental Health services – Acute / In-patients (Adults & Older Adults)

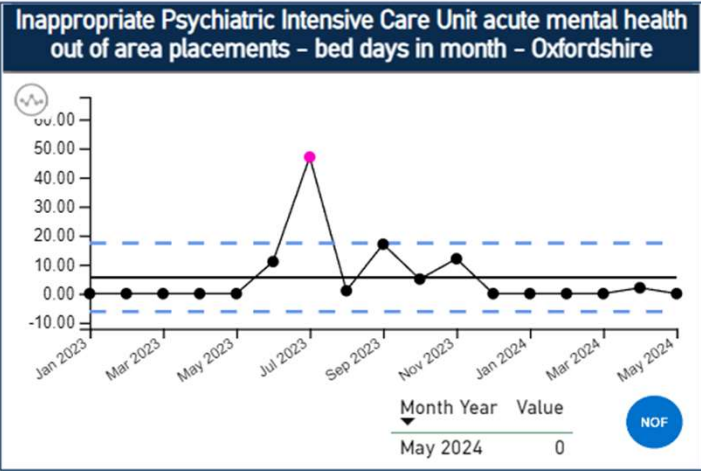
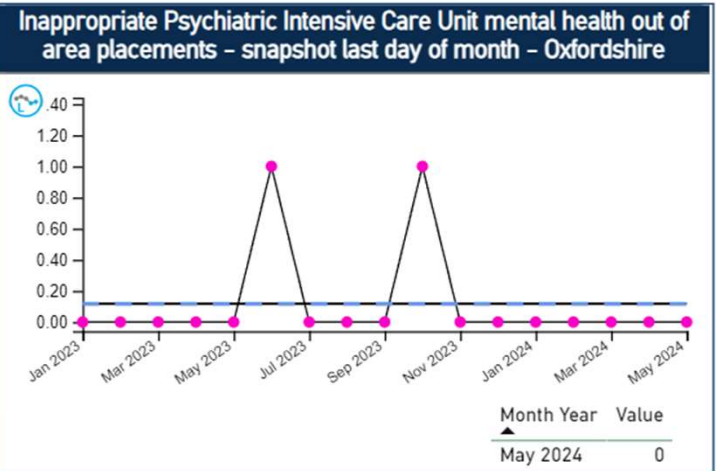
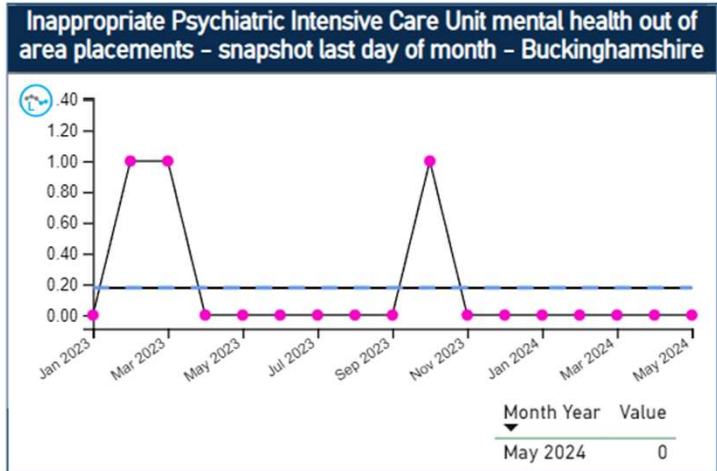
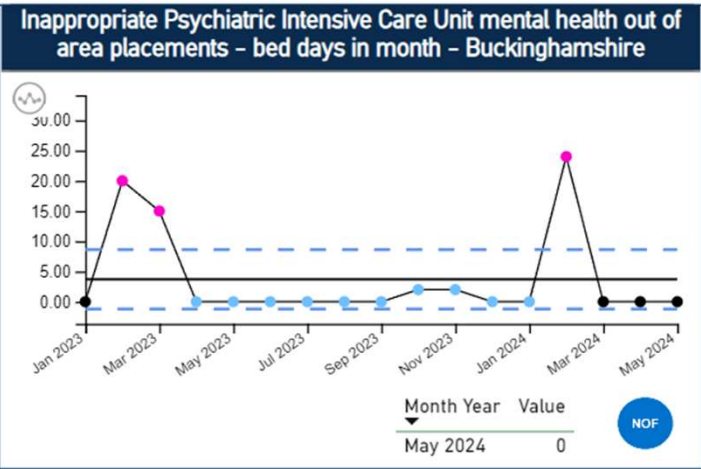
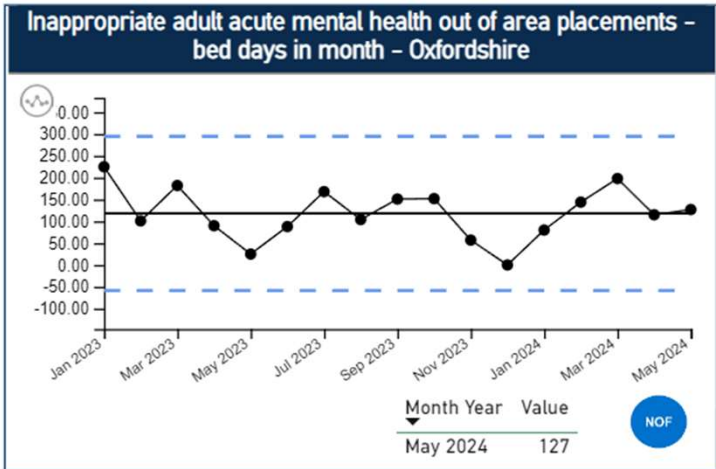
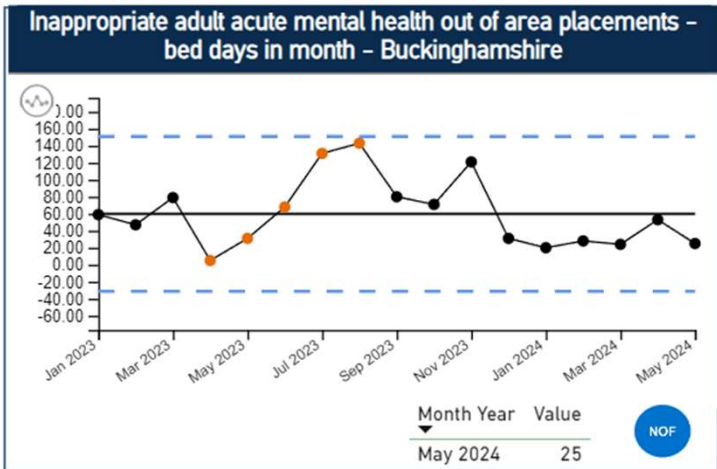
Metrics meeting target, being baselined or with target yet to be confirmed:



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Mental Health services – Acute / In-patients (Adults & Older Adults)

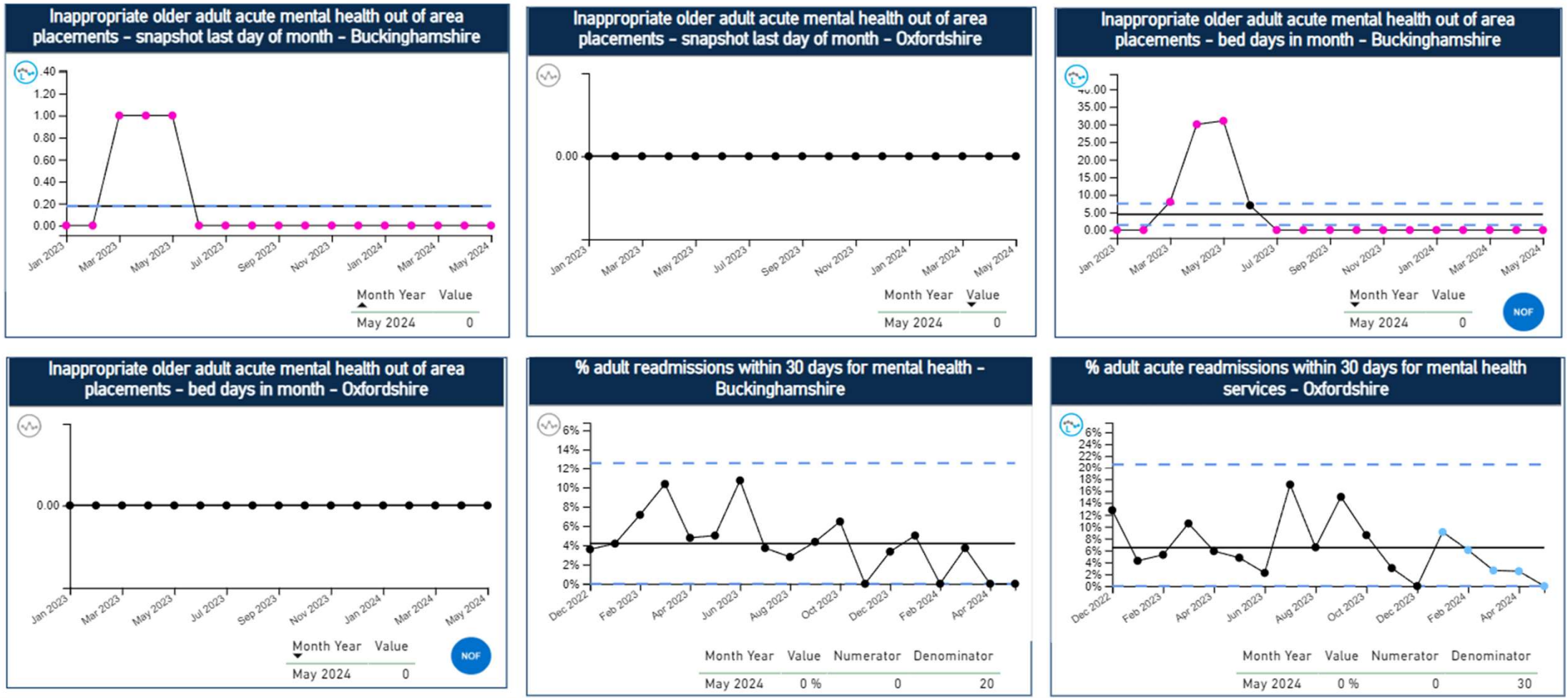
Metrics meeting target, being baselined or with target yet to be confirmed:



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Mental Health services – Acute / In-patients (Adults & Older Adults)

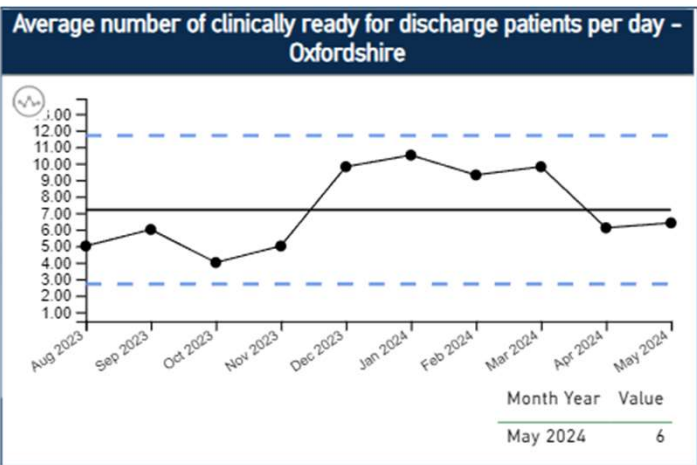
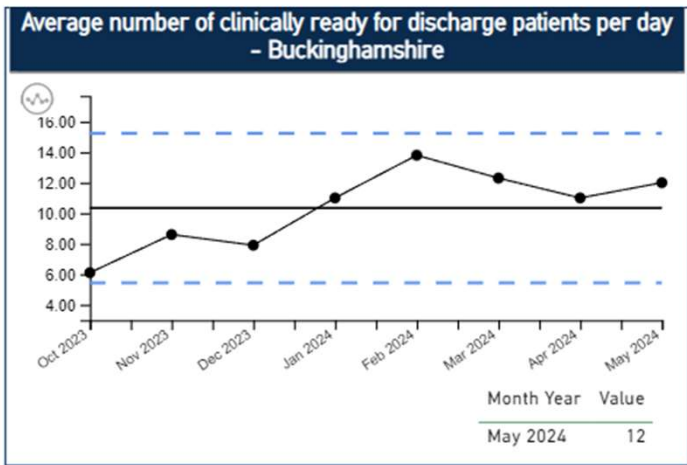
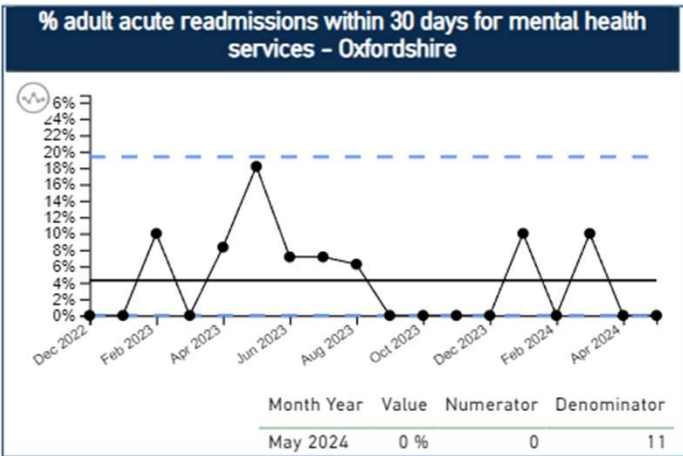
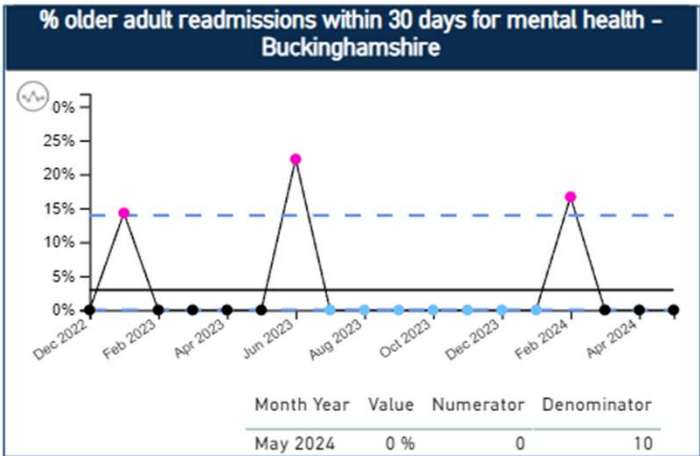
Metrics meeting target, being baselined or with target yet to be confirmed:



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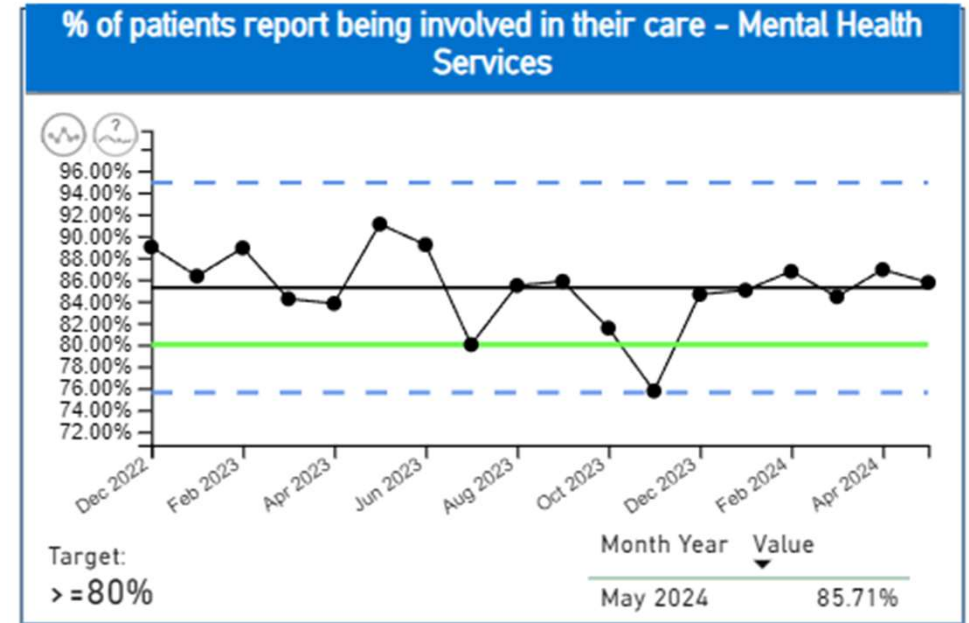
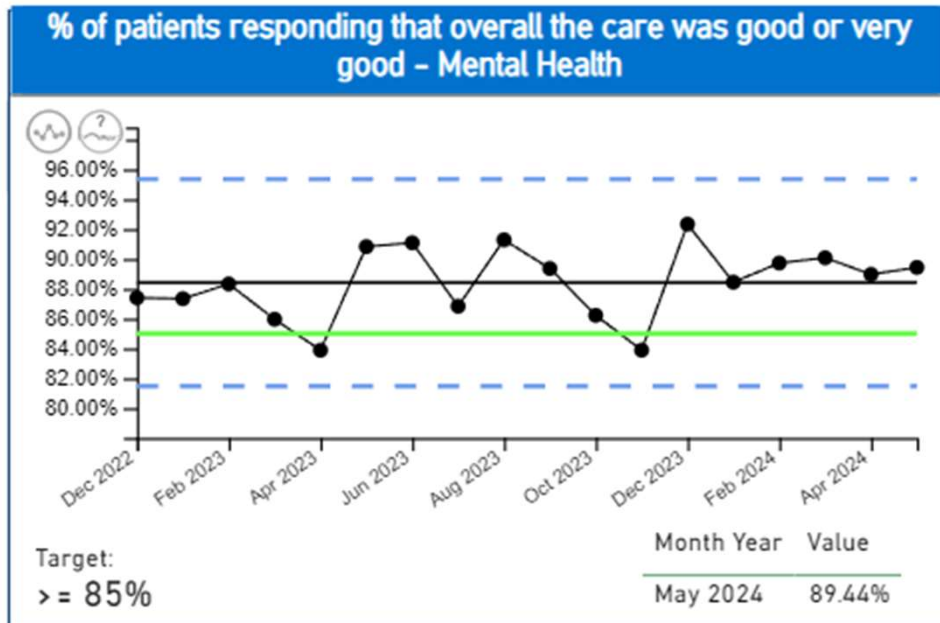
Mental Health services – Acute / In-patients (Adults & Older Adults)

Metrics meeting target, being baselined or with target yet to be confirmed:



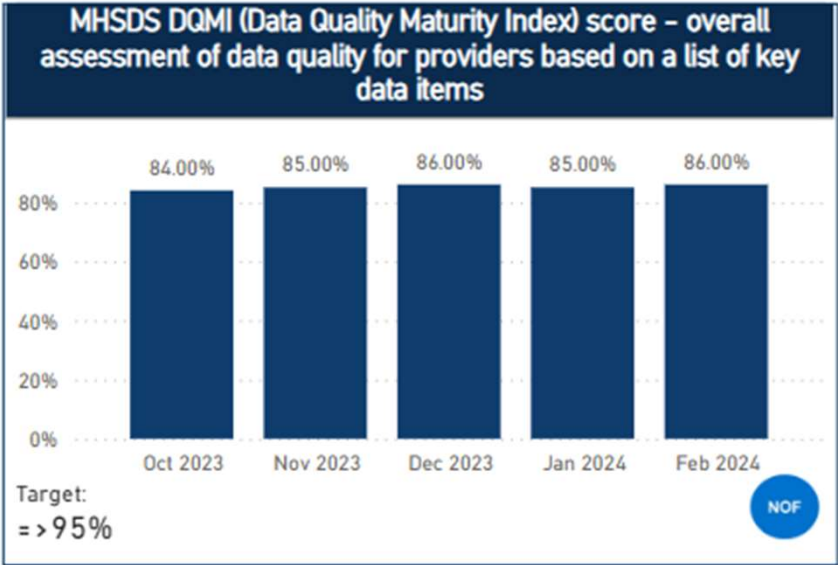
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Mental Health services – In-Year Strategic metrics – For Information only



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Mental Health service – Mental Health Services Data Set Data Maturity Index



Summary

The Trust's DQMI position has been impacted by the reporting outage. The Trust started making MHSDS submissions for FY23/24 in October 2023. The recovery programme continues to progress to enhance the completeness and accuracy of the MHSDS submission. Additionally, there is a national requirement to move to a new version of MHSDS from May data onwards. The Trust is prioritising this redevelopment and will then look to review the DQMI position and take appropriate action to improve.

Actions

- Develop the new version of MHSDS as nationally mandated and then review DQMI position and develop an action plan as needed.

Section 1.2

Clinical performance (Community Health services, Dentistry and Primary Care standards)

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Community Health services, Dentistry and Primary Care services – Summary Dashboard

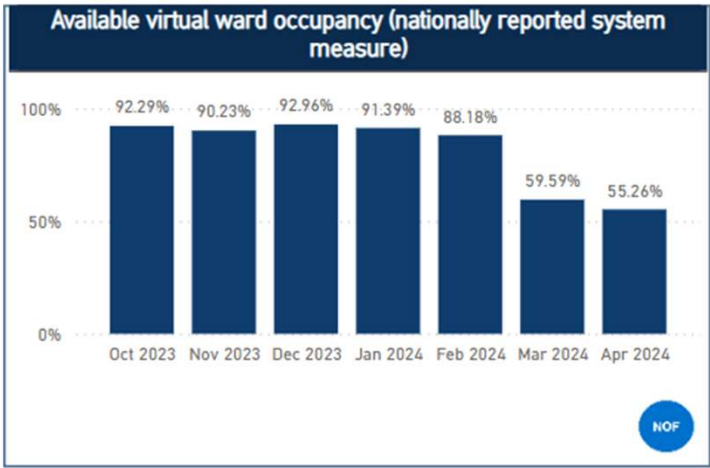
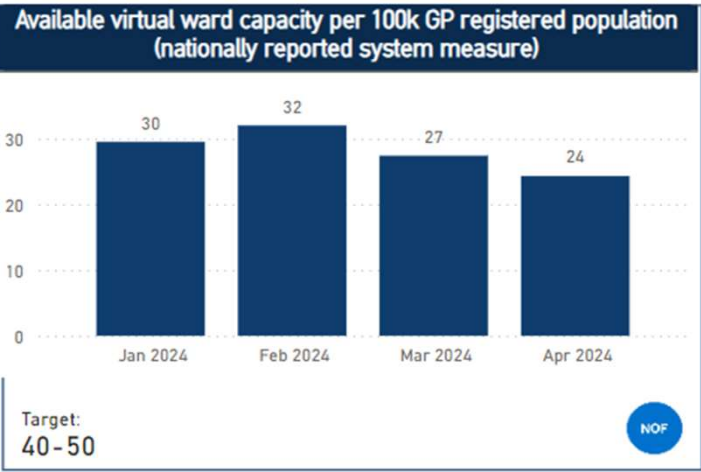
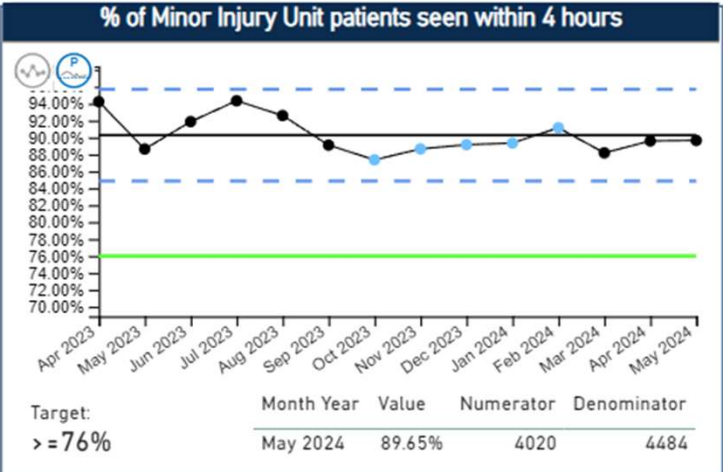
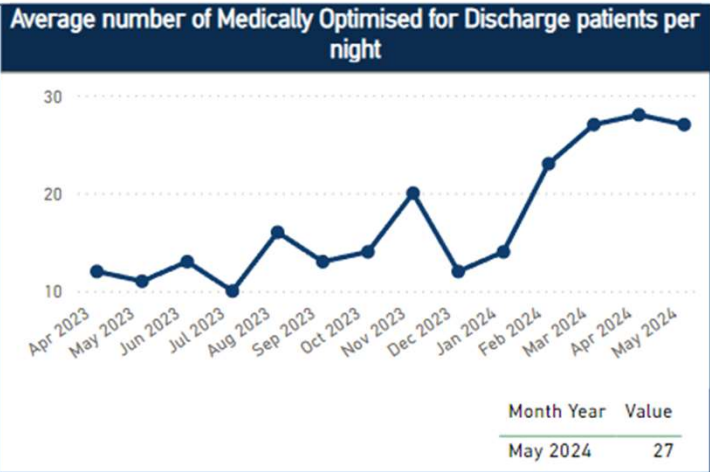
Narrative provided only for metrics under target (value coloured in red) – none in April 2024. Please note that narrative for system measures will not be provided as these are monitored at Integrated Care Board (ICB) level and figures are provided to Trust Board for information only.

Type of metric	Metric	Target	Period	OHFT value	Change from previous month	Better is
	Average Length of Stay in Community Hospitals by basket of care	<i>In development for FY25. Status: Development of EPR required (initiated). Followed by technical development (not started)</i>				
	Average number of Medically Optimised For Discharge (MOFD) patients per night	Baseline	May-24	27	↓	↑
National Objective	% of Minor Injury Unit patients seen within 4 hours	76%	May-24	89.65%	↑	↑
National Objective	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	<i>In development for FY25</i>				
NOF National Objective	Proportion of patients discharged from hospital by pathways	<i>In development for FY25. Status: Development of EPR required (initiated). Followed by technical development (not started)</i>				
NOF	Available virtual ward capacity per 100k head of population (System measure)	40-50	Apr-24	24	↓	↑
NOF National Objective	Virtual ward occupancy (System measure)	TBC	Apr-24	55.26	↓	↑

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Community Health services, Dentistry and Primary Care services

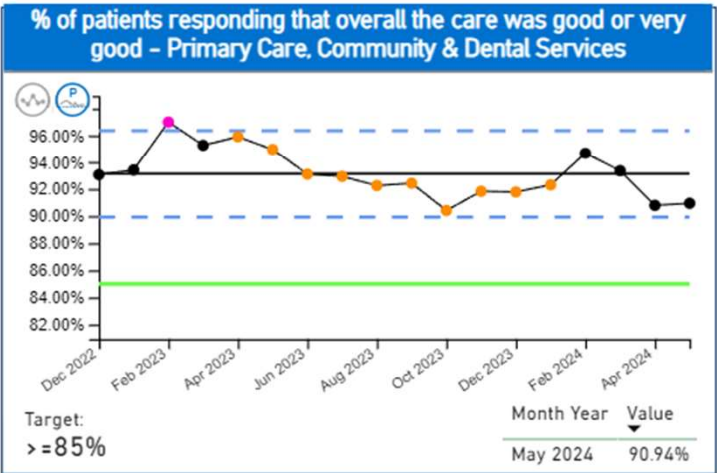
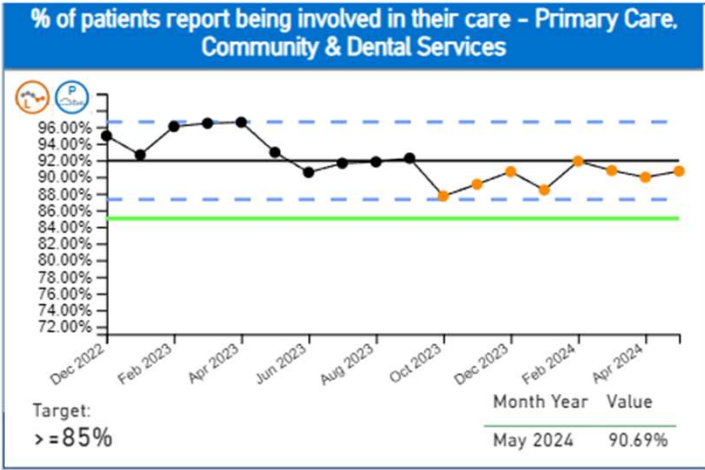
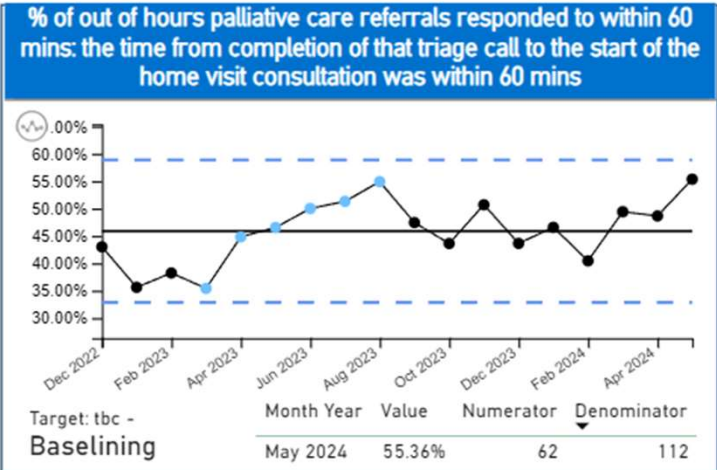
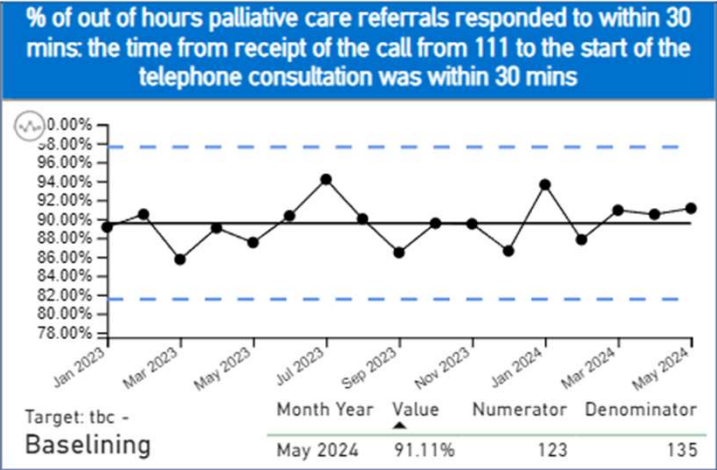
Metrics meeting target, being baselined or with target yet to be confirmed:



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Community Health services, Dentistry and Primary Care services

In-Year Strategic metrics – For Information only



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Section 2

Quality People

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Quality - Deliver the best possible care and health outcomes

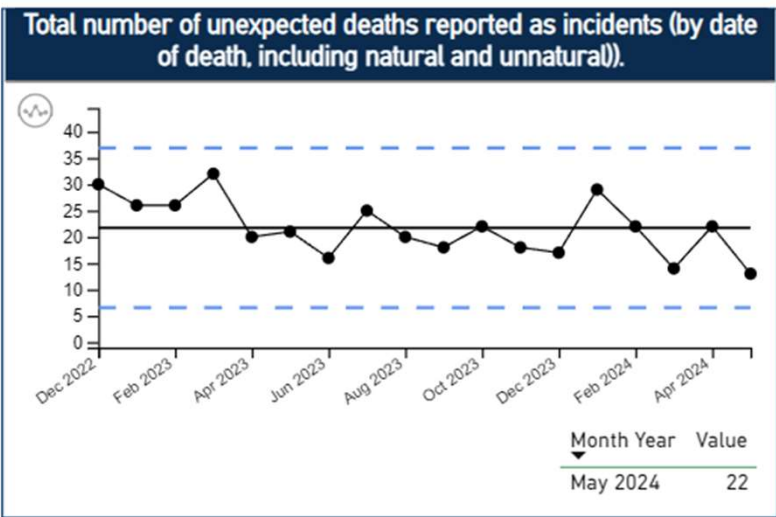
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Quality – Summary Dashboard

Type of metric	Metric	Target	Period	OHFT value	Change from previous month	Better is
	Total number of patient incidents (all levels of harm)	TBC	May-24	1504	↓	↑
	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)	TBC	May-24	22	↓	n/a
	Number of suspected suicides	TBC	May-24	0	→	n/a
	Total number of Patient Safety Incident Investigations (patient incidents of moderate and above harm, excluding deaths)	TBC	May-24	77	↓	n/a
	Total number of incidents involving physical restraint	TBC	May-24	298	↓	n/a
	Total number of complaints	TBC	May-24	8	→	n/a
	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	TBC	May-24	359	↑	n/a
Strategic Metric - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint)	Less than 16 per month	May-24	12	↓	↓
Strategic Metric - Quality	Reduction in use of seclusion (number of incidents involving seclusion)	Less than 48 per month	May-24	36	↓	↓
Strategic Metric - Quality	% of community mental health patients with "My Safety Plan" completed where suicide is identified as a risk within assessment	In development for FY25. Status: Definition of reporting work in progress				
Strategic Metric - Quality	Rate per 100,000 population of detentions on admissions to hospital of black or black British patients in relation to all other ethnic groups	In development for Q1 FY25. Status: Technical development initiated eta July 2024				

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Quality

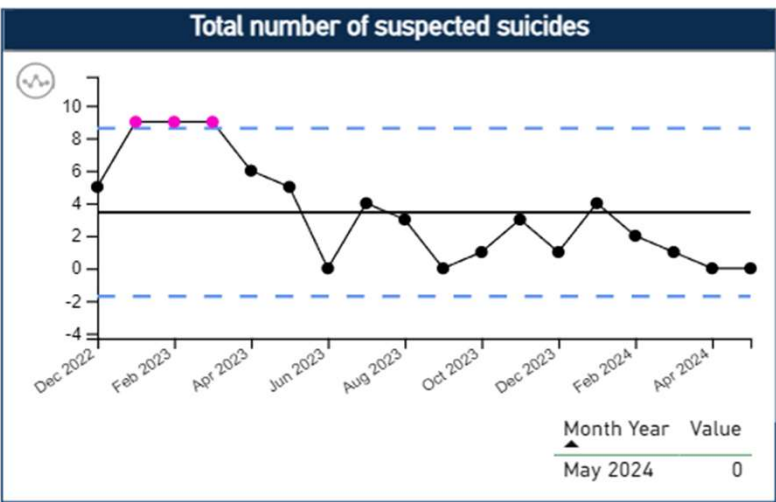


Summary, highlights, actions

The Trust takes our role and responsibilities very seriously around reviewing, learning and taking appropriate actions after a death. The Trust's learning from deaths process reviews all known patients against a national database to ensure we identify and review all deaths, including patients under our care at the time of their death and those who die within 12 months of their last contact. The oversight of key themes and learning is led by the Trust's Mortality Review Group chaired by the Chief Medical Officer which reports quarterly to the QCG sub-committee and Quality Committee.

Our internal process involves 2 senior clinicians screening every known patient death and then depending on the outcome of this initial review and/or the circumstances of the death this is then reported onto Ulysses (graph based on deaths reported onto Ulysses). All unexpected deaths are then scrutinised by the Directorate senior management team through their weekly safety meeting, which will identify any actions and if a further review is required. Alongside this we link into multi-agency reviews for all deaths of children, people who are homeless, and people with a diagnosis of autism and/or a learning disability. As well as coroner inquests and the BOB ICS learning from deaths network.

In line with the national programme and new legislation, we are working with the regional medical examiner officers hosted by the local acute hospitals, to expand the roll out of the independent medical examiner role for inpatient deaths from Sept 2024.



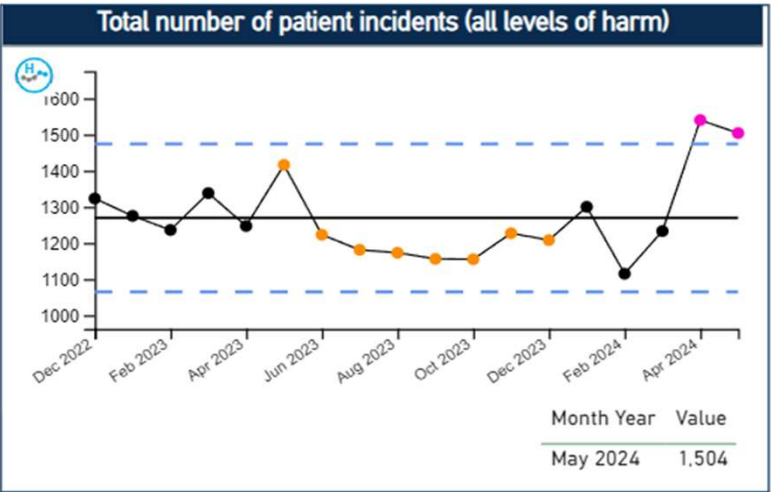
Summary, highlights, actions

All suspected suicides are identified in real-time daily and reviewed. Most will have an incident learning huddle completed with the clinicians involved in addition to the offer of psychological support to staff and support to bereaved relatives. We also receive and review suicide data from the real time surveillance system for the whole population in the Thames Valley area.

The Trust has a Suicide Prevention Group to steer our work linked into national and regional priorities and also the work of the Oxford Centre of Suicide Research. There has been lots of work in the last year on training/education around suicide risks and prevention. The regional Suicide Prevention and Intervention Network (SPIN) continues to meet quarterly, which enables regional oversight of data, actions, sharing of information and progress against national strategy.

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Quality

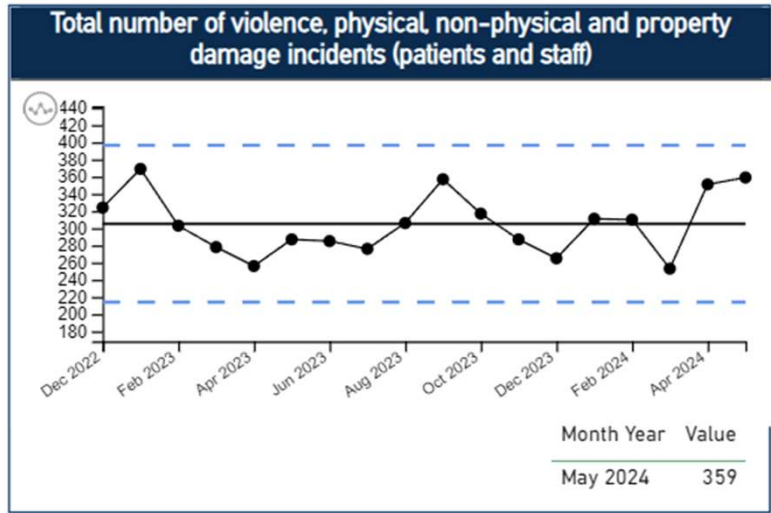


Summary, highlights, actions

During May 2024 most incidents related to self-harm (patient striking self/ tying ligatures) or violence from patients towards staff (no physical injury or were verbal abuse). The majority of incidents resulted in no harm/near misses (51%) or minor harm (41%).

The 3 Children and Adolescent Mental Health (CAMHS) wards including the new PICU (Psychiatric Intensive Care Unit) reported the highest number of incidents in April and May 2024 (and showed an increase over the last 2 months) mostly involving a small number of patients carrying out self-harming behaviours. The increase in incidents correlates with an increase in use of restraint (see next slide for more details). The CAMHS wards have a positive reporting culture to use incident data to identify trends and learning, with nearly all incidents resulting in no harm or minor harm.

A deep dive has been completed across all CAMHS wards to look into themes from incidents, use of restrictive practice and some of the staff challenges highlighted in the quality and safety dashboard.

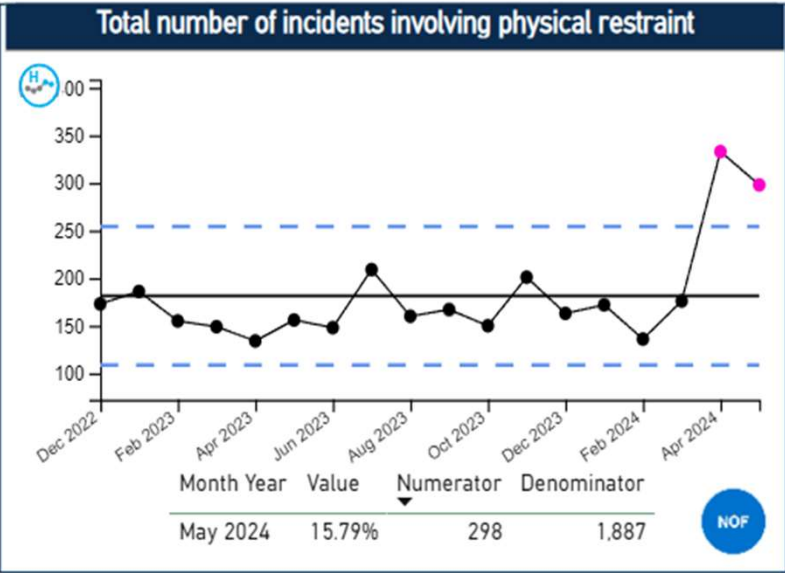


Summary, highlights, actions

There is no significant change over time in the number of violent incidents reported. The majority of incidents are on our mental health inpatient wards and relate to violence from patients to staff with no injury, verbal abuse by patients to staff and threat of violence patients to staff. In May 2024 - 62% of the incidents caused no harm and 36% caused minor harm. 12% of the violent incidents were reported as associated with racial discrimination – predominantly on 2 wards.

There is a new violence working group to review data and themes arising from incidents experienced by staff and undertake improvement activity to increase staff safety and identify early triggers to deescalate violence, this coupled with work to increase the safety and security of inpatient environments and work within the Positive and Safe Committee to continue to reduce the use of restrictive practice.

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Summary, highlights, actions

The use of physical restraint significantly increased in April 2024, this is largely attributable to two Child and Adolescent Mental Health Services (CAMHS), Highfield and Meadow Psychiatric Intensive Care Units (PICU). Although a reduction in May, there remains an increased level of restraint attributable to these two units.

- CAMHS Highfield Unit: 67 of the incidents reported, decrease from the previous month of 106 uses of physical restraint. The high levels during May have been due to nasogastric feeding (37) and the management of self-harm (19) 10 individuals were restrained during May.
- CAMHS Meadow Unit (PICU): 90 incidents reported, an increase from the previous month of 82 uses of restraint. The increase relates to 4 young people. The restraint were due to management of self-harm and violence towards others. Each person has an individual Positive Behavioural Support (PBS) plan to support use of least restriction. The staff team complete the management of self-harm and ligature training and are working closely with the PEACE team to reduce restrictive practice

A focussed review of restrictive practice across CAMHS services is underway to better understand the challenges and provide support to work with young people in least restrictive ways.

The total number of restraints was 300 involving 59 patients spread across 21 wards. Both eating disorder wards (Cotswold house Oxford & Marlborough) saw increased restraint with 19 & 17 restraints largely due to nasogastric feeding, but also self-harm.

Quality

Reduction in the use of prone restraints (number of incidents involving prone restraint)



Summary

Reduction in the use of restrictive practices remain as key priority for the trust in line with the requirements of the Mental Health Units (Use of Force) Act 2018.

Use of prone restraint (being held in a face or chest down position) carries increased risks for patients and should be avoided and only used for the shortest possible time.

The most common cause for utilising this type of restraint is Health followed by violence, followed by self-harm and health. In May the most common cause was Health, followed by Self harm. The prone position is used mostly to administer immediate medication via intramuscular injection (IM) followed by seclusion exit procedure.

Highlights

The graph shows the use of prone by month for all wards over the last year. The Trust can demonstrate a sustained reduction in use of prone restraint since 2021. However, during April 2024 this increased above the trend line with 31 uses of Prone. This has reduced back down to 10 uses of Prone in May 24.

The 14 episodes of Prone in May involved 12 patients were spread across 10 wards. 10 episodes were to enable administration of IM medication.

The Positive and Safety Strategy work is focusing on quality improvement projects around the use of prone for IM medication and for seclusion procedures.

Reduction in use of seclusion (number of incidents involving seclusion)



Summary

Reduction in the use of restrictive practices remains as a key priority for the trust in line with the requirements of the Mental Health Units (Use of Force) Act 2018.

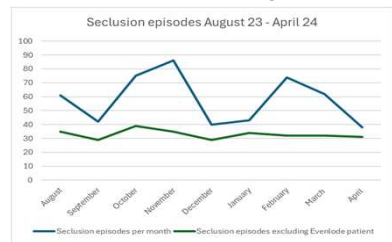
Seclusion is only utilised when all other options to manage the situation without the use of restriction have been considered and exhausted. In very rare situations individual patients may have bespoke care plans that include access to seclusion as a therapeutic option.

The most common reason that seclusion is utilised is to support the management of violent and aggressive behaviour

Highlights A significant increase in the use of seclusion is noted since August 2023, this is largely attributable to a patient on Evenlode who has an individualised plan that includes the use of seclusion to support them to feel safe and secure and aid their ability to sleep and rest. In May there were 3 seclusion episodes for this patient, the decrease in use has contributed to the reduction in episodes across the trust this month although the person has had long periods of seclusion but with a care plan that supports to access activities outside of seclusion.

Removing this individual patient data shows the use of seclusion across the trust did not rise over 39 episodes in any single month over the past 16 months sitting below the target threshold of less than 48 episodes a month, data presented in chart to the right

In May there were 36 seclusions across 13 wards, involving 22 patients. The highest use of seclusion within the month was on Ashurst PICU (n=6), Ruby 9n=5) & Meadow CAMHS PICU (n=5



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Quality

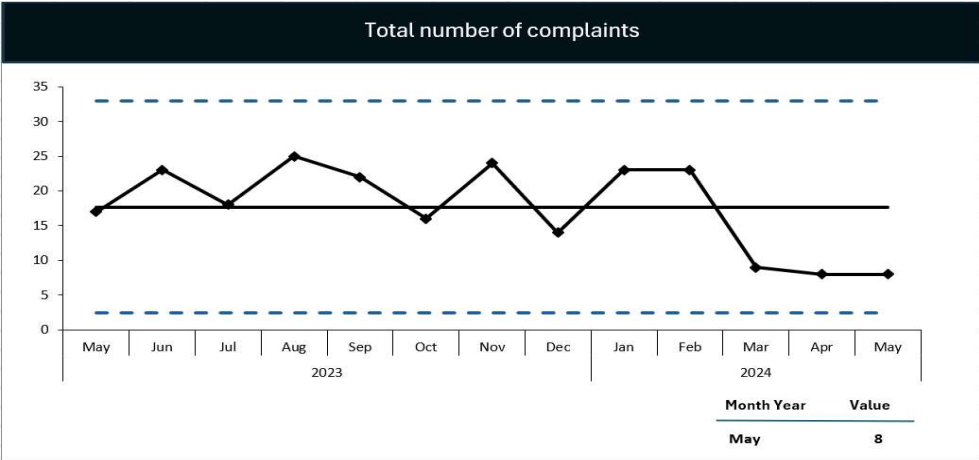
Summary, highlights

The Trust continues to value all complaints and concerns raised to use these as opportunities to make improvements. We actively monitor the key themes identified within complaints received alongside information from other sources of feedback such as Patient Safety Incidents, Legal Claims, Inquests and HR investigations. Discussions to triangulate the information take place on a weekly basis at the Trust-wide Clinical Weekly Review Meeting and monthly at the Trust-wide Quality and Clinical Governance Sub-Committee. There is a new national Complaints standards since December 2023 and we are in the process of implementing it. The new standards focus on the following pillars:

- 1. Welcoming complaints in a positive way.
- 2. Early resolution.
- 3. Being fair and thorough.
- 4. Learning from complaints.

During the month of May, the Trust received 36 rapid resolution complaints, seven (7) low-level complaints and one (1) high-level complaint. The breakdown of low/high level complaints by service was as follows: Ruby Ward, Wintle Ward, CAMHS Wiltshire SPA, CAMHS Bucks Eating Disorder Service, CAMHS Highfield, AMHO Adult ADHD, Physical Disability Physiotherapy Service and Community hospitals Didcot Ward. Of the total number of complaints, the following services received two complaints; AMHO Adult ADHD, CAMHS BANES Getting More Help, CAMHS BANES Getting More Help, CAMHS Oxon NHC Pathway, CAMHS Swindon LD, CAMHS Wiltshire SPA and EDPS. 17 of the total number of cases related to CAMHS.

In terms of compliments, 276 were received across the Trust in May. These are broken down by directorates as follows; Buckinghamshire Mental Health = 21, Oxfordshire & BSW Mental Health= 138 Primary and Community Services = 98, Specialised Services = 11 and Corporate Services = 8. The top four teams with the highest number of compliments were as follows; Talking Therapies (Oxon) Including Employment Service, Cotswold House, Oxon (Eating Disorders Unit), Eating Disorders Wiltshire Community Team (Adult) and Ageing Well (Urgent Community Response).



Note: Recent changes to the Complaints procedure introduced the following terms: rapid resolution complaint (previously known as concern) and low/high level complaint. At present the above graph shows only a number of low/high level complaints – development work is underway to incorporate rapid resolution complaint reporting on Trust Online Business Intelligence (TOBI) system.

Actions :

- Early resolution.
- Working with teams to ensure, service and team managers are contacting individuals within the 72 hours when concerns are raised and making sure the early resolution process is completed within 15 days time frame. To continue with engagement process with teams to continue to socialise the new standards and new ways of managing concerns and complaints.
- Extensions process: To strengthen the process within directorates with a greater oversight for clinical directors by introducing some KPIs and auditing of standards.
- Learning from complaints and sharing learning
- To introduce complaints panels

People - Be a great place to work

Caring, safe and excellent

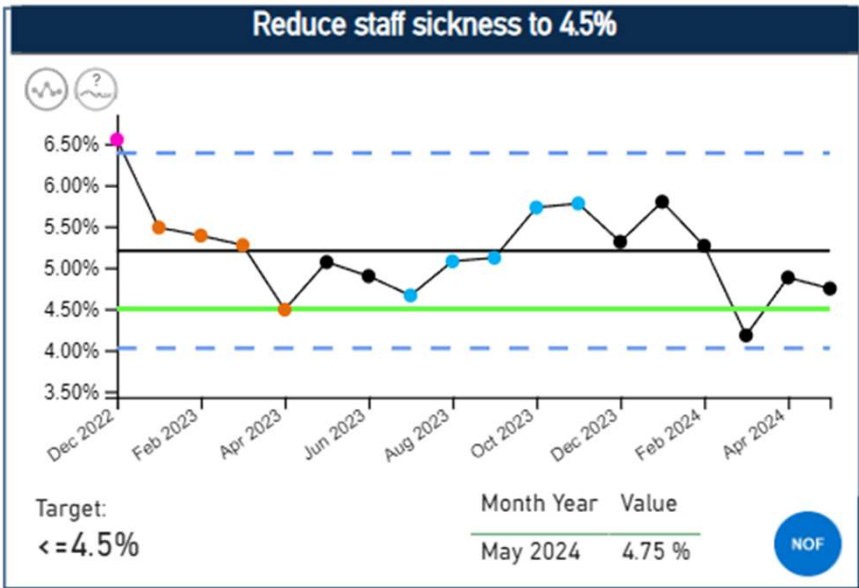
People metrics – Summary Dashboard

Type of metric	Metric	Target	Period	OHFT value	Change from previous month	Better is
NOF	Aggregate score for NHS staff survey questions that measure perception of leadership culture	In development for Q1 FY25				
NOF	Staff survey bullying and harassment score	In development for Q1 FY25				
NOF	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	TBC	May-24	77.93%	↓	↑
NOF	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	In development for Q1 FY25				
NOF	Reduce staff sickness to 4.5%	4.5%	May-24	4.75%	↓	↓
	PDR compliance*	95%	May-24	39.07%	↑	↑
NOF	Reduction in vacancies	9%	May-24	12.72%	↑	↓
	% of early turnover	14%	May-24	14.00%	↓	↓
	Statutory and mandatory training compliance	95%	May-24	89.58%	↑	↑
	Clinical supervision completion rate	95%	May-24	79.3%	↑	↑
	Management supervision rate	95%	May-24	72.5%	↑	↑
Strategic Metric - People NOF	Reduce agency usage to meet target (% of agency used)	6.50%	May-24	10.84%	↑	↓
Strategic Metric - People	Reduction in % labour turnover	14%	May-24	12.00%	↓	↓
Strategic Metric - People	% of staff completing Quality Improvement Training Level 1	In development for FY25, Status: plan to make part of stat training in OTR from July 24 onwards (initiated). Technical development initiated for wider OTR reporting. Specification of this measure not yet initiated				
Strategic Metric - People	Black, Asian and Minority Ethnic (BAME) representation across all pay bands including Board level.	19%	May-24	23.42%	↑	↑
Strategic Metric - People NOF	Black, Asian and Minority Ethnic (BAME) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	19%	May-24	12.44%	↑	↑

- PDR season between 01 April and 31 July 2024, therefore no narrative provided currently. PDR compliance rate at 67.25% as of 04.07.24
- NOF (National Oversight Framework) NHS England's approach to oversight of integrated care boards and trusts. The Oversight metrics are applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework. The metrics are under review and subject to change.

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People



Summary

The sickness absence slightly decreased from 4.88% to 4.75%.

Whilst sickness absence remains just above target the proportion of long term versus short term cases remains broadly consistent with the previous month. The most common reasons for absence based on number of cases were Cough/Cold, Headache, Gastrointestinal, Anxiety/Stress non-work related and Flu.

Actions Sickness Absence

The HR Operational teams continue to work closely with the Good Shape absence management team to review the management of individual sickness absence cases. The HR Operational Teams are particularly focussing on the areas with the highest levels of absence.

As Stress/Anxiety non work related continues to be one of the key reasons for absence, we continue to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees. We also continue to signpost to the various support/assistance programmes that are available (e.g. our Employee Assistance Programme).

Focus on upskilling managers, including manager briefings and bespoke absence management training continues. We are also working on virtual e-learning sessions to make accessing training modules and materials easier for managers.

Actions Occupational Health/ Well being

The Occupational Health undertook 223 management referrals, 5 self-referrals and 72 reviews during May. Of the 37 management referrals relating to Musculo-skeletal (MSK) causes, 15 were attributed to work-related issues. 41 physiotherapy treatment sessions were undertaken in relation to MSK issues impacting work. From a mental health and stress (both attributed to work and non-work-related causes) 60 referral appointments were completed.

The Staff Psychology Service received 8 new referrals during May and completed 72 consultation/assessment/treatment sessions.

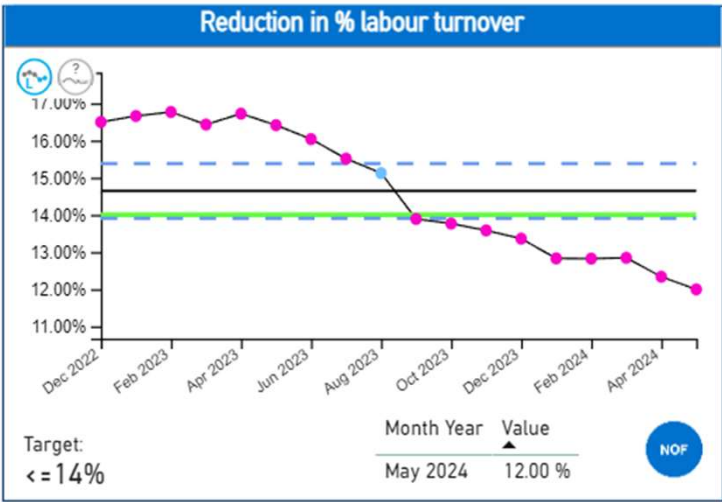
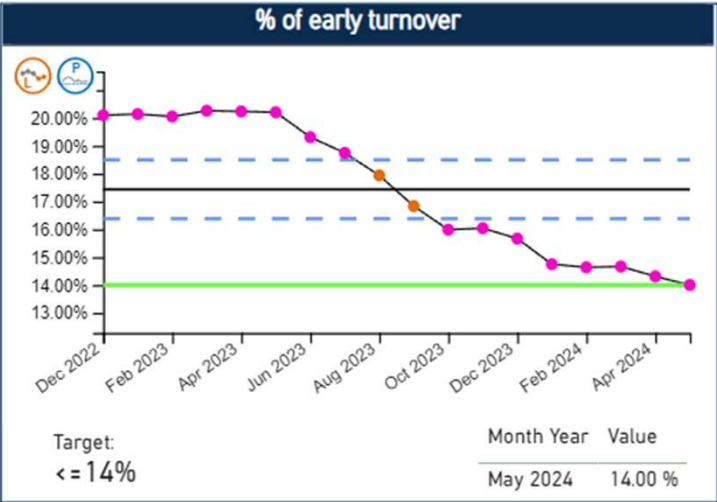
Other activities included workstation specialist advice/assessment; management of blood borne virus incidents and case conferences working alongside HR colleagues in support of employees and managers.

The health & wellbeing team continue to take a proactive and preventative approach. The data indicates the need / importance of the civility & respect/Kindness into Action and RJLC cultural change work along with the importance of Wellbeing conversations.

Employee Assistance Programme: 77 Counselling calls, 12 legal calls, 32 calls for mental health support, Health & Wellbeing Team-19 confidential contacts
Themes: Line manager/ senior manager -12, Teams – 4, Mental wellbeing – 3

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People



Summary

Staff turnover decreased from 12.33% to 12.00% and remains below the 14% target. Early labour turnover has also decreased from 14.31% to 14.00% which means it is now within target.

The early turnover of BAME staff is considerably higher than turnover of white staff with a reported 18.11% of staff leaving within 12 months of start date.

High levels of turnover impact on vacancies, agency spend, quality of patient care and staff experience so the Trust has put in place a number of interventions to improve the staff experience, and these are ongoing.

Note: Reduction in % labour turnover is an In-Year Strategic metric

Actions

The Retention team has taken a universal approach to reducing retention and a number of key activities, together with wider economic changes, have led to a reduction in both total turnover and early turnover. We now need to take a more segmented approach to allow us to focus attentions on the more stubborn areas and reduce the gap between white and non-white staff in particular.

The retention team are currently carrying out a full data analysis looking through a number of different lenses to identify high areas of impact. The Retention Team will make recommendations to the People Steering Group (PSG) on 19th August to agree the areas of focus so that we can move to action.

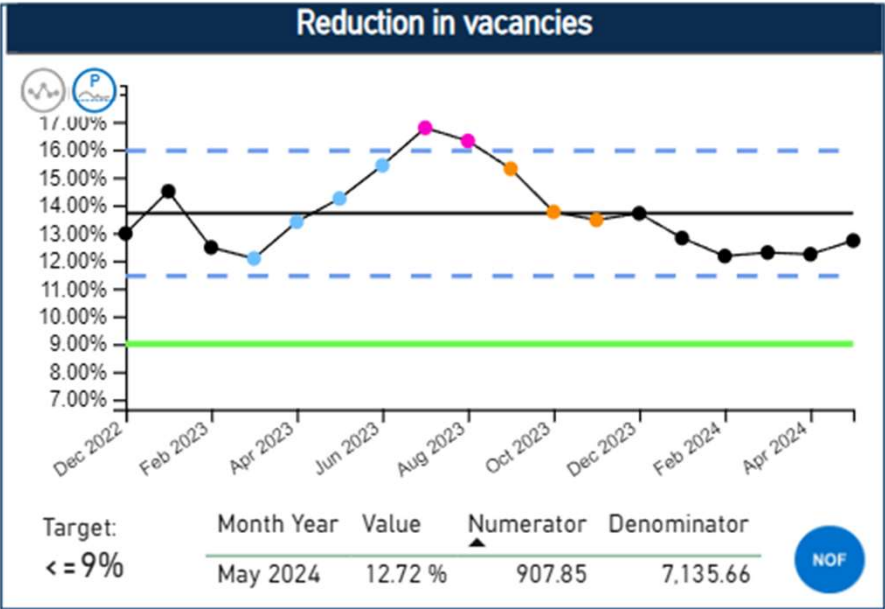
The following projects are ongoing:

- New starter Onboarding Experience – a number of improvements have been made as a result,; this is an ongoing project.
- Talent Management – currently in the scoping phase, Options appraisal and recommendations to be made by 31st July 2024.

The People Promise Manager started on 4th June and has completed the self-assessment tool which has been submitted to the ICB. A Project Initiation Document (PID) has been written to identify key areas of focus for the coming 12 months. Alignment with the findings of the retention team analysis over the past 12 months will allow for a clear strategy developed with a clear timeline of strategic interventions over the next 1-5 years

Staff leaving the NHS has decreased from 7.16% at the end of April to 7.11% in May 24.

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Summary

The vacancy rate has increased from 12.23% to 12.72%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients. The length of time that it is taking to hire an employee results in candidates withdrawing from recruitment process or securing roles in other organisations.

Hiring challenges due to low unemployment, an increasing number of budgeted posts across the Trust, talent market conditions, talent and skills shortages in key areas such as nursing alongside the high cost-of-living and below inflation pay offer is impacting on staff recruitment.

Actions:

The Trust budgeted establishment has continued to increase, month on month, from 6,776 FTE in May 2023 to 7,135 in May 2024, an increase of 359 new posts created within the last year, with 78 new posts (budget FTE) created between April 2024 and May 2024.

The recruitment transformation QI project is ongoing, based on survey feedback gathered in the discovery phase, the project team are now reviewing application requirements with a view to adding a range of application forms to TRAC, these will be based on the application needs of each staff group, tailored to remove barriers to entry. The project group are exploring options to improve accessibility and inclusivity in the application and shortlisting stage, removing avenues for bias creep, this includes looked at new technology to support the application process.

The one-stage offer process is being trialled with the District nursing team after recent successful recruitment campaigns where over 30 nurses have been offered roles.

Recruitment events continued throughout June, including University careers days, and a recruitment open day for District nursing. Recruitment Roadshows have been very successfully, they have now closed for this season, and have taken place in Aylesbury (Whiteleaf Centre), Swindon (off-site), Banbury (off-site), Oxford (Unipart) with the final roadshow for this programme taking place in High Wycombe (off-site). The campaigns team have begun to book event space for a second roadshow later this year, in November 2024.

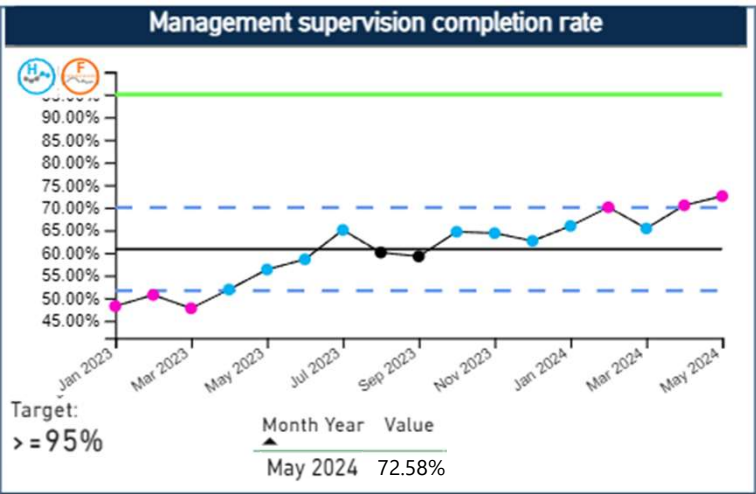
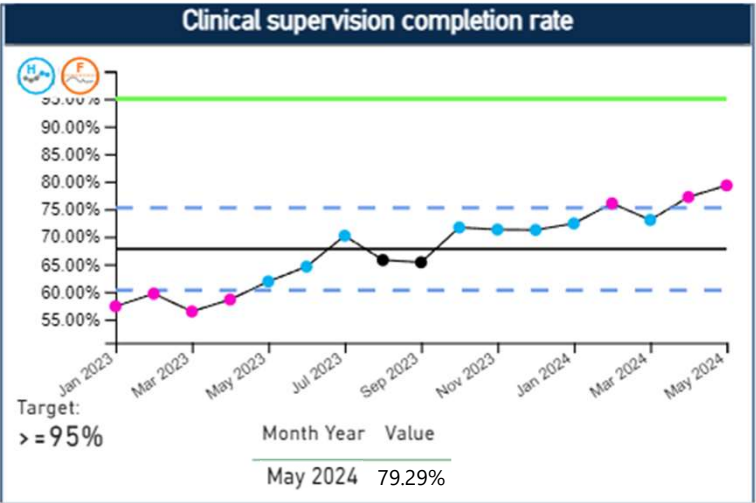
Priorities:

The recruitment team are working on ensuring that the new immigration legislation that came into force in April 2024 does not unnecessarily impact our workforce, all Home Office reporting and monitoring is currently up to date and a process has been developed for ongoing monitoring and reporting. The team are now looking at the longer-term impact of the visa changes to the future workforce, whilst being aware that the legislation may change post the July general election.

The new centralised recruitment phone line is now live and is fully active, this has now been advertised on the Trust website / careers page. This will aid the improved customer service approach we want to provide to all candidates.

Recruitment roadshows and events have been the priority throughout May and June, ensuring prospective candidate details are captured and skills tagged on a talent pool, allowing us to continue to engage with these individuals and reach out about future vacancies that may meet their needs. Success data will be presented over the coming months.

People



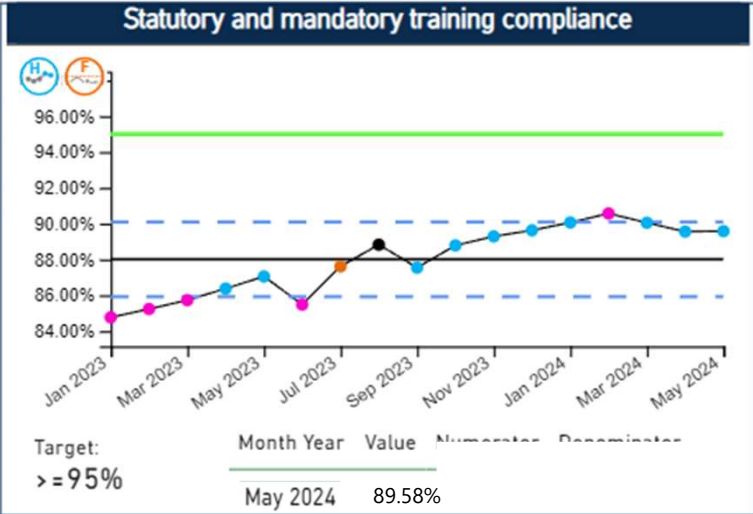
Summary

Good quality and regular management and clinical supervision is essential for ensuring that we provide high quality patient care and that we support staff in relation to their professional development and wellbeing. Whilst improvement has been slow there has been an upward trajectory of both clinical and management supervision since January 2023. Clinical supervision rate went up by 3% compared April '24 (from 77.2% to 79.29%). Management supervision rate also went up by 2% compared to April '24 (from 70.5% to 72.58%).

Action

- The Supervision steering group has now been stopped, and oversight of supervision has been moved to the Education Strategy group with the next meeting on 23rd July 2024.
- The Head of Learning and Development and the Deputy Chief Nurse have started a QI project with the aim to understand how to improve the Trust supervision compliance rates. (The first QI project was undertaken 18 months ago and did improve compliance rates as the trajectories illustrate).
- This review will include, better alignment of Trust supervision reporting with CQC requirements, a rewrite of the Trust supervision policies and clearer definitions of clinical, professional and management supervision to ensure processes and expectations are clear to all staff. Both Professional and Directorate leads will be invited to input into this project.
- Last PDR season, it was felt that staff were not recording their supervision whilst PDR's were taking place. This year, communications has and continue to go out during the PDR season, reminding staff to record supervision at the same time.

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Summary

The percentage of Statutory and Mandatory training modules reported as complete at the end of May has remained much the same 89.58%. Individuals who have not completed their training may not have the skills and knowledge to carry out their role safely.

- The dip in compliance can be attributed to:
- the fact that The L1 Oliver McGowen was added to the overall compliance reporting as planned and
 - the need to add a re-certification training to the Trust Conflict resolution training in line with the National Statutory and mandatory project and Core Skills training framework requirements.

Staff continue to report that at times due to ongoing staffing pressures, they are not being released to attend. Work continues to correct anomalies in job roles to ensure accurate training is allocated to each staff member as this remains an issue.

Actions

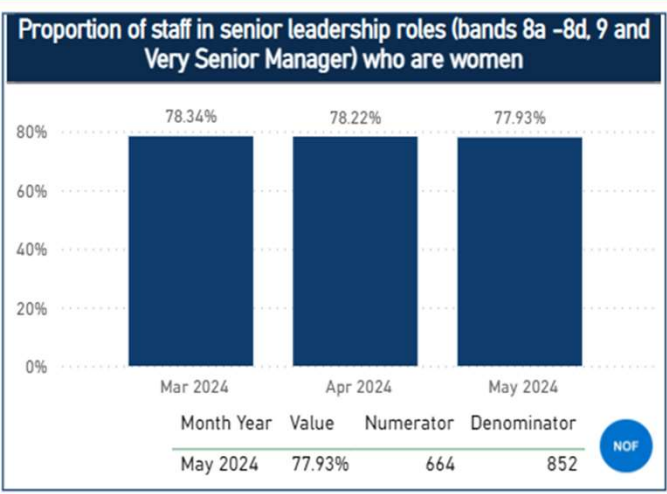
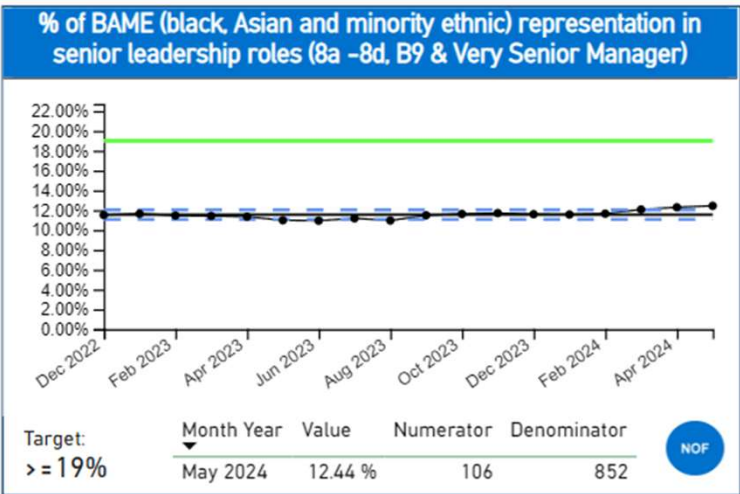
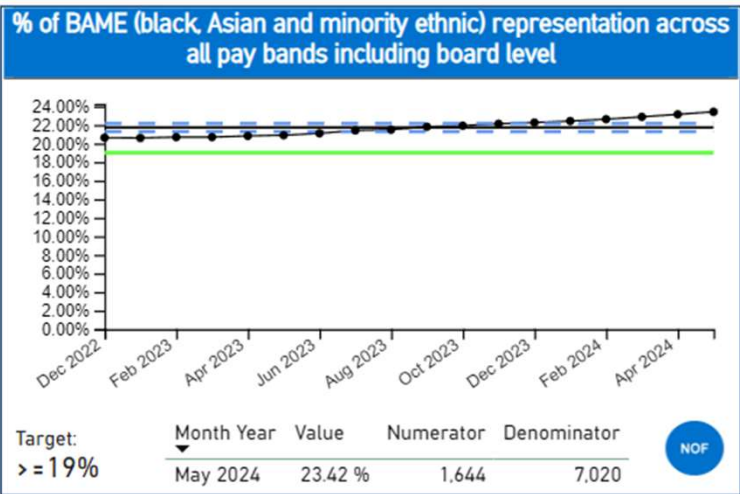
Despite the change to conflict resolution which has resulted in a drop in the overall position for Statutory and Mandatory training, all of the directorates in the Trust are circa 85% completion which demonstrates the continued commitment to supporting staff to complete this.

There is a clear understanding of the risks and barriers which are resulting in the training subjects that are significantly below expected compliance rates. Plans are in place to address these, and they are being monitored by the risk register. Compliance for both Resus and PEACE are monitored quarterly at Quality and Clinical governance sub-group. A review of current establishment and budgets is also underway to provide assurance that the Trust has enough staff to deliver required training for increased requirements and number of overall headcount. This is also being done for PEACE and Moving & handling training courses.

The Trust continues to roll out Level 1 of the Oliver McGowan training with continued improved compliance which currently sits at 82.92%. This has now been moved to the Statutory and Mandatory training category as planned from April 2024.

NSHE have launched a national review of all Statutory and Mandatory Training, and we will be working closely with them to ensure we are actioning any national changes that are cascaded. The programme aims to improve quality and safety, build a competent workforce and enable staff to move more easily between NHS Employers. Oxford Health have been reported as an Example of progressive practice in the latest update webinar.

People



Summary

There has been an increase of +0.28% in the representation of BAME staff across all pay bands in the May reporting period.
There has been an increase of +0.14% in the representation of BAME staff in senior leadership roles (8A-8D, B9 and VSM) in the May 2024 reporting period.
There has been a decrease of -0.29% in the representation of Female staff in senior leadership roles (8A-8D, B9 and VSM) in the May 2024 reporting period.

Actions

All three KPIs will be worked on under High Impact Action 2 to secure diverse and fair representation of staff in the workforce with the aim of producing the draft inclusive recruitment and talent management strategy by the end of June 2024. We will also draw on the analysis of the WRES 2024 data and the Gender Pay Gap Report 2024 to understand how we improve representation for race and gender as this cannot be examined separately to the equality agenda.

High Impact Action 2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

2.1 Create and implement a talent management plan to improve the diversity of executive and senior leadership teams by June 2024 and evidence progress of implementation by June 2025.

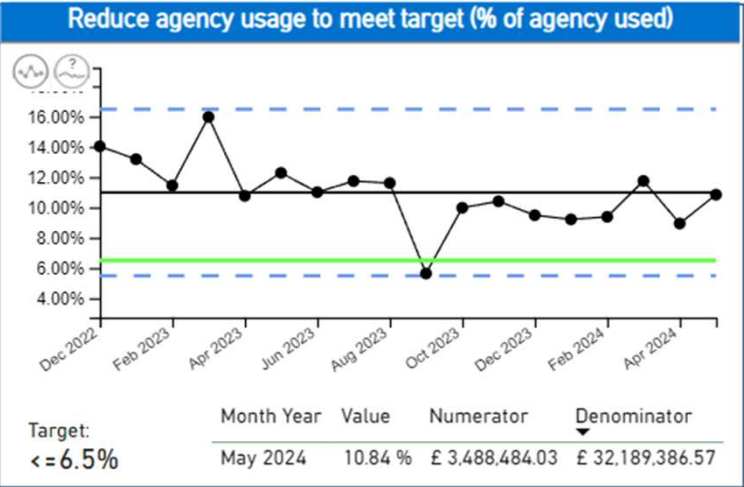
HIA 2 Project Team has been set to explore the development of an inclusive talent management strategy. The next stage is to launch a 12-month QI Talent Management Project which will consist of a:

This will be a 12-month QI project with delivery by end of April 2025.

One key action from the Inclusive Recruitment & Talent Management Strategy is to ensure diversity on interview panels via the involvement of an Inclusion Representative. To this end, the following has been agreed at the EDI Steering Group at the meeting held on the 2nd of July 2024:

- a) Make Inclusion Representatives mandatory for 8C and above roles
- b) Scope and train the numbers to make them mandatory for 8A and above roles

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Summary

Overall, total agency spend in May was £3,489K (10.84% of total pay bill) or 17.8% above May budget of £2,868k

In May 62% of our temporary staffing shifts (based on hours) were filled by bank workers; 34% were filled by agency workers and 4% were unfilled

Agency Spend as a % of Temporary Staffing was 55.5% (£3,488k) and Bank was 44.5% (£2,797)

Highlights, updates, actions

Managed Service Provider Update

NHS Professionals (AfC):
The NHSP contract for 24/25 has been finalised and is pending signatures, the KPI's have been updated and reflect the Trust position on Bank First approach with increases being delivered Q2 onwards.

The temporary staffing team are holding meetings in June and July with inpatient teams to discuss booking behaviours, this includes recording accurate reason for the requirement, eradicating retrospective shifts and short notice requests. Meetings held so far have been positive, those teams who need support with improving their booking behaviours have asked for monthly follow up meetings. A scoping exercise is being undertaken to explore the utilisation of restricting direct booking permissions by services in the NHSP system to promote the Trust's bank first approach and greater levels of controls. A review of substantive workforce not currently working for NHSP is being undertaken to enable a targeted attraction campaign to be launched. NHSP colleagues are visiting clinicians and front-line staff to understand their needs and requirements and to promote a better service. We have escalated to NHSP that they need to fill their vacancies as a matter of urgency to support the Bank First approach.

ID Medical (AfC):

The programme of work to move lines of work through the multi-faceted rate card is now underway, this will bring out savings through reductions in hourly rates. The temporary staffing team are continuing to support the directorate agency control panel meetings and their agency reduction plans for FY 24/25.

There are currently 158 lines of work in place across the Trust, the number of lines of work at price cap have increased from 37 to 70, phase 1 has reduced from 89 to 76 and phase 2 have reduced from 29 to 12. Work will continue to drive more lines of work into the price cap range. The temporary staffing team are continuing to support teams in migrating agency workers to the bank and substantive roles, to date 20 agency workers have migrated to the bank, 11 agency workers and 20 bank members have joined the Trust on a substantive basis. A new scheme will be implemented in Q2 to incentivise agency staff to transfer to substantive roles and we will be targeting agency workers who have worked with us the longest.

ID Medical (Medical):

The medic contract has been finalised with targeted cost savings and rates, pending signatures. GP charge rate reductions in OOH's service have been agreed, this represents a £50 Per Hour saving from the starting position with no risk to the service. This is effective from 1st July and will put Agency GPs at the same or lower cost than current bank pay rates.

A programme of work is underway to reduce mental health charge rates through reduction or replacement, ID Medical are working directly with AMDs to achieve best results. Direct Engagement for Medics continues to be a priority; however, the momentum has lessened for existing workers.

Review of Temporary Staffing Arrangements in OHFT:

The Southeast Temporary Staffing Collaborative Team have been commissioned to undertake an independent review of our arrangements with a view to making recommendations to the Executive as to the optimal arrangements we need to continue to make savings in relation to agency. These are expected in Q2.

Section 3

Strategic dashboard

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Strategic objectives

Strategic objectives guide the priority setting and decision-making. Each objective has a set goal and overarching ambitions, which are then linked to specific measures and targets. Full Strategic Dashboard will be first reported to the Trust Board in November 2024; in-year strategic metrics, where possible, are reported monthly.

Quality	People	Sustainability	Research
Deliver the best possible care and health outcomes	Be a great place to work	Make the best use of our resources and protect the environment	Be a leader in healthcare research and education
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.	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	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	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
• Care is planned and delivered around the needs of patients • Patients are receiving effective care • We provide timely access to care and when waits occur, we will effectively monitor patients and minimise harm • We are addressing health inequalities • We consistently provide safe care, which a reduction in avoidable in-services harm • We have a safe and learning culture	• We have a sustainable workforce • We have an engaged, well led workforce • We have a skilled, learning workforce • We foster a just work environment	• We are spending and investing as efficiently as possible and sustaining our financial position over the medium term • We are on track for Net Zero Carbon emissions by 2045 as defined within the NHS Carbon Footprint plus • Our digital systems work for us, providing and asking for the right information to enable clinical care and population health management • We will have moved toward a modern, efficient estate that enables access and wellbeing for staff and patients	• We will sustain our leadership in research, strengthen our academic partnerships and embed research capability in the organisation • We will build our capacity to translate our research into services • Education ambition

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Strategic Dashboard – to be reported to Board in November 2024

Strategic Objective	Strategic ambition	Strategic metric	Target 24-25	Target 25-26
Quality	Care is planned and delivered around the needs of the patient	% of patients responding that overall the care was good or very good - mental health	> =85%	> =90%
		% of patients responding that overall the care was good or very good - Primary, Community and Dental	> =85%	> =90%
		% of patients report being involved in their care - mental health	> =80%	> =85%
		% of patients report being involved in their care - Primary, community and dental	> =85%	> =90%
	Patients are receiving effective care	% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice	Baseline	Depending on baseline
		% of children and young people accessing mental health services, having their outcomes measure recorded at least twice	Baseline	Depending on baseline
		% of women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice	Baseline	Depending on baseline
		TBC - % of Oxfordshire Stroke Rehabilitation Unit (OSRU) patients reporting improved functioning	tbc	tbc
	We provide timely access to care and when waits occur we will effectively monitor patients and minimise harm	% of children and young people, carers/families receiving meaningful contact within 4 weeks from request for mental health service	61%	tbc
		Average response time for out of hours palliative care referrals: the waiting time from receipt of the call from 111 to the start of the telephone consultation (<=30mins)	Baseline	tbc
		Average response time for out of hours palliative care referrals: the time from completion of that triage call to the start of the home visit consultation (<=60mins)	Baseline	tbc
	We are addressing health inequalities	% of breastfeeding prevalence at 6-8 weeks	60%	tbc
		Equity of experience for black and Afro-Caribbean Service Users: use of Mental Health Act	tbc	tbc
	We consistently provide safe care, with a reduction in avoidable in-service harm	National Early Warning Score (NEWS) [national tool for detecting clinical deterioration], completed correctly where applicable – Community	> =90%	tbc
		Outcome of National Early Warning Score (NEWS) [national tool for detecting clinical deterioration] escalated appropriately – Community	> =90%	tbc
		Reduction in use of prone restraint	10% against 23-24 baseline	20% against 23-24 baseline
		Reduction in the use of seclusion	10% against 23-24 baseline	20% against 23-24 baseline
		% of patients with 'My Safety Plan' completed, where suicide is identified as risk on Risk Assessment Form	Baseline	tbc
	We have a safe and learning culture	Response to staff survey question-I would feel secure raising concerns about unsafe clinical practice	23-24 position	tbc

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Strategic Dashboard – to be reported to Board in November 2024

Strategic Objective	Strategic ambition	Strategic metric	Target 24-25	Target 25-26
People	We have a sustainable workforce	Reduce agency usage to meet target	tbc	tbc
		Reduction in % labour turnover	<=14%	tbc
		Develop approach to workforce planning (Process Measure)	Narrative	tbc
	We have an engaged, well led workforce	Staff survey staff engagement score	>=6.45	tbc
		Confirm Trust's approach to leadership development (Process Measure)	Narrative	tbc
	We have a skilled, learning workforce	% of staff completing Quality Improvement Training Level 1	95%	tbc
	We foster a just work environment	Black, Asian and Minority Ethnic representation across all bands including Board level	>=19% tbc	tbc
		Black, Asian and Minority Ethnic representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Manager)	>=19% tbc	tbc
		Develop our approach to mitigating the intersectional impacts of disadvantage, discrimination & bias (Process Measure)	Narrative	tbc
Sustainability	We are spending and investing as efficiently as possible and sustaining our financial position over the medium term	Set and meet plans to deliver a balanced or surplus budget each year in revenue	Within Budget	Within Budget
		Set and meet plans to deliver a balanced or surplus budget each year in capital	Within Budget	Within Budget
		Achieve National Cost Collection of 100 or below	<=100	<=100
	We are on track for net zero carbon emissions by 2045 as defined with the NHS Carbon Footprint plus	By 2026, achieve 29% reduction in direct carbon emissions compared to 2019 baseline.	22%	29%
		Confirm the baseline for supply chain carbon emissions and update the Trust Green Plan to show how carbon reductions will be delivered.	Baseline/Narrative	tbc
	Our digital systems work for us, providing and asking for the right information to enable clinical care and population health management	Achieve an average score of 4 out of 5 in the sections 'ensuring smart foundations and improved care' within the Digital Maturity Assessment	>=4	tbc
Research	We will have moved towards a modern, efficient estate that enables access and wellbeing for staff and patients	Develop a strategy for our estates (Process Measure)	Narrative	tbc
	We will sustain our leadership in research, strengthen our academic partnerships and embed research capability in the organisation	Participants recruited to Clinical Research Network (CRN) portfolio studies by directorate	Narrative	tbc
		Number of active or aspirational principal investigators by directorate	Narrative	tbc
	We will build our capacity to translate our research into services	Number of dual academic/clinical role	Narrative	tbc
		Develop infrastructure to translate research into services and demonstrate impact (Process Measure)	Narrative	tbc
	Education ambition TBC	TBC - Education ambition	tbc	tbc

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Appendices

ICB BOB performance

Extract from BOB ICB Integrated Performance Report (presented to BOB ICB Board in July 2024; [20240716-bob-icb-board-item-12-performance-and-quality-report-m1.pdf](#))

Please note that Children and Young People and Out of Area Placement metrics reported below are impacted by Carenotes outage and data flows to the Mental Health Services Data Set hence may not be reflecting an accurate position.

Children and Young People Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Feb 24	95.0%	83.0%		
	CYPED Urgent cases that wait 1 week or less from referral	Feb 24	95.0%	0.0%		
	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	Feb 24	26,531	20,535		

Dementia and Out of Area Placement (OAP) Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external) - Commissioner	Jan 24	0	1,915		
	Estimated Diagnosis rate for people with dementia	Mar 24	66.7%	62.2%		

Talking Therapies Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Talking Therapies: Treated within 6 weeks	Apr 24	75.0%	97.0%		
	Talking Therapies: Treated within 18 weeks	Apr 24	95.0%	100.0%		
	Talking Therapies: Moving to reliable recovery (national)	Apr 24	50.0%	50.0%		
	Talking Therapies access (total numbers accessing services)	Feb 24	3,914	3,260		

Severe Mental Illness Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	People with severe mental illness receiving a full annual physical health check and follow up interventions	Mar 24	60.0%	67.8%		

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Glossary of metrics (in continuous development)

Area	Metric/theme	Definition	Why is it important?
Child and Adolescent Mental Health Services	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)	Long term plan measure to monitor expansion of mental health services to ensure additional capacity for children and young people to receive mental health services	Additional capacity to meet growing demand with the aim of addressing mental health needs early and potentially reducing long-term impact on the individual, improving overall health outcomes
	Four (4) week wait (interim metric - one meaningful contact within episode)	Interim proxy measure measuring the time from referral to first meaningful contact. Meaningful contact is one that informs assessment and intervention, that is related to the identified/coded problem and is intended to assess or change feelings, thoughts, behaviour, or physical/bodily state. This may involve advice, support, or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment. These may be delivered through direct or indirect work where there is a referral.	To monitor number of children and young people waiting for support from mental health services as longer waiting times may lead to development of more intractable problems and worse patient outcomes.
	% referred cases with suspected Eating Disorder that start treatment within 7 days or 4 weeks	Proportion of routine and urgent referrals starting treatment within 7 days for urgent cases and within 4 weeks for routine cases.	To monitor number of children and young people who have accessed or are waiting for treatment following a routine or urgent referral for suspected eating disorder. Offering evidence based, high quality care and support as soon as possible can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions.
Talking Therapies	Increase the number of adults and older adults accessing Talking Therapies treatment	Long term plan measure monitoring expansion and accessibility of Talking Therapies services	To ensure those suffering from depression and anxiety can access effective psychological therapies as first choice interventions and those who are seen by Talking Therapies services receive a course of NICE recommended psychological therapy from an appropriately trained and supervised individual and have their clinical outcomes monitored and reported,
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000		
	Reliable recovery rate	The proportion of patients who start treatment with a score for anxiety and depression which meets the threshold for a clinical case, whose score at the end of treatment has reduced to below the clinical threshold.	The Talking Therapies Recovery Rate measures the effectiveness of Talking Therapy services and can also be used to identify different outcomes of the service for different patient groups – thereby providing useful intelligence to help reduce health inequalities.
	Reliable improvement rate for those completed a course of treatment adult and older adults combined;	A referral has shown reliable improvement if there is a significant improvement in their condition following a course of treatment, measure by the difference between their first and last scores on questionnaires tailored to their specific condition.	The Talking Therapies Recovery Rate measures the effectiveness of Talking Therapy services and can also be used to identify different outcomes of the service for different patient groups – thereby providing useful intelligence to help reduce health inequalities.
	% of people receiving first treatment appointment within 6-18 weeks of referral	One of the stated targets of the NHS Talking Therapies for anxiety and depression programme is that for referrals finishing a course of treatment in the month, 75% access services within 6 weeks, and 95% within 18 weeks. These are based on the waiting time between the referral date and the first attended treatment appointment.	Monitoring of Talking Therapies waiting times ensures that patients receive timely access to treatment (early intervention can prevent conditions from worsening and improve outcomes), helps to identify disparities and potential delays or capacity issues in the system.
	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments)		
	Meet and maintain at least 50% Talking Therapies recovery rate with improvement to 52% by end of Financial Year 24-25	Recovery in NHS Talking Therapies is measured in terms of 'caseness' – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were defined as a clinical case at the start of their treatment ('at caseness') and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. The Government target is that 50% of eligible referrals to NHS Talking Therapies services should move to recovery.	The Talking Therapies Recovery Rate measures the effectiveness of Talking Therapy services and can also be used to identify different outcomes of the service for different patient groups – thereby providing useful intelligence to help reduce health inequalities.

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Glossary of metrics (in continuous development)

Area	Metric/theme	Definition	Why is it important?
Adult and Older Adult Community mental health services	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Long term plan measure to monitor expansion of mental health services to ensure sufficient capacity for adults and older adults to receive mental health services	Additional capacity to meet growing demand with the aim of addressing mental health needs early and potentially reducing long-term impact on the individual, improving overall health outcomes
	4 week wait (28 days) standard (interim metric - two contacts within episode)	Interim proxy measure measuring two meaningful contacts within a care episode within the four (4) week period. Meaningful contact is one that informs assessment and intervention, that is related to the identified/coded problem and is intended to assess or change feelings, thoughts, behaviour, or physical/bodily state. This may involve advice, support, or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment. These may be delivered through direct or indirect work where there is a referral.	To monitor number of adult and older adults waiting for support from mental health services as longer waiting times may lead to development of more intractable problems and worse patient outcomes.
	Deliver annual physical health checks to people with Severe Mental Illness (System Measure)	Number of people on the General Practice Severe Mental Illness register at the end of each quarter and how many of these have received a comprehensive physical health check in the 12 months to the end of the reporting period. This is an ICB metric combining data from GP practices and other providers of primary care services.	Annual physical health checks are a key level to address the reduced life expectancy both people with Severe Mental Health Illnesses.
	Improve access to perinatal mental health services	Long term plan measure monitoring expansion and accessibility of Perinatal Mental Health services	To monitor support available for women with moderate to severe or complex mental health needs support (including on how to develop the relationship between parent and baby)
	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	The Access and Waiting Time Standard for Early Intervention services requires that at least 50 per cent of people experiencing a first episode of psychosis will be seen by an early intervention team, allocated a care coordinator and have started treatment with a NICE approved package of care, within two weeks of referral. The standard is aimed at people aged 14-65.	Monitoring is important in ensuring that care is robust and early intervention services work alongside primary care services to support recovery
	Number of people accessing IPS (Individual placement and support)	IPS is an evidence-based model of supported employment. Part of the Long Term Plan for mental health improvement.	Monitoring the number of people accessing IPS supports tackling unequal outcomes and access challenges, improved population health and helps the NHS to support broader social and economic development.
	Recover dementia diagnosis rate (System measure)	Two thirds of the estimated number of people with dementia should have a diagnosis.	Monitoring dementia diagnosis rate supports Systems and provider making informed choice about how to plan services around patient needs.
Mental health urgent care services	Face to face response time from Mental Health Urgent care services	Measures face to face response time from Psychiatric liaison service (1 hour) and Crisis services (4 and 24 hours)	Monitoring response times in a Mental Health Crisis circumstances helps to prevent escalation of situations that may threaten the life, long-term health or safety of an individual or others.

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For Information

Finance Report

June 2024 (Month 3), FY25

Report to Board of Directors

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Executive Summary

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Annexes (private report only)

- A. Directorate Financial Performance Detail
- B. Block Income Variances
- C. Provider Collaborative Financial Performance
- D. New & Existing Business Opportunities
- E. Detailed Directorate Financial Performance (in separate file)
- F. Out of Area Placements Analysis
- G. Pay Trends Analysis

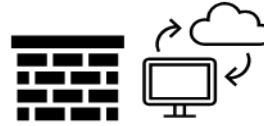
A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.

Executive Summary



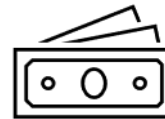
Income & Expenditure position

- YTD £1.4m deficit – on plan
- Forecast £2.7m deficit – on plan



Capital Expenditure

- £1.0m underspend YTD



Cash

- Actual £87.4m, £9.2m behind plan

Key messages:

1. The YTD position at month 3 is a deficit of **£1.4m**, which is on plan.
2. The annual plan is for a deficit of **£2.7m** and the profile improves over the year – PFI costs are only included for the 1st half of the year and one-off benefits are profiled later in the year.
3. Capital expenditure is **£1.0m** underspent YTD.

1. Income Statement

	INCOME STATEMENT											
	Month 3				Year-to-date				Forecast			
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Forecast £m	Variance £m	Variance %
Clinical Income	43.0	41.3	-1.7	-4.0%	129.5	126.3	-3.2	-2.5%	518.8	504.6	-14.2	-3%
Other Operating Income	11.1	10.8	-0.3	-3.1%	29.0	32.7	3.7	12.9%	125.0	131.5	6.5	5%
Operating Income, Total	54.2	52.1	-2.1	-3.8%	158.5	159.0	0.5	0.3%	643.9	636.2	-7.7	-1%
Employee Benefit Expenses (Pay)	32.1	30.3	1.8	5.6%	96.0	93.5	2.5	2.6%	383.2	377.8	5.4	1%
Other Operating Expenses	20.9	21.2	-0.2	-1.2%	59.1	63.4	-4.3	-7.3%	246.7	246.3	0.4	0%
Operating Expenses, Total	53.0	51.5	1.5	2.9%	155.0	156.8	-1.8	1.2%	629.9	624.1	5.8	1%
EBITDA	1.2	0.6	-0.5	-45.2%	3.5	2.2	-1.3	37.1%	13.9	12.1	-1.9	
Financing costs	1.6	0.7	0.9	56.9%	4.7	3.4	1.3	38.4%	16.6	14.7	1.8	11%
Surplus/ (Deficit)	-0.4	0.0	0.4	-90.8%	-1.3	-1.3	0.0	2.4%	-2.6	-2.7	0.0	
Adjustments	0.0	0.0	0.0	0.0%	-0.1	-0.1	0.0	0.0%	-0.1	-0.1	0.0	0.0
Adjusted Forecast Surplus/ (Deficit)	-0.4	-0.1	0.4	-82.8%	-1.4	-1.4	0.0	2.2%	-2.7	-2.7	0.0	

Year-to-Date Performance

The YTD position at month 3 is a deficit of **£1.4m**, which is on plan. EBITDA is **£1.3m** adverse to plan, offset with a favourable variance of **£1.3m** on financing costs due to higher than planned interest receivable (**£0.2m**) and lower than planned PFI interest costs following the decision to change the accounting treatment for the PFI exit settlement from a prior period adjustment to a provision (**£0.7m**) and lower than planned depreciation costs (**£0.4m**).

The favourable variance on income (**£0.5m**) is driven by **£2.7m** higher than planned sales in Oxford Pharmacy Store and favourable variances in the Oxford Institute for Psychology training (**£0.4m**), R&D (**£0.3m**), HR (**£0.2m**) and Primary, Community and Dental (**£0.2m**). This is offset a **£1.9m** adverse variance on Provider Collaboratives where income has been matched to spend, a **£0.9m** adverse variance on Sustainability & Transformation funding (SDF) which has been matched to spend and a **£0.5m** adverse variance due to a contract dispute with NHS England.

The adverse variance on expenditure (**£1.8m**) is due to higher cost of sales in Oxford Pharmacy Store (**£2.6m**), an overspend on mental health out of area placements (**£0.8m**), higher expenditure in the Oxford Institute for Psychology training (offset more income), higher than planned expenditure in R&D (offset with income) (**£0.1m**) and a **£0.2m** net adverse variance across other areas. These are offset with a favourable variance on Provider Collaboratives (**£1.9m**).

2. Forecast Risks & Opportunities

Risks	£'000	Likelihood
Frontline Digitisation income not received	1300	High
Audit/Balance Sheet year-end risks	3000	Medium
Increase in agency	2000	Medium
Jordan Hill costs	200	Medium
Learning Disabilities OAPs increase	500	Medium
Mental Health OAPs	1000	Medium
Warneford Park project overspend	800	Medium
PFI settlement costs	4000	Low
	12,800	

Opportunities	£'000	Likelihood
Forensic growth funding not yet in budgets	877	High
Release ED NHSE loan	850	High
Additional income from BOB ICB	2,291	Medium
Audit/Balance Sheet year-end opportunities	3,000	Medium
Discharge of Learning Disabilities OAPs	250	Medium
Further agency reductions	600	Medium
Market Equivalent Asset Valuation	1,000	Medium
NHSE contract dispute	1,800	Medium
VAT on IT licenses	1,000	Medium
	11,668	

The Trust's Forecast Outturn is for a **£2.7m** deficit, which is on plan.

There are **£12.8m** of risks and **£11.7m** of opportunities to the forecast. This gives a forecast range of between **£11.7m** better than plan and **£12.8m** worse than plan.

Taking into account the risks and opportunities with a high likelihood only, gives a forecast range of between **£1.7m** better than plan and **£1.3m** worse than plan.

£3.0m has been included as a risk and opportunity for any requirement to adjust balance sheet values with an effect on the revenue position.

Forecast range - all risks and opportunities

	£'000	Full Year Budget	Full Year Actual	Forecast Outturn to Plan
Upside Forecast		2,700	14,368	11,668
Downside Forecast		2,700	-10,100	-12,800

Forecast range - high likelihood risks and opportunities

	£'000	Full Year Budget	Full Year Actual	Forecast Outturn to Plan
Upside Forecast		2,700	4,427	1,727
Downside Forecast		2,700	1,400	-1,300

3. Capital Investment Programme

Project Names	FY25 Budget		FY25 Expenditure			FY25 Outturn To Date			FY25 Estimated Outturn	
	Latest	(B) Budget	(C) Profiled Budget	(D) Actual Expenditure	(C-D) Variance	(E) System Comm't's	(F=D+E) Actual Plus Comm't's	(B-F) Variance	(G) Estimated Forecast	(B-G) Variance
		£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Estates - Projects Carried Forward		1,221	364	228	136	667	894	327	3,752	(2,531)
Estates - Transformational Projects		6,048	1,025	249	776	224	473	5,575	5,354	694
Estates - Operational		2,421	3	-	3	32	32	2,389	2,368	53
Oxford Pharmacy		117	29	-	29	-	-	117	117	-
Sub Total-Estate Improvements & Transformation		7,270	1,388	418	970	833	1,251	6,019	8,968	(1,698)
Sub Total-Operational		2,421	3	59	(57)	91	150	2,271	2,506	(85)
Sub Total-Pharmacy		117	29	-	29	-	-	117	117	-
Grand Total - All Estates		9,809	1,421	476	945	923	1,400	8,409	11,592	(1,783)
IT Capital		227	57	-	57	208	208	19	283	(56)
IM&T Clinical Systems		2,242	420	456	(36)	112	567	1,675	2,919	(677)
Grand Total - IM&T		2,469	477	456	21	320	775	1,694	3,203	(734)
PFI		-	-	-	-	-	-	-	-	-
Grand Total		12,278	1,897	932	965	1,243	2,175	10,103	14,794	(2,517)

Funding Sources	Latest Funding
Confirmed Funding Available (inc PICU)	10,945
Funding/Budgeted expenditure shortfall (£12,278k - £10,945k)	1,333
Funding Shortfall against forecast outturn (£14,794k - £10,945k)	3,849

The Trust spent **£932k** on its core capital programme at the end of June, **£965k** behind plan.

£1,398k of leased assets were capitalised as 'Right of Use Assets' in the first 3 months of FY25.

The capital plan is forecasting a **£3.8m** overspend, and there is at least one known overspend not included in this figure. The Estates team are reviewing the capital programme in order to propose which projects to prioritise for this year's capital expenditure.

4. Directorate Financial Performance Summary

Directorate	Month 3				Year-to-date				Forecast			
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Forecast £m	Variance £m	Variance %
Oxfordshire & BSW Mental Health	9.4	8.9	0.5	0.0	28.3	28.2	0.1	0.0	114.3	113.7	0.5	0%
Buckinghamshire Mental Health	5.0	4.6	0.3	0.1	14.3	14.0	0.3	0.0	58.2	57.2	1.0	2%
Forensic Mental Health	0.2	0.5	-0.3	-1.5	0.6	1.1	-0.5	-0.8	2.5	4.1	-1.6	-65%
Learning Disabilities	0.5	0.6	-0.1	-0.2	1.4	1.8	-0.4	-0.3	5.8	6.6	-0.8	-14%
Provider Collaboratives	-0.8	-0.8	0.0	0.0	-2.4	-2.4	0.0	0.0	-9.8	-9.8	0.0	0%
MH Directorates Total	14.2	13.7	0.5	0.0	42.3	42.7	-0.4	0.0	171.0	171.8	-0.9	-1%
Primary Community & Dental	8.3	8.2	0.1	0.0	24.5	24.5	0.0	0.0	96.4	98.1	-1.7	-2%
Corporate	5.6	5.8	-0.2	0.0	17.2	17.4	-0.2	0.0	68.3	71.5	-3.2	-5%
Oxford Pharmacy Store	0.0	-0.1	0.0	-1.1	-0.1	-0.2	0.1	-1.3	-1.0	-1.0	0.0	0%
Research & Development	0.1	0.0	0.1	1.1	0.2	0.0	0.2	1.0	0.6	0.4	0.2	29%
Covid-19 Costs	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0	
Reserves	0.7	1.7	-0.9	-1.3	3.2	3.5	-0.3	-0.1	13.6	7.4	6.2	46%
Block Income	-30.1	-29.9	-0.1	0.0	-90.7	-90.1	-0.6	0.0	-362.8	-360.3	-2.4	1%
EBITDA	-1.2	-0.6	-0.5		-3.5	-2.2	-1.3		-13.9	-12.0	-1.9	
Financing Costs	1.6	0.6	0.9	0.6	4.7	3.4	1.3	0.3	16.6	14.7	1.8	11%
Adjustments	0.0	0.0	0.0		0.1	0.1	0.0		0.1	0.1	0.0	
Adjusted (Surplus)/Deficit	0.5	0.0	0.4		1.4	1.4	0.0		2.7	2.8	0.0	

Block contract income is reported in a separate directorate. Clinical Directorate positions reflect the expenditure position less non-clinical income (mainly Education & Training income) and some specific income streams such as Sustainability & Development Funding (SDF).

The Reserves full-year plan includes budget that will be allocated to services when costs start being incurred. For example, pay inflation and budget for Sustainability & Transformation Funding schemes.

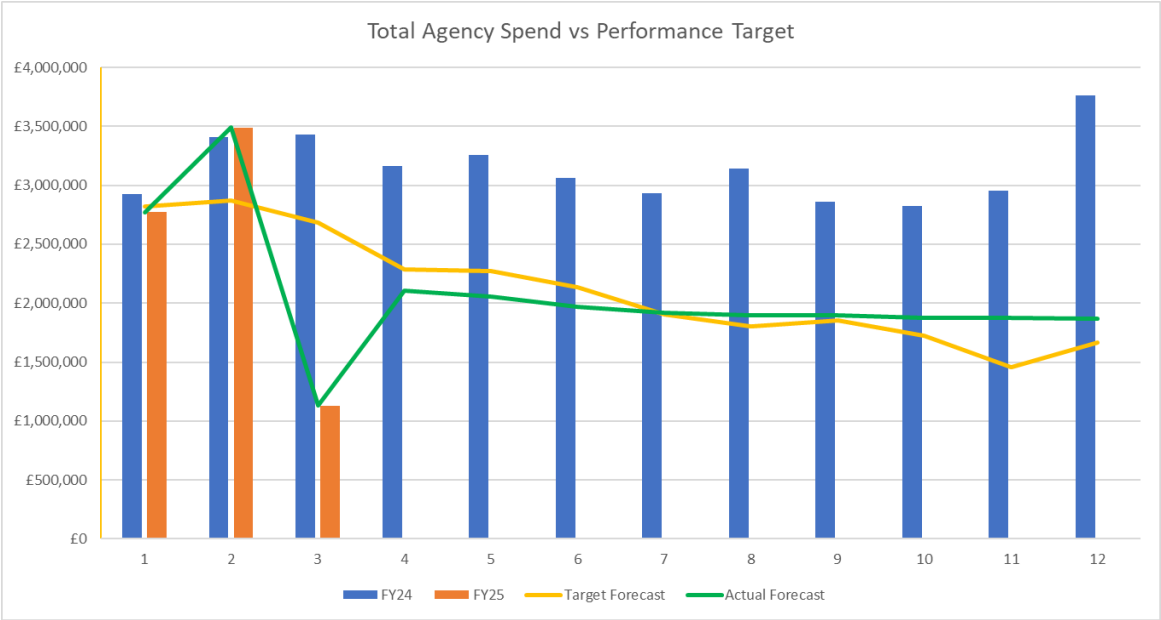
5. Provider Collaboratives Financial Performance Summary

	Month 3			Year-to-date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Secure	7.9	8.2	(0.3)	23.8	23.5	0.3	95.2	94.1	1.1
CAMHS	2.4	2.0	0.4	7.2	6.6	0.6	28.9	26.5	2.4
Adult AED	0.8	0.9	(0.1)	2.3	2.3	0.0	9.3	9.3	0.0
Provider Collaboratives Total	11.1	11.1	0.0	33.3	32.4	0.9	133.4	129.9	3.5

For the Provider Collaboratives income is deferred in the YTD position to match spend. The table above details the expenditure position.

The Provider Collaboratives (PC) YTD position is **£0.9m** favourable to plan and is reported as breakeven in the Trust overall position in line with the principles of the PC to reinvest savings into services.

6. Agency Analysis



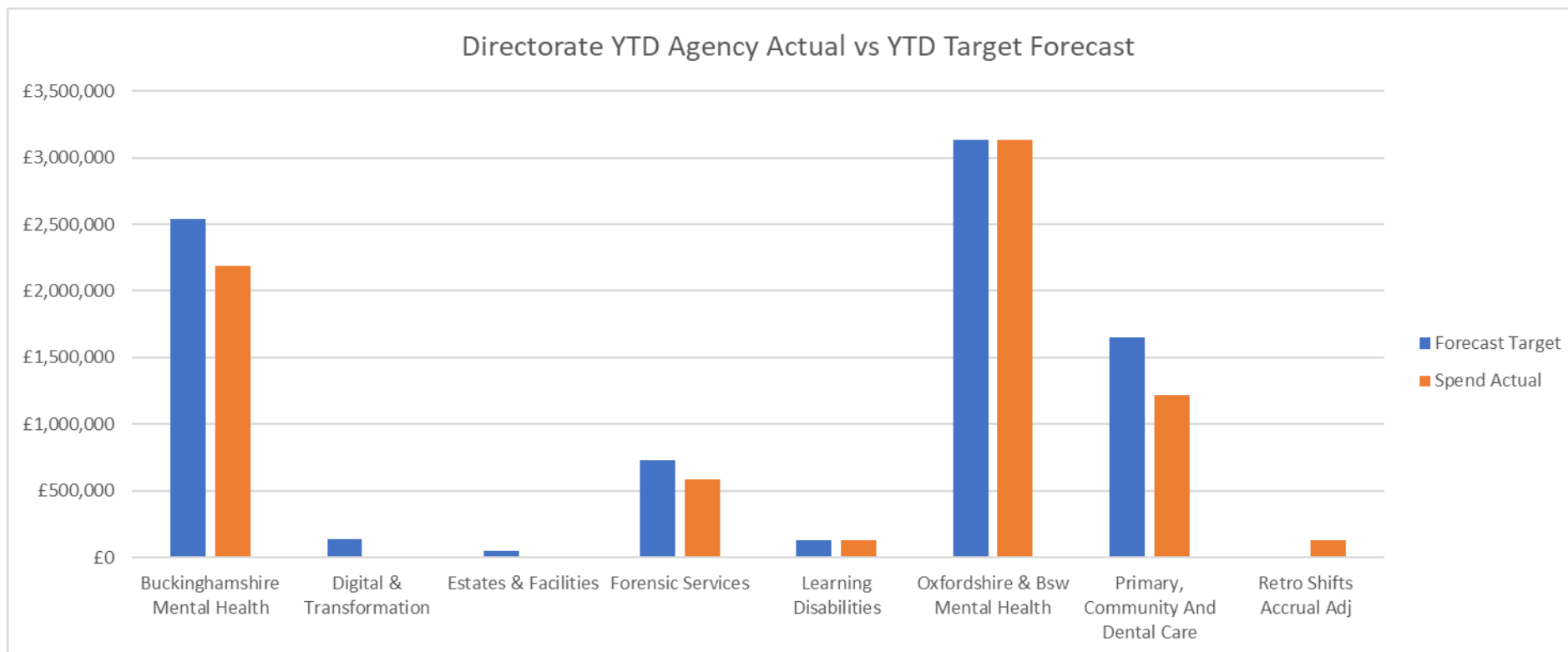
	FY24 April - June	FY25 April - June	Change from FY24
Medical	£4,071,082	£3,208,008	-£863,074
Nursing	£4,814,850	£3,630,506	-£1,184,344
AHP/HSS	£631,156	£401,385	-£229,771
Admin & Clerical	£217,187	£8,075	-£209,112
Estates	£30,119	£10,457	-£19,662
Total	£9,764,394	£7,258,430	-£2,505,964
FY24 VC's & FY25 Retros	£13,909	£131,780	£117,871
Prior year/Finance adjustments	-£13,910	£0	£13,910
Total Reported	£9,764,394	£7,390,211	-£2,374,183

In Month 3 temporary staffing was **13%** of the Trust total pay bill with Agency at **4%** and Bank at **9%**. Included in the month 2 figures is **£1m** of agency cost related to FY24 which has been reversed in month 3 as the FY24 accounts have been amended to reflect this. When removed, the normalised temporary staffing position is **16%** of the trust total pay bill with **7%** of this being attributable to agency spend.

The Trust has submitted a plan to BOB ICB and NHS England to spend a maximum of **£24.4m** on Agency in FY25.

Year to date agency spend, is **£1m** better than plan and **£2.4m** better than the same period in FY24.

Agency Analysis Continued



Directorates have been allocated targets to reduce agency spend in line with the submitted plan of **£24.4m**.

An additional **£0.1m** was accrued in month 3 to account for any retrospective shift bookings related to this period.

All Directorates have delivered spend levels within the target forecast year to date at month 3. Buckinghamshire Mental Health and Primary, Community and Dental have submitted plans for agency WTE reductions which will further decrease their spend against target forecast. Both Forensic and Oxfordshire & BSW have WTE reduction plans already included within their target forecasts. Directorate targets will be revised in month 4 to reflect all submitted plans for Agency WTE reductions in FY25.

7. Pay Spend Analysis

	Month 3 WTE					Month 3 (£'000s)					Year-to-Date (£'000s)					Forecast (£'000s)			
Category of Spend	Budget	Actual	Variance	% Variance		Budget	Actual	Variance	% Variance		Budget	Actual	Variance	% Variance		Budget	Actual	Variance	% Variance
Agency	0.00	297.93	-297.93			2	1,130	-1,129			6	7,390	-7,384			24	24,860	-24,836	
Bank	35.57	607.87	-572.30			493	2,841	-2,348			1,479	8,429	-6,949			5,916	34,662	-28,746	
Substantive	7,143.19	6,000.79	1,142.40	16.0%		31,565	26,307	5,258	16.7%		94,471	77,658	16,813	17.8%		377,278	318,289	58,989	15.6%
Total	7,178.76	6,906.59	272.17	3.8%		32,060	30,278	1,782	5.6%		95,956	93,477	2,479	2.6%		383,218	377,811	5,407	1.4%

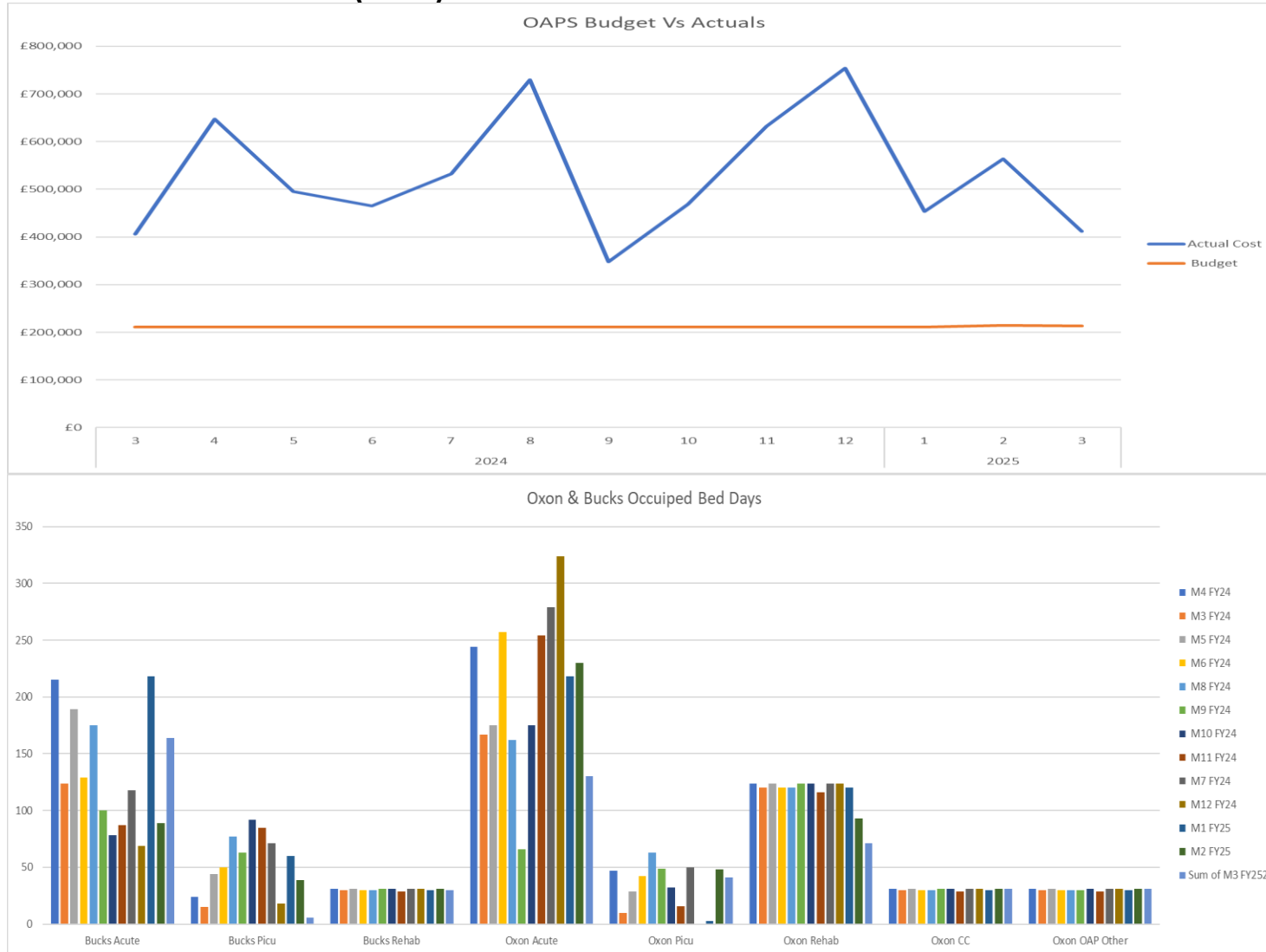
Pay is underspent by **£2.5m** YTD at month 3. **£1.4m** of this variance is due to investment funding (e.g. SDF) which has not yet been allocated to services while plans are developed. The remainder is driven by substantive vacancies of 1,142.40 WTE partly offset with bank and agency spend.

8. Non-Pay Expenditure Analysis

£'000s	Month 3				Year-to-Date			
Category of Spend	Budget	Actual	Variance	% Variance	Budget	Actual	Variance	% Variance
Clinical Supplies & Services	1,965	2,120	-155	-8%	5,065	6,301	-1,236	-24%
Drugs	322	422	-100	-31%	967	1,213	-246	-25%
Establishment	890	809	80	9%	2,507	2,715	-208	-8%
General Supplies And Services	275	179	95	35%	824	750	74	9%
Other	1,281	3,321	-2,040	-159%	4,166	5,467	-1,301	-31%
Oxford Pharmacy Store Cost of Sales	4,784	5,729	-945	-20%	14,184	16,943	-2,759	-19%
Premises	766	1,137	-371	-48%	3,117	3,409	-292	-9%
Provider Collaborative Contracts	6,066	4,519	1,547	25%	18,197	16,620	1,577	9%
Purchase of Services	371	424	-53	-14%	1,028	1,264	-236	-23%
R&D non-staff costs	3,743	2,101	1,642	44%	6,774	7,244	-470	-7%
Reserves	-3	0	-3	100%	778	0	777	100%
Transport	490	436	53	0%	1,469	1,439	29	0%
	20,950	21,198	-248	-1%	59,075	63,365	-4,291	-7%

- Clinical Supplies & Services are overspent by **£1.2m** driven by a **£0.3m** overspend in the Primary, Community & Dental directorate on clinical equipment, a **£0.5m** overspend on Learning Disabilities out of area placements, a **£0.4m** in Oxfordshire CAMHS due to using pay underspends to fund a subcontract with the Owl centre.
- Other costs are overspent by **£1.3m** due to project spend of **£2.3m** offset with **£0.7m** growth and investment budget to be allocated to services once plans are finalised, a **£0.2m** underspend in Provider Collaborates and **£0.1m** net favourable variance across other areas.
- The overspend on Oxford Pharmacy Store Cost of Sales is offset by additional sales income.
- The underspend on Provider Collaborative contracts reflects lower activity in providers than budgeted and is offset with deferred income.
- The underspend on Reserves is made up of **£0.4m** released contingency reserves and **£0.4m** as yet unallocated inflation budget.

9. Out of Area Placements (OAPs)



Out of Area Placements are **£789K** adverse at month 3, **£519K** adverse in Oxfordshire and **£271K** adverse in Buckinghamshire.

This continues to include the cost of the 4 block beds contract with Elysium Potters Bar. Plus, a further 2 block beds at Elysium Chadwick Lodge which has been agreed until 30th September 2024. In addition, there is £22k of secure transport costs across the two directorates.

Oxfordshire Acute beds have decreased by 103 days compared to month 2, the PICU, Rehab, Continuing Care & OAP Other remain stable.

Buckinghamshire Acute have increased by 58 bed days compared to month 2. PICU beds days have decreased to 6 days and Rehab placement remains the same.

10. Cost Improvement Programme (CIP)

The Trust's external CIP target as reported to NHSE is **£40.2m** made up of a **£6.2m** efficiency from contract uplifts (CIP) and **£34m** cost management. The Trust is reporting a full delivery of the **£40.2m** to NHS England on the assumption that any shortfall in these programmes has been mitigated by other non-recurrent benefits in the Trust's position.

Table of Planned Efficiencies				
Recurrent or Non Recurrent	Efficiency Programme Area	YTD Plan £000	YTD Actual £000	Full Year Forecast £000
Non-Recurrent	Non-Pay - Digital transformation	387	387	1,548
	Non-Pay - Service re-design	2,604	2,604	10,416
	Pay - Agency - reduce the reliance on agency	1,224	1,224	5,068
	Pay - Establishment reviews	3,771	3,771	15,084
Total Non-Recurrent		7,986	7,986	32,116
Recurrent	Income - Non-Patient Care	177	177	708
	Non-Pay - Corporate services transformation	21	21	84
	Non-Pay - Digital transformation	78	78	312
	Non-Pay - Estates and Premises transformation	588	588	2,352
	Non-Pay - Fleet optimisation	3	3	12
	Non-Pay - Other	9	9	36
	Non-Pay - Service re-design	42	42	168
	Pay - Establishment reviews	273	273	1,092
	Pay - Service re-design	807	807	3,372
Total Recurrent		1,998	1,998	8,136
Grand Total		9,984	9,984	40,252

Cost Improvement Programme (CIP) Cont.

Internally the Trust has an additional **£1.8m** CIP for FY24 CIPs that were not delivered recurrently last year, making the total internal CIP target **£7.9m**.

£7m of the **£7.9m** CIP target has been delivered through CIPs including upfront savings from investment, staffing establishment reviews and includes a non-recurring benefit of **£0.7m** within Corporate.

£'000							
Directorate	CIP Target	Fully Developed	Plans In Progress	High Risk	No Plans	Expected Slippage	Total
Community	2,548	688	20	2,618	0	-778	2,548
Oxon & BSW MH	2,038	2,038	0	0	0	0	2,038
Bucks MH	983	983	0	0	0	0	983
Forensic MH	526	526	0	0	0	0	526
Learning Disabilities	199	199	0	0	0	0	199
Corporate	1,636	684	704	0	248	0	1,636
Total CIP	7,930	5,118	724	2,618	248	-778	7,929
		65%	9%	33%	3%	-10%	100%

11. Statement of Financial Position

Statement of Financial Position at 30 Jun 2024					
31 Mar 24		31 May 24	30 Jun 24	Movement	
£'000		£'000	£'000	In-Month £'000	YTD £'000
Non-current assets					
7,013	Intangible Assets	7,022	6,985	(37)	(28)
216,328	Property, plant and equipment	215,393	215,129	(264)	(1,199)
33,133	Finance Leases	33,473	33,175	(298)	42
1,125	Investments	1,125	1,125	0	0
412	Trade and other receivables	432	432	0	20
651	Other Assets	652	652	0	1
258,662	Total non-current assets	258,098	257,499	(599)	(1,163)
Current Assets					
3,184	Inventories	5,493	5,044	(449)	1,859
21,722	Trade and other receivables	19,508	22,251	2,743	529
200	Non-current assets held for sale	200	200	0	0
85,628	Cash and cash equivalents	87,415	86,993	(422)	1,364
110,735	Total current assets	112,616	114,487	1,871	3,752
Current Liabilities					
(77,857)	Trade and other payables	(76,252)	(77,556)	(1,304)	301
(2,614)	Borrowings	(3,018)	(2,546)	472	68
(4,019)	Lease Liabilities	(4,015)	(4,061)	(46)	(42)
(16,518)	Provisions	(16,414)	(16,399)	15	119
(24,222)	Deferred income	(27,110)	(28,202)	(1,092)	(3,980)
(125,230)	Total Current Liabilities	(126,809)	(128,764)	(1,955)	(3,534)
Non-current Liabilities					
(12,049)	Borrowings	(12,049)	(12,049)	(0)	(0)
(21,814)	Lease Liabilities	(22,632)	(22,187)	445	(373)
(6,545)	Provisions	(6,663)	(6,663)	(0)	(118)
(1,500)	Other Liabilities	(1,517)	(1,517)	0	(17)
(41,908)	Total non-current liabilities	(42,861)	(42,416)	445	(508)
202,259	Total assets employed	201,044	200,806	(238)	(1,453)
Financed by (taxpayers' equity)					
113,336	Public Dividend Capital	113,336	113,336	0	0
83,359	Revaluation reserve	83,360	83,360	0	1
1,125	Other reserves	1,125	1,125	0	0
4,439	Income & expenditure reserve	3,223	2,984	(239)	(1,455)
202,259	Total taxpayers' equity	201,044	200,806	(238)	(1,454)

1. Net Non-current assets have decreased by £1.2m YTD. This is represented by capital additions of £2.3m (including £1.40m of leased assets – mainly Unipart) less cumulative depreciation of £3.5m.
2. Inventories have increased by £1.9m YTD and decreased by £0.4m in-month. The increase is due to a new infusion drug line being sold by OPS following a distribution agreement with NHSE/Sandoz, and the in-month decrease is driven by the sale of this stock.
3. Receivables have increased by £2.7m in-month and £0.5m YTD. Most of the increase in month is due to a higher level of prepayments.
4. The cash balance has increased by £1.4m over the year and decreased marginally in-month.
5. Trade and other payables have decreased by £1.3m in year and decreased marginally by £0.3m in month. This is due to normal monthly swings in payables and accruals.
6. Borrowings have decreased marginally in year and £0.5m in month. The decrease in month relates to PFI financing charges that were reversed from M1-2 due to an FY24 accounts adjustment.
7. Deferred income has increased by £4.0m in year and £1.1m in month.
8. The increase in net lease liabilities is largely driven by the newly signed lease for Unipart House.
9. The £1.5m downward movement in year reflects the Trust's reported deficit in year.

12. Cash Flow

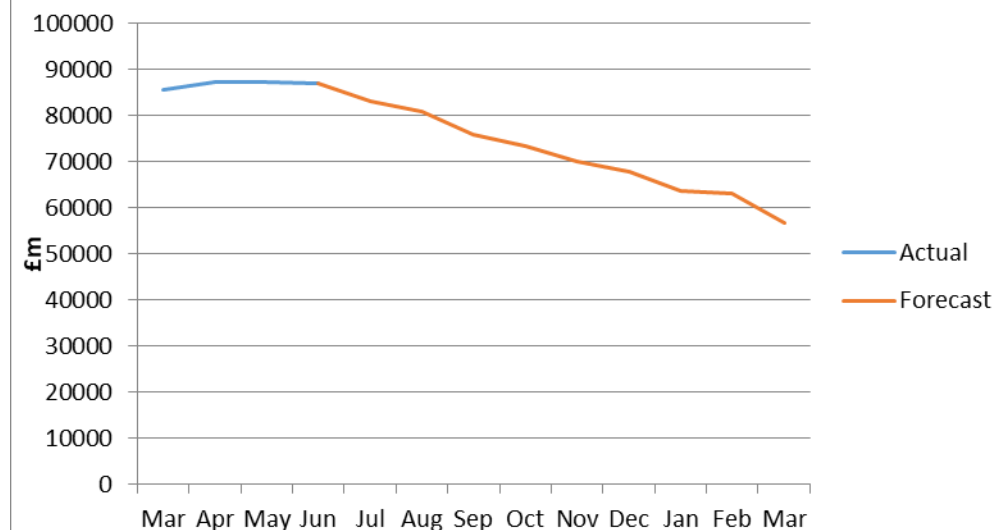
STATEMENT OF YEAR TO DATE CASH FLOWS

	Actual £'000	Plan £'000	Variance £'000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations	(1,545)	(1,224)	(321)
Operating surplus/(deficit)	(1,545)	(1,224)	(321)
Non-cash income and expense:			
Depreciation and amortisation	3,525	3,701	(176)
(Increase)/Decrease in Trade and Other Receivables	(1,461)	0	(1,461)
(Increase)/decrease in other assets	(1)	0	(1)
(Increase)/Decrease in Inventories	(1,859)	(2,415)	556
Increase/(Decrease) in Trade and Other Payables	3,271	16,109	(12,838)
Increase/(Decrease) in Deferred Income	3,980	0	3,980
Increase/(Decrease) in Provisions	(0)	(31)	31
NET CASH GENERATED FROM/(USED IN) OPERATIONS	5,909	16,140	(10,231)
Cash flows from investing activities			
Interest received	1,424	1,369	55
Purchase of Non Current Assets	(4,351)	(4,236)	(115)
Net cash generated from/(used in) investing activities	(2,927)	(2,867)	(60)
Cash flows from financing activities			
Public dividend Capital Received	0	0	0
Loans repaid	42	0	42
Capital element of lease rental payments	(1,101)	(3,055)	1,954
Capital element of Private Finance Initiative Obligations	(139)	(9)	(130)
Interest paid	0	0	0
Interest element on leases	(122)	(63)	(59)
Interest element of Private Finance Initiative obligations	(298)	(134)	(164)
PDC Dividend paid	0	0	0
Net cash generated from/(used in) financing activities	(1,618)	(3,261)	1,643
Increase/(decrease) in cash and cash equivalents	1,365	10,012	(8,647)
Cash and Cash equivalents at 1st April 2024	85,628	86,148	(520)
Cash and Cash equivalents at 30 June 2024	86,993	96,160	(9,167)

Summary Notes

- The cash flow movements are consistent with the comments made on the Statement of Financial Position.
- The closing cash position at the end of June was **£87.0m** (£87.4m in May).
- The cash forecast is for £56.7m at 31 March.

Cashflow Forecast



13. Working Capital Indicators

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	12	
Debtors % > 90 days	5.0%	14.0%	
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	93.7%	
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	87.4%	
Cash (£m) - per year-end plan	58.4	87.0	

Summary Notes

- Debtor days ahead of target.
- Debtors % over 90 days is below target, due to unpaid invoices. These are mainly various ICB's £157k, Salary overpayments £343k, OUH £277k, East London £71k, NHSE £86k, Connect Health £112k, MOD £72k and other £248k.
- NHS BPPC (Better Payments Practice Code) marginally below target. .
- Non-NHS BPPC (Better Payments Practice Code) below target.
- Cash better than year-end target.

14. PFI Exit Settlement Risk

A PFI agreement is due to terminate on 6th September 2024, the 25th anniversary of the PFI (PFI is a 125yr lease and 25yr Facilities Management contract).

PFI is off the national balance sheet therefore a capital charge will be incurred on settlement, against system capital envelope, up to the net book value of the asset.

If settlement value is in excess of the net book value, any element above will score to the Trusts revenue position.

Current position in timeline – valuation work has been completed by both parties but not yet shared, we do not know the PFI providers valuation. Extra work has been requested by OHFT in relation to conditions surveys and due diligence as both expected to impact, and reduce, the final settlement value.

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 11(i)

24th July, 2024

Report from Audit Committee on matters to Alert, Advise or Assure

Executive Summary

The draft minutes of the Committee's most recent meeting - on June 19 of this year - are available for information in the Reading Room.

Important context - The primary purpose of the June Audit Committee meeting was to review the **2023-24 Annual Accounts and Annual Report** - and to the related auditors' reports - prior to recommending the accounts for adoption by the Board (the deadline for their submission being June 28). This deadline was subsequently met, with a "clean" (unqualified) external auditor's opinion secured.

At the time the Committee met, the external auditor's opinion was not available, as a small number of matters were still under review with the Finance Team. These matters were satisfactorily concluded the following week, in time for the Trust to meet the deadline, and have already been shared with and discussed by the Board. To avoid unnecessary repetition, these matters are not included in this report.

From the Committee's scrutiny of other papers, and reflecting on the matters discussed at the meeting, I would draw the Board's attention to the following additional matters:

For Alert (may require discussion)

The Board is asked to note the following:

- No alerts identified for the Board's attention.

To Advise (to monitor)

The Board is asked to note that:

- Action to review members' feedback regarding the **annual self-assessment** of the Audit Committee's effectiveness earlier this year had been scheduled to take place in the autumn in a workshop format. This was to enable any impact of the changes to the chairing arrangements of the Committee to be considered in concert. However, at its June meeting, the Committee noted that the Healthcare Financial Management Association (HFMA) has recently published a fully revised edition of its **NHS Audit Committee Handbook**. In light of this development, the changes included in the new guidance will be reviewed by the Committee at its next meeting, and considered alongside the feedback from the self-assessment.

For Assurance (to note)

The Board is asked to note the following:

- The preparation and audit of the **2023-24 Annual Accounts** was assessed by all parties to have gone relatively smoothly. However, it was agreed that as good practice the Chief Financial Officer and the Trust's auditors will discuss the opportunities for making further improvements to the process, in due course, and will report back to the Committee.
- The Committee reviewed the **Annual Whistleblowing Report for 2023-24** and noted the important work that has been undertaken by this small team over the past year.
- The Committee reviewed the revised drafting of **BAF risk 3.4-Financial Plan and Financial Sustainability** and carried out of a deep dive of the risk and mitigating actions. The Committee agreed that the revised drafting of the risk was an improvement and it was satisfied that appropriate action is being taken to manage this risk at this time.

Sharing of learning

None identified.

Recommendation

The Board is asked to note the above.

Author and Title: Chris Hurst, Chair of Audit Committee

1. ***Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes*** – this report relates to or provides assurance and evidence against the following Strategic Objectives of the Trust:

1) *Quality - Deliver the best possible care and health outcomes*

Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).

2) *People - Be a great place to work*

Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.

3) *Sustainability – Make best use of our resources and protect the environment*

Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects.

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 11(ii)

24 July 2024

**Report from People Leadership & Culture Committee on matters to Alert,
Advise or Assure**

Executive Summary

The Committee continues to meet every quarter and last met 10 July 2024 and considered the agenda attached (minutes attached).

Recommendations

The Committee recommends the Board approves the following for onward submission:

- a) **Medical Appraisal and Revalidation Statement of Compliance** The Committee is assured that the statutory functions of the Responsible Officer (Karl Marlowe) are being appropriately fulfilled. 96% of doctors with a prescribed connection to the Trust and who are not exempt from the requirement have completed or booked their appraisal. 15 doctors have agreed delays. There are no cases of non-compliance. Appraisees rate the process positively (90%+ on all dimensions). Significant progress has been made to the organisational infrastructure to support appraisal and revalidation including the successful recruitment and engagement of Appraisers. The drafting of a new Medical Appraisal and Revalidation Policy has been completed and is awaiting feedback from LNC colleagues.
- b) **Workforce Race Equality Standard (WRES) Report** The data indicate that the experience of minority ethnic staff has seen improvement across most dimensions. There is a mixed picture on the percentage of ethnic minority staff in AfC bands, notably Band 9s, while Board representation and the likelihood of staff entering formal disciplinary processes have

deteriorated. The Committee notes the ongoing gap in staff experience from other data including turnover and early turnover, and the wellbeing of Medics. Specific action is underway to include Inclusion representatives at Band 8+ roles and this work is being scoped so that it can be rolled out at scale. Action plans will be developed by end July 2024.

- c) **Workforce Disability Equality Standard (WDES) Report** The data again indicate improved experience across most dimensions with a mixed picture in representation at different AfC bands. The likelihood of entering a formal capability process has deteriorated as has the percentage of staff experiencing harassment, bullying or abuse and the reporting of it. Action plans will be developed by end July 2024.

For Alert

There are no new matters for Alert to the Board.

To Advise

1. NHSE 6 high impact actions as set out in the NHS EDI Improvement Plan

- 8 of 17 sub-actions due to be completed by end of June 2024 have been completed, and the Committee received additional assurance that the recommendations of *Mend the Gap: The independent review of the Gender Pay Gap in England 2020* which relates to medics have been fully implemented
- 9 of 17 sub-actions due in June 2024 are pending – all now have an estimated delivery date and an action owner. These include:
 - ◊ HIA 3.1 which relates to how the board reviews EDI data and track and monitor via the Trust BAF – estimated completion Sept 2024
 - ◊ HIA 2.2 which relates to widening of recruitment opportunities within local communities – estimated completion October 2024
 - ◊ HIAs 5.1/5.3/5.3/5.4 which all relate to international recruits and will be completed together by January 2025
- A further 9 sub-actions are due by end of December 2024 and are all in progress.
- A reminder that an EDI sub-action must be completed by the Board:

- ◇ By March 2025: Board members should demonstrate how organisational data and lived experience have been used to improve culture.

2. Enablers and barriers to Bringing about change The Committee regularly invites colleagues to share their experience of working in the Trust. Dr Emma Fergusson, Consultant psychiatrist in the Oxfordshire CAMHS Community Service joined the meeting to share her experience of bringing about change. She described how senior support for her initiative to use machine learning in the triage of assessments for young people with neurodiversity, along with introductions to suitable university partners and the funding and appointment of a skilled and motivated project manager had helped her to progress the project in the two years since its inception. She also outlined barriers including:

- Once senior support was secured, having to navigate a large number of internal requirements held by different and changing teams, each operating independently of one another and each with their own purview, hierarchy and process
- Once modest seed funding agreed in principle, long deliberations about from which budget funds would be secured
- A cultural anxiety about risks attached to a new course of action without a counterbalancing pricing of the risk of inaction and/or opportunity
- The requirement to work within existing digital systems (True Colours) when these were not always well integrated with other Trust systems (Rio), rather than a multi-app approach
- The requirement to work with an existing vendor for coding requirements rather than the university partner

The Committee thanked Emma for her leadership and tenacity and observed:

- The challenge of competing priorities
- The presence of themes identified previously in Internal Audit reports on SCAD and Buckinghamshire Service review which identified similar internal barriers.

For Assurance

3. Temporary Staffing The Committee received a verbal update on the Trust's use of Temporary Staffing showing a better than projected performance at Q1 (£7.4m vs £8.4m) driven by improved Agency rates, migration from Agency to

Bank and from Bank to permanent staff. Work is underway to further optimise rates and to manage demand. Agency Control Panels are now operating in all four of the service directorates led by the relevant Service Director and the Trust is undertaking a phased move to a 'Bank-first' approach to fill vacant shifts. Plans have been agreed in relation to how the Trust will address the barriers to the implementation of e-rostering and pilot wards have been identified so that we can test and learn at a small scale before we roll out. The Trust has also commissioned an external and independent review of Temporary Staffing arrangements which will be undertaken by the Programme Director of the South East Temporary Staffing Programme. This will report back to the Executive in late summer with recommendations.

- 4. Retention strategy** A segmented Retention Strategy is being developed to build upon the progress in reducing total turnover (16.66% to 12.66%) and early turnover (19.75% to 14.10%) and will be completed by end of Q2.
- 5. Compliance across core experience** The Committee notes the second PDR season is underway and looks set to improve on the excellent progress made last year, this year focusing on improvements to the quality of PDRs. Statutory and Mandatory Training compliance remains stuck at the improved rate of 89.5% (as at end May 2024) driven largely by variability in Resus and PEACE training. Work is being undertaken to diagnose and address these shortfalls. Clinical and Management Supervision rates are improving but more slowly than planned with ongoing issues with the separate recording of clinical and management supervision which are being addressed by Deputy Chief Nurse and Head of Learning and Development.
- 6. International Nurse Retention** The Committee considered data showing turnover among this group of nurses to be higher than Trust average (19.2% vs 12.46%), but further work will be done to establish if this difference holds when considered by Band. As central funding has now come to an end, the team are using this pause as an opportunity to review and improve how the Trust selects, onboards, supports and develops international staff who require OSCE qualification with the aim of recommencing in January 2025. The review will also inform the action plans for all internationally recruited staff as required by the EDI High Impact Actions.

Author and Title:

Mindy Sawhney

Chair of People Leadership and Culture Committee

1. **Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** – this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust [OR N/A – no Strategic Objectives/Priorities apply] **(please delete as appropriate)**:

1) Quality - Deliver the best possible care and health outcomes

Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).

2) People - Be a great place to work

Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.

3) Sustainability – Make best use of our resources and protect the environment

Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects.

4) Research and Education – Become a leader in healthcare research and education

Strategic risk themes: failure to realise Research and Development potential.

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 12

24 July 2024

**NMAHPP RESEARCH CAPACITY AND CAPABILITY (C&C) DEVELOPMENT
PROGRAMME**

For: Approval

Executive Summary

Staff with a job role to build research capacity and capability within Oxford Health NHS Foundation Trust (OHFT) initiated the Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacists, and Psychologists (NMAHPP) Research Capacity and Capability (C&C) Development (in short: NMAHPP Research C&C) Programme and formed a steering committee.

The purpose of the NMAHPP Research C&C Programme is to set strategic and operational priorities related to the development of research capacity and capability in NMAHPPs and Wider Healthcare Staff. This purpose will be realised by determining the research interest, engagement, capacity and capability of NMAHPPs and Wider Healthcare Staff at the individual level and the readiness for research at an organisational level.

The programme consists of four projects:

- Project 1 involves the contextual validation of a tool to capture research interest, engagement, capacity, and capability. This tool will be the first in England and can be rolled out nationwide.
- Project 2 will capture the research interest, engagement, capacity, and capability of NMAHPP and Wider Healthcare Staff at OHFT at an individual level. The results will provide us with a database, directory, and dashboard and will inform focused approaches to supporting staff in their research needs.
- Project 3 explores the organisational readiness for research in OHFT. The Self-assessment of Organisational Readiness Tool (SORT) that will be used for the purposes of this project, was commissioned and released by NHS England. NHS England encourages all trusts to use this tool to map their research support activities and initiatives.

- Project 4 draws the results of Project 2 and Project 3 together in a consensus study to determine context-specific strategic and operational priorities related to the development of research capacity and capability amongst NMAHPPs and Wider Healthcare Staff in OHFT.

Project 2 (capturing research interest, engagement, capacity, and capability of individual staff) and Project 3 (mapping and assessing OHFT's research support structures and activities) will run annually to assess our progress and adapt our implementation plans accordingly. This programme's rigorous and systematic approach will allow us to strengthen existing and develop new, context-appropriate evidence-informed research support structures and activities.

Due to this programme's long-term impact and the importance of buy-in from OHFT staff in its success, we'd like to get approval from the Board of

Governance Route/Escalation Process

The NMAHPP Research C&C Programme has been presented online via the Zoom platform on 22 February 2024 to public stakeholders including but not limited to Oxford University Hospitals Foundation Trust (OUHT), the Applied Research Collaboration (ARC), National Institute of Health and Care Research (NIHR) to create awareness, invite comments and suggestions, and seek feedback in terms of existing projects, duplication of efforts and opportunities to merge energies.

Dr Vanessa Raymont briefly reported on this programme to the Board on 27 March 2024 as part of the Research and Development/Innovation Report.

Statutory or Regulatory responsibilities

This programme does not relate to any statutory or regulatory responsibilities.

Recommendation

The Board is asked to approve the NMAHPP Research C&C Programme, which aims to develop research capacity and capability in NMAHPPs.

Author and Title: Benita Olivier, Professor of Rehabilitation, Oxford Brookes University & Clinical-Academic, Oxford Health NHS Foundation Trust

Lead Executive Director: Dr Karl Marlowe, Chief Medical Officer

1. *An official risk assessment has not been undertaken around the legal issues that this report presents. However, we do not anticipate any issues that need to be referred to the Trust Solicitors.*
2. **Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** – *this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust:*
 - 1) *Quality - Deliver the best possible care and health outcomes*
 - 2) *People - Be a great place to work*
Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.
 - 3) *Research and Education – Become a leader in healthcare research and education*
Strategic risk themes: failure to realise Research and Development potential.

Report to the Meeting of the Oxford Health NHS Foundation Trust

Agenda item:13

Board of Directors

24 July 2024

Research and Development/Innovation Report

For information

This report covers recent activity related to the R&D Senior Management Team (SMT) and Research Office under the direction of Dr Vanessa Raymont (R&D Director).

Oxford Health Biomedical Research Centre (BRC) and its impact

The BRC is now planning for its mid-term review, which will be held in March 2025. Below are just some the impact stories the BRC themes submitted to the NIHR in the latest annual report, which includes references to some of the research clinics described in the last R&D report to the Board.

Molecular Targets Theme – Long term effects of COVID-19 on mental/brain health

Persisting effects of COVID-19 on mental/brain health are a significant concern. In the past year, the Molecular Targets Theme showed the two-year trajectory of risks compared to a range of other conditions; how these risks differ depending on age, viral strain, prior vaccination, severity of infection; and investigated two possible mechanisms. The research has used two unique resources: the health records of >90 million people and the NIHR/UKRI PHOSP-COVID cohort study. The work received global media interest, influencing policy documents and briefings from WHO, NICE, NIH, and governments. It is informing the public, shaping evidence-based policies, and preparing the way for testing therapeutic interventions. Benefits are accruing to patients recovering from COVID-19, the public, health care systems (including the NHS) and policy makers. The research was also cited in UK Parliament Briefing, by national health/scientific agencies (in Belgium, Canada, France, Germany, Italy, Japan, Norway, Sweden, and Switzerland), and in 2600+ news outlets.

The work, including five papers in the past year has informed several key debates about COVID-19 and its long-term implications for brain and psychiatric health, namely:

- What proportion of patients develop a psychiatric or neurological diagnosis in the 2 years after the infection, and what is the time course?
- How big are the risks compared to matched people recovering from other infections or health events?
- Are the risks the same in children as in adults and older adults?
- Do the risks differ between the SARS-CoV-2 strains?

- Does prior vaccination reduce the risks of post-COVID brain disorders?
- Does the severity of the infection affect the risks of these disorders?
- Can we predict who will develop a post-COVID neuropsychiatric disorder?
- Is there evidence of ongoing brain injury after COVID-19 infection?

The three main changes as a result of the work are:

- Better and more accurate information for the public and health care providers about the course of mental and brain health after COVID-19 infection
- Producing evidence for policy documents to inform health systems and others about the magnitude and nature of the challenges posed, including the relative risks and benefits of vaccination.
- Identification of the first acute biomarker of risk for post-COVID brain health problems, and thereby illuminating a possible mechanism.

Psychological Treatments and Mental Health in Development Themes - NICE approval and NHS implementation of digital therapies for adults, adolescents and children with anxiety or posttraumatic stress disorder

Cognitive behavioural therapies (CBTs) are effective in anxiety disorders, posttraumatic stress disorder (PTSD) and psychosis. The large number of people suffering from these disorders and lack of trained therapists mean that many patients cannot currently access these treatments. The Psychological Therapies and Mental Health in Development Themes have developed guided internet-delivered CBT and virtual reality (VR) therapies that these problems, in collaboration with service users.

David Clark and Anke Ehlers' team developed internet-delivered versions of their NICE recommended cognitive therapies for adults with social anxiety disorder and PTSD (iCT-SAD and iCT-PTSD). These treatments realise all treatment procedures in online modules with video illustrations that patients work through at a time and place convenient to them. A therapist supports patients through weekly calls and messages. An adolescent version of the social anxiety disorder programme was also developed (OSCA).

Cathy Creswell's team developed a novel digitally augmented therapist-guided, parent-led CBT approach using an online platform Online Support and Intervention (OSI) for child anxiety, with the specific aims of enabling efficient, engaging, and accessible treatment for child anxiety disorders.

Patients with psychosis are sedentary for large periods of the day. Building on observations that physical inactivity arises, at least in part, from anxious avoidance of everyday activity, Daniel Freeman's team developed gameChange VR therapy where patients are taken into sophisticated simulations of the real-life scenarios they find troubling. They learn to master these situations in a graduated way with the help of a therapist avatar. The development of the treatments and RCTs were funded by the NIHR (OSI and gameChange), the Wellcome Trust (iCT-SAD, iCT-PTSD and OSCA) and UKRI (OSI). The NIHR Oxford Health BRC provided additional funds to contribute to the maintenance of the online platforms, and the VR lab (VR expert, equipment and software). The Oxford and Thames Valley NIHR ARC contributed to the research programme on OSI. A project team across Oxfordshire & Buckinghamshire is engaging with primary and secondary care teams in OHFT to understand local mental health needs and identify pilot sites for implementation. Collaborations with pilot sites will focus on developing infrastructure for identifying, assessing, and treating patients while addressing potential health and digital inequalities to ensure inclusivity. Coordination with the Clinical Systems Transformation Team will ensure regulatory approvals are met before deployment. Mental health workers who are interested in, and identified as suitable to deliver gameChange VR will receive comprehensive training, support, and supervision. The project will continuously monitor and evaluate outcomes to generate real-world evidence, establish an evidence-based business case, create an implementation blueprint, and develop a national centre of excellence within OHFT for the nationwide roll-out of gameChange VR in the NHS.

Randomised clinical trials have demonstrated excellent outcomes for each of these digital treatments. They were effective or more effective than routine therapy, whilst also saving therapist time. The treatments are acceptable to patients and not only reduced their distressing symptoms, but also improved their quality of life greatly. Patients have reported high satisfaction with all of the treatments. The positive results led to recommendations by National Institute of Care and Clinical Excellence (NICE) Early Value Assessments in 2023 that the new digitally-enabled therapies are used in the NHS and evaluated further. In collaboration with health tech companies, the digital treatments are now being extended into the NHS.

Brain Technologies Theme - The “DyNeuMo” Brain Machine Interface: Development and translation of a fully implantable, bioelectronic system for applying chronobiology to improve the treatment of neurological disorders

Deep brain stimulation (DBS) is a recognised treatment for neurological disorders such as Parkinson's Disease, epilepsy, and dystonia. However, existing DBS systems overlook the impact of circadian rhythms on physiological and neurological functions, limiting their effectiveness, and, similar to pharmaceutical interventions, response may vary depending on the timing of stimulation relative to the circadian phase. The Brain Technologies Theme is addressing the need for incorporating circadian rhythms into DBS therapy to optimise existing therapies in the short-term, and then exploring the opportunity to ultimately slow or reverse disease progression by reestablishing healthy sleep-wake rhythm. They are co-developing the Picostim DyNeuMo system, a highly configurable, implantable bioelectronic platform, in collaboration with a UK-based industry partner, Bioinduction. This project supports three first-in-human trials (epilepsy, chronic pain, disorders of consciousness) that aim to demonstrate the feasibility and potential benefits of circadian responsive DBS. By establishing a research ecosystem that prioritises chronobiology in DBS therapy, the project marks a pivotal step towards more personalised and effective treatment protocols for neurological conditions. The DyNeuMo is designed and manufactured in the UK at a facility in Welwyn Garden City. This project has significantly expanded the active implantable medical device (AIMD) capability of the UK.

The Picostim DyNeuMo is currently supporting five clinical studies exploring new treatments for the NHS. The trials are at various stages of maturity:

1. **MINDS (MotioN aDaptive Deep Brain Stimulation for MSA):** This Oxford sponsored trial investigates circadian-based stimulation therapies for multiple system atrophy (MSA).
2. **NIHR Funded - MORPHEUS-2 (Manipulating and Optimising Brain Rhythms for Enhancement of Sleep):** Focuses on improving circadian dysfunction in PD patients, underscoring the system's chronotherapeutic potential.
3. **EPIONE (Efficacy of Pain Intervention with Deep Brain Stimulation):** Targets chronic central post-stroke pain, showcasing the system's application in pain management.
4. **BRAINSTATE (BRAIN Stimulation for Recovery of Minimally Conscious STATE):** Aims at enhancing recovery in patients with minimally conscious state (MCS).
5. **CADET (Children's Adaptive Deep Brain Stimulation for Epilepsy Trial):** Focused on Lennox-Gastaut syndrome, CADET explores the potential of the DyNeuMo system in paediatric epilepsy management.

Mental Health in Development Theme - Accelerating the development and improvement of psychological interventions for anxiety disorders and depression in children and young people: the Anxiety and Depression in Young People (AnDY) Research Clinic – Oxford

Anxiety disorders and depression are common in children and young people. Although effective treatments exist, many young people cannot access timely and evidence-based treatment and around half continue to experience difficulties following treatment. Anxiety disorders affect around 6.5% of children and young people (Polanczyk et al., 2015). They are associated with significant impacts on children's home, school, and wider lives and lead to a range of ongoing problems into adulthood (Pollard et al, 2023). Yet few children

access timely evidence-based treatments (Reardon et al, 2019) and around half continue to experience difficulties following treatment (James et al., 2020).

The Mental Health in Development Theme have established an integrated research and clinical centre for children and adolescents with anxiety disorders and depression, the Anxiety and Depression in Young People (AnDY) Research Clinic – Oxford, in collaboration with Oxford Health (OH) NHS Foundation Trust Child and Adolescent Mental Health Services (CAMHS). This partners, and builds upon, the experiences of the successful AnDY Research Clinic – Reading (University of Reading/Berkshire Healthcare NHS Foundation Trust), which has supported a range of research studies, including several major studies funded through the NIHR (e.g., [https://doi.org/10.1016/S2215-0366\(23\)00429-7](https://doi.org/10.1016/S2215-0366(23)00429-7)) and provided interventions to over 1,000 young people (~80% improved; ~60% remission; >90% not requiring further input). AnDY Oxford will provide high quality assessments and brief psychological treatments to patients, including those with neurodiversity (who have traditionally been underserved) and improved access to research opportunities. They have developed the service specification, set up systems and built relationships across OH CAMHS to establish reliable and effective processes to identify eligible young people. They have reviewed >100 young people on existing waiting lists and started contacting families to arrange assessments. They have procured IT patient management software that will optimise routine clinical data collection that can then be used for research purposes (subject to the necessary ethical permissions being in place). The clinical team has been recruited and is currently being trained to deliver evidence-based assessments and treatment. They are working closely with the OH R&D team to ensure appropriate systems and processes are in place to support research (e.g., around study approvals and data flows) and AnDY Reading to support an integrated programme of clinical research across sites and have set up a research steering committee (in partnership with multiple University and NHS stakeholders and people with lived experience) to oversee the development and implementation of the research programme. To date, support has been approved for the first three studies to be conducted in the clinic (as such, we are on track to meet our medium term (2-3 years) milestone of recruiting clinical participants to three or more research studies).

The long-term plan is to create a blueprint for further scaling through a national network of clinics to provide benefit to patients at a national level. NIHR funding (via the BRC) has provided support for staff and IT systems to support research.

Pain Theme - Improving pain visibility and treatment in hospitalised neonates through parental involvement

Pain in early life can have long-term consequences for development, shape future pain experiences, and lead to parental anxiety, so research into effective pain management for infants is essential. Comfort measures such as breastfeeding or swaddling are inconsistently used in newborn care and are not always practical. In contrast, stroking which activates nerve fibres involved in social touch, could offer a simple and safe parent-led way to reduce neonatal pain during procedures. The Pain Theme's Parental Touch Trial (*Petal Trial*) investigated whether parental stroking before a painful clinical procedure provides effective pain relief in neonates. The trial also assessed parental anxiety and surveyed parents' experiences in neonatal pain research. Parents reported reduced anxiety after the procedure and found providing touch was reassuring and useful. Based on these findings, they developed extensive resources for parents and professionals in collaboration with the UK-leading charity for neonates and their parents to enable parental involvement in providing comfort to their infants during painful interventions. Parental involvement in neonatal pain relief is one of the core elements of family-centred care and can help parents to establish their caregiver role. However, there was a lack of research regarding parental motivations and experiences in delivering care, which needed to be addressed to improve parental involvement in the Neonatal Intensive Care Unit (NICU).

Collaborating with *Bliss* (<https://www.bliss.org.uk>), a leading national charity supporting sick and premature babies and their families, the theme initiated a national campaign to raise awareness of the importance of

parental touch in providing comfort to babies during painful medical procedures. The campaign goals align with the Lancet Commission on Paediatric Pain (2021), that called for pain in children to be “understood” and to be made “better”. This work directly informed an NIHR commissioned grant ‘*Pain management for children and young people (0-19 years)*’ (<https://www.nihr.ac.uk/documents/pain-management-for-children-and-young-people-0-19-yearseme-programme/29335>). The campaign resources have been created to empower both parents and health care professionals to involve parents in babies’ care during painful procedures. Guided by input from parents and neonatal care staff across the UK via a survey and several focus groups, *Bliss* created original web content focusing on parental touch during neonatal painful procedures. The research team and a filming team from the University of Oxford Public Affairs Directorate have worked closely with *Bliss* and the Oxford University Hospitals NHS Foundation Trust Newborn Care Team to create video resources about this topic for parents and neonatal care teams. The videos feature examples of how parents and clinical staff can comfort babies, and interviews with parents, clinicians and researchers. The University of Oxford Public Affairs Directorate also produced a video to showcase this exceptional example of relationship building and collaboration between Oxford researchers, clinicians, and a national charity to create direct impact for the improvement of public awareness and patient care. The campaign resources were published in December 2023, which coincided with the publication of the *Petal Trial* results. The resources were shared via the *Bliss* website and on *Bliss* social media. The campaign reached over 50,000 people through a social media campaign (20,000 via *Bliss*’ Instagram profile; 49,000 via Twitter; 72,000 via Facebook). In addition, the campaign reached approx. 5,000 families currently experiencing neonatal care through *Bliss*’ contact with neonatal units across the UK, and 2,000 neonatal care staff through the *Bliss* newsletter and journal. In addition, the University video was shared on the University of Oxford website and social media channels.

BBC (Baseline Biomarker Check) clinic

Psychotic disorders affect 2-3% of the population, are among the most disabling of all health conditions. Most people with psychotic disorders are unable to work or lead a normal social life. The total cost of caring for psychotic disorders in England is around £12bn per year. Psychosis can have a number of different causes, and the treatment for each cause is different. It is therefore critical to determine what type of problem is causing the symptoms as early as possible, so patients can then be offered the right type of treatment (Blackman et al, World Psychiatry, 2024). However, at present, people presenting with psychosis for the first time are not being assessed in a systematic way, and the assessments are often carried out several weeks after patients have first contacted services. This delays the diagnosis of the underlying cause, and also delays the offer of appropriate treatment (Blackman et al, JAMA Psychiatry, 2024). For example, in some people, psychosis results from the effects of a tumour in the brain. If these individuals are not assessed with a brain scan, the problem may be undetected, and they are likely to receive treatment with antipsychotic medication instead of neurosurgery. This delay in receiving the right treatment reduces their chances of recovery and increases the cost of care.

The BBC clinic aims to address this issue by ensuring that every person who develops a first episode of psychosis in Oxford will have access to a comprehensive assessment shortly after their initial clinical presentation. The assessment includes a detailed clinical evaluation, cognitive testing, the collection of blood and urine samples, and an MRI scan. All of the assessments are collected by the BBC clinic staff in a single session, which is less burdensome for the patient than having multiple different assessments at different times. The BBC clinic organises all of the bookings and transport, which reduces the demands on the early intervention team. The results are rapidly provided in an easy to read report which is added to the patient’s electronic health record. This approach allows new patients to be stratified according to the cause of their psychosis, and then be offered the most appropriate treatment the cause in their case. It provides patients with access to the right treatment at the right time - as soon as possible after illness onset. Our PPI work shows that service users with psychosis like this approach, and their experiences of the clinic have been positive.

NIHR infrastructure funding (through the NIHR Oxford Health BRC), along with the support of Oxford Health R &D, has been critical to supporting the BBC clinic. It was set up in partnership with the local Early Intervention service for Psychosis in Oxford Health NHS Foundation Trust, and operates as an adjunct to a well-established clinical care pathway. Patients who contact the Early Intervention team and have a diagnosis of first episode psychosis are immediately referred to the BBC clinic, which organises and completes the baseline assessments at the NIHR Clinical Research Facility (CRF), Warneford Hospital. NIHR funding supports the costs of staffing the BBC clinic, the cognitive, neuroimaging and blood biomarker assessments, the PPI work, and the CRF where the assessments are carried out.

The next steps are to finalise the assessment protocol and complete health economic analysis to show cost effectiveness of BBC clinic. They will then submit a bid to Oxford Health NHS Foundation Trust for NHS funding of the BBC clinic.

Oxford Health Clinical Research Facility (OH-CRF) achievements

The Aftercare Project

This is a joint quality improvement project between OH-CRF and R&D which is exploring the needs of research participants as they end study participation. We have supported the creation of a co-designed resource to support these participants and are identifying ways of sharing research study results with participants. We have co-produced an aftercare leaflet for participants and a guide for researchers on how best to share results with participants. The PPIE contributor who was part of the working group reported: "I was actively encouraged to comment, and I was able to participate fully in online meetings...I was always made to feel an integral part of the project." This project has been presented as a poster at the latest UKCRFN Conference in Leicester and won first place in the 'Improvement and Quality' category nationally.

CRF Activity 2023-24

There are a number of significant achievements by OH-CRF during current reporting period. One of high significance is the set-up and delivery a portfolio of studies investigating psychedelic drugs for the treatment of mental disorders. Psychedelic treatment provides an innovative approach to mental health disorders, where there has previously been little progress in developing new treatment options; however, their mechanism of action is not completely understood and their use in clinical populations requires specifically trained staff and expertise. Building on our current experience of delivering intravenous ketamine in healthy volunteers and in people with treatment resistant depression, we offer expertise and purpose-built facilities, with multidisciplinary staff trained to support these studies in diverse mental health conditions. So far, we have received 5 Home Office schedule I licenses, and will lead experimental medicine studies and clinical studies locally and across the country: *psilocybin* and *5-MeO-DMT* in treatment resistant depression; *5-MeO-DMT* in bipolar depression and peri-partum depression; and *methylone* in post-traumatic stress disorder. We expect to progress to run Phase II and III trials in these treatments.

Secondly, OH-CRF has continued the successful collaboration with the Oxford Experimental Medicine Clinical Research Facility (EMCRF) for mutual training of staff but also for the set-up of a novel Phase I trial (CELIA), using the EMCRF access to critical care facilities and OUH pharmacy expertise. Both CRFs are committed to collaborate further by holding regular operational meetings and conducting joint study feasibility assessments when appropriate, making best use of resources within the Oxford research infrastructure landscape.

Lastly, the novel approach developed by the OH-CRF in collaboration with industry, UOXF, and OHFT for disease modifying drugs for dementia, currently under consideration by National Institute for Health and

Care Excellence (NICE). It is likely that they will be offered on the NHS, but their use may be restricted to a small proportion of patients who meet criteria including evidence of amyloid positivity. This presents a challenge for NHS services as this biomarker is only detectable via positron emission tomography (PET) scan – very expensive - or lumbar puncture (LP). LP is likely to be the preferred NHS option on the basis of cost and availability of scanners, but LP is not part of the routine NHS assessment of dementia. In collaboration with industry, to provide proof of concept of a new clinical pathway for the Trust, we are setting up a point-of-care bespoke LP clinic as an addition to usual dementia care pathways in the NHS. LPs will be provided at the OH-CRF, with associated monitoring using an OH-CRF Advanced Nurse Practitioner trained to complete LPs. This complements our portfolio of dementia studies (for example the Deep and Frequent Phenotyping study) investigating biomarkers for dementia.

The OH-CRF 23/24 activity in numbers: We had a portfolio of 74 studies, out of which 68% were high and medium-risk and intensity and we recruited 515 participants. With a 91.7% room occupancy over the reporting period, we facilitated a total of 677 participant visits. We foster and continue to develop over twelve commercial collaborations and over 40% of our studies are industry funded. We continue to proactively seek to engage industry with the OH-CRF Manager sitting on the national Industry Liaison Group of the UKCRFN.

Oxford Bioresource plans

Biological samples (blood, urine, CSF, stool) are increasingly being collected from participants in research studies, and now clinical services, in mental health and memory disorders. This has been driven by a series of recent findings that indicate that biomeasures can be used to help with accurate diagnosis, predicting key clinical outcomes, such as the onset of illness, or the future response to treatment.

At present, there is no dedicated place in Oxford to store biological samples collected from research studies in mental health. The OH-CRF at the Warneford hospital has the potential to host and support a high quality bioresource for this purpose. It has the necessary space, and already employs a large number of specialised staff who are trained in the handling and processing of biosamples. The proposed facility would involve a range of local stakeholders, including OH R&D, OH BRC, OH-CRF, and academics who are leading research studies in psychosis, mood disorders and dementia.

Thames Valley and Surrey Secure Data Environment (TVS SDE)

The current Head of Research Informatics and Deputy Head of R&D, Tanya Smith, has recently been offered a secondment post, with Oxford University Hospitals (OUH), as the TVA SDE Mental Health Data Lead. This is an exciting opportunity, that will ensure that Oxford Health and mental health remains at the forefront of the ongoing SDE development and support mental health research using real world health data, linking with primary, secondary, and acute care, including imaging and genomics datasets. Whilst this role will be based at OUH, Tanya will remain an integral part of Oxford Health regarding mental health datasets and will continue to link with the Digital & Data Strategy Board to provide regular SDE updates and continue to work closely with R&D, BRC and Mental Health Mission colleagues.

Community Directorate achievements

Community Directorate achievements

Our community directorate research delivery team continues to support a number of research studies:

- Open/Active Studies: 15
 - NIHR portfolio studies: 8
- Pipeline/Under R&D review: 3
 - NIHR portfolio studies: 2
- Directorate based Principal Investigators: 8 (+ 2 in pipeline)
- Directorate based Chief Investigators: 2 (both are preparing to submit for regulatory approvals)

Studies include:

- Community Respiratory Nursing Pulmonary Rehab - **Improving completion of Pulmonary Rehabilitation with PR-Buddies (IMPROVE; improvetrial.co.uk)**
- Children's Community Nursing Palliative Care - **C-POS Questionnaire Study: The Children's Palliative Outcome Scale Validation Study**
- Abingdon and Witney MIUs - **Distal Radius Acute Fracture Trial CAst versus Splint (DRAFT 3 CASP)**
- Health Visitors - **A Cluster Randomised Controlled Trial of a Service to Support the Mental Health and Coping of Parents with Excessively Crying Infants**
- OH was the top NHS recruiting centre for C-POS regionally (TVSM) and ranking joint 13th / 107 sites nationally.
- A monthly Directorate Research Forum is ongoing and regularly attended by a growing core group of staff
- The community directorate research delivery team held a QI/Research Showcase Event on 8 May 2024, with research prizes funded courtesy of R&D.

R&D Engagement

R&D is finalising its revised webpages, both for internal and external use. Our published strategic aims (which align with our overall Trust strategic aims, but are aimed at streamlining our focus for collaborators and industry partners) are:

- 1) Ensure research is embedded and integrated across Oxford Health
- 2) Improve access to our research for all patients or staff, to support the development of cutting edge care
- 3) Promote our research activities to attract and retain staff across all disciplines

Author: Dr Vanessa Raymont

Lead Executive Director: Dr Karl Marlowe

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 14

24 July 2024

**Equality, Diversity, and Inclusion:
Summary of Workforce Race Equality Standard and Workforce Disability
Equality Standard Reports for year ending March 2024**

Executive Summary

The paper reports on our annual submission of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) as required by the NHS Standard Contract.

The report analyses the progress against the nine WRES Indicators and ten WDES Metrics, as well as proposing recommended actions plans for 2024/25 to continue improving both mandated standards.

The Trust Board is asked to receive the paper for assurance on the information presented in the report and the proposed high-level WRES and WDES actions.

The WRES data indicates that the experience of minority ethnic staff has seen improvements across most Indicators. The People, Leadership and Culture (PLC) Committee noted a mixed picture on the increased percentage of ethnic minority staff in AfC bands, notably Band 9s, while Board representation and the likelihood of staff entering formal disciplinary processes have deteriorated. Specific action is underway to include Inclusion Representatives at Band 8+ roles and this work is being scoped so that it can be rolled out at scale after a pilot indicated positive impact.

The Committee were also apprised of specific action the CEO and CPO are now undertaking in relation to ethnic minority staff who are being forward to formal disciplinary.

In relation to the WDES, the People, Leadership and Culture (PLC) Committee also noted improvements across most Metrics with a mixed picture in the representation of disabled staff at different Agenda for Change (AfC) bands. The likelihood of entering a formal capability process has deteriorated as has the percentage of staff experiencing harassment, bullying or abuse and the reporting of it.

A summary and detailed review of the WRES can be found on pages 4 – 8. The summary and detailed review of the WDES can be found on pages 11– 15. The data packs for the WRES and WDES are included in Appendix 1 and 2.

The Committee welcomed action plans being drawn up for race and disability that consider the areas of WRES and WDES that require improvement. The WRES 2024/25 Action Plan can be found on page 9 and the WDES Action Plan 2024/25 can be viewed on page 15.

Governance Route/Escalation Process

Feedback from staff, EDI leads, staff network members and Executives were incorporated into the report that was presented to the People, Leadership and Culture Committee at the meeting held on 10 July 2024.

The Committee recommended that the Board approves the report for onward submission.

Statutory or Regulatory Responsibilities

The Trust Board is asked to receive this report as a statement of assurance and compliance with responsibilities to produce the WRES and WDES Reports in line with our contractual reporting requirements under the NHS Standard Contract.

Recommendation

The Trust Board is asked to approve:

- The contents of the WRES and WDES 2024 Reports
- Confirm assurance with the progress made with respect to the majority of WRES Indicators and WDES Metrics

Author and Title: Mo Patel, Deputy Head of OD – EDI

Lead Executive Director: Charmaine De Souza, Chief People Officer

A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors.

Strategic Objectives/Priorities – *This report relates to and provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust:*

2) People - Be a great place to work

WRES and WDES 2024 Reports

The WRES and WDES Reports provide analysis against the nine WRES Indicators and the ten WDES Metrics for the reporting period 2024 and include comparative data analysis for the years 2023 and 2022 to aid trend study.

The WRES and WDES reports are made up of the 2023 Staff Survey and ESR 2024 data, which together provide insight into the experiences, treatment, and opportunities of staff from diverse ethnic communities and staff with disabilities respectively against the WRES Indicators and WDES Metrics presented in the attached slide decks.

The report is being presented to invite the Trust Board to consider the content, comment on the findings and confirm assurance of the WRES and WDES Reports 2024 and the respective Action Plans 2024/25.

Workforce Race Equality Standard (WRES)

Summary of where we have improved, remained the same and worsened.

In this reporting period, the WRES 2024 Report sets which indicators have:

- **Improved:**
 - Indicator 1 (increases in BME staff in some clinical and non-clinical AfC Bands)
 - Indicator 2 which relates to likelihood of staff being appointed from shortlisting
 - Indicator 4 which relates to likelihood of staff accessing non mandatory training/CPD
 - Indicator 5 which relates to staff experiencing harassment, bullying or abuse from patients, relatives or the public
 - Indicator 6 which relates to staff-on-staff experiences of harassment, bullying or abuse
 - Indicator 7 which relates to staff perceptions related to equal opportunities for career progression or promotion
 - Indicator 8 which relates to percentage of staff experiencing discrimination at work.
- **Remained the same:**
 - Indicator 1 – Some bands have remained the same in the representation of non-clinical and clinical BME staff

- **Worsened:**
 - Indicator 1 which relates to representation (decreases in BME staff in some clinical and non-clinical AfC Bands)
 - Indicator 3 which relates to likelihood of staff entering the formal disciplinary process
 - Indicator 9 which relates to the percentage difference between the organisations Board membership and its overall workforce in relation to ethnicity

N.B.

- Indicator 1 appears multiple times in the analysis to fully draw out the changes in the representation of BME staff by AfC banding.

More detailed analysis of the WRES Indicators

WRES Indicators: Improved

Indicator 1: BME Staff

Non-Clinical:

- There have been increases of BME staff in the following non-clinical bands:
 - 12 BME staff in Band 2 (an increase of 5.7%)
 - 3 BME staff in Band 3 (an increase of 2.0%)
 - 15 BME staff in Band 4 (an increase of 2.2%)
 - 15 BME staff in Band 5 (an increase of 6.6%)
 - 2 BME staff in Band 7 (an increase of 1.0%)
 - 3 BME staff in Band 8c (an increase of 7.9%)

Clinical:

- There have been increases of BME staff in the following clinical bands:
 - 4 BME staff in Band 2 (an increase of 12.0%)
 - 34 BME staff in Band 3 (an increase of 2.1%)
 - 56 BME staff in Band 5 (an increase of 3.9%)
 - 50 BME staff in Band 6 (an increase of 3.2%)
 - 13 BME staff in Band 7 (an increase of 1.6%)
 - 9 BME staff in Band 8a (an increase of 1.3%)
 - 4 BME staff in Band 8b (an increase of 1.3%)
 - 1 BME staff in Band 8c (an increase of 0.5%)

Indicator 2: Relative likelihood of white staff being appointed from shortlisting compared to BME staff

- The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 0.76 times, which is below the equitable figure of 1.00, indicating that BME staff are more likely than white staff to be appointed from shortlisting for the Trust as a whole.
- This is the fourth consecutive year this indicator has been below 1.00, making it increasingly identifiable as a trend.

Indicator 4: Relative likelihood of white staff accessing non-mandatory training & CPD compared to BME staff

- This indicator shows total parity between white staff and BME staff accessing non-mandatory training & CPD.
- This is the first time for any indicator to have achieved the equitable figure of 1.00 for the Trust since the introduction of the WRES in 2015.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

- There has been a decrease of 0.3% from 30% to 29.7% in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public.
- The decrease of 3.0% for white staff from 24.7% to 21.7% makes it the lowest % this indicator has achieved for white staff since the introduction of the WRES in 2015 and marks it out as one of the most notable improvements for white staff in this reporting period.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

- There has been a decrease of 1.9% from 20% to 18.1% in the percentage of BME staff experiencing harassment, bullying or abuse from staff.
- This is the lowest % this indicator has achieved for BME staff since the introduction of the WRES in 2015.

Indicator 7: Percentage of staff believing the organisation provides equal opportunities for career progression or promotion

- There has been an increase of 4.4% from 50.1% to 54.5% in the percentage of BME staff believing the organisation provides equal opportunities for career progression or promotion.
- There has been an increase of 0.6% from 62.7% to 63.3% in the percentage of white staff believing the organisation provides equal opportunities for career progression or promotion.
- This is the highest % this indicator has achieved for both BME and white staff since the introduction of the WRES in 2015.

Indicator 8: Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in last 12 months

- There has been a decrease of 2.4% from 12.7% to 10.3% in the percentage of BME staff experiencing discrimination at work from manager/team leader or other colleagues,
- This is the lowest % this indicator has achieved for BME staff since the introduction of the WRES in 2015.

WRES Indicators: Remained the same

Indicator 1: BME Staff

Non-Clinical:

- There have not been any changes in headcount, however the % representation has changed in some instances due to the variance of BME representation in the overall workforce:
 - No change in number of BME staff in Band 8a (a decrease of 1.7%)
 - No change in number of BME staff in Band 8d (a decrease of 1.3%)
 - No change in number of BME staff in Band 9 (percentage remains at 0%)
 - No change in number of BME staff in VSM (an increase of 5.5%)

Clinical:

- There have not been any changes from the previous year in the representation of clinical BME staff in:
 - Band 8D (1 BME staff, 0%)
 - Band 9 (0 BME staff, 0%)
 - VSM (2 BME staff, 0%)

WRES Indicators: Worsened

Indicator 1: BME Staff

Non-Clinical:

- There have been decreases of BME staff in the following bands:
 - 4 BME staff in Band 6 (a decrease of 2.5%)
 - 1 BME staff in Band 8B (a decrease of 1.6%)

Clinical:

- There has been a decrease of BME staff in the following band:
 - 12 BME staff in Band 4 (a decrease 0.7%).

Indicator 3: Relative likelihood of BME staff entering into formal disciplinary process compared to white staff

- There has been an increase of 1.06 from 2.08 to 3.14.
- The actions from EDI QI Project 2 have only recently been implemented, so they will be monitored to see if they have any impact.
- Additionally, the CPO and CEO are now reviewing all cases that involve BME staff who are involved in Preliminary Fact Finding before they go forward to a formal hearing.

Indicator 9: Percentage difference between the organisation's Board membership and its overall workforce

- The representation of BME members on the Board has improved over the years, from 0% in 2015, 17.6% in 2022, to 20% in 2023 which saw its highest percentage of BME Board members since the introduction of the WRES. In 2024, the representation of BME members on the Board is 16.7%
- In this reporting period, the indicator shows that the difference between the BME Board membership and the Trust's overall BME workforce has increased from 0.7% in 2023 to 6.2% in 2024.
- The 6.2% difference is partly due changes in Board membership and an increase of 2.2% in the percentage of BME Staff in the overall workforce which together have widened the gap.

WRES Action Plan 2024/25

WRES Indicator/ QI Project	OBJECTIVE (What are we going to do?)	ACTION (How will we do it?)	TIMESCALE (When will we do it?)	MILESTONE (What do we want to achieve?)
Indicator 1: Increasing workforce diversity	Embed fair and inclusive recruitment processes that target under-representation and lack of diversity	Introduce and include an 'Inclusion Representative' on interview panels for Band 8a and above positions Recruit staff volunteers from directorates, equality networks, and wider workforce Train and on-board all staff volunteers to become 'Inclusion Representatives'	For Band 8c and above posts by August '24 For Band 8a and above posts by October '24	50 staff members are trained as 'Inclusion Representatives' Inclusion Reps included on all interview panels/ stakeholder groups for Band 8c and above posts Inclusion Reps included on all interview panels/ stakeholder groups for Band 8a and above posts
Indicator 3: De-biasing the disciplinary process	De-bias the process and ensure practice does not have differential impact by ethnicity	Launch revised Respect, Civility & Resolution Policy (Disciplinary Process) with supporting documentation Investigation training to all case managers and investigating officers	September '24	Policy launched with a review at the end of the financial year All case managers and investigating officers trained
Indicator 7: Improving equal opportunities in career development and progression	Embed fair and inclusive talent management strategies that target under-representation and lack of diversity	Audit current talent pipeline and research issues that hinder the development of an ethnic minority talent pipeline or produce disparity in experience Assess access to career progression, training and development opportunities for	December '24 December '24	Diverse BAME talent is identified and developed Clear pathways to career development and progression developed

		BAME staff, including IEN staff		
		Produce an Ethnicity Pay Gap Report and put in place an improvement plan, if required	September '24	Ethnicity Pay Gap Report produced, and any remedial action put into place

Workforce Disability Equality Standard (WDES)

Summary of where we have improved, remained the same and worsened.

In this reporting period, the WDES 2024 Report analyses which indicators have:

- **Improved:**
 - Metric 1 which relates to representation at each band (increases in disabled staff in some clinical and non-clinical AfC Bands)
 - Metric 2 which relates relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting
 - Metric 4 which relates to staff experiencing harassment, bullying or abuse and the reporting of it
 - Metric 5 which relates to percentage of staff who believe that the Trust provides equity in relation to career progression and training
 - Metric 6 which relates to percentage of staff who feel pressured to come to work if unwell
 - Metric 7 which relates to percentage of staff who believe their work is valued
 - Metric 8 which relates to percentage of staff who feel adequate adjustments have been put in place
 - Metric 9 which relates to staff engagement
 - Metric 10 which relates to difference between the organisations Board membership and overall workforce in relation to disability.
- **Remained the same:**
 - Metric 1 which relates to representation at each band (Bands 8A, 8C, 9 & VSM non-clinical and Bands 8D, 9 & VSM clinical disabled staff)
- **Worsened:**
 - Metric 1 which relates to representation at each band (decreases in disabled staff in some clinical and non-clinical AfC Bands),
 - Metric 3 which relates to the likelihood of disabled staff entering the formal capability process
 - Metric 4 which relates to staff experiencing harassment, bullying or abuse and the reporting of it

N.B.

- Metric 1 appears multiple times in the analysis to fully draw out the changes in the representation of disabled staff by AfC banding.
- Metric 4 appears multiple times in the analysis because it is made up of Part A's three sub-metrics and Part B, for disabled and non-disabled staff.

More detailed analysis of the WDES Metrics

WDES Metrics: Improved

Metric 1: Non-Clinical disabled staff

- By headcount, there have been increases in the representation of non-clinical disabled staff in Bands 3, 4, 5, 6, 7 and 8A.
- Highest increases of disabled staff in Band 4 (+6), Band 8A (+4) and Bands 3 & 5 (+3).

Metric 1: Clinical non-disabled staff

- By headcount, there have been increases in the representation of clinical disabled staff in Bands 2, 3, 4, 5, 6, 7, 8A, 8B and 8C.
- Largest increases of disabled staff in Band 5 (+26), Band 3 & 5 (+24) and Band 4 (+12).

Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

- The relative likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff is 0.73 times, which is below the equitable figure of 1.00, indicating that disabled staff are more likely than non-disabled staff to be appointed from shortlisting for the Trust as a whole.
- This is the third consecutive year this indicator has been below 1.00.

Metric 4: Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, their relatives, or other members of the public

- There has been a decrease of 3.7% from 32.8% to 29.1% in the percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives, or the public.
- There has been a decrease of 2.3% from 23.3% to 21% in the percentage of non-disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public. This is the lowest % this indicator has achieved for non-disabled staff since the introduction of the WDES in 2019.

Metric 4: Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers

- There has been a decrease of 0.4% from 12.3% to 11.9% in the percentage of disabled staff experiencing harassment, bullying or abuse from managers.
- There has been a decrease of 1.2% from 6.2% to 5% in the percentage of non-disabled staff experiencing harassment, bullying or abuse from managers. This is the lowest % this indicator has achieved for non-disabled staff since the introduction of the WDES in 2019.

Metric 4: Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they, or a colleague, reported it

- There has been an increase of 0.8% from 60.3% to 61.1% in the percentage of disabled staff saying that the last time they experienced harassment, bullying and abuse at work, they or a colleague reported it.
- This is the highest % this indicator has achieved for disabled staff since the introduction of the WDES in 2019.

Metric 5: Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

- There has been an increase of 2.1% from 55.8% to 57.9% in the percentage of disabled staff believing the organisation provides equal opportunities for career progression or promotion.
- There has been an increase of 1.0% from 61.8% to 62.8% in the percentage of non-disabled staff believing the organisation provides equal opportunities for career progression or promotion.
- This is the highest % this indicator has achieved for both disabled and non-disabled staff since the introduction of the WDES in 2019.

Metric 6: Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

- There has been a decrease of 0.5% from 18.6% to 18.1% in the percentage of disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- There has been a decrease of 1.7% from 12.6% to 10.9% in the percentage of non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- This is the lowest % this indicator has achieved for non-disabled staff since the introduction of the WDES in 2019.

Metric 7: Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

- There has been an increase of 2.5% from 45.7% to 48.2% in the percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work.
- There has been an increase of 0.9% from 57% to 57.9% in the percentage of non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Metric 8: Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

- There has been an increase of 2.6% from 81.2% to 83.8% in the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
- The improvement maintains it as one of the strongest and most favourable metrics for the Trust compared to the national average (73.4%) regional average (75.6%) and BOB ICS average (75.5%).

Metric 9: The staff engagement score for disabled staff, compared to non-disabled staff

- On a scale of 1–10, the staff engagement score for disabled staff is currently at 6.9, up slightly from 6.8 last year.
- This is expected to improve with further engagement with the relevant staff network and support groups.

Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

- There has been an increase of 6% from 5% to 11% in the percentage of disabled members on the Board, resulting in a 4% positive difference in favour of disability representation between the board (11%) and the overall workforce (7%).

Remained the same

Metric 1: Non-Clinical disabled staff

- By headcount, there has been no change from the previous year in the representation of non-clinical disabled staff in Band 8A (4).
- Bands 8C, 9 and VSM continue to have no non-clinical disabled staff.

Metric 1: Clinical non-disabled staff

- By headcount, there has been no change from the previous year in the representation of clinical disabled staff in Band 8D (1).
- Band 9 and VSM continue to have no clinical disabled staff.

Worsened

Metric 1: Non-Clinical disabled staff

- There has been a minor decrease of non-clinical disabled staff in Band 2 (-2 or -0.9%).

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

- Although there has been a decrease of 0.86 from 5.98 to 5.12, disabled staff are 5 times more likely than non-disabled staff to enter the capability process.

Metric 4: Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues

- There has been an increase of 0.2% from 18% to 18.2% in the percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues.

WDES Action Plan 2024/25

AIM	OBJECTIVE (What are we going to do?)	ACTION (How will we do it?)	TIMESCALE (When will we do it?)	MILESTONE (What do we want to achieve?)
Improve the experience, opportunities, and treatment of disabled staff	Achieve 'Leader' Level 3 of the Disability Confident accreditation	Complete draft submission of current Level 2 accreditation	August '24	Re-accreditation of Level 2
		Submit Level 2 evidence to DWP	August/September '24	
		Develop a Disability Equality Action Plan based on a gap analysis of the Level 2 and Level 3 criteria requirements	October/November '24	Achieve Level 3

Appendices (in Reading Room)

Appendix 1 – WRES Data Pack

Appendix 2 – WDES Data Pack

Oxford Health NHS FT

Equality, Diversity & Inclusion

Workforce Race Equality Standard (WRES) 2024

To find out more about what Oxford Health NHS FT is doing to be a fair and equal employer and care provider, please contact:
EqualityandInclusion@oxfordhealth.nhs.uk

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the [NHS standard contract](#).

The [NHS Equality and Diversity Council](#) announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

This is important because studies show that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated through the NHS standard contract, starting in [2015/16](#). From 2017, independent healthcare providers are required to publish their WRES data.

The [first WRES report](#), was published in June 2016, followed by the [2016 WRES report](#) on 19 April 2017.

NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

[NHS England » NHS Workforce Race Equality Standard](#)

1 = Indicator 1

Indicator 1

Percentage of staff in each of the AfC bands 1 to 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: non-clinical staff & clinical staff (non-medical staff, medical and dental staff).

2 = Indicator 2

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts.

3 = Indicator 3

Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

4 = Indicator 4

Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD.

5 = Indicator 5

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

6 = Indicator 6

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

7 = Indicator 7

Indicator 7

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

8 = Indicator 8

Indicator 8

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months

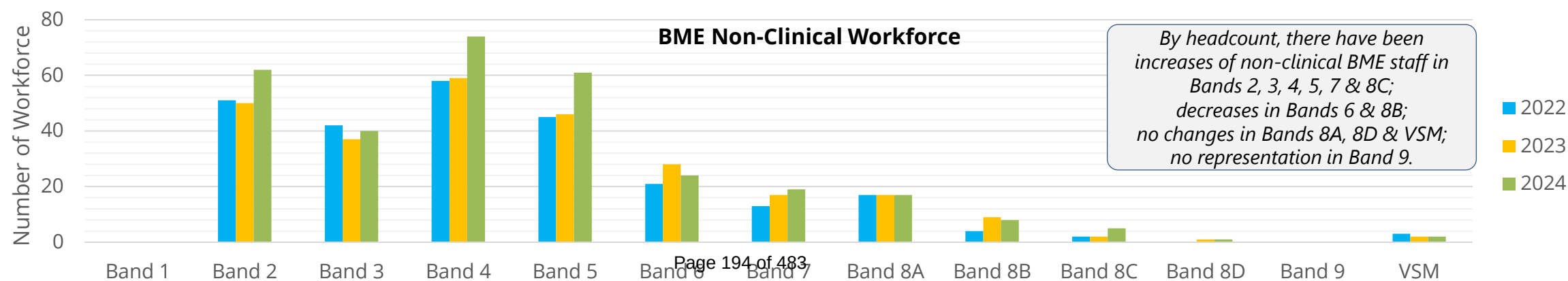
9 = Indicator 9

Indicator 9

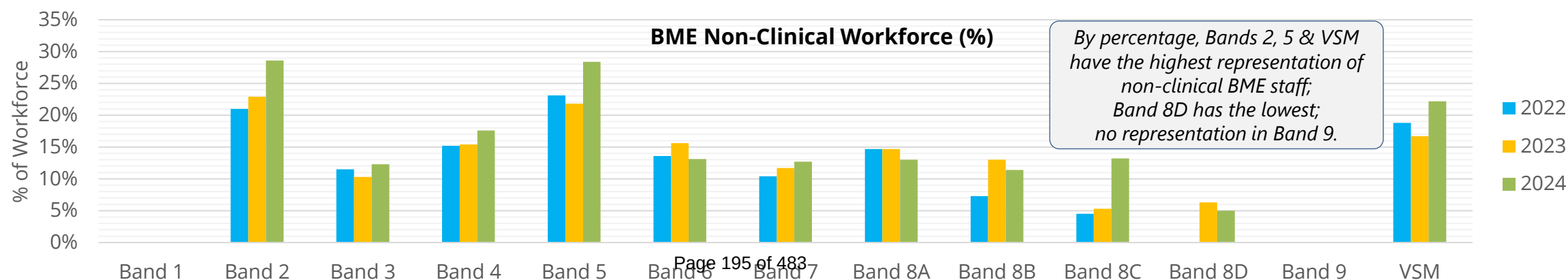
Percentage difference between the organisations' Board membership and its overall workforce disaggregated:

- By voting membership of the Board
- By executive membership of the Board

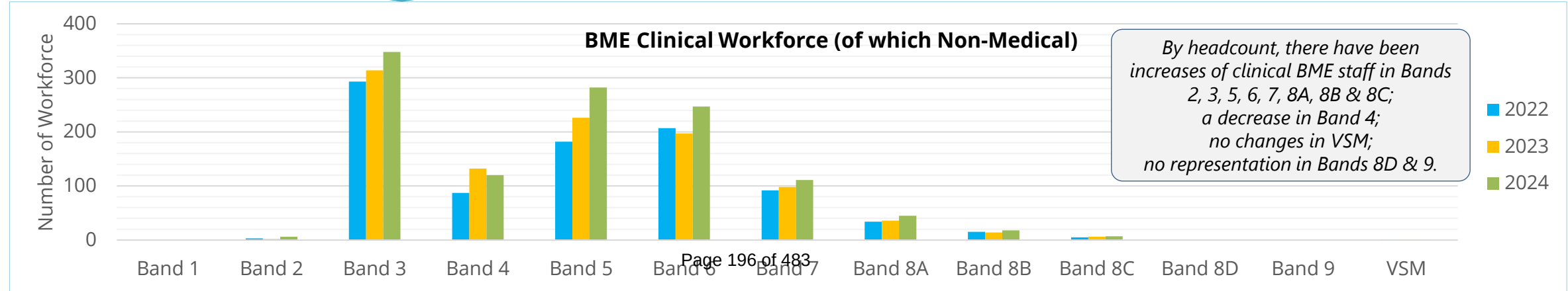
Non-Clinical Workforce	BME 2022	BME 2023	BME 2024	White 2022	White 2023	White 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	0	0	0	1	1	1	0	0	0
Band 2	51	50	62	182	153	138	10	15	17
Band 3	42	37	40	316	309	279	7	13	7
Band 4	58	59	74	313	317	337	10	8	9
Band 5	45	46	61	142	153	151	8	12	3
Band 6	21	28	24	122	135	144	11	16	15
Band 7	13	17	19	107	117	122	5	11	9
Band 8A	17	17	17	97	96	110	2	3	4
Band 8B	4	9	8	49	57	61	2	3	1
Band 8C	2	2	5	41	35	33	1	1	0
Band 8D	0	1	1	10	15	19	0	0	0
Band 9	0	0	0	4	5	7	0	0	1
VSM	3	2	2	10	8	7	3	2	0



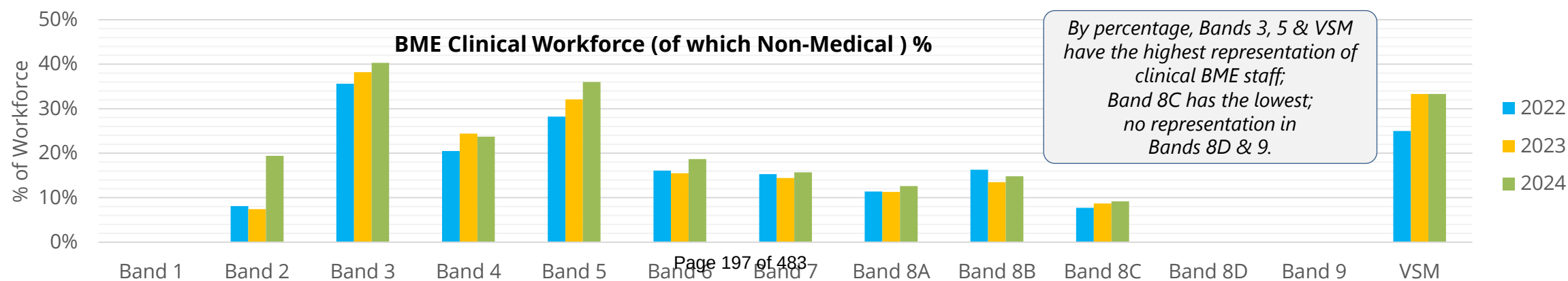
Non-Clinical Workforce	BME 2022	BME 2023	BME 2024	White 2022	White 2023	White 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Band 2	21.0%	22.9%	28.6%	74.9%	70.2%	63.6%	4.1%	6.9%	7.8%
Band 3	11.5%	10.3%	12.3%	86.6%	86.1%	85.6%	1.9%	3.6%	2.1%
Band 4	15.2%	15.4%	17.6%	82.2%	82.6%	80.2%	2.6%	2.1%	2.1%
Band 5	23.1%	21.8%	28.4%	72.8%	72.5%	70.2%	4.1%	5.7%	1.4%
Band 6	13.6%	15.6%	13.1%	79.2%	75.4%	78.7%	7.1%	8.9%	8.2%
Band 7	10.4%	11.7%	12.7%	85.6%	80.7%	81.3%	4.0%	7.6%	6.0%
Band 8A	14.7%	14.7%	13.0%	83.6%	82.8%	84.0%	1.7%	2.6%	3.1%
Band 8B	7.3%	13.0%	11.4%	89.1%	82.6%	87.1%	3.6%	4.3%	1.4%
Band 8C	4.5%	5.3%	13.2%	93.2%	92.1%	86.8%	2.3%	2.6%	0.0%
Band 8D	0.0%	6.3%	5.0%	100.0%	93.8%	95.0%	0.0%	0.0%	0.0%
Band 9	0.0%	0.0%	0.0%	100.0%	100.0%	87.5%	0.0%	0.0%	12.5%
VSM	18.8%	16.7%	22.2%	62.5%	66.7%	77.8%	18.8%	16.7%	0.0%



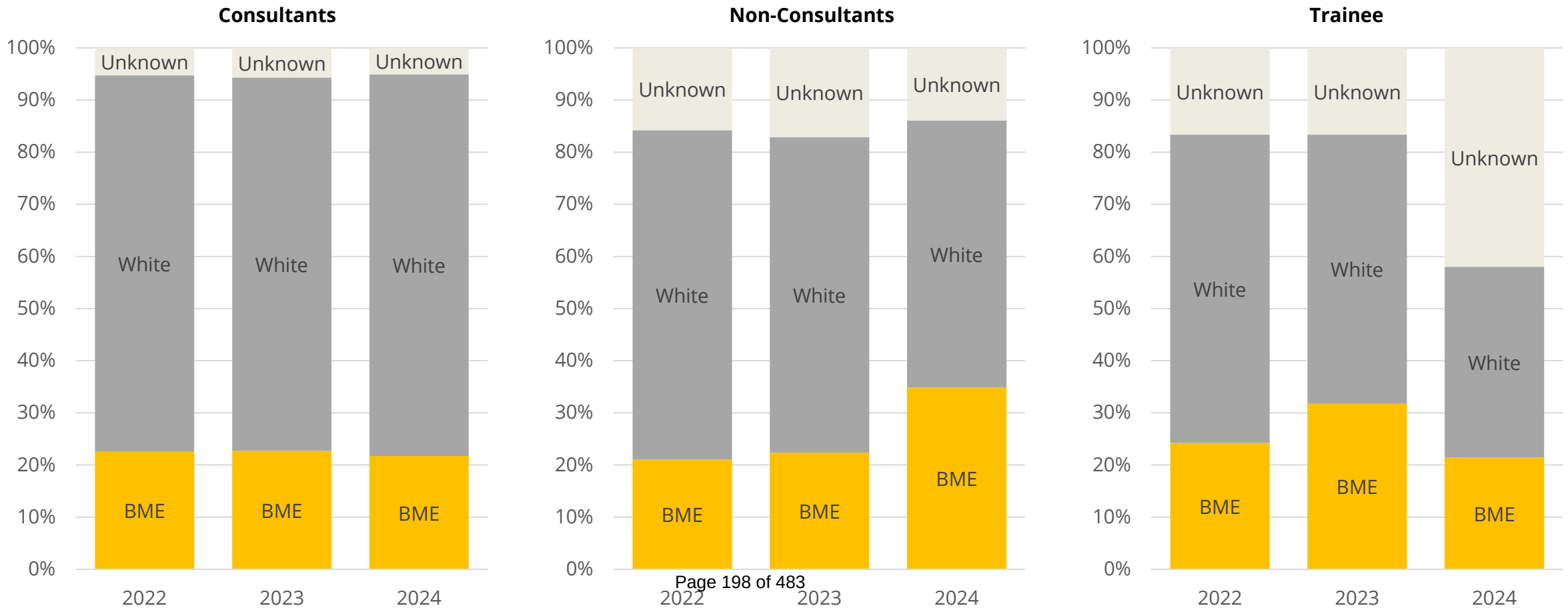
Clinical Workforce	BME 2022	BME 2023	BME 2024	White 2022	White 2023	White 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	0	0	0	0	0	0	0	0	0
Band 2	3	2	6	33	24	24	1	1	1
Band 3	293	314	348	502	468	484	29	39	32
Band 4	87	132	120	324	384	370	14	24	17
Band 5	182	226	282	422	410	449	41	67	52
Band 6	207	197	247	973	957	995	103	117	79
Band 7	92	98	111	495	563	582	13	19	16
Band 8A	34	36	45	256	273	297	7	10	16
Band 8B	15	14	18	76	88	98	1	2	6
Band 8C	5	6	7	59	62	69	1	1	0
Band 8D	0	0	0	8	8	10	0	2	2
Band 9	0	0	0	2	2	2	0	0	0
VSM	1	1	1	3	2	2	0	0	0



Clinical Workforce	BME 2022	BME 2023	BME 2024	White 2022	White 2023	White 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	-	-	-	-	-	-	-	-	-
Band 2	8.1%	7.4%	19.4%	89.2%	88.9%	77.4%	2.7%	3.7%	3.2%
Band 3	35.6%	38.2%	40.3%	60.9%	57.0%	56.0%	3.5%	4.8%	3.7%
Band 4	20.5%	24.4%	23.7%	76.2%	71.1%	73.0%	3.3%	4.4%	3.4%
Band 5	28.2%	32.1%	36.0%	65.4%	58.3%	57.3%	6.4%	9.5%	6.6%
Band 6	16.1%	15.5%	18.7%	75.8%	75.3%	75.3%	8.0%	9.2%	6.0%
Band 7	15.3%	14.4%	15.7%	82.5%	82.8%	82.1%	2.2%	2.8%	2.3%
Band 8A	11.4%	11.3%	12.6%	86.2%	85.6%	83.0%	2.4%	3.1%	4.5%
Band 8B	16.3%	13.5%	14.8%	82.6%	84.6%	80.3%	1.1%	1.9%	4.9%
Band 8C	7.7%	8.7%	9.2%	90.8%	89.9%	90.8%	1.5%	1.4%	0.0%
Band 8D	0.0%	0.0%	0.0%	100.0%	80.0%	83.3%	0.0%	20.0%	16.7%
Band 9	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
VSM	25.0%	33.3%	33.3%	75.0%	66.7%	66.7%	0.0%	0.0%	0.0%



Medics & Other	BME 2022	BME 2023	BME 2024	White 2022	White 2023	White 2024	Unknown 2022	Unknown 2023	Unknown 2024
Consultant	30	32	30	96	101	101	7	8	7
Non-consultant	16	17	30	48	46	44	12	13	12
Trainee	16	21	24	39	34	41	11	11	47
Other	2	2	0	4	5	0	6	4	0



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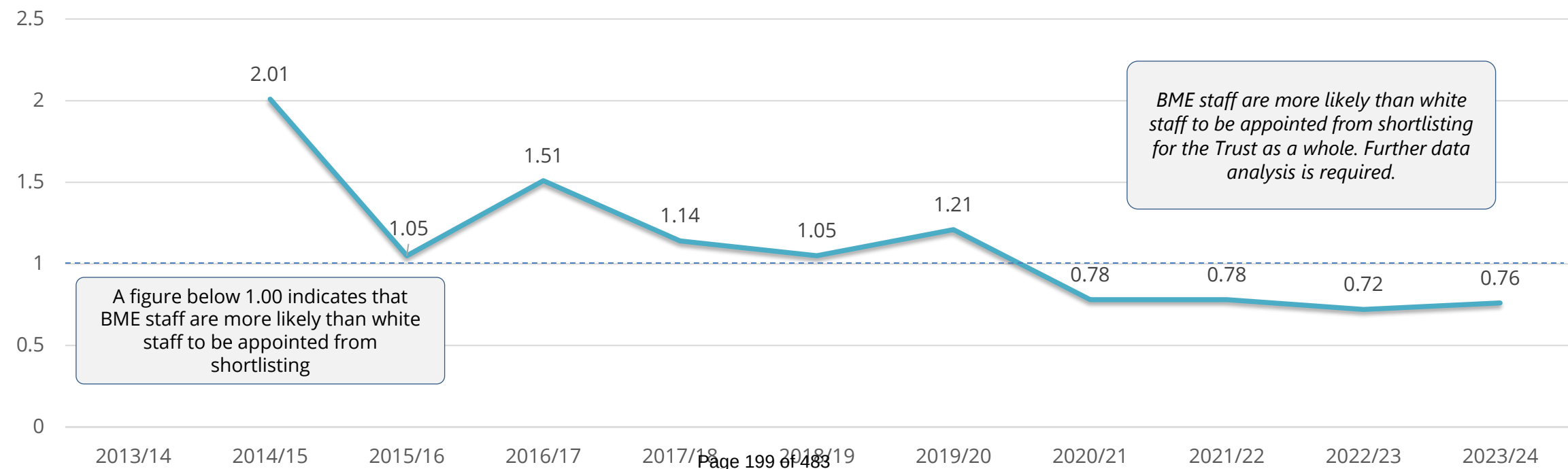
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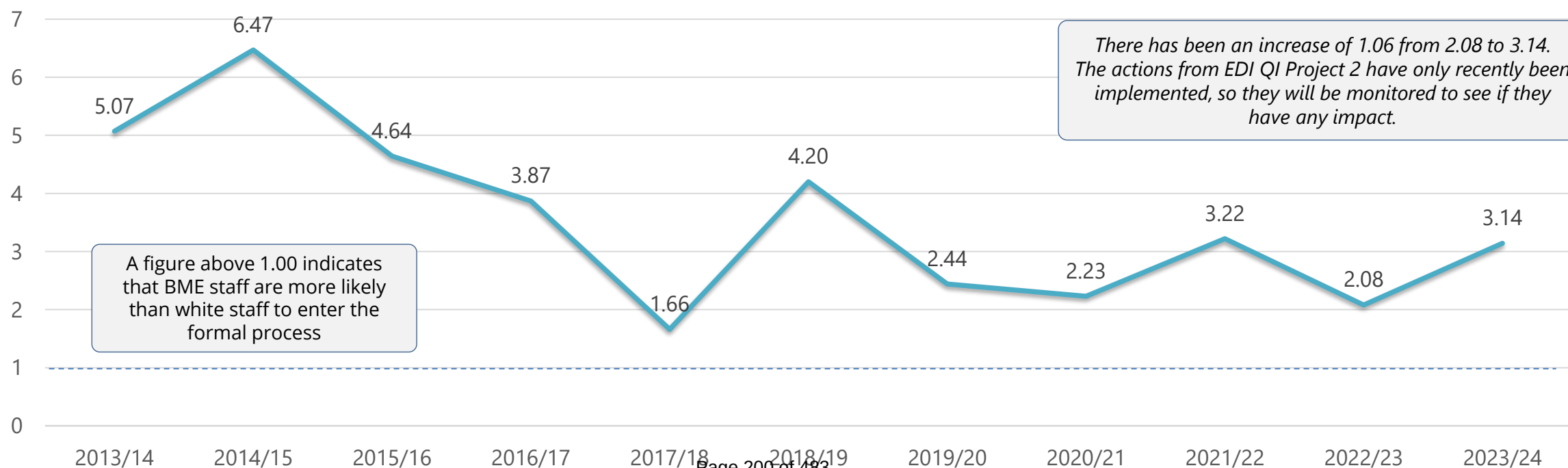
Relative likelihood of white staff being **appointed from shortlisting** compared to BME staff

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
No data	2.01 times more likely	1.05 times more likely	1.51 times more likely	1.14 times more likely	1.05 times more likely	1.21 times more likely	0.78 times more likely	0.78 times more likely	0.72 times more likely	0.76 times more likely
-	-	-0.96	+0.46	-0.37	-0.09	+0.16	-0.43	0.00	-0.06	+0.04



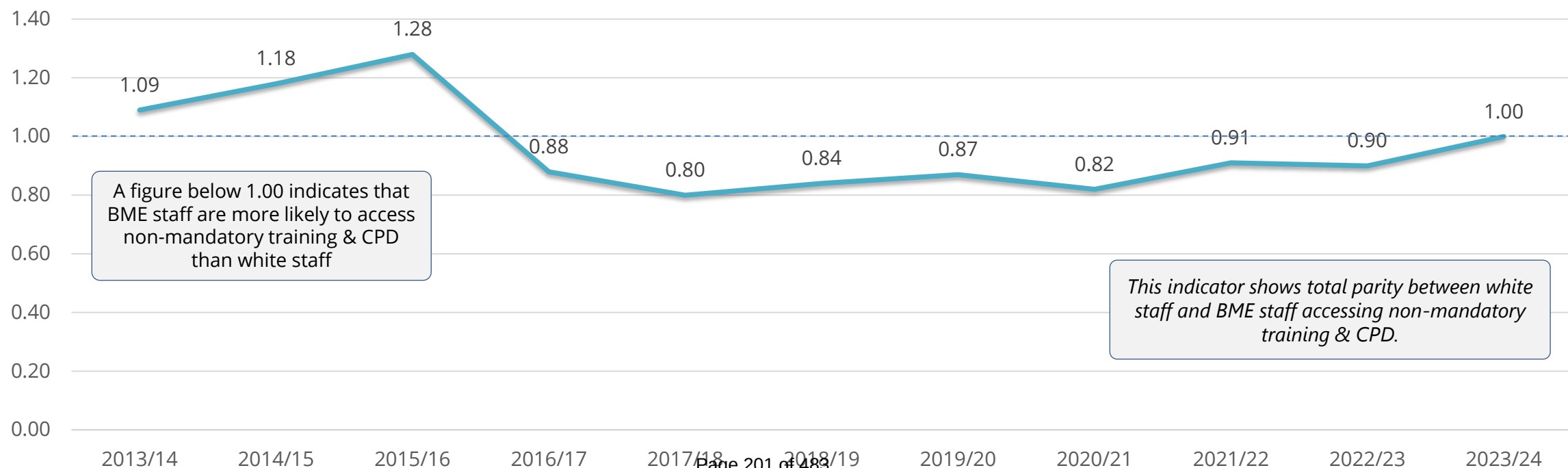
Relative likelihood of BME staff entering into **formal disciplinary process** compared to white staff

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
5.07 times more likely	6.47 times more likely	4.64 times more likely	3.87 times more likely	1.66 times more likely	4.20 times more likely	2.44 times more likely	2.23 times more likely	3.22 times more likely	2.08 times more likely	3.14 times more likely
-	+1.4	-1.83	-0.77	-2.21	+2.54	-1.76	-0.21	+0.99	-1.14	+1.06



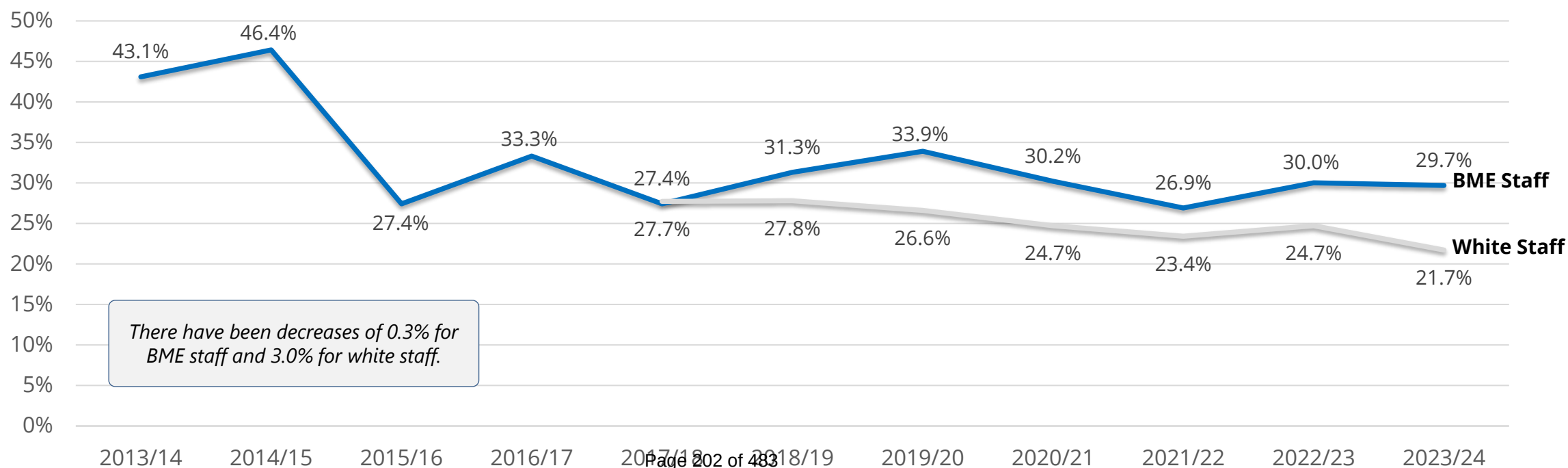
Relative likelihood of white staff accessing **non-mandatory training & CPD** compared to BME staff

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
1.09 times more likely	1.18 times more likely	1.28 times more likely	0.88 times more likely	0.80 times more likely	0.84 times more likely	0.87 times more likely	0.82 times more likely	0.91 times more likely	0.90 times more likely	1.00 times more likely
-	+0.09	+0.10	-0.40	-0.08	+0.04	+0.03	-0.05	+0.09	-0.01	0.00



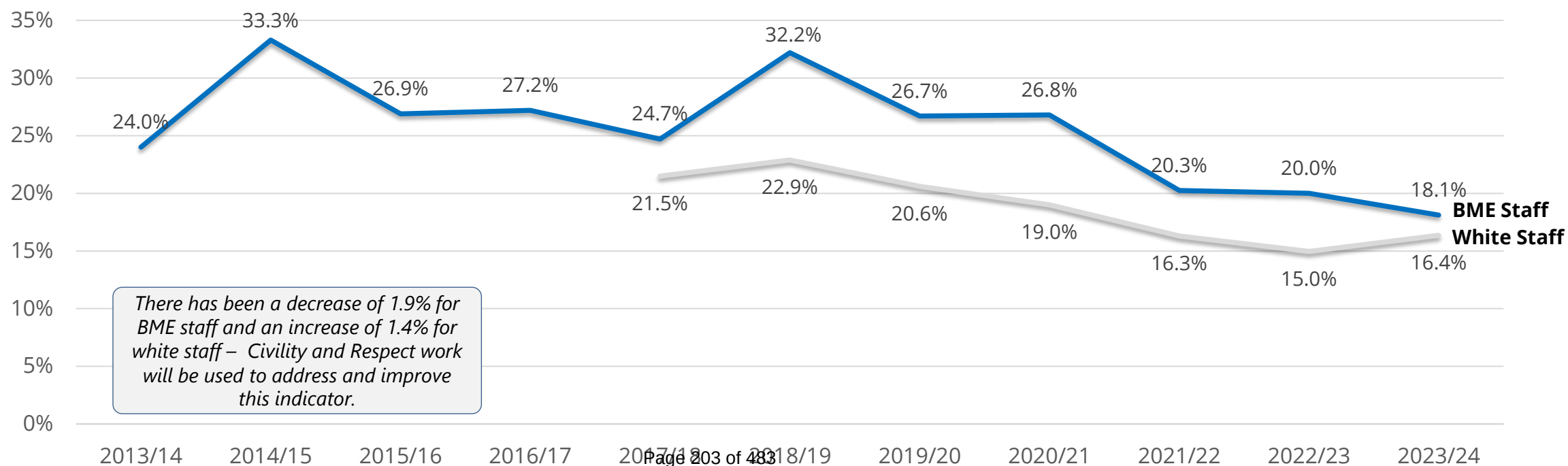
Percentage of staff experiencing harassment, bullying or abuse
from patients, relatives or the public in last 12 months

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
BME Staff	43.1% -	46.4% +3.3%	27.4% -19.0%	33.3% +5.9%	27.4% -5.9%	31.3% +3.9	33.9% +2.6%	30.2% -3.7%	26.9% -3.3%	30.0% +3.1%	29.7% -0.3%
White Staff					27.7% -	27.8% +0.1%	26.6% -1.2%	24.7% -1.9%	23.4% -1.3%	24.7% +1.3%	21.7% -3.0%



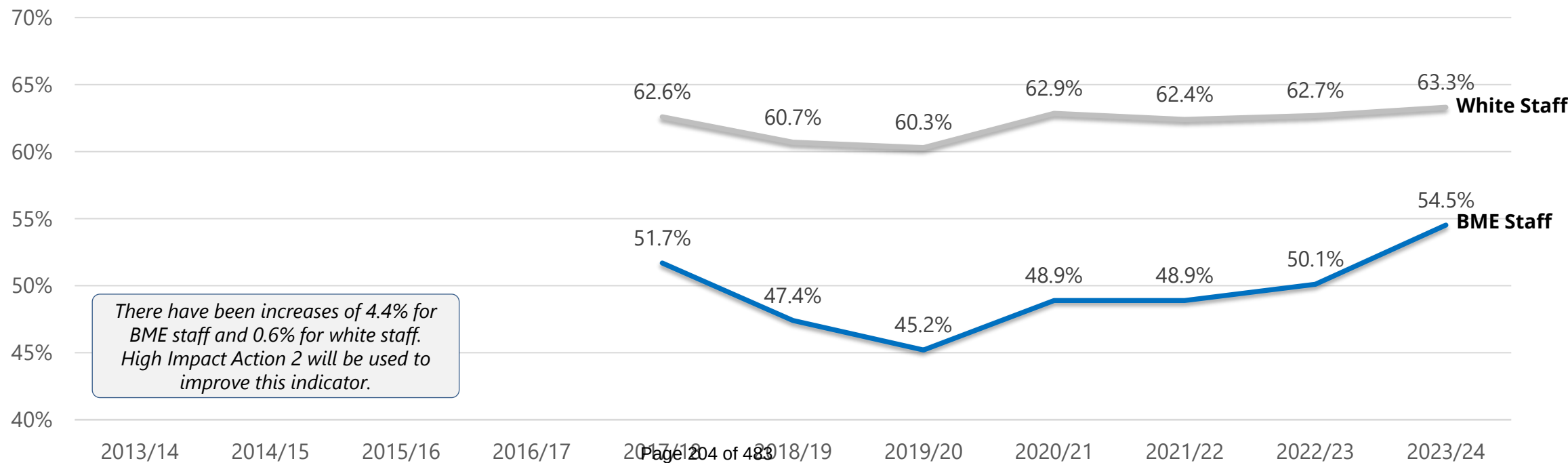
Percentage of staff experiencing harassment, bullying or abuse
from staff in last 12 months

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
BME Staff	24.0%	33.3% +9.3%	26.9% -6.4%	27.2% +0.3%	24.7% -2.5%	32.2% +7.5%	26.7% -5.5%	26.8% +0.1%	20.3% -6.5%	20.0% -0.3%	18.1% -1.9%
White Staff	-				21.5% -	22.9% +1.4%	20.6% -2.3%	19.0% -1.6%	16.3% -2.7%	15.0% -1.3%	16.4% +1.4%



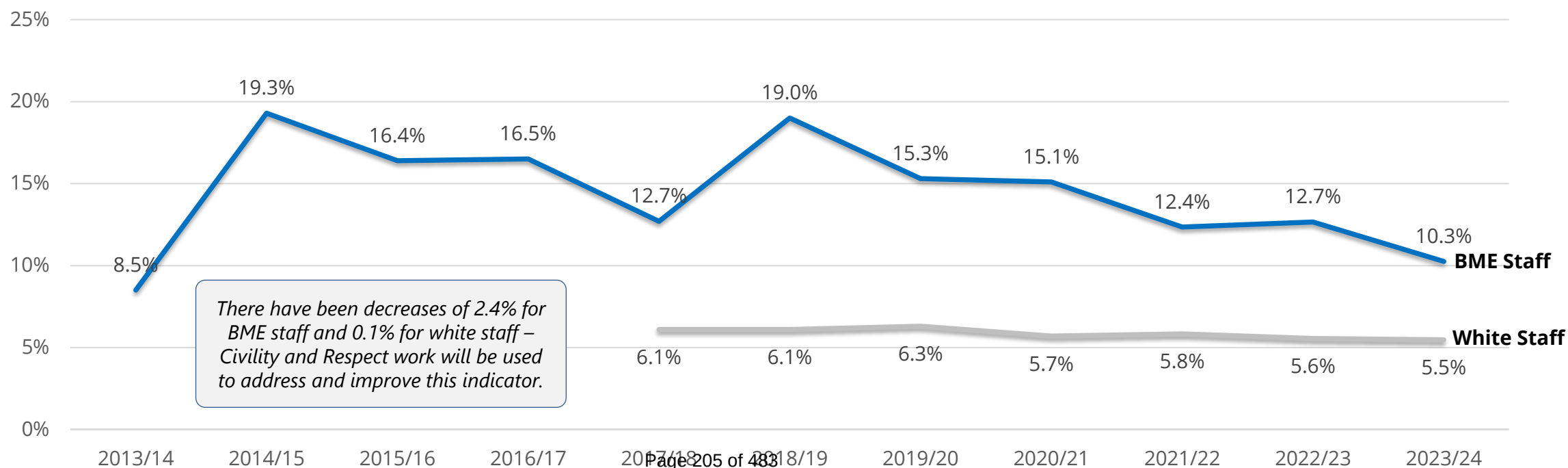
Percentage of staff believing the organisation provides **equal opportunities** for career progression or promotion

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
BME Staff	The calculation for this indicator has been changed, and the data prior to the change in 2017 is unavailable.				51.7% -	47.4% -4.3%	45.2% -2.2%	48.9% +3.7%	48.9% +0%	50.1% +1.2%	54.5% +4.4%
White Staff					62.6% -	60.7% -1.9%	60.3% -0.4%	62.9% +2.6%	62.4% -0.5%	62.7% +0.3%	63.3% +0.6%



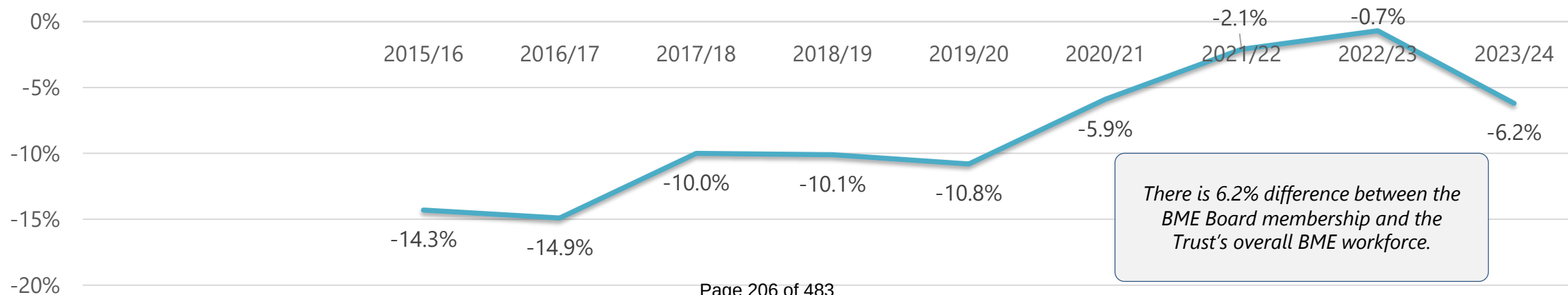
Percentage of staff experiencing discrimination
at work from **manager/team leader** or **other colleagues** in last 12 months

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
BME Staff	8.5% -	19.3% +10.8%	16.4% -2.9%	16.5% +0.1%	12.7% -3.8%	19.0% +6.3%	15.3% -3.7%	15.1% -0.2%	12.4% -2.7%	12.7% +0.3%	10.3% -2.4%
White Staff					6.1% -	6.1% 0%	6.3% +0.2%	5.7% -0.6%	5.8% +0.1%	5.6% -0.2%	5.5% -0.1%



Percentage difference between the organisations' Board membership and its overall workforce disaggregated by voting membership of the Board & by executive membership of the Board

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Percentage of BME members on the Board	0%	0%	5.9%	6.3%	6.3%	12.5%	17.6%	20.0%	16.7%
Percentage of BME Staff in Overall Workforce	14.3%	14.9%	15.9%	16.4%	17.1%	18.4%	19.7%	20.7%	22.9%
Percentage difference between the organisations' Board membership and its overall workforce (BME representation)	-14.3%	-14.9%	-10.0%	-10.1%	-10.8%	-5.9%	-2.1%	-0.7%	-6.2%

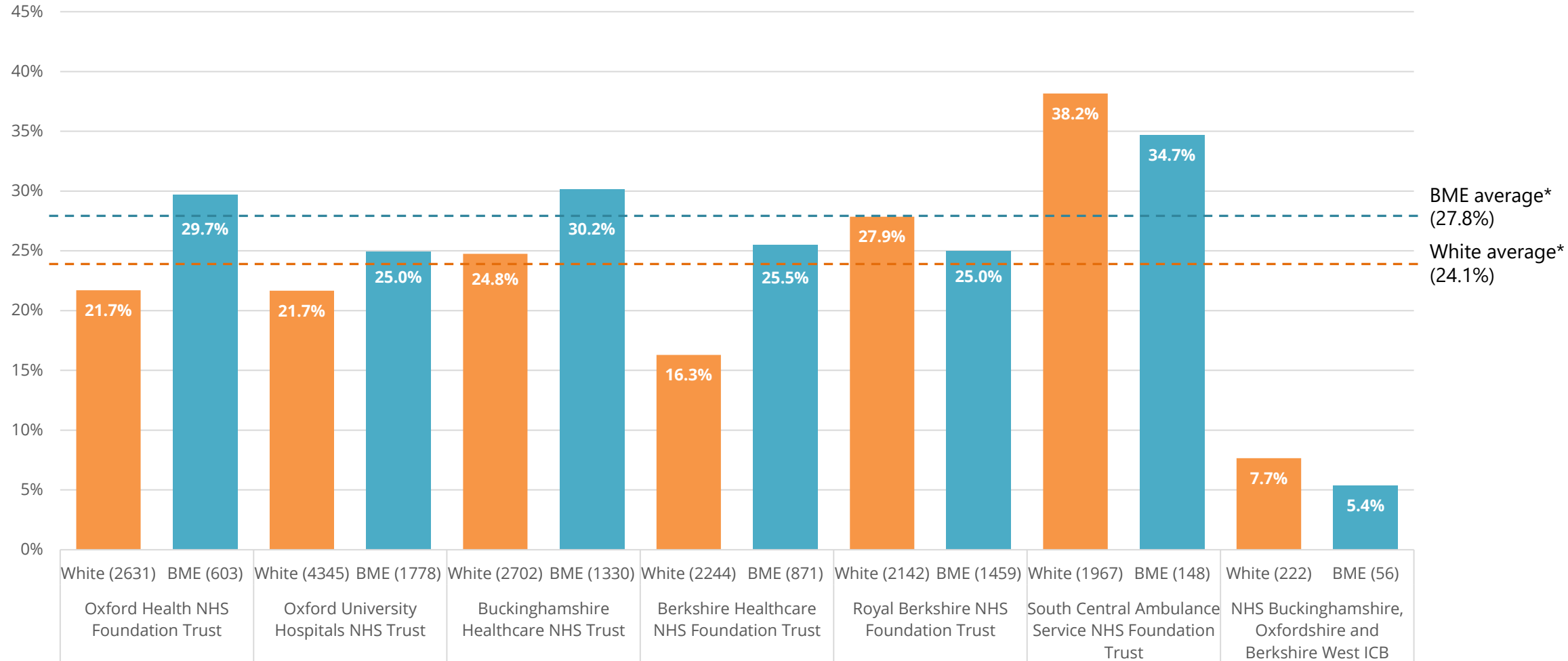


TIMELINE	ACTIONS	STATUS
1st – 30th May	- Gather WRES data from internal sources for indicators 1,2,3,4 and 9 - Review WRES Indicators 5 to 8 sourced from the latest NHS Staff Survey - Complete the Mandated Standards returns using the Data Collection Framework (DCF)	Complete
June - July	- Review progress made in the latest action plan - Gain input from key stakeholders to produce a draft action plan	
September – October	- Schedule a meeting date to gain sign-off from the Board for the annual report which should contain a review and an action plan: 5th September: EDI Steering Group 7th October: Extended Leadership Team 16th October: PLC Committee	
October	Publish the annual report on public facing website by 31 October 2024	
November 2024 – October 2025	- Involve workforce, learning development, talent management and organisational development to help deliver the actions - Share progress and achievements within and beyond the organisation	

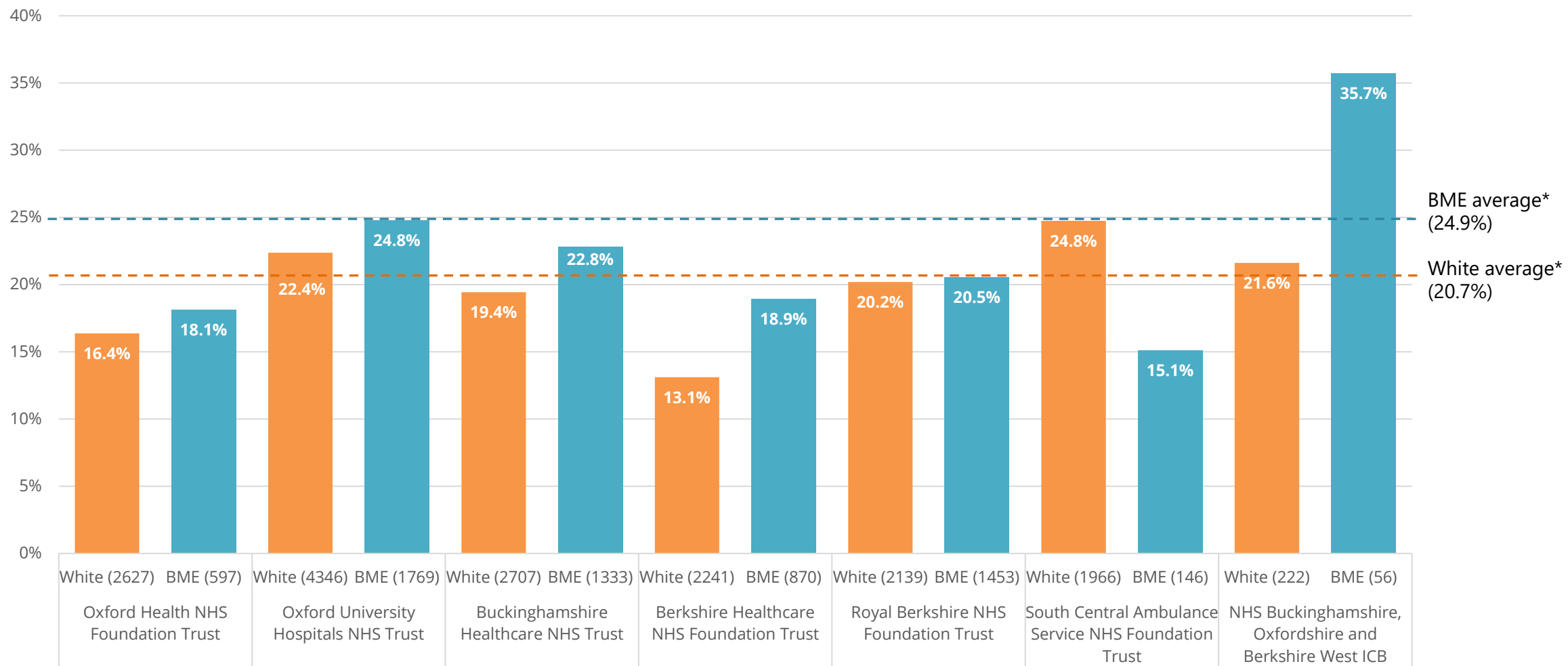
Workforce Race Equality Standard 2024: **Benchmarking**

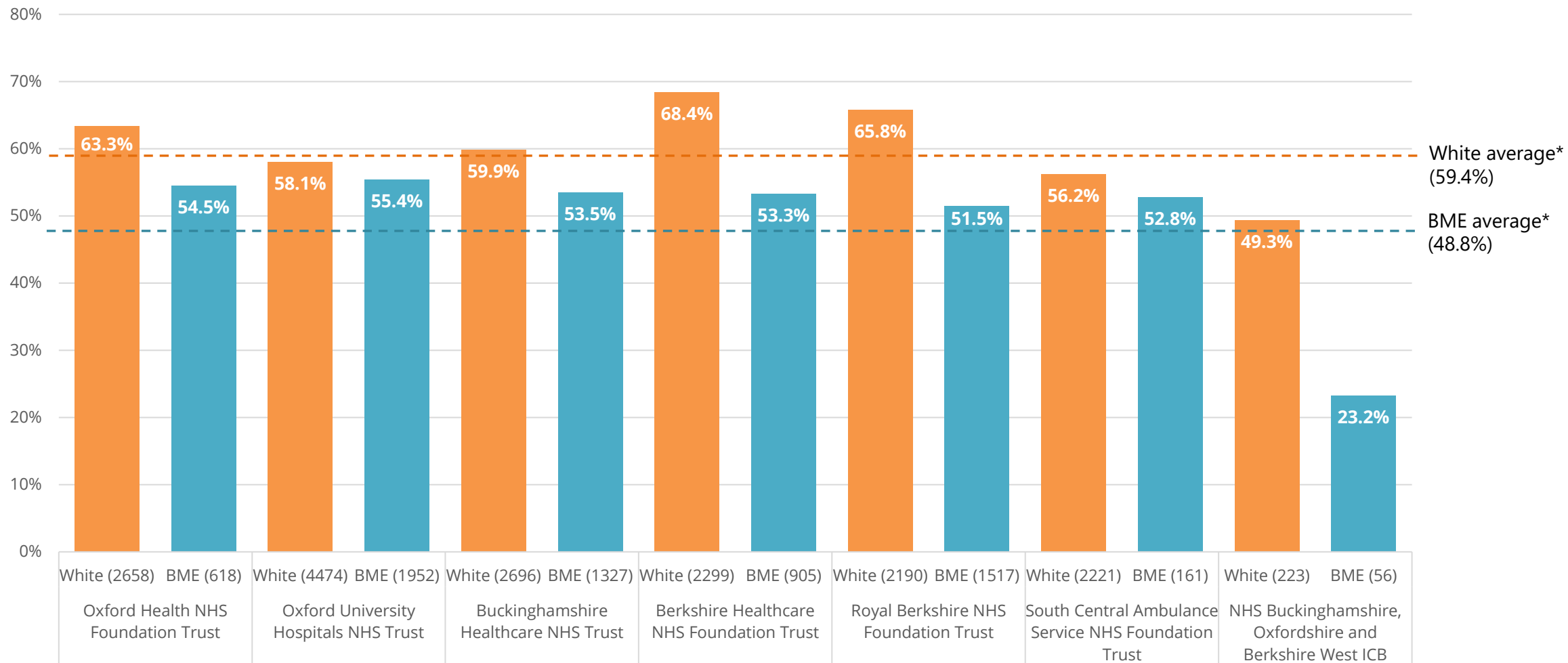
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Berkshire Healthcare NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- NHS Buckinghamshire, Oxfordshire and Berkshire West ICB

Percentage of staff experiencing harassment, bullying or abuse
from patients, relatives or the public in last 12 months

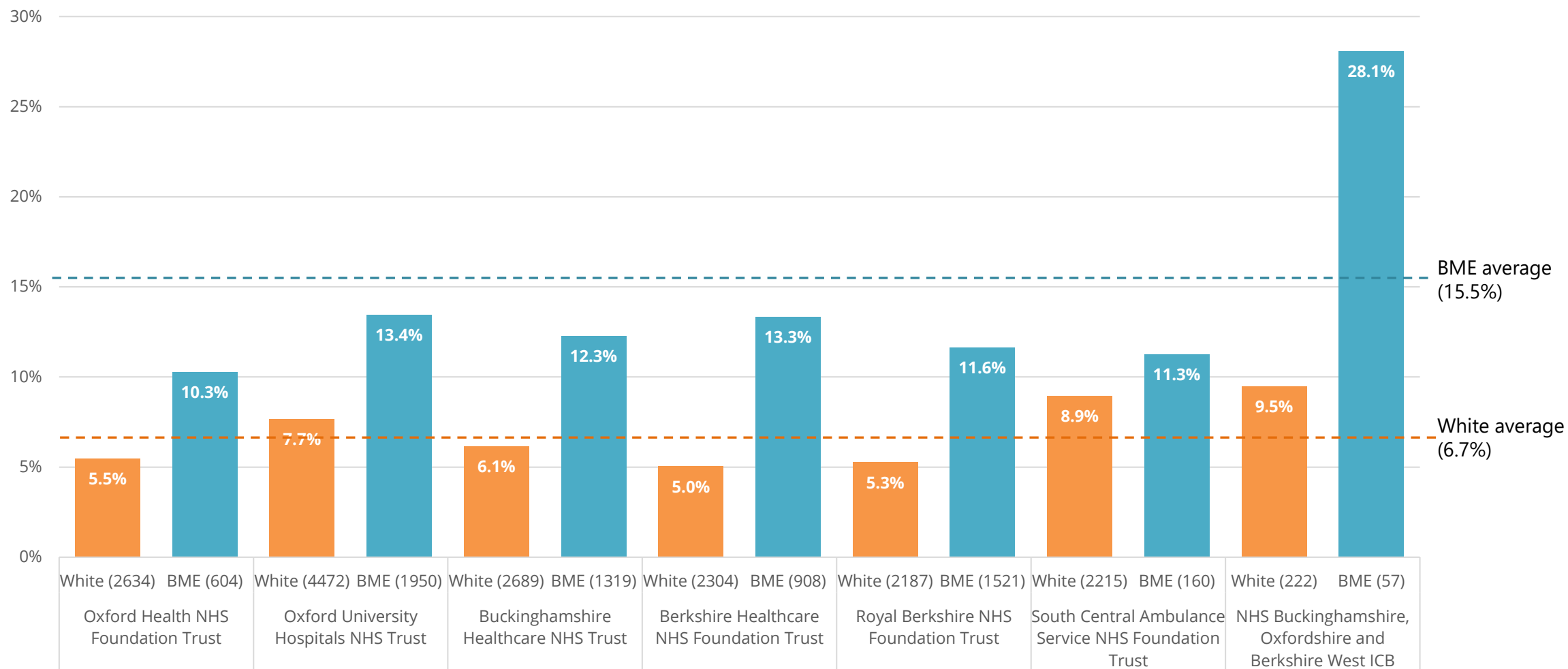


Percentage of staff experiencing harassment, bullying or abuse
from staff in last 12 months



Percentage of staff believing the organisation provides **equal opportunities** for career progression or promotion


Percentage of staff experiencing discrimination
at work from **manager/team leader** or **other colleagues** in last 12 months



Oxford Health NHS FT

Equality, Diversity & Inclusion

Workforce Disability Equality Standard (WDES) 2024

To find out more about what Oxford Health NHS FT is doing to be a fair and equal employer and care provider, please contact:
EqualityandInclusion@oxfordhealth.nhs.uk

The NHS **Workforce Disability Equality Standard** was introduced in 2019 and is designed to improve the workplace experience and career opportunities for Disabled people working or seeking employment in the NHS.

The WDES is a series of evidence-based metrics that provide us with a snapshot of the experiences of our Disabled colleagues.

By providing comparative data between Disabled and Non-Disabled staff, this information can be used to understand where key differences lie and will provide the basis for the development of action plans, enabling us to track progress year on year.

1 = Metric 1

2 = Metric 2

3 = Metric 3

4 = Metric 4

5 = Metric 5

6 = Metric 6

7 = Metric 7

8 = Metric 8

9 = Metric 9

10 = Metric 10

Metric 1

Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Metric 2

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Metric 3

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Metric 4

- a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:
 - i) Patients, their relatives or other members of the public
 - ii) Managers
 - iii) Other colleagues
- b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Metric 5

Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

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Metric 6

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Metric 7

Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Metric 8

Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Metric 9

- a) The staff engagement score for Disabled staff, compared to non-disabled staff.
- b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Metric 10

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board.
- By Executive membership of the Board.

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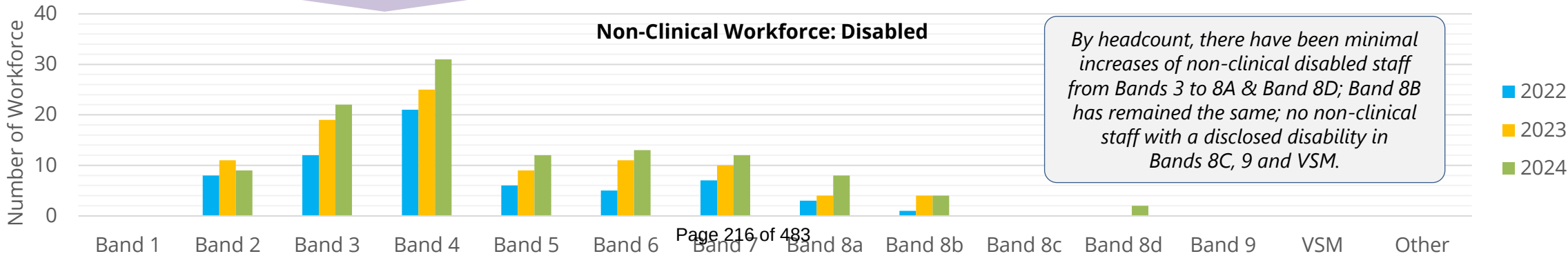
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Non Clinical Workforce	Disabled 2022	Disabled 2023	Disabled 2024	Non-Disabled 2022	Non-Disabled 2023	Non-Disabled 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	0	0	0	1	1	1	0	0	0
Band 2	8	11	9	177	154	165	58	53	43
Band 3	12	19	22	299	290	268	54	50	36
Band 4	21	25	31	322	330	353	38	29	36
Band 5	6	9	12	171	187	191	18	15	12
Band 6	5	11	13	131	149	157	18	19	13
Band 7	7	10	12	101	119	126	17	16	12
Band 8a	3	4	8	92	93	104	21	19	19
Band 8b	1	4	4	43	53	61	11	12	5
Band 8c	0	0	0	39	34	34	5	4	4
Band 8d	0	0	2	7	13	17	3	3	1
Band 9	0	0	0	4	5	6	0	1	2
VSM	0	0	0	9	9	9	7	2	0
Other	0	0	0	0	0	0	0	0	0



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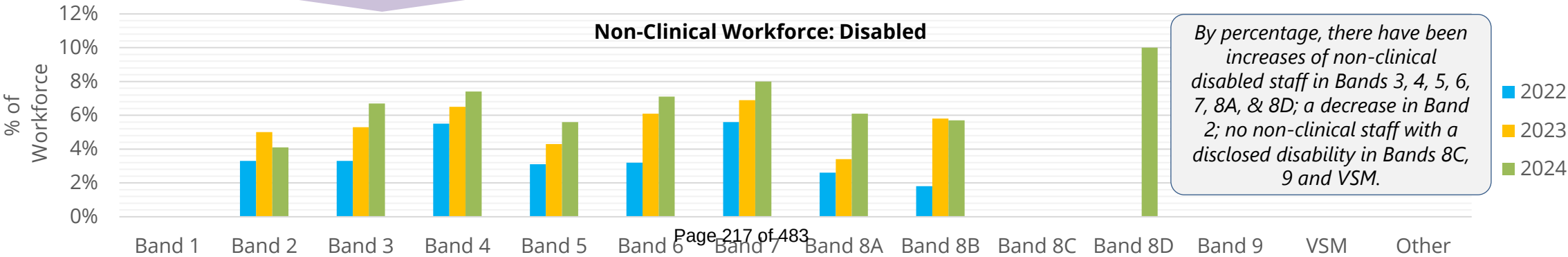
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Non Clinical Workforce	Disabled 2022	Disabled 2023	Disabled 2024	Non-Disabled 2022	Non-Disabled 2023	Non-Disabled 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Band 2	3.3%	5.0%	4.1%	72.8%	70.6%	76.0%	23.9%	24.3%	19.8%
Band 3	3.3%	5.3%	6.7%	81.9%	80.8%	82.2%	14.8%	13.9%	11.0%
Band 4	5.5%	6.5%	7.4%	84.5%	85.9%	84.0%	10.0%	7.6%	8.6%
Band 5	3.1%	4.3%	5.6%	87.7%	88.6%	88.8%	9.2%	7.1%	5.6%
Band 6	3.2%	6.1%	7.1%	85.1%	83.2%	85.8%	11.7%	10.6%	7.1%
Band 7	5.6%	6.9%	8.0%	80.8%	82.1%	84.0%	13.6%	11.0%	8.0%
Band 8a	2.6%	3.4%	6.1%	79.3%	80.2%	79.4%	18.1%	16.4%	14.5%
Band 8b	1.8%	5.8%	5.7%	78.2%	76.8%	87.1%	20.0%	17.4%	7.1%
Band 8c	0.0%	0.0%	0.0%	88.6%	89.5%	89.5%	11.4%	10.5%	10.5%
Band 8d	0.0%	0.0%	10.0%	70.0%	81.3%	85.0%	30.0%	18.8%	5.0%
Band 9	0.0%	0.0%	0.0%	100.0%	83.3%	75.0%	0.0%	16.7%	25.0%
VSM	0.0%	0.0%	0.0%	56.3%	81.8%	100.0%	43.8%	18.2%	0.0%
Other	-	-	-	-	-	-	-	-	-



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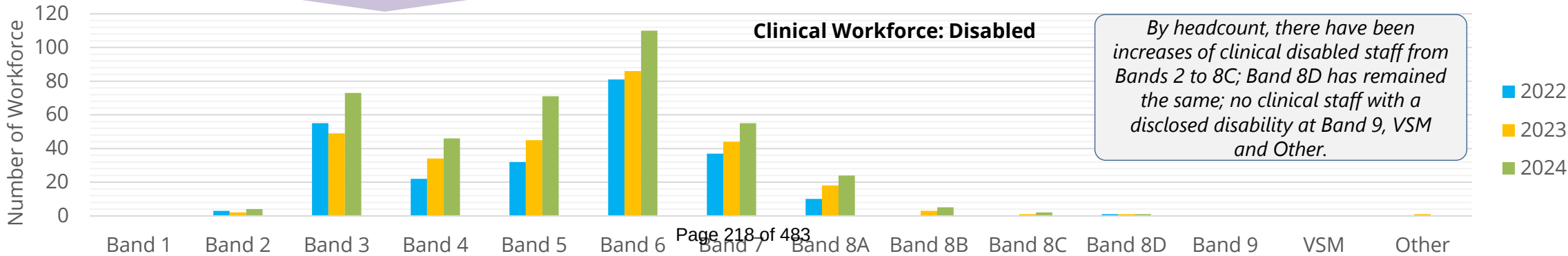
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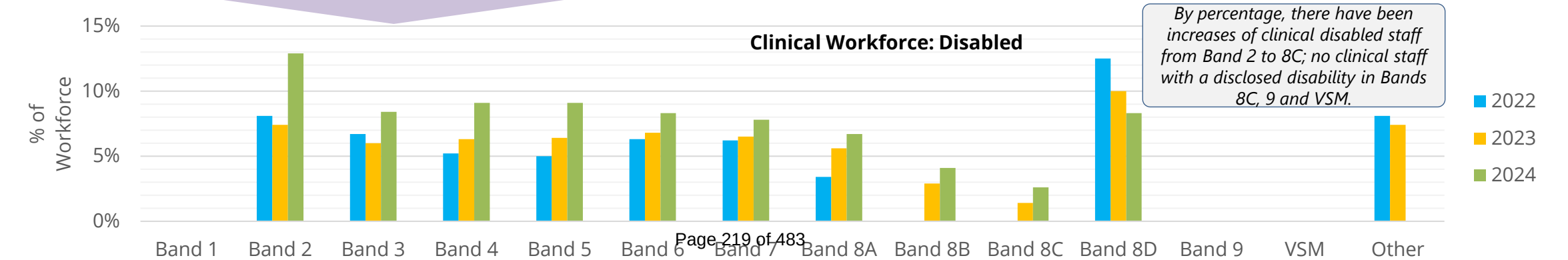
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Clinical Workforce	Disabled 2022	Disabled 2023	Disabled 2024	Non-Disabled 2022	Non-Disabled 2023	Non-Disabled 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	0	0	0	0	0	0	0	0	0
Band 2	3	2	4	31	23	24	3	2	3
Band 3	55	49	73	672	705	735	97	67	56
Band 4	22	34	46	361	457	428	42	50	33
Band 5	32	45	71	525	556	617	88	102	95
Band 6	81	86	110	983	957	1035	219	228	176
Band 7	37	44	55	491	573	601	72	63	53
Band 8a	10	18	24	257	272	305	30	29	29
Band 8b	0	3	5	72	86	105	20	15	12
Band 8c	0	1	2	58	60	64	7	8	10
Band 8d	1	1	1	5	7	9	2	2	2
Band 9	0	0	0	2	2	2	0	0	0
VSM	0	0	0	3	3	3	1	0	0
Other	0	1	0	1	5	0	11	5	0



Clinical Workforce	Disabled 2022	Disabled 2023	Disabled 2024	Non-Disabled 2022	Non-Disabled 2023	Non-Disabled 2024	Unknown 2022	Unknown 2023	Unknown 2024
Band 1	-	-	-	-	-	-	-	-	-
Band 2	8.1%	7.4%	12.9%	83.8%	85.2%	77.4%	8.1%	7.4%	9.7%
Band 3	6.7%	6.0%	8.4%	81.6%	85.9%	85.1%	11.8%	8.2%	6.5%
Band 4	5.2%	6.3%	9.1%	84.9%	84.5%	84.4%	9.9%	9.2%	6.5%
Band 5	5.0%	6.4%	9.1%	81.4%	79.1%	78.8%	13.6%	14.5%	12.1%
Band 6	6.3%	6.8%	8.3%	76.6%	75.3%	78.3%	17.1%	17.9%	13.3%
Band 7	6.2%	6.5%	7.8%	81.8%	84.3%	84.8%	12.0%	9.3%	7.5%
Band 8a	3.4%	5.6%	6.7%	86.5%	85.3%	85.2%	10.1%	9.1%	8.1%
Band 8b	0.0%	2.9%	4.1%	78.3%	82.7%	86.1%	21.7%	14.4%	9.8%
Band 8c	0.0%	1.4%	2.6%	89.2%	87.0%	84.2%	10.8%	11.6%	13.2%
Band 8d	12.5%	10.0%	8.3%	62.5%	70.0%	75.0%	25.0%	20.0%	16.7%
Band 9	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
VSM	0.0%	0.0%	0.0%	75.0%	100.0%	100.0%	25.0%	0.0%	0.0%
Other	8.1%	7.4%	0.0%	83.8%	85.2%	0.0%	8.1%	7.4%	0.0%



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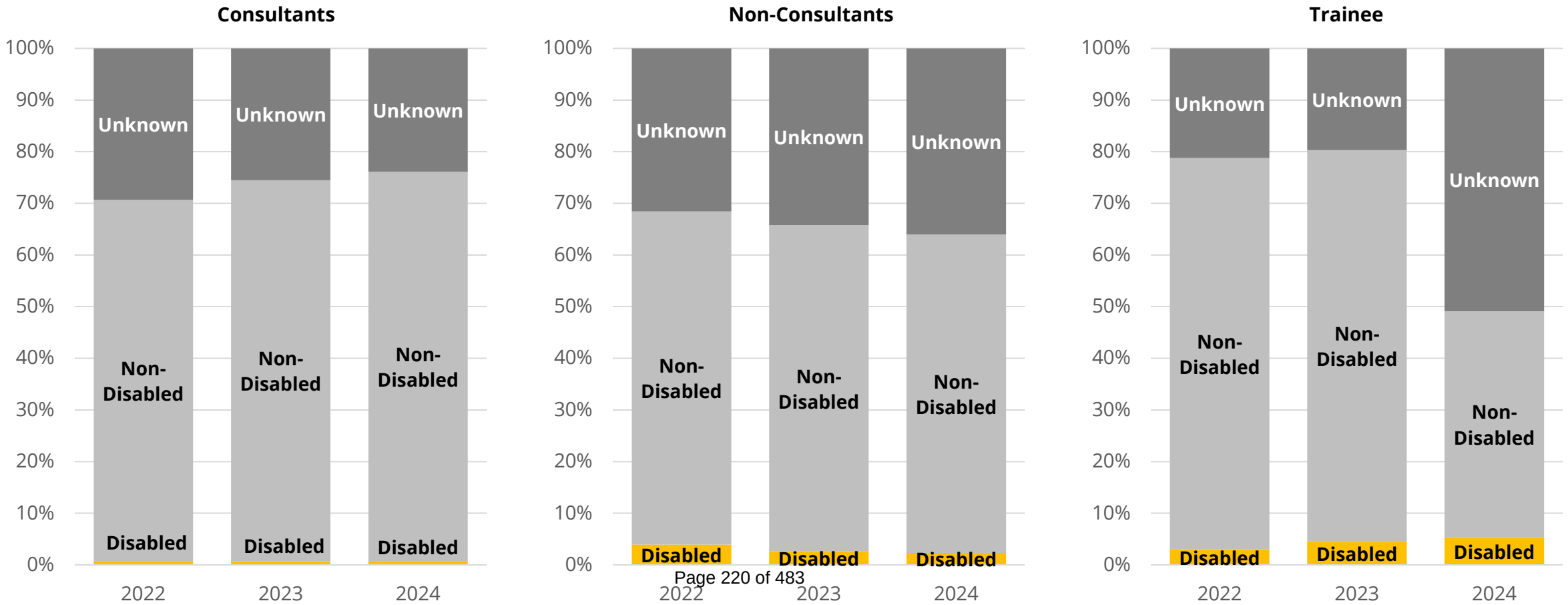
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	Disabled			Non-Disabled			Disability Unknown or Null		
	2022	2023	2024	2022	2023	2024	2022	2023	2024
Consultant	1	1	1	93	104	101	39	36	32
Non-consultant	3	2	2	49	48	53	24	26	31
Trainee	2	3	6	50	50	49	14	13	57



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Electronic Staff Record

Disclosure rates for disability have increased with 7.4% of staff declaring a disability. The disability status of 11.2% of the workforce is unknown, down by 1.9% from the previous year.

2

Staff are requested to review their data every 6 months on the ESR (Electronic Staff Record), so is dependable on the individual logging in to update their details.

3

Also, the disability status may change in the course of employment, therefore, fully accurate data even for those declaring (as disabled or non-disabled) is unlikely.

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Staff Survey

Disclosure rates for disability are higher in the staff survey with 27.2% of staff declaring a disability. The disability status of 2.3% of the workforce remains unknown.

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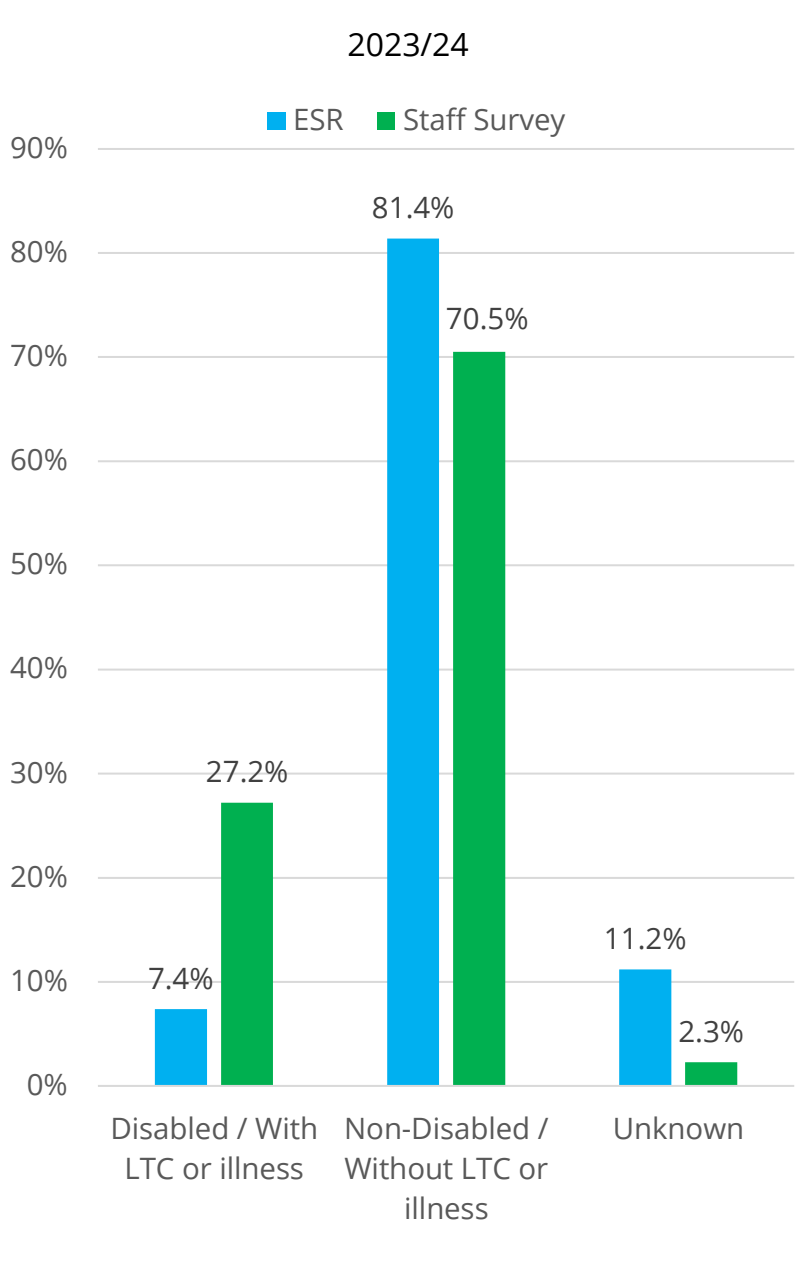
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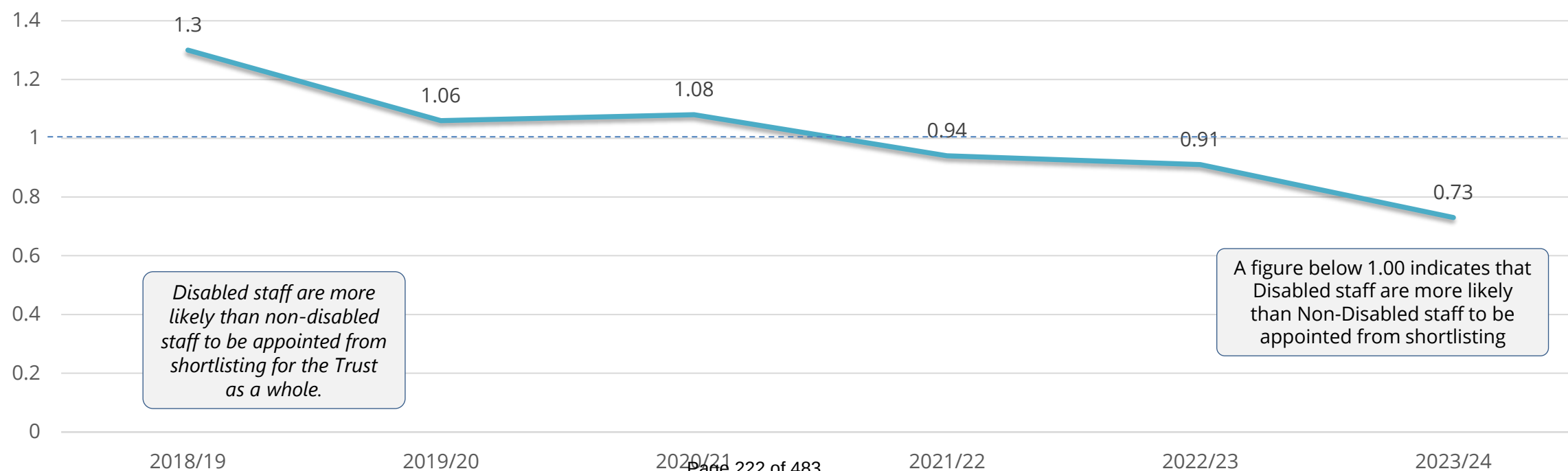
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	Electronic Staff Record (ESR)		Staff Survey	
	2022/23	2023/24	2022/23	2023/24
Disabled / Staff with LTC or illness	383 (5.8%)	513 (7.4%)	799 (24.4%)	908 (27.2%)
Non-Disabled / Staff without LTC or illness	5345 (81.0%)	5623 (81.4%)	2462 (75.1%)	2354 (70.5%)
Unknown	869 (13.1%) ↓	772 (11.2%) ↓	18 (0.005%) ↓	77 (2.3%) ↑
TOTAL	6597	6908	3279	3339



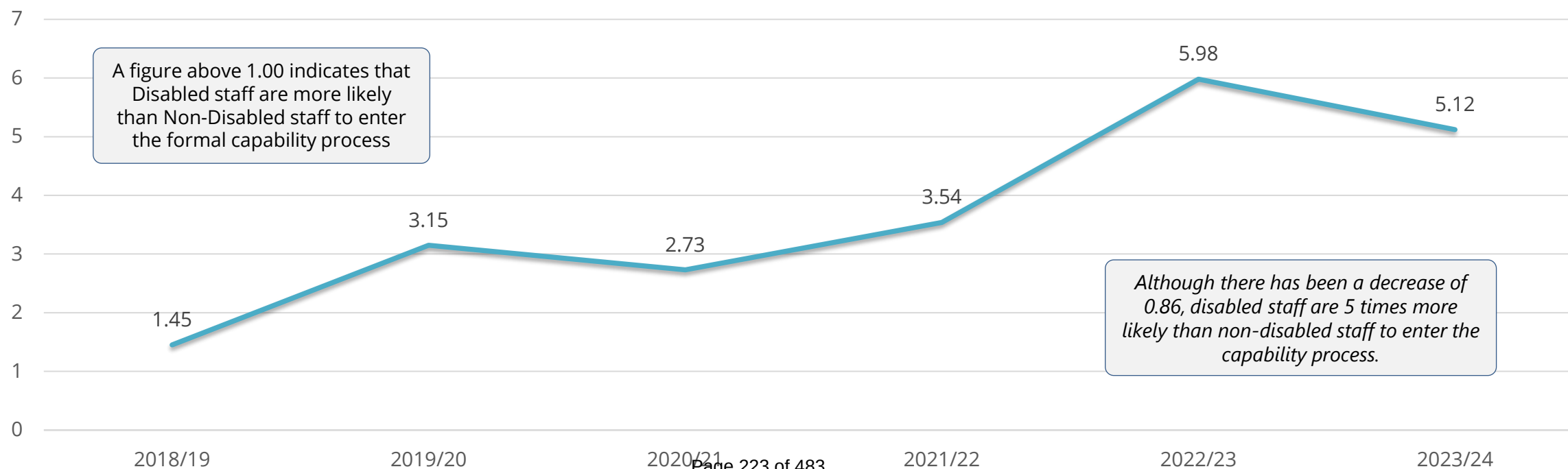
Relative likelihood of non-disabled staff being **appointed from shortlisting** compared to disabled staff
A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting

2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
1.30 times more likely	1.06 times more likely	1.08 times more likely	0.94 times more likely	0.91 times more likely	0.73 times more likely
-	-0.24	+0.02	-0.14	-0.03	-0.18



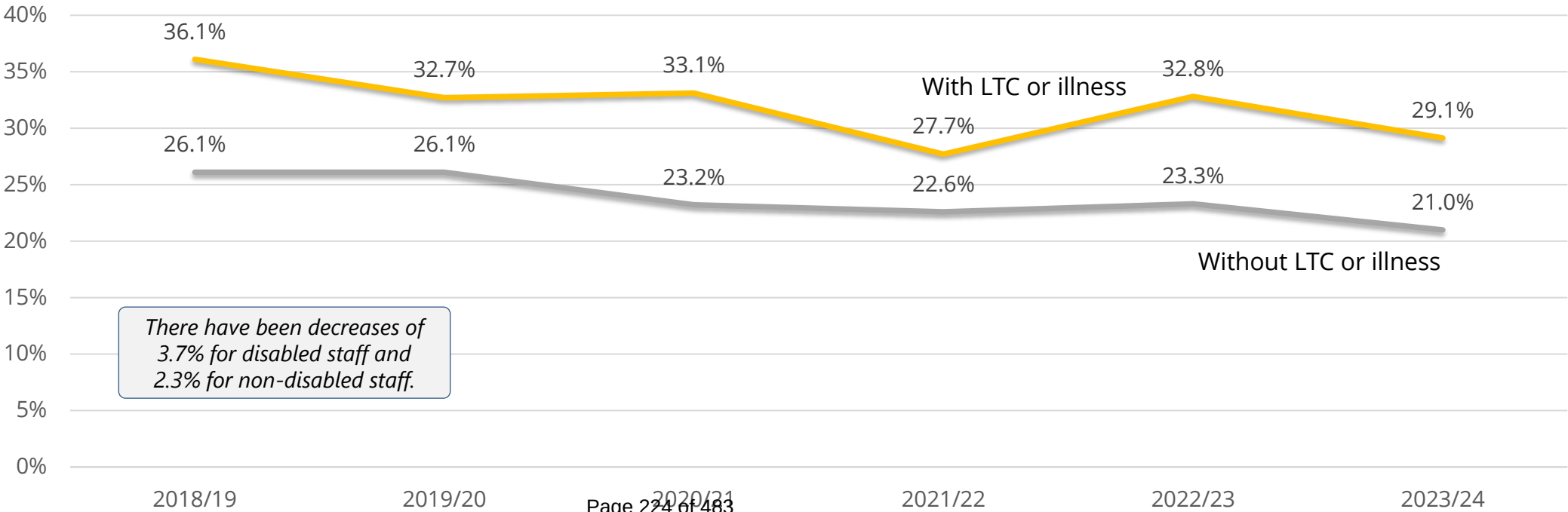
Relative likelihood of disabled staff entering into **formal capability process** compared to non-disabled staff
A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process

2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
1.45 times more likely	3.15 times more likely	2.73 times more likely	3.54 times more likely	5.98 times more likely	5.12 times more likely
-	+1.70	-0.42	+0.81	+2.44	-0.86



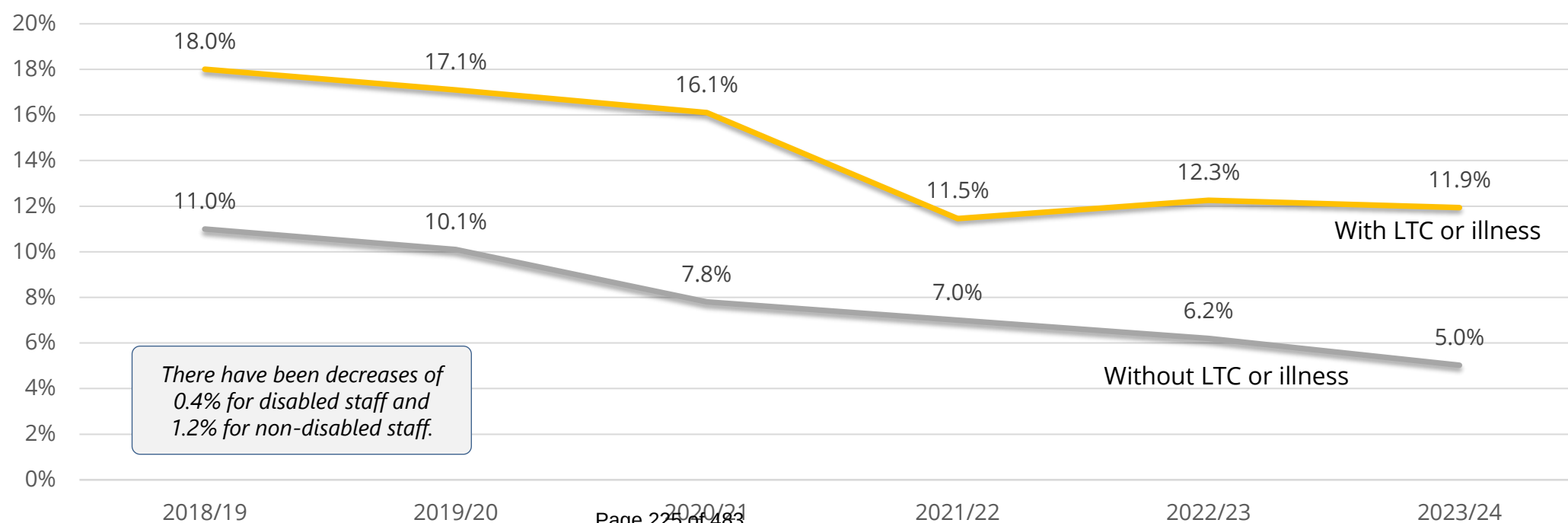
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from Patients/service users, their relatives or other members of the public

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	36.1% -	32.7% (-3.4%)	33.1% (+0.4%)	27.7% (-5.4%)	32.8% (+5.1%)	29.1% (-3.7%)
Staff without LTC or illness	26.1% -	26.1% (0%)	23.2% (-2.9%)	22.6% (-0.6%)	23.3% (+0.7%)	21.0% (-2.3%)



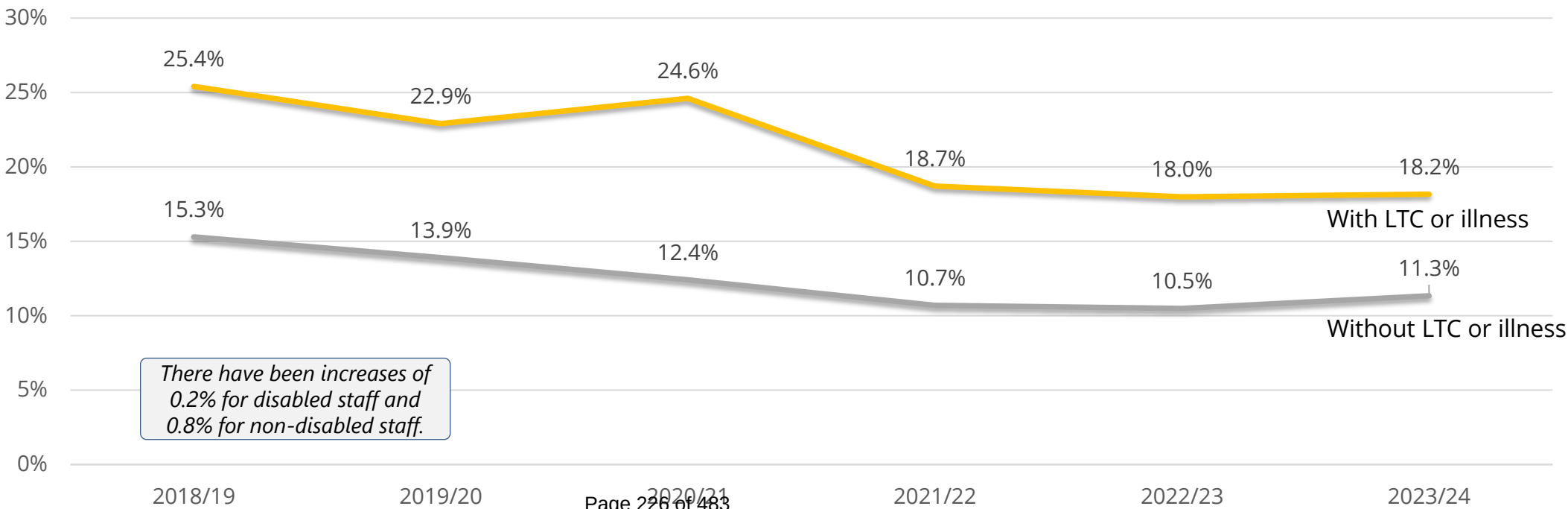
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from Managers

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	18.0% -	17.1% (-0.9%)	16.1% (-1.0%)	11.5% (-4.6%)	12.3% (+0.8%)	11.9% (-0.4%)
Staff without LTC or illness	11.0% -	10.1% (-0.9%)	7.8% (-2.3%)	7.0% (-0.8%)	6.2% (-0.8%)	5.0% (-1.2%)



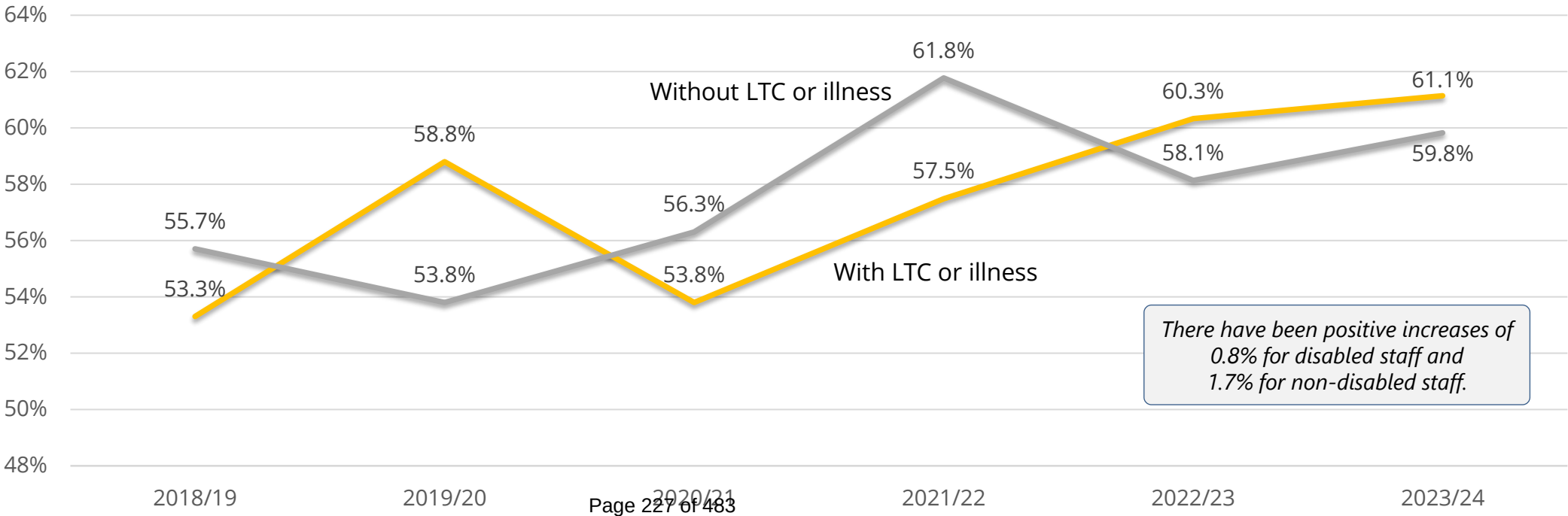
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from other Colleagues

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	25.4% -	22.9% (-2.5%)	24.6% (+1.7%)	18.7% (-5.9%)	18.0% (-0.7%)	18.2% (+0.2%)
Staff without LTC or illness	15.3% -	13.9% (-1.4%)	12.4% (-1.5%)	10.7% (-1.7%)	10.5% (-0.2%)	11.3% (+0.8%)



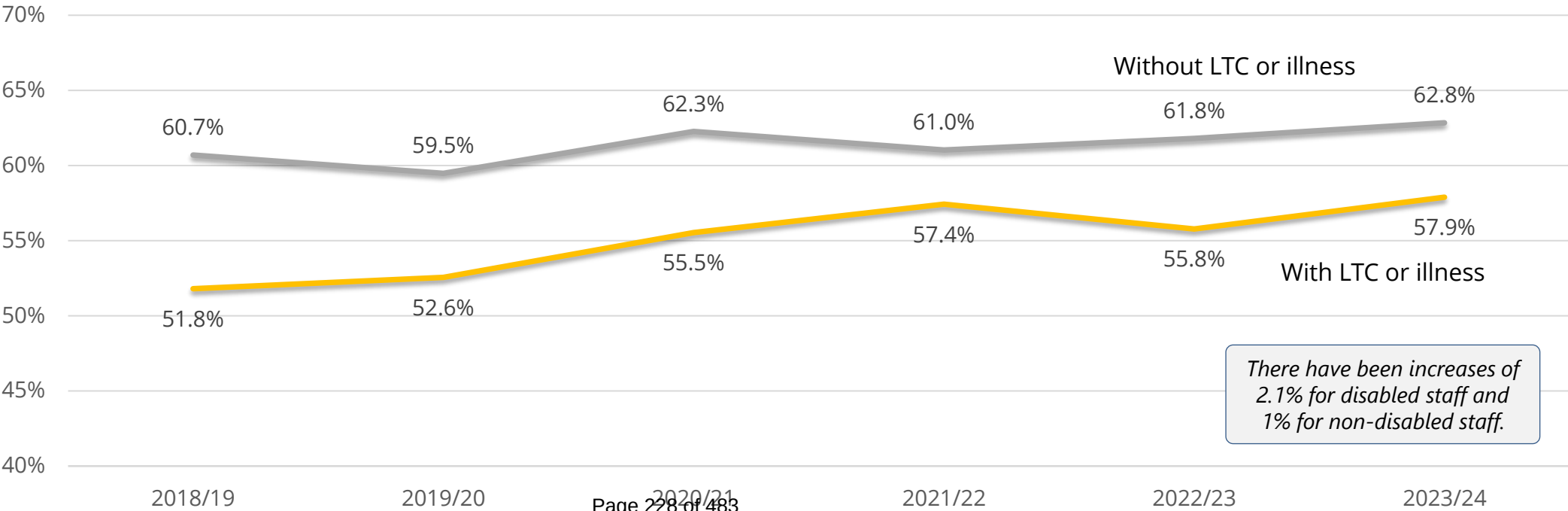
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	53.3% -	58.8% (+5.5%)	53.8% (-5.0%)	57.5% (+3.7%)	60.3% (+2.8%)	61.1% (+0.8%)
Staff without LTC or illness	55.7% -	53.8% (-1.9%)	56.3% (+2.5%)	61.8% (+5.5%)	58.1% (-3.7%)	59.8% (+1.7%)



Percentage of staff who believe that their organisation provides **equal opportunities** for career progression or promotion

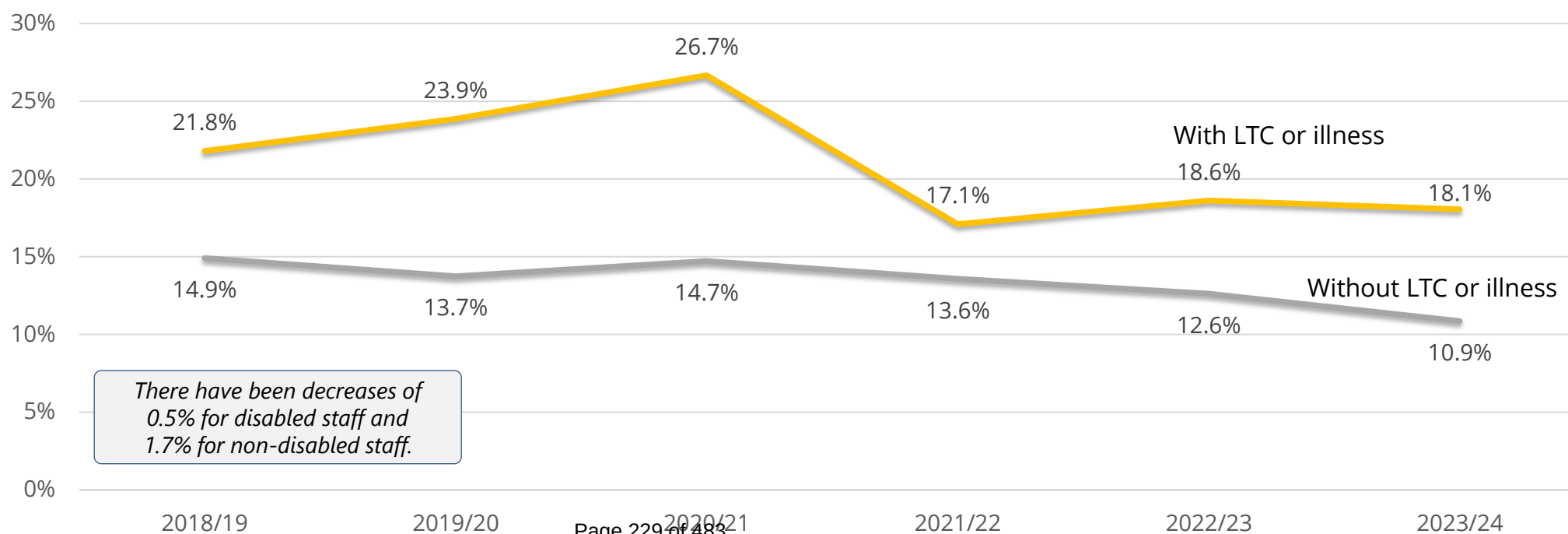
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	51.8% -	52.5% (+0.7%)	55.5% (+3.0%)	57.4% (+1.9%)	55.8% (-1.6%)	57.9% (+2.1%)
Staff without LTC or illness	60.7% -	59.5% (-1.2%)	62.3% (+2.8)	61.0% (-1.3%)	61.8% (+0.8%)	62.8% (+1.0%)



There have been increases of 2.1% for disabled staff and 1% for non-disabled staff.

Percentage of staff who have **felt pressure from their manager to come to work**, despite not feeling well enough to perform their duties

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	21.8% -	23.9% (+2.1%)	26.7% (+2.8%)	17.1% (-9.6%)	18.6% (+1.5%)	18.1% (-0.5%)
Staff without LTC or illness	14.9% -	13.7% (-1.2%)	14.7% (+1.0%)	13.6% (-1.1%)	12.6% (-1.0%)	10.9% (-1.7%)



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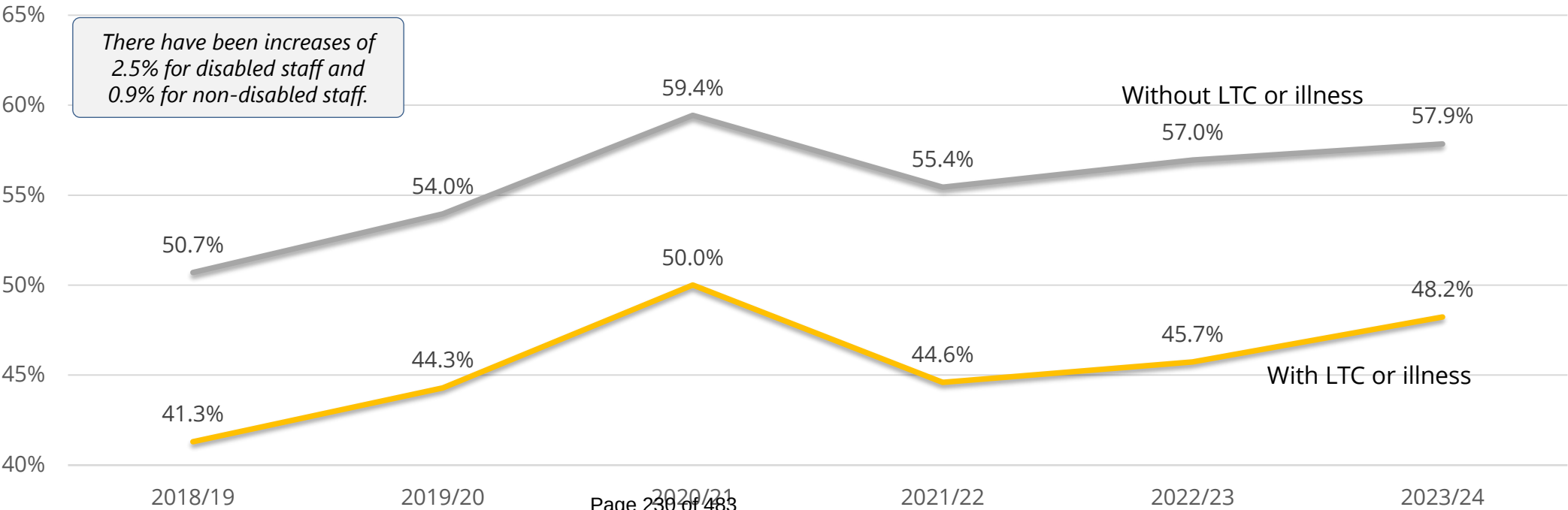
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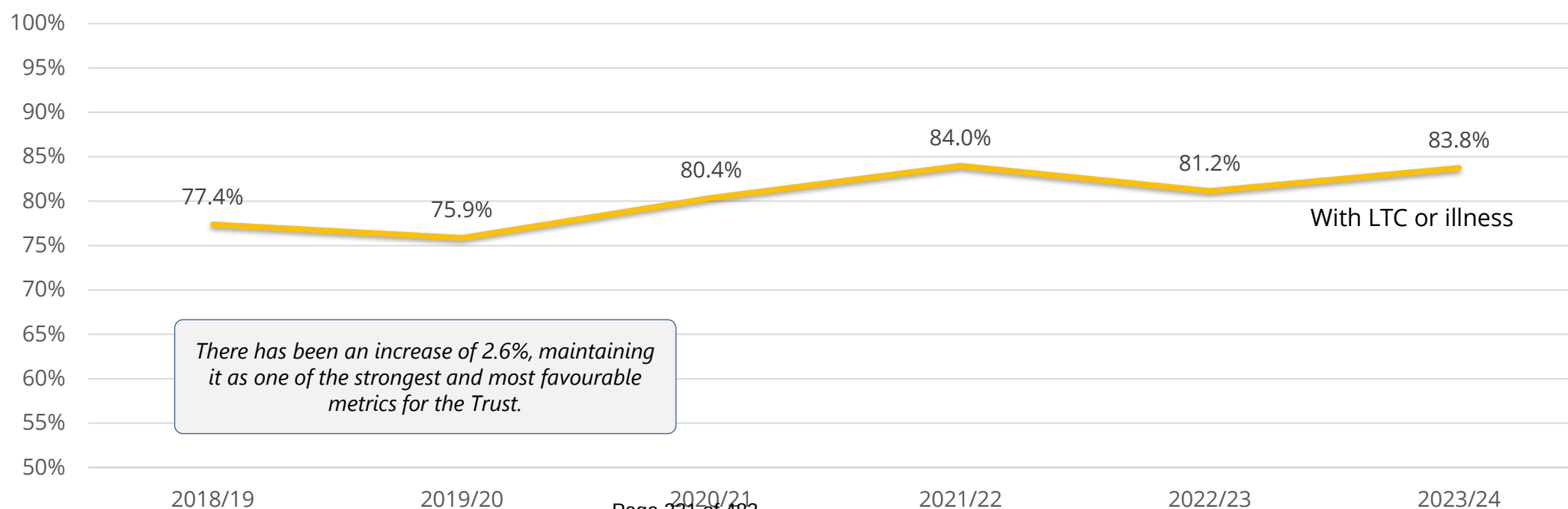
Percentage of staff satisfied with the extent to which the **organisation values** their work

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	41.3% -	44.3% (+3.0%)	50.0% (+5.7%)	44.6% (-5.4%)	45.7% (+1.1%)	48.2% (+2.5%)
Staff without LTC or illness	50.7% -	54.0% (+3.3%)	59.4% (+5.4%)	55.4% (-4.0%)	57.0% (+1.5%)	57.9% (+0.9%)



Percentage of staff with a long lasting health condition or illness saying that their employer has made **adequate adjustment(s)** to enable them to carry out their work

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	77.4%	75.9% (-1.5%)	80.4% (+4.5%)	84.0% (+3.6%)	81.2% (-2.8%)	83.8% (+2.6%)



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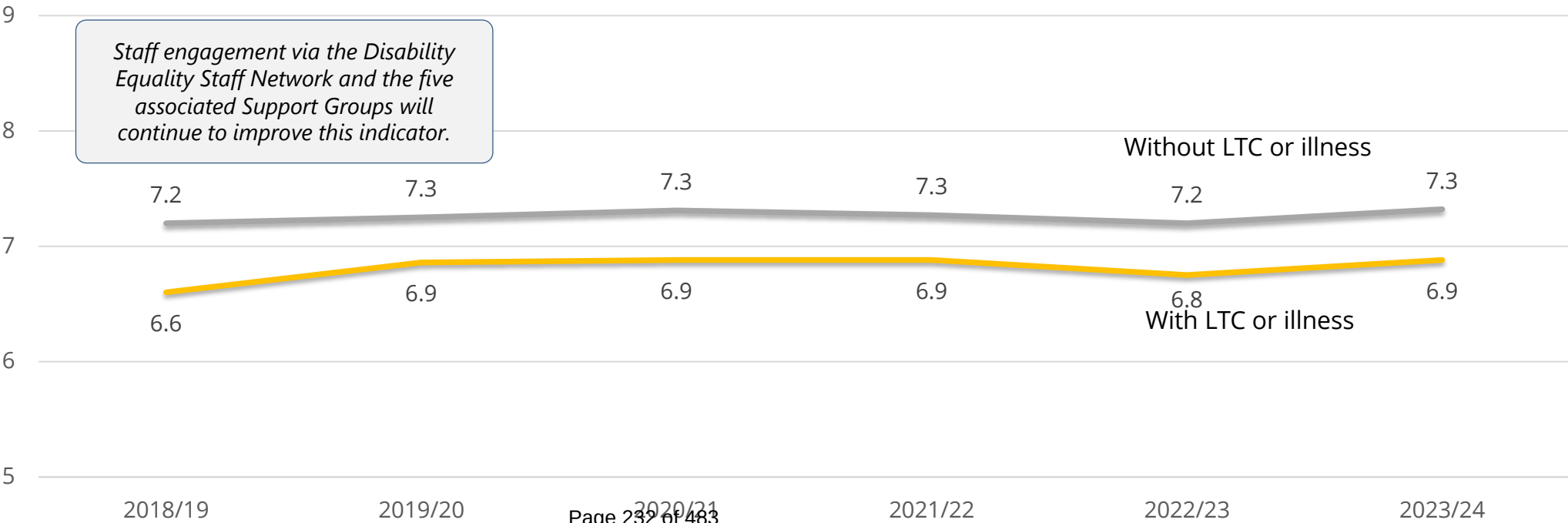
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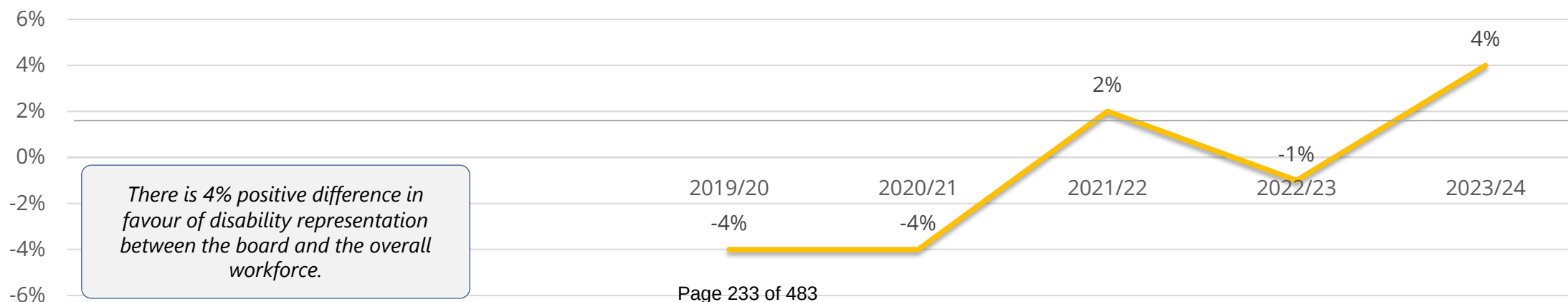
Staff engagement score (0-10)

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Staff with LTC or illness	6.6 -	6.9 (+0.3)	6.9 (0%)	6.9 (0%)	6.8 (-0.1%)	6.9 (+0.1)
Staff without LTC or illness	7.2 -	7.3 (+0.1)	7.3 (0%)	7.3 (0%)	7.2 (-0.1%)	7.3 (+0.1)



Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board & by Executive membership of the Board

	2019/20	2020/21	2021/22	2022/23	2023/24
Percentage of disabled members on the Board	0%	0%	7%	5%	11%
Percentage of disabled staff in Overall Workforce	4%	4%	5%	6%	7%
Percentage difference between the organisation's Board membership and its overall workforce (Disability representation)	-4%	-4%	2%	-1%	4%

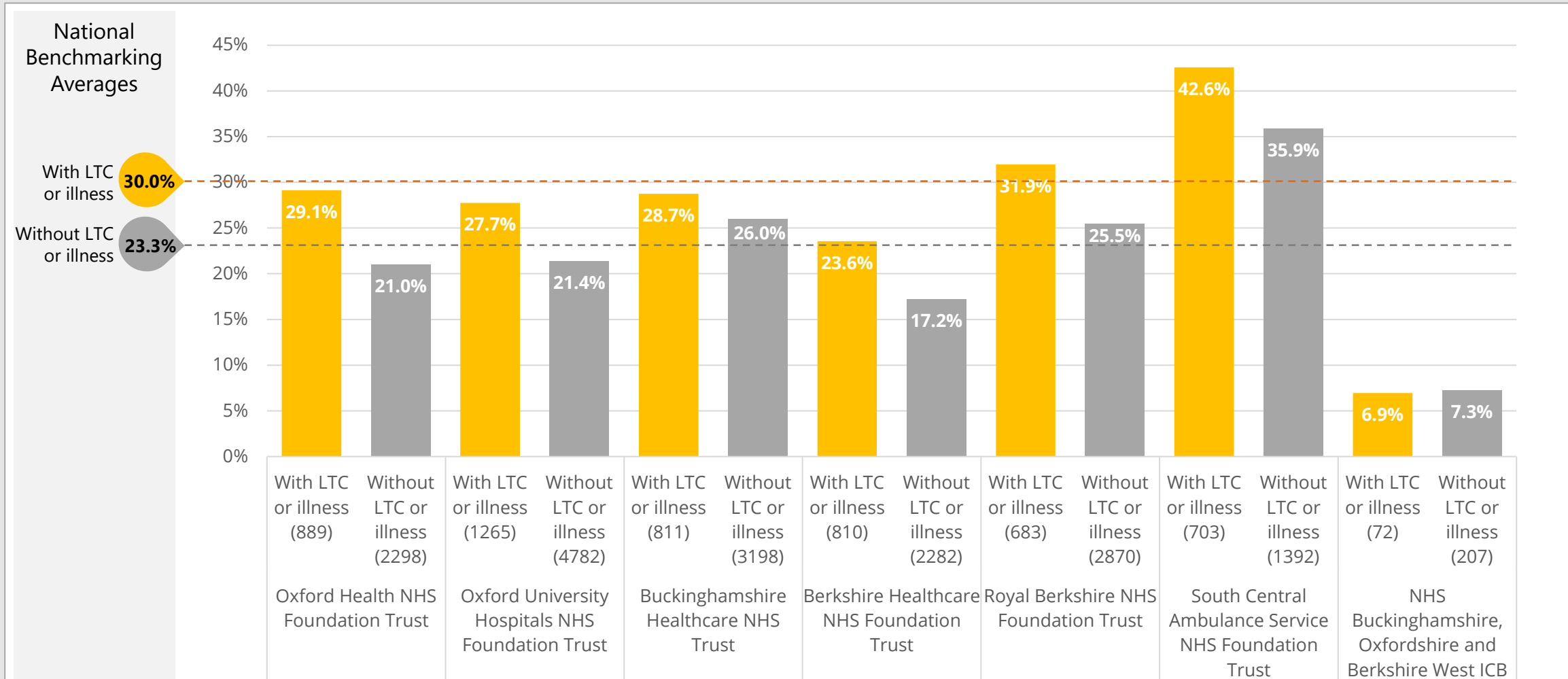


TIMELINE	ACTIONS	STATUS
1st – 30th May	• Gather WDES data from internal sources for metrics 1,2,3, 9b and 10 • Review WDES metrics 4 to 9a sourced from the latest NHS Staff Survey • Review the narrative questions in the WDES Survey section to ensure a comprehensive and high- quality return can be provided • Complete the Mandated Standards returns using the Data Collection Framework (DCF)	Complete
June - July	• Review progress made in the latest action plan • Gain input from key stakeholders to produce a draft action plan	
September – October	• Schedule a meeting date to gain sign-off from the Board for the annual report which should contain a review and an action plan: • 5th September: EDI Steering Group • 7th October: Extended Leadership Team • 16th October: PLC Committee	
October	• Publish the annual report on public facing website by 31 October 2024	
November 2024 – October 2025	• Involve workforce, learning development, talent management and organisational development to help deliver the actions • Share progress and achievements within and beyond the organisation	

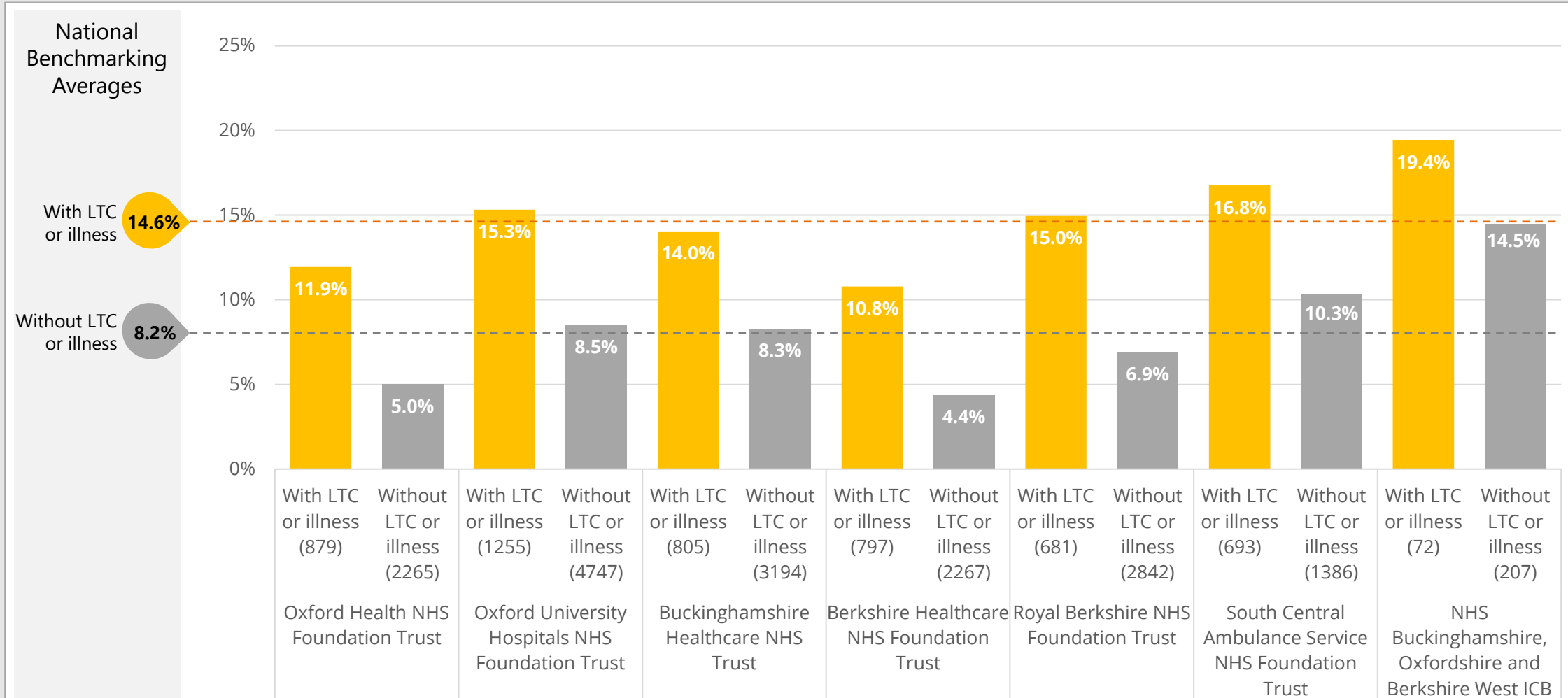
Workforce Disability Equality Standard 2023: **Benchmarking**

- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Berkshire Healthcare NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- NHS Buckinghamshire, Oxfordshire and Berkshire West ICB

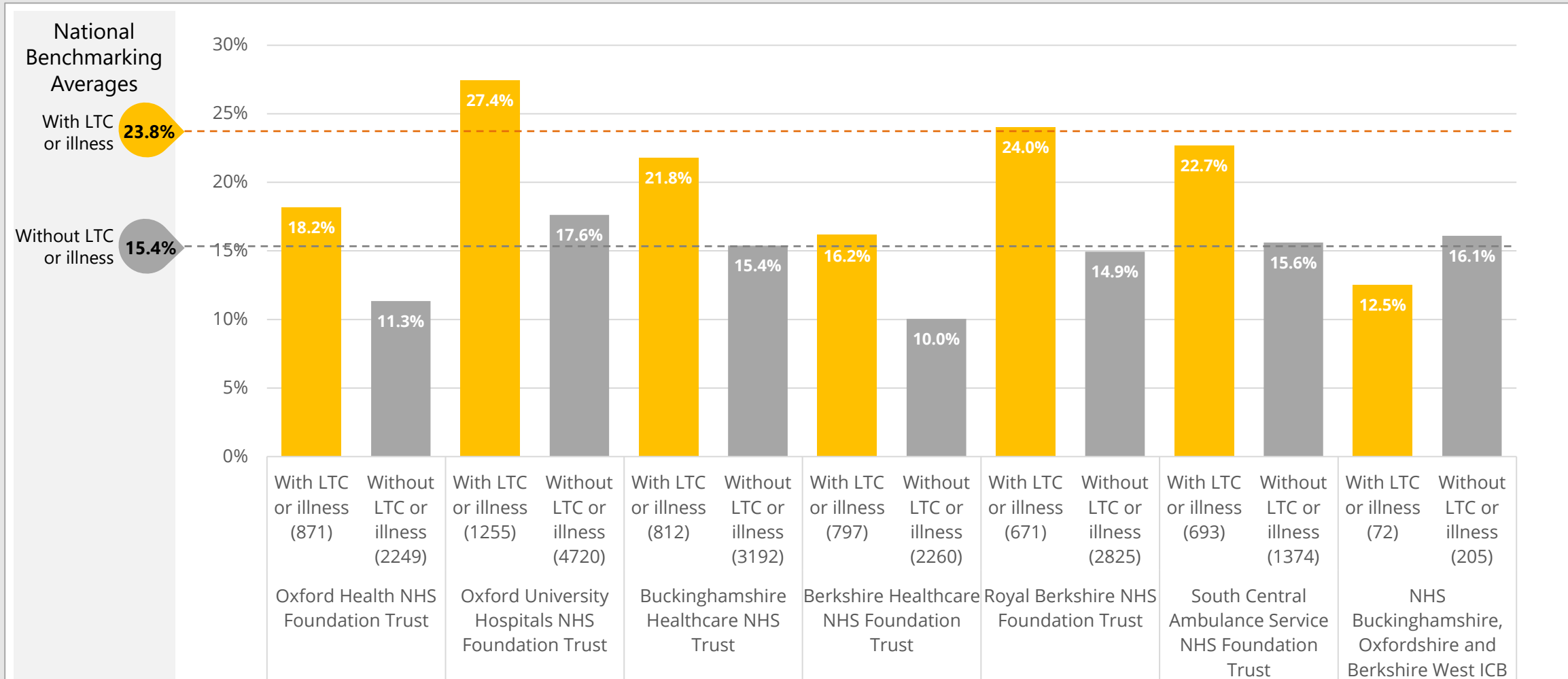
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from Patients/service users, their relatives or other members of the public



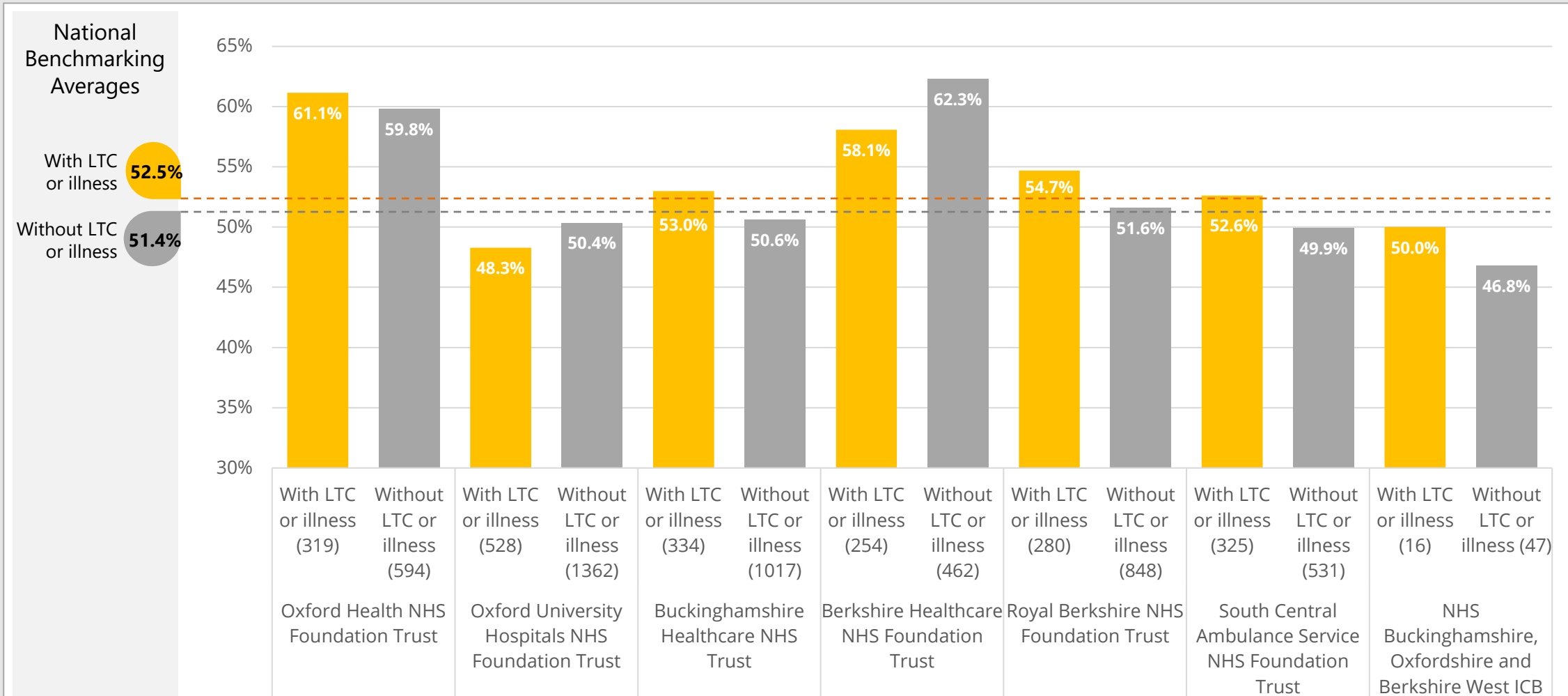
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from Managers



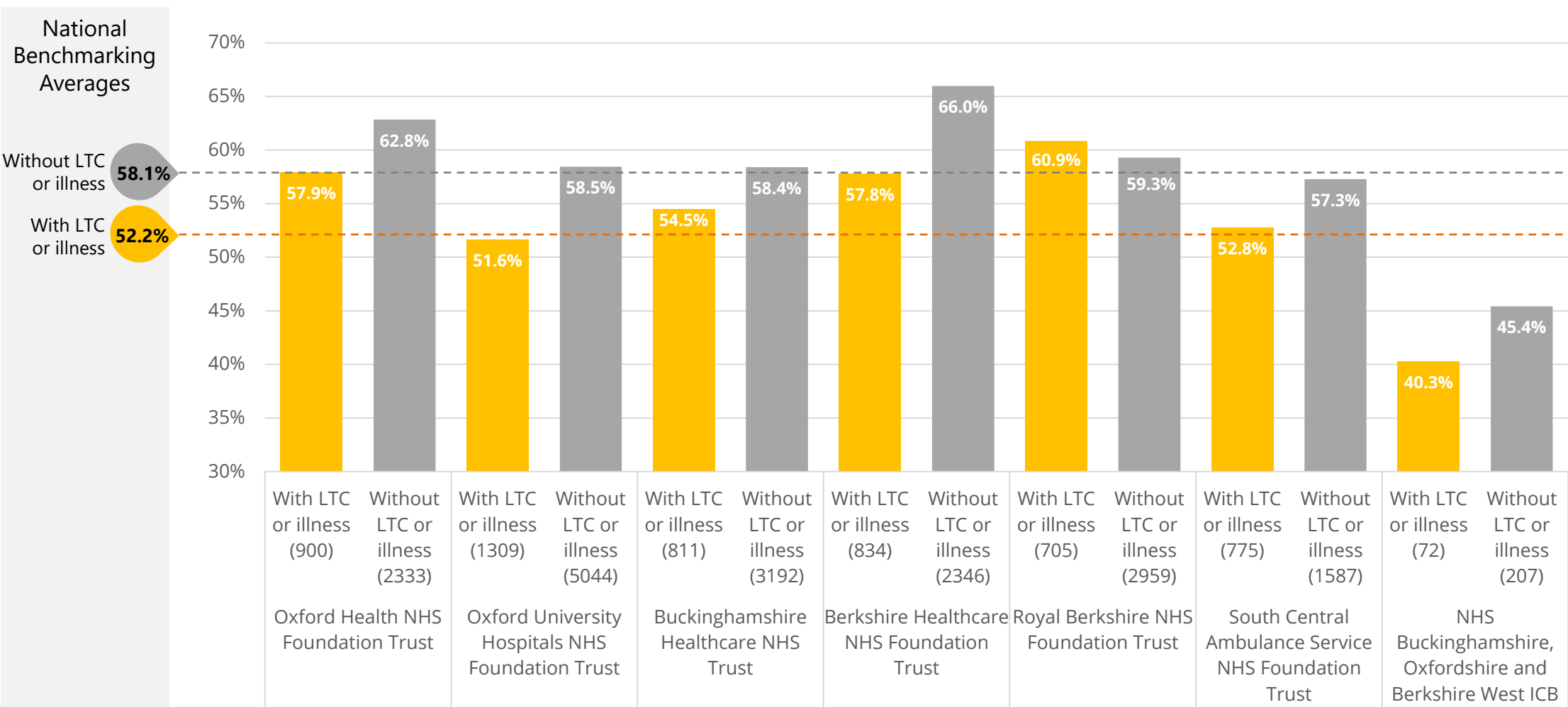
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
from other Colleagues



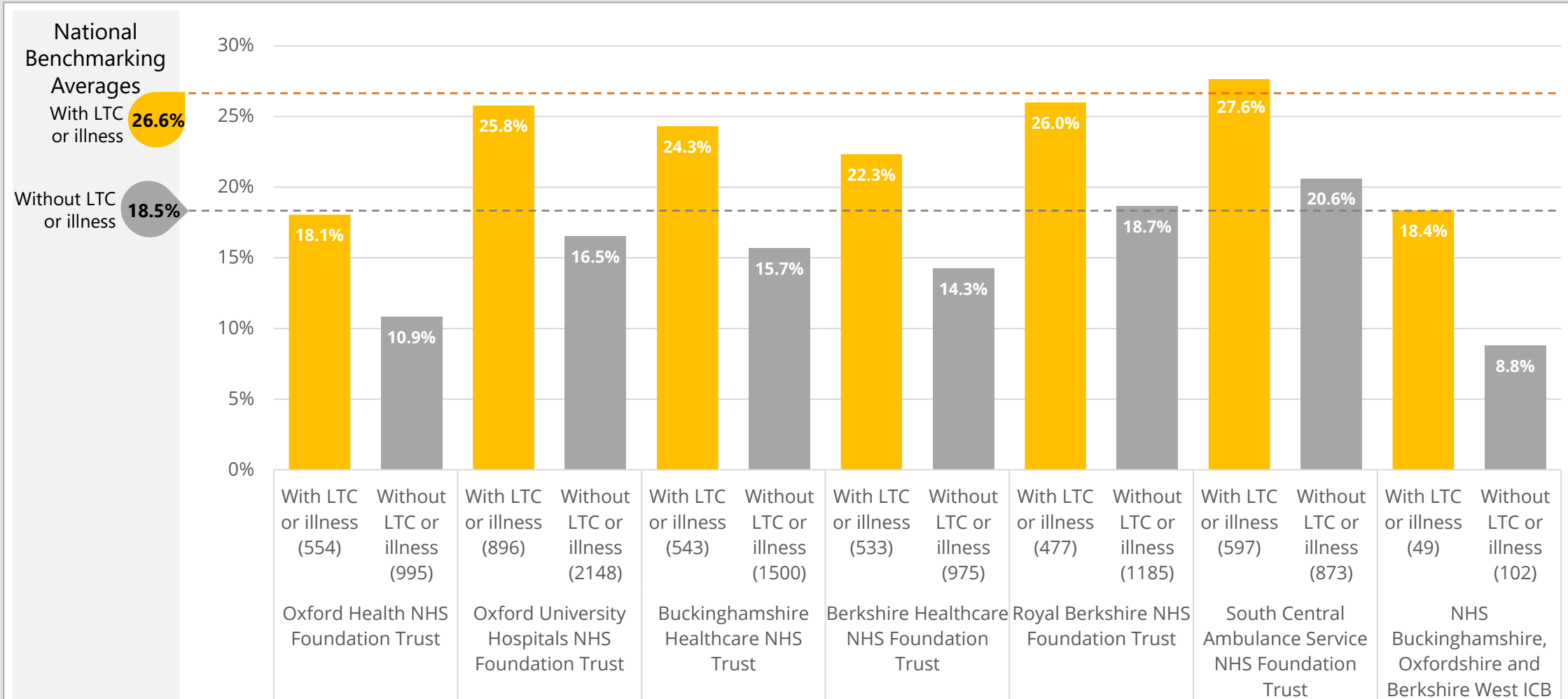
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work,
they or a colleague reported it



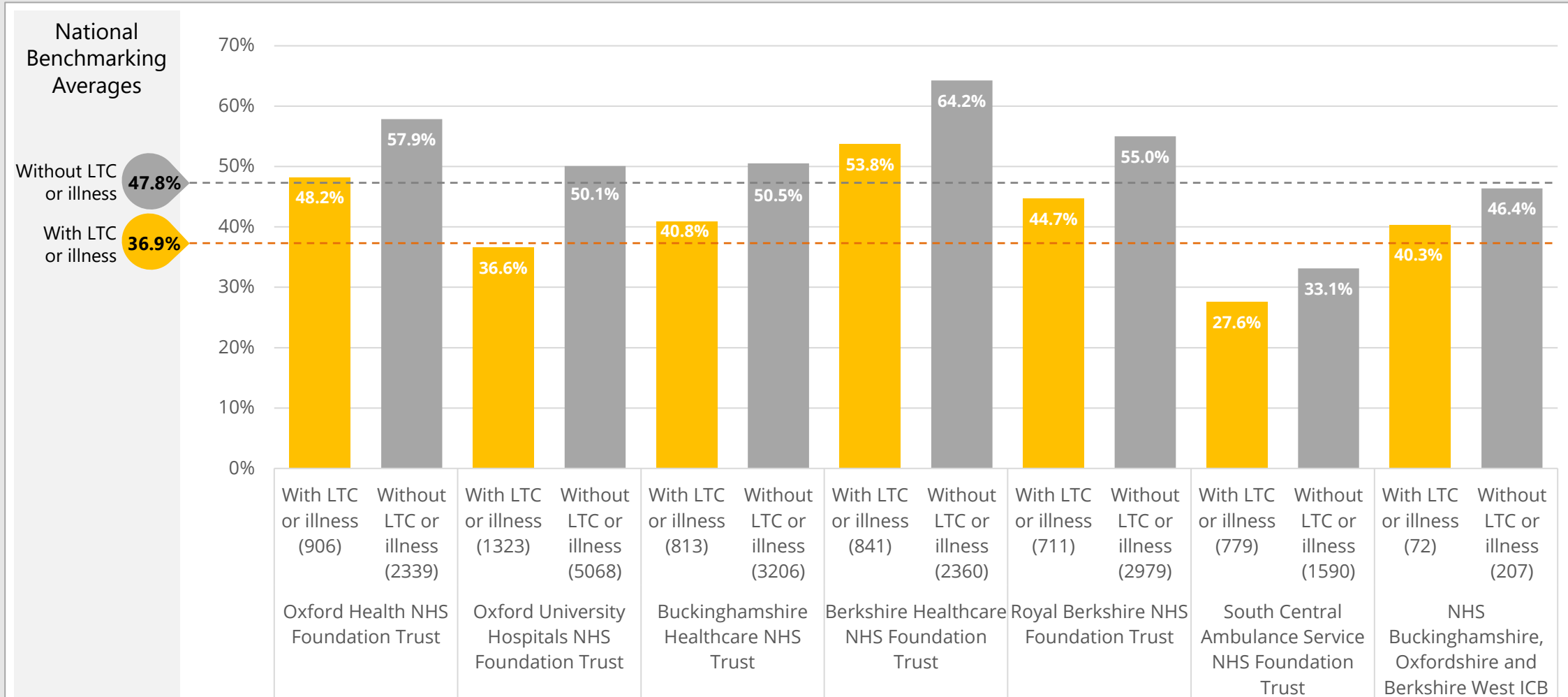
Percentage of staff who believe that their organisation provides **equal opportunities** for career progression or promotion



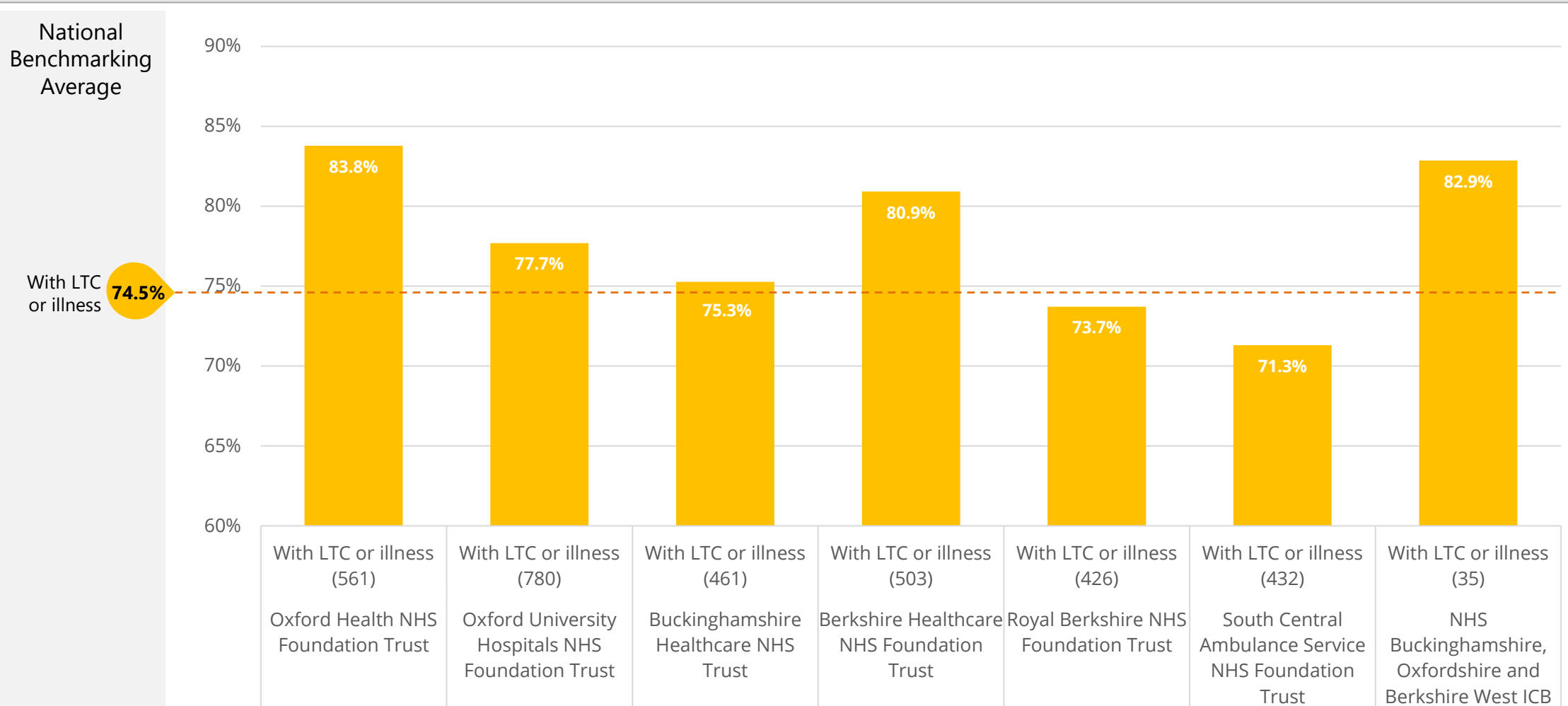
Percentage of staff who have **felt pressure from their manager to come to work**, despite not feeling well enough to perform their duties



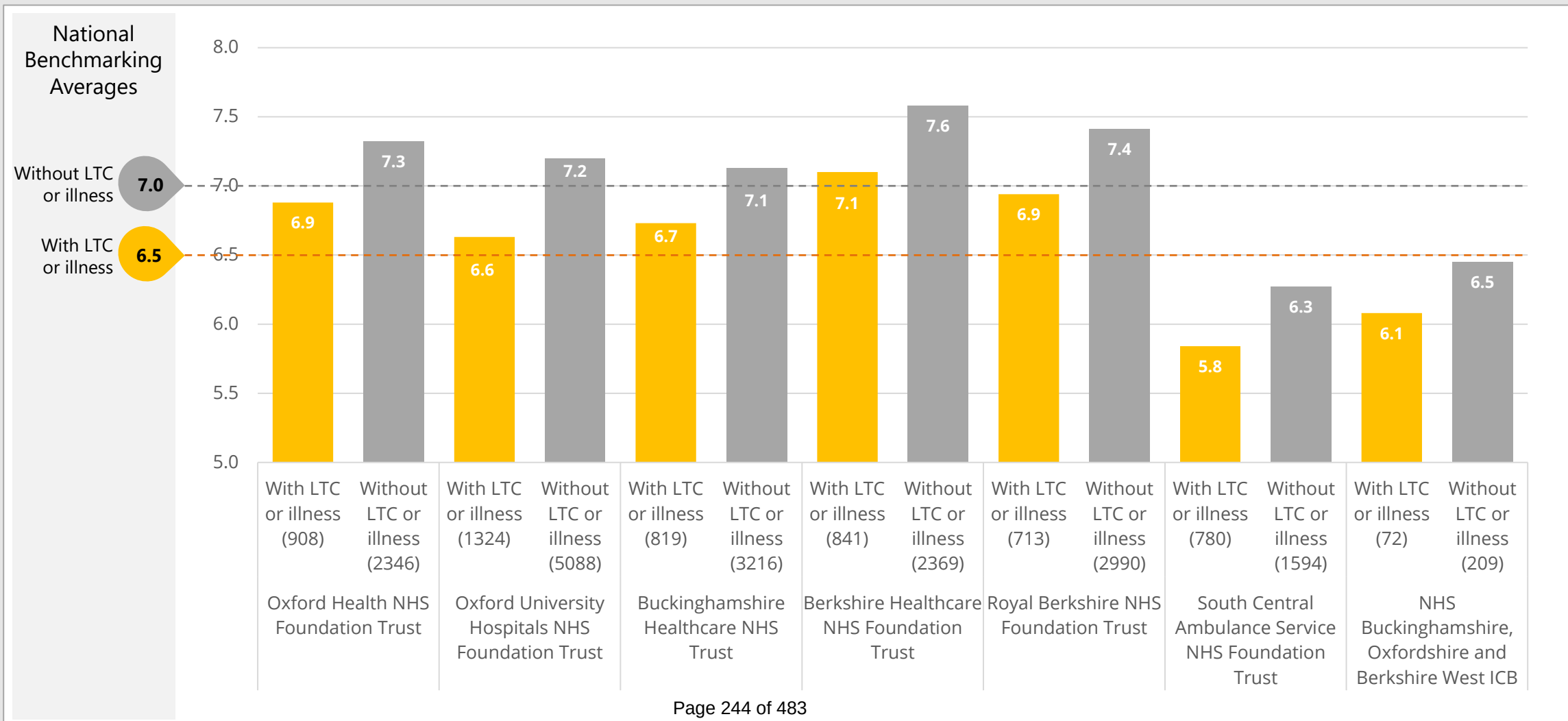
Percentage of staff satisfied with the extent to which the **organisation values** their work



Percentage of staff with a long lasting health condition or illness saying that their employer has made **adequate adjustment(s)** to enable them to carry out their work



Staff engagement score (0-10)



**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

24 July 2024

Board Committee annual reports

For: Receipt and Assurance

Agenda item: 16

Executive Summary

The NHS Act and codes of practice/governance provide the Board with the power to appoint board committees, and to delegate to such committees any of the authority of the Board.

The Board can appoint committees based on what it wants to achieve for the year as these committees should help the Board achieve its objectives. The statutory committees of the Trust are the Audit Committee and the Nominations, Remuneration and Terms of Service Committee. There can be any number of other standing committees operating on a more permanent basis, and ad-hoc committees, which are in place for a particular time frame.

Board Committees represent an essential part of the corporate governance process and should have clear reporting procedures and scope. Each committee is required to have clear terms of reference, reviewed annually by the Board to ensure their relevance. Terms of reference charter the duties, responsibilities and expectations of the committee and the committees of the Board are expected to be accountable for making timely reports to the full Board. Ultimately, the Board is looking for comprehensive information that committees can present to them in a concise manner to help inform decisions (or votes) on specific issues.

While the Board may make use of committees to assist in particular its consideration of appointments, succession, remuneration, quality and safety, audit, risk, and remuneration, it retains responsibility for final decision in all of these areas. The Governance Code and best practice conveys that the remit of each committee, and the processes of interaction between committees and between each committee and the Board, should be reviewed regularly.

It is the Trust Chair's responsibility to ensure board committees are properly structured with appropriate terms of reference, and the Chair should ensure that committee membership is periodically refreshed and that individual independent non-executive directors are not over burdened when deciding the chairs and membership of committees.

Even though Board Committees require strong expertise, it is probable their work often overlaps with the work of other committees of the Board. With an eye on efficiency and to prevent duplicity, many Boards structure their committees with multi-committee directors. Directors who sit on a number of committees are able to alleviate issues with information segregation.

The Board is invited to review and receive the available collective annual reports for FY24 (updated Terms of Reference and overview work plans will be available in September 2024). By seeing these together, the Board can take a universal view of the work which it has delegated to its Committees and confirm that authority has been delegated appropriately and that the Committees are appropriately focused on delivery in satisfying those delegations through the workplans provided, or suggest changes for the year ahead.

The Committee annual reports summarise performance and the work each committee considered during the year. The detail is available in the Reading Room if required, so that the Board can more directly compare and contrast areas of focus and also areas of overlap and shared responsibility between the:

- Audit Committee;
- Quality Committee
- People, Leadership & Culture Committee;
- Mental Health & Law Committee;
- Charity Committee; and
- Warneford Park Programme Board.

The annual report of the Finance & Investment Committee will follow in September 2024 (following its recent review by the Finance & Investment Committee on 23 July 2024) together with updated Terms of Reference and overview work plans for other committees.

Governance Route/Escalation Process

The annual reports have been approved and recommended to the Board at the recent meetings of the above delegated Board Committees. As part of this work, they have been commented upon and developed by Committee Chairs and members. This is now the opportunity for the Board to take a universal view of the authority that it has delegated.

Recommendation

The Board is asked to receive the annual reports of its delegated Committees and confirm that it is assured that authority has been delegated appropriately and that the Committees are appropriately focused or suggest changes for the year ahead.

Lead Executive Director: Georgia Denegri, Associate Director of Corporate Affairs

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** – *this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust:*
 - 1) **Quality - Deliver the best possible care and health outcomes**
Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).
 - 2) **People - Be a great place to work**
Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.
 - 3) **Sustainability – Make best use of our resources and protect the environment**
Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects.

**Report to the Meeting of the
Oxford Health NHS Foundation Trust**

Board of Directors

Agenda item: 17

24 July 2024

Modern Slavery Act – Transparency Statement 2023/24

For: Approval

Executive Summary and Statutory responsibilities

The Modern Slavery Act 2015 (Section 54) requires commercial organisations undertaking business in the UK supplying goods or services with a total global annual turnover of £36 million to produce a slavery and human trafficking statement for each financial year. The statement must contain details of the steps that the organisation has taken in that year to identify and eradicate modern slavery from both its own business and its supply chain. It is encouraged that organisations report within six months of the organisation's financial year end.

Recommendation

The Board is asked to approve the Modern Slavery Act Statement 2023/24 for publication on the Trust's website and to support the Trust to foster a culture in which modern slavery is not tolerated in any form.

Background

The Transparency in Supply Chains provision in the Modern Slavery Act 2015 seeks to address the role of businesses in preventing modern slavery from occurring in their supply chains and organisations. Modern slavery is a crime resulting in an abhorrent abuse of human rights. It is constituted in the Modern Slavery Act 2015 by the offences of 'slavery, servitude and forced or compulsory labour' and 'human trafficking'. Many organisations are taking action to promote ethical business practices and policies that protect workers from being abused and exploited in their own organisation and global supply chains.

From October 2015 the Government introduced a provision in the Modern Slavery Act 2015 which requires certain businesses to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and their supply chains. If an organisation has taken no steps to do this, their statement should say so. The measure is designed to create a level playing field

between those businesses, whose turnover is over a certain threshold, which act responsibly and those that need to change their policies and practices.

Section 54 of the Modern Slavery Act 2015 gives the Secretary of State the power to issue guidance. The provision in the Act requires that any *commercial* organisation in any sector, which supplies goods or services, and carries on a business or part of a business in the UK, and is above a specified total turnover, must produce a slavery and human trafficking statement for each financial year of the organisation.

For the purposes of this requirement, 'supply chain' has its everyday meaning. Regulations have set the total turnover threshold at £36 million. The Act specifically states that the statement must include *'the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business'*.

When the Act refers to ensuring that slavery and human trafficking is not taking place in any part of its supply chain, this does not mean that the organisation in question must guarantee that the entire supply chain is slavery free. Instead, it means an organisation must set out the steps it has taken in relation to any part of the supply chain (that is, it should capture all the actions it has taken). The provision requires an organisation to be transparent about what is happening within its business meaning that, if an organisation has taken no steps to ensure slavery and human trafficking is not taking place, it must still publish a statement to this effect.

If a business fails to produce a slavery and human trafficking statement for a particular financial year, the Secretary of State may seek an injunction through the High Court requiring the organisation to comply. In practice, failure to comply with the provision will mean the organisation has not produced a statement, published it on its website, or has not set out the steps taken by the organisation in the relevant financial year. This can include setting out that it has taken no such steps or is just beginning investigations.

It is expected that organisations will build on their statements year on year and for the statements to evolve and improve over time. The Government has not been prescriptive about the layout or content of a statement. It is up to organisations how they present information in the statement. However, organisations must include all the steps they have taken. The information presented in the statement will be determined by the organisation's sector, the complexity of its structure and supply chains, or the particular sectors and nations its suppliers are working in.

To ensure the information contained is relevant and up to date, it is expected that organisations publish their statements as soon as reasonably practicable after the end of each financial year. In practice, it is encouraged that organisations report within six months of the organisation's financial year end.

For a body corporate (other than a limited liability partnership), the statement must be approved by the board of directors. This ensures senior level accountability, leadership and responsibility for modern slavery. To effectively combat modern slavery, senior managers will need to ensure everyone in an organisation is alive to the risks of modern slavery, to ensure informed decisions are made in a timely way which mitigate and manage risks, and to monitor the implementation of relevant policies.

The Act requires each organisation to publish a slavery and human trafficking statement on their website and include a link in a prominent place on its homepage. The purpose of this measure is to increase transparency and it is vital that the statement can be easily accessible by anyone who wants to see it – the public, consumers, employees, NGOs or investors.

Recommendation:

The Board is asked to approve the Modern Slavery Act Statement 2023/24 for publication on the Trust's website and to support the Trust to foster a culture in which modern slavery is not tolerated in any form.

Lead Executive Director: Georgia Denegri, Associate Director of Corporate Affairs

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors.*
2. **Strategic Objectives/Priorities** - N/A – no Strategic Objectives/Priorities apply

MODERN SLAVERY ACT TRANSPARENCY STATEMENT 2023/24

Slavery and Human Trafficking Policy Statement

1. Introduction

Modern Slavery remains a hidden blight on society. We all have a responsibility to be alert to the risks of modern slavery, however small, in our organisation and in the wider supply chain. Trust colleagues are expected to report concerns and our management teams are expected to act upon them. At Oxford Health NHS Foundation Trust (OHFT) we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain upholding the provisions of the Modern Slavery and Human Trafficking Act 2015.

This statement sets out actions taken by OHFT to understand all potential modern slavery and human trafficking risks and to implement effective systems, controls and best practice in order take all reasonable steps to prevent slavery and human trafficking. We expect our staff and suppliers to comply with the legislation and report any concerns where they may have them.

OHFT wishes its service users, staff, and all stakeholders to be confident in the knowledge that we operate a zero tolerance approach to modern slavery and human trafficking, and we are working as best we can to ensure that such practise does not exist anywhere in our Trust or in our supply chain.

2. Our commitment

We are fully aware of the responsibilities we bear towards our service users, staff and local communities. We aim to follow good practice and to take all reasonable steps to prevent slavery and human trafficking.

We are committed to promoting a proactive and inclusive approach to equality in both employment and service provision which supports and encourages an inclusive culture which values diversity. This includes a commitment to building a workforce which is valued and whose diversity reflects the communities it serves, enabling the Trust to deliver the best possible healthcare services.

OHFT is guided by a strict set of ethical values in all of its business dealings and expects its suppliers to adhere to these same principles. The Trust is committed to ensuring there is no modern slavery in any part of the business and, in so far as possible, requires suppliers to hold the same ethos.

OHFT is also committed to ensuring that all staff are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that an individual may be or is at risk of modern slavery and human trafficking.

3. About Oxford Health

OHFT provides physical, mental health, learning disability and social care for people of all ages across Oxfordshire, Buckinghamshire, Bath and North East Somerset, Swindon and Wiltshire. The Trust's services are delivered at community bases, hospitals, clinics and in people's homes. The Trust focuses on delivering care as close to home as possible. Further information can be found on the 'About us' pages of the Trust's [website](#).

Our supply chains enable the procurement of a wide range of goods and services on behalf of our clients and service users.

4. Our Policy on Slavery and Human Trafficking

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures.

5. Due Diligence, Risk Assessment and Management

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Undertake appropriate pre-employment checks on directly employed staff and agencies on approved frameworks. Agency compliance is audited to provide assurance that pre-employment clearance has been obtained for agency staff;
- Adhere to National NHS Employment Checks/Standards. This includes right to work in the UK, employees' UK address and factual references;
- Implement a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair Terms and Conditions of employment and equitable access to training and development opportunities. We are working towards embedding an overarching just and restorative learning culture throughout the organisation which will underpin our ongoing provision of fair employment terms and conditions;
- Consult and negotiate with Trade Unions on proposed changes to contractual terms and conditions and proposals relating to organisational change, in the context of ongoing dialogue to provide a supportive work environment;

- Have systems to encourage the reporting of concerns, including a whistleblowing policy (also known as Management of Concerns) so that all staff know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our Trust or supply chain, without fear of reprisals. We also make every effort to promote the role of our Freedom to Speak up Guardians and Ambassadors;
- Purchase a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour;
- Our purchase orders and tender specifications comply with the NHS Standard Terms and Conditions, thereby complying with the UK Modern Slavery Act (2015), all of which set out our commitment to ensuring no modern slavery or human trafficking related to our business;
- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria and processes. All NHS Contracts for the Supply of Goods and Provision of Non-Clinical Services have contractual clauses requiring compliance with the Modern Slavery Act (2015);
- Include a minimum of 10% Social Value criteria evaluation in our tender documents and ensure appropriate weight is given to modern slavery and human trafficking elements;
- Ensure adherence to the Cabinet Office Procurement Police Notice for Tackling Modern Slavery in Government Supply Chains by identifying and managing risks in new and existing procurement activities.
- Uphold professional codes of conduct and practice relating to procurement and supply, including through adherence to Sustainable and Ethical Values as advocated through the Chartered Institute of Procurement and Supply and/or other appropriate professional bodies; and
- Ensure ongoing due diligence through effective contract management and by building strong working relationships with suppliers;
- Monitoring of actions put in place to review and provide assurance on their effectiveness.

6. Training and Awareness

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our Safeguarding policies and procedures and our Safeguarding leads.

As part of our recruitment process we consider the extent to which applicants have knowledge of and skills to comply with their obligations to safeguard service users which includes Modern Slavery and Human Trafficking. It is extremely important to Oxford Health that all employed staff are supported to recognise signs and indicators of abuse which includes concerns relating to modern slavery and human trafficking. We have a responsibility as an organisation delivering care and treatment to vulnerable children and adults and we take this duty very seriously.

The organisation monitors any modern slavery issues through our Safeguarding Service and together with partner agencies.

7. Board of Directors' Approval

This statement has been approved by the Trust's Board of Directors of (July 2024) who will continue to support the requirements of this legislation. The Board will aim to review and update it on an annual basis.

The statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes Oxford Health NHS Foundation Trust's slavery and human trafficking statement for the financial year ended 31 March 2024.

BAF SUMMARY Contents of this summary table (p.1-4) are hyperlinked to full BAF (at p.5 onwards).						
REF.	LEAD EXEC. DIRECTOR (ED)	RISK	CURRENT RATING	TARGET	MOVEMENT	REVIEW Date
	MONITORING COMMITTEE					
1. Quality - Deliver the best possible care and outcomes						
1.1	Chief Nurse/ Chief Finance Officer	Utilising digital, data and technology to drive quality, efficiency, economy, research, and innovation (formerly Triangulating data and learning to drive Quality Improvement and still subject to review)	9	8	↔	27/02/24
	Quality Committee / Finance & Investment Committee	A failure to utilise and engage with digital, data and technology to drive quality, efficiency, economy, research, insights and innovation resulting in poorer patient outcomes and/or poor patient experience, lack of insights to support decisions, lower return on investments, lack of insights driving quality improvements.				02/05/24
1.5	Exec MD for MH & LD	Unavailability of beds/demand and capacity (Mental Health inpatient and LD)	16	8	↔	09/07/24
	Quality Committee	Lack of local admission beds due to demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge could lead to: (i) increase in Out of Area Placements (OAPs)further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations.				16/07/24
1.6	Exec MD Primary Care & Community	Sustainability of the Trust’s primary, community & dental care services	12	9	↔	09/07/24
	Quality Committee	There is a risk that the inability to progress, with key partners, the re-design and re-commissioning of primary, community and dental care services across Oxfordshire threatens the medium- and long-term sustainability of these services. In this scenario, waiting lists/delays will continue to grow, quality and safety of care will be increasingly compromised, the financial position will deteriorate, the needs of the service users will be insufficiently met and there will be poorer health outcomes and experiences. The successful mitigation of this risk requires the Trust to work effectively with a wide range of ICB partners and stakeholders to deliver a number of priority strategic actions and enablers (set out below), which in turn will enable the successful transformation of key primary and community care pathways.				16/07/24
2. People - Be a great place to work						

<u>2.3</u>	Chief People Officer	Succession planning, organisational development and leadership development Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change;	12	4	↔	04/07/24
	People Leadership and Culture Committee					10/07/24
<u>2.4</u>	Chief People Officer	Developing and maintaining a Culture in line with Trust values A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	12	9	↔	04/07/24
	People Leadership and Culture Committee					10/07/24
<u>2.5</u>	Chief People Officer	Retention of staff A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	12	9	↔	04/07/24
	People Leadership and Culture Committee					10/07/24
<u>2.6</u>	Chief People Officer	Adequacy of Staffing [will be subject to minor refinements led by future committee discussions] Inability to plan for, attract and secure sufficient and appropriately trained staff may lead to inadequate levels of staffing to provide: i. safe and/or quality patient care; or ii. the range of services which the Trust aspires to. If the Trust cannot secure adequate levels of permanent staffing, then it may turn to planned bank staff or temporary agency staffing which may be unsustainable in the medium to long term and could, without adequate controls, have financial and quality of care implications. [Replaces former BAF risks 2.1 and 2.2]:	16	9	↔	01/07/24
	People Leadership and Culture Committee					10/07/24

3. Sustainability - Make the best use of our resources and protect the environment

3.1	Executive Director of Strategy & Partnerships	Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level.	12	9	↔	02/07/24
	Quality Committee	Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.				16/07/24
3.4	Chief Finance Officer	Delivery of the financial plan and maintaining financial sustainability	16	12	↔	19/06/24
	Finance & Investment	Failure to deliver financial plan and maintain financial sustainability over the short (1-2 years) or medium-term (3-4 years), including, but not limited to: through funding reductions; non-delivery of CIP savings; budget overspends; and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England; and insufficient cash to fund future capital programmes.				09/05/24
3.6	Director of Corporate Affairs & Co Sec	Governance and decision-making arrangements	8	4	↓	19/03/24
	Audit Committee	Failure to maintain and/or adhere to effective governance and decision making arrangements, and/or insufficient understanding of the complexities of a decision may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.				23/04/24
3.7	Executive Director of Strategy & Partnerships	Ineffective business planning arrangements	12	6	↔	24/04/24
	Finance & Investment	Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.				09/05/24

3.10	Chief Finance Officer	Information Governance & Cyber Security	12	9	↔	08/03/24
	Finance & Investment	Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions), cyber-attacks which could compromise the Trust’s infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; reputational damage.				09/05/24
3.12	Director of Corporate Affairs & Co Sec	Business continuity and emergency planning	9	9	↓	16/02/24
	Emergency preparedness, resilience and response committee (sub-group to Executive Management Committee) and Audit Committee	Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.				23/04/24
3.13	Chief Finance Officer	A failure to take reasonable steps to minimise the Trust’s adverse impact on the environment , maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties (Health & Care Act 2022), national targets, the NHS Long Term Plan and ‘For a Greener NHS’ ambitions (Reach net zero NHS Carbon Footprint	9	3	↔	12/01/24
	Finance & Investment	by 2040, reducing emissions by at least 47% by 2028 – 2032. Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036 2038) could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.				09/05/24
3.14	Chief Finance Officer	Major Projects	16	6	↔	09/05/24
	Finance & Investment	Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; non-delivery of required savings, unplanned expenses, delays and wasted resources.				09/05/24
4. Research & Education - Become a leader in healthcare research and education						
4.1	Chief Medical Officer	Failure to realise the Trust's Research and Development (R&D) potential.	6	3	↔	08/02/24
	Quality Committee	Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.				16/07/24

Risk rating matrix and scoring guidance appears at [Appendix 1](#)

Strategic Objective 1: Deliver the best possible care outcomes

1.1: Utilising digital, data and technology to drive quality, efficiency, economy, research and innovation
(formerly *Triangulating data and learning to drive Quality Improvement* and still subject to review)

Date added to BAF	10 February 2022					
Monitoring Committee	Quality Committee / Finance & Investment Committee			Impact	Likelihood	Rating
Executive Lead	Chief Nurse / Chief Finance Officer		Gross (Inherent) risk rating	4	5	20
Date of last review	23/02/2024		Current risk rating	3	3	9
Risk movement	↔		Target risk rating	4	2	8
Date of next review	June 2024		Target to be achieved by	March 2025		

Risk Description: A failure to utilise and engage with digital, data and technology to drive quality, efficiency, economy, research, insights and innovation resulting in poorer patient outcomes and experience, lack if insights to support decisions, lower return on investments, lack of insights driving quality improvements.

Risk Description: A failure to utilise and engage with digital, data and technology to drive quality, efficiency, economy, research, insights and innovation resulting in poorer patient outcomes and experience, lack if insights to support decisions, lower return on investments, lack of insights driving quality improvements.

Key Controls	Assurance	Gaps	Actions
	Level 1: reassurance		
Trust Digital Strategy and implementation of this strategy.	Digital, Data and Technology Board monthly meetings.	GAP: The clinical systems outage due to the supplier cyber-attack from August - December 2022 resulted in clinical data being captured outside of clinical systems in an unstructured format.	ACTION: Optimisation of core clinical systems to ensure data captured at point of care and can be used for insights into population health, service transformation, quality improvements.
NHSE Digital Maturity Framework “What Good Looks Like”.	Digital Innovation Group monthly meetings facilitating an innovation pipeline.		
NHSE Data Security and Protection Toolkit Compliance.	Clinical Safety Group supported by CCIO.	As the new systems were implemented, they were only basic systems initially capturing basic clinical data.	
Digital, Data and Technology Governance within the Trust and across the ICS.	Digital Leadership Team now including CNIO.	Therefore, there are 2 data gaps – the data from the outage and the data which is not captured until the new system optimisations take place.	
Use of TOBI (Trust Online Business Intelligence) data from ward to Board level.	AI Strategic Group to facilitate innovative AI projects.		
Integrated Performance Report to Board.	Digital, Data and Technology Skills and Workforce Group within the Trust, ICS and Regional.	GAP: Lost opportunities to develop data insight,	ACTION: Ensure the Trust engages to focus on realising

Oxford Healthcare Improvement (OHI) Centre. Experience & Involvement Strategy. Population Health and Data Insights and Analytics. Collaboration with Oxford University and research to support innovation, quality improvements and commercial development.	Data, Analytics and Research Group within the Trust and ICS. Clinical Systems Governance. Monthly Directorate Quality Groups. Information Management Group Digital Update.	population health analytics, system interoperability, health innovations due to the focus being on recovery from the outage. GAP: Interdependency on other NHS organisations for data platforms such as Federated Data Platform, Shared Care Record, Secure Data Environment.	the benefits of the data analytics platforms with links to the optimisation programme. ACTION: Ensure resources are applied to engage with the programmes around external data platforms.
	Level 2: internal Digital Data and Technology Group reporting into Exec and Board. Finance and Investment Committee oversight of Frontline Digitisation Programme. Integrated Performance Report to Board. Quality Committee Oversight. Internal Trust Assurances – Cyber Security, Infrastructure Assessment, Clinical Safety.	GAP: Potential funding shortfalls to realise benefits of available digital capabilities. GAP: Digital skills and capabilities of the Trust workforce to realise the benefits of the digital tools available. GAP: Outcome data collected in a structured way from the clinical services. GAP: Research opportunities lost due to data not being available for the research team. GAP: Digital innovations within the Trust need more oversight and support.	ACTION: Working with NHSE to ensure all relevant funding opportunities are realised. ACTION: Digital, Data and Technology Group to facilitate and have oversight of improving the workforces' digital skills and capabilities. ACTION: Focus on facilitating the digital recording of patient outcome measures. ACTION: Engage with patients and research team around "Count me in". ACTION: Support digital innovations from idea to implementation using agile methodology.
	Level 3: independent Mandatory Reporting. CQC Inspections. Patient/carer feedback, incl. 'I Want Great Care' results. What Good Looks Like Framework for Digital Maturity. ICS Digital, Data and Technology Governance. DSPT Toolkit Compliance. NHSE compliance around DD&T - DTAC / MFA .		

	Performance against national NHS Oversight Framework indicators.		

Strategic Objective 1: Deliver the best possible care outcomes
1.5: Unavailability of beds/demand and capacity (Mental Health inpatient and LD)

Date added to BAF	Pre-Jan 2021		Impact	Likelihood	Rating
Monitoring Committee	Quality Committee				
Executive Lead	Executive Managing Director for Mental Health & Learning Disabilities				
Date of last review	09/07/24				
Risk movement	↔				
Date of next review	September 2024	Gross (Inherent) risk rating	4	5	20
		Current risk rating	4	4	16
		Target risk rating	4	2	8
		Target to be achieved by			

Risk Description:

Lack of local admission beds due to demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge could lead to: (i) increase in Out of Area Placements (**OAPs**) further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations..

Key Controls	Assurance	Gaps	Actions
1) Lead organisation for CAMHS single point of access for provider collaborative network beds. Roll out of Hospital at home to prevent admission and support earlier discharge.	Level 1: reassurance	1) Newly commissioned opened PICU not working to capacity due to lack of staff. 2) Staffing level challenge, delays in accessing.	1). Monitoring by the collaborative, and the directorate to develop directorate action plan to ensure adequacy of staffing includes working with the Retention and Recruitment workstreams and the Improving Quality Reducing Agency programme (monitored through the People, Leadership & Culture Committee). Ongoing Development of hospital at home CAMHS. 2) Adult Eating Disorder (ED) service to extend and
	- Staffing reports performance reports via oversight with collaborative IPR as well Clinical oversight via Directorate monthly Senior Management Team (SMT) meetings and Exec, daily monitoring SITREP reviews.		
	Level 2: internal		

2) Adult eating disorder collaborative. 3 Timely access to beds for patients with Learning Disabilities - Proactive management of flow and OAPs; Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors; - Care Planning;	- Monthly Integrated Performance reports. - Review of incidents, restraints, seclusions and inappropriate use of s.136 by Heads of Nursing and through Weekly Review Meeting; - OAPs trajectory monitoring internally through Directorate OMT and Executive; Level 3: independent NHSE reporting and monitoring of progress against OAPs trajectories. Regional monitoring of CAMHs acute pathway metrics	3) Intensive support team in community has a finite capacity, combined with a lack of, local beds that LD team can utilise. Shortage of substantive nursing, medical and therapy staff across the Trust National reduction in Assessment & Treatment Unit (ATU) beds and estate hinders support for individuals with LD or autism that require reasonable adjustments or a single person placement.	develop Day Hospital and Hospital at Home offerings; with aim to reduce need for T4 admission for ED treatment. 3) Vacancies details will continue to be reported in the Quality and Safety Dashboard provided to the Quality Committee (and to the Board), as well as in highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate SMT. Operational risks also monitored through the Trust Risk Register at 1068 (mental health waiting times) Directorate Harm Minimisation Groups well established and will report findings to Directorate SMTs to inform Transformation Programme Demand and Capacity projects, 1024 (reporting on waits) Work with operational services has been undertaken to identify and document clinical waiting time standards re emergency, urgent and routine referrals to develop waits reporting to 'red flag' patients waiting longer than agreed standard as captured in TRR 1001 (OAPs). Directorates will continue to focus on reducing use

4) Adults and older Adults: Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors; - Proactive management of flow and OAPs; - Care Planning; - System partner calls to improve discharge; - Roll out of Crisis Resolution, Home Treatment, Early Intervention, Intensive Support and Hospital at Home teams to prevent admission and support earlier discharge;		4) Shortage of substantive nursing and therapy staff across the Trust (and in some team's difficulties in recruiting medics e.g. CAMHS community, adult acute mental health and Adult Eating Disorder services) i.e. vacancies continue to result in capacity pressures and increased reliance on agency staffing at a time when demand is increasing. Ultimately can reduce capacity to see patients and families. Waiting lists and access to some services are rising as a result of increased demand, pressures in the wider system i.e., housing, shortage of staff and the aftermath of COVID-19. Some mental health community teams are also managing high numbers of patients unallocated to a care coordinator due to demand being higher than capacity. This impacts inpatient areas and creates the need to use Out of Area Placements (OAPs).	of OAPs to improve the quality of patient care and improve cost control. LD services to continue to provide specialist LD support to mainstream MH health wards to facilitate reasonable adjustments. OWNER: Executive MD for Mental Health & Learning Disabilities 4) Vacancies continue to be high. Details reported in the Quality and Safety Dashboard provided to the Quality Committee (and to the Board), as well as in highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. Mitigations via Retention and Recruitment workstreams and the Improving Quality Reducing Agency programme (monitored through the People, Leadership & Culture Committee). Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate Senior Management Team. Operational risks also monitored through the Trust Risk Register at 1068 (mental health waiting times) Directorate Harm Minimisation Groups well established and will report findings to Directorate SMTs to inform Transformation Programme Demand and

			Capacity projects, 1024 (reporting on waits) work with operational services has been undertaken to identify and document clinical waiting time standards re emergency, urgent and routine referrals to develop waits reporting to 'red flag' patients waiting longer than agreed standard. 1001 (OAPs). Monitoring also through highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control.

Strategic Objective 1: Deliver the best possible care outcomes

1.6: Sustainability of the Trust's primary, community & dental care services

Date added to BAF	Pre-Jan 2021			
Monitoring Committee	Quality Committee		Impact	Likelihood
Executive Lead	Executive MD for Primary Care and Community	Gross (Inherent) risk rating	4	5
Date of last review	09/07/24	Current risk rating	4	3
Risk movement	↔	Target risk rating	3	3
Date of next review	September 2024	Target to be achieved by		

Risk Description:

There is a risk that the inability to progress, with key partners, the re-design and re-commissioning of primary, community and dental care services across Oxfordshire threatens the medium- and long-term sustainability of these services.

In this scenario, waiting lists/delays will continue to grow, quality and safety of care will be increasingly compromised, the financial position will deteriorate, the needs of the service users will be insufficiently met and there will be poorer health outcomes and experiences.

The successful mitigation of this risk requires the Trust to work effectively with a wide range of ICB partners and stakeholders to deliver a number of priority strategic actions and enablers (set out below), which in turn will enable the successful transformation of key primary and community care pathways.

Key Controls	Assurance	Gaps	Actions
Delivery of the Oxfordshire community services transformation programme, incorporating these steps across adult and children's services: 1. Pathway review and re-design 2. Re-commissioning and re-contracting 3. Implementation of changes Daily system working and collaboration processes amongst providers embedded, with step-ups during periods of peak pressure, such as OPEL 4 status, Demand and Capacity App and other data analysis and reporting to visualise patient demand based on previous activity. Deployment of system for the management and rostering of staff. This enables operational managers to plan shift patterns and to identify	Level 1: reassurance	• Limited capability and capacity in Community Services for innovation and quality improvement. • Senior Clinical Leadership gaps in some services. • Quality and Risk issues in some services linked to insufficient capacity to maintain urgent care and non-urgent planned care (e.g., pressure-related harms, podiatry, CTS/district nursing). • Limited workforce planning and high staff vacancy rates in specific services linked to local or national workforce shortages (e.g., podiatrists, dieticians). • Fragmentation of care pathways across siloed service management and support structures	<i>Short-term:</i> Daily system calls are held 7-days-a-week on how to balance the risks across different provider organisations, including ambulance and acute services, and how to free up space to provide for patient discharge or flow through the system. The challenge of balancing demands on staff, finances, and achievement of longer-term strategic goals are regularly discussed and monitored through Trust Weekly Review Meetings (safety / complaints / incidents review) • Monthly Directorate Quality SMT Board • Monthly Finance Review meetings with each Head of Service • Monthly Directorate Performance Board • Quarterly Executive Performance Review To manage unexpected surges in demand, Mutual Aid arrangements have been put in place across the BOB ICS to help manage capacity challenges. Staffing risks are being managed via a people plan (workforce & wellbeing meeting) reported to PLC. A Trust pay framework for substantive GP roles is being developed and will be discussed with LNC colleagues shortly.
	Level 2: internal		
	- Integrated Performance Report to the Board (standing item) includes reporting on performance against National Oversight Framework, delivery of strategic Objective Key Results and Directorate highlights and escalations		
	At Trust level, the community services transformation programme will report into the Trust Strategy Delivery Group. At Directorate Level, it will be coordinated by and report into a Directorate Transformation Board.		
	Level 3: independent		
	At Place level, the work will report into the Oxfordshire Integrated Leadership Board (OILB). ICB-level		

and resolve gaps in staffing. Reporting on activity and waiting times (with revised metrics agreed with services) Monitoring of key mitigating actions through Directorate and Trust reporting processes (including monitoring of relevant Directorate Plan objectives) Delivery and monitoring of Frontline Digitisation Plan	governance is still being finalised but will likely include a Place Partnership Board constituted of the Trust CEOs and GP leadership representatives. Some components of the change programme report into ICB or regional/national governance structures (e.g., NHSEI virtual ward and urgent community response programmes).	(e.g., H@H, OOH services, IT systems). •Change management capability gaps – limited mid-tier experience in change management and QI. •Substantial need for re-design of costed service models and consequent contract and finance re-negotiation – many service contracts contain irrelevant KPIs, commissioning gaps or duplications, and some have seen no income uplift for over 10 years, despite significant expansions in provision due to legislative and population changes. Other core services, such as the Urgent Community Response, have continued to operate as extended national pilots since the pandemic, without a secured service contract, which limits long-term planning. • Lack of suitable premises to collocate the staff and deliver sustainable service models.	A Transfer of Care hub operates daily to deliver the nationally recommended Discharge-to-Assess process, jointly with Adult Social Care (Oxfordshire County Council) and Oxford University Hospitals NHS FT (OUH) colleagues to develop a jointly managed Transfer of Care team to facilitate more effective and timely hospital discharges and best use of community bed resources. The performance data for this Hub, and the other services in the acute admission and discharge pathway, is reviewed regularly at Oxfordshire UEC Board. A second programme of work has started. This is focusing on improving the sustainability of the UEC pathway to be delivered during 2024. There have been unexpected delays to the FY24 Estates work programme delaying on our ability to increase the capacity and sustainability of services in the UEC pathway into FY25. <i>Longer-term:</i> A community service transformation programme is underway with system partners at Oxfordshire Place to improve patient outcomes and service sustainability, supported by external programme management team. This will align closely to the Frontline Digitisation Programme which will also improve sustainability. Resources have been identified by the Trust to establish a community services transformation team to deliver this work, and support its implementation in services, led by the Transformation Director role within the Directorate Leadership. An Oxford City estates plan and business case to develop a new North

		and South city hub was approved by Trust Board in autumn 2023. A more sustainable delivery model for the Oxfordshire 0-19 healthy child services, which have been reprocured by Oxfordshire County Council, went live on the 1st April 2024, but it is too soon to report any impacts /performance data as yet. At Place level, regular meetings are held with the ICB Oxfordshire Place Director to progress work on local stakeholder engagement for transformation work (focusing on Wantage CH services initially) and at a county level with system Exec leads at the Oxfordshire Integrated Leadership Board. May 2022, the Trust and OUH signed a Memorandum of Understanding (MoU) to support closer working for Oxfordshire residents, with a focus on community urgent and planned care. This has facilitated the delivery of a joint OH-OUH Hospital at Home service, launched in winter 2023 The MoU was reviewed in December 2023 and an updated programme of work is being developed. The Trust is also leading development of the Thames Valley Dental Services provider partnership with Berkshire Healthcare and CNWL NHS Trusts to improve sustainability of these services and secure future funding. A steering board regularly meets, and a partnership agreement has been developed. Commissioners have written to the partnership expressing their intention to extend the contract until 2026.

Strategic Objective 2: Be a great place to work

2.3: Succession planning, organisational development and leadership development

Date added to BAF	Pre-Jan 2021			
Monitoring Committee	People Leadership and Culture Committee		Impact	Likelihood
Executive Lead	Chief People Officer	Gross (Inherent) risk rating	4	4
Date of last review	04/07/24	Current risk rating	3	4
Risk movement	↔	Target risk rating	2	2
Date of next review	September 2024	Target to be achieved by		
				Rating
				16
				12
				4

Risk Description:

Failure to maintain a coherent and co-ordinated structure and approach to **succession planning, organisational development and leadership development** may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change.

Key Controls	Assurance	Gaps	Actions
- Service model review and modifications of pathways across Operations (cross-reference to 1.2 and the risk against failure to deliver integrated care); -Investment in the Affina Team journey – an all-in-one assessment and development tool for team leaders - multi-disciplinary leadership trios within clinical directorates to support and develop clinical leadership; - the Organisational and Leadership Development	Level 1: reassurance	a. Staff do not have access to the correct Statutory and mandatory training due to ESR errors. b. The priority for 2024 is to ensure mandatory training figures achieved to date remain consistently strong. Aggregated compliance reporting of statutory and mandatory training mask success and risk areas.	a. The L&D team will continue to monitor the L&D system and revise the training matrices as required and work with teams and areas where compliance is particularly low. b. Training with poorest compliance to be the focus; Resus and PEACE. Review of team establishments and required delivery underway to ensure that Trust have adequate resources allocated. Delivery methods being reviewed including the removal pre-requisite e-learning. Trust to write Statutory and mandatory training policy once National alignment is
	-6 weekly Compliance reporting board within L&D monitoring all training compliance.		
	- Monthly report to Executive Leadership Team on key workforce metrics – currently focuses on Stat and Man training but opportunity to include other metrics		
	- _Education Strategy Group (ESG)		
	Level 2: internal		
	- People, Leadership & Culture Committee;		
	- Analysis and use of annual staff survey to measure progress and		

Strategy Framework (approved by the Board, October 2014) – aims to maximise effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery. - Clearly defined development pathways for all professional groups including clinical and non-clinical staff. - Delivery of a Masters’ framework offering relevant development opportunities for all staff including both registered and unregistered professionals. - Inspire Network (replaced Linking Leaders conferences) event focused on Organisational Development on 10 March 2022 and considered Staff Survey results; and - Implementation of a Trust wide approach to Leadership development under the NHS Leadership Academy ‘Our Leadership way’ framework	perception of leadership development; - Yearly staff appraisals; PDR compliance rate was 91% in yr 1 following successful implementation of PDR season. 2nd yr currently underway. - Monitoring of Clinical supervision rate. 77.39% in June compared to 74% in January 2024. - Monitoring of Mandatory training compliance Current compliance rate 87.47%. -Monitoring of Resus and PEACE training compliance at Quality and clinical governance sub-committee Level 3: independent -Internal audit completed by PWC in May 2023 identifying 5 key areas for improvement. With agreed action plan to deliver improvement. Trust have completed all actions and created internal quality assurance processes to ensure changes upheld. -National NHSE Statutory and Mandatory training alignment to the Core skills training framework underway enabling centralised oversight. -National Retention Self-assessment tool against the seven elements of the NHS people Promise.	c. The Trust have responded to the need to ensure all staff have access to a PDR by implementing a new ‘PDR Season’ delivery style. There is a need to measure its continued success as well as measure the effectiveness of the PDR process in providing staff with the appropriate development opportunities. d. Unclear response to staff development for areas of high risk in relation to staffing levels. e. Unclear progression routes for non-clinical progression pathways f. There is a need for a clear segmented retention plan created in response to People Promise self-	complete to ensure maintenance of recorded success in approach to delivery of training. c. The first PDR season had a 91% compliance rate in October 2023. Current compliance is at 61% with a month left in the 2nd PDR season. OD teams to analyse staff survey response results relating to ‘we are always learning’ elements. L&D team to analyse the uptake of CPD and developmental opportunities following PDR to measure effectiveness of appraisal process. d. Podiatry service highlighted as an area of high risk in relation to current short-term staffing levels and longer-term succession planning. L&D to explore the option to deliver Podiatry apprenticeship locally including possible accelerated routes from existing professions such as Registered Nursing Associates from Jan ’25. e. L&D to support the development of apprenticeship opportunities in Estates directorate to support staff development and succession planning. This is to include apprenticeship posts in plumbing, electrical, and carpentry. Advertising of posts to start Jan ’25. f. Trust has successfully appointed People Promise manager and complete the national retention self-

		assessment – this is now being formulated. g. There is a need for clear representation of Leadership development training for all staff including opportunities to develop skills and access Coaching and mentoring. Initial analysis of current offer identified gaps in New/Aspiring Leader programme. h. Equality and Diversity. The WRES and WDES are monitored against national benchmarks and areas variation are reviewed and action plans developed..	assessment tool which identified 'We work flexibly' as area most important to staff to focus retention plan. g. L&D Leadership team to undertake initial review of current Leadership training offer to ensure it is accessible to all staff and meets the standards outlined by the Our Leadership way framework. Team to engage with other NHS providers, NHS Elect and NHS Leadership academy about new areas of development for consideration. Team to create proposal of training offer to be presented to Execs for approval in September'24. h. . work of the Equality & Diversity Lead. NHS Workforce Race Equality Standard reporting. Focus at Board level. Ongoing work with HR to develop routine statistical analysis to identify key areas for actions and follow-up. Development of Quality Improvement Race Equality programme. The EDI team have adopted the QI approach to deliver organisational change and have 3 QI Race Equality programmes and 3 QI Disability programmes ongoing, these are evidenced based programmes based on the needs identified in the WRES and WDES. The QI programmes for Race have all delivered outcomes and considerations are now being given to what future

		i, No formal succession planning/talent process in the Trust for clinical and non-clinical staff j, Leadership	QI race programmes will look like in light of the March 2024 WDES and WRES data. OWNER: Head of OD i, Phase one of a QI project was completed in Feb 2024 and was sent back to 'Design' following review of People Steering Group The Trust is adopting the national 'Scope for Growth' model with target completion December 2024. OWNER: Head of OD Phase one of a QI project was completed in Feb 2024 and was sent back to 'Design' following review of People Steering Group j, The Trust is adopting the national 'Scope for Growth' model with target completion December 2024.

Strategic Objective 2: Be a great place to work

2.4: Developing and maintaining a culture in line with Trust values

Date added to BAF	19/01/21
Monitoring Committee	People Leadership and Culture Committee
Executive Lead:	Chief People Officer
Date of last review	04/07/24
Risk movement	↔
Date of next review	September 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	3	12
Current risk rating	3	3	9
Target risk rating	2	2	4
Target to be achieved by			

Risk Description:

A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes being compassionate and inclusive, recognition and reward, having a voice that counts, **health, safety & wellbeing of staff, working flexibly**, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture.

The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

Key Controls	Assurance	Gaps	Actions
- HR Policies & strategies, include Workplace Stress Prevention & Response, Equal Opportunities, Dignity at Work, Flexible Working, Grievance and Sickness policies; - Freedom to Speak Up Guardian; - Health & Wellbeing Strategy, groups, services and Intranet site & resources; - Employee Assistance Programme; - Occupational Health Service; - Signed Sexual Safety Charter and EIDA Charter - Equality, Diversity and Inclusion team, plans, training and groups, Staff Equality Networks; - Health & Safety Policies, and H&S Team; - Zero-Tolerance of Violence and Aggression to Staff Policy; - Training, supervision and Performance and Development Review (PDR) processes; - Communications bulletins & intranet resources and news.	Level 1: reassurance	Need to improve staff experience and respond to issues identified in the Enabler 3 Programme – Supporting our People and Teams. The broad issues identified include: - Disconnect between leadership and those on the “shop floor”. - Lack of autonomy. - Poor communication. The quarterly People Pulse consistently identifies gaps in communication as well. - Leadership / Managers not demonstrating values of ‘caring, safe and excellent’. Need to improve staff experience and respond to issues identified by both the Staff Survey and quarterly People Pulse. The Staff Survey identifies a gap in flexible working with the Trust score for this People Promise element being below the national median. The score for ‘we are safe and healthy’ is in line with the national median.	Enabler 3 Programme – Supporting our People and Teams Two reference groups have taken place. The project is in the design phase. Plan is to consult on the project design at the November 2024 reference group with view to move to delivery stage early 2025. Expected to be a 2–3-year programme of work. Flexible working The Trust is taking part in Cohort 2 of the national NHSE Retention Exemplar Programme. In addition, a dedicated People Promise Manager has been appointed for 12 months from June 2024 to review and develop a project to support flexible working (and remove the barriers to it) across the Trust. Health & Wellbeing Ongoing promotion of a Wellness culture taking a proactive and preventative
	– Learning Advisory Group (LAG) Group (now called Education Strategy Group (ESG)); - Equality & Diversity Steering Group; (all reporting to People Steering Group – which has oversight from the People Leadership and Culture Committee); - H&S group SEQOSH accredited - Analysis of completed H&W Framework. - Completed analysis of Sexual Safety 10 principles.		
	Level 2: internal		
	- People, Leadership & Culture Committee (quarterly); - Quarterly People Pulse checks (measures of staff engagement)		
	Level 3: external		
	- National Staff Survey results; - External endorsement of the Trust's wellbeing work via take-up of Trust's model through BOB ICS.		

		approach. Five working groups are in place to embed Civility & Respect, including Restorative Just & learning Culture as part of cultural change. Kindness into action modules have been purchased – these will enable the Trust to develop “The OHFT Way” through training. Commenced process to make Kindness into Action Essential training with the aim to have it in place in September 2024. Policy work will include implementation of a new Respect, Civility & Resolution Policy (Disciplinary Process). Publication in July 2024. Collaborative working with EDI QI project 2 is exploring this Policy through a race lens. Annual Stress Survey took place in May 2024. Analysis of results will take place in July 2024. REACT training is promoted to support uptake of wellbeing conversations. Violence & Aggression Working Group includes Sexual Safety/Domestic Abuse and Sexual Violence as a specific pathway. Mental Health First Aid training for managers; Enabling safe spaces and confidential support to all staff. EDI
		Sexual Safety Charter 10 principles analysed, and gaps identified. EDI

		Recurring work to embed EDI following the Quality Improvement 'Plan Do Study Act' Cycle – priorities for the Race Disability and Gender to be identified through analysis of WRES and WDES and pay gap data.	The Race Equality Work Programme's three Quality Improvement (QI) Projects concluded their first PDSA cycle in April 2024. Following the submission of the Workforce Race Equality Standard (WRES) 2024 in May 2024, engagement and consultation is underway with relevant stakeholders, such as the Race Equality Staff Network to co-produce and develop the Race Equality Action plan for 2024/25 which will reflect the Trust WRES priorities and align with the BOB ICB Equality Objectives and the 6 High Impact Actions. The draft Race Equality Action Plan is to be presented for approval to the EDI Steering Group on 2nd July 2024. Considerations and thinking are also being given to how we could potentially learn from other Trusts such as Berkshire who have committed to being "anti-racist" organisations.

Strategic Objective 2: Be a great place to work

2.5: Retention of staff

Date added to BAF	May 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer
Date of last review	04/07/24
Risk movement	↔

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	4	3	12
Target risk rating	3	3	9

Date of next review	September 2024	Target to be achieved by	

Risk Description:

A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.

Controls	Assurance	Gaps	Actions
- Director of Clinical Workforce Transformation to lead quality improvement, to review in reducing. - delivering career development pathway for HCAs; - Learning from Exit Questionnaires / Interviews; - Health & Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives; - Freedom to Speak Up Guardians to support identifying factors driving staff leaving and sharing these with Executives and Board - Training, supervision and Performance and Development Review (PDR) processes to provide a process for line manager and staff interaction on career aspirations; - Monthly multi-disciplinary meeting; review community and mental health hotspots	Level 1: reassurance	Not currently reporting on areas flagging as hotspot areas to senior management or Exec. Work now planned to take a more segmented view in relation to retention. Not currently offering any career conversations via L&D which could impact on staff leaving due to promotion. No specific work focusing on BAME early turnover/turnover.	– The early turnover rate remains just over the 14% target. We will continue to monitor and highlight hot spot areas within reports to senior management and Executive teams. Analysis of leavers' data has highlighted some pressure points that we will look to address. The Retention team is focusing activity in hot spot areas; community nursing, clerical workers and health care support workers as well as early turnover of BAME staff particularly in admin and clerical roles. In future, hotspot areas brought to the MDT meeting will be reported on and shared with Senior management or the Executive team to highlight areas of high turnover. Onboarding QI project identified issues with Managers signing off training completed externally, Induction booking confirmations not being received by new starters, and no telephone line for recruitment. These are just some of the issues that have been
	- Quarterly review of leavers exit interview data by HR SMT.		
	Level 2: internal		
	- Reports to Executive Management Team (monthly); - Reports to People Leadership and Culture Committee (quarterly); - Performance data reports to Board: - Turnover March 2024 12.89% and April 2024 12.82% (target <14%); - Vacancies March 2024 11.8% and April 2024 12.3% (target <9%); - Quarterly People Pulse checks (measures of staff engagement)		
	Level 3: independent		
	- National Staff Survey results (annual process) - National – BOB ICS recognition for R&R with Enhanced Occupational Health & Wellbeing Pilot - Regionally - H&W key group member of R&R planning and new national resource.		

		identified and resolved as part of this project. There are a number of other improvements that are being worked on. There has been some development on the Career Conversations QI project, 1:1 coaching has been dropped in favour of L&D sessions. These have been poorly attended so a decision was made not to run them anymore. L&D is working on a Comms strategy to make information about learning opportunities more accessible. A review of the staff survey around the quality of PDRs will take place to see if this is still an issue. The Retention team have initiated the discovery phase of a QI talent management project, with a view to introducing a talent management framework to aid retention and assist with career development and personal development. We are now in the middle of the PDR season and as of June 2024 the PDR compliance is 48%. The annual comparative is ahead of last year's position. New Starter Experience QI group. is now meeting on a quarterly basis to share and review feedback and identify areas of improvement. This has been successful and new

		starter feedback has improved. Staff Survey 2024 32 site visits were undertaken. Teams were prioritised due to low response rates in the 2022 Staff Survey and a further 2 teams where a visit was linked to their 'one action'. In addition to the site visits, colleagues from EDI, Wellbeing, Retention and Core OD Team organised and held 4 Roadshows with one of the objectives to promote the staff survey engagement-

Strategic Objective 2: Be a great place to work

2.6: Adequacy of Staffing

Date added to BAF	17/01/24
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer (& potentially Chief Nurse)
Date of last review	01/07/2024
Risk movement	↔
Date of next review	September 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
Current risk rating	4	4	16
Target risk rating	3	3	9
Target to be achieved by			

Risk Description:

Inability to plan for, attract and secure sufficient numbers of appropriately trained staff may lead to inadequate levels of staffing to provide:

- ii. safe and/or quality patient care; or
- iii. the range of services which the Trust aspires to.

If the Trust cannot secure adequate levels of permanent staffing, then it may turn to planned bank staff or temporary agency staffing which may be unsustainable in the medium to long term and could, without adequate controls, have financial and quality of care implications.

This is a current, live risk and the scale of the challenge could increase in the future, further to national challenges outside of the Trust's immediate control around cost of living, national pay scales, industrial action, education and training, and nationally available supply of key professions. We accept, and plan for a tolerance of temporary staffing usage to enable flexibility in our workforce to respond to ebbs and flows in demand, but the current levels of temporary staffing usage places the Trust under increased financial pressure and additionally potentially impacts upon the quality of care to patients. Our strategic plan for the medium and longer term incorporates measures to reduce temporary staffing usage, such as development of more sustainable workforce models, working with universities on clinical training, better demand and capacity modelling, career, and organisational development interventions to link to retention and linking with national and regional teams to maximise learning from other Trusts and national exemplars. We are also aligning more closely, through the Annual Planning process for 24/25, the OHFT People Plan with the NHS Long Term Plan.

Even if the Trust succeeds in Recruitment, if it fails at Retention then it jeopardises those gains. Recruitment and Retention in proportion will be key to mitigating the risk, with a focus upon:

- Recruitment: Trust to be seen as employer of choice, marketing, induction, rewards and benefits; and
- Retention: organisation culture, personal and leadership development, training, appraisals, staff support and wellbeing, and rewards and benefits.

Controls	Assurance	Gaps	Actions

The priorities and actions set out within our updated OHFT People Plan are the key controls to mitigate the impact of this risk. Our People Plan links to the NHS wide Workforce plan with 3 themes of a. TRAIN; b. RETAIN; c. REFORM. A summary of the themed key actions (train, retain, and reform) are set out below. The assurance routes are broadly consistent across each element, and so are consolidated. Train theme: This relates to how we grow the workforce in the Trust and strengthen our pipelines for the professions where we are carrying the highest vacancies. There is a focus in the NHS Workforce Plan on increasing the supply of domestic education and training and therefore reducing our reliance on internationally educated staff.	Level 1: reassurance consistent and regular updates to staff via whole staff communication, support to managers to deliver key messages, and easily accessible intranet resources. Level 2: internal – 6 monthly updates on Trust People plan Progress to PLC and its sub committees, including Learning Advisory Group, EDI Steering Group, HR Policy Group etc. – Targeted quarterly updates on specific topics (e.g. retention, recruitment, people policies) to People Steering Group (PSG) and Extended Leadership Team (ELT) – specific updates to full Board on people related issues as and when they arise (e.g. FTSU arrangements). Regular updates on key measures are included within the Integrated Performance Report Level 3: independent -provision of information to external sources (e.g. CQC, Ofsted, external auditors) as required for external assurance and validation and outcomes from Internal audits	Elements of the OHFT People plan will remain challenging to deliver. Examples of where this is the case are set out in the subsequent sections. Not enough capacity to deliver as many places as could be utilised by OHFT Staff (both in internally provided programmes, and for places within programmes provided by external providers) Vacancies make it very difficult for clinical teams to release staff to undertake education programmes. However, inability to enable this release in the short term exacerbates the issue in the medium and longer term. Lack of sufficient centrally understood data on learning needs (training needs analyses) and aspirations for career development.	Development of non-clinical career pathways Establishment of other clinical apprenticeship offers including pathways in dental, pharmacy and social work. Complete Training Needs Analysis based on information gathered from a variety of sources (PDRs, individual feedback, discussions with leaders and managers) Hold Workshops for Managers and Staff to promote L&D opportunities prior to PDR season. Refreshed Study Leave Policy (particularly to make expectation of release clear) Educational experience programme to review effectiveness and impact. Improved engagement with school/colleges - development of Trust work experience policy. With a continued focus on our development offer to staff who wish to join the Trust which can be highlighted at recruitment fairs. Development of Education career pathway for all staff including L3 – L7 qualification offer in response to the newly published Educator workforce strategy.

Enhanced Education and Training initiatives, including Apprenticeship programmes, and career development pathways from HCA to Advanced Practice.		Lack of assurance that all OHFT leavers in critical roles felt adequately supported during their employment, and therefore that leavers could be avoidable. Dedicated support for those in the first 6-12 months of employment leading to early turnover.	Development of IT Functional skills offer. Launch of Podiatry assistant apprenticeship addressing vacancy gaps in Podiatry service. NHSE incentive payment support also allows for 12month fixed term AHP apprenticeship support post. Review of other pathways for professionals which are hard to recruit to. Establishment of Peer support worker apprenticeship offer including gaining agreement for PSW role to be included in team establishments and budgets in line with expansion of role in NHS workforce plan. Increase uptake of Nursing Associate apprenticeship programme to ensure consistent pipeline to Nurse degree as well respond to NHSE workforce plan to increase overall numbers in NHS workforce. Launch of 'Braver than before' Leadership programme Launch of 'Our Leadership way' Leadership behavioural framework and development of Leadership training offer.

Retain Theme This relates to embedding the right culture and improving retention and in particular reducing the leaver rate which is the numbers of staff who leave the NHS (as opposed to moving internally within the NHS sector). With a continued focus on making the NHS People Promise a reality for staff utilising tools such as the NHS EDI Improvement Plan and High Impact Actions; publicising pension reform changes and continuing investment in wellbeing. Ongoing and consistent work to ensure that our people recognise OHFT as a good place to work and choose to stay working with us.		Lack of assurance that all possible efforts were being made to ensure that OHFT is the employer of choice in our field for critical roles.	Development of a just and restorative culture through which people feel supported and enabled to do their best work. Use of the externally funded NHS People Promise exemplar programme cohort 2 support to better embed the People Promise across the Trust, utilising the best practice support and examples. Created a segmented Retention plan for 24/25 and beyond that focus on particular areas through the lens of profession; location; protected characteristics. Further expansion of Psychological professionals including EMHPs who will be working in Mental health support teams in schools. Enhanced health and wellbeing offer including the promotion of the new resource that in Occupational health to support psychological wellbeing for staff. Targeted support to deliver actions relating to outcomes from the annual staff survey (and ongoing regular pulse surveys) with a focus on year-on-year improvement. Refreshed annual awards approach from 23/24 which will be continued for 24/25 to recognise exceptional individual and team

		Gaps current relate to resource to undertake Trust wide Workforce Planning - work has been done on a medium-term workforce plan for inpatient nursing but a wider view is required to understand our workforce needs.	achievements and contributions. Better local induction and candidate and new starter experience to ensure our people have the best start. Embedding Flex working into 'Delivering the People Promise' Training for managers. TRiM business case being reviewed pending Trust wide roll out. Investment in marketing and branding to position the Trust and its offer (including the broad and extensive L&D opportunities which are a USP) as an employer of choice. Refreshed approach to design of job descriptions to reduce duplication and any delays in the transactional approach to recruitment. Work with clinical leaders to identify, understand, and define opportunities to introduce different workforce models (e.g., ACPs, PAs etc). Reduce time to hire by simplifying and modernising the offer and contract process. Unblock the application and selection process, making it simpler, faster, more reliable, inclusive and seamless.

Reform Theme - working and training differently. New approach to recruitment and onboarding to better attract and secure talent to the Trust. Together with planning for future technologies and a focus on data quality and systems that enable and empower staff to make better decisions. Continued focus on embedding a culture reflects a restorative, just and learning culture.			Talent Attraction and Hiring - Create a proactive, Talent Acquisition and Compliance team by redesigning resourcing. Managed Service Providers – Continue to work closely with our MSP. NHSP Improvement plan now in place and requirement to deliver actions as set out in the Internal Audit of NHSP bookings processes. SE temporary staffing programme have been commissioned to undertake a review of OHFT Temp Staffing arrangements with a view to making recommendations to the CNO and CPO. This will focus on how we build on the progress already made in relation to agency savings. L&D now reviewing our approach to the pastoral care and support given to all international new joiners and will make recommendations in Q3. Deliver the 6 High Impact Actions as set out in the NHSE EDI Improvement Plan as part of a wider programme of EDI work. Invest and grow staff membership of equality networks so that we support employee voice. Maximise the impact of Executive Director sponsorship and identify training offer for Execs in

Temporary Staffing Temporary Staffing central team will lead on corporate and contract management of Managed Service Providers and will			relation to the Sponsorship role. Continue to invest in Employee Assistance Programmes. One of our 4 Enabling Workstreams will focus on the “Supporting Our People and Teams” and will aim to put in place interventions that shape our culture based on positive behaviours that are drawn from the overarching concepts of civility, respect and fairness. Improved access to HR through: • Implementation of HR Service Desk for all HR queries • Rebuild of HR and L&D Intranet • Implementation of new Document Management system and transfer of data Increased workforce efficiency through: • Continued Implementation of E-Rostering system • Inpatient E-Rostering Improvement work • Implementation of medics E-Rostering Continued system optimisation and efficiency through:

collaborate with SE Temp Staffing Collaborative.			• Expenses system review • Implementation of new Occupational Health system • Transition of absence management from Goodshape to E-Rostering system • Continued advancement of Learning & Development system Continue the work on reforming our HR policies and guidance (including development of employee handbook) in line with national policy templates and frameworks, and our restorative, just and learning culture principles. Incidents and Complaints working group – focused on safety, learning & patient care. Continue to work with ICB on Scaling People Services to understand if automation and process redesign at system level can bring about efficiencies across provider boundaries. A review of our current Workforce Planning requirements has been done by the Director of S&P and Executives agreed we need a Trust wide approach to workforce planning that considers supply and demand and current workforce model. This is to be taken forward by the Chief People Officer and will

			draw from best practice models such as those published by the CIPD. It will also be one of our 4 Enabling Workstreams – whereby we will develop our approach to workforce planning with attention to effective clinical models and we will develop clinical models with attention to the available workforce. Further detail to be added once objectives for 24/25 are confirmed.

Strategic Objective 3: Make the best use of our resources and protect the environment
3.1: Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level

Date added to BAF	Pre-Jan 2021 Refocused and revised in July 2022			
Monitoring Committee	Quality Committee		Impact	Likelihood
Executive Lead	Executive Director of Strategy & Partnerships			Rating
Date of last review	02/07/24	Gross (Inherent) risk rating	5	5
Risk movement	↔	Current risk rating	4	3
Date of next review	October 2024	Target risk rating	4	2
		Target to be achieved by	Q1 2024/25	

Risk Description:

Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.

Key Controls	Assurance	Gaps	Actions
Governance and joint-decision-making: - Active participation in shaping emerging BOB and place-levels governance; - Development of Provider Collaborative arrangement in Mental Health. BOB Mental Health Partnership recognised as key governance for Mental Health in BOB ICS in the ICS Joint Forward Plan; - Joint work / operational processes with local authorities and other partners including PCNs; - Development of alliances and	Level 1: reassurance - Reporting through Directorate SLTs and BOB MH Provider Collaborative Executive Oversight Meeting Executive steering group in place for Community Dental Partnership	Performance and planning: Absence of system-wide data sets and aligned reporting. ICS and Place-level governance BOB Mental Health Partnership Governance has been reviewed and updated to reflect agreed transformation priorities this will need to be fully embedded and operationalised to enable collaborative working and joint decision making. No additional resourcing agreed at system-level to support this work.	Performance and planning: Work progressing to agree performance reporting at System, Place and Trust levels, aligned with Internal Planning process. Owner: Executive Director of Strategy and Partnerships
	Level 2: internal - Reporting through: Executive Management Committee; Strategic Delivery Group and Trust Board.		ICS and Place-level governance Working with Place-based and local partners to ensure place and system governance. Resourcing requests for BOB Mental Health Provider Collaborative sent to ICB.
	Level 3: independent - ICS-level and Place-level emerging governance for Mental Health, Learning Disability and Autism (MH, LD&A) and Community		Oxon MH LD&A place-based board is currently being reviewed alongside the Outcomes Based Contract. Strategic partnership approach for Community Services still to be developed as part of new

partnerships with other organisations, including the voluntary sector, to deliver services into the future e.g. Oxfordshire Mental Health Partnership. - Exec to Exec engagement with partner organisations. Partnership Group in place for community Dental Services including membership from BHFT, CNWL. Resourcing: - Role of Associate Director to lead work on the BOB Mental Health Provider Collaborative on behalf of the Trust has been appointed to and role commenced; - Service development lead for each Mental Health directorate now in post. Director of Transformation for Community Services leads on OHFT Community input into Oxfordshire's Improvement Programme (urgent care) and partnership working with Oxford University Hospital's Trust (OUH) joint working arrangements; - new Executive Director role of Executive Director of Strategy &	- Partnership and Alliance arrangements with other organisations, including the voluntary sector; - Provider Collaborative Governance - Oxfordshire's Place Based Partnership board (CEO attendance) - Oxfordshire's Urgent and Emergency Care (UEC) Board for the cross-system Oxfordshire Improvement Programme - Southeast Planning Group for Community Dental Services in place to oversee overall commissioning process	Lack of oversight and governance for Community services at ICS and Place-level. Unclear decision-making impeding collaborative working with partners. Learning Disability governance being developed by ICS. Investment Financial pressure on ICSs, County Councils and Social Care impacting adversely on required MH & LD investment. Arrangements outside of urgent care funding that is managed at Place level lack a clear forward planning engagement mechanism. No growth funding awarded to community services in 24/25. Approach to system working.	Community Services Transformation Programme. Collaborative arrangements for community services in Oxfordshire the most developed through urgent care pathways through the systemwide Oxfordshire Improvement Programme. Special Education Needs and Disabilities (SEND) emerging partnership working but still embryonic. Other areas of focus with the ICS to be developed including. OWNER: Executive Managing Directors, Executive Director of Strategy & Partnerships and Chief Executive Investment Continued engagement in funding dialogue with ICSs for system clinical and financial planning. For Mental Health, enable this via Provider Collaborative arrangements. Finance (OH Director of Finance) is represented at the BOB Mental Health Partnership Board. Continued development of Provider Collaborative transformation programmes with ongoing discussions with ICB regarding resourcing. CEO representation and engagement at the ICB led System Recovery Transformation Board. To raise and influence through Place Based Partnership Board OWNER: Chief Finance Officer, Executive Director of Strategy & Partnerships and Executive Managing Directors Approach to system working. Embedded resources now in place within operational

Partnerships from April 2022. - Head of Strategy in post from Oct 2023 to support coherent response and process in place national planning from ICB to Trust to Place level. - Senior Programme Manager in place to manage Thames Valley Dental Partnership		No systematic approach to support partnership working in Place.	Directorates, and role of Associate Director of Mental Health leading on the BOB Mental Health Provider Collaborative has been recruited to and commenced. Ways of working and internal governance for this work are being established. NHSE supported and funded workshops being held with VCSE partners to develop an action plan to strengthen partnership working between BOB Mental Health Provider Collaborative and VCSE sector. OWNER: Executive Managing Directors, Executive Director of Strategy & Partnerships Strategy development work ongoing and will help clarify the ambition for partnership working in the organisation. Assessment and mapping of our key Principle 'We work in partnership and are an active player in our ICS' underway for all Strategic Programmes. This will show (and give assurance on) to what extent our programmes align to this principle and what the gaps to address are. OWNER: Executive Director of Strategy & Partnership. Engagement with the BOB ICS led system review of 24/25 planning round. This will inform the 2025/26 planning being clear on the principles, processes, and ways of working the system will sign up to. OWNER: Executive Director of Strategy & Partnership & Chief Finance Officer

Strategic Objective 3: Make the best use of our resources and protect the environment

3.4: Delivery of the financial plan and maintaining financial sustainability

Date added to BAF	11/01/21			
Monitoring Committee	Finance and Investment Committee		Impact	Likelihood
Executive Lead	Chief Finance Officer	Gross (Inherent) risk rating	5	5
Date of last review	19/06/24	Current risk rating	4	4
Risk movement	↔	Target risk rating	4	3
Date of next review	September 2024	Target to be achieved by	2027	
				Rating
				25
				16
				12

Risk Description:

Failure to deliver financial plan and maintain financial sustainability over the short (1-2 years) or medium-term (3-4 years), including, but not limited to: through funding reductions, non-delivery of CIP savings; budget overspends; and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England; and insufficient cash to fund future capital programmes.

Controls	Assurance	Gaps	Actions
- Financial culture, meaning the skills and ownership, systems and incentives to manage budgets over the medium term across the Trust; - Annual Financial Plan and Budget produced, and approved by FIC and the Board; - Medium-Term Financial Plan produced annually and reviewed by FIC and the Board. - Monthly cash-flow and Balance Sheet reports; - Established Finance and Business Services teams and recently deepened Procurement team capability; - Standing Financial Instructions and Financial Policies;	Level 1: reassurance	a) Funding pressures – BOB system faces significant shortfalls and financial capability challenges and Oxfordshire community services contract is known to be under-funded. Although there appears to be commitment to the Mental Health Investment Standard, there is uncertainty on the level of new funding for mental health going forward. b) Agency spend – the Trust's workforce challenges have led to excess agency usage and spend which puts	a) Financial challenges escalated to the ICS and NHSE. Offer support to ICB financial capability building and improved cross system-working. Handed back loss-making contracts (CHC and s117). <u>FY25 plans currently remain a deficit.</u> Owner: Chief Finance Officer b) Deliver plans to reduce agency spend further in FY25.
	- Monthly finance review meetings within Finance team and with directorates; - Monthly analysis of forecast, run rates, risks and opportunities; - Reconciliations of ledger accounts; - Monthly Capital Programme Sub-Committee review.		
	Level 2: internal		
	- Monthly Exec scrutiny of overall financial position with Quarterly Deep Dives; - Quarterly Exec scrutiny as part of Service Directorate performance reviews.		

- regular reporting on Financial position and impact of wider financial system risks to FIC and Board; - temporary-staffing programme; - active management of Capital Programme.	- Finance and Investment Committee (every 2 months); - Monthly Finance reporting to the Board to provide assurance on progress and recovery actions. -Monthly Directorate agency review panels	pressure on ability to remain within budget. Workforce planning is not universally well-supported across the Trust. c) Cost Improvement Plans process does not yet capture all efficiencies or look ahead to future years. More use of costing data, benchmarking and challenge of underlying cost base is required. Better linkage of costs to activity, and in due course to outcomes, is needed as is improved analysis of gross over and underspends and intentionality of resource allocation decisions.	Improve workforce planning capability. Owner: Chief People Officer c) Use Community Transformation programme, Mental Health Improvement programme and the Corporate Services and Central Teams enabler work to determine medium-term CIP programmes informed by regularly reported costing analysis. Embed and develop CIP reporting process begun in FY24. Better link workforce, activity and resources in Annual Plan FY26 and factor in time for early analysis of resource analysis. Assess value for money implications of outcome measures as they become available. Owner: Chief Finance Officer
	Level 3: independent		
	- Internal Audit reviews including annual review of financial controls; - External Audit review of financial statements; - Monthly reporting to, and monitoring by, NHSE and the Integrated Care Board (ICB).		

Strategic Objective 3: Make the best use of our resources and protect the environment

3.6: Governance and decision-making arrangements

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Audit Committee
Executive Lead	Director of Corporate Affairs & Co Sec
Date of last review	19/03/2024
Risk movement	↓

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	4	2	8
Target risk rating	2	2	4

Date of next review	June 2024	Target to be achieved by	

Risk Description:

Failure to maintain and/or adhere to **effective governance and decision making arrangements**, and/or **insufficient understanding of the complexities of a decision** may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.

Controls	Assurance	Gaps	Actions
In accordance with the NHS Code of Governance, the delivery of good governance is controlled through an effective Board of directors, with an appropriate balance of skills and experience to enable them to discharge their respective duties and responsibilities effectively. The purpose of the organisation and the vision set by the Board are the starting point for the system of governance which is set out in the Integrated Governance Framework (IGF). 2024 'spring clean' of IGF and reframing so as to simplify description of the governance architecture and include clarity of accountabilities (individuals and committees). Systematic approach to strategic planning, risk management and performance management – enhanced through Enabler 1 – visualising the organisational structure,	Level 1: reassurance	GAP (Controls): Not resolving longer term issues around operational performance management or taking a longer view of achievement of Strategy (rather than fire-fighting issues). Potential gap in governance structure and not yet being plugged by improved Integrated Performance Reporting to the Board since 2021/22 – discussion can still focus on way the data is presented rather than what it says in terms of issues or sub-optimal performance. Lack of Board discussion on long-term operational impact upon services of performance issues or risks may lead to lack of decision around whether or how to continue to run certain services. Risks could cycle and stall on risk registers. Gap remains relevant in February 2024 until IPR developments complete and strategy and risk better integrated.	Risk rating increased to 12 in November 2021, pending assurance that capital project (PICU) gaps resolved. Finance & Investment Committee (FIC), Audit Committee and Board) during 2022 received assurance that programme and project governance strengthened Major Projects is now a separate risk included on the BAF at 3.14 to monitor major projects e. g. Warneford redevelopment (see 3.14 for more detail). PICU learning presented to Audit Committee and embedded in project oversight process. Action closed. Consequently, overall risk Likelihood is agreed to be reduced back to 2 from 3. However, risk rating to remain under review if clinical outage gap not closed by the next review date. ACTION: review after April IMG meeting and return rating to 12 if not resolved and our ability to govern performance confidently not restored.
	The Nominations, Remuneration and Terms of Service Committee (NEDs) and Nominations and Remuneration Committee (Governors) review the composition, balance, skills and experience annually as per minutes of meetings and Board refresh. Jan 2024 reshuffle of Committee Chairs / members to protect independence of judgement. Board self-assesses (and CoG) against various statements and declarations with evidence of compliance to include – AGS, Corporate Governance Statement (2022). Annual Report declarations, Code of Governance comply or explain, EPRR statement and various Annual Reports – H&S, Infection Control, Safeguarding, Quality Accounts, Modern Slavery Statement etc		
	Level 2: internal		

governance and assurance framework and performance management framework – collectively, the ‘Operating Framework’. Board and Executive Team Development programme to ensure balanced and collaborative relationship and to question status quo. Honest self-reflection through such as ‘True for Us’ curiosity and Well Led Framework self-assessments. Policy and Procedure frameworks to include: - Trust Constitution and Standing Orders for the Board and Council (CORP01) (next review due 2025); - Standing Financial Instructions and Scheme of Delegation. (next reviews due Sept 2024) - Integrated Governance Framework (IGF); reviewed as above; - Engagement Policy (significant transactions); - Procurement Policy (CORP04) and Procurement Procedure Manual; Investment Policy (CORP10), Treasury Management Policy (CORP09) review dates monitored through policy oversight process; - Annual Planning process linked to strategic delivery;	- Annual Governance Statement reviewed by Audit Committee and Auditors annually, next review due Apr-Jun 2024; - Strategic Objectives approved by Board, with progress against objectives reported to Board Committees and Board; - Quality Committee, Finance & Investment Committee, People, Leadership & Culture Committee and Audit Committee at every meeting review management of significant risks and key governance issues; - Escalation reports from the Sub Committees to Board Committees and on to Board (3 As reports); - Annual Report and reports for Council of Governors to demonstrate engagement with Governors and FT members. Level 3: independent - Internal Audit review of governance arrangements; Internal Audit reviews have included reviews of Quality Strategy & Governance, Clinical Audit, Electronic Health Record Programme Governance, the Research Governance Framework, Information Governance, the Board	The gap has been exacerbated by the clinical outage from which the Trust has not yet fully recovered - report due to April IMG meeting. Until recovered there is an ongoing reliance on manual interventions to collect full suite of data which compromises timely data collections for national reporting and local intelligence	Enabler 1 – Operating Framework – simplifying description of governance architecture – Governance Framework to be approved by Board, and description of organisational structure. OWNERS: Director of Corporate Affairs & Co Sec (Governance Framework) Director of Strategy and Partnerships (Delivery/Op F TARGET: first phase March 24 Governance Framework Executive Director of Strategy & Partnerships in post from April 2022 and has refocused BAF risk 3.7 on ineffective business planning arrangements which may lead to the Trust failing to achieve its strategic ambition etc. Next Annual Plan 24/5 due to Mar CoG and BoD - Bringing together draft Directorate service priorities and financial position. Once finalised by the end of March 2024, the Annual Plan will provide a single view of the Trust’s key priorities for 2023/24 to inform internal decision-making and better influence the healthcare systems in which the Trust operates. The finalisation of the strategic planning work with the Board will drive reviews of the BAF and the IPR including the focus of the Board on variance/exception. Feb 2024 Audit Committee – supported following finalisation of annual plan a review as to whether the Trust’s business cycle appropriately aligned with

- Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts / hospitality); - Processes for capturing meeting minutes to log: consideration of discordant views, discussion of risks, and decisions; - Risk Management Strategy/Policy; - Board Assurance Framework; - Trust Risk Register and local risk registers at directorate and departmental levels; - Business continuity planning processes and emergency preparedness; - Council of Governors (COG), COG Working Groups and development sessions and involvement in Trust forward plans and CoG agendas. - Speak up systems embedded – whistleblowing policy, F2SUG, Wellbeing Guardian (NED), PALS & Complaints and policies, compliments, surveys, IWGC, governors. SID role attached to NED lead role for Whistleblowing processes. F2SU Guardians in place and report frequently to Board on trends/themes	Assurance Framework, Risk and Quality Governance and the Feb 2024 Counter Fraud review of conflicts of interest – minor improvements; - Annual External Audit (including review of risk management /governance) informing the Head of Internal Audit Opinion; - Well Led inspection (CQC) March 2018/19; and - Positive Well Led review focused on Quality Governance, conducted by the Good Governance Institute (reported in December 2022, presented to the Board in December 2022-January 2023) (semi ‘independent’) – Reports from F2SU Guardians directly to the Board of Directors to include Annual Report	GAP (Controls): Risk Appetite Statement agreed by Board to support sound decision making and avoid inopportune risk taking or overly cautious approaches stifling growth/development. GAP (Controls): COG working groups paused for COVID-19 pandemic. Gap closed. GAP (Controls): Effectiveness of processes in identifying if systems have failed an individual thereby being compelled to use F2SU Guardian or whistleblowing routes – impedes opportunities to improve management /leadership systems.	and attuned to the system (e.g. winter pressures, system strategy/planning etc) OWNERS: Director of Corporate Affairs & Co Sec, and Executive Director of Strategy & Partnerships. TARGET DATE: April 24; BAF review against agreed strategic plan Feb 2024 Risk Appetite considered with Board and Audit Committee (last in March 21). Latest version shared with ExELT Feb 2024 and Feb 2024 Board workshop. OWNER: Director of Corporate Affairs & Co Sec/Board of Directors TARGET DATE: approval to Board in Q1/Q2 FY25. COG working groups reinstated and now reestablished. <i>Gap & Action Closed</i>. Invitations to observe Board Committees will continue with ongoing potential to make old subgroup structures redundant. Effectiveness of Speaking up arrangements to be ‘tested’ with Board to include how well the Board ‘listens up’ Discussed at Board workshop on 28 February 2024.

Strategic Objective 3: Make the best use of our resources and protect the environment

3.7: Ineffective business planning arrangements

Date added to BAF	Risk description revised July and September 2022				
Monitoring Committee	Finance and Investment Committee		Impact	Likelihood	Rating
Executive Lead	Executive Director of Strategy & Partnerships	Gross (Inherent) risk rating	4	4	16
Date of last review	24/04/24	Current risk rating	4	3	12
Risk movement	↔	Target risk rating	3	2	6
Date of next review	July 2024	Target to be achieved by	2024		

Risk Description:

Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.

Potential enablers in order to mitigate the risk:

- develop a strategic plan and an integrated business plan for the organisation;
- realign performance management metrics to these plans; and
- monitor and align the delivery of strategic programmes across the Trust.

Controls	Assurance	Gaps	Actions
- Strategic Framework including 5-Year Strategy 2021-26 and Digital Health and Care Strategy 2021-26; First iteration of Strategy Delivery Plan being finalised for use by Trust Leadership Team to guide delivery of current strategy and as basis for engagement process with staff, patients, carers and partners to develop next Trust's strategy. Strategy team fully resourced as of April 2024 and is implementing and embedding the strategic delivery approach for the Trust. Annual Planning process (jointly led by Finance and	Level 1: reassurance	Service Change and Delivery (SCAD) Team disestablished (Oct 2023) following consultation process and resources now embedded in directorates. Data outage means that planning work for 2024/25 will not include robust and systematic trajectory-setting process for all directorates and that objectives will not be as SMART as required. Although process to make plan more quantitative will start as part of 2024/25 planning process, it will require further trajectory and metrics development	Following disestablishment of SCAD team, develop new reduced central approach for Change and Programme Management oversight and implement. OWNER: Exec Director of Strategy & Partnerships and relevant Executive Leads for each delivery area. Change Management Group established to develop a central model to change identification and management. Project and Programme best practice frameworks reviewed for Trust wide approach.
	1 year cycle of strategy development completed with Trust Board resulting in first iteration of Strategy Delivery Plan now finalised. Corporate Strategy Governance is being set up to oversee the progress of the Strategy Delivery Plan.		
	Level 2: internal Integrated Performance Report to the Board in public currently being revised with focus on delivery against the strategic objectives via the strategic dashboard and performance against key performance measures.		

Strategy and involving: Performance & Intelligence, HR, Capital, and Business Services team) is near competition. Final draft of the 24/25 Annual Plan to be submitted to the Trust Board in May 24 for sign off.	Integrated Annual Planning Process co-lead by Finance and Strategy and reporting to Executive Management Committee Bi –annual reporting to the Board to provide oversight of Trust Annual Plan. Board strategy workshop scheduled for November 24 to develop strategic planning.	work as part of 2025/26 planning process. ICS Planning process not fully established, also limiting ability to progress this work in the Trust. Workforce Planning function and leadership is a gap. Need to clarify performance processes, resources, and leadership. Trust could benefit from medium term (3 year) plan to tie together finance and service improvement/sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an implementation for the Trust strategy.	Develop Annual Plan for 2024/25, iterate process for 25/26 aiming to embed trajectory setting and more quantitative approach. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. Limited quantitative measures included within the 24/25 Annual Plan. Continue to iterate process for 25/26 aiming to embed trajectory setting and more quantitative approach. Track delivery of 2023/24 Annual Plan and report to the Board, aim to iterate this reporting process so it becomes more quantitative in 2024/25 and 2025/26. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. Board updated on the progress of the 23/24 Annual Plan (Nov 23 and March 24). Support development of ICS Planning process (link with BAF risk 3.1). OWNER: Exec Director of Strategy & Partnerships. Collaborative process in place for National planning 24/25 (Mental Health activity). Collation and alignment of priorities, MH trajectories and support to systems
	Level 3: independent		

		goals through from MH place-based board to ICB. Put in place Strategic Delivery approach to identify and align strategic programmes of work to current Strategy Delivery Plan and report to Trust's Leadership and Board. Put in Place new Board Strategy development cycle and governance. OWNER: Exec Director of Strategy & Partnerships. Corporate Strategy Governance is being set up. Strategic Programmes have been identified and are being aligned to the delivery plan. Regular reporting is in place through the Strategic Delivery Group (SDG), Executive Forum and Board. Workforce Planning approach and leadership to be identified. OWNER: Executive Team Proposal for Performance processes, resourcing and leadership to be developed. OWNER: Executive Director of Strategy & Partnerships. IPR to be iterated to reflect Strategy development and performance work. OWNER: Executive Director of Strategy & Partnerships. Strategic Dashboard developed to show strategic ambition and

			outcome measure for each strategic objective as well as performance against key performance measures. This will be signed off as part of the 24/25 Annual Plan.
Strategic Objective 3: Make the best use of our resources and protect the environment			

3.10: Information Governance & Cyber Security

Date added to BAF	12/01/21				
Monitoring Committee	Finance & Investment Committee	Impact	Likelihood	Rating	
Executive Lead	Chief Finance Officer	Gross (Inherent) risk rating	5	4	20
Date of last review	08/03/24	Current risk rating	4	3	12
Risk movement	↔	Target risk rating	3	3	9
Date of next review	June 2024	Target to be achieved by			

Risk Description:

Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions); cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; and reputational damage.

Controls	Assurance	Gaps	Actions
- Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing; - Information assets and systems are risk assessed using standard Data Protection Impact Assessment (DPIA) tool; - 'Third Party Cyber Security Assessment' (checklist & questionnaire) developed, to provide a systems requirement specification and to ensure any new Information Systems being	Level 1: reassurance	In August 2022, IT failure with patient record systems provided and externally hosted by a third-party supplier led to staff being unable to access patient record systems and clinical information, thereby leading to risks to staff and patient harm. Trust internal operational and cyber security not compromised. The clinical system outage, which resulted from the failure with third	Major incident response set up to manage contingency plans, resolve the technical issue and provide alternative access to clinical information. Patient safety risk and more detailed incident-related risks maintained at Trust Risk Register level. Cyber assessments for alternative solutions fast tracked. The Trust has initiated a project working with a third party to support the recovery of reporting (project runs May 2023 - January 2024); the priority is to enable prompt recovery of reporting whilst
	Level 2: internal		
	- Information Management Group (IMG); - Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group - Finance & Investment Committee receives reports from IMG - Monitoring of IG training attendance; - Incident management and response process (enhanced to meet DSPT requirements) - NHS Digital Data Security and Protection Toolkit		

procured adhere to DSPT Cyber Security standards; Systems access control and audit managed by way of: programme of penetration testing (annually from 2020); cyber security assessed and tested prior to 3rd party contracts being awarded; Implementation of new Security information and event management system (SIEM) has taken place. Event logs are now being automatically monitored for suspicious activity; Microsoft Defender for mobile has been applied to mobile devices managed by InTune. Those devices now have malware and web filtering applied.; Privileged Access Management (PAM) has been implemented which controls and constrains access to elevated administrative accounts on the network; USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender Advanced Threat Protection); - Mail filtering system to flag or block suspicious, malicious or unsafe communications, to limit	(DSPT) annual self-assessment. - Programme of Phishing simulation/testing of all staff and subsequent report (annual from 2023) Level 3: independent - Improved NHS Digital's BitSight cyber rating, which exceeds peers in benchmarking and is in top 30% of organisations globally. - VMS Vulnerability Scanning, and NCSC WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated; -Independent, annual penetration test planned for Q1 annually; Independent DSPT annual audit for external assurance; -Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. - Secure messaging accreditation achieved/maintained (NHS Digital DCB1596);	party supplier-hosted patient record systems, has prevented the Trust from submitting mandatory data-set information and contractual information to commissioners, which could lead to contractual and reputational consequences. R&D Trials are also facing delays due to gaps in data. Penetration testing undertaken in Feb 2024 identified several risks which are being remediated as a priority by the operational IT teams involved. With the rise of AI, there is an increasing reliance on staff proficiently handling suspicious Web, Teams, and Email content, Staff awareness of such threats is only partially mitigated via existing guidance. The Trust needs a dedicated mandatory customisable targeted Cyber Security Awareness Training solution, providing audited participation, knowledge validation and success metrics and reporting, to significantly mitigate the risks from poor cyber security behaviours. Desktop Third Party Software Patch	ensuring that robust processes are in place when restarting automated data reporting. The recovery work will report on the data available but some gaps in data will continue because: (i) whilst mitigations have been put in place to ensure that the data that was captured during the outage is accessible to clinicians, it will not be possible to use this data for external reporting; and (ii) reduced functionality of the new systems RIO and EMIS, due to the pace at which these needed to be implemented, means that some data will not be available for reporting and analysis purposes until the full functionality is implemented. Funding and approval to recruit to enhance the cyber security team has been secured and recruitment is ongoing. ICO Data Protection audit (achieved 'Reasonable' assurance), November 2021. ICO published Audit completed. BAU for partially accepted actions. Lack of Cyber Security specific awareness training has been raised at ICS level to explore the potential for a joint approach and will be a subject covered by the ICS collaborative working group. Direction and guidance is being sought from the SIRO before any work begins on an awareness training solution, which would likely need to be a collaborative effort between L&D and Cyber. Phishing Simulation Report (Aug 2023) produced for the SIRO and next steps being discussed for IMG, Execs and Audit Committee awareness. OWNER: Head of IT User account deletion process is being strengthened to ensure timely disablement and deletion of leavers accounts. A new

the flow of phishing emails, malware and/or unsafe URLs; - Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises; - Cyber Security Awareness and Cyber Security SharePoint sites		Management is currently reactive only via ATP and internal resource fails to keep pace with the requirements. IG Data Security Awareness Training and awareness. Maintenance of 95% training completion. As Cyber Security hardening such as assessments, penetration testing, and other enhancements continue to be developed. Cyber team resources available to ensure the trust is able to meet the increasing demands for cyber security and compliance is inadequate.	process ensuring NHSP provided resources are known and all have end dates supplied at the beginning of their assignments has been created. Further analysis and actions to ensure all leavers are identified and removed is taking place. OWNER: Head of IT All Trust managers ensure mandatory Training completed. OWNER: Head of IG

Strategic Objective 3: Make the best use of our resources and protect the environment
3.12: Business continuity and emergency planning

Date added to BAF	19/01/21			
Monitoring Committee	Emergency preparedness, resilience, and response (EPRR) committee (sub-group to Executive Management Committee) and Audit Committee		Impact	Likelihood
Executive Lead	Director of Corporate Affairs & Company Secretary	Gross (Inherent) risk rating	5	3
Date of last review	13/02/2024	Current risk rating	3	3
Risk movement	↔	Target risk rating	3	3
Date of next review	August 2024	Target to be achieved by		
				Rating
				15
				9
				9

Risk Description:

Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for

example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.

Key Controls	Assurance	Gaps	Actions
- Accountable Emergency Officer (currently Director of Corporate Affairs & Company Sec), supported by a clinical director; - Designated Emergency Planning Lead, supporting the executive in the discharge of their duties; - EPRR committee 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates & facilities. - Psychosocial Response Group (subgroup reporting to EPRR committee. - Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic;	Level 1: reassurance		
	- Emergency Preparedness Resilience and Response (EPRR) Committee 3 x per year; - Psychosocial response group (sub-group of EPRR committee); - Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee.		
	Level 2: internal		
	- Annual EPRR report (most recently to the Audit Committee and the Board in Nov 2023); - EPRR Committee ensures that learning from EPRR Exercises, and live incidents, are incorporated into policy / procedure / practice. This is in addition to learning being incorporated into major incident plans, business continuity plans and shared with partners; - Self-assessment against NHS EPRR Core Standards. 2023 Full compliance		

- EPRR Response Manual incident response plan - (updated February 2024) provides emergency response framework; - On call system; - Directorate/service specific Business Continuity Plans (BCPs) in place for services, in respect of:	Based on the quality of response to the following, reputation and resilience have been safeguarded through 'no surprises' – No serious harms from Major Incident of IT clinical systems outage; from Industrial Action; from COVID response, from OOH business continuity incident, from locality floods etc		
Reduced staffing levels (for any reason e.g., pandemic); evacuation; technology failure; interruption to utility supplies (gas & electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown; infection control; food supply; pharmacy supply; - Completion and updating of BCPs supported and monitored by Emergency Planning Lead, with register of BCPs held centrally; - BCPs are reviewed annually or following an incident; - Training for directors on call (strategic and tactical), heads of service (tactical), key staff with operational	Level 3: independent - 2023 Self-assessment (as set out in annual report to the Audit Committee and the Board in November 2023) examined and accepted by BOB ICB on behalf of NHSE - There is no formal mechanism in place to obtain assurance from any independent third parties that take place in EPRR exercises. If the Trust participates in a multi-agency exercise, then other participants can make comment during any verbal or written debrief process. In June 2023, KPMG governance risk and compliance services inspected a total of 13 assertions from a total of 33 mandatory assertions in the data security and protection toolkit. All four assertions relating to		

responsibility for hazmat/CBRN response - Undertaking of exercises (live exercise every three years, tabletop exercise every year and a test of communications cascades every six months (NHS England emergency preparedness framework, 2022)). Lessons incorporated into incident response plans, business continuity plans and shared with partner organisations; - training scenarios on intranet for services to use to exercise business continuity plans; - Engagement with Local Health Resilience partnerships, and Membership of Oxon & Bucks Resilience Groups; - Horizon scanning and review of National and Community Risk registers by Emergency Planning lead.	EPRR were rated as substantial.		

Strategic Objective 3: Make the best use of our resources and protect the environment

3.13: The Trust's impact on the environment

Date added to BAF	09/02/21
Monitoring Committee	Finance & Investment
Executive Lead	Chief Finance Officer

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	3	4	12

Date of last review	12/01/2024	Current risk rating	3	3	9
Risk movement	↔	Target risk rating	3	1	3
Date of next review	June 2024	Target to be achieved by	2023		

Risk Description:

A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties (Health & Care Act 2022), national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028 – 2032. Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036 2038), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.

Key Controls	Assurance	Gaps	Actions
- Trust Green Plan/Strategy 2022-25; (Green Plan 2 2025-28 to be developed for sign off. Jan 25) - Executive Lead for Sustainability Chief Finance Officer; - Commitment by Board to Zero Carbon Oxford Charter (Jan 2021); - Full time Sustainability Manager post within Estates & Facilities Team; - Green Task Force - Benchmarking and annual emissions reporting; - Procurement Policy – sets out sustainability commitments required by suppliers; - Green Energy Supplier for electricity via CCS, - New Developments in accordance with NHS Net Zero Buildings Guidance	Level 1: reassurance	Trust is not meeting annual carbon budget FY 23 (Actuals 4960 Tco2- Target 4508 Tco2) GAP: current resource may be insufficient to implement Green Plan.	Sustainable travel Trial (EV for Community Nursing Team) commenced in May 2023, data from trial will be used to inform Trust long term sustainable travel plan. Executive team have approved Target temperature for non-inpatient areas of 20-degree C Developing Green Plan 2 which will set out aims and objectives to reduce carbon impact 2025-28 . OWNER: Director of Estates and Facilities/Sustainability Manager. Additional resources to be considered (Sustainable Travel Officer / Sustainability Coordinator)
	Level 2: internal - Monitoring of deliverables by Sustainability Manager - Green Task Force Group to deliver Green Plan 2 chaired by Chief Finance Officer; meets Quarterly. - Estates Buildings & Transport Sustainability Group meets quarterly; - Annual staff Travel Survey monitoring against base-line; - Annual CO2 emissions against previous year; FY23 has seen 19% reduction in carbon emissions when compared to the 2019 baseline year. Annual target of 5% reduction when compared to FY22 not met due to increase in Business mileage. - The modal shift of staff travel into more sustainable alternatives will be focus of the next		

	iteration of Green Plan in 2025.		
	Level 3: external		
	- BOB ICS Net Zero Program Board - Total Carbon Footprint Plus now reported by NHS England (54,000Tco2) Trust is leading on the BOB ICS Sustainable Travel Group . - The Trust is also part of ZCOP sprint group with Oxford University to review how to adapt our building estate to climate change risk e.g., extreme heat, floods.		

3.14 Major Projects

Date added to BAF	20/09/22
Monitoring Committee	Finance and Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	09/05/24
Risk movement	↔
Date of next review	November 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
Current risk rating	4	4	16
Target risk rating	3	2	6
Target to be achieved by	December 2024		

Risk Description (revised June 2023):

Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; non-delivery of required savings, unplanned expenses, delays and wasted resources.

Key Controls	Assurance	Gaps	Actions
- Programme Boards for key projects. - Standing Financial Instructions and Scheme of Delegation. - Senior teams' leadership of change and focus on ensuring delivery. - Recent increases in internal programme leadership capability and reform of former Strategic Change and Delivery (SCAD) model, complemented where needed by external resource.	Level 1: Reassurance - Programme governance has been mapped out for Trust's highest priority strategic programmes. - Warneford Park Programme Board with partners chaired by Non-Executive Director of Trust Level 2: Internal - Portfolio management of Strategic Programmes and enablers being introduced in FY24 for Execs, FIC and Board; - Strategy Delivery Group introduced to support delivery of the portfolio and to consider impact of changes in the round. - Capital Programme sub-committee (reviews capital project progress, attended by Services, IM&T and Estates leaders) and reports to FIC; and - FIC receives specific updates on Major Projects including the Warneford programme. - Lead Non-Exec for Digital in process of being appointed. Level 3: Independent - Internal audit reviews. - KPMG assurance over Frontline Digitisation programme.	a) Portfolio oversight has been designed but is not yet embedded. b) User engagement in change and change load management not always well-managed. c) Patient voice and experience is not yet routinely embedded in programmes. d) Specific challenges in Estates resourcing and model. e) Methodology for major capital programmes investment appraisal and project management not yet issued.	a) Board, Committee and Exec to feedback on and help develop new portfolio management approach. b) Enabler work on the Trust's Culture is engaging staff across the Trust on our approach to change management. c) Patient Experience and Involvement strategic programme to be implemented. d) Estates model to be developed, communicated and implemented. e) Publish new capital programmes investment appraisal methodology before August. Owner: Chief Finance Officer

	- ICB representation at Digital and Data Strategy Board.		

Strategic Objective 4: Become a leading organisation in healthcare research and education

4.1: Failure to realise the Trust's Research and Development (R&D) potential

Date added to BAF	Pre-Jan 2021				
Monitoring Committee	Quality Committee		Impact	Likelihood	Rating
Executive Lead	Chief Medical Officer	Gross (Inherent) risk rating	3	3	9
Date of last review	08/02/24	Current risk rating	3	2	6
Risk movement	↔	Target risk rating	3	1	3
Date of next review	September 2024	Target to be achieved by			

Risk Description:

Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.

Controls	Assurance	Gaps	Actions
- Director of R&D; - NIHR Infrastructure Managers meetings provides an opportunity for managers of the OH hosted NIHR awards and the R&D Director to meet regularly to ensure alignment and discussion future opportunities. On a quarterly basis these meeting will be augmented by the OUH BRC and CRF Managers. - Clinical Research Facility (CRF) steering committee - Biomedical Research Centre (BRC) Steering Committee and Partnership Board; - Oxford Applied Research Collaboration Oxford and Thames Valley (OxTV) (ARC);	Level 1: reassurance	GAP: The clinical system outage from August 2022, which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting data-set information and contractual information which could lead to contractual and reputational consequences. R&D Trials will also face some delays due to gaps in data. GAP: Owing to the clinical system outage and issues with migration and recording of diagnosis within RIO the ability to produce accurate recruitment lists has caused severe delays in meeting recruitment	The loss of CareNotes and the move to RiO has the potential to impact all areas of research from set-up and participant recruitment through to study delivery. The Head of Research Informatics is part of the RiO programme board. • Optimisation is well underway for the Trusts new Clinical Systems, RIO & EMIS, with over 60 items going live during the period July – Dec 24, including key assessments / templates, data migration, clinics; • Over 8000 users set up on RIO & EMIS including partner organisations; • Integration now in place from RIO to EPMA,
	Level 2: internal		
	- Research updates and R&D reporting into the Quality Committee; - R&D reports to Board (at least twice a year), - BRC reports to Board on a regular basis Toronto - Oxford Psychiatry Collaboration also provided to the Board		
	Level 3: independent		
	- The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR); - Annual Statement of Expenditure Reports are submitted to DH for the BRC, CRF, ARC and MIC		

- ARC Management Board; - The R&D Director sits on the OUH Joint R&D committee (JRDC). - Toronto – Oxford Psychiatry Collaboration under a Memorandum of Understanding between the Trust, University of Oxford, the University of Toronto and the Centre for Addiction and Mental Health in Toronto - Joint Research Office (JRO) - is a collaboration between Oxford Health NHS Foundation Trust (OH), Oxford University (OU), Oxford University Hospitals NHS Foundation Trust OUH), and Oxford Brookes University (OBU). It brings together the teams responsible for supporting clinical research across both NHS Foundation Trusts and both Universities in Oxford, as part of an initiative supported at the highest level in all organisations and by the Board of the Oxford Academic Health Partners The JRO reports into the JRDC. OH have recently been in conversation with the BOB ICS to discuss how research with the 5 NHS Trusts OH has links with OBU in relation to the development of the research element of NMAPS.	- Annual Report of Research Capability Funding (RCF) is submitted to DH - R&D is audited by the Thames Valley & South Midlands Clinical Research Network (TV&SM- CRN) annually;	targets for national trials. Diagnosis migration issues should be resolved by end of September 2023. GAP: The Trust 'Count me in (CMI)' programme paused following the CareNotes outage. Recruitment reverted to a consent model and direct clinician referrals. This remains on hold as a Trust research recruitment strategy, awaiting new research forms in RIO and the ability for appointment letters with CMI leaflet attached, to be sent direct from RIO. If CMI service resumes, it will require a relaunch to staff and patients. We have no date for this to be resolved. GAP (Controls): Warneford redevelopment – to progress. Complicated capital project and is being carefully monitored by the Finance & Investment Committee and with regular updates to the Board in private session. GAP (Controls): R&D Strategy in development. Includes Monitor and Improve study set-up times, Sustain and expand existing Research Clinics, Develop Clinical Academic posts, support early adoption of innovation to reduce waiting lists and increase productivity, Review / re-launch "Count me in"	Truecolours, ICE, TVS SCR; • 64 out of 70 Oxfordshire GP Practices now sharing with EMIS Community Services; • EMIS Mobile App pilot started Dec 23; • Thames Valley and Surrey Shared Care Record is live in RIO. Monitoring through reporting into the Finance & Investment Committee (FIC) and the Board. FIC also monitoring BAF risk 3.14 on delivery of Major Projects, such as the Warneford. The R&D operational plan will be developed as part of the OH Planning process.

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Table 1a: Risk Matrix

		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Impact/severity	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Table 1b: Likelihood scores (broad descriptors of frequency and probability)

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might/does it occur	This will probably never happen/recur	Do not expect it to happen/recur but it is possible	Might happen or recur occasionally	Will probably happen/recur, but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	<0.1%	0.1-1%	1-10%	10-50%	>50%

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Table 1c - Assessment of the impact/severity of the consequence of an identified risk: domains, consequence scores and examples

	Consequence score (severity) and examples				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness requiring minor intervention Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Incident resulting serious injury or permanent disability/incapacity Requiring time off for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident resulting in fatality Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ Complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major safety implications if findings are not acted upon	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Major patient safety implications	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

			Low staff morale Poor staff attendance for mandatory/key training	competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Informal recommendation from regulator. Reduced performance rating if unresolved.	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage– long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage of a week	5–10 per cent over project budget Schedule slippage of two to four weeks	10–25 per cent over project budget Schedule slippage of more than a month Key objectives not met	>25 per cent over project budget Schedule slippage of more than six months Key objectives not met
Finance including claims	Negligible loss	Claim of <£10,000 Loss of 0.1–0.25% of budget	Claim of between £10,000 and £100,000 Failure to meet CIPs or CQUINs targets of between £10,000 and £50,000 Loss of 0.25–0.5% of budget	Claim of between £100,000 and £1million Purchasers fail to pay promptly Uncertain delivery of key objective / Loss of 0.5–1.0% of budget	Loss of major contract / payment by results Claim of >£1million Non-delivery of key objective/loss of >1% of budget

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Additional examples	Incorrect medication dispensed but not taken Incident resulting in bruise/graze Delay in routine transport for patient.	Wrong drug or dosage administered with no adverse effects Physical attack such as pushing, shoving or pinching causing minor injury Self harm resulting in minor injury Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare acquired infection (HCAI)	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure sore Long term HCAI Loss of a limb Post-traumatic stress disorder	Unexpected death Suicide of patient known to the service in the last 12 months Homicide committed by mental health patient Incident leading to paralysis Rape/serious sexual assault Incident leading to long term mental health problem

Audit Committee
Minutes of the meeting held on
23 April 2024 at 09:30
via MS Teams

Present¹:

Chris Hurst	Non-Executive Director (the Chair/CMH)
David Clark	Non-Executive Director (DC)
Mohinder Sawhney	Non-Executive Director (MS)
Rick Trainor	Non-Executive Director (RT)

In attendance:

External Audit - Ernst & Young LLP (EY)

Maria Grindley	External Audit – Partner, Ernst & Young (MG)
Claire Mellons	External Audit - Senior Manager, Ernst & Young (CM)

Internal Audit and Counter Fraud – KPMG

Jack Stapleton	Internal Audit – KPMG (JS) – <i>part meeting</i>
Neil Thomas	Internal Audit – Partner, KPMG (NT) – <i>part meeting</i>
Katrina Tumilty	Internal Audit- KPMG (KT)

Oxford Health NHS FT

Attending Board members

Georgia Denegri	Associate Director of Corporate Affairs (GD)
Grant Macdonald	Chief Executive (the CEO/GM)
Kerry Rogers	Director of Corporate Affairs & Company Secretary (the DoCA/CoSec /KR)
Heather Smith	Chief Finance Officer (the CFO/HeS)
David Walker	Trust Chair (DW) – <i>part meeting</i>

Other Trust staff in attendance

Brian Aveyard	Risk, Assurance & Compliance Manager (BA)
Ben Cahill	Deputy Director of Corporate Affairs (the Deputy DoCA/BC)
Charmaine De Souza	Chief People Officer (CDS)
Angie Fletcher	Deputy Chief Nurse (AF) – <i>part meeting</i>
Claire Forrest	Head of Clinical Standards (CF) – <i>part meeting</i>
Alison Gordon	Head of Financial Management (AG)
Peter Milliken	Director of Finance (the DoF/PM)
Hannah Smith	Assistant Trust Secretary (HaS) (Minutes)
Angela Ward	Clinical Audit and NICE Guidance Manager (AW) – <i>part meeting</i>
Michael Williams	Financial Controller (MW)

¹ The quorum is 3 members (all Non-Executive Directors) and may include deputies.

The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members and Auditors and Counter Fraud.

1.	Welcome and Apologies for Absence	
a	The Chair welcomed attendees to the meeting.	
b	There were no apologies for absence from Committee members.	
c	Apologies from non-Committee members were received from: Adam Makda, Local Counter Fraud Specialist – KPMG; and Karl Marlowe, Chief Medical Officer	
2.	Minutes of the Meeting on 22 February 2024 and Matters Arising	
a	The minutes of the Audit Committee meeting on 22 February 2024, at paper AC 12/2024, were approved as a true and accurate record.	
	Matters Arising	
b	The following actions were noted as complete (with supporting detail in the Summary of Actions document) or on the agenda for this meeting: • item 2(a) updates to Minutes; • item 3(a) updates to Committee workplan; • items 4(c), (f)&(h) BAF deep dives into BAF 2.6 (Adequacy of Staffing) and BAF 3.6 (Governance and decision-making arrangements); and • item 10(b) Board Standing Orders.	
c	Item 15, November 2023 – Agency fee structures – the Director of Finance provided an oral update that discussions were ongoing with the framework provider used for the procurement of various agencies and there were still details to be worked through. He agreed with the Chair that, given the priority work to take place on the Annual Accounts for the next meeting, an update on agency fee structures would be scheduled instead for the September meeting and the action would be listed as on hold and not due until then.	
d	Item 6(a), June 2023 – Risk Management policy – the Associate Director of Corporate Affairs provided an oral update and reported that the policy was undergoing more significant changes, subject to consultation, to be worked into a combined strategy and policy document and would therefore be held for the June meeting.	
3.	Committee workplan	
a	No comments.	

INTERNAL AUDIT & COUNTER FRAUD	
4.	Internal Audit progress report and Internal Audit Plan 2024/25 and 2025/25
a	Neil Thomas, KPMG, presented the report at AC 13/2024 which provided: an update on the progress of the Internal Audit Programme for FY24, including action tracking; review reports on the Bank Booking Process and Operational Risk Management; and the revised Internal Audit Plan FY25-26 (updated after discussion with the Executive). Fieldwork had been completed for the Data Quality review and was in progress for the review into the Data Security & Protection Toolkit. The Draft Head of Internal Audit Opinion FY24 was also included and, subject to completion of the remaining reviews, indicated a finding of significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the framework of governance, risk management and control. <i>Bank Booking Process review – partial assurance with improvements required</i>
b	Jack Stapleton, KPMG, presented the review report which had identified opportunities to: improve behaviours at ward level to book and pay bank workers in a timely manner; manage the relationship with the bank/agency provider including enhancing reporting from them and recording of challenges to raise with them; and create a bank booking policy or Trust-wide standard operating procedure for booking bank staff.
c	The Chief People Officer thanked the Internal Audit team and noted that the review had come at the right time to support managers on how to better integrate and work with the bank/agency provider, especially as certain issues should have been identified and resolved prior to, or immediately after, 'go live'. In response to a question from the Chair, she confirmed that the target dates in the report were achievable. She had Interim Executive leadership of temporary staffing and had introduced new resource into the team, including a dedicated contract manager; the work which was now taking place would dovetail neatly with the recommendations in the review. The Chief Finance Officer agreed and noted that the Internal Audit review had been delivered at a useful time just as new processes after the initial 'go live' had begun to stabilise and improvements could be implemented.
d	David Clark commented upon the lack of a standard bank booking policy or operating procedure and asked whether Internal Audit had been able to provide examples to use or whether the Executive were already aware of some which could be put into place. Mohinder Sawhney added that it would be useful as a matter of course if Internal Audit could reference good practice beyond the organisation and provide helpful examples to follow; the Chair noted that the section in review reports highlighting good practice within the organisation could be a useful point to also reflect upon a comparison with, or learning from, other organisations. Jack Stapleton noted that Internal Audit would be happy to work with the Chief People Officer on this. The Chief People Officer added that she was working closely with other trusts within the local Integrated Care System who had a variety of different bank and temporary staffing arrangements and procedures. The Chief Executive supported the findings of the review report and added that the bank/agency provider also

	provided substantial guidance on its website for staff such that not all organisations would need further standard operating procedures. He emphasised that there had also been significant improvement and reduction in the Trust's overall agency use since December 2023.	
e	In response to questions from Mohinder Sawhney on progress being made against recommendations at 2.4, 2.7 and 2.10 in the review report, the Chief People Officer provided assurance that actions were underway and the Executive had signed-off on an improvement plan for rostering on inpatient wards.	
f	In response to a question from Mohinder Sawhney, the meeting considered the Trust's approach to change management and learning from the implementation of new systems. The Chief Executive noted the importance of proper project planning. The Chair reflected upon: the importance of the undertakings built into contracts with third parties so that Trust teams would have appropriate support; the need to check how well processes worked for staff members, especially when they could be under pressure and therefore more likely to deviate; and the appropriateness of the report given the red current risk rating of Adequacy of Staffing on the Board Assurance Framework and the workforce/staffing risks on the Trust Risk Register. Operational Risk Management review – significant assurance with minor improvement opportunities	
g	Katrina Tumilty, KPMG, presented the review report which set out that Operational Risk Management processes and controls largely operated effectively; she noted that the Extended Leadership Team's new processes to receive reporting on high-rated risks from operational directorates would strengthen the escalation process.	
h	The Director of Corporate Affairs & Company Secretary thanked the Internal Audit team and noted that the review had been useful for directorates. She also reminded the meeting that there had been Board consideration of an overarching Risk Appetite Statement since at least 2021 but it had been decided not to take it further; however, a draft Risk Appetite Statement had been developed and would potentially now align with the work of the Associate Director of Corporate Affairs on the Risk Management strategy and policy.	
i	The Committee noted the progress report and the review reports and APPROVED the Internal Audit Plan 2024/25 and 2025/26.	
5.	Counter Fraud annual report FY24 and Counter Fraud Plan FY25	
a	Neil Thomas, KPMG, presented the report at AC 14/2024 which provided the Counter Fraud annual report on the Counter Fraud Programme for FY24 and the revised Counter Fraud Plan for FY25. He highlighted the work of the Local Counter Fraud Specialist on raising awareness, conducting risk-based reviews (including jointly with Internal Audit on Supplier	

b	Metadata, Recruitment and the Bank Booking Process as well as separately on Managing Conflicts of Interest) and managing Counter Fraud referrals (of which there had been 11 received during the reporting period). Appendices 2-3 on the self-assessment against the Government Functional Standard on Counter Fraud set out the steps being taken to move remaining ratings from amber to green by the submission deadline. The Chief Finance Officer thanked Counter Fraud for the work done, especially on awareness raising and the referrals received. The Committee received the Counter Fraud annual report FY24 and APPROVED the Counter Fraud Plan FY25.	
DRAFT ANNUAL REPORT & ACCOUNTS AND SUPPORTING DOCUMENTS		
6.	Draft Financial Statements and Accounts a The Chief Finance Officer presented: (i) the Draft Annual Statutory Accounts – Year Ending 31 March 2024; (ii) a high-level Analytical Review of the Primary Financial Statements from the draft 2023/24 Annual Accounts illustrating variance compared to the 2022/23 Annual Accounts; and (iii) a Private Finance Initiative (PFI) accounting paper to provide an update on the Trust's accounting treatment of its PFI scheme in FY24 as part of its PFI exit plan in FY25 (together forming paper AC 15/2024). She summarised that the revenue position had remained stable and this had been a year for consolidation rather than revenue growth; however, there were impairments connected to the PFI exit to take into consideration for the Statement of Financial Position. She commended the Finance team on financial management over the year of various different income and expenditure lines and also tight working capital management. The Director of Finance also highlighted the relatively stable position on cash balances. b The Head of Financial Management took the meeting through Operating Income and Expenditure from the Analytical Review FY24, highlighting the positive impact upon Operating Income of the national pay award and tariff uplift and the increase in Biomedical Research Centre (BRC) income due to the start of the second BRC and Mental Health Investment Standard funding. There had, however, also been reductions as the Trust was no longer providing COVID mass vaccination centres and Oxford Pharmacy Store sales had reduced as COVID vaccine storage and delivery was no longer required. c The Financial Controller took the meeting through movement on the Statement of Financial Position between FY23 and FY24, from the Analytical Review FY24, highlighting capital programme expenditure on Jordan Hill and noting impairments against the Psychiatric Intensive Care Unit (anticipated for a newbuild to have a downwards valuation upon first becoming operational) and the Warneford (a remeasurement further to a correction of the gross internal area). The overall cash position remained strong, outstanding debtors relatively low and payables and other liabilities were being managed. The most significant change related to the PFI exit liability which had also led to a restatement of the prior period's closing net assets.	

d	The meeting reviewed the PFI accounting paper and the Chief Finance Officer confirmed that professional advice had been received from KPMG and through national consultation with other organisations. The Financial Controller took the meeting through the background to the PFI contract, the historical accounting approach and the potential impact of the exit liability. The Chief Finance Officer explained that due to ongoing commercial negotiations and the nature of the prior period adjustments and relevant accounting disclosures, it may be necessary to include redactions or delay publication of the Annual Accounts until negotiations were concluded and subject to advice from NHS England. The Chair reflected upon asset ownership under PFI schemes and the importance of recognising from the outset that compensation payments may be likely upon exit, as well as obligations of the PFI company in relation to the condition of the building. The Committee was assured that the Finance & Investment Committee and the Board would also be updated on the implications of the PFI exit.	MW/ HeS
e	The Chair asked for assurance on whether there had been any changes in accounting policies, if so whether the Trust had been able to comply with these and their impact. The Financial Controller replied that there had not been any fundamental changes to accounting policies.	
f	The Chair recommended including: • a glossary to explain acronyms such as 'ABI'; • more detail in a footnote to explain the increasing cost of Non-Executive Directors as this encompassed a number of changes, not just pay awards; and • clarification on page 61 of the Draft Accounts that the Related Parties listed under 'government bodies' may be more accurately described as 'other bodies'.	
g	The Committee RECEIVED AND APPROVED the Draft Annual Statutory Accounts and the high-level analytical review of the 2023/24 Annual Accounts Primary Financial Statements and, subject to the comments above and further changes to be made, AGREED that these should be submitted to NHS England.	
7.	Preparation of Statutory Accounts on a Going Concern basis	
a	The Chair introduced the report at paper AC 16/2024, the draft Going Concern Statement which included, at Appendix 1, references to the sources and documentation to support the going concern basis for preparation of the 2023/24 Statutory Accounts. In due course, in approving the final Statutory Accounts, the Committee would be asked whether it agreed with the decision made by management to prepare the accounts on a going concern basis and based on the anticipated continuation of future provision of services in the public sector.	
b	The Financial Controller reminded the Committee that, since FY22, the focus of the Going Concern Statement had shifted from organisational future financial sustainability to	

	anticipated continuity of the provision of services in the public sector. The HM Treasury Financial Reporting Manual and the NHS FT Annual Reporting Manual (NHS FT ARM) set out that inclusion of financial provision for such services in published financial accounts was normally sufficient evidence of anticipated continuity of services and going concern status. As healthcare services continued to be provided, it was therefore highly unlikely that an NHS body would prepare its accounts on anything other than a going concern basis. The key consideration was whether the services it was providing would continue to be provided in the public sector. The Trust could evidence this by reference to the sources and documentation listed in Appendix 1 which set out NHS commitments to mental health and community services and to Provider Collaboratives, including NHS England FY25 priorities and planning guidance.	
c	The Chair supported the statement that the Trust was clearly a going concern and it was appropriate for the (draft) accounts to be presented on a going concern basis, in light of ongoing commissioning of mental health and community services.	
d	The Committee noted the report and preparation of the draft 2023/24 Annual Accounts on a going concern basis.	
8.	Draft Annual Governance Statement	
a	The Director of Corporate Affairs & Company Secretary introduced the report at paper AC 17/2024 which set out the draft Annual Governance Statement (AGS) on the system of internal control. She highlighted the AGS's role in reflecting the existence, or otherwise, of any significant control weaknesses and any associated remedial actions. The NHS FT ARM provided examples to consider in determining whether an internal control issue was 'significant', including taking into account advice from Internal or External Audit and considering whether an issue might: prejudice achievement of priorities or undermine the integrity or reputation of the NHS; put at risk the delivery of standards expected of the Accounting Officer; make it harder to resist fraud or other misuse of resources; divert resources from another significant aspect of the business; have a material impact on the accounts; or put at risk national or data security or integrity.	
b	The Deputy Director of Corporate Affairs reminded the Committee of the prescribed nature of much of the drafting, in accordance with the NHS FT ARM and noted that the first draft of the Remuneration Report had been supported by the Nominations, Remuneration & Terms of Service Committee.	
c	The Chair commented upon the comprehensive draft, noted that it was a fair and reasonable reflection of challenges and the Trust's response and encouraged further comments to be sent through to the Deputy Director of Corporate Affairs over coming weeks. In particular, he supported the final paragraph and noted that whilst the Trust had ambitions to improve, it maintained an adequate and effective governance assurance system that enabled the identification and control of risks.	

d	The Committee noted the draft AGS and supported the direction of the narrative in setting out the work of the Trust in assuring the effectiveness of controls and management of risk and that it reflected the existence, or otherwise, of any significant control weaknesses and any associated remedial actions.	
9.	Update on approach to 'Oxford Health in numbers 2024-27'	
a	The Chief Finance Officer explained that paper AC 18/2024 was not currently available but that she had been working with the Associate Director of Communications and Engagement on the development of this year's version, which would facilitate comparison with the previous year and also be even more accessible.	
b	The Committee noted the update. <i>The meeting took a break for 10 minutes. The Trust Chair and Jack Stapleton and Neil Thomas from Internal Audit, KPMG, left the meeting.</i>	
10.	External Audit progress report	
a	Maria Grindley, EY, provided an oral update and reported good progress with the External Audit and noted that they had been fully briefed on the PFI accounting point. Key areas of the External Audit, such as the Remuneration Report, were also being focused upon early. Claire Mellons, EY, added that being in post for the full financial year had also made a significant positive difference, especially to the scoping and interim testing which could be undertaken.	
b	The Committee noted the update.	
RISK, GOVERNANCE & ASSURANCE		
11.	Board Assurance Framework (BAF) and Trust Risk Register (TRR) update	
a	The Director of Corporate Affairs & Company Secretary presented the report at paper AC 19/2024 which provided: (i) the annual overview of the position of the BAF and the TRR; and (ii) further deep dives into BAF risks 2.6 (Adequacy of Staffing) and 3.6 (Governance and Decision-making Arrangements) further to discussion at the last meeting. In relation to BAF 3.6, she confirmed that it had been updated further to comments at the previous meeting and that the slightly reduced Current Risk Rating (still overall orange/high risk) was recommended further to the recent Information Management Group meeting. The Chair thanked her for the update and confirmed that the refinements were as hoped for.	
b	The Chief People Officer presented BAF 2.6 (Adequacy of Staffing) which had replaced BAF 2.1 and 2.2 (Workforce Planning and Recruitment) and explained that it had been developed to demonstrate alignment between the Trust's People Plan and the NHS Workforce Plan, with controls and assurances set out against those headings. A heading had also been	

c	retained on the 'Improving Quality and Reducing Agency' programme in the interim whilst work continued on temporary staffing. Mohinder Sawhney commented upon the workshop approach to developing this risk and noted that although it would still take some time to mature over the coming year, it was better framed upon the main drivers of the risk. The Chair also commented positively upon bringing together the Workforce Planning and Recruitment themes under one risk. The Committee noted the report and was assured by the updates to BAF risks 2.6 (Adequacy of Staffing) and 3.6 (Governance and Decision-making Arrangements).	
12.	Clinical Audit annual assurance report a The Deputy Chief Nurse, the Clinical Audit and NICE Guidance Manager and the Head of Clinical Standards joined the meeting and presented paper AC 20/2024. The Deputy Chief Nurse introduced the Head of Clinical Standards as the new lead for Clinical Audit and thanked the Clinical Audit and NICE Guidance Manager for her work, noting that she would be leaving the Trust. b The Clinical Audit and NICE Guidance Manager provided an update of Clinical Audit activity against the 10 criteria from the Healthcare Quality Improvement Partnership (HQIP) Clinical Audit guide for NHS boards and partners. The assurance levels against the 10 criteria had not yet changed but this was to be expected when adapting to new areas. Good progress had however been made in aligning Clinical Audit with Quality Improvement. c The Committee discussed and requested that future reporting; • include target dates and responsibilities • track the previous year's actions and progress against these, and also identify common themes from Clinical Audit activity and provide assurance that these were being addressed; • evolve to cover more monitoring of patient outcomes or maximising of the benefits of this to support services to use the patient outcome data which they already collected. Although it was acknowledged that minimum reporting requirements were being met, there may be more to do in order to maximise the benefits of such data collation for services and the public; and • consider a schematic at the end of the report to track data flows, especially if some of the detail requested above may sit more appropriately in separate reporting to the Quality Committee rather than the Audit Committee. d The Committee thanked the team and noted the report.	CF/KM
13.	Risk Management Policy a The Committee confirmed that this had already been discussed at item 2(d) above.	

14.	Draft Audit Committee annual report	
a	The Director of Corporate Affairs & Company Secretary presented the Draft Audit Committee annual report. The Chief Finance Officer noted that she would have some comments on the sections for Internal Audit and External Audit, the Chair invited further comments before the next meeting in June and noted that, as set out in the Summary of Actions document, a Committee self-assessment exercise would take place separately from September/October 2024 when the impact of a new Chair had had time to embed.	
b	The Committee noted that a final version of the Audit Committee annual report would be presented to the next meeting in June.	HaS
Any Other Business		
15.	Any Other Business	
a	The Chair noted that this was the final Audit Committee meeting for the Director of Corporate Affairs & Company Secretary and thanked her for her input over the years and her contribution during her time on the Board.	
	Meeting Close: 11:55	
	Date of next meeting: 19 June 2024	

Audit Committee
[DRAFT] Minutes of the meeting held on
19 June 2024 at 09:30
via MS Teams

Present¹:

Chris Hurst	Non-Executive Director (the Chair/CMH)
Philip Rutnam	Non-Executive Director (PR) – <i>deputising for David Clark and Rick Trainor</i>
Mohinder Sawhney	Non-Executive Director (MS)

In attendance:

External Audit - Ernst & Young LLP (EY)

Daniel Edwards	External Audit - Assistant Manager, Ernst & Young
Maria Grindley	External Audit – Partner, Ernst & Young (MG)
Michael Mason	External Audit, Ernst & Young
Claire Mellons	External Audit - Partner, Ernst & Young (CM)

Internal Audit and Counter Fraud – KPMG

Jack Stapleton	Internal Audit – KPMG (JS)
Katrina Tumilty	Internal Audit - KPMG (KT)

Oxford Health NHS FT

Attending Board members

Georgia Denegri	Associate Director of Corporate Affairs (GD)
Grant Macdonald	Chief Executive (the CEO/GM)
Heather Smith	Chief Finance Officer (the CFO/HeS)

Other Trust staff in attendance

Brian Aveyard	Risk, Assurance & Compliance Manager (BA)
Ben Cahill	Deputy Director of Corporate Affairs (BC)
Charmaine De Souza	Chief People Officer (CDS) – <i>part meeting</i>
Alison Gordon	Head of Financial Management (AG)
Peter Milliken	Director of Finance (the DoF/PM)
Atif Saeed	Head of Financial Accounts
Hannah Smith	Assistant Trust Secretary (HaS) (Minutes)
Mark Underwood	Head of Information Governance (MU) – <i>part meeting</i>
Michael Williams	Financial Controller (MW)

The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members and Auditors and Counter Fraud.

¹ The quorum is 3 members (all Non-Executive Directors) and may include deputies.

1.	Welcome and Apologies for Absence	
a	The Chair welcomed attendees to the meeting.	
b	Apologies for absence from Committee members were received from David Clark and Rick Trainor, Non-Executive Directors.	
c	Apologies from non-Committee members were received from: Adam Makda, Local Counter Fraud Specialist – KPMG; and Neil Thomas, Internal Audit – Partner, KPMG	
2.	Minutes of the Meeting on 23 April 2024 and Matters Arising	
a	The minutes of the Audit Committee meeting on 23 April 2024 were approved as a true and accurate record.	
	Matters Arising	
b	The following actions were noted as complete (with supporting detail in the Summary of Actions document) or on the agenda for this meeting: • item 6(f) from April 2024 on the draft Annual Accounts; • item 14(b) from April 2024 Audit Committee annual report; and • item 5(c)&(e) from September 2023 on BAF 3.4 (delivery of the financial plan and maintaining financial sustainability).	
c	Item 14(f) from November 2023 – Audit Committee self-assessment on hold for September/October 2024 and the Committee will also consider the impact of updated guidance for NHS audit committees from the Healthcare Financial Management Association.	
3.	Committee workplan	
a	No comments.	
SUPPORTING DOCUMENTS TO THE ANNUAL REPORT & ACCOUNTS		
4.	Internal Audit annual report 2023/24 including final Head of Internal Audit Opinion	
a	Jack Stapleton, KPMG, presented the report and confirmed that the Head of Internal Audit Opinion was one of significant assurance with minor improvement opportunities on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.	
b	The Committee acknowledged that this was a very positive report for an organisation as large and complex as the Trust. However, Philip Rutnam asked whether the Trust was using Internal Audit to shed as much light as reasonably possible on the organisation, especially in light of the operational pressures and risks which it was managing as best it could within limited resources. He commented that would inevitably lead to stress upon the organisation; and that an organisation which was under operational stress may also demonstrate less meticulous management across dimensions such as finance, HR or data control. Jack Stapleton replied that the Internal Audit reviews conducted had demonstrated that processes to respond to such challenges were well designed and operating as they should be. The Executive, as well as this Committee, also actively directed the attention of	

	Internal Audit to challenging areas which were under pressure, such as the review of the Bank Booking process. The Chief Finance Officer added that Internal Audit had been directed deliberately to look into areas which were potentially under pressure, for example the focus upon Estates and Digital Procurement as part of the Core Financial Controls review. The assurances which the Trust had received from Internal Audit had been helpful to demonstrate that the Trust was addressing risks in a controlled way, understood the level of risk which it was carrying and that processes were being followed appropriately. Mohinder Sawhney and Philip Rutnam both commented that, although the Trust could be proud of the outcome of the Head of Internal Audit Opinion, the Executive and Internal Audit should continue to probe and consider where Internal Audit resource could be best used to shed light on the most challenging and difficult activities in the organisation. The Chair commented that this was a useful challenge and reminder for the Committee to be both alert and enquiring; the collaborative approach to Internal Audit planning and the way that Internal Audit work was conducted supported the Committee's ability to do this effectively.	
c	The Chair referred to appendix 2 of the report on Internal Audit performance, in particular the section on delivery of audit reviews where performance had not met targets in areas such as timescales for management responses and issue of audit reports, and asked whether there had been correlation between delays and areas of staffing shortage. Jack Stapleton replied that there were points of learning for within the Internal Audit team itself, as more complicated topics such as Bank Bookings had needed to take longer in order to ensure that the review was conducted in appropriate detail. He confirmed that there were no concerns about how Trust colleagues had engaged with the team.	
d	The Chief Finance Officer added that engagement between the Trust and Internal Audit was generally going well but acknowledged that there were some historic management actions which remained ongoing, in particular in relation to Health & Safety training. She reported that there had been leadership and management changes in the Health & Safety team and Estates were also transferring into the central contract management system.	
e	The Committee noted the report and the Head of Internal Audit Opinion and thanked Internal Audit for their work. <i>The Head of Information Governance joined the meeting.</i>	
5.	Final Internal Audit reports pertaining to FY24	
a	Katrina Tumilty, KPMG, presented the report and confirmed that the FY24 programme of work had completed, with the final reviews being reported to this meeting, and work and planning had commenced on the FY25 reviews starting with Risk Management (Health & Safety), Cyber Security and Core Financial Controls. There were no significant findings to highlight from work to date and overdue medium priority actions were summarised in the report. <i>Data Security & Protection Toolkit (significant assurance)</i>	
b	Katrina Tumilty presented the review into the Data Security & Protection Toolkit which had received significant assurance overall and only one low priority recommendation. In response to a question from Mohinder Sawhney on why management's view had been more critical than that of Internal Audit, the Head of Information Governance replied that a naturally cautious approach had been taken internally and it was gratifying that the Internal Audit assessment had found a high degree of confidence in the processes around	

	Information Governance, Data Security and Protection. The Chair agreed, noting that this was an area which might have represented a greater risk and it was heartening to see the evidence of good practice referred to in the report. <i>Design of Data Quality System (significant assurance with minor improvement opportunities)</i> c Katrina Tumilty explained that there was an annual requirement to review Data Quality and that this review report had focused upon arrangements for contracts and governance and had considered lessons learned after the cyber outage. Jack Stapleton concluded that overall the processes to enter contracts were operating as designed and assurance could be taken that the quality of ongoing data was complete and accurate. d In response to a question from Mohinder Sawhney on inconsistencies identified between information recorded in the Trust's incident management system and its electronic patient record, the Chief Executive replied that: the findings of only two incidents of prone restraint not being recorded in both systems was a very low number; the current electronic patient record was still being developed further to the clinical systems outage which had impacted its predecessor; and automating entry into both systems was not currently offered by patient record systems generally and may not be practicable as the two systems served different purposes and required differing levels of detail. The Chief Finance Officer added that the Trust was looking into how and where to potentially deploy automation and machine learning, noting that it was important to use such tools to support effectiveness and not rely on staff to undertake manual processing. e Philip Rutnam reminded the meeting of the importance of considering patient outcomes and ensuring that full use was being made of data which was already being recorded; although this may be beyond the scope of this particular Internal Audit review, it would be relevant to the ongoing development and improvement of Data Quality in the Trust. The Chair acknowledged that this was a useful reminder. f The Committee noted the Internal Audit review reports and the positive results which had been achieved. <i>The Head of Information Governance left the meeting.</i>	
6.	External Audit results report and Value For Money update (draft report on the financial statement audit for the year ended 31 March 2024) a Maria Grindley, EY, presented the draft External Audit results report and commented positively upon this year's process, especially in working through complex areas such as the Private Finance Initiative (PFI) exit and disclosures in the Remuneration Report, as set out in the draft report. Daniel Edwards, EY, took the Committee through the detail in the report highlighting adjustments which had been made, the accounting treatment for the PFI exit which had been agreed with management and a prior year adjustment within the Remuneration Report. There were no significant weaknesses to report in relation to Value For Money (VFM) and final VFM commentary would be issued by the end of June as part of the Auditor's Annual Report; the manager review process was due to conclude this week and the final External Audit Opinion was anticipated to be ready for the Board meeting on 26 June 2024.	

b	The Chair commended the Finance team and External Audit for their work on technical accounting issues including estates valuations and the PFI exit, as well as their overall efforts within a relatively short space of time. In response to questions from the Chair: (i) Daniel Edwards confirmed that there were no particular concerns to raise around ongoing actions and recommendations from the previous year and that these were being addressed appropriately by the Chief Finance Officer; and (ii) the Associate Director of Corporate Affairs did not have concerns to raise on the processes which had been followed or learning from the previous year. The Chief Finance Officer confirmed that management responses to recommendations would be available in the final version of the report and risks were being mitigated appropriately.	
c	The Committee noted the draft External Audit results report and that the External Audit remained ongoing but would be complete by the end of June 2024.	
ANNUAL ACCOUNTS AND ANNUAL REPORT		
7.	Going Concern Statement 2023/24	
a	The Financial Controller confirmed that there had been no changes to the Going Concern Statement since the draft presented at the last meeting in April 2024. He reminded the Committee that assessment of the Going Concern Statement should be based upon anticipated continuity of the provision of services in the public sector therefore it was unlikely that any NHS organisation would prepare its accounts on anything other than a going concern basis. The key consideration was whether the services it was providing would continue to be provided in the public sector. The Trust could evidence this by reference to the sources and documentation listed in Appendix 1 which set out NHS commitments to mental health and community services and to Provider Collaboratives, including NHS England FY25 priorities and planning guidance.	
b	Mohinder Sawhney commended the thorough work and level of detail available to evidence going concern status, especially in the context and overall environment within which the Trust operated.	
c	The Committee scrutinised the draft Going Concern Statement, which formed the basis for preparation of the statement of accounts on a going concern basis, and confirmed that it was not aware of any material issues that had not been taken into account; the Trust was clearly a going concern and able to continue to provide services and, subject to conclusion of the External Audit and provision of the External Audit Opinion, it was appropriate for the accounts to be presented on a going concern basis; and the Trust had adequate resources to continue in operational existence for the next 12 months.	
8.	Financial Statements and Accounts (audited) 2023/24	
a	The Financial Controller took the Committee through the updated financial statements and the summary document highlighting changes and movement between FY23 and FY24, noting that the final page summarised the changes across the financial statements, disclosure notes and the Annual Report. In relation to Income & Expenditure, he highlighted the impact of:	

	- the PFI exit and the accounting treatment as agreed with External Audit; - updated agency charges; - reductions in impairments relating to year-end valuations of the Warneford and Marlborough House, as agreed with External Audit and consistent with the previous year's approach; and - a reduction in interest charges related to a PFI reclassification.	
b	He commented upon the improvement in adjusted financial performance further to the overall impact of the above and took the meeting through balance sheet only adjustments on the Statement of Financial Position. He also explained a further change which would be made after the meeting today to current liabilities in relation to the PFI exit.	
c	The Chair summarised the position and commented upon the relatively small number of changes, a number of which were to expand upon explanations in the disclosure notes and which generally did not affect the assessed financial performance of the Trust. He noted that buildings would inevitably depreciate over time and valuation estimates would need to be updated accordingly and their impact reflected in the financial statements. The summary of the primary changes to the financial statements had been helpful and had demonstrated that suggestions for refinements from the last meeting had been addressed.	
d	Subject to any material matters arising from the ongoing External Audit, the Committee RECEIVED AND APPROVED the preparation of the Annual Accounts on a Going Concern basis and RECOMMENDED the Annual Accounts to the Board for final approval and submission to NHS England. <i>The meeting took a break for 10 minutes and resumed at 10:50.</i>	
9.	Annual Report 2023/24 and 'Oxford Health in Numbers' (OHIN) publication	
a	The Deputy Director of Corporate Affairs presented: (i) the audited draft Annual Report, including the Annual Governance Statement, and confirmed that there were no significant control weaknesses to disclose; and (ii) the working draft of the 'Oxford Health in Numbers' summary document to supplement the Annual Report & Accounts 2023/24. He also provided an update on the timetable for the laying of the Annual Report & Accounts noting the potential impact of the general election; the Trust was working towards approval at the Board meeting on 26 June 2024, followed by submission to NHS England.	
b	The Committee commented upon its assurance with the comprehensive draft Annual Report. Further to a question from the Chair, the Associate Director of Corporate Affairs confirmed that the Annual Governance Statement had been drafted by the former Director of Corporate Affairs & Company Secretary and she did not have comments to make.	
c	Further to a comment from Mohinder Sawhney on references to gender rather than sex in the OHIN publication, the Chief Finance Officer agreed to review these and share a revised draft with Mohinder Sawhney.	HeS
d	The Chief Finance Officer added that the figures and graphs in the draft Annual Report and the OHIN publication would also be updated to align with the final version of the Annual Accounts. Maria Grindley noted that after Board approval, no further changes should be made except to correct minor typographical errors and External Audit would require assurance that any such changes were not significant. The Chair agreed and noted that	

e	although this year's External Audit process had been commented positively upon, it would still be good practice for the Chief Finance Officer and External Audit to discuss opportunities to make further improvements to the process and report back to the Committee. The Committee APPROVED the text of the draft Annual Report and RECOMMENDED the Annual Governance Statement to the Board for approval and signature by the Chief Executive. The Committee supported and noted the accompanying draft 'Oxford Health in Numbers' publication.	EY/ HeS
RISK, GOVERNANCE & ASSURANCE		
10.	Whistleblowing arrangements annual report	
a	The Chief Finance Officer presented the report on the whistleblowing arrangements in place and which also set out whistleblowing case conclusions and new cases raised over the last nine months. The procedures were designed to encourage concerns to be raised before they became a serious problem and to enable the Trust to recognise and take appropriate action in relation to concerns which may put patient safety at risk. She noted that, further to the Staff Survey, there was a culture of incident reporting and speaking up in the Trust.	
b	The Chair emphasised the importance of joining the dots and piecing together relevant information available to the organisation. Mohinder Sawhney referred to ongoing work by the People, Leadership & Culture (PLC) Committee to develop a dashboard to identify leading indicators which could warn of emerging problems and influence change, rather than reporting lagging indicators which had already happened. The PLC Committee would also be considering the Whistleblowing policy and she invited Philip Rutnam, in his capacity as Non-Executive Director lead for Whistleblowing, to participate in this review.	
c	The Committee commented upon the helpful analysis in the report and the assurance which this provided that appropriate procedures were in place and appropriate investigations had been undertaken when concerns were raised through those procedures. Philip Rutnam however reminded the meeting of the size and complexity of the organisation, especially when taking into account the number of temporary agency staff or transient team members, and cautioned that for effective outcomes, good whistleblowing procedures also needed good organisational culture across many teams with appropriate strength in local management and training. The Chair agreed and noted the importance of local leadership and middle management in promoting and demonstrating a good organisational culture, including meaningful conversations between staff and managers to surface issues and concerns and enable them to be addressed before they became problems. He took confidence from the approach demonstrated by the Executive, the leadership of the current interim Chief Executive and their predecessor and the support of the Freedom to Speak Up Guardians. The Chief Finance Officer agreed with the importance of team culture and empowerment, noting that agency staff were well inducted into the importance of incident reporting; she emphasised that whistleblowing procedures were also not the solution to any problems of poor clinical practice but part of a safety net in support of quality.	
d	The Chair summarised that the report was helpful and provided assurance but noted that in the future there may need to be further development of joint protocols with service delivery partners where there are shared responsibilities along some care pathways and	

e	with the continued development of provider collaborative arrangements across the health system. The Committee noted the report and was assured of the effectiveness of the whistleblowing arrangements in place.	
11.	Board Assurance Framework (BAF) risk deep dive: Financial Sustainability	
a	The Chief Finance Officer took the meeting through the deep dive into BAF risk 3.4 on delivery of the financial plan and maintaining financial sustainability. She highlighted updates across assurances, gaps and mitigating actions, in particular noting the positive changes which had taken place in planning, workforce and financial culture. She commented upon the Trust's relatively stable financial sustainability and the opportunities being taken to mitigate gaps through improving workforce planning capability and transformation programmes to support Cost Improvement Plans (CIPs).	
b	The Committee supported the revised articulation of the risk and the areas identified for action. The Chair noted that the risk operated across two dimensions: (i) the Trust's internal environment, including its management and planning; and (ii) as part of a wider system which has its own financial challenges. Mohinder Sawhney welcomed the inclusion of workforce planning and emphasised the importance of supporting local leaders to develop their financial and budget management skills. The Chief People Officer and the Chief Executive acknowledged the importance of medical engagement and wider clinical team engagement and ownership of financial discipline.	
c	Philip Rutnam emphasised the importance of strengthening processes around business planning, business case development and change management (including the mitigating actions referred to in this risk on use of the Community Transformation Programme and the Mental Health Improvement Programme as wider enablers to support CIPs). However, the challenge may be to address a diffuse organisational culture.	
d	The Committee noted the report and was assured that there was effective management of BAF risk 3.4 on delivery of the financial plan and maintaining financial sustainability.	
12.	Audit Committee annual report	
a	The Chair presented the Committee's annual report and noted Mohinder Sawhney's suggestion to also include reference to Committee members and the wider Board expanding their knowledge and understanding of risk through Board Workshops.	HaS/GD/ CMH
b	Subject to the comment above, the Committee APPROVED the Audit Committee annual report and RECOMMENDED it to the Board for final approval.	
Any Other Business		
13.	Any Other Business	
a	The Chair thanked Maria Grindley for her work and leadership on the External Audit and wished her well for the future.	
	Meeting Close: 11:41	
	Date of next meeting: 03 September 2024	

Minutes of the

Oxford Health Charity Committee – Governance Meeting

Wednesday 7th May 2024 09.30-10.30am, held via. Microsoft Teams

PLEASE NOTE, THESE MINUTES ARE A DRAFT COPY AND HAVE NOT BEEN FINALISED/APPROVED BY THE COMMITTEE

Present:

Rick Trainor (RT)	Non-Executive Director (Chair)
Charlotte Evans (CE)	Executive Assistant (Minutes)
Jane Appleton (JA)	Associate Director of Communication & Engagement
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Charmaine Desouza (CD)	Chief People Officer
Michelle Evans (ME)	Development Manager – Oxford Health Charity
Chris Hurst (CH)	Non-Executive Director
Britta Klinck (BK)	Chief Nurse
Hemashu Kotecha (HK)	Community Fundraiser
Chris Langridge (CL)	Oxford Health Charity Administrator
Julie Pink (JP)	Head of Charity & Involvement
Olga Senior (OS)	External Non-Voting Member
David Walker (DW)	Chair - Oxford Health NHS FT
Michael Williams (MW)	Financial Controller

Guests – present for relevant agenda item:

Dexter Baum (DB)	LGT Wealth Management UK LLP, Investment Manager

Apologies:

Grant Macdonald (GM)	Chief Executive
Danielle Manning (DM)	Oxford Health Charity Finance Manager
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care

1	Introductions and Apologies	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. Georgia Denegri was welcomed to the committee in her role as Associate Director of Corporate Affairs. The meeting was confirmed to be quorate.	
2	Declarations of interest	
	Chris Hurst (CH) raised a new declaration of interest which may be pertinent to matters on the agenda of today's meeting and future meetings. CH has become the chair of Audit Committee and wanted to state there may be areas where matters are discussed that relate to controls etc. and CH would exercise his contribution carefully so as to not compromise his independence. It was also noted that RT is a member of Audit Committee.	
3	Minutes of the Meeting on 7th February 2024 and Action Updates	
	The minutes for the Governance Charity Committee Meeting on 7th February 2024 were accepted as an accurate record of the meeting. There were no comments or amendments to be made and they were formally approved. In regard to matters arising, please see separate action tracker. There are currently the following outstanding actions: • Investment Report – on agenda for discussion today. Michael Williams (MW) clarified this is still an outstanding action with LGT Wealth Management but is not a priority at the moment in relation to the monthly reporting cycle we follow. When we have the report template it would help to move things in the right direction. MW will follow up with LGT as they have done an outline, but we have not seen the full report. Agreed to have it by next meeting in September. • Investment Portfolio Proposal – on agenda for discussion today. • Risk Register – on discussion for today. RT and Julie Pink (JP) to have a catch up before the next meeting in September to see if a separate risk meeting is needed or if the risk register comes to every meeting. • Terms of Reference – these have been approved by the board. Action now closed.	
4	Annual Committee Report	
	The annual committee report was presented in draft form for approval before going to Audit Committee and then the board. The report details activities of the Charity Committee from June 2023 to February 2024. Olga Senior (OS) advised that it looked nice and clear.	

	Georgia Denegri (GD) asked about the need for an annual report as the Charity Committee is not an assurance committee, so it is not necessary in terms of governance. Charmaine Desouza (CD) advised that this can be clarified at some point, but at the moment this has been treated as a sub-committee into how it is organised. There was discussion around corporate trustees, non-executive and executive directors being entrusted with assets and use of public money. It is a matter of good practice to provide an annual report. Also, it is felt it is important that there is some accountability back to the board. It was noted that there is an annual report and accounts submitted by the end of January, so this feels like a duplication. The Committee approved the report and are happy with the contents. The report will now go to Audit Committee.	
5	Investment Report	
	Dexter Baum (DB) joined the meeting to present the investment report. DB advised that the transition from ABDRN & Standard Life Aberdeen plc to LGT Wealth Management has gone smoothly and they are moving clients onto a new portal towards the end of the year. Otherwise, everything has gone well, and they are expanding investment solutions for charities should they wish to change anything. With our investment, nothing has changed in terms of investment restrictions. Nothing has directly changed in terms of our investment solution, which is currently at a medium level of risk. In terms of performance, over the last 2 years the global equities have had quite a volatile time, with bonds in the UK having a tough time and still struggling. Wider markers are being used to give an idea of single asset performance. At the time of writing the report, the portfolio was valued at £485,000. Over the first quarter, this is up by 2.7%, and 20% since inception on 1st August 2019. The portfolio is made up of around just under 60% in equities, and bonds just under 25%. As mentioned, bonds are in a tough place to hold cash as whilst interest rates have risen, bonds have fallen. However, it is not the right time to sell out when in a balanced portfolio. Cash is tactically high. In terms of cash withdrawals, JP advised that after this withdrawal we will be moving to a new request process for charitable grants on a quarterly basis. This will make it easier to have better forecasting over the longer-term. At the moment we are not expecting a withdrawal before or including the autumn.	

	There was discussion on what types of energy we invest in, and how this can link with the Trust's green/sustainability plan. DB advised that energy companies are aware of the need to try to reduce carbon footprints over all of the portfolios and look into renewable energy. Shell and BP are also trying to reduce their carbon footprint. A void in the short-term would be detrimental but in the longer-term we may have a slightly lower carbon footprint. We are actively engaging in a transition to something greener. <i>Please note the revenue for adult entertainment is incorrect and should say 3%.</i> The Committee noted the information provided in the papers and in the discussion.	
6	Financial Management Accounts	
	MW presented the financial management accounts and draft figures for 2023-2024 before there is the independent examination of accounts. The Charity has had a total income of £346,000 for the year. Income from dividends and interest is up by £8,000 on year. Salary costs have reduced from last year by £72,000. This is largely due to a new agreement between the Trust and the charity around ROSY staffing costs which will be around £6,000 less each month going forward. £44,000 has been spent on Lucy's Room and £70,000 has been spent on Charities Together. Investments have seen a positive return of £22,000 compared to a loss of £64,000 last year. There has been a reduction in the value of investments. There has been a significant decrease in the amount received from legacies and grants. Grants are covered in more detail in the Development meeting. There have been some legacies received during the year, including a new legacy of £5,000 for Oxon CAMHS Services. Legacies are covered in more detail later on in today's Governance meeting. It was advised that some of the fund balances have negative balances, which are errors that need to be refined to the commitment figures. MW clarified there is nothing wrong with the figures in the accounts, but the commitment figures appear to have been double counted. RT commented on how the assets and total value of the charities have reduced by about 1/6th. This prompted discussion and it was advised there has been a huge reduction in grants, which was always to be expected due to the increased and high level of grants given during Covid from NHS Charities Together. The fundraising and grants through Covid did inflate income significantly; everyone will be seeing that change in their income and in their reporting this year. NHS Charities Together no longer has	

	surplus money from Covid-related funding. The team are applying for grants regularly, but they do require focused time. JP advised that the quarterly approach for grant making will have a good impact for forecasting and fundraising. The Spring Requests review will be this week which enables us to look at what has been requested and whether any of these requests need to be delayed in order to fundraise for them. It was advised we are moving into a period where we will be much more like NHS Charities, fundraising or seeking grants for projects to deliver them, with funds transactionally coming in and out, rather than having a surplus of funds that we have 'sat on'. CH advised that when looking at things from a longer-term perspective, expectations have changed and we may have an issue around and wanting staff to raise funds, rather than having funds stagnant and not being used how we would expect. <i>Please note the management accounts fund balances are inaccurate in the paper provided.</i> The Committee is asked to note this information provided in the papers and discussion. MW will complete the final accounts for draft approval at the next meeting in September, which will have hopefully been to the auditors in the interim. The annual accounts will then go to the Board and Corporate Trustee in November.	
7	Investment Portfolio Proposal	
	The Committee had asked to be updated on charity investment options and management of those going forwards. Whilst this report does not make any recommendations, it does give options that are available to the charity for investing surplus cash and generating income. Current investment arrangements: The charities investment portfolio is currently managed by LGT Wealth Management (formerly ABDRN & Standard Life Aberdeen plc). Contract start date 29 January 2019 Contract end date 28 January 2024 Extension option 5 years Management Fee £6,728.99 - 1 Jan 2023 to 31 Dec 2023 Opportunities & Risks Investments can go up and down. Other investment options: Charities Aid Foundation: Acting on behalf of charities. Their investment funds are managed by LGT Wealth Management (our current providers).	

CAIF - Charity Authorised Investment Funds:

A CAIF is both an investment fund authorised by the Financial Conduct Authority and a registered charity.

Requires HMRC registration.

For tax purposes the charity would benefit from direct tax exemptions (recover VAT)

Not aware of any NHS Charity setting up a Charity Authorised Investment Fund.

Bank Deposit/Treasury Call a/c

Opportunities & Risks - Low risk and certainty of return, albeit lower than potential stock market returns.

Current rate (Lloyds) 5.14%

Funds can be accessed the same day.

Nearly £7k of interest has been earned against an initial deposit of £255k by the ROSY Fund

£25k potential earnings on current value of investments at 5.14%.

Over last 3 years investment returns have been:

2023/24 £22k profit

2022/23 (£64k) loss

2021/22 £46k profit

Short term fixed deposits:

Funds are placed on deposit for a fixed period. Once funds are tied in, you cannot withdraw the funds, and these are only returned at the maturity date.

Opportunities & Risks - Certainty of return, albeit lower than potential stock market returns, and relatively low risk.

As funds are tied up, cash flow projections will be required to meet charity needs over this period for funds not invested.

Current rate (Lloyds) 5.29% for a 4-week deposit

Management of Investments Options:

External Provider

Advantages

Expert knowledge and expertise

Daily management of investments

Disadvantages

Management fee c£7k

In-House

Advantages

Lower cost and control

Disadvantages

Lack of knowledge and expertise

No additional resources

There would still be a 'manpower' cost.

Other considerations:

If the charity decides to implement a non-investment / stock market strategy, it will have to disinvest its current portfolio.

A hybrid model. This could consist of bank deposits and stock market investments so exposure to investment risk is reduced.

The Committee is asked to note the information provided in the report and discussion, and to consider in order to identify a preferred investment strategy/option.

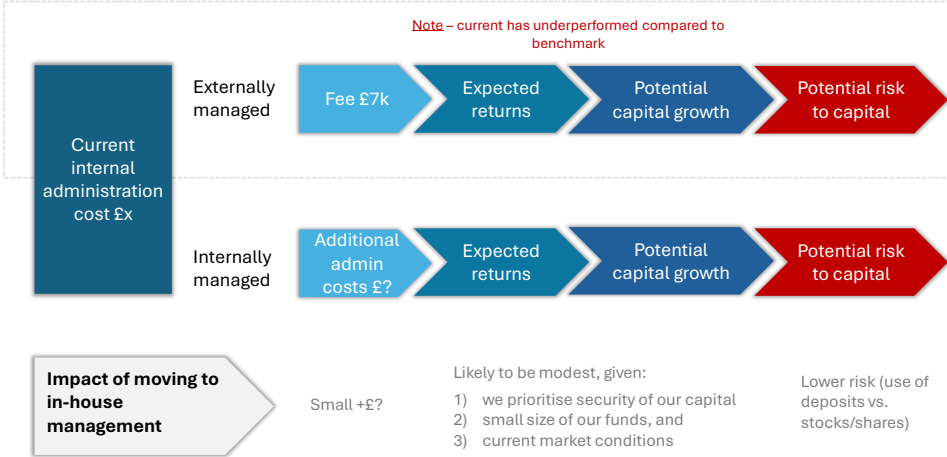
It was noted we are currently on a month-by-month extension agreement.

Jane Appleton (JA) asked about when opportunities arise, such as with ROSY, to swap to a longer-term account that gives better yield, who makes this decision? Does this come to the committee or does someone inhouse make this decision autonomously? It was advised that the decision was made outside of the committee to take advantage of the interest rates at the time.

JP felt there were some good options, and maybe the hybrid approach maybe the right way forward. JP is also attending the NHS Charities Together conference next week, which includes a session on making the most of investments.

CH had been reflecting on the investment proposals and how the current performance of our portfolio is not really meeting the benchmarking average, and as such has underperformed. The current market conditions look uncertain, and how rates will not come back to what we have seen, but the risk is perhaps reduced. It was noted that interest rates are high at the moment, along with the cost-of-living crisis and issues across the country will make fundraising difficult from the public.

CH shared the following diagram as a framework that could be used as part of our decision making:

	 OD raised concern about being 4 months out of contract with our current provider and the urgency for this. This is not good governance, it was suggested. It was agreed that there is a real urgency to this decision, but it is not a decision that can be made quickly. It was agreed that a further discussion in a separate session was warranted, in order to allow a proper discussion and all views taken on board. It could be that external parties are involved to present their offerings, with interested parties/committee members/auditors attending. A finance review meeting is to be arranged ASAP. ACTION. It was raised as to whether Lloyds could feedback at an additional session?	CE
8	Legacies and Inactive Funds Information was provided on the current inactive funds as follows: • Chalgrove and Watlington Surgeries (Fund 3134) – now closed. • OCCG Learning (Fund 3137) – now closed. • Chaplaincy (Fund 4018) – awaiting new head of department to start, meeting to discuss spend to be set up. • South Oxon Psychiatry Training (Fund 4029) – missed meeting with Katrina and Lola due to sickness – to be rearranged and final plan on activity for these funds to be agreed. • Thames Valley Cognitive Research and Education (Fund 4050). • Medical Trainees Training (Fund 4551). • Specialist Child and Adolescent Neuro Psychiatry Fund (Fund 4038). • OFAFE (Fund 4077) – new requests for Carers received in Spring set. • N Bucks Older Adult (Fund 4555) – awaiting meeting with Tina and Donna. A couple of inactive funds have been spent from and then closed down. There are outstanding meetings to take place regarding other inactive funds with fund advisors, to decide on whether to close or to progress.	

	Information was also provided on legacies, which are being worked through by the charity team and solicitors as appropriate: • Lansbury Legacy - £5,000 now received to support Oxon CAMHS Services. • Burridge Legacy – a sizeable legacy shared with other charities but will be supporting ROSY. • Baker Legacy – a potential legacy which is currently sitting with the Charity Commission. If agreed, this will be for community health services with a restriction around location. The Committee is asked to note this information provided in the discussion.	
9	Risk Register	
	There have been no new risks added, however there are still 2 risks that are over and above where we would hope them to be in terms of risk/RAG rating. 1. ROSY Management Transfer: Cause - Move from external fundraising team to internal management for all ROSY activity. Impact - Potential further reductions in fundraising income and wider impact on ROSY service delivery. Effect - Loss of ROSY services. Action - SLA development linked to the CCN team transformation programme alongside new financial approach (to be agreed). Gaps - Agreements on new financial models and SLA discussions have not been possible to date. Larger scale transformation programme for the whole service underway - may have knock on effects. 2. Fund Availability: Cause - Spend high compared to income will result in long term reduction in capital. Impact - Reduction in ability to meet requests for funding. Effect - Impact of charity reduced and may require cessation of spend until further fundraising has taken place. Gaps - Increase in funds coming in still needed to increase fund availability. The Committee is asked to note this information provided in the papers and discussion.	
10	Governance Code and Policy Review	
	This outlined the Charity Governance Code and provided a current gap analysis of the code for Oxford Health Charity. Significant progress has been	

	made since 2023, with the gap analysis now showing six of the eight principles as amber and two as green (compared to the four red, three amber and 1 green of 2023). Work is ongoing around foundational elements and organisational purpose. The communications element to the corporate trustee is improving. However, there are still issues around decision making and risk management. These have been reflected in the Terms of Reference around our diversity, openness and accountability. OS raised a question about independent members, as she has been an independent member for over 8 years and will be leaving at some point. JP and OS to have a discussion around the process of recruiting 3 independent members. ACTION. The Committee is asked to note the information provided in the papers and discussion.	JP/OS
11	Any Other Business/Close	
	It was noted that More Partnership are meeting with some members of the committee and others. The Oxford Health Charity and More Partnership are working together on a project to scope how we can develop major gift donor relationships. This is a really important piece of work for us to ensure we have future capacity to support large scale projects and appeals through the Trust.	
10		
	- 4th September 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting. - 4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting.	

DRAFT

Attendance – Governance Sub-group

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024	May 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓	✓
Non-Executive Director	<i>Chris Hurst</i>		<i>Chris Hurst</i>	<i>Chris Hurst & David Clark</i>	Non-Executive Director	<i>Chris Hurst</i>	<i>Chris Hurst</i>
Amelie Bages					Amelie Bages		
Marie Crofts	✓	✓			Britta Klinck	✓	✓
Kerry Rogers	✓	✓	✓	✓	Kerry Rogers/Georgia Denegri from May 2024	✓	✓
Ben Riley					Ben Riley		
David Walker		✓			David Walker	✓	✓
Julie Pink	✓	✓	✓	✓	Julie Pink	✓	✓
Michelle Evans	✓	✓	✓	✓	Michelle Evans	✓	✓
Michael Williams		✓		✓	Michael Williams	✓	✓
Olga Senior	✓	✓	✓	✓	Olga Senior	✓	✓
Donna Clarke	✓				Donna Clarke		
Donna Mackenzie/ Beth Morphy					Donna Mackenzie/ Beth Morphy		
Zoe Moorhouse	✓				Zoe Moorhouse		
Learning & Development					Learning & Development		
Jane Appleton/Comms			✓		Jane Appleton/Comms		✓
Mark Waring/Ellyn Carnall	✓	✓ & <i>Claire Dalley</i>			Mark Waring/Ellyn Carnall		

DRAFT

Minutes of the
Oxford Health Charity Committee – Development Meeting
Wednesday 7th May 2024 10.30am - 12.00pm, held via. Microsoft
Teams

**PLEASE NOTE, THESE MINUTES ARE A DRAFT COPY AND HAVE NOT
 BEEN FINALISED/APPROVED BY THE COMMITTEE**

Present:

Rick Trainor (RT)	Non-Executive Director (Chair)
Charlotte Evans (CE)	Executive Assistant (Minutes)
Jane Appleton (JA)	Associate Director of Communication & Engagement
Ellyn Carnall (EC)	Operational Support Officer
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Charmaine Desouza (CD)	Chief People Officer
Michelle Evans (ME)	Development Manager – Oxford Health Charity
Chris Hurst (CH)	Non-Executive Director
Hemashu Kotecha (HK)	Community Fundraiser
Chris Langridge (CL)	Oxford Health Charity Administrator
Julie Pink (JP)	Head of Charity & Involvement
Jeremy Philpot (JPh)	Interim Director of Estates and Facilities
Olga Senior (OS)	External Non-Voting Member
David Walker (DW)	Chair - Oxford Health NHS FT

Guests – present for relevant agenda item:

Kate Saunders (KS)	Consultant, Adult Mental Health Assessment & Treatment Team North

Apologies:

Rose Hombo (RH)	Deputy Director of Nursing
Britta Klinck (BK)	Chief Nurse
Grant Macdonald (GM)	Chief Executive
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care

1	Introductions and Apologies	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. Georgia Denegri was welcomed to the committee in her role as Associate Director of Corporate Affairs. The meeting was confirmed to be quorate.	
2	Declarations of interest	
	Chris Hurst (CH) raised a new declaration of interest which maybe pertinent to matters on the agenda of today's meeting and future meetings. CH has become the chair of Audit Committee and wanted to state there may be areas where matters are discussed that relate to controls etc. and CH would exercise his contribution carefully as to not compromise his independence. It was also noted that RT is a member of Audit Committee.	
3	Minutes of the Meeting on 7th February 2024 and Action Updates	
	The minutes for the Development Charity Committee Meeting on 7th February 2024 were accepted as an accurate record of the meeting. There were no comments or amendments to be made and they were formally approved. In regard to matters arising, please see separate action tracker. There are currently no outstanding actions.	
4	Charity Strategy Update	
	Julie Pink (JP) provided an update on the end of year performance for 23/24 and the action plan for 24/25 in relation to the Charity Strategy 23-28. The majority of actions in 23/24 were completed or at least started: given the timelines following approval of the Strategy in late Autumn this is a positive achievement. Those actions not completed have been moved forward into the 24/25 plan with new actions to continue the growth and development of the Charity. A separate Communications Plan and Finance Management Plan are under development for 24/25 and will sit alongside the main action plan with support from the Communications and Engagement Team and the Trust Finance Team.	

	The same format and performance update will come back to each Charity Committee meeting (every quarter), including demonstrating where we are within our KPIs. There was a discussion around the new Charity Appeal Grant Request Process and how this relates to the action plan/KPIs around engagement and meaningful impact. The spring requests have been closed and are due to be reviewed, with the summer requests due to be reviewed early August. JPh asked about requests related to estates and was advised there have not been many requests that are estates related but these will be presented at the Grant Request Review Template and Presentation Meeting this week. CD asked for clear information about bids and the request windows, and it was advised that work is ongoing with communications and Jane Appleton (JA), and it will focus on what happens on the 'charity' journey and when the windows are. It was also advised that some requests can be made outside the window but hoping that most requests are during the window to allow a quarterly approach to requests which is more effective and less reactive. It was noted that the number of requests that were being received on a daily basis had got quite overwhelming. The Committee is asked to note this information provided in the papers and discussion.	
5	Oxfordshire Health Services Research Grant	
	Kate Saunders (KS) attended the meeting to discuss the Oxfordshire Health Services Research Grant (OHSRC). Grants of up to £10,000 are made to salaried staff working within the NHS in Oxfordshire, including those with honorary contracts, and to general practitioners. The OHSRC aims to: • support research to the benefit of the patients of Oxfordshire in the areas of: ○ clinical research ○ community/primary care research ○ relevant laboratory studies • provide opportunities for research by health service workers arising out of, and closely related to, their day-to-day practice.	

	• wholly fund small projects or pilot studies which can be carried out within three years. • provide opportunities for younger researchers who are in the early years of their research careers (this normally means that established researchers are very unlikely to receive an award). The Committee's funding comes from research legacies left to Oxford Hospitals Charity and an annual grant from the Nuffield Oxford Hospitals Fund (NOHF) charity. Some of these funds are specifically allocated to projects focussing on a pre-specified disease area; others are 'open' depending on the wishes of the donor. Funds are limited and awards are made on the scientific merit of the application. The awarding committee is made up of clinical academics, NMAHPS and PPI representatives from across the two NHS trusts, the University of Oxford and Oxford Brookes. To date there has been not specific financial support for OHSRC awards from the Oxford Heath Charity although just under £75,000 has been awarded to mental health-related projects in the past 5 years alone. OHSRC awards have played an important role in the early career development of a number of senior local academic psychiatrists. KS advised that the purpose of coming to today's meeting was to discuss whether the Charity wanted to consider being involved. It was highlighted this would be the first major gift appeal with focused attention on research and supporting research. It was felt this is positive to work towards as there is an agreement that research, education and innovation are important. It was agreed that there is a lot of detail that needs to be worked out regarding the funding, however it was noted it would not be used to fund salaries as this is not done anymore. The committee was asked to approve is asked to approve the request and request for funding. The committee were happy to approve this. Olga Senior (OS) was supportive in principle.	

	CH advised that we should be looking at making immediate progress in terms of the funds we already have, then bring in an action plan and strategy. David Walker (DW) felt we should be do something/progressing ASAP. There will be an audit in terms of whether there are existing funds that could be used in terms of education grants. ACTION. The Oxfordshire Health Services Research Grant will come back to the Charity Committee for further approval. JP and KS to meet to discuss next steps. ACTION.	JP/ME JP/KS
6	Impact Reporting	
	JP provided a summary of project and impact reporting. There were 48 requests in the period of January to March for a total of £28,000. 35 of these were approved, 3 are currently held for a review and 10 were declined. Reasons for requests being declined included: • Projects not approved by other stakeholders. • Error in process for directorate underspend. • Request for staff fleeces. Recent projects/specific appeals have included: • Ward spring celebrations. • Soundproofing at older adult mental health services. • Yoga sessions for inpatients at Cotswold House. • Supporting Trust services with World Parkinson's Day. As mentioned earlier the new charity guidance and application process has launched. Following this, there is a new impact gathering process. This will be scaled for the projects on how wide the impact will be or how big the projects are. CD commented that it is really good to see the breadth and volume of fundraising and activities. The Impact Report and Fundraising/Income Generation presentations from today's meeting will be circulated within the next couple of weeks. The Committee noted the information provided in the papers and discussion.	

7	Fundraising Update	
	There have been successful grant applications including a £2,500 grant secured by the OHAP Team for a pilot music project in inpatient units from the WOMAD Foundation. There has also been a grant application submitted for Volunteering for Health, which we are awaiting a decision on. We are also waiting for decisions on grant applications from NHS Charities Together, GWR for £10,000 to support a partnership project in Didcot with the train station, hospital and District Council and from South Oxfordshire District Council for £8,500 for an arts and nature project. There have been fundraising activities including: • Baking for Oxford Health Charity, raising £617. • 10k for Melksham/West Community CAMHS Fund, raising £530. • Dukes Ukulele Group, raising £270. • Rock Choir Witney, raising £178. • ROSY Walk, raising £13,000. • OSRU Appeal, has now raised funds over there £7,500 target. • Cambridge half for OSRU, raising £1,700. There are future fundraising activities arranged with a 2024 poster created to help engage with staff. Activities include: • The Blenheim 7k in May. • The Bike Oxford in June. • The Inflatable Fun Run in September. • The Oxford Half in October. Information was also provided on legacies, which are being worked through by the Charity team and solicitors as appropriate: • Lansbury Legacy - £5,000 now received to support Oxon CAMHS Services. • Burridge Legacy – a sizeable legacy shared with other charities but will be supporting ROSY. • Baker Legacy – a potential legacy which is currently sitting with the Charity Commission. If agreed, this will be for community health services with a restriction around location. CD commented that it is really good to see the breadth and volume of fundraising and activities.	

	The Impact Report and Fundraising/Income Generation presentations from today's meeting will be circulated within the next couple of weeks. The Committee is asked to note this information provided in the papers and discussion.	
8	Spring Requests Update	
	The new Charity Guidance and Application has launched in line with new Strategy. Each quarter we have a month-long application window (January, April, July and October). A request review panel will be introduced with key stakeholders to discuss and widen awareness of grants being submitted. This will enable fund advisors to review all projects on a quarterly basis, rather than on a first-come-first-served, to ensure precious Charity funds are spent on the most worthwhile projects. April application window has now closed with 21 requests received and to be reviewed. These will be reviewed at the Grant Request Review Template and Presentation Meeting this week. The requests have been for a variety of things, including patient-based activities which fits under the transforming activities area of focus. There are also things that cover well-being and enhanced environment. Feedback on the process has been positive and the new form has been well-received. There are not any issues about the question being asked. OS asked for more information on the panel for the Grant Request Review Template and Presentation Meeting. It was advised there is a variety of stakeholders including representatives from innovation, clinical, estates, learning and development, organisational development and communications. There is also someone from patient experience and expert by experience. The expert by experience will bring a viewpoint from the patients' side around impact. The panel will not be used to make decisions about funding as this sits with the fund advisors. The panel will help the fund advisors to say yes in appropriate cases by looking at whether the project fits in with what our stakeholders are trying to do, what we are trying to achieve or something they were thinking of using Trust funds for. As a Charity we need to ensure we are not duplicating or	

	causing concern. The Committee is asked to note this information provided in the discussion.	
9	Any Other Business/Close	
	It was noted that More Partnership are meeting with some members of the committee and others. The Oxford Health Charity and More Partnership are working together on a project to scope how we can develop major gift donor relationships. This is a really important piece of work for us to ensure we have future capacity to support large scale projects and appeals through the Trust.	
10	Date of Next Meeting(s)	
	• 4th September 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting. • 4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting.	

Attendance – Development Sub-group

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024	May 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓	✓
Non-Executive Director	<i>Chris Hurst</i>		<i>Chris Hurst</i>	<i>Chris Hurst</i>	Non-Executive Director	<i>Chris Hurst</i>	<i>Chris Hurst</i>
Amelie Bages				✓	Amelie Bages		
Marie Crofts	✓	✓			Britta Klinck	✓	✓
Kerry Rogers	✓	✓	✓	✓	Kerry Rogers/Georgia Denegri from May 2024	✓	✓
Ben Riley					Ben Riley		
David Walker		✓			David Walker	✓	✓
Julie Pink	✓	✓	✓	✓	Julie Pink	✓	✓
Michelle Evans	✓	✓	✓	✓	Michelle Evans	✓	✓
Michael Williams		✓			Michael Williams		
Olga Senior	✓	✓	✓	✓	Olga Senior	✓	✓
Donna Clarke	✓			✓	Donna Clarke		
Donna Mackenzie/ Beth Morphy				✓	Donna Mackenzie/ Beth Morphy		
Zoe Moorhouse	✓				Zoe Moorhouse		
Learning & Development					Learning & Development		
Jane Appleton/Comms			✓		Jane Appleton/Comms		✓
Mark Waring/Ellyn Carnall	✓	✓ & <i>Claire Dalley</i>		✓	Mark Waring/Ellyn Carnall	✓	✓

DRAFT

Meeting of the Finance and Investment Committee

Thursday, 09 May 2024

09:00 – 12:00

Microsoft Teams virtual meeting

Apologies to nicola.gill@oxfordhealth.nhs.uk

AGENDA

		Start time	Allocated time (mins)
1. Apologies for Absence, ¹ and quoracy check	LW	09:00	
2. Minutes of Meeting held on 12 March 2024 and Matters Arising (paper – FIC 23/2024)	LW		5
3. Annual Planning & Budget setting			
• Annual Plan and oversight arrangements (paper – FIC 24/2024)	HeS/PT/PM	09:05	45
• Budget			
• Mental Health & Community Directorate spotlights	RB/BR		
4. Financial Management			
• Financial Report M12 (paper – FIC 25/2024)	PM/HeS	09:50	30
• Analytical Review of Financial Accounts Year End (paper – FIC 26/2024)	HeS		
• Capital Report M12: (paper – FIC 27/2024)	HeS		
• Estates Update (paper – FIC 28/2024)	JP		
• IM&T Update (paper – FIC 29/2024)	AC		
<i>Supporting information: Capital Programme Sub-Committee minutes and agenda (to note) - see Reading Room/Appendix (papers – RR/App 09/2024)</i>			
5. Major Projects			
• Warneford Park Programme update (paper – FIC 30/2024)	SC/HeS	10:20	30
<i>Information to note: Warneford Park Internal Programme Board minutes and agenda - see Reading Room/Appendix (papers – RR/App 10/2024)</i>			
• Business Case Review (paper – FIC 31/2024)	PM/HeS		
<i>Supporting information – see Reading Room/Appendix (papers – RR/App 12/2024)</i>			
• Oxford Clinic PFI Exit – Sept 2024 (paper – FIC 32/2024)	JP/HeS		

¹ The quorum for the committee is three members to include at least two non-executive directors (which could include the Chair of the Trust) and at least one executive director to be the Chief Finance Officer or nominated Deputy.
Apologies: None received

- Improving Quality Reducing Agency benefits realisation update (paper – FIC 33/2024)

PM/CDS

Break 10:50 – 11:00 (10 minutes)

6. Operational & Strategic Risks (paper – FIC 34/2024)

- Deep Dive BAF 3.4 Delivery of the financial plan & maintaining financial sustainability (*focus on gaps and actions*)
- BAF 3.14 Major Projects – Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; and unplanned expenses, delays and wasted resources.

HeS/PM

11:00

25

HeS

7. Information Governance, Financial Governance & Other Matters

- Information Management Group (IMG) 3As report (paper – FIC 35/2024)

MU/GD/
BC

11:25

25

*Supporting information: IMG Minutes and agenda – see **Reading Room/Appendix (papers – RR/App 11/2024)***

- FIC Draft Annual Report/Workplan/ToR (paper – FIC 36/2024)

LW

8. Any Other Business: *to include matters referred to FIC from other sub committees*

LW

11:50

9. Brief reflections on today's meeting

LW

Meeting Close

12:00

Date of next meeting: 23 July 2024 09:00 - 12:00 via Microsoft Teams virtual meeting

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted -

10. Capital Programme Sub-Committee minutes and agendas: February 2024 and March 2024 (to note) (papers – RR/App 09/2024)

11. Warneford Park Internal Programme Board minutes and agenda: March 2024 (to note) (paper – RR/App 10/2024)

12. Information Management Group minutes and agenda: January 2024 (to note) (paper – RR/App 11/2024)

13. Business Case Review attachments (papers – RR/App 12/2024)

FIC Attendance 2024/25

FIC - Core members (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Jan-25	Mar-25
Rob Bale						
Amélie Bages*						
Philip Rutnam						
Ben Riley						
Heather Smith						
Lucy Weston						
Attending Board members (voting & non-voting included in quorum)						
Georgia Denegri*						
Grant Macdonald						
David Walker						
Regular Attendees (non-voting)						
Brian Aveyard						
Peter Milliken						
Priya Thompson						
Hannah Smith						

* = non-voting

Meeting of the Finance and Investment Committee

Tuesday, 23 July 2024

09:00 – 12:00

Ascot Room, Littlemore Mental Health Centre, Sandford Road, Oxford. OX4 4XN

Apologies to nicola.gill@oxfordhealth.nhs.uk

AGENDA

		Start time	Allocated time (mins)
1. Strategic approach to Value for Money workshop	HeS	09:00	90
Break 10:30 – 10:40 (10 minutes)			
2. Apologies for Absence, ¹ and quoracy check	LW		
3. Minutes of Meeting held on 09 May 2024 and Matters Arising (paper – FIC 37/2024)	LW		
4. Annual Plan			
• Annual Plan oversight arrangements (paper – FIC 38/2024)	HeS/ PT/PM	10:40	10
5. Financial Management			
• Financial Report (revenue and capital) – M3 (paper – FIC 39/2024)	PM/HeS	10:50	25
• Capital Programme Sub Committee 3As report (paper – FIC 40/2024)	HeS		
<i>Supporting information: Capital Programme Sub-Committee minutes and agenda (to note) - see Reading Room/Appendix (papers – RR/App 12/2024)</i>			
• Review of National Reference Costs – draft return (paper – FIC 41/2024)	HeS		
6. Major Projects			
• Warneford Park Programme update (paper – FIC 42/2024)	SC/HeS	11:15	20
<i>Information to note: Warneford Park Internal Programme Board minutes and agenda - see Reading Room/Appendix (papers – RR/App 13/2024)</i>			
• Jordan Hill update (paper – FIC 43/2024)	SB/JP		
• Oxford Clinic PFI Exit – Sept 2024 (paper – FIC 44/2024)	JP/HeS		
7. Information Governance, Financial Governance & Other Matters			
• Data gaps and data quality assurance report (paper – FIC 45/2024)	CP/ NMCD	11:35	15

¹ The quorum for the committee is three members to include at least two non-executive directors (which could include the Chair of the Trust) and at least one executive director to be the Chief Finance Officer or nominated Deputy.
Apologies: Rob Bale, Executive Managing Director for Mental Health & Learning Disability

- Procurement Report incl Single Action Tender Waiver (SATW) (paper – FIC 46/2024) JL/PM/HeS
- Information Management Group (IMG) 3As report (paper – FIC 47/2024) MU/GD/BC
*Supporting information: IMG Minutes and agenda – see **Reading Room/Appendix (papers – RR/App 14/2024)***
- FIC Draft Annual Report/Workplan/ToR (paper – FIC 48/2024) LW

8. Policies

- Investment Policy (*last reviewed Feb 23*) (paper – FIC 49/2024) HeS 11:50 5

9. Any Other Business: *to include matters referred to FIC from other sub committees* LW 11:55

10. Brief reflections on today's meeting LW

Meeting Close 12:00

Date of next meeting: 17 September 2024 09:00 - 12:00 via Microsoft Teams virtual meeting

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted -

11. Capital Programme Sub-Committee minutes and agendas: April, May and June 2024 (to note) (papers – RR/App 12/2024)

12. Warneford Park Internal Programme Board minutes and agenda: April, May and June 2024 (to note) (paper – RR/App 13/2024)

13. Information Management Group minutes and agenda: April and June 2024 (to note) (paper – RR/App 14/2024)

FIC Attendance 2024/25

FIC - Core members (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Jan-25	Mar-25
Rob Bale	✓					
Amélie Bages*	Apols					
Philip Rutnam	✓					
Ben Riley	✓					
Heather Smith	✓					
Lucy Weston	✓					
Attending Board members (voting & non-voting included in quorum)						
Georgia Denegri*	✓					
Grant Macdonald	✓					
David Walker	✓					
Regular Attendees (non-voting)						
Brian Aveyard	✓					
Peter Milliken	✓					
Priya Thompson	✓					
Hannah Smith						

* = non-voting

MINUTES of the Mental Health & Law Committee meeting held on Monday 13 May 2024 at 0900 hrs via Microsoft Teams

Present:	
Geraldine Cumberbatch (The Chair) (GC)	Non-Executive Director
David Walker (DW)	Trust Chair
Karl Marlowe (KM)	Chief Medical Officer
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Mark Underwood (MU)	Head of Information Governance

In attendance:	
Heather Smith (HS)	Chief Finance Officer
Amy Allen (AA)	Mental Capacity Act and LPS Lead
Brian Aveyard (BA)	Risk, Assurance and Compliance Manager
Rose Hombo (RH)	Deputy Director of Quality
Leanne Dunkley (LD)	Corporate Governance Officer (<i>minutes</i>)

Item	Discussion	Action
1.	Welcome and Apologies for Absence (GC)	
a	The Chair welcomed members of the Committee and confirmed the meeting was quorate.	
b	Apologies were received from Britta Klinck, Chief Nurse.	
2.	Minutes of previous meeting held on 29 February 2024 and Matters Arising (GC)	
a	The minutes of the meeting held on 29 February 2024 were approved as a true and accurate record.	
b	Matters Arising No matters arising.	
3.	Trends in Mental Health Act (MU)	
a	The Head of Information Governance took the Committee through the Trends in Mental Health Act presentation at paper MH&LC 07/2024, which provides an update on: • Mental Health Act activity; • Mental health Act managers; • Duration of detention;	

	• CQC activity and compliance; and • Adequacy of guidance/training on MHA legislation. From the presentation The Head of Information Governance highlighted the following for the Committee to be aware of: • work to alter facilities for Tribunal hearings, is working well, having adapted an area at the entrance to Phoenix and Ashurst Wards. Further work to take place to provide a separate entrance; • an area in the Warneford has been adapted for Tribunal hearings; • a few issues still emanate from CQC review's including the availability of second opinion appointed doctors (SOAD), and occasional issue with responsible clinicians who do not get certification completed in time for consent to treatment purposes; • a few uses of Places of Safety (POS) for an admission facility for short periods, a few stray into 2-3 days whilst awaiting a bed on the ward; • during 2023-2024, there were eight cases where detention was not valid, due to missing signatures and dates of examinations; • lapses of detention, whereby the detention finishes without being discharged by responsible clinician, there are a few of these whereby renewal reminders are missed with CTO's, working with staff to reduce these occurrences; • Improvement overall in training figures, now achieving 80%; • A number of T2's and T3's consent forms have been issued over the past quarter, which are the certificates from a SOAD. Currently 22 SOAD requests outstanding, 24 requested during the past 4 months. Responsible Clinicians are having to rely on section 62 of Mental Health Act which is an urgent treatment provision, mostly to prevent deterioration or suffering by the patient, which provides a legitimate way for them to get treatment, but there continues to be issues with CQC and the availability of SOAD's; • CQC inspections have taken place at Amber Ward, Pheonix Ward, Sandford Ward and Cherwell ward, all of these visits have had the recommendations completed and actions embedded; • White any other group, is the group that is recognised in the Annual Mental Health Act statistics report from NHS digital, as the most overrepresented group in the detentions; • Continue to have data quality issues, with 23.5% of patients who do not have an ethnic category recorded and we are working with Access group and EHR team to develop functionality within Rio to make it easier to record Mental Health Act details; and • Over representation of Mixed or Black British per 100000, ethnicity groups, compared to the white category, which is a recognised national issue;	

b	The Chief Medical Officer asked whether there was a forum where the Places of Safety admission is interrogated and that considers how this is operationally working? The Head of Information Governance explained that this is discussed at weekly safety review and partnership in practice meetings, as this can put increased pressure on other places of safety if the space is required for section 136 use.	MU
c	The Chief Medical Officer, asked regarding Section 136, is often when the police pick someone up and bring to these Places of Safety room, where there is no right of appeal, which leads to someone being detained for hours/days, this seems a disproportionate degree of restriction and does the Places of Safety then go into restrictive practice conversation. The Head of Information Governance clarified that these people are detained under the appropriate section of Mental Health Act, usually section 2 or 3, where the section136 area is being used as an admission bed due to blocks and challenges with admitting them to the acute wards, noting that Section 136 extensions, can be extended for up to 12 hours.	
d	The Committee Chair noted lapses and reminders were being missed and asked what was happening systematically to ensure these were not missed and were embedded? The Head of Information Governance explained that there is an extensive use of reminders through outlook, which provide direct reminders to the responsible clinician, but they are missed at times. The Chief Medical Officer commented that this has not been raised by the CQC during their visits, however this is a complex practice issue. The Head of information Governance noted the majority of these are just lapses and do not represent unlawful practice. However there are a few incidents whereby the detention does lapse and should have been renewed, due to failing to respond to reminders and the difficulty in organising a review, which requires consult with other practitioners. These are few and far between. The Committee Chair noted that it would be beneficial to focus on these renewal ones in reporting.	
e	The Chief Medical Officer asked about Managers discharges, and whether these patients were followed up. The Head of Information Governance confirmed that these patients were followed up and had not encountered any adverse events.	
f	The Committee Chair asked what the themes of the cancelled managers hearings were. The Head of information Governance explained that some were due to staff sickness and others relate to a delay in the	

	availability of reports or the data is out of date and the managers have adjourned until they have sufficient information.	
g	The Trust Chair asked what the risk potential is of those seriously ill individuals that have been discharged who could possibly resort back to dangerous behaviour. The Chief Medical Officer explained that previously Hospital Managers rarely discharged people as it was considered too risky, however following better training, and understanding of the risks then they are able to decisions on discharges. Normally these cases are not of a Mental Health nature, but due to social care in most cases and it is the aftercare that is delaying the discharge and therefore the Mental Health Act should not be being utilised for a lack of care in the community. The Head of Information Governance supported the Chief Medical Officers response and explained that Managers are generally conservative by nature and use discretion and not discharge a lot of the time, it is where risk is considered low that they will not discharge against a responsible clinician's advice.	
h	The Chief Medical Officer commented in relation to Tribunals there is more risk association compared to Managers discharge, with no right to appeal. The Head of Information Governance noted that not many discharges from Tribunal's but will consider that for the next report.	MU
i	The Chief Medical Officer highlighted that the Trust is trying to utilise good patient flow, however sometimes the Mental Health Act in terms of discharge from inpatient to community can be delayed. Previously continuity of care meant that responsible clinician's were the consultant for the patient in the community as well as in the hospital, however there are now functional splits with the consultant being a different consultant to the community consultant, which is monitored by the legislation group and we now have Inpatient Assistant Medical Directors (AMD) who are trying to address the flow issue, as if the community consultant considers there to be a risk in the community then the community consultant delays discharge resulting in the patient staying in hospital longer.	
j	The Chair summarised suggesting that a thematic review of the data concerning ethnicity should be undertaken to consider the types of detention and reasons leading to detention. This would be considered further offline. The Committee noted the report.	MU/GC
4.	Trust Risk Register update (KM/BA)	

a	The Chief Medical Officer took the paper at MH&LC 08/2024 as read which: provides the Committee with information regarding TRR risk 1033 (Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)).	
b	The Chief Medical Officer noted that the Trust Risk Register had been updated at the last meeting and no further update was required today. The Trust Risk, Assurance and Compliance Manager confirmed that there were no changes to risk or mitigations.	
c	The Mental Capacity Act and LPS lead asked whether the Committee had as agreed at the last meeting to recommend the removal of the risk from the TRR. The Chief Medical Officer and the Trust Risk, Assurance and Compliance Manager described the process for this, which has been started and now requires submission Executives to agree to remove this from the TRR and sit on the local directorate risk register, unless the situation changes. The Committee noted the report.	
5.	Mental Health and Law Committee Annual Report, Terms of Reference and Workplan	
a	The Committee Chair took the papers at MH&LC 09/2024 Annual report as read, which highlights the work of the Committee over the past year, asking for comments from the Committee Members.	
b	The Chief Medical Officer noted that he had flagged one area for The Head of Information Governance to comment on, which has now been incorporated into the Draft Annual Plan, and noted that The Deputy Director of Quality should link with the Head of Information Governance and the Committee Chair to consider the Patient and Carers Race Equality Framework (PCREF) as the use of the Mental Health Act is one of the big frames for the PCREF, which our annual plan and workplan should represent.	
c	The Committee Chair noted that the Committee's Terms of Reference (ToR), as part of the purposes of the Committee to have it a bit more explicit regarding equality, diversity, and inclusion (EDI). The Committee Chair will recirculate after the meeting, with amendments. The Chief Medical Officer proposed Health and Equality, which considers population. He also noted that the Managing Director for Mental Health should be a member of the Committee, which the Committee Chair agreed with and will extend the invite to him.	GC GC/LD

d	The Associate Director for Corporate Affairs noted that there is a Committee Chairs meeting scheduled to review all the committee's terms of reference. The Committee noted the reports, to be brought back to the next meeting to be approved.	
6.	Patient Participation Group and PALS update (RH)	
a	The Deputy Director of Quality provided an oral update on the patient Participation Group noting: • this Patient Experience Strategy, which is a 3-year strategy launched in September 2023; • there are 5 key areas within the strategy which include: co-production of care at all levels; ensuring patient voices are heard; enabling lived experiences within the organisation; using feedback to improve services; and promotion and inclusion; • key targets are 82% of patients responding that their care was very good in physical health services, at present 93% responded that their care was very good and 62% of patients to report that their care was very good in Mental health, currently 89% of patients report their care was very good; • I want Great Care (IWGC) is the main mechanism of feedback within the organisation; • considering how we can link the IWGC feedback with the TOBI data; • revised Mental Health Survey, this is the first year collecting data from 16–18 year-olds, using new methodology, which makes it difficult to compare with the data from previous years; • The Trust scored higher than other Mental Health Trusts in 5 questions, and 5 questions we scored lower in comparison. 22 questions were roughly the same as previous years; • overall, the strengths were in having discussions with service users about the purpose and benefits of their medication; number of care plans in place undergoing annual review and offering support to service users whilst awaiting treatment to start; • areas to focus on were; review of assistance to service users accessing care and treatment, need to consider when reviewing service users what additional support may be needed; ensuring service users know who to contact in a crisis on their care plans, this needs to be more specific for the individual rather than a generic go to A&E and reviewing the materials available on accessing services and financial support for service users, which	

	need to be available in differing language and styles so accessible for all; • data is collated from IWGC, complaints and concerns from PALS, patient and family stories used to generate improvement plans; • received 1400 more responses on previous year with an average score of 4.6 out of 5, this shows the Trust is receiving huge amounts of feedback across all services; • currently have 41 improvement projects going on based on this feedback; and • trying to increase response rate from Black and ethnic minority groups to 5% and currently around the 2% mark, so work still to do.	
b	The Deputy Director of Quality, asked whether the Committee would be interested in seeing the reports published for quality committee on patient activity, feedback and complaints, which includes patient experience and carers involvement. The Committee Chair felt that information on feedback and complaints may be helpful to inform other issues and address patient specific issues. The Deputy Director agreed that rather than providing the whole report she could provide an extract from it highlighting the themes.	RH
c	The Trust Chair noted that it is duplication, and we need to watch that we do not go beyond the remit of the Committee, which is are they being legally maintained.	
d	Patient Carer Equality Race Framework (PCERF) • framework to be implemented by end of April 2025; • three main components to the framework; • launched a PCREF Board, which has had its first meeting and The Chief Nurse and Managing Director for Mental Health & Learning Disabilities Lead; • key actions and project plan have been developed and are currently recruiting patients and carers to join the group; • joint partnership work with Berkshire at ICB level; • receiving mentorship form NHS England; • key activities to complete within the next 12 weeks one of which is how we increase the ethnicity data, including educating staff to have ethnicity conversations with patients, the second component is around EDI strategy and the third is around how we use the feedback to improve.	
e	Complaints and Compliments:	

f g h	• 229 complaints received in 2023-2024, an increase of 29 on the previous year; • the highest number of complaints this year was received in Q2; • most of the complaints received a response within 3 days as per national timeframe; • a number of delays in terms of investigation and responding, which should be addressed with the new complaints' standard; • over 500 more compliments received this year; • recurrent themes from complaints are similar to previous years, which include: insufficient care and support in the community, staff attitude and behaviour, lack of communication, poor sharing of information across teams and other agencies and waiting times and access; and • new national complaints standards are being implemented, which has an early resolution stage to address complaints and concerns locally and if after 15 days that is not successful moves to a low-level complaint, finally to a serious complaint. The focus of this is to focus more on learning and less on the investigation. The Chief Medical Officer noted that the content of the update was very interesting, however for this Committee the focus needs to be on mental health and law components that are relevant. Is there a reference or triangulation that involves the Independent Mental Health Advocates as part of the PCERF group. The increased representation of Expert by Experience in sub-committee boards is positive, and there is a discussion about where these experts by experience should sit to provide assurance to the Board that there is good engagement. The Deputy Director of Quality updated the Committee that the current advocacy provider has changed to VoiceAbility, which has resulted in the Trust not receiving the quarterly report yet. The new provider took over between February and March, however communication with the new provider was initially difficult, however meeting dates have now been scheduled so that we can work together and getting their attendance at the PCERF meetings. The Chief Finance Officer noted that with the missing data on ethnicity, particularly in those detained under the Mental Health Act, that this could be a good area for The Deputy Director of Quality and The Head of Information Governance to consider working together to achieve more than a 5% increase in the reporting of ethnicity. The Mental Health Act and LPS lead suggested that she attends the meetings scheduled with VoiceAbility to get an overall picture of the position.	RH/MU AA/RH

i	The Trust Chair noted that should contact VoiceAbility continue to be difficult then need to consider going back to the commissioners, as we want to ensure that statutory functions are fulfilled, as there is a danger that the work needing to be completed is not happening and he would be happy to link with colleagues to address this.	RH/KM
j	The Chief Medical Officer asked for feedback following the first meeting with VoiceAbility, so that timeframes can be considered and report it back to the Committee for assurance that patient's voices are being heard. The Committee noted the update.	RH/KM
7. a	Mental Capacity Act & DoLS update: (AA) The Mental Health Act and LPS lead took her report at MH&LC 10/2024 as read which provides an overview of the application of the Mental Capacity Act and DOLS within the Trust, highlighting: • From April this year we have started collecting ethnicity data in relation to DoLS, the national DoLS data, published by NHS Digital is published every August, so will provide an update to the Committee following its publication at the November Committee meeting; • Steady number of requests for DoLS coming in with approximately 20 live requests at time, the overwhelming group is older age adults, with more females than males and mainly those from a white British ethnicity, which is in line with the England, Southeast region, and Oxfordshire County Council data from 2022/2023; • Training level now steady at 75%-80% compliance in Mental Health Act training and the face-to-face training for the junior doctors is going well; and • The Mental Capacity Act policy is due for review in July 2024, so it will be brought back to the Committee in July for approval.	AA
b	The Chief Medical Officer commented that the training in the community hospitals is fantastic. The Mental Health Act and LPS lead explained that she has been visiting the wards to deliver it face to face and allows it to be tailored to the patients on the wards and has also been undertaking some bespoke training within teams such as the Learning Disability team. Upskilling the safeguarding team is the next step. The Committee noted the update	AA

8. a b c	Use of Force Act update: (KM) The Committee Chair noted that apologies had been received by the Chief Nurse and no paper has been submitted. The Head of Information Governance noted that the use of Force Act has a hefty information component to it that the Committee will hear about at a future meeting as there is a lot of information that will need to be collected and submitted as part of this. The Committee Chair responded that it would be good to consider how to use existing data sets to obtain some of this information and will need a focus on this at the next meeting. The Committee noted the update	
9. a	Legal and Regulatory update (GD) The Committee Chair and Associate Director of Corporate Affairs agreed that no update was needed at this meeting.	
OTHER BUSINESS		
8. a b	Any other business MU updated the Committee that the Trust has recruited a few more Associate Hospital Managers, and training will begin this week. Actions: • ToR to be taken offline before sign off at the next Committee meeting; • Invite the Managing Director for Mental Health and Learning Disabilities to future meetings; • Committee Chair to discuss offline with Deputy Director for Quality and Head of Information Governance to consider reports; • Mental Health Act Policy is due a review, to be brought back to July meeting; and • The Trust Chair to raise concerns with Council around VoiceAbility contract.	CG/KM/GD GC/LD GC/RH/MH AA
9. a	Meeting Review (ALL) None.	
10.	Meeting Close	

a	There being no other business the meeting closed at 10:38 hrs.	

****The next meeting is scheduled to be held on Tuesday 16 July 2024 at 0900 hrs via Microsoft Teams****

DRAFT

Meeting of the Mental Health & Law Committee

Tuesday, 16 July 2024
0900-1100 hours

Microsoft Teams Virtual meeting (invitation only)

Apologies to Leanne Dunkley, Leanne.dunkley@oxfordhealth.nhs.uk

AGENDA

1. Welcome, apologies for absence and quoracy check <i>(defined as 4 of the membership to include at least one Non-Executive Director and at least one Executive)</i>	Chair	09:00
2. Minutes of the Previous meeting (paper MH&LC 11/2024)	Chair	09:00
3. Trends in Mental Health Act (paper MH&LC 12/2024) 09:05 <i>To include updates on:</i> • Mental Health Act Managers • CQC Activity/Compliance • Adequacy of guidance/training on MHA legislation	MU	
4. Trust Risk Register update (paper MH&LC 13/2024)	KM/BA	09:30
5. Draft Annual report (paper MH&LC 14/2024) • Draft Terms of Reference • Workplan 2024-25 v1	GC/KM/GD	09:40
6. Patient Participation Group & Pals update (oral update to include themes form complaints)	Rose Hombo	09:50
7. Mental Capacity Act & DOLS update (paper MH&LC 15/2024) (to include Mental Health Act Policy Review for sign off)	Amy Allen	10:00
8. Use of Force Act & Restrictive practice Update (oral update)	BK/DM	10:10
9. Mental Health Managers Story (paper MH&LC 16/2024)	KM	10:20
10. Inpatient Mental Health Survey (paper MH&LC 17/2024)	KM	10:35
11. ~~True For Us Report~~	~~GD~~	~~10:45~~
Any Other Business		
11. Any Other Business (oral discussion)	All	10:45
Meeting close		11:00

Date of next meeting: 16 July 2024, 09:00-11.00

Mental Health & Law Committee
Member Attendance 2024 - 2025

Name	18 April 2024	16 July 202	15 Oct 2024	2025
Geraldine Cumberbatch (Chair)	✓			
Amy Allen	✓			
David Walker (Trust Chair)	✓			
Britta Klinck	Apologies			
Karl Marlowe	✓			
Georgina Dengie	✓			
Mark Underwood	✓			

Regular attendees

Rose Hombo	✓			
Leah Awi				
Brian Aveyard	✓			

People, Leadership and Culture Committee
10 July 2024, 09:30 – 13:00, via MS TEAMS

Agenda

Item no:	Item:	Action: (for approval/ information/ assurance)	Paper / Reading Room/ verbal	Presenter:	Time:
1	Welcome, introductions, apologies and quoracy Apologies: Britta Klinck (Angie Fletcher in attendance) Observers: Sri Sabapathy (Governor) Evin Abrishami (Governor) Laura Bartlett (Retention Programme Lead) Joe Smart (Head of OD)		Verbal	MS	09:30
2	Declaration of Interests	For assurance	Verbal	MS	
Voice of slot					
3	Project to use machine learning to triage and process assessments for young people with neurodiversity	For assurance	Discussion	Emma Ferguson	09:35 30m
4	Minutes of previous meeting on 30 April 2024	For approval	PLC 42(i)/2024	MS	10:05
5	Action tracker and matters arising from the minutes	For assurance	PLC 42(ii)/2024	CDS	
Matters arising - actions/updates from previous meeting					
6	Establishment update (total figures by role type and separate non-clinical roles)	For assurance	<i>RR/App 01/2024</i>	CDS	
7	Guardian of Safe Working hours Update with clarification on where/to whom the issues raised in the report go and to receive a response from them on these issues	For assurance	<i>RR/App 02/2024</i>	CDS	
8	EDI HIAs - Confirmation summary that all 7 recommendations of Mend the Gap have been completed as suggested in the last meeting. - Additional columns for improvement and meeting of the requirement to be added to the tracker document	For assurance	<i>Included within RR/App 09(ii)/2024 on pages 8-11</i>	CDS/ MPI/ HD	10:15 5 mins
9	HR Operations Casework report To include analysis as to what is driving increases in Disciplinary & Grievance cases	For assurance	<i>RR/App 03/2024</i>	CDS/ ZM/JC	10:20 5 mins

10	Retention update To include: - Update on the design principles that will be used by the Trust in relation to a more targeted approach to retention e.g. protected characteristics, locations, professions. - To advise the committee on the performance against the Trust improvement plan. - Updated analysis to see comparative data within Trust against national and BOB data. - To advise on key topics of concern and any units of concern and how we are addressing / supporting these areas, as well as local and national comparators. - Update on coaching of corporate teams - FTSU comparators	For assurance	PLC 44/2024	CDS/ LB	10:25 10 mins
11	Staff Survey analysis	For assurance	PLC 45/2024	CDS/ BM	10:35 10 mins
People insights					
12	People Insights Report Associated risks: -Succession planning, organisational development & leadership development (BAF 2.3) -Workforce planning (BAF2.1 / TRR1020) To provide assurance on key people performance activities, and to be assured the Trust is able to identify and respond to emerging and current issues.	For assurance	PLC 46/2024	AB	10:45 10m
13	Workforce Report – Data packs - Summary data - HR & L&D - Whole Trust - Mental Health - Community Services - To assure the Committee of escalations of actions/interventions that haven't been delivered against the people element of the 2023/24 Annual plan.	For assurance	PLC 47/2024 + RR/App 04/2024	CDS SB EL RB	10:55 10m
Equality and Diversity					
14	EDI Race QI programme updates Assurance on 3 EDI Race focussed QI programmes of work	For assurance	PLC 48/2024	CDS/ MP	11:05 10m
15	WRES and WDES Reports Update on the analysis of the latest WRES and WDES data – the areas of improvement, areas where there has been no change and areas where our position has worsened. Together with an outline of when we will have in place a Race Equality Action Plan and Disability Action Plan for 2024/25.	For assurance	PLC 49/2024	CDS/ MP	11:15 15m
BREAK					11:30 (10m)

Risk management					
16	Strategic and Operational Risks - To provide an update on revised Workforce risk. - To provide an update on the BAF Retention Risk	For assurance	PLC 50/2024	HS/BA	11:40 15m
17	Temporary Staffing update Associated risks: -Retention of Staff (BAF 2.5 / TRR 1146) -Recruitment (BAF 2.2/TRR 1019) To ensure the Committee is assured that: - Confirmation of the ceiling target set by NHSEI and the directorate agency targets that have been set to comply with the ceiling target - underlying dynamics of Agency use increasingly understood and improving strategies to address - Performance against plan being managed and course corrected - Interdependence with other Trust initiatives identified - Focus on reduction of long lines of Agency and related actions - Overview of NHSP Improvement plan	For assurance	PLC 51/2024	CDS/ DW/ JB	11:55 15m
18	E-Rostering improvement plan Update on plan to improve e-rostering generally and with specific reference to supporting the reduction of agency usage and a bank first approach.	For assurance	PLC 52/2024 + RR/App 05/2024	SB	12:10 10m
19	Medical Appraisal & Revalidation Report - To assure the Committee that the statutory functions of the Responsible Officer are being appropriately and adequately discharged. - To report on performance in relation to those functions; to update on progress since the 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks.	For assurance	PLC 53/2024	KL/AB	12:20 15m
20	International Nurses Recruitment – review of the centralised programme to recruit Intl Nurses To review the achievements and challenges of the IR programme over the last three years with particular reference to retention and promotions that have been achieved.	For assurance	PLC 54/2024	BE	12:35 10m
For information only – Papers in Reading room					
21	PLC Workplan	For assurance	RR/App 06/2024	CDS	
22	Highlight / Escalation Reports - People Steering Group (ZM) - Education Strategy Group (prev. LAG) (BE) - EDI Steering Group* (MP) - People Systems Programme Board (SB)	For information	RR/Apps 07/2024 08/2024 09/2024 10/2024		

	e. Health & Safety Committee (JP) <i>*EDI H&E Report to include full HIA update</i>		11/2024		
23	ER Casework review Report (papers PLC(i)+PLC(ii)/2024) Associated risk: -Staff Wellbeing (TRR 1018) To ensure that PLC has sight of numbers of staff currently suspended; and that their wellbeing is being supported	For assurance	RR/App 12/2024	JC/ZM	
24	HR Whistleblowing Policy To review progress of Whistleblowing Policy so PLC can onward assure the Board of its current format and its next update.	For assurance	RR/App 13/2024	AB	
	Closing				
25	AOB		Verbal		12:45 10m
26	New risks identified and actions for other Committees and the Board	For assurance	Verbal		12:55
27	Date of next meeting October 16 th , 2024 13:30 – 17:00				
	Meeting close				13:00

Meeting of the Oxford Health NHS Foundation Trust Quality Committee

**Minutes of a meeting held on
Thursday, 02 May 2024 at 09:00**

virtual Microsoft Teams meeting

Present¹:

Core members and attending Board members included in quorum

Andrea Young	Non-Executive Director (Committee Chair) (AY)
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (RB)
Britta Klinck	Chief Nurse (BK)
Grant Macdonald	Chief Executive (GM)
Karl Marlowe	Chief Medical Officer (KM)
Ben Riley	Executive Managing Director Primary, Community & Dental Care (BR)
Georgia Denegri	Associate Director of Corporate Affairs (GD)
Heather Smith	Chief Finance Officer (HeS)
David Walker	Trust Chair (DW)
Lucy Weston	Non-Executive Director (LW)

In attendance²:

Brian Aveyard	Risk Assurance and Compliance Manager (BA)
Helen Ward	Head of Quality, BOB ICB representative (HW)
Leanne Dunkley	Corporate Governance Officer (LCD) (minutes)
Benjamin Cahill	Deputy Director of Corporate Affairs (BC)
Mike Hobbs	Public Governor (MH)-part meeting
Hannah Smith	Assistant Trust Secretary (HS)-part meeting
Rose Hombo	Deputy Director of Quality (RH)
Jane Kershaw	Head of Quality Governance (JK)
Angie Fletcher	Deputy Chief Nurse (AF)
Tina Malhotra	Clinical Director, Buckinghamshire Mental Health Directorate (TM)
Michael Marven	Chief Pharmacist and Clinical Director for Medicines Management (MM)

¹ Members of the Committee. The membership of the committee will include executive director members and at least two non-executive directors. The quorum for the committee is five members to include the chair of the committee (or the vice chair of the committee in their absence), one non-executive and one executive director. Deputies will count towards the quorum and attendance rates. Deputies for the chairs of the quality sub-committees (the named vice chair of the sub-committee) will attend in an executive's absence. Non-executive director members may also nominate a non-executive deputy to attend in their absence.

² Regular non-member attendees and contributors.

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Pete McGrane	Clinical Director, Community Services (PMcG)
Claire Forrest	Head of Clinical Standards (CF) <i>part meeting</i>
Lola Martos	Interim Clinical Director Older Adults Mental Health Teams (LM)
Rami El-Shirbiny	Clinical Director Forensic Services (RE)
Etelvina Ferreria	Lead Infection Prevention and Control Nurse (EF) <i>part meeting</i> .
Helen Bosely	Nurse consultant Infection Prevention and Control (HB) <i>part meeting</i>
Emma Leaver	Service Director Primary, Community and Dental Services (EL) <i>part meeting</i> .
Nicola Taylor	Senior Clinical Lead for Children and young People Service (NT) <i>part meeting</i>

1.	Apologies for Absence	Action
a	Apologies for absence were received from the following Committee members/Board members: Amélie Bages, Director of Strategy and Partnerships; and David Clark, Non-Executive Director	
b	Apologises received from Bill Tiplay and Rosalind Mitchell	
c	The Chair confirmed the meeting was quorate.	
2.	Minutes of the Quality Committee on 9 November 2023 and Matters Arising	
a	The Chair welcomed all to the meeting and introduced the new Associate Director of Corporate Affairs to members of the QC.	
b	The minutes at QC 15/2024 Minutes of the Quality Committee (QC) on 02 May 2024 were confirmed as a true and accurate record.	
c	Matters Arising The Committee noted that the following actions were on today's agenda: 3(k) Quality and Safety Dashboard with further data reporting on waiting times; 4(b) Board to Ward Governance flowchart; 9(f) BAF 1.1 Triangulating data and learning to drive quality improvement; 6(c) Patient and Carer Equality Framework; 10(d) Health and Social care Gap analysis, the Annual Director of Infection Prevention control, with further assurance being provided that the IPC committee is reviewing regularly; and 9(g) Separating the Trust Risk Register TRR and Board Assurance Framework BAF, the committee has discussed this, and they will continue to receive a report of the TRR and directorates Risk register which are discussed at the wider extended leadership team.	
d	Therefore, these actions could be closed.	

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e	The Chief Nurse provided the Committee with an oral update on the following items on the matters arising: 3(b)-Weigh Forward Buckinghamshire, the service continues to run on the capacity available, with no clinical risk associated with that. It is not possible to implement a waiting list management system within this service as it is a small service with capacity to accept 100 referrals per year at present. This remains a service that the ICB are being asked to take a view on as the demand is outstripping capacity. The Chief Nurse highlighted that the demand for this service has increased largely due to the new medications available to support weight loss and the requirement for psychological therapy before prescribing. It was noted by the Clinical Director for Community Services that the Trust is working with the ICB to consider how bariatric services can be integrated into community-based services.	
f	The Chair summarised that the evidence highlights that bariatric patients are a high-risk group, often have a shorter life expectancy and those with mental health conditions should be a high priority group. The Committee agreed to close this action and bring back any risks in relation to the service.	
g	3(e)Resuscitation training, the Chief Nurse noted that an update report was provided to the Quality Clinical Governance Sub-committee (QGC-SC), which identified changes being made that will help going forward. At present the training figure is around 65% across the Trust, and Intermediate Life support is at 73%. Mitigations are in place across all inpatient wards to ensure that there are always suitably trained staff on shift. At present there is no timeline, as there are changes being considered by the Resuscitation Council around technical issues of directors being present to qualify the training. The QCG-SC have been asked to provide a timeline at the next meeting to show the projection of when the Trust will be able to meet the demand for resuscitation training, which will be brought to this Committee in July.	BK
h	The Committee agreed to keep on the action log.	
i	The Committee noted that the following actions remain: 3(0) Safe Staffing report to be brought back to the July Committee meeting, including the work around in reporting on long days; 6(b) Quality Account has been deferred as it requires more work to make it accessible and change the format. Not due to be published until the end of June, which is before the next Quality Committee meeting, so will be circulated to Committee members outside of this meeting. The Quality Account does not contain any items that have not already been reported to this Committee;	BK ALL

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	9(f) BAF 3.1 scheduled as a deep dive in the risks report for July meeting; and 5(d) Mental Health, Learning Disability and Autism inpatient Quality Transformation programme due to come back in July as part of the deep dive and the Annual report to be brought to the September 2024 meeting. The Committee Chair welcomed Mike Hobbs, Governor observer to the meeting.	GD/BA/HS BT/AF
SAFETY		
3. a	Quality and Clinical Governance Sub-Committee (QCG-SC) escalation report Quality and Safety Dashboard: The Chief Nurse took the Papers at QC16(i)(ii), as read which provided a summary of the areas discussed at the Quality and Clinical Governance Sub-committee meeting on 30th April 2024 and highlighted matters for the Committee to note and key escalations, which closely aligns with the Quality and Safety Dashboard with each informing the other. The wards and team particularly struggling are highlighted in the Dashboard with the mitigations and actions being taken. The two escalations raised today are: - the shortage of substantive nursing, medical and therapy staff across the Trust; and - timely access to treatment and services across the Trust. The Chief Nurse noted that on the whole fill rates are achieved through the high use of agency staffing, which is impacting on quality and continuity of care and places additional burden on substantive staff. The Chief Medical Officer noted that this report is triangulated with incident reporting, which highlights that Ruby ward has seen a significant reduction in incidents despite staffing vacancies and secondly, District nurses (DN's) where there are demand and capacity issues have seen a reduction and stabilisation in the number of acquired in service pressure damage. There has also been a significant improvement in the fill rate for the GP out of Hours service through bank and agency use.	
a		
b	The Trust Chair commented that a senior psychiatrist had commented that the services they attempt to provide in the City Adult AMHT team are not safe, which if correct needs to be addressed and a response provided to the individual so that the Trust is not seen to be normalising a lack of safety. The Chief Executive commented that safety is not a binary thing and that this service has been monitored through the Dashboard for around 6 years, with mitigations in place regarding safety concerns, from benchmarking of incidents through to the mortality group review there is no indicator suggesting this service is less safe than other services. It would be worth considering as a Trust whether there is more that could be done to mitigate or reduce the risk. The Chief Medical Officer noted that an increase in incident or investigations in this service has not been seen, however an increase in complaints had been noted which is being triangulated in comparison to the size of the team. The number of medics in the team has remained stable, however there is high turnover of Care Coordinators.	

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c	LW challenged the Committee as to the confidence in the mitigation in place and whether there is a risk of complacency and something different needs to be considered. The Executive Managing Director for Mental Health and Learning Disabilities replied noting that high turnover of non-medical staff in the city is one of the biggest challenges and experienced staff are needed to support and develop new starters, which puts additional demands and pressures on the team. There will always be fluctuation in staffing, which the team managers are managing, however there is nothing in the triangulation of data to suggest that there is an increased safety issue at present. LW noted that this was reassuring, however asked if the Committee was confident that the root of the problem has been identified and the service is receiving the right support and attention to turn it around. The Chief Executive replied that this is a good prompt to take a deeper look at the service and review the mitigations to obtain an objective review and see if more can be done. An update of this review will come back to the July meeting, He noted that more challenge on the issue of community nursing was also appropriate. The Chair added that the City AMHT was discussed a year ago and the recruitment and retention team were asked to support them. In relation to community nursing, there are concerns with this service, however there are no vacancies, it is a shortage of staff as the Trust is under commissioned, which is a risk that is being held with the ICB, who are actively involved in triage and prioritisation conversations, however it remains a risk that the Committee continues to feel concerned about.	BK/AF
d	The clinical director for Community Services noted that there is 26% commissioning gap in community nursing, which equates to 62 whole time equivalent nurses, which would not be easy to fill even if there was the budget to do so. This is a system wide issue, with no easy resolution, having maximised effective skill mix. Work continues with the ICB, but to assure the Committee that pressure related harm is taken seriously and there is no normalisation of this in the context of the challenges the service faces. The Chief Nurse noted that pressure related harm is reported weekly and two thematic reviews have taken place into pressure related harm. Some of the stabilisation seen is related to the changing criteria for Grade 3 and Grade 4 pressure damage. The dashboard is enabling us to triangulate data to identify quality risks.	
e	The Chief Executive asked whether the Meadow and Highfield units had been discussed at the QGC-SC? The Chief Nurse confirmed that they had and that a deep dive into the Meadow unit is due to be presented at the May meeting and a deep dive into restrictive practice across the CAHMS wards is due to be presented in June. This is the first time that the Meadow unit has been flagged on the Dashboard. Vacancies is the main driver for the eight wards flagged on the dashboard this month. This is also the first month that waiting times have been on the dashboard, as previously been unable to report on this, although not meaningful data at present as unable to show the trajectory of how those waits are moving. She also highlighted that there was lots of transformation taking place in DN teams, who have recently presented to the CQC. It is important the Trust	BK/AB

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f g h i	continues to review and learn from incidents to ensure that it is sighted in emerging issues and risks to ensure that the Trust is operating in a safe way. The Chair asked whether there was any intelligence as to the increasing vacancy rate in mental health community teams. The Chief Nurse explained that that there have been challenges in the community for some time, however we were less sighted on them as there has been a focus on fill rates on wards, which has had an impact on community teams affecting the continuation of care. There has been success in the Trust growing their own nurses from nurse associates, but small numbers compared with what is required. There are specific challenges in certain areas of the Trust, such as being close to the London weighting. The Chief Executive noted that it is important not to lose focus of the fact that the Trust has grown the clinical workforce by over 1000 staff since 2019, with no change in supply into community mental health services and new types of teams, vacancy rates remain a national issue. The Chief Nurse is reviewing the safe staffing report against the findings from the Greater Manchester Mental Health Trust review, which will be brought back to the Committee in due course. Included in the report is Care Hours per Patient Day (CHPPD) diagram, which rates Oxford Health Foundation Trust as having the highest number of registered nursing hours, above the national average, which demonstrates the Trust does fill staff gaps. b. Patient Safety Incident Report including Mortality and Homicide Reviews. The Chief Nurse took the paper at QC 17/2024 as read, which provides an update to the Committee on: • Incidents identified under our Patient Safety Incident Response Plan; • All severe and moderate incidents and suspected suicides at a glance; • Oversight of current Investigations and Reviews; • Incident Learning Huddles; • External/ System reviews; • Internal Thematic Reviews; • Learning from completed reviews including deaths; and • Update against the National Patient Safety Strategy. The Chief Medical Officer updated the Committee that the Patient Safety partners are now established and as they start reporting, with a different perspective, it may be something for the Committee to review later in the year. LW asked how the Committee could be assured on the effectiveness of the changes and mitigations put in place, and that this is working better than the old practice. The Chief Nurse replied by explaining that this new framework will help to identify recurrent themes and take a quality improvement approach. The quality improvement and learning group oversee the themes and the quality improvement projects linked to them, to review the test of change. The Chief Medical Officer added that previously a root cause analysis approach was used, however there is no evidence to suggest that this method makes improvements paradoxically. This is a very different system of systemic learning, and clinical directors are starting to see the shift in culture and are receiving	KM

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j k l m n o	positive feedback. The Committee Chair confirmed we will review the new approach at this committee in 12 months' time. The Chief Nurse noted that moderate harm has increased, however this is likely to relate to a change in the way in which moderate and severe harm are reported, as the categories have changed. c. Positive and Safe The Deputy Chief Nurse took the Report at QC 18/2024 as read, which provides an annual summary on the use of restrictive practice within the Trust and demonstrates that the Trust has robust monitoring and assurance arrangements via the Positive and Safe Committee. The Committee also serves to identify and act on opportunities to reduce restrictive practises and oversee and monitor the progress of specific improvement projects for the minimisation of their use. An update of PEACE training levels compliance is also included for information and assurance of progress. The Chief Executive asked whether rapid tranquilisation is a practice issue rather than a patient issue as one of the wards drawn out in the report was an older adult's ward and female ward. The Deputy Chief Nurse responded by saying it is likely linked to a practice issue and how we approach things, or how equipped staff feel to manage in that situation. More work is needed to understand the rapid tranquilisation on the older adult ward. The Chief Nurse added that these wards have had more acute patients, and they report a changing patient group over the past few years, however it warrants deeper understanding and review. The CAMHS wards show to have high levels of restrictive practice, as head banging had been a big issue within these services, which causes high anxiety within the staff group. The Chief Medical Officer offered to attend the Positive and Safe Committee, to gain better understanding, as it could be that the use of pre-agreed proactive use of medication in collaboration with the patient may have been agreed rather than rapid tranquilisation, which could be an issue in relation to the terminology used. It was agreed that this would be reported upon in the July meeting to better understand the use of rapid tranquilisation on the CAMHS and older adult ward. LW asked for clarity as to when the use of prone restraint and rapid tranquilisation would be considered acceptable and when it would not. The Chief Nurse explained that our wish would be zero use of restraint and rapid tranquilisation, however with the acuity of patients and a reduction in the number of beds, which means that patients present with severe illness, that has not been the case. It is about ensuring staff are practising the least restrictive	BK KM/AF

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p	manner possible, there is no set criteria. The key is understanding why it occurs and what is driving the data. The behaviour needs to be challenged alongside the data to learn how we could change practice or offer a medication earlier. The Chief Pharmacist and Clinical Director for Medicines Management echoed the Chief Nurse's comments, highlighting that when rapid tranquilisation is used appropriately it can be very effective, so it is not always a bad thing. One of the key reports following the rollout of the eMPA will be the prescribing of rapid tranquilisation in real time which will help to inform discussions. The Chair summarised that it would be good to see this data for the July meeting to understand the complete picture of how the practice is being used and whether it is supportive or not. The national target is a reduction of 25% in restrictive practice over the next three years, which at a high level the Trust appears to have achieved, however it does not show a sustained reduction at this point. The Chief Nurse confirmed that the deep dive into restrictive practice across CAHMS wards would be reported on in July. Committee noted the reports.	BK/MM BK
4. a b c d	Deep Dive Trust Response to 0-19 services commissioning framework and response to SEND review. EL provided an oral update on the Special Educational Needs and Disability (SEND) programme, noting that this was a system wide review of the services, and that the accountability sits with the ICB and Council, with the Trust being an active and trusted provider of services. She reflected that this is work in progress, and a large programme resource has been brought in by the Council with three task groups been developed to implement the changes. The focus at present is on meeting the regulatory demands, however we also need to consider the ambition for the programme, within the availability capacity. There is strong leadership in the team and strong engagement and relationships with all partner organisations. EL then took the Committee through the presentation at RR 03/2024 which provides an overview of the new 0-19 service. The Trust Chair asked whether there was anything that the Board could or should be doing to help foster relationships and improve collaboration between suppliers and organisations. EL responded that this service has strong relationships with the local authority, and they are keen to be involved with the service and is confident that this will move forward with the new structure in place. The Committee Chair asked whether there are outcome measures within the contract? NT responded by explaining that this is the case, there is a large performance schedule which is data driven against the healthy child programme and they have brought in softer, qualitative outcomes. We are working with our partners to ensure that we care using common tools across the partnership, for	

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e	example staff are being trained in the Graded Care Profile (GCP), which is the recognised tool for identifying neglect used by Social Care colleagues. The Chief Executive asked in relation to the significant staff post reduction, are we losing clinical staff? NT responded that the biggest reduction was in Health Visiting staff, so as part of the tender process we considered our current workforce in line with the service needed to be delivered and how we could develop this in terms of skill mix roles, providing there was sufficient training and competencies put in place. The workforce has been completely remodelled in terms of skill mix, with real clarity around where roles start and end and how we share that with our partners, as they often get pulled into safeguarding work which should be led by Social Care. One of the key aspects of this contract is provision of a universal approach to meeting need, so it is important that everyone is clear on their role and boundaries.	BR/PMcG
f	The Chief Executive questioned when the reduction in whole time equivalents would come down? NT responded by saying that Health Visitors dropped by nearly 20 whole time equivalents, but that has been converted into different banding and skill mixes, so no one was made redundant. At present there is a mismatch in bands of staff so not quite where we need to be to work within the model. It is a flat contract so numbers will need to reduce over the duration of the contract.	
g	The Committee Chair thanked Nicky and Emma for the update and the brilliant work undertaken in meeting the deadlines and engaging and preparing staff for this. It would be good to review this in a years' time as to how it is going and to consider how to use the outcome data to influence commissioners and sponsors of this work.	
h	LW noted that this is an outstanding and positive story looking at how to better meet needs and would be interested to have this presented to Board to consider how we can share that learning to other parts of the Trust that offer similar challenges. EL responded that this process has really reviewed everything that the service does. Senior colleagues from the council have just spent some time shadowing staff on visits, and the feedback is positive and are impressed with the outcome of the contract award. NT shared some of the words that had been used of those who had shadowed staff which include Inspirational; passionate and committed staff; humbled; flexible and responsive staff; high quality provision; excellent service delivery; warm respectful staff; inclusive and innovative in approach. EL and NT welcomed a review in 12 months' time.	
i	The Committee Chair asked for thanks to be passed to the staff as completely transforming how you work is no easy task especially with a substantial reduction in staff. The Committee noted the update. <i>EL and NT left the meeting.</i>	
5.	Quality Compliance & Regulation Update	

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b	The Chief Nurse highlighted how the report shows the vast amount of work undertaken by this small team, which provides a high level of assurance that the Trust is compliant with infection prevention control. The Chief Medical Officer commented that the glove reduction project will remove some of the practice that has become the norm following on from the Covid pandemic and increase sustainability.	
c	The Chair asked about the increase in UTI's, The Lead Infection Control Nurse replied that the recording of this only started last year so is difficult to know whether there is more prevalence of UTI's, for the year ahead we have improved the collection data, which considers the population we serve. Further work needs to be undertaken so that the data can accurately be captured. This will include looking at impact on morbidity, length of stay and cost. The Committee approved the report.	
8.	Oxford Pharmacy Stores (OPS)	
a	The Chief Pharmacist and Clinical Director of Medicines Management took the paper at QC 23/2024 as read, which updates the Committee on the status and developments regarding Oxford Pharmacy Store (OPS) Quality agenda, in line with Good Distribution Practice (GDP) under the terms of its Wholesale Dealer Authorisation (WDA). This report highlights for information and assurances that OPS is cognisant of the relevant standards and that performance against these standards is regularly reviewed and monitored.	
b	The Chief Finance Officer commented that OPS board oversight has been greatly improved. The responsible person framework is an important part of the assurance. It is important from the operational point of view that everything is in place, and this is done well to provide assurance of the quality and health & safety of the new facility in Banbury. The granting of the license has caused the move to be delayed, the impact has been well managed, and everyone is working together to ensure that this is a smooth a process as possible.	
c	LW commented that oversight from a commercial perspective was monitored through the Finance & Investment Committee, however the quality domain should sit with the Quality Committee for oversight and monitoring. The Chair explained that we now take Quality governance of OPS as a separate item to the Medicines Management report to assure ourselves as the licence holder that we have the correct things in place.	
d	The Committee noted the report. The Committee stopped for a 5-minute break. <i>The Chief Finance Officer and Mike Hobbs, Governor observer left the meeting.</i> <i>The Assistant Trust Secretary joined the meeting.</i>	

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Caring Safe and Responsive		
9.	Learning from Patients, Family and Carers report	
a	The Deputy Director of Quality took the annual report on Patients/Carer/Family Experience & Involvement for 2023 at QC 24/2024 as read. The report gives a six-month oversight of performance against the patient experience strategy, a three-year strategy which was launched in July 2023. There are examples and highlights across the Trust of the involvement and participation work to demonstrate the range of work in progress. There is no risk to escalate but the Committee is asked to note that a review of the resources required to deliver these developments is needed.	
b	The Committee Chair noted that there is a lot of work taking place within patient experience and the data from IWGC suggests there are positive trends, however the national survey does not seem to reflect that level of improvement. Do we know that what we are doing is making a difference for patients if the national survey data is not helping, should we be pushing to increase the response rate in the national survey to allow us to triangulate the data. The Deputy Director of Quality responded explaining that there is a small-time window to complete the national mental health survey, which can cause delays in terms of how encouraged our patients feel to respond. There are other various mechanisms used locally alongside IWGC to collect feedback and how we act on it. The focus areas for the future are responding and publicising the feedback that we receive. At present there are 40 quality improvement projects running based on feedback, but we need to consider innovative ways to publicise this information to share and show progress both internally and externally.	
c	The Chief Nurse commented that there is more we could do in alerting individuals that the survey is coming out and that it is helpful to the Trust if they can provide feedback. It would be helpful to map out where all the feedback mechanisms including ward groups and family groups is collected and triangulated.	
d	The Chief Executive commented the Safe Staffing report based on the Greater Manchester NHS report, provides a good summary of rebasing thinking and challenging complacency in some of these areas. Need to consider what matters most to patients, carers families and loved ones, to ensure that we do not lose sight of what matters.	
e	LW commented that it is great to see this getting more traction and the performance to date against the strategy. Could clarification be provided on the comment in the recommendation that a review of the experience programme development and resources is needed to deliver it. Is this suggesting that there is not sufficient resource to deliver our ambitions? The Deputy Director for Quality felt that more resource was required to deliver the programme. The introduction of peer support workers has helped in terms of support and recovery, however the investment is required to allow involvement to be done, as currently doing in a structured but ad-hoc manner. Need to consider centralisation of how we recruit, induct and train staff, ensuring that we are meeting legal issues, but need	

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f	to consider how we can increase involvement so that we have patients as part of the recruitment process, however this would require investment to get to this point. The Chief Nurse noted that the Trust needs to ensure that coproduction is a part of what we do and how we do things, rather than something that sits separately. We need to consider coproduction from the beginning when designing and transforming services, which we still need to transition to, and this will require a more structured approach to how we prepare patients and carers to be able to engage with us. The Committee noted the report	RH
10. a b c d	Complaints and PALS annual report The Committee Chair took the paper at QC 25/2024 as read, which is the annual report on formal complaints, patient advice and liaison service (PALS) contacts, MP enquiries and compliments received by Oxford Health NHS Foundation Trust (OHFT) between 1 April 2023 and 31 March 2024. This paper provides assurance that the Trust is meeting the legal regulations for the Care Quality Commission's regulation 16: receiving and acting on complaints. It was noted that the Trust makes extensive use of requesting extensions to deadlines, but within this was meeting those deadlines. The Deputy Director of Quality noted that the Trust is now in the process of setting up panels to review the complaints in all directorates using the new framework, and that she would have a role in overseeing the quality of the complaint's response along with Non-Executive Director. The Chief Nurse noted as the new complaint's framework has allowed for the complaints process to be reviewed in terms of how the Trust approaches complaints and will focus on early, meaningful resolution and responses for individuals. This is being done with the support of the QI team and directorate staff. The Committee approved the Report.	
11. a b	Clinical Effectiveness update: a) Clinical Effectiveness Decision Group The Chief Medical Officer took the papers at QC 26/2024 as read noting, The Clinical Effectiveness Decision Group (CEG) oversee and monitor the implementation of Clinical Improvement initiatives across the Trust. CEG reviews and approves service transformations and oversees improvements or issues identified from clinical audits, NICE guidance, external accreditations, and commissioning goals related to outcomes. There is a focus on improvements as well as quality control. b) Clinical Audit Annual Report	

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c d	The Chief Medical Officer took the paper at QC 27/2024 as read The Clinical Audit & NICE Guidance Annual Report 2023/24 which provides a year end summary for: • Clinical Audit; ○ Resource; ○ Governance; ○ Policies and Standard Operating Procedure updates; ○ Audit Management and Tracking (AMaT) oversight and development; ○ Training and Guidance; ○ Clinical Audit Activity and outcomes; • NICE compliance; • Promotional activity; and • Update on agreed key priorities. He then thanked the Clinical Audit and NICE manager for her fantastic work in the team, who has helped to provide strong governance around clinical audit, which links in with the improvement care group and quality improvement, which drives the changes through directorates. C) Medicines Management report The Chief Medical Officer took the paper at QC 28/2024 as read noting the use of medicines in clinical services is regulated by the CQC, but the Trust also has significant regulatory obligations to the MHRA and Home Office with respect to Oxford Pharmacy Store (OPS), and to the General Pharmaceutical Council for the Trust pharmacy services. Established governance and assurance processes are in place for all aspects of medicines (including controlled drugs, medical gases etc.) and this report provides a summary of recent updates and key areas of attention within the Trust. The Trust Chair mentioned the responsible officer's advisory group, he was surprised that this group did not monitor the effectiveness of individual clinicians, and challenged the Committee as to whether we can be assured that we know through clinical audit and measures of effectiveness, that the clinical interventions of doctors are effective. The Chief Medical Officer explained that this is down to line managers to monitor and ensure that job descriptions are accurate and up to date, this is overseen by clinical directors. The Committee noted the updates and reports.	
Policies and Governance		
12 a	Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) The Assistant Trust Secretary took the paper as read noting that BAF 1.1 has been reframed and re-focused on utilising digital data and technology, to identify the impact of the data gap following on from the systems outage. The nature of this risk sits between Quality Committee (QC) and Finance & Investment Committee	

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b c d e f g	(FIC), and so it is helpful that LW the FIC Chair had attended the meeting today. The decision today would be how to monitor this risk, whether it should be jointly owned by both Committee's or QC continues to oversee it, with regular updates being provided to FIC. LW noted that BAF 1.1 was due to go back to FIC at the next meeting with some further revisions, work has continued to tighten this up further and get some traction on reducing the risk. As the digitalisation strategy sits within FIC, the committee naturally has a role with this risk as it falls within existing workstreams, and therefore would make sense to share the risk. The Chief Nurse supported the shared ownership of this as there is relevance for both committees. For quality improvement and measurement, it is critical we have good data at ward and board level. The Chief Executive did not support the sharing of the risk as it could lead to lack of clarity and accountability. The Committee Chair expressed that she strongly felt that QC should keep an oversight on this, as we require the data to provide reasonable assurance, that what we are doing is effective. The Committee Chair, Director of Corporate Affairs and FIC Chair to have a discussion outside of the meeting to decide how to manage taking a single view on this across both committees. To be brought back to the next meeting with decision. The Managing Director for Mental Health and Learning Disabilities provided an update on risk 1.5 which relates to unavailability of beds/demand and capacity, which has been refreshed and updated to take account of service changes and mitigations. The risk score remains at 16. The Committee confirmed agreement with that rating. To come back to BAF 1.1 and 3.1 at the next meeting. The Committee noted the report and revisions to the BAF and TRR.	AY/LW/GD
13. a	Provider Collaboratives: The Committee Chair took the paper at QC 30/2024 as read, noting that there has been a change in the team that underpins this, and the quality of the report reflects and demonstrates the depth of clinical oversight they now have. The Committee noted the report.	

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14 a b	Quality Committee Annual Report, Terms of Reference and Workplan: The Committee Chair took the papers as read, suggesting that the Terms of Reference should be discussed offline following the governance seminar last week. The workplan needs to be reviewed to take account of any of the decisions that the Committee has made today, and any feedback from the members of the Committee. She reminded the Committee that the workplan will be approved at Board in May and it underpins the commitment between the Board and the Committee of the work being undertaken on the Boards behalf. Any revisions or comments to be emailed to the Chair and Associate Director of Corporate Affairs. The Assistant Trust secretary noted that it will go to the July Board rather than May so that the suite of papers goes as one group. The Committee approved the Annual Report.	GD/AY
15. a b c d e	Board to Ward Governance The Committee Chair introduced the agenda item, noting that the Committee had requested to see this to understand how the quality management system works and for clarity for regulators and CQC that we truly understand how quality issues get addressed and give us confidence that we have oversight. The Deputy Chief Nurse shared some slides available at RR 03/2024, which shows the flow of information through the organisation, from team meetings to Board. This provides assurance that each directorate has the own mechanisms and framework for reviewing and sharing. The Deputy Director of Corporate Affairs noted that this has been an interesting process to map this out and it shows that there is some variety within directorates, it is whether there needs to be less variety so that there are consistent steps to enable comparison and oversight. The Chief Executive highlighted that there is work underway on the operational framework and operating model for the Trust, which this needs to be folded into. There is clearer and more detailed version of this that needs to be brought back to this Committee at the next meeting. The Committee Chair noted that this shows that directorates have got governance processes in place for looking at quality. The Committee noted the update.	GM
16. a	Trust Policy Register update: The Committee Chair took the paper at QC31/2024 as read, noting that the Executive leadership of this is changing from the Chief Nurse to the Associate Director of Corporate Affairs, and the Quality Committee will continue to have oversight of this. The Committee noted the report.	

PUBLIC
Minutes of the Quality Committee, 02 May2024

17. a	Research and development Policy. The Committee Approved the Policy.	
16. a	AOB The Chief Executive wanted clarity that the Committee has oversight of the licenses for psychedelic medications in the research centres. The Chief Medical Officer responded that the NIHR infrastructure has been reported to this Committee and the Committee will receive 6 monthly updates. The Chief Pharmacist noted that update on the Home Office inspection and licences was brought to the Committee previously. They are just awaiting the approval and hope to start the trials in the next few months.	
17. a	Review of the meeting NA	
	Meeting closed at 12:07 Date of next meeting: 16 July 2024 at 09:00 via Microsoft Teams virtual meeting	

Meeting of the Quality Committee

Tuesday, 16 July 2024

13:00 - 16:00

Microsoft Teams virtual meeting

(live video streaming – invitation only)

Apologies to leanne.dunkley@oxordhealth.nhs.uk

AGENDA

			Indicative Time
1. Apologies for Absence and quoracy check ¹		AY	13:00
Minutes and Matters Arising			
2. Minutes of the meeting of the Quality Committee on 02 May 2024 and Matters Arising (paper – QC 34 /2024)	<i>To confirm & report matters arising</i>	AY	13:05
Safety			
3. Quality and Clinical Governance Sub-Group (QCG-SG) escalation reporting including:	<i>For assurance</i>	JK/BK	13:10
a. Quality and Safety Dashboard (paper – QC 35/2024)			
b. Patient Safety Incident report including mortality and homicide reviews (paper – QC36 /2024)			
c. Safe Staffing (paper—QC 37/2024)			
d. Quality Account 2023/2024 (paper-QC 38/2024)	<i>To note</i>		
~~Service Deep Dive~~ deferred to October	<i>For assurance</i>	BK/RB	13:45
~~e. Update on Strategy (2022-2027) and service development in Learning Disability service (oral update)~~			
4. Quality Compliance & Regulation update	<i>To note</i>	BK	13:50
a. CQC Compliance & Regulation-well led guidance.(paper-QC39 /2024)		HS/JP	
5. Safety of the Physical estate (paper-QC 40/2024)	<i>To Approve</i>		14:00
6. City Adult AMHT update (QC-RR06)	<i>For Assurance</i>	KA/TI	14:10

¹ Apologies received from Committee members: No apologies received.

Apologies received from regular attendees: Amèlie Bages, Director of Strategy and Partnerships,.

The quorum for the committee is five members to include the Chair of the Committee (or the vice chair of the Committee in their absence), one Non-Executive Director and one Executive Director.

Caring, Responsive & Effectiveness

7. QI Spotlight presentation and plan for the year (paper-QC 41 /2024)	To approve	JM/BK	14.25
8. Clinical Effectiveness updates:			14:40
a. Clinical Effectiveness Group (CEG) report (paper – QC 42/2024)	For assurance	KM/RM	
b. Clinical Audit update Report (paper – QC 43/2024)			
c. Medicines Management report (paper – QC44 /2024)	To Approve	AF/CF MM/KM	
For supporting detail: CEG minutes & action log in the Reading Room/Appendix (papers – RR/App 05/2024)			

Break – 5 minutes

14:55

Policies and Governance

9. Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) (paper – QC45 /2024)-BAF 3.1 Deep Dive/1.1 Revised steer	To discuss & for assurance	NMcL/ HS/BA/ GD	15:00
10. Health Inequalities-Quality Improvement (paper-QC 46/2024)	To approve	JP	15.10
11. Friends, Family and Carers Strategy-annual report (paper-QC 47/2024)	For assurance	BK/RH	15:20
12. Legal Proceedings Policy (paper-QC 48/2024)	To Approve	NM/GD	15:30
13. QC Workplan and ToR (paper-QC 49/2024)	To approve	AY/BK/ GD	15:35
14. Quality Governance System including Ward to Board Governance. (oral update)	For assurance	GD/BC	15:45

Any Other Business

15. Any Other Business and summary of matters of interest for the Board, any key risks to escalate or actions agreed, any items to add to the plan for the next meeting.	AY	15:55
16. Review of the meeting	AY	
Meeting Close	AY	16:00

Date of next meeting:

12 September 2024, 09:00 – 12:00 Face to face at Unipart-Sycamore Room level 4.

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted –

Attendance 2023/24

QC - Core membership (Quorum)	May-23	Jul-23	Sep-23	Nov-23	Feb-24
Andrea Young	✓	✓	✓	✓	✓
Rob Bale	N/A	N/A	x	✓	✓
Marie Crofts	✓	<i>Britta Klinck deputised</i>	<i>x (Britta Klinck deputised)</i>	✓	<i>Britta Klinck</i>
Geraldine Cumberbatch	✓	✓	✓	x	✓
Grant MacDonald	✓	✓	x	✓	✓
Karl Marlowe	✓	✓	✓	✓	✓
Ben Riley	✓	✓	x	✓	✓
Heather Smith	✓	✓	✓	✓	✓
Kerry Rogers*	✓	✓	✓	✓	✓
Attending Board members (voting & non-voting included in quorum)					
Amelie Bages*		✓	x	x	✓
Charmaine DeSouza	x	x	x	x	x
David Walker	✓	✓	x	✓	✓

QC - Core membership (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Feb-25
Andrea Young	✓				
Rob Bale	✓				
Britta Klink	✓				
Geraldine Cumberbatch	x				
Grant MacDonald	✓				
Karl Marlowe	✓				
Ben Riley	✓				
Heather Smith	✓				
Georgia Dengei	✓				
Attending Board members (voting & non-voting included in quorum)					
Amelie Bages*	<i>Mat</i>				

Charmaine DeSouza					
David Walker	✓				

Quality Committee – overview plan for 2024 - 2025, mapped against Quality Domains

Key: ✓ on agenda
x item planned
x deferred

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
SAFETY							
Quality and Clinical Governance Sub-Committee escalation report including Quality and Safety Dashboard <i>(to include positive and safe each month and May meeting to include ToR and work plan)</i>	Jane Kershaw/Britta Klinck	x <i>(ToR & workplan included)</i> ✓	x	x	x	x	
Directorate/Service area 'deep dive' <i>(Presentation)</i>	Britta Klinck/Grant Macdonald/Ben Riley	x <i>0-19 service</i> ✓	x <i>Learning Disabilities</i>	x	x	x	
Quality Account (quality priorities) <i>(May meeting includes annual report)</i>	Rose Hombo	x ✓			x		
Patient Safety Incident Report (PSIs) <i>(Learning from Deaths Report, to include mortality and homicide reviews)</i>	Jane Kershaw/Britta Klinck	x ✓	x	x	x	x	
Safe Staffing	Britta Klinck		x			x	
Quality Compliance and Regulation update <i>(CQC, NHSE/I etc - report as and when required)</i>	Britta Klinck	x ✓	x <i>Well led guidance</i>	x	x	x	
Director of Infection Prevention & Control (IPC) – IPC annual report	Helen Bosley/Britta Klinck	x ✓					
Safety of the physical estate – annual report <i>Ligature update (BK/MC)</i>	Britta Klinck/Heather Smith		x				

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Learning Disabilities & Autism Services – access to healthcare annual report	Kirsten Prance/Rob Bale			X			
Inquests & Claims – annual report	Neil McLaughlin/ Hannah Smith/ Georgia Dengei			X			
Safeguarding Service annual report	Lisa Lord/Britta Klinck			X			
Oxford Pharmacy Store (OPS) <i>(quality assurance report around the governance and quality of medicines regulation in OPS)</i>	Natasha Arif/Nicola Mayes/Mark Byrne/Heather Smith/Karl Marlowe	X <i>(review of programme)</i> ✓			X		
EFFECTIVENESS							
Clinical Effectiveness Decision Group (CEDG) <i>(RR minutes from CEDG group, new NICE guidance)</i>	Ros Mitchell/Karl Marlowe	X ✓	X	X	X	X	
Clinical Audit updates	Angie Fletcher/Karl Marlowe	X ✓	X	X	X	X	
Clinical Audit annual plan and annual report	Angie Fletcher/Karl Marlowe	X ✓					
Medicines Management	Michael Marven/Karl Marlowe	X ✓	X	X	X	X	
Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) <i>review each one at each meeting</i>	Ben Cahill/Brian Aveyard/Hannah Smith/Neil McLaughlin	X ✓	X	X	X	X	
Health Inequalities-Quality Improvement <i>(smoking cessation/SMI Health checks/ dashboarding waiting list for Index of Multiple deprivation/ethnicity data)</i>	Karl Marlowe		X				
QUALITY IMPROVEMENT							
QI Spotlight presentation <i>(developing capability and the impact on staff and patients)</i>	Angie Fletcher/Britta Klinck		X <i>Plan for the year</i>		X <i>(projects)</i>	X <i>(projects)</i>	

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Mental Health Inpatient transformation programme	Britta Klink			x			
CARING & RESPONSIVE (patient & carer experience)							
Learning from Patients, Family & Carers <i>(Experience and involvement) update on strategy</i>	Donna Mackenzie-Brown/Rose Hombo/Britta Klinck	x ✓			x		
Experience and Involvement report <i>(update on strategy)</i>	Donna Mackenzie-Brown/ Rose Hombo / Britta Klinck				x		
PCREF Framework <i>(update on strategy)</i>	Rose Hombo/Britta Klinck		x		x		
Complaints & PALS annual report	Claire Price / Jane Kershaw / Britta Klinck	x ✓					
RESEARCH							
R&D update (Governance aspects)	Vanessa Raymont/Karl Marlowe			x			
POLICIES & STRATEGIES							
Nursing Strategy	Britta Klinck				x		
Friends, Family and Carers Strategy	Britta Klinck		x				
AHP Strategy	Britta Klinck					x	
Learning Disability Strategy (2022-2027)	Kirsten Prance/Britta Klink		x				
Trust Policies <i>(as and when – new policies for approval and certain policies for review)</i>							
Legal Proceedings Policy	Neil McLaughlin/Georgi a Dengie		x				
GOVERNANCE							

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Minutes of the Quality Committee	Georgia Dengie/Ben Cahill	x ✓	x	x	x	x	
Quality Committee annual report	Georgia Dengie/Ben Cahill	x ✓					
Integrated Governance Framework (Including Quality Management system)	Ben Cahill	x ✓		x			
Provider Collaboratives	Britta Klinck	x ✓	x	x	x	x	
Partnership update	Amélie Bages				x		
Trust Policy Register	Britta Klinck/Georgia Dengie	x ✓		x			
Annual Planning Process	Amelie Bages					x	
OTHER REQUESTED ITEMS							
2024-2025 Developing Quality Governance (being clear ward to board and testing its effectiveness)	Georgia Dengie/Ben Cahill/Britta Klink	x ✓					
Number of Items on Agenda		21	17	15	18	15	

Note

NHSEI – issues for QC oversight *(Dec 2021)*

- Children & Young People
- Learning from Deaths
- Resuscitation
- Security Management – Violence & Aggression
- Palliative and End of Life Care
- Safeguarding
- Sexual safety
- Well-Led Guidance

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

Agenda item: 16(a)

24 July 2024

Audit Committee annual report 2023/24

For Receipt

Executive Summary

The Audit Committee's annual report summarises the performance and work programme of the Audit Committee during the period 01 April 2023 to 31 March 2024 and how it met its Terms of Reference.

Governance Route/Approval Process

Further to the Audit Committee's review, comments and approval at its meeting on 19 June 2024 the Audit Committee annual report is presented to the Board of Directors in July 2024.

Strategic Objectives/Priorities – this report relates to or provides assurance and evidence against the following Strategic Objectives/Priorities of the Trust:

3) Sustainability – Make best use of our resources and protect the environment

Recommendation

The Board is asked to receive the Audit Committee annual report.

Author and Title: Hannah Smith, Assistant Trust Secretary

Lead Executive Director: Heather Smith, Chief Finance Officer

Committee Chair: Chris Hurst, Non-Executive Director

1. *A **risk assessment has been undertaken around the legal issues** that this report presents and there are no issues that need to be referred to the Trust Solicitors.*
2. *This report satisfies or provides assurance and evidence against the requirements of the following **Terms of Reference of the Audit Committee:***

- *to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control (clinical and non-clinical activities) that supports the achievement of the Trust's objectives;*
- *to ensure that there is an effective Internal Audit function;*
- *to review the work and findings of the External Auditor and consider the implications and management's response to their work;*
- *to review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust;*
- *to work with other committees within the Trust whose work can provide relevant assurance to the Committee's own scope of work, particularly the Quality Committee and the Charitable Funds Committee;*
- *in reviewing the work of other committees relating to clinical risk management, to satisfy itself on the assurance that can be gained from the clinical audit function;*
- *to monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance and to review the Annual Report and Financial Statement before submission to the Board; or*
- *to ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.*

Audit Committee Annual Report 2023/24

For the period 01 April 2023 to 31 March 2024

The Audit Committee is a standing committee of the Board of Directors established in line with good practice (NHS Audit Committee Handbook) to provide an independent and objective review of the Trust's internal controls. It seeks high-level assurance on the effectiveness of the Trust's integrated governance (clinical and corporate governance), risk management, and internal control systems and reports to the Board on its level of assurance. In essence the Audit Committee's remit is to assure the Board that the systems and processes that the Trust relies upon that inform its financial statements, its operational decision making, and its compliance with healthcare and governance standards are accurate, robust and can be relied upon.

The Committee receives assurance from the Executive team and other areas of the organisation through regular and bespoke reports. It validates the information it receives through the work of Internal Audit, External Audit, and Counter Fraud. In addition, it gains assurance from other areas of Non-Executive Directors' work, cross-membership with other committees, committee chairs' meetings, minutes of all committee meetings to the Board, and other.

Further information about the work of the Committee is presented below.

The Committee also has responsibility for ensuring that, should the External Auditors carry out any non-audit work, their independence is maintained. The Committee will do this by reviewing and approving the scope of the work and the fees charged prior to the work being undertaken.

1. Membership of the Committee, Attendance and Frequency of Meetings

The members of the Committee are all Non-Executive Directors. During the reporting period, the Chairs were: Lucy Weston until December 2023; and Chris Hurst from January 2024.

The Trust Chair may not be a member of the Committee but is invited to attend the meetings during the financial year which receive drafts of the Annual Report & Accounts. Other Non-Executive Directors may be invited to attend on an ad-hoc basis, either when it is deemed appropriate for a particular agenda item, or to ensure quoracy.

The Committee's Terms of Reference state that meetings will occur no less than 4 times per year. The Committee held 5 meetings during the reporting period, all of which were quorate:

- 25 April 2023;
- 16 June 2023 (extraordinary meeting to review the Annual Report and Accounts);
- 14 September 2023;
- 21 November 2023; and
- 22 February 2024.

Attendance of members during the reporting period:

Committee members	Attendance
Lucy Weston (Chair until December 2023)	4/4 meetings
Chris Hurst (Chair from January 2024)	5/5 meetings
Mohinder Sawhney	5/5 meetings
David Clark	0/1 meetings
Rick Trainor	1/1 meetings

During the reporting period, meetings of the Audit Committee were attended on a regular basis by the Chief Financial Officer, the Director of Corporate Affairs and Company Secretary, and the Chief Executive. Internal Audit and Counter Fraud representation was provided by KPMG and External Audit by Ernst & Young.

In addition to the officers that regularly attend the Committee, invitations were extended to members of the Executive team and senior managers who attended meetings to present papers and provide assurances as required.

In line with good practice, the Terms of Reference also state that the Audit Committee should meet privately with the External and Internal Auditors at least once a year, without officers present. During the reporting period, the Committee met privately with the External and Internal Auditors and representatives of the Counter Fraud/Anti-Crime Service before each of its meetings.

The full attendance list of regular attendees, other officers and governors is presented at Appendix 1.

A member of the office of the Director of Corporate Affairs & Company Secretary attended all meetings during the reporting period to take a true and accurate record of the proceedings of the Committee.

2. Business transacted by the Committee

Set out below is the remit of the Committee together with a summary of the business transacted over the reporting period 01 April 2023 to 31 March 2024 (text in *italics* is taken from the ToR).

Governance, Risk Management, and Internal Control

Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical). This includes Whistleblowing, the Charity and Cyber Security.

The Terms of Reference state that the Committee should review the adequacy of all risk and control related disclosure statements, in particular the Annual Governance Statement, and review any Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

The Committee reviewed these prior to submission to the Board as follows:

- Annual Governance Statement – April and June 2023;
- Head of Internal Audit Opinion – April and June 2023;
- Annual Financial Statements including External Audit Opinion – June 2023; and
- Annual Report – June 2023.

Through regularly considering the Board Assurance Framework (**BAF**) and the Trust Risk Register (**TRR**), the Committee gains ongoing assurance of action being taken to mitigate risks. As part of the annual Internal Audit Plan, the Committee is assured of the effectiveness of the BAF and TRR processes and the overall adequacy and effectiveness of the framework of governance, risk management and control (i.e. the system of internal control). Committee members and the wider Board also expanded their knowledge and understanding of risk through Board Workshops on 25 April 2023 (including a Risk workshop facilitated by PwC) and on 28 February 2024 (which considered Risk in a Strategic context and a draft Risk Appetite Statement).

In fulfilment of the remit to review the underlying assurance processes that indicate the level of achievement of the organisation's objectives and the effectiveness of the management of principal risks, the Committee received BAF update reports at all of its meetings and undertook risk deep dives into:

- Sustainability of Primary, Community & Dental Care Services;
- Workforce Planning and Recruitment;
- Adequacy of Staffing;
- Major Projects;
- Delivery of the Financial Plan and maintaining Financial Sustainability;
- Unavailability of Mental Health Beds;

- Governance and Decision-making Arrangements; and
- Business Continuity and Emergency Planning.

The Committee received Internal Audit reports, as part of the Internal Audit Plans 2022/23 and 2023/24, on key systems of internal control including:

Area	Risk rating / assurance level
<i>Internal Audit Plan 2022/23</i>	
Projects and Programme Assurance/Service Change and Delivery function	High risk rating
Learning & Development	Medium risk rating
Provider Collaborative Governance	Low risk rating
<i>Internal Audit Plan 2023/24</i>	
Data Security & Protection Toolkit	Significant assurance
Core Financial Systems	Significant assurance
Recruitment Process review report	Significant assurance
Bank Booking process	Partial assurance
Operational Risk Management	Significant assurance

The Committee also received assurance on more historic reports and actions from:

- management updates on Internal Audit actions;
- other committee Chairs on themes previously identified in Internal Audit reviews and delegated for monitoring to other committees; and
- the Executive, in relation to:
 - Health and Safety training from a previous Health, Safety and Staff Security review;
 - Prevention of Future Deaths notices;
 - the People, Leadership & Culture Committee: mandatory training and actions continuing from the Payroll review in FY22; and
 - the Finance & Investment Committee: the specially commissioned report into the Psychiatric Intensive Care Unit (PICU) project.

With regard to the Counter Fraud/Anti-Crime Service, the Committee received:

- regular reports on ongoing investigations, outcomes of investigations and awareness raising activities;
- the Counter Fraud/Anti-Crime Service annual report 2022/23 - in June 2023;
- the current service provider's annual report 2023/24 – in April 2024; and
- compliance reporting on Managing Conflicts of Interest (including gifts and hospitality) in February 2024 (with 3 low risk recommendations).

The Committee also received its regular reporting on:

- Whistleblowing arrangements – in September 2023;
- the Charity's annual report – in February 2024;

- Cyber Security update reports - in April 2023, September 2023 and February 2024; and
- Emergency Planning annual report - in November 2023.

The Committee also reviewed updates to core governance documents:

- the Scheme of Reservation and Delegation of Powers;
- the Governance Framework; and
- the Board of Directors' Standing Orders.

Internal Audit

Ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors.

The Committee received final updates on the procurement of the Internal Audit and Counter Fraud contracts in April 2023.

The Committee fed into the process to develop the Internal Audit and Counter Fraud Plans for 2023/24 at its meetings in June and September 2023 and reviewed the draft Internal Audit and Counter Fraud Plans for 2024/25 in February 2024.

The Committee was assured that the Internal Audit Plan 2023/24 had been developed in line with the BAF and risk registers, previous audit coverage of fundamental systems and accumulated Internal Audit knowledge and experience. The Committee also noted the importance of being able to use the Internal Audit Plan as part of the approach to managing risk, including ensuring that it could be demonstrated that no Executive bias had influenced the Internal Audit Plan away from any challenging areas. At its regular meetings, the Committee received updates on progress against plan, updates on the performance of Trust management in meeting any overdue recommendations and monitored implementation by management of Internal Audit recommendations (from 'low' to 'high').

The Committee received the draft and final Head of Internal Audit Opinion for 2022/23 in April and June 2023 from the previous provider of Internal Audit services. The overall Head of Internal Audit Opinion for 2022/23 was that of reasonable/moderate assurance – equivalent to the previous terminology used of 'generally satisfactory'. There was one 'high' risk rated report, on Projects and Programme Assurance/SCAD function, with two individually 'high' risk rated findings; all the other individual findings across the remaining FY23 review reports were either 'medium' (12 findings) or 'low' (6 findings) risk rated.

External Audit

Review the work and findings of the External Auditor appointed by the Trust's Council of Governors and consider the implications and management's responses to their work.

The 2022/23 accounts timeframe was delayed by the need for a revised asset valuation after the initially commissioned valuation did not meet standards required. The Committee received a planning report from the new External Audit provider in April 2023, which set out the focus for the External Audit for 2022/23, and a draft External Audit results report in June 2023. The External Audit for 2022/23 was not complete for the Committee's meeting on 16 June 2023 and a final External Audit annual report to support the 2022/23 process, including commentary on Value for Money arrangements, was presented to the meeting on 14 September 2023.

The Committee considered an External Audit 'lessons learned' report at its meeting on 21 November 2023, which also summarised the debrief after the 2022/23 process and agreed actions for the 2023/24 process. Progress updates for the 2023/24 External Audit were provided to the meetings in November 2023 and February 2024.

The Committee received the following reports from the External Auditors which they considered in formal session:

- External Audit results report (ISA260) and External Audit opinion and completion certificates (report on the financial statement audit for the year ended 31 March 2023, including draft letters of representation); and
- External Audit annual report to support the 2022/23 External Audit process and including commentary on Value For Money arrangements.

Other Assurance Functions and Management (including Clinical Audit)

Review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust; the Committee members will wish to satisfy themselves on the assurance that can be gained from the Clinical Audit function. Review the work of other committees whose work can provide relevant assurance to the Committee's own scope of work; this may be by way of the committee minutes provided to the Board as part of the pack of Board papers.

The members of the Committee had access to the minutes of all Board Committees and other committees via the packs of Board papers, being:

- the Quality Committee (**QC**);
- the Finance & Investment Committee (**FIC**);
- the Charity Committee;
- the Mental Health & Law Committee (**MH&LC**);
- the People, Leadership & Culture (**PLC**) Committee; and
- the external Warneford Park Programme Board.

The annual reports, terms of reference and work plans of the QC, FIC, MH&LC, and PLC Committee were also presented to the Board meeting on 19 July 2023.

The members of the Committee were also able to gain assurance from other means outside of their direct Committee membership as full members of the Board. The Chairs of the FIC and of the PLC Committee have been members of the Committee and have provided oral and written updates to the meetings on progress and assurance in relation to themes previously identified in audits and being monitored by their committees (especially in relation to mandatory training, Payroll and the PICU project). In addition, the presentation of the regular Finance and Integrated Performance reports to the Board (including out-of-session updates in the months between Board meetings) provided Committee members with assurance. From 2023/24, the Audit Committee will be able to benefit from cross-Committee membership with the PLC Committee, the QC and the Charity Committee.

The Committee also considered the findings of the:

- BAF and the TRR (internal to the Trust);
- Finance function (internal to the Trust) with regular reporting on: (i) Losses & Special Payments; and (ii) Single Action Tender Waivers; and
- IT function (internal to the Trust) in relation to Cyber Security.

As mentioned above, during the reporting period the Committee also received and reviewed reports on Whistleblowing arrangements, the Emergency Planning annual report and the Charity's annual report in support of relevant assurance to the Committee's own scope of work.

The Committee continued to develop the assurance it was receiving on the work of the Clinical Audit function. During the reporting period it received:

- the Clinical Audit annual report 2022/23 in June 2023; and
- Clinical Audit interim reporting in November 2023.

Financial Reporting

Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. Review the Annual Report and Financial Statements before submission to the Board. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee reviewed the 2022/23 Annual Report text and Financial Statements (with analytical review) over April to June 2023, prior to formal presentation to the Board in June 2023. It also considered the Annual Governance Statement, Statement of the Chief Executive's responsibilities as the Accounting Officer, the Head of Internal Audit Opinion and the Going Concern Statement. The External Audit for 2022/23 was not complete for the Committee's meeting on 16 June 2023 and a final External Audit annual report to support the 2022/23 process, including commentary on Value for

Money arrangements, was presented to the meeting on 14 September 2023, with lessons learned then considered at the meeting on 21 November 2023 (as referred to in section 2.3 above).

Reporting and self-assessment

The Audit Committee meetings were formally recorded by a member of the office of the Director of Corporate Affairs & Company Secretary and minutes were circulated and presented to the Board.

The Audit Committee noted its disappointment that the Accounts and External Audit had not been completed for its meeting on 16 June 2023, due to onboarding new providers, some process issues and the need for a second asset valuation report. However, subject to no significant findings being escalated from the External Audit for 2022/23, the Audit Committee agreed to recommend the Financial Statements for approval to the Board.

The Committee undertook a self-assessment of its effectiveness, with consideration of initial and informal feedback from External Audit and considered the findings at its meeting on 21 November 2023. In light of the change of Chair from January 2024, it was decided to hold a further workshop for consideration of the Committee's self-assessment from September/October 2024 when the impact of the change of Chair could also be considered alongside work on how various Board Committees interacted and reported to the Board.

3. Conclusion and look forward

The Audit Committee executed its core responsibilities under its Terms of Reference and appropriate consideration and scrutiny was given to governance, risk management and internal control; the work of internal and external assurance functions, including Internal Audit, External Audit and Counter Fraud; and the 2022/23 Annual Report & Accounts and supporting documents. An overview plan for February 2024 – June 2025 is provided for information at Appendix 3.

As the primary governance committee of the Board of Directors, the Audit Committee preserved its independence from operational management by not having executive membership (although members of the Executive Management Team support the Committee by providing information and context only). It added value by maintaining an open and professional relationship with Internal Audit, External Audit, and Counter Fraud. It carried out its work diligently, discussed issues openly and robustly, and kept the Board apprised of any possible issues or risks and routinely reports back to each public board (using a 3As Report on matters to alert, advise or assure the Board on). The Committee kept under review its work programme throughout 2023/24 to prioritise areas as appropriate.

The Chair of the Audit Committee considers that the Committee has fulfilled its role and provided assurance to the Board on the adequacy and effective operation of the organisation's risk management and internal control systems.

The Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

Appendix 1 – Attendees 2023/24

Attendance of Trust regular attendees at formal meetings during the reporting period:

Regular attendees	Attendance
<i>Executive Directors</i>	
Grant Macdonald (Chief Executive)	2/5
Kerry Rogers (Director of Corporate Affairs & Company Secretary)	4/5
Heather Smith (Chief Finance Officer)	5/5
<i>Other Trust staff</i>	
Ben Cahill (Deputy Director of Corporate Affairs)	5/5
Peter Milliken (Director of Finance)	5/5
Hannah Smith (Assistant Trust Secretary)	4/5
Michael Williams (Financial Controller)	2/5

All 5 meetings were attended by lead representatives from the Internal Audit, External Audit and the Counter Fraud/Anti-Crime Service.

During the reporting period the following officers of the Trust and other interested parties were invited to attend for all or part of formal meetings:

Oxford Health NHS FT attendees	Attendance
<i>Board members</i>	
Amélie Bages (Executive Director of Strategy & Partnerships)	1/5
Charmaine De Souza (Chief People Officer)	3/5
Karl Marlowe (Chief Medical Officer)	1/5
Ben Riley (Executive Managing Director for Primary and Community Care Services)	2/5
David Walker (Trust Chair)	1/5
<i>Other Trust staff</i>	
Brian Aveyard (Risk, Assurance & Compliance Manager)	5/5
Alison Bourne (Head of HR Policy, Reward & Projects)	1/5
Karen Drabble (Thames Valley & Wessex Forensic Network Head of Programme)	1/5
Rebecca Elsworth (Head of Learning & Development)	1/5
Angie Fletcher (Head of Quality Improvement)	1/5

Nicola Gill (Executive Project Officer)	1/5
Will Harper (Head of IT)	1/5
Tara O'Brien (Head of Resourcing)	1/5
Priya Thompson (Head of Strategy)	1/5
Angela Ward (Clinical Audit and NICE (National Institute for Health & Care Excellence) Manager)	2/5

During the reporting period, the following also attended to observe formal meetings:

Governor observers	Attendance
Penny Thewlis (Governor nominee from Age UK)	1/5

Report for the Meeting of the Oxford Health Charity Committee Meeting

7th May 2024

Oxford Health Charity Committee 2023/24 Annual Report

For: Approval

Executive Summary

This report provides an overview of the Charity Committee including frequency of meetings and attendance, and a summary of business transacted by the committee.

Governance Route/Escalation Process

This is an annual report compiled for review by the Audit Committee.

Recommendation

The Committee is asked to approve this report, which will then be presented to the Trust's Audit Committee.

Author and Title: Charlotte Evans, Executive Assistant to the Director of Corporate Affairs & Company Secretary.

Lead Executive Director: Georgia Denegri, Associate Director of Corporate Affairs.



Charity Committee Annual Report For the period April 2023 – March 2024

The Charity Committee's key responsibility is to support the duties of the Corporate Trustee in the management of the Oxford Health Charity (Charity Number 1057285). The Committee's Terms of Reference were reviewed and given final approval in February 2024.

Lucy Weston, Non-Executive Director, was the chair of the Committee up until 2024, with Rick Trainor, Non-Executive Director, becoming the chair of the Committee from the meeting in February 2024. The Committee functions were supported by Charlotte Evans, Director of Corporate Affairs & Company Secretary's Executive Assistant.

1. Frequency of Meetings and Attendance

The Terms of Reference state that the Committee should meet not less than four times a year. During the reporting period the Committee met this requirement with meetings taking place on 20th June 2023, 12th September 2023, 22nd November 2023 and 7th February 2024.

In addition, as part of the strategy consultation in 2022 and 2023, there has been Stakeholder Consultation Sessions, surveys, Corporate Trustee engagement, a consultation project with More Partnerships, Philanthropic Giving discussions, engagement with peer charities across NHS Charities Together, Strategic Planning sessions with Oxford Health NHS Foundation Trust Strategy Team and Charity Committee agenda discussions.

Membership of the Committee comprised:

- 3 Non-Executive Directors of the Trust
 - Lucy Weston (Chair)/Rick Trainor (Chair from 2024)
 - David Walker
 - Chris Hurst (from 2024)
- 3 Executive Directors of the Trust
 - Kerry Rogers
 - Marie Crofts (who has now left the Trust as of December 2023)/Britta Klinck (from 2024)
 - Charmaine Desouza

During this period, the following officers of the Trust and other interested parties were invited to attend for all or part of meetings (number of times shown in brackets):

- Associate Director For Communications And Engagement (1)
- Deputy Director Of Quality/Patient Experience And Involvement Lead (1)
- Director Of Estates And Facilities (3)
- Head Of Charity And Involvement (4)
- Head Of Learning And Development (0)
- HR Representative (2)
- Independent Member (4)
- Investment Management Representative (1)
- OHC Administrator (4)
- OHC Development Manager (4)
- OHC Finance Manager (4)
- Senior Leader For Mental Health And Learning Disability Services (1)
- Senior Leader For Primary, Community And Dental Care (2)

The Committee quorum is three members to include at least two Non-Executive Directors including the Chair of the Committee and the Director of Corporate Affairs and one other Executive Director (or their nominated deputy). All meetings were quorate.

Attendance by the core members has been as follows:

	20th June 2023	12th September 2023	22nd November 2023	7th February 2024
Exec	2	2	2	3
Non-Exec	2	2	2	3
Total	4	4	4	6

Under the direction of the Director of Corporate Affairs & Company Secretary, the meetings were attended by the Director of Corporate Affairs & Company Secretary's Executive Assistant to take a true and accurate record of the proceedings of the Committee.

All meetings took place via Teams as a result of COVID-19 restrictions and flexible working.

2. Business transacted by the Committee

The Charity Committee meetings are split into two sections – Governance and Development to allow for a more focussed approach to both charity governance requirements and funding requests/impact assessments.

The following updates reflect on the activity of the committee through 2023-24 in relation to each point.

Ensure the activity of the Oxford Health Charity is managed appropriately and within required parameters (including but not limited to the delegation of fund management, investments, expenditure and income)

The committee undertakes a review of expenditure, income, legacies and restricted funds at each meeting.

The management of investment funds is undertaken by LGT Wealth Management UK LLP and reports on the portfolio are provided at alternate meetings.

The committee review the charity risk register as a standing item on the agenda and this register is regularly revised to reflect changing circumstances. The register is formatted in line with Trust risk management processes and reflects both an accepted risk level and current compliance with this for each risk. The risk register was amended slightly to reflect Charity Commission guidance and comments on the best way to read the register. A note has been added on how to read the register and it is now more accessible in terms of reading from left to right.

Provide oversight on the Oxford Health Charity Strategy

The 2023-28 Oxford Health Charity Strategy was developed as a result of consultation with committee members, key stakeholders and fund advisors and approved at the September 2023 committee meeting.

This strategy has been drafted following a period of consultation in 2022 and 2023, including Stakeholder Consultation Sessions, surveys, Corporate Trustee engagement, a consultation project with More Partnerships, Philanthropic Giving discussions, engagement with peer charities across NHS Charities Together, Strategic Planning sessions with Oxford Health NHS Foundation Trust Strategy Team and Charity Committee agenda discussions.

The strategy demonstrates a period of growth following the foundations of the 2019-22 Strategy and is based on delivery with the current infrastructures in place. The core vision of the charity has not changed but

a set of growth objectives has been proposed with a focus on their delivery through the lens of 'Positive Spaces'. Positive Spaces was identified as the priority for Oxford Health Charity through the Corporate Trustee seminar in Spring 2023 and provide a unique and clear focus in support of Oxford Health NHS Foundation Trust.

Following recommendations through the More Partnerships report and ongoing discussions in relation to the Warneford Park Project, there is potential for higher levels of growth should there be scope for investment in Oxford Health Charity infrastructure. This would be shown through an increase in the achievements of the KPIs (for example, the percentage of fundraising income expected and the growth of 'warm' contacts) and allow for increased impact against all areas of the strategic objectives. Work within the first year of the new strategy would further define the investment requirements alongside discussions on a willingness to support investment with the Corporate Trustee.

The design of the strategy document has been discussed with More Partnership and the Trust Associate Director for Communications and Engagement with an aim to reflect the growth of the charity beyond an internal only audience. It has been designed in house and will be published both internally and externally, particularly allowing access for potential donors.

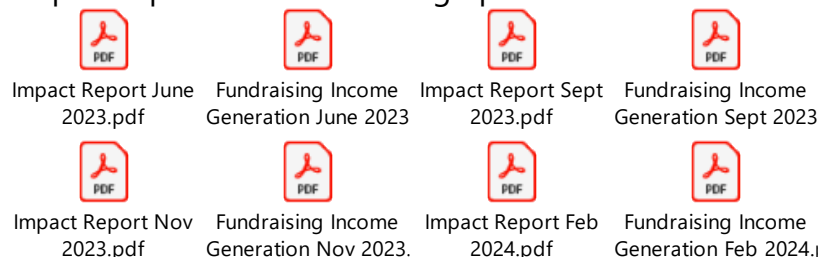
An action log related to the delivery of the strategy was developed and is reported on at each committee meeting following this – demonstrating ongoing progress in each of the objectives. The majority of actions in 23/24 were completed or at least started, given the timelines following approval of the Strategy in late Autumn this is a positive achievement. Those actions not completed have been moved forward into the 24/25 plan with new actions to continue the growth and development of the Charity. A separate Communications Plan and Finance Management Plan are under development for 24/25 and will sit alongside the main action plan with support from the Communications and Engagement Team and the Trust Finance Team.

The objectives for the strategy state:

- To develop an evidence base demonstrating the positive and meaningful impact of charity projects.
- To create a culture of engagement and involvement through volunteers, donors, fundraising and staff to boost charity income and awareness.
- To encourage innovation and research through bespoke funding opportunities.

– through levels of requests for funding, fundraising events and activities and through website/social media stories. The report also highlights new ways for individuals to engage, support or advocate for the charity. The report has since been split into impact and fundraising. It contains more of an overview of all the things that are currently taking place and being worked on to generate income within the charity. This has been broken down into grant applications, fundraising, specific appeals and upcoming opportunities. Feedback on the new report has been positive, especially as it will help improve awareness of fundraising and the impact this can have.

Copies of impact reports and fundraising updates can be found below:



A guide for all trustees on how they can advocate for the charity will be circulated to new Exec and Non-Exec members as they join the Board.

Approve funding requests over £10,000 or with specific impact outside of the normal approvals process

The committee were asked to consider the following projects over £10,000 in this period:

Project Title	Detail	Approved/Declined
Landscaping at Lucy's Room	This request related to the landscaping elements of Lucy's Room and covered: • Design and expert time to create on site • Planters to border the space and create a 'gateway' opening • All planting in planters and surrounding areas • Nature hotspots • Signage and graphics to incorporate the butterfly theme • Furniture for outside seating	Approved

	All elements have been developed with Chiltern Rangers and RAW with a clear understanding of the location requirements and with a focus on sustainability, future growth and the engagement of volunteers in ongoing upkeep. Total Project Costs - £12,132.	
Soundproofing Panels for Clinic Rooms in the Mental Health Building at Abingdon Community Hospital	The South Oxon Older Adult CMHT requested the use of legacy funds for the purchase of acoustic wall and ceiling panels that will provide essential soundproofing for nine of our clinic rooms in the Mental Health Building at Abingdon Hospital. These panels will also help to brighten these assessment rooms, which currently appear stark and unwelcoming for patients. Total Project Costs - £12,622.80	Approved.

As shown, all projects were approved and the projects have progressed.

Escalate successes, risks and strategic plans to the Corporate Trustee annually or as required

The Corporate Trustee met in December to review and approve the 2022-23 Annual Accounts and Report prior to submission to the Charity Commission in January 2024. This Annual Report and Accounts were approved by the Charity Committee on 22nd November 2023, pending the Independent Review which had since been completed. Both papers were approved by the Corporate Trustee.

In addition to the above, the committee receives and reviews the following updates:

- Charity Legal, Regulatory and Policy Update
- Strategy Report
- Impact Report
- Management Accounts
- Investment Portfolio Report

3. Reporting

Meetings are formally recorded and minutes have been circulated to all Committee members and formally reported to the Board of Directors.

Report to the Meeting of the Oxford Health NHS Foundation Trust

Mental Health & Law Committee 16 May 2023

Agenda Item: 16(c)

Mental Health & Law Committee Annual Report 2023/24 For Assurance

Executive Summary

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within its terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for the users of services through the effective governance of its organisation. The Mental Health and Law Committee has a key role in assisting the Board to fulfil its oversight responsibilities to ensure it is operating effectively and in accordance with legislation.

The Annual Report summarises the performance and work programme of the Mental Health & Law Committee during the period 01 April 2023 to 31 March 2024. Annual reviews of committees are intended to support the Board and Accounting Officer by providing assurances to meet their needs. Whilst this Annual Report reflects the period to March 2024, monitoring of Committee effectiveness has been part of the end of meeting wash up. The business of each meeting has consistently been reported to the Board of Directors through escalations as necessary and via presentation of the minutes.

Governance Route/Approval Process

The Mental Health & Law Committee is asked to review and approval the Annual Report for presentation to the Board of Directors. The Committee agrees it has throughout the year reported upon, monitored, reviewed, and escalated to the Board of Directors the fitness of the Trust's processes to support the Trust's delivery of care in accordance with mental health legislation.

Forward view

The Committee has considered its forward planning in the context of the impending changes to legislation in areas covered in its remit which form part of this Annual Report. It plans over the next year to understand the effectiveness of the role of Independent mental health advocacy to ensure they are able to help patients understand and exercise their rights and ensure their views and preferences are expressed.

Recommendation

The Committee is requested to approve the report for recommendation to the Board.

Author and Title: Leanne Dunkley, Corporate Governance Officer

Committee Chair: Geraldine Cumberbatch, Non-Executive Director (from 29 February 2024), David Walker, Non-Executive Director was the Chair for the remainder of the reporting period.

Lead Executive Director: Karl Marlowe, Chief Medical Officer

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors.*
2. *This report satisfies or provides assurance and evidence against the requirements of the following*
Terms of Reference of the Mental Health & Law Committee:
 - *to monitor, review and report to the Board of Directors the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983 and the Mental Capacity Act 2005, taking into account best practice;*
 - *ensure that there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role;*
 - *monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary. Consider the implication of any changes to legislation and regulations within a local context;*
 - *receive reports following Care Quality Commission visits and ensure appropriate action is agreed and implemented within the organisation;*
 - *scrutinise delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by the Board of Directors;*
 - *approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts;*
 - *monitor the provision of adequate guidance, information, education and training on mental health legislation to staff, service users, carers and other stakeholders;*
 - *monitor the application of Human Rights principles and frameworks across the Trust and draw attention to any shortcomings in particular:*
 - *checking that patients receive information regarding their rights, especially at key points such as prior to an MHA Hearing or Tribunal. This includes checking that patients have access to papers prior to hearings and tribunals and are offered the support of an Independent Mental Health Advisor (IMHA)*
 - *checking that patients are given the opportunity to be involved in planning their care*
 - *checking that the Mental Health Act is applied equitably to people of all ethnicities and that people with learning disabilities and autism are not at a disadvantage*
 - *checking that, especially as regards the use of segregation and restraint, the principle of the application of the least restrictive option is always followed*
 - *to monitor the incident of out of area treatments to ensure they are minimised to the maximum extent possible within overall system limitations.*

Mental Health & Law Committee Annual Report 2023/24

For the period 01 April 2023 to 31 March 2024

The Mental Health & Law Committee is the principal sub-committee of the Board with responsibility to ensure the organisation is working within the legal requirements of the Mental Health Act (1983) as amended by the 2007 Act and Mental Capacity Act 2005. This Committee is required to provide assurance to the Board on the suitability of the Trust's processes to support the operation of mental health legislation.

1. Membership of the Committee and Frequency of Meetings

The core membership of the Committee has included two Non-Executive Directors, the Chief Medical Officer, the Director of Corporate Affairs and Company Secretary, the Deputy Director of Nursing/Chief Nurse and Head of Information Governance, David Walker, Non-Executive Director and Trust Chairman was the Chair of the Committee until 29 February 2024 when Geraldine Cumberbatch, Non-Executive Director became the Committee chair.

The Terms of Reference state that meetings will occur no less than four times per year and the Committee met 4 times in the reporting period.

To be quorate at least four members must be present one of whom must be a non-executive director. Each meeting during the period satisfied quoracy.

Attendance by Committee members:

Committee member	Attendance
David Walker (Non-Executive Director, Committee Chair 16/05/23-17/10/23)	4/4**
Geraldine Cumberbatch (Non-Executive Director, Committee chair from 29/02/24)	2/2**
Britta Klinck (Deputy Chief Nurse/Chief Nurse from December 2023)	1/4**
Karl Marlowe (Chief Medical Officer)	4/4**
Kerry Rogers (Director of Corporate Affairs & Company Secretary)	4/4**
Mark Underwood (Head of Information Governance)	4/4**

Regular attendees of the Committee and their attendance:

During the reporting period, the following officers of the Trust and other interested parties were invited to attend for all or part of meetings:

Regular Attendee	Attendance
Nicola Gill (Executive Project Officer) – Committee Administration	4/4
Amy Allen (Mental Capacity Act and Liberty Protection Safeguards (LPS) Lead)	2/4*
Brian Aveyard (Risk, Assurance and Compliance Manager)	1/4*
Rose Hombo (Deputy director of Quality)	1/4*
Leanne Dunkley (Corporate Governance Officer)	1/4
Lynda Dix (Associate Director of Nursing, Forensic Services)	1/4*
Kirsty Smith (PEACE Manager, Learning and Development)	1/4*
Lisa Lord (Head of Safeguarding)	1/4*
Pula Hur (Senior Named Nurse, Safeguarding Adults)	1/4*
Howard Ryland (Consultant Psychiatrist, Ashurst Psychiatric Intensive Care Unit)	1/4*
Roisin Mooney (Oxford Brookes University)	1/4*

*Attended when invited to cover specific agenda items

** Member of Mental Health & Law Committee

The Executive Project Officer attended meetings during the reporting period to take a true and accurate record of the proceedings of the Committee.

During the reporting period, the following also attended to observe meetings:

Observer	Attendance
Benjamin Cahill (Deputy Director of Corporate Affairs)	1/4

2. Reflections

National statistics mean we all remain concerned that Black or Black British people are more likely to be detained under the MHA, spend longer in hospital and have more subsequent readmissions than White people. Reliable local and national data is key to identifying inequalities in care and measuring progress towards closing these gaps and as a Committee we have ensured oversight of the Trust's position. The issue of missing data, clouds the accuracy of analysis of the Trust data, which has been interrogated, but does not indicate an increased use of the MHA than predicted by the population by ethnicity.

3. Business transacted by the Committee

Set out below is the remit of the Committee together with a report on the business transacted over the reporting period 01 April 2023 to 31 March 2024.

3.1. Monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary. Consider the implication of any changes to legislation and regulation within a local context.

During the reporting period the Committee discussed the trends in the application of the Mental Health Act with the Head of Information Governance providing an update report which included regular updates on:

- Detentions & CTOs;
- Use of the Places of Safety
- Second Opinion Appointed Doctors
- CQC (Section 120) Visits;
- CQC updates;
- Training Summary;
- Work of MHA/MCA Legislation Group; and
- Work of Mental Health Act Managers
- Right to a fair trial
- Complaints relating to the Mental Health Act

DoLS/Liberty Protection Safeguards update

At the May 2023 meeting, the Head of Safeguarding provided an update on the Liberty Protection Safeguarding, explain that the process has been delayed for the life of this government, with no implementation date. This presentation included what would be changing and how the Trust can prepare for this.

At the October 2023 meeting, the Mental Capacity Act and LPS lead provided an update to the Committee on Deprivation of Liberty Safeguards (**DoLS**) highlighting that the Trust had a robust standard operating procedure in place for community hospitals regarding **DoLS** and has started to provide bespoke training for the community hospital staff on the mental capacity act and **DoLS** to ensure that requests are appropriate and contained the right information. It was noted that best interest assessors were required alongside a medic for Dols, which the Trust has several trained professionals who were Approved Mental Health Professionals (**AMPs**) who are trained as best interest assessors and there is a plan in place to refresh the training for these individuals to allow them to complete the assessment for **DoLS**.

At the February 2024 meeting, the Mental Capacity Act and LPS lead provided an update to the Committee, highlighting that there had been an increase in training compliance with mental health act training across all directorates.

3.2. Receive reports following Care Quality Commission (CQC) visits and ensure appropriate action is agreed and implemented within the organisation.

A CQC update was presented at every meeting giving Members a sense of the visit findings and the Trust's processes for tracking implementation of recommendations. The themes coming out of the reviews were found to be consistent with the areas of improvement activity known to the Trust through such as incident reporting and other feedback mechanisms for which learning, and improvement projects were underway. The privacy of the person and their right for respect and dignity form part of each of these visits, including the environment and considers room design and layout, such as viewing portal on doors, the use of seclusion and restraint, which are discussed at weekly safety review meetings, to identify any escalations. These reports offer some reassurance, as the Trust's practice in relation to the Mental Health Act is being reviewed by an external organisation.

In May 2023, the Head of Information Governance highlighted that there had been two CQC visits to date with 6 actions outstanding and that the Trust regular inspector had now left the organisation.

In the July 2023 meeting, the Head of Information Governance updated the Committee that a further two CQC visits had taken place, which included Marlborough House (CAMHS), Kennet Ward, Wintle Ward and Vaughan Thomas Ward, with all the identified actions from Marlborough House and Kennet Ward having been completed.

In October 2023, the Head of Information Governance confirmed that further CQC visit had taken place to Allen Ward and Lambourne House, which identified recurring improvement themes requiring attention, including, section 17 leave, rights, consent to treatment, care plans and recording of capacity, all of which had been completed. The Deputy Chief Nurse noted the Trust had received CQC feedback regarding staffs understanding of the Use of Force Act and work was being undertaken to address this and communication was due to be disseminated to staff to help support understanding.

In February 2024 the Head of Information Governance assured the Committee that the Trust is on target with completed actions following CQC recommendations. The common theme identified were around training and there has been improvement seen. Amber Ward has recently had an inspection and the reports is pending for this.

3.3. Approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts.

No policies were brought to the Committee for approval during the reporting period as there had been no policy changes requiring the Committee's approval.

3.4. Monitor the provision of adequate guidance, information, education, and training on mental health legislation to staff, patients, carers, and other stakeholders.

The Head of Information Governance provided updates on the state of training at all the meetings held during the reporting period included as part of the Mental Health Trends update report.

At the meetings in April, July, October 2023, and March 2024 he commented that whilst there had been issues with the recording of training on the system, the uptake of training had increased month on month, however work needed to continue to achieve the 95% target, which as of March 2024 was around 75%.

In July 2023 the Mental Capacity Act and LPS lead highlighted that a plan to improve the delivery and content of the training programme and to improve figure moving forwards was being implemented.

In October 2023, the Head of Information Governance highlighted that discussions had taken place review learning and development for the following year, proposing separating the Mental Health Act and Mental Capacity Act training and to provide different offerings to the Community, Primary and Dental directorate and mental health focussed services to make the training more relevant to enable people's needs to be better met.

In February 2024, the Head of Information Governance reported that proposals had been made to learning and development to increase the duration of the training to two hours, following discussion with clinic staff, which is due to be implemented from April 2024. The face-to-face training for Doctors in training has commenced and is seeing good attendance.

3.5. Monitor the application of Human Rights principles and frameworks across the Trust and draw attention to any shortcomings in particular:

- **checking that patients receive information regarding their rights, especially at key points such as prior to an MHA Hearing or Tribunal. This includes checking that patients have access to papers prior to hearings and tribunals and are offered the support of an Independent Mental Health Advisor (IMHA);**
- **checking that patients are given the opportunity to be involved in planning their care;**
- **checking that the Mental Health Act is applied equitably to people of all ethnicities and that people with learning disabilities and autism are not at a disadvantage; and**
- **checking that, especially as regards the use of segregation and restraint, the principle of the application of the least restrictive option is always followed.**

During the period of this report, attention through the reports of the Head of Information Governance was given to the equitable application of the MHA for people of all ethnicities such that the Committee understood the Trust's position and the work that was being undertaken to improve in this important area. The clinical outage has of course made the automation of data analysis challenging. As Part of the regular report to the Committee, the Head of Information Governance reports on the MHA hearings and Tribunals, identifying any cases that were delayed due to incomplete paperwork, or lack of information, of which there were few. The use of Places of Safety as an admission bed are also interrogated as part of this report, and the rights of those individuals. Any lapses in detention are also discussed as part of this report. The availability of Second Opinion Associate Doctors and the gaps in this are discussed at each Committee meeting and the mitigations that are being used to ensure that patients receive timely good quality care.

The reporting from the Positive and Safe sub-committee of the Trust has supported the Committee's confidence that through oversight and Quality Improvement initiatives, significant activity is focussed on segregation and restraint and the principle of least restrictive options is embedded in practice.

In May 2023, the Associate Director of Nursing, Forensic Services and the PEACE manager provided an update on Mental Health Units (Use of Force Act) 2018, which came into effect on 31 March 2022. Part of this review of the Use of Force Act included the development of a Benchmarking checklist highlighting where the gaps were, and actions identified.

In May 2023, the Consultant Psychiatrist provided the Committee with an in-depth discussion and presentation on experience of working for the Parliamentary Office of Science and Technology (POST) on the Mental Health Act Reforms and the efforts to increase patient choice and autonomy.

In October 2023, The Deputy Chief Nurse provided an update on Restrictive Practice that all the policies that sit under restrictive practice had been reviewed, there had been a long Positive & Safe Policy which was more of a mission statement, an intention and direction setting. There would now be a Reducing Restrictive Practice Positive & Safe overarching strategy for the Trust, under that would sit the Use of Force Policy which set out the use of any kind of restrictive practice across inpatient areas and under that would sit seclusion, restraint etc. This would help staff articulate the Use of Force Act.

In February 2024, the Deputy Director of Quality, provided an update on Advocacy, which reflects the work of the Independent Mental Health Advocates, which are increasing in numbers and are now frequently present on the wards supporting patients.

The Head of Information Governance highlighted in the February 2024 meeting that the Trust had been issued with directions from the Tribunal in relation to facilities and following the securing of additional funding, there has been positive developments in this area, and changes are being made to the rooms that could be used for Tribunal and assured the Committee that these issues in relation to facilities were being addressed.

3.6. Other business transacted.

The following additional reports were received and reviewed:

- Legal & Regularity Update
- Liberty Protection Safeguarding
- Restrictive Practice
- Oxevision
- Mental Capacity Act
- Co-PACT
- Advocacy Report
- Patient Participation Groups
- Annual Report & Review of Terms of Reference
- Trust Risk register

Legal & Regularity Update

The Director of Corporate Affairs and Company Secretary provided oral updates as required, as part of this at the July 2023 she discussed the Strathdee Report and highlighted that the Trust would need to consider the regularity of training for Non-Executive Directors, as there is a risk of them only receiving this as part of their induction.

The Chief Medical Officer highlighted the consultant strikes which took place on 20 and 21 July, which were not expected to have a significant impact on the Trust, however correspondence received from the Mental Health Tribunals judge, stating to lessen the impact on patients, Tribunals would be scheduled outside of these dates where possible.

The Director of Corporate Affairs and Company Secretary at the October 2023 meeting highlighted the recent case law in gender critical beliefs, which made her reflect as Trust with acute and forensic wards and the changes happening rapidly regarding transgenderism were our policies adapting to this and were we giving due consideration to single sex accommodation. It was noted that by the Chief Medical Officer that that the NHS and the Department of Health & Social Care were still working on biological sex and therefore urged caution before changing policies, which

was supported by the Deputy Chief Nurse who noted NHSE had issued guidance in the past saying single sex wards should be gender based rather than sex based. However, as with all individual cases one would consider any kind of risks that might be known about that patient and work around them. The Trust were admitting people who were of a different sex to their gender onto their gender preferred ward.

At the February 2024 meeting, the Director of Corporate Affairs and Company Secretary highlighted that the Terms of Reference for the Health Service Safety Investigation branch had been announced. This branch will conduct investigations into Mental Health inpatient settings as directed by the Secretary of State. She also highlighted the newly released guidance published by the Department of Health which provides greater clarity on the duty to co-operate on discharge, in terms of working with local authorities to ensure that there are safe places in the community.

Liberty Protection Safeguards

The Head of Safeguarding and Senior Named Nurse Safeguarding Adults presented at the May 2023 meeting to provide an update on the Liberty Protection Safeguarding, which has at present been delayed. This presentation included what was changing and how the Trust could prepare for the proposed changes to ensure that the Trust was in a good position.

Restrictive Practice

At the May 2023 meeting, the Consultant Psychiatrist shared his experience of working on the Parliamentary Office of Science and Technology (POST) on the Mental Health Act reforms, specifically focusing on increasing patient choice and autonomy. He also described in depth about the MHA reform in England and Wales, the aspects of the proposed reform including Care and Treatment Plans, Advance Choice Documents, Nominated person, Advocacy, Tribunal review and Mental Health Commissioner. He then went on to highlight what may be next in terms of the reform. This generated a lot of discussion within the Committee, particularly around the resource implications of the reform.

Oxevision

The Chief Medical Officer provided an update at the July meeting on the Oxevision system which was being rolled out across all the Trusts general adult wards. This system allows staff to remotely observe a patient and monitor breathing rate and pulse rate without disturbing the patient. It allows staff to see a 15 second video when they need to take observations. The resolution of the video camera was exceptionally low, so there were no issues with privacy being breached. The Chief Medical Officer explained that there had been some Freedom of information requests following the roll out of Oxevision. The Trust was considering an early implementation of Oxevision

for observations on the wards to reduce impact on disturbance of sleep for patients who had 1:1 observation.

Mental Capacity Act

At the October 2023 and February 2024 meeting the Mental Capacity Act and LPS Lead provided an update to the Committee on the Deprivation of Liberty Safeguards (**DoLS**), which is the current legal framework for authorising **DoLS** in our hospitals. She noted the Trust had oversight of the number of **DoLS**, with an average of 20 people with a **DoLS** authorisation request in progress at any time. She highlighted the difficulty for the Trust is that these are authorised by the local authority, but assured the Committee that the Trust had a robust **SOP** in place and that an audit was scheduled to take place to look at the quality of the requests to ensure that they are appropriate.

Co-PACT

The Chief Medical Officer and Researcher and at Oxford University presented at the October 2023 meeting, explaining that Co-Pact was about giving a voice to those who had experienced a coercive use of the mental health act and co-designing a project for that voice to be noted in the context of the new mental health act due. This project started in February 2021, funded by NIHR, using photovoice methodology as a way for them to share their experiences as opposed to traditional interviews/questionnaires. This study was to feed into national policy development, and it was noted that the role of the Committee to recognise that there was a role for them to listen to advocacy as much as some of the operation delivery of its work.

Advocacy

The Deputy Director of Quality provided an update at the February 2024 meeting, highlighting the work of the Independent mental Health Advocates in Oxfordshire and Buckinghamshire, commissioned through the local authority on all inpatient wards. She explained that the number of independent advocates on the wards were increasing, following them being dropped during the pandemic. She will provide regular updates to the Committee, that will focus on the learning and triangulate data to understand whether there is a need to increase activities. The team is working to address issues with access to advocacy identified through PALS and complaints. It was noted in the report that the Trust is doing well at ensuring people are read and understand their rights under the Mental Health Act. The Introduction to advocacy is viewed positive, as 80% of the Trusts mental health inpatients are detained under the Mental Health Act.

Patient Participation Groups

The Deputy Director of Quality provided an oral update at the February 2024 meeting on the development of the Patient Participation Groups which have been set up across the Trust using the "Your Voices". She highlighted that new groups are due to start in

the Young Peoples pathway and the neurodivergent groups. It was noted that the Trust is increasing involvement and numbers of experts by experience increasing co-production in projects. Work has been commissioned by a company called Onlog, which is aiming to develop the young people's pathway to enable them to visit schools to engage in wellbeing discussions.

Annual Report and review of Terms of Reference

The Committee discussed iterations of the Annual Report at its meetings in July and October 2022 and approved its presentation to the Board at its November 2022 meeting. The Committee agrees it had throughout the year reported upon, monitored, reviewed, and escalated to the Board of Directors the fitness of the Trust's processes to support the Trust's delivery of care in accordance with mental health legislation.

Trust Risk Register

The Trust Risk Register and the risks pertinent to the Committee were discussed at the meetings in October 2023 and February 2024 and as a result of this those risks directly linked to the Committee are now featured on every agenda with updates where required and assurance gained by constant oversight of these. It was agreed at the October 2023 meeting to remove the risk 1066 from the Trust Risk Register.

4. Reporting

All Committee meetings were formally recorded. The minutes were distributed to all Committee members and formally reported to the Board of Directors.

5. Overall

This report records the third year of the Committee's operation. Overall, it was a productive year in which it delivered against the purposes set out in its Terms of Reference.

The Committee is through its work across the year able to offer assurance to the Board that the arrangements to monitor and review the way functions under the Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

Mental Health and Law Committee Effectiveness Questionnaire 2023/2024

- 1) Has the Committee's membership been effective (range, skills, frequency of attendance, contribution)
Yes
- 2) Does the Committee's work programme cover the relevant assurance needs of the organisation and does the Committee provide insight and constructive challenge to the organisation where required?
Yes

- 3) Has the Committee made a conscious decision about how it wants to operate and the level of information it would like to receive for each of the items in its business cycle?

This has been done for 2024-25

- 4) Does management fully brief the Committee in relation to key risks, assurances, gaps in controls/assurances in a timely fashion?
Yes
- 5) Do the Committee's papers and meetings (length and frequency) support the Committee to perform its role effectively?
Yes
- 6) Does discussion at meetings (agenda items concluded, clarity on how progress will be monitored and reflection on outcomes/decisions) support the Committee to perform its role effectively?
Yes

Report to the Meeting of the Oxford Health NHS Foundation Trust

People, Leadership and Culture Committee 30 April 2024

Annual Report 2023-24 For Approval

Agenda item: 16(d)

Executive Summary

The Annual Report summarises the work of the People, Leadership and Culture (PLC) Committee during the period of April 2023 to March 2024.

The Committee has prioritised assuring plans to increase fill rates, reduce agency spend and demand together with the internal practices to improve recruitment and retention. Equality and Diversity were also a priority for the Committee and this is reflected in reports that were noted on the Trust performance in relation to WRES/WDES and Gender Pay Gap. Progress was noted by the Committee in the significantly improved compliance rates in relation to statutory and mandatory training and PDR compliance and it was noted that although supervision compliance rates had improved, further work was needed to meet the target.

For the first time the Committee has also received 6 monthly reports to provide assurance of the trends and current position of Employee relations cases and this has included reviewing trend data through the lens of protected characteristics.

In relation to the medical workforce, the Committee took updates in relation to medical appraisal and revalidation and recommendations for clinical excellence award distribution and a policy should these continue into the 24/25 financial year. There was a focus on supporting the engagement and wellbeing of the medical workforce, The Committee also took assurance via the Guardian of Safe Working Hours in relation to the current practices.

Part way through the year it was agreed that the Health and Safety Committee would come within the remit of the PLC Committee and reflecting this, the Committee noted an Annual Report in relation to Health and Safety.

Reflecting the Board's recent self-assessment in relation to speaking up arrangements, the Committee also noted an annual report from Guardians on speaking up arrangements within the Trust.

Clarity was also reached in relation to the working groups that support the people agenda and the Committee now receives quarterly highlight reports. As with other sub committees, the Chair of PLC updates the Board via a 3A reporting system so can be alerted and assured of the work of the committee.

Governance Route/Approval Process

The People, Leadership and Culture Committee is asked to review and approve the Annual Report for presentation to the Board of Directors. The Chair of the PLC Committee will also consider the merit of taking this report to Audit Committee to provide assurance of the programme of work that was undertaken.

Strategic Objectives/Priorities

The work of the PLC Committee is broadly focused on assuring the formulation and delivery of the strategic priorities and attendant risks related to workforce as set out in the OHFT Strategy 2021-2026. However there are links and interdependencies to the other three priorities – Quality; Sustainability and Research and as such the membership of the Committee includes a number of the Executives who lead on these particular areas.

Recommendation

The Committee is requested to approve the report.

Author and Title: Charmaine De Souza, Chief People Officer

Lead Executive Director: Charmaine De Souza, Chief People Officer

People, Leadership and Culture Committee Annual Report 2023/24

For the period April 2023 to March 2024

The People, Leadership and Culture Committee is a principal sub-Committee of the Board, with responsibility for assuring the effective planning and scrutiny of workforce matters. This Committee provides assurance to the Board on key workforce decisions and policy, workforce metrics and matters pertaining to organisational development such as leadership, equality and inclusion, and staff wellbeing. The Committee also ensures there are clear governance arrangements in place to oversee the operational activity.

1. Membership of the Committee and Frequency of Meetings

The Committee is chaired by a Non-Executive Director with at least two other NEDs attending as members. At least three Executive Directors including the Chief People Officer attend. Other Executive Directors will be invited to attend as appropriate to the business of the meeting. The CEO and Chair have standing invitations to attend any meeting.

Other Directors and senior managers may be asked to attend in support of agenda items or to provide further information required by the Committee. Regular attendees, who are not voting members unless formally deputising and exercising the vote of their principal, include senior clinical and operational management leaders.

The Committee meets as required to fulfil its remit and will meet at least four times in each year. The Committee may consider urgent matters through correspondence. The lead Executive (Chief People Officer), along with the Director of Corporate Affairs and Company Secretary, support the Chair to set the forward look for the Committee and the agendas for each Committee ensuring that work and actions delegated from other Committees is considered in a timely way.

The quorum for the Committee is six members, to include the Chair of the Committee (or the vice Chair of the Committee in their absence), one other Non-Executive Director and one Executive Director. Deputies count towards the quorum and attendance rates. Attendance is monitored as part of the Annual Report on the Committee's performance to the Board of Directors and members are expected to attend at least 75 per cent of Committee meetings.

Four meetings took place in the 2023-24 year – these were in April 2023, July 2023, October 2023, and January 2024.

Attendance by Committee members:

COMMITTEE MEMBERS	TITLE	ATTENDANCE	ELIGIBLE ATTENDANCE
Mindy Sawhney	Non-Executive Director (as Chair)	4/4	4/4
Andrea Young	Non-Executive Director	4/4	4/4
Nick Broughton	Chief Executive	0/4	1/4
Grant Macdonald	Chief Executive	2/4	3/4
Charmaine De Souza	Chief People Officer	4/4	4/4
Heather Smith	Chief Finance Officer	3/4	4/4
Kerry Rogers	Director of Corporate Affairs & Company Secretary	4/4	4/4
Grant Macdonald	Executive Managing Director, Mental Health & Learning Disabilities	1/4	1/4
Rob Bale	Executive Managing Director, Mental Health & Learning Disabilities	1/4	2/4
Amelie Bages	Executive Director of Strategy & Partnerships	4/4	4/4
Ben Riley	Executive Managing Director, Primary, Community & Dental care	3/4	4/4
Karl Marlowe	Chief Medical Officer	0/4	4/4
Marie Crofts	Chief Nurse	0/4	3/4

The quorum was achieved in all 4 meetings during the reporting period.

Regular and Occasional attendees of the Committee and their attendance:

During the reporting period, the following officers of the Trust and other interested parties were invited to attend for all or part of some meetings:

REGULAR ATTENDEES	TITLE	ATTENDANCE
Alison Bourne (nee Cubbins)	Head of HR Policy, Rewards and Projects	4/4
Becky Elsworth	Head of Learning & Development	1/4
Hannah Smith	Assistant Trust Secretary	4/4
Jill Castle	Head of HR, Community & Corporate	3/4
Joe Smart	Head of Organisational Development	4/4
Matt Edwards	Director of Clinical Workforce Transformation	3/4
Brian Aveyard	Risk Assurance and Compliance Manager	4/4
Sigrid Barnes	Head of HR Systems & Reporting	1/4
Tara O'Brien	Head of Resourcing	2/4
Zoe Moorhouse	Head of HR, Mental Health & Specialised	3/4
Christina Foster	Head of Health & Safety / Estates Support Services	2/4
Emma Leaver	Service Director	2/4
Ben Cahill	Deputy Director of Corporate Affairs	2/4
Priya Thompson	Head of Strategy	2/4
Shirley Innes	Executive Assistant to Chief People Officer	3/4

OCCASIONAL ATTENDEES	TITLE	ATTENDANCE
Geraldine Cumberbatch	Non-Executive Director	1/4
Kezia Lange	Deputy Chief Medical Officer	1/4
Mo Patel	Head of EDI	1/4
Becky Rowe	Project Manager, HR Systems	1/4
Peter Milliken	Director of Finance	1/4
Deboarh Darch	Executive Assistant To Chief Medical Officer and Executive Director of Primary, Community and Dental Care	1/4
Diane Woodward	Nursing Workforce Transformation Manager	1/4
Freya Waller	Education Mental Health Practitioner (as voice of slot)	1/4
Bill Tiplady	Director of Psychological Professions	1/4

Alastair Reid	Consultant Psychiatrist and Director of Medical Education	1/4
Ade Adegboyega	Matron, Bicester and City Community Hospitals (as voice of slot)	1/4
Mandy Murch	Head Housekeeper, Wallingford Community Hospital (as voice of slot)	1/4
Kelly Whipp	Facilities Support Manager	1/4
Tina Malhotra	Clinical Director, Adult MH Assessment & Treatment Team South	1/4
Tom Ayre	Rotational Physiotherapist (as voice of slot)	1/4
Emma Rockall	Senior AHP Clinical Lead for Intensive Integrated Community Care and First Contact and Primary Care Services (as voice of slot)	1/4
Lianne Bowes	Freedom to Speak up Guardian	1/4
Rita Bundhoo-Swift	Freedom to Speak up Guardian	1/4

An Executive Assistant attended meetings during the reporting period to take a true and accurate record of the proceedings of the Committee.

During the reporting period, the following also attended to observe meetings:

OBSERVER	TITLE	ATTENDANCE
Vicki Bull	Head of Business Services	1/4
Emma Short	Governor	1/4
Carl Jackson	Governor	1/4

Remit of the People, Leadership and Culture Committee

1. The broad role of the Committee is to:

- Provide **assurance** that we have in place and are implementing appropriate policies, procedures, systems and processes to ensure we have adequate staffing and that we are supporting our staff to undertake their duties to the best of their abilities. We seek assurance both in relation to the underpinning corporate work done by the HR function, and also in relation to workforce activity led and delivered by divisions
- Provide **assurance** that the Trust is compliant with employment legislation and regulatory frameworks and that we are meeting our own Trust targets in relation to being appropriately trained and deployed
- The CPO agreed that the work programme should be reviewed for assurance??
- **Monitor** and take assurance that **action** is taken in relation to workforce metrics and identify and **update** relevant risks
- **Approve** and **monitor** strategies related to the full employment lifecycle
- It was agreed at the PLC Committee in April 2023 that such Policies and procedures should in future be signed off by the Chief People Officer, and that the PLC Committee should receive assurance of the principles guiding policy development, a forward annual view of work that will be done, and an annual summary of Policies that have been approved.

2. Business Transacted by the Committee:

Set out below is the remit of the PLC Committee together with reporting on the business transacted over the reporting period 01 April 2023 to 31 March 2024:

3.1 In relation to the following elements of the Terms of Reference:

Policy supports the Trust to use best practice in effective staff deployment and workforce planning to achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually;

The right staff with the right skills are in the right place at the right time – as per requirements;

Staff establishments are up to date and processes in place to ensure a full complement of staff, thereby minimising reliance on temporary staffing

The Committee received the following updates:

- The **Improving Quality Reducing Agency programme** was scrutinised at all four meetings in relation to the performance against NSHEI targets to reduce both agency demand and expenditure, utilising the targets in relation to

recruitment and retention inputs into the programme that support agency avoidance costs as well the performance of the managed service providers as they were launched during the course of the 23-24 year; the April 2023 meeting took assurances and updates regarding the implementation of NHS Professionals which had recently launched in February 2023 but had experienced technical issues as a result of failure of NHSP systems during the first few weeks of launch; the July 2023 meeting were assured that the contract for medical bank with the Patchwork supplier had gone smoothly; the October 2023 meeting took assurances about the multi-year nature of the programme and how the agency reduction targets would be set beyond the 23/24 year, and noted that while improvements had been made in relation to Agenda for Change (AfC) Bank fill rates, the performance of NHSP was not yet on target; in January 2024 the update report focused on a summary of progress in relation to our Managed Service Providers – namely NHSP; IDM contracts (for AfC and for Medical) and Patchwork, and discussed that the focus for the year ahead would be on improving rostering practices.

- The Committee continued to review the work to address the levels of **mandatory training** which had improved significantly reaching c90% compliance rates (at end of March 2024) but had not yet reached the 95% target. The October 2023 Committee asked for further analysis to be done on the teams and courses that were below the Trust average – particularly in relation to Resuscitation Training. The Committee also noted that progress had been made in rolling out Oliver McGowan Level 1 training and that this would continue ahead of the training being merged into Statutory and Mandatory requirements from April 2024.
- Supplementing the assurances in relation to the internal inputs to agency reduction, the Committee reviewed the end to end **recruitment process** (April 2023) and the work that was underway to reduce time to hire.
- Interventions to improve **retention** were examined to understand how the Trust was undertaking work to reduce turnover particularly in relation to early turnover (July 2023)
- For the first time the Committee began to review 6 monthly reports in relation to **Employee Relations** particularly in relation to length of time to conclude cases and analysis of protected characteristics in relation to those who were subject to disciplinary procedures.

3.2 In relation to the following elements of the Terms of Reference:

There is effective management of the key risks the Trust is seeking to manage in the context of realising its People Strategy;

- The Committee was provided assurance that the **TRR risks and BAF risks** were being monitored.

- The risk in relation to Payroll Contract (TRR1139) was closed following assurances that a new contract was now in place.
- The risk in relation to historical low PDR compliance rates (TRR 1168) was closed given that the PDR Season that had been implemented in Spring of 2023 had been effective in reaching a c90% compliance rate.
- The risk in relation to Statutory and Mandatory Training (TRR 1166) was agreed to be kept open but it was agreed that Executives were to review the risk so that it better reflected the directorates and courses that were below the Trust average of c90% compliance rate.
- Following a workshop to discuss the risk in relation to adequacy of staffing, the BAF 2.6 was reviewed and this was agreed to be put forward to the Audit Committee for discussion.
- All four Committees received **Workforce** metric reports and these were refined across the year to link the metrics to the national People Plan and People Promise. This was further refined to produce commentary and reports for the Mental Health and Community Directorates. These were supplemented with updates against the Trust Annual Plan and the Directorate people objectives.

3.3 In relation to the following elements of the Terms of Reference:

Sufficient focus is given to regional People priorities and key requirements of the NHS National People Plan;

Relevant Trust strategies help the Trust diagnose its cultural issues, develop collective leadership strategies to address them and implement changes;

There is effective management of delivery against agreed key performance metrics to support realisation of its People Strategy and there is evidence of continuous improvements across all these areas;

- Update of results of the **Staff Survey** (April 2023) and response rates with information on the corporate action plan to improve engagement was reviewed following a more high-level report to the full Board; the Committee noted the difficult circumstances in relation to industrial action that had prevailed during the period ahead of this survey and that plans were well advanced to address PDR compliance rates in relation to the forthcoming PDR season. The Committee also reviewed the survey results in relation to professional groups and protected characteristics. At the July 2023 Committee meeting, plans were reviewed in relation to team coaching offers being made available to teams that scored lower than average engagement results. Medical engagement and wellbeing was discussed separately to the overall Trust staff survey results (July 2023) to provide assurance on a range of areas including reward; retention and recruitment.

- Following the review of the **Leadership** training offer in the previous year (July 2022) the Committee endorsed the proposal to adopt the NHSE "Leadership Way" framework set by the NHS Leadership academy
- **HR Policy Review Programme** in a change to previous governance arrangements, the Committee agreed that going forward HR Policy updates and new policies should be signed off by the CPO with an annual report to come to the Committee to provide assurance of this. The first of these annual reports would be due in the first Committee of 24/25.
- The Committee examined **Medical Appraisal and Revalidation** progress (July 2023) and noted that the shift to e-appraisals in line with NHSE requirements had gone well and there was good feedback from those being appraised.
- Assurance was provided in relation to the Trust response to **WRES/WDES indicators** with progress updates of the discovery and design phases of the QI Race Equality programmes; this was supplemented with updates on the Trust progress to implement the NHSE High Impact actions as set out in their EDI Improvement Plan (Jan 2024).
- **Gender Pay Gap** reports were reviewed for the years ending March 2022 and 2023 and the Committee noted that for the year ending 2024, the NHSE EDI Improvement plan was recommending that Trusts also expand their analysis beyond the statutory requirements to include race and disability pay gap analysis.
- The Committee agreed how **Clinical Excellence Awards** were to be distributed for the 2023/24 year and in the January 2023 Committee, proposals were assured for the 2024/25 financial year noting that if the BMA approved the current government pay offer then this would not need to be implemented as the revised pay deal would bring CEAs to an end.
- The Committee discussed a report in relation to the **Wellbeing Guardian responsibilities** and how these were being discharged by the Trust (October 2023).

Other business:

- The Committee took direct feedback via a **staff story** at each meeting. This included an Education Mental Health practitioner who works in schools supporting students; a Matron from one the Trust Community hospitals; a head housekeeper from community services; and also colleagues leading change on behalf in relation to allied health professions.
- Updates were received in related to **Food Provision** across the site and it was agreed that this would come back to the Committee when further work had been done to agree a future plan.
- Part way through the 23-24 year, it was agreed that the work of the **Health and Safety Committee** would be part of the PLC remit and following this an Annual Health and Safety Report was discussed in the January 2024 meeting.

- The **People Systems Development Programme** provided a more in-depth report to the Committee which was noted in January 2024.
- An annual report from the **Freedom to Speak Up Guardians** was noted by the Committee and it was agreed that a future report, which would move to a financial year report would include analysis of referrals by protected characteristics, role type and location.

Report to the Meeting of the Oxford Health NHS Foundation Trust

Quality Committee 02 May 2024

Agenda item:16(e)

Draft Quality Committee Annual Report 2023/24 For Approval

Executive Summary

The Annual Report summarises the performance and work programme of the Quality Committee during the period 01 April 2023 to 31 March 2024.

Overview from QC Chair

The Committee has strived to achieve a balanced approach to quality governance. This includes,

- a deeper understanding of the context and innovative approaches teams are taking to address capacity issues (urgent care, neurodivergent services);
- modernising pathways (community mental health framework implementation);
- attention to culture and leadership (forensic services and the national mental health programme);
- promoting QI as an improvement tool and supporting the development of our patient and carer experience strategy;
- regular and timely review of the quality dashboard; and
- oversight of new assurance systems including the Patient safety improvement framework and our new automated clinical audit management system (**AMAT**)

Inevitably the Committee's attention has been drawn to staffing gaps, which remain around 30% across the Trust. The Committee focusses on the Quality dashboard to see where this is triangulated with quality concerns and has ensured management action is in hand to address those issues. The safer staffing report confirms no overall deficit in patient care hours and fill rates continue to demonstrate our reliance on temporary staff. However we continue to work closely with People, Leadership and Culture sub-committee to address all potential areas for improvement and to identify where more innovative approaches to skill mix for example can help e.g. podiatry care.

The Committee has contributed to the refresh of the Trust strategy including the selection of strategic quality indicators to measure progress. The Committee is keen to see more outcome focussed measures over time, as data sets become available. The lack of data due to the system outage last year meant that we relied on manual systems for assessing waiting times and experience. In February we received the first waiting time data since August 22. Our focus in

24/25 is to seek assurance through improved data and analysis, enabling deeper consideration on the choices and innovation options available.

My thanks to the staff who contribute so openly to the work of this Committee. There is energy and ambition in the conversations. Getting closer to the experience of our patients supplemented with real time data will support our journey to excellence.

Governance Route/Approval Process

The Quality Committee is requested to review and if appropriate recommend the Quality Committee Annual Report to the Board for final approval in May.

Strategic Objectives/Priorities – this report relates to or provides assurance and evidence against the following Strategic Objectives/Priorities of the Trust:

- 1) Quality - Deliver the best possible clinical care and health outcomes

Recommendation

The Committee is requested to note the Quality Committee Annual Report, overview workplan and revised Terms of Reference (**ToR**).

Author and Title: Leanne Dunkley, Corporate Governance Officer

Contribution: Andrea Young, Non-Executive Director & Quality Committee Chair

Lead Executive Director: Britta Klinck, Chief Nurse

1. *A **risk assessment has been undertaken around the legal issues** that this report presents and there are no issues that need to be referred to the Trust Solicitors.*
2. ***Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** - this report relates to, or provides assurance and evidence against, the following Strategic Objective(s)/Priority(ies) of the Trust:*
 - *Quality - Deliver the best possible clinical care and health outcomes; and*
 - *Strategic risk themes: Triangulating data and learning to drive Quality Improvement (QI); Unavailability of beds/demand and capacity (Mental Health inpatient and LD); and demand and capacity (Community Oxfordshire).*
3. *This report satisfies or provides assurance and evidence against the requirements of the following **Terms of Reference of the Quality Committee**:*
 - *to oversee the effective development of the Trust's **corporate and clinical governance** arrangements;*
 - *to ensure that there is an objective and systematic approach to the **identification and assessment of risk and delivery of the organisation's priorities** in the context of all national standards;*
 - *overview of the draft **Quality Account and Quality Report**;*
 - *to ensure the development and maintenance of the **integrated governance framework**; to review and approve any major change to the governance framework, structures or management taking account of national strategies, priorities and developments concerning governance and risk management;*
 - *to critically review and recommend to the board, and to receive annual progress reports where applicable on, the following strategies and programmes: **patient and carer experience**, including **complaints and PALS**; **quality, including safety and harm reduction, incident reporting** and management, **clinical audit**; **quality improvement**; **safety of the physical estate**; and **compliance with national requirements** and standards including CQC, NICE, NHS Resolution;*
 - *to approve supporting strategies relating to these key strategies, including **resourcing, training and development and communication**;*
 - *to ensure effective **interface between the Audit Committee, the Quality Committee and the Quality and Clinical governance Sub-committee and the co-ordination of risk management** processes across the Trust, both clinical and non-clinical;*

- to ensure that **workforce planning, education and training** are fully integrated into the integrated governance framework, ensuring a workforce fit for purpose overseen by the People, Leadership and Culture Committee;
- to ensure the Trust's readiness for submission to **external governance reviews and developing and monitoring action plans** to identify shortfalls e.g. CQC, Health & Safety Executive, general auditors, and NHS Improvement;
- to provide an annual report to the Audit Committee of assurance gained throughout the year or consider having a joint meeting with the Audit Committee;
- to agree and **monitor the work of the Quality and Clinical governance Sub-Committee**, through their annual report, their performance and effectiveness within the integrated governance framework;
- to receive and review at each of its meetings an **escalation report from the Quality and Clinical Governance Sub-Committee that provides a summary of the business transacted and escalates any matters requiring the Committee's attention**. More substantive issues arising from the business of the Quality and Clinical Governance Sub-Committee will be brought to the Quality Committee through the provision of papers consistent with the guidelines for committee papers; and
- to receive briefings on legal and key national policy developments.

Quality Committee Annual Report 2023/24

For the period 01 April 2023 to 31 March 2024

The Quality Committee (**Committee**) is the principal sub-committee of the Board with responsibility to oversee the effective development of the Trust's corporate and clinical governance arrangements, in that there is an objective and systematic approach to the identification and assessment of risk and delivery of the organisation's priorities in the context of all national standards. This Committee oversees the structures and processes of the Trust to offer assurance in effective governance. It seeks to examine continuous improvement of the quality of the Trust's services in how clinical and non-clinical risk management is coordinated across functions and responsibilities; and how the Trust will evidence compliance with national standards.

1. Membership of the Committee and Meetings

Committee membership as outlined in the current Terms of Reference (**ToRs**) at Appendix 1, were approved at the July 2023 meeting. The Committee met the criteria as laid out in the ToRs around meeting quoracy, frequency of meetings and attendance by Committee members, detailed at Appendix 2, that also notes attendance by regular attendees and other interested parties invited to attend for all or part of meetings. During the reporting period a member of the Corporate Governance team attended to record a true and accurate record of the proceedings of the Committee.

2. Remit of the Quality Committee

The broad role of Quality Committee and its sub-committee, Quality and Clinical Governance Sub-Committee (**QCG-SC**), is to:

- provide **assurance** that we have in place and are implementing appropriate policies, procedures, systems, processes and structures to ensure our services are safe, effective and efficient;
- provide **assurance** that the organisation is compliant with regulatory frameworks and legislation;
- **approve** changes in clinical or working practices or the implementation of new clinical or working practices;
- **approve** new or amended policies and procedures;
- **monitor** and ensure **action** is taken on the quality, effectiveness and efficiency of services and identify any associated risks;
- **approve** and **monitor** strategies relating to quality; and
- **monitor** the development of clear quality outcomes

3. Business transacted by the Committee

Set out below is the remit of the Committee as outlined in the current ToRs. The fulfilment of the Committee's remit is supported by the Quality Committee overview plan for 2023 – 2024, which details frequency of reporting and business transacted over the reporting period. Notes

below will support any highlight or exception reporting to information detailed in the overview plan.

3.1 Overview of the draft Quality Account and Quality Report

The Annual Quality Account and Quality Priorities 2023/24 was presented and approved at the May 2023 meeting and following Board approval had been published by the national deadline. The Chair summarised the Quality Account, noting it drew on a patient centred approach; offered an important lens to view services; supported learning; provided information for audits and surveys; amplified the Experience and Involvement strategy; supported the discipline of employing QI across the Trust; and affirmed that more numeric targets would further help us measure and evaluate progress.

A one-page summary of the Quality Priorities was approved at the July 2023 meeting.

At the September 2023 meeting an update report was presented which took the Committee through progress against the 10 quality objectives identified. It was highlighted that the ongoing impact of the clinical systems outage, further to the cyber-attack upon a third-party supplier to the Trust last year was affecting the data sources for objectives around (i) management of pressure damage, and (ii) measuring and capturing outcomes in mental health services. As a result of this the Trust was unable to submit national data for Commissioning for Quality and Innovation (**CQUIN**) indicators. The Trust was still able to present monthly data to the Buckinghamshire, Oxfordshire and Berkshire West (**BOB**) Integrated Care System (**ICS**). Updates were also provided on the pilot of a Trauma Risk Management (**TRiM**), routine Clinical Outcome Measure in the mental health services and improving physical health for people with a serious mental health illness. It was noted by the Chair that the Trust had set itself ambitious quality objectives and therefore had a considerable amount to achieve. It was also significant that 5 out of the 10 quality objectives were being affected by the impact of the clinical systems outage and although this was not preventing productive activity from taking place, the Trust's ability to measure that activity was being hampered. This would also be relevant to consider when the meeting later discussed waiting times and the impact of the clinical systems outage upon the Trust's ability to measure waiting times.

At the February 2024 meeting a further update was provided which highlighted:

- the Trust continues to make progress in all 10 areas, however due to the legacy of the IT outage it was not able to demonstrate this in all areas, which should improve over the next 6 months;
- the transformation work around district nursing is ongoing which aims to maximise capacity, manage demand and improve quality;
- the use of prone restraint in clinical practice continues to fall; and
- the transition to Patient Safety Incident Response Framework (**PSIRF**).

3.2 To ensure the development and maintenance of the integrated governance framework; to review and approve any major change to the governance framework,

structures or management taking account of national strategies, priorities and developments concerning governance and risk management

Adherence to national strategies and any required changes was referenced in reports received by the Committee when applicable. The Committee's work is mapped against the themes of: Safety; Effectiveness; Quality Improvement (**QI**); Caring and Responsive; Research; Policies and Strategies; and Governance. In addition, standard reporting includes Quality Compliance and Regulation updates; Operational and Strategic risk reporting via the Trust Risk Register (**TRR**) and Board Assurance Framework (**BAF**); and Provider Collaboratives (**PCs**) updates for oversight and governance of PCs where the Trust is the lead provider.

Strategies and policies allocated to the Committee were approved during the reporting period, detailed in the overview plan, which included the Nursing strategy; Experience and Involvement Strategy; Friends, Family and Carers Strategy; Legal Proceedings Policy; and Research and Development Policy.

At the May 2023 meeting the Executive Managing Director for Mental Health and Learning Disability & Autism brought an update to the Committee on the New National Mental Health Learning Development and Autism inpatient quality transformation programme which was underway following the Edenfield documentary.

The Committee discussed at the May 2023 the importance of governance for the Oxford Health Biomedical Research Centre (**BRC**) including how they would link with the Board and its sub-committees and how to develop transitional work into clinical practice.

Following Internal Audit on the Trust's processes in relation to Prevention of Future Death (**PVD**) notices, three areas for improvement were identified and presented to the Committee. The Committee was assured by the improvement actions taken.

3.3 To critically review and recommend to the Board, and to receive annual progress reports where applicable on, the following strategies and programmes: patient and carer experience, including complaints and PALS; quality, including safety and harm reduction, incident reporting and management, clinical audit; quality improvement; safety of the physical estate; and compliance with national requirements and standards including CQC, NICE, NHS Resolution

The Committee received annual update reports, mandatory reports and strategies as outlined in the Committee workplan.

During 2023/2024 managers have reported on the evolving roll out of the Audit Management and Action tracker tool which has enabled us to track audit activity and compliance with NICE recommendations. A regular report is provided to each Quality Committee. Audit findings are then appropriately directed into the Learning and Development group.

The Committee also oversaw the transitioning to a new Patient Safety Improvement Reporting Framework, meeting the April 24 deadline.

At the May 2023 meeting the Director of Infection Prevention and Control Annual Report was presented and recommended to the Board, noting that the Social Care Act had been updated in December 2022 and that the year's programme would focus on taking responsibility for the environment, cleanliness, ventilation and cleaning standards. The Policy Register Annual

update was noted, and the Complaints Annual Report was recommended to Board and the Quality Committee Annual Report was recommended to report to the Audit Committee.

At the September 2023 meeting the Head of Safeguarding presented the Safeguarding Service Annual Report, noting that during the reporting period the service had undergone a restructure and become a more integrated adult and children service.

An update on the strategic dashboard draft proposal was presented at the September meeting which highlighted the Objective Key Results included in the Integrated Performance Report (IPR) to the Board were being reviewed in order to: give more strategic focus to the IPR and the Annual Planning process; and better define what the Trust wanted to achieve by the end date of its current Strategy, March 2026. For each of the current 4 Strategic Objectives, the lead Executive and Non-Executive Director had participated in defining an ambition and outcome measures; ultimately the final outcome measures would be brought together in a Strategic Dashboard to sit at the front of the IPR. The draft proposed Quality and Research ambitions and outcome measures were presented for the Committee's review.

3.4 To approve supporting strategies relating to these key strategies, including resourcing, training and development and communication

The requirement of resourcing, training and development now fell under the PLC Committee. However, workforce related matters were incorporated in reports where relevant. Workforce overview, mandatory training, and safer staffing information was routinely reported in the QCG-SC and dashboard updates.

The Committee continued to be updated with the resuscitation training plan over the year, along with regular updates on safe staffing levels and the transition of staff from temporary/bank staff to NHS Professionals.

At the May 2023 meeting a presentation was made to the Committee on the New out of Hospital Services, through the eyes of a patient journey.

In July 2023 the Committee considered an ambitious strategy aimed at improving patient and carer experience. The strategy was well received by the Board. The Committee will take six monthly progress reports on the agreed metrics.

At the July meeting the Head of Quality Governance presented papers highlighting that learning from incidents was moving to a new framework, which would focus on family involvement; safety planning; and shared care with partners, which was due to be rolled out in September 2023. At the September meeting the Committee approved the local safety areas in the Patient Safety Incidents Response Plan, which was a pre-requisite for transitioning to the national Patient Safety Incident Response Framework

3.5 To ensure effective interface between the Audit Committee, the Quality Committee and the Quality and Clinical Governance Sub-Committee and the co-ordination of risk management processes across the Trust, both clinical and non-clinical

Effective interface was achieved through the singular governance committee below the Quality Committee, the QCG-SC. The Trust Solicitor and Risk Manager is a member of the QCG-SC and the Quality Committee ensuring co-ordination of effective interface and risk management. The Committee Chair and Risk Assurance and Compliance Manager are regular attendees of

both Committee's. The Chief Nurse chairs the QCG-SC and is a regular member of the Quality Committee.

3.6 To ensure that workforce planning, education and training are fully integrated into the integrated governance framework, ensuring a workforce fit for purpose overseen by the People, Leadership and Culture Committee (PLC)

Since the introduction of the PLC Committee responsibility for workforce and education is the remit of the PLC. The Chair of the Quality Committee is a member of the PLC together with Quality Lead Executive Directors.

Issues relating to workforce were discussed at all Committee meetings, noting that there were high levels of vacancies which were being covered by temporary staffing, which was allowing fill rates to be met. Following a review of the Trust's current position by the Chief Nurse against the expectations of 'Right Staff, Right Skills, and Right Place and Time' a number of areas for improvement were identified with next steps including:

- using validated tools and data collection during November to ascertain acuity and dependency levels in all ward areas;
- confirming with ward managers the unavailable hours across the working week to ensure that the establishment is accurate (e.g., deputy ward managers having time to supervise junior staff);
- taking forward in Q4 the e-rostering improvement programme; and
- further driving down the use of temporary staffing.

3.7 To ensure the Trust's readiness for submission to external governance reviews and developing and monitoring action plans to identify shortfalls e.g. CQC, Health & Safety Executive, general auditors, and NHS Improvement

A QI focus across reporting to the Committee ensured readiness on an on-going basis for internal and external reviews with relevant reports including updates against the monitoring of action plans.

The Committee takes regular reports on Quality Improvement work across the Trust, from small projects at ward level aimed for example at user engagement or reducing restraint to larger scale innovation such as using AI to improve triage times in neurodiversity services (Feb 24). The Committee also considered new approaches to out of hospital care (May 23) enabling a good understanding of the clinical risks being managed by our community teams in keeping patients as close to home as possible, maintaining independence.

At the July 2023 meeting the Director of Corporate Affairs and Company Secretary provided an oral update on the interim feedback received from the Good Governance Institute who had led a developmental mock Care Quality Commission (**CQC**) inspection. The interim summary was good with individuals showing responsibility, credibility and passion.

3.8 To agree and monitor the work of the Quality and Clinical Governance Sub-Committee, through their annual report, their performance and effectiveness within the integrated governance framework

The Committee reviewed QCG-SC reporting throughout the reporting period. It was agreed at the July agenda setting meeting there was no longer a requirement for a QCG-SC annual report as on-going sequential reporting of mitigating actions against concerns took place. The QCG-SC ToR and yearly workplan would continue to be submitted at the first Committee in each year, next May 2024.

At the July 2023 meeting there were three areas of escalation from the QCG-SC which related to the availability of substantive staff across the Trust, services were being challenged in being able to provide timely access to services and the impact and complexity of Trust-wide issues were still being addressed from the transition of temporary staff from the Trust's internal staff bank to NHS Professionals. These areas remained an escalation at the September 2023 meeting.

3.9 To receive and review at each of its meetings an escalation report from the Quality and Clinical Governance Sub-Committee that provides a summary of the business transacted and escalates any matters requiring the Committee's attention. More substantive issues arising from the business of the Quality and Clinical Governance Sub-Committee will be brought to the Quality Committee through the provision of papers consistent with the guidelines for committee papers

Update reports were received from the QCG-SC at each meeting.

In May 2023, an independently provided CAMHS inpatient unit within our CAMHS Tier 4 Provider Collaborative closed following repeated poor CQC assessments. The Committee oversaw the initial improvement plan and then the transition of over 30 young people to alternative placements, in some cases, closer to home. This was new governance work for the Trust and to the Committee and reflected well on our clinical leaders in safely managing the reduction of inpatient capacity within Thames Valley without detriment to the service users.

In July 2023 we followed up with our forensic team on the improvement plan they had presented to the Committee in November 2022 following the BBC Panorama documentary of services at Edenfield Centre, Greater Manchester Mental Health NHS Foundation Trust. The team were honest in their appraisal of delivery and confirmed they would be prioritising multi-disciplinary team development. Following an evaluation of security cameras, it was also agreed these would be installed in communal areas. The Committee also requested the Directorate respond to concerns raised by the Forensic MH Provider Collaborative on use of restraint numbers within our services. The issue was satisfactorily closed in September 2023.

At the November meeting the Chief Nurse reported positively on the segregation garden at Evenlode being completed in September and the new Meadow Unit opening on 31 October 2023.

3.10 Receive briefings on legal and key national policy developments.

Updates received via individual items where relevant and regular reporting via the Quality Compliance and Regulation update.

3.12 Other Business transacted

As recorded on the 2023-2024.

Quality Committee Effectiveness Questionnaire 2023/24

Quality Committee Effectiveness Questionnaire 2023/2024

- 1) Has the Committee's membership been effective (range, skills, frequency of attendance, contribution)?

We have had consistent, and engaged attendance from Trust senior clinical leaders, reflecting their commitment and interest in quality issues. Non-executive membership of the Committee has recently been confirmed which is helpful in shaping the workplan and developing more effective ways of working. We have also been fortunate to have the Trust Chair attend most if not all, QC meetings during 23/24 which brings challenge and insights from a different perspective.

We have begun to talk about the new workplan 24/25 with our new Chief Nursing Officer and to shape a more strategic approach, whilst being relevant on matters of quality assurance.

- 2) Does the Committee's work programme cover the relevant assurance needs of the organisation and does the Committee provide insight and constructive challenge to the organisation where required?

The Committee's work programme is comprehensive in attending to all matters of Quality Assurance. However, this can sometimes be at the cost of a deeper conversation or understanding.

The executive has worked hard to produce a dashboard permitting the rapid identification of risk, there is more work to do on this following the IT outage to reinstate waiting times information and to commence outcome data gathering.

At times the work programme needs to be flexed to deal with emerging issues, such as newly launched NHSE mental health programmes, or national reviews which require us to consider our own context/reality.

- 3) Has the Committee made a conscious decision about how it wants to operate and the level of information it would like to receive for each of the items in its business cycle?

We have agreed a regular cycle of reporting and hopefully can begin to track trends over time. We are currently reviewing the business cycle but would like to move some items to less frequent reporting to allow for deep dives into specific services e.g. the recent topic of neurodiversity. In that way we hear much more from frontline teams and what they are trying

to improve/change and how Trust leadership can support them. These topics also help us understand how we need to influence, connect with the system for our patients.

- 4) Does management fully brief the Committee in relation to key risks, assurances, gaps in controls/assurances in a timely fashion?

Yes. The Committee receives a regular Quality dashboard which usually reports on the previous month. sometimes we can be out of sync so that the data is two months old by time of consideration. However, the executives and teams will verbally report updated information.

Reporting on the BAF has improved over time, controls have been reviewed and updated leading to stronger assurance. The role of the Audit Committee is reviewing BAF risks has been helpful as it is another set of eyes, although it is also helpful when they revert the risk back to the QC for final review and determination of rating.

The full Board receives the agenda, minutes, 3As report and an updated dashboard at each public meeting.

- 5) Do the Committee's papers and meetings (length and frequency) support the Committee to perform its role effectively?

Mostly, this has improved. Quality is better but length could still be reduced. Sometimes there is repetition on the cover sheet with the full paper. Sorting this would help time pressed NEDs get to the nub of an issue. Reading the papers in full takes about a day.

- 6) Does discussion at meetings (agenda items concluded, clarity on how progress will be monitored and reflection on outcomes/decisions) support the Committee to perform its role effectively?

Mostly, with the help of a good Exec assistant and meetings between Committees enable us to track work coming out of and going back to QC. The Chairing of the meeting can always be improved and specifically ensuring everyone is clear on outcomes/decisions (Action for self)

Appendix 1-Terms of Reference with revisions May 2024

**Terms of Reference for the
QUALITY COMMITTEE****1. Introduction**

- 1.1 The **Board of Directors** is accountable for:
- continuously improving the quality of the Trust's services, reducing harm and safeguarding high standards, by creating an environment in which excellence will flourish; and
 - ensuring that there is an appropriately structured control environment in place, where risks are identified, assessed, and properly managed.
- 1.2 HSC 1999/65 requires Trusts to establish a sub-committee of the Board of Directors to oversee a governance framework with clear aims and objectives for governance in the Trust; the structures and processes which will assure effective governance; how clinical and non-clinical risk management will be coordinated across functions and responsibilities; and how the Trust will evidence compliance with national standards including CQC.
- 1.3 The Board of Directors has delegated, in accordance with its Standing Orders, responsibility to the Quality Committee for:
- overseeing the effective development of the Trust's corporate and clinical governance arrangements; and
 - ensuring that there is an objective and systematic approach to the identification and assessment of risk and delivery of the organisation's priorities in the context of all national standards.
- 1.4 The **Quality Committee** will be a formal committee of the Board of Directors and its terms of reference will be incorporated into the Trust's Standing Orders.
- 1.5 The Committee is authorised to obtain outside legal or other independent professional advice and secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's Standing Orders.

2. Membership

- 2.1 The membership of the committee will include:
- at least 2 Non-Executive Directors (including the Chair);
 - Chief Nurse;
 - Chief Medical Officer;
 - Director of Corporate Affairs and Company Secretary;
 - Executive Managing Director for Mental Health and Learning Disability & Autism Services; and
 - Executive Managing Director, Primary, Community, and Dental Care.
- 2.2 The Trust Chair and Chief Executive have standing invitations to attend any meeting.
- 2.3 The Committee shall be chaired by a Non-Executive Director.
- 2.4 The Quality and Clinical Governance Sub-Committee, as the Executive led committee reports into the Quality Committee.
- 2.5 The Deputy Chair for the Quality and Clinical Governance Sub-Committee will attend in the Chief Nurse's absence. Non-Executive Director members may also nominate a Non-Executive deputy to attend in their absence.
- 2.6 Regular attendees, who are not voting members unless formally deputising and exercising the vote of their principal, include: the four Clinical Directors from each of the service directorates; and the Deputy Chief Nurse.
- 2.7 The Board of Directors will review membership of the Committee annually, which can be through receipt of the Committee's Annual Report.
- 2.8 The Committee shall appoint one member to be the vice chair of the committee who shall exercise the powers and functions of the Chair of the Committee in their absence.

3. Attendance at meetings

- 3.1 The quorum for the committee is five members to include the Chair of the Committee (or the vice chair of the committee in their absence), one Non-Executive Director and at least one Executive Director to be the Chief Nurse or nominated Deputy. Deputies and other attending Board members will count towards the quorum and attendance rates. Attendance will be monitored as part of the Annual Report on the Committee's performance to the Board of Directors and members are expected to attend at least 75 per cent of committee meetings.
- 3.2 Deputies may be nominated by Executive and Non-Executive members of the Committee and be included in the quorum. The Non-Executive Director members of

the Committee will be entitled to nominate any other Non-Executive Director of the Trust as their deputy to attend meetings in their absence. The name(s) of the nominated deputy(ies) will be recorded in the minutes of the Committee and deputies will exercise full voting rights at meetings and be included in the quorum. Where more than one individual attends to deputise for a committee member, they may between them only exercise the one vote of that member; the vote may not be divided between the deputies and if agreement upon exercise of the one vote cannot be reached then this will be recorded as the vote not being able to be cast.

- 3.3 The Committee may invite other managers and staff of the Trust or other NHS bodies, and general auditors to attend meetings, in a non-voting capacity.

4. Frequency of meetings

- 4.1 Meetings shall be held not less than four times per annum.
- 4.2 The frequency of meetings can be varied at the discretion of the Chair of the Committee.
- 4.3 An indicative timetable for business to be considered by the Committee is set out in an annual work-plan of the Committee. However, the agenda is not restricted to those items shown in the work-plan and can be changed at the discretion of the Chair of the Committee, to deal with any other governance matter.

5. Calling meetings

- 5.1 Meetings will be called and conducted in accordance with the Trust's Standing Orders. The notice period will be a minimum of ten days. Written reports are to be sent to members at least five clear days before the meeting.

6. Remit

- 6.1 The broad role of Quality Committee and its sub-committee is to:
- provide **assurance** that we have in place and are implementing appropriate policies, procedures, systems, processes and structures to ensure our services are safe, effective and efficient;
 - provide **assurance** that the organisation is compliant with regulatory frameworks and legislation;
 - **approve** changes in clinical or working practices or the implementation of new clinical or working practices;
 - **approve** new or amended policies and procedures;
 - **monitor** and ensure **action** is taken on the quality, effectiveness and efficiency of services and identify any associated risks;
 - **approve** and **monitor** strategies relating to quality; and
 - **monitor** the development of clear quality outcomes

- 6.2 Within that, the Quality Committee will specifically undertake the following tasks:
- 6.3 Undertake specific overview and approval of updates throughout the year of the draft Quality Account and Quality Report and then the final annual Quality Account and Quality Report.
- 6.4 Ensure the development and maintenance of the integrated governance framework; review and approve any major change to the governance framework, structures or management taking account of national strategies, priorities and developments concerning governance and risk management.
- 6.5 Critically review and recommend to the Board of Directors the strategies and programmes set out below, and receive annual progress reports where applicable:
- patient and carer experience, including complaints and PALS;
 - quality, including safety and harm reduction, incident reporting and management, infection control, clinical audit;
 - quality improvement;
 - safety of the physical estate; and
 - compliance with national requirements and standards including CQC, NICE, NHS Resolution (formerly the NHSLA).
- 6.6 Approve supporting strategies relating to these key strategies including resourcing, training and development, and communication.
- 6.7 Ensure effective interface between the Audit Committee and the Quality Committee, and with the Executive led Quality and Clinical Governance Sub-Committee and the co-ordination of risk management processes across the Trust, both clinical and non-clinical.
- 6.8 Ensure effective interface with the People, Leadership and Culture Committee to ensure staffing issues, workforce planning, and promotion of safe and just culture are fully integrated into the Board governance framework.
- 6.9 Ensure the Trust's readiness for submission to external governance reviews and developing and monitoring action plans to identify shortfalls e.g.:
- Care Quality Commission (CQC);
 - Health & Safety Executive;
 - General auditors; and
 - NHS England and the Integrated Care Board
- 6.10 Provide an annual report to the Audit Committee of assurance gained throughout the year or consider having a joint meeting with the Audit Committee.
- 6.11 Agree and monitor the work of the Quality and Clinical Governance Sub-Committee, through their annual report, their performance and effectiveness within the integrated governance framework.

- 6.12 The Committee shall receive and review at each of its meetings an escalation report from the Quality and Clinical Governance Sub-Group that provides a summary of the business transacted and escalates any matters requiring the Committee's attention. More substantive issues arising from the business of the Quality and Clinical Governance Sub-Group will be brought to the Quality Committee through the provision of papers consistent with the guidelines for committee papers.
- 6.13 Receive briefings on legal and key national policy developments.

7. Reporting

- 7.1 Minutes of the committee meetings will formally be recorded and circulated to the committee members within **fifteen** working days and be formally reviewed at the next appropriate Board of Directors meeting.
- 7.2 The Chair of the Committee will submit an Annual Report of the work of the Committee to the Board of Directors to include reports on frequency of meetings, members' attendance, and any recommendations to address non-attendance or changes to membership, business conducted by the Committee (cross referenced to its remit) and consideration of the Quality and Clinical Sub-Committee's. The purpose of the Annual Report is to ensure that the Committee is working to its terms of reference and has appropriate membership.

8. Limitations of Authority

- 8.1 The Committee shall be delegated the power of the Board of Directors to require the attendance of any member of the Trust staff.
- 8.2 Save as is expressly provided in the terms of reference, the Committee shall have no further power or authority to exercise, on behalf of the Board of Directors, any of its functions or duties.
- 8.3 For the avoidance of doubt, the Committee shall not itself be responsible for undertaking any operational involvement in the Trust's governance (internal control) or risk management systems. Its responsibilities shall be limited to providing strategic leadership and supervision of the work of the Quality and Clinical Governance Sub-Committee or specific issues referred to the Committee, requiring directors and managers of the Trust to undertake certain work, to receiving their reports (both verbal and written), considering such and reporting to the Board of Directors, thereafter.

Terms of Reference revisions

Approved by the Board of Directors at its meeting on 24 October 2014, together with the abolition of the Integrated Governance Committee and the transition to the new Quality Committee and four sub-committees from 01 January 2015.
Presented with revisions approved by the Board on 28 January 2015.
Further revision to increase membership of Non-Executive Directors approved by the Board on 25 February 2015 to take effect from 01 March 2015.

Further revision to provide for the Committee to be chaired by a Non-Executive Director other than the Trust Chair approved by the Board of Directors on 27 September 2017.

Presented with revisions approved by Quality Committee on 14 July 2022

Presented with revisions approved by Quality Committee on 13 July 2023

Presented to the Quality Committee on 02 May 2024 with revisions for approval

Appendix 2 – Quality Committee attendance 2023-2024

Name	May 2023	July 2023	Sept 2023	Nov 2023	Feb 2024	
Andrea Young (Chair)	✓	✓	✓	✓	✓	5/5
Dr Rob Bale			x	✓	✓	2/3
Professor David M Clark					✓	1/1
Marie Crofts	✓	x	x	✓		2/4
Britta Klinck					✓	1/1
Geraldine Cumberbatch	✓	✓	✓	x		3/4
Grant Macdonald	✓	✓	x	✓	✓	4/5
Karl Marlowe	✓	✓	✓	✓	✓	5/5
Ben Riley	✓	✓	x	✓	✓	4/5
Heather Smith	✓	✓	✓	✓	✓	5/5
Lucy Weston					✓	1/1
Kerry Rogers*	✓	✓	✓	✓	✓	5/5
Attending Board members (voting & non-voting included in quorum)						
Amelie Bages*	x	✓	x	x	✓	2/5
Charmaine De Souza	x	x	x	x	x	0/5
Dr Nick Broughton						0/1
David Walker	✓	✓	x	✓	✓	4/5
Quorum achieved	Yes	Yes	Yes	Yes	Yes	

Name	May 2023	July 2023	Sept 2023	Nov 2023	Feb 2024	
Brian Aveyard	✓	✓	✓	✓	✓	5/5
Rami El-Shirbiny	✓		✓			2/5
Angie Fletcher	✓	✓	✓		✓	4/5
Claire Forrset	✓				✓	2/5
Rose Hombo	✓	✓	✓	✓	✓	5/5
Jane Kershaw	✓	✓	✓	✓	✓	5/5
Tina Malhotra	✓	✓		✓	✓	4/5

Michael Marven	✓	✓	✓	✓	✓	5/5
Pete McGrane	✓			✓	✓	3/5
Neil McLaughlin	✓					1/5
Ros Mitchell	✓	✓	✓	✓	✓	5/5
Tendai Mugariri	✓					1/5
Susan Palmer	✓					1/5
Kristen Prance	✓				✓	2/5
Bill Tiplay	✓		✓	✓		3/5
Helen Ward	✓				✓	2/5
Hannah Smith	✓	✓	✓		✓	4/5
Susan Wall	✓					1/5
Helen Bosely	✓			✓		2/5
Wendy Corner	✓					1/5
Colin Davenport	✓					1/5
Lynda Dix		✓	✓	✓	✓	4/5
Michelle Fisher		✓				1/5
Ann Helsdon		✓				1/5
Karen Lascelles		✓				1/5
Vicki Power		✓				1/5
Chad Zuriekat		✓				1/5
Katrina Anderson			✓			1/5
John Campbell			✓			1/5
Laura Carter			✓			1/5
Natalie Cleveland			✓			1/5
Gillian Combe			✓			1/5
Julie Fulea			✓			1/5
Lisa Lord			✓			1/5
Stephanie Oldroyd			✓			1/5
Jeff Parker			✓			1/5
Catherine Sage			✓			1/5
Vanessa Rayment			✓			1/5
Helen Vincent			✓			1/5
Debbie Walton			✓			1/5
Rachel Caira				✓		1/5
Michelle Barclay				✓		1/5
Mike Hobbs				✓	✓	2/5
Janice Leaffe				✓		1/5
Lucy Weston					✓	1/5
Mohinder Sawhney					✓	1/5
Vicki Bull					✓	1/5
Emma Fergusson					✓	1/5

Sarah Hill					✓	1/5

Appendix 3

Quality Committee – overview plan for 2024-2025, mapped against Quality Domains

Key: ✓ on agenda
x item planned
x deferred

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
SAFETY							
Quality and Clinical Governance Sub-Committee escalation report including Quality and Safety Dashboard <i>(to include positive and safe each month and May meeting to include ToR and work plan)</i>	Jane Kershaw/Britta Klinck	X <i>(ToR & workplan included)</i> ✓	x	x	x	x	
Directorate/Service area ‘deep dive’ <i>(Presentation)</i>	Britta Klinck/Rob Bale/Ben Riley	X <i>0-19 service</i> ✓	X <i>Learning Disabilities</i>	X	X	X	
Quality Account (quality priorities) <i>(May meeting includes annual report)</i>	Rose Hombo	X ✓			X		
Patient Safety Incident Report (PSIs) <i>(Learning from Deaths Report, to include mortality and homicide reviews)</i>	Jane Kershaw/Britta Klinck	X ✓	X		X	X	
Safe Staffing	Britta Klinck		X			X	
Quality Compliance and Regulation update (CQC, NHSE/I etc - report as and when required)	Britta Klinck	X ✓	X <i>Well led guidance</i>	X	X	X	
Director of Infection Prevention & Control (IPC) – IPC annual report	Helen Bosley/Britta Klinck	X ✓					
Safety of the physical estate – annual report <i>Ligature update (BK/MC)</i>	Britta Klinck/Heather Smith		X				

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Learning Disabilities & Autism Services – access to healthcare annual report	Kirsten Prance/Rob Bale			X			
Inquests & Claims – annual report	Neil McLaughlin/ Hannah Smith/Georgia Denegri			X			
Safeguarding Service annual report	Lisa Lord/Britta Klinck			X			
Oxford Pharmacy Store (OPS) <i>(quality assurance report around the governance and quality of medicines regulation in OPS)</i>	Natasha Arif/Nicola Mayes/Mark Byrne/Heather Smith/Karl Marlowe	X <i>(review of programme)</i> ✓			X		
EFFECTIVENESS							
Clinical Effectiveness Decision Group (CEDG) <i>(RR minutes from CEDG group, new NICE guidance)</i>	Ros Mitchell/Karl Marlowe	X ✓	X	X	X	X	
Clinical Audit updates	Angie Fletcher/Karl Marlowe	X ✓	X	X	X	X	
Clinical Audit annual plan and annual report	Angie Fletcher/Karl Marlowe	X ✓					
Medicines Management	Michael Marven/Karl Marlowe	X ✓	X	X	X	X	
Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) <i>review each one at each meeting</i>	Ben Cahill/Brian Aveyard/Hannah Smith/Neil McLaughlin	X ✓	X	X	X	X	
Health Inequalities-Quality Improvement <i>(smoking cessation/SMI Health checks/ dashboarding waiting list for Index of Multiple deprivation/ethnicity data)</i>	Karl Marlowe		X				
QUALITY IMPROVEMENT							
QI Spotlight presentation <i>(developing capability and the impact on staff and patients)</i>	Angie Fletcher/Britta Klinck	X <i>Review of programme</i> ✓	X <i>Plan for the year</i>		X <i>(projects)</i>	X <i>(projects)</i>	
Mental Health Inpatient transformation programme	Britta Klink			X			

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
CARING & RESPONSIVE (patient & carer experience)							
Learning from Patients, Family & Carers <i>(Experience and involvement) update on strategy</i>	Donna Mackenzie-Brown/Rose Hombo/Britta Klinck	X ✓			X		
Experience and Involvement report <i>(update on strategy)</i>	Rose Hombo / Britta Klinck				X		
PCREF Framework <i>(update on strategy)</i>	Rose Hombo/Britta Klinck		X		X		
Complaints & PALS annual report	Claire Price / Rose Hombo/ Britta Klinck	X ✓					
RESEARCH							
R&D update (Governance aspects)	Vanessa Raymont/Karl Marlowe			X			
POLICIES & STRATEGIES							
Nursing Strategy	Britta Klinck				X		
Friends, Family and Carers Strategy	Britta Klinck/Rose Hombo		X				
AHP Strategy	Britta Klinck/Rose Hombo					X	
Learning Disability Strategy (2022-2027)	Kirsten Prance/Britta Klink		X				
Trust Policies <i>(as and when – new policies for approval and certain policies for review)</i>							
Legal Proceedings Policy	Neil McLaughlin/DoCA		X				
GOVERNANCE							
Minutes of the Quality Committee	Georgia Denegri/Ben Cahill	X ✓	X	X	X	X	

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Quality Committee annual report	Andrea Young/Britta Klinck/Georgia Denegri	X ✓					
Integrated Governance Framework (Including Quality Management system)	Ben Cahill	X ✓		X			
Provider Collaboratives	Britta Klinck	X ✓	X	X	X	X	
Partnership update	Amélie Bages				X		
Trust Policy Register	Britta Klinck/Georgia Denegri	X ✓		X			
Annual Planning Process	Amelie Bages					X	
OTHER REQUESTED ITEMS							
2024-2025 Developing Quality Governance (schematic showing ward to board and testing its effectiveness in deep dives)	Corporate Governance/Ben Cahill/Britta Klink	X ✓					
Number of Items on Agenda		21	17	15	18	15	

Report to the Meeting of the Oxford Health NHS Foundation Trust, Board of Directors

Warneford Park Annual Report 2023/24

Agenda item:16(f)

Executive Summary

This Annual Report summarises the performance and work programme of the Warneford Park Internal Board (WPIB) during the period 01 April 2023 to 31 March 2024.

Governance Route/Approval Process

The Board of Directors is asked to approve the Warneford Park Annual Committee Report. The Finance and Investment Committee received a copy of the Annual Report on 9th May 2024, and it was approved by the Warneford Park Internal Board on 1st May 2024.

Strategic Objectives/Priorities – this report relates to or provides assurance and evidence against the following Strategic Objectives/Priorities of the Trust:

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

Recommendation

The Board of Directors is requested to approve the Warneford Park Internal Board's Annual Report.

Author and Title: Lindsay Fenn, Senior Programme Manager Warneford Park

Lead Executive Director: Heather Smith, Chief Financial Officer, Estates & Facilities, Information Management & Technology, Warneford Park Programme

Annual Report for the period 01 April 2023 to 31 March 2024

The Warneford Park (Internal) Programme Board is a time limited Committee of the Board of Oxford Health NHS Foundation Trust.

Warneford Park (Internal) Programme Board has no executive powers other than those specifically delegated in the Internal Board's Terms of Reference (Appendix 1).

The Warneford Park (Internal) Programme Board is responsible for delivering the Trust's component to the Warneford vision. It will deliver Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) documentation, as directed by the Trust Board and undertaking wider activity to secure the necessary public funding for the Hospital. It is responsible for developing clinical and estate solutions, appropriate enabling strategies (as required) through its work streams and leading on the planning application for the whole Warneford Park development, including the Hospital. The Warneford Park (Internal) Programme Board is responsible for developing and delivering the WP Hospital programme, proactively managing risks.

The Warneford Park (Internal) Programme Board is required to report progress, issues, and risks to the Warneford Park External Programme Board throughout the process.

The Warneford Park (Internal) Programme Board is ultimately accountable to the OHFT Board of Directors (BoD) and reports to the Trust's Finance and Investment Committee monthly. In the last year, the BoD has approved the SOC and authorised the signing of the COA.

1. Membership of the Committee and Frequency of Meetings

Committee membership as outlined in the current Terms of Reference (**ToRs**), Appendix 1, were approved at the February 2024 meeting. The Committee met the criteria as laid out in the ToRs regarding meeting quoracy, frequency of meetings and attendance by Committee members. The WPIB is Chaired by Grant MacDonald, Interim Chief Executive Officer.

To be quorate five members must be present including:

- Chair or deputy chair (100% attendance from Chair or deputy Chair)
- Medical or clinical lead (80% attendance)
- Project director or project manager (100% attendance)

2. Business transacted by the Committee

Set out below is the remit of the WPIB as outlined in the current ToRs.

The Committee has overseen multiple key decisions and milestones for the Programme in the last 12 months. Some of the milestones are listed below. Please note this is not an exhaustive list:

Decision, deliverable or milestone met	Date or comment
Final Strategic Outline Case (SOC) signed off internally	Signed off in meeting on 05/06/2023. Submitted to the Board of Directors on 21/06/2023 and formally resubmitted to NHSE in June 2023
Master programme plan	Approved in September 2023
Conditional Option Agreement (COA) agreed between the Trust, University of Oxford (UoO), and Warneford Park LLP (JV). This is a legal agreement and is a major milestone in the Programme.	Signed on 20 th December 2023.
Memorandum of Understanding (MOU) between the Trust, University of Oxford (UoO), Ian Laing and Warneford Park LLP (JV)	Signed on 20 th of December 2023
HOSC engagement	Throughout the year
Funding Campaign and influencing, including philanthropy	Throughout the year – Whitehall, local MPs.
Established several key workstreams to more effectively support the programme. These include: • Communications • Estates & Facilities • Funding • Clinical Requirements • Research & Development • Change Management & Benefits Realisation • Planning and Design • Transport assessment and planning	Throughout the year
WP Website and brochure	Launched in January 2024

In addition to the above, the committee has provided oversight and assurance of risks and issues, budget and the management of financial risks and resources.

The committee has proactively identified key stakeholder groups relevant to the project and ensured involvement of and engagement via stakeholder groups is maintained.

Forward view for FY25

The primary focus of the WPIB for the next year will be to secure capital funding and support the programme to submission of Oxford City Council planning application. Key milestones for the next year are as follows:

Milestone, deliverable or activity	Expected completion
Agreed budget for FY25	April 2024
Approve next Tranches of Funding	Tranche 3b (1 st May 2024 meeting), Tranche 3c (October 2024)
Public Consultations to support a successful Planning Application	Public Consultation 1 planned for June 2024 Public Consultation 2 planned for Oct 2024
Relevant surveys to support a successful Planning Application	August 2024. These include Noise, traffic, ecology, Biodiversity Net Gain (BNG) etc.
HOSC engagement complete	May 2024
POWIC Design finalised	June 2024
POWIC Lease finalised	July 2024
Design freeze. Architecture and planning drawings ready	October 2024
Oxford City Council (OCC) engagement	Regular throughout the year
Planning application submission	March 2024
Refresh the Strategic Outline Case (SOC), ready for submission to NHSE subject to inclusion in next Spending Review.	April 2025

3. Key Programme Risks

The below risks have been identified as high risks for the Warneford Park Programme as at 1st May 2024:

Area	Date Raised	Risk Description	Impact Budget	Impact Schedule	Overall Impact	Trend	Post Mitigation Risk	Mitigation Actions
Funding	20/12/2022	There is a risk that national capital funding may not be available, as there are other national competing priorities, and that alternative funding will not be available or acceptable to national health authorities, which means the hospital project will not be able to proceed.	●	●	▶	➡	▶	a) Establish a funding workstream led by HS to focus on a funding campaign in Whitehall during 2024 and early 2025. b) Identify alternative funding to mitigate a lack of central funding c) Review Mar 24 post Spring Budget to refocus campaign on forthcoming election / strategic spending review
Funding	30/09/2022	There is a risk that the revenue consequences of the preferred option are not affordable in which case the project will be cancelled or delayed whilst mitigating reductions are identified	●	●	▶	➡	▶	a) Project team to develop robust cash releasing savings plans - [Cash releasing schemes have been identified, to be developed further at OBC]. b) Consider a smaller hospital c) Rationalise non-clinical areas in hospital design
P&D	15/02/2024	If SANE objects publicly about the Trust's request for it to move to accommodate the Research Building, then this has the potential to affect the outcome of the planning process.	●	●	▶	➡	▶	Continue to build relationship with SANE. Dinner to be held with VC of UoO. Continue to invite MW opportunity to engage with design dev process. Draft plans shared with SANE and MW in March 2024 - due date for SANE comment is end of June 2024.
P&D	05/01/2024	If there is fundamental conflict between the car parking aspirations of the scheme and the OCC car reduction policies this may either affect the viability of the scheme or the success in achieving SPP.	●	●	▶	➡	▶	Engage with OCC planners re rationale for parking requirement. Demonstrate reduced parking spaces / head. Transport Assessment. Collaborate with Universities and OUH to mitigate traffic impact.
JV	28/03/2024	There is a risk that there is insufficient resource / pressure to focus on the human and organisational aspects of the project which are vital to maximise the benefits.	●	●	▶	➡	▶	Change Management and Benefits Realisation Workshop conducted in February 2024. Paper with recommendation put forward to External Board in March 2024, Programme to look into resourcing options to properly utilise this in order to get the full benefits from the Programme.
Comms	15/02/2024	If residents are negative about the project it may affect the outcome of the planning application.	●	●	▶	➡	▶	Have a clear plan to properly resource stakeholder engagement during the pre planning application process. Continue resident engagement meetings. Ensure that we listen to residents' concerns and address them where possible.

P&D	13/03/2024	There is a risk that we cannot have the EV charging points provided safely in the basement. Insurance implications. 25% of parking needs to be EV and there is not sufficient space above ground.						Further investigation re how EV charging points can safely be provided in basement carpark. Hoare Lea have provided a report on this - NP to share with the group.
Clinical	15/02/2024	If the design vision does not maximise the benefits for clinical care, particularly for privacy & dignity, security and maximising views of garden space then the hospital will struggle to deliver the best quality of care for its patients.						Ascertain shared views with Clinical leads and identify the extent of problem. Work with the Design team to address any concerns during the pre-planning phase. Explore all available solutions to minimise risks and impacts. Engagement with clinical and leadership directorate and EBEs on options. Options presented to WPIB on 16 April 2024. Recommendation for decision at WPIB 1st May 2024.
Clinical	15/02/2024	If digital solutions/options to free time to care are not incorporated within the design then opportunities for increased time to care will be lost and patient care will not be maximised. Staff satisfaction will also be negatively impacted.						Undertake initial "Perfect day" workshop to explore potential areas for solutions that digital can assist with. Research digital solutions for healthcare, looking at principles of standardisation. Engage with others who are looking at digital solutions for new builds e.g. room booking systems. Focussed session with IM&T colleagues to assess options to best enable care. Meeting with SR and RD to discuss the 'so-what' of some of the digital solutions.
PMO	23/11/2023	If the allocated budget and funding to resource the programme of work proves insufficient, then we have to stop or seek additional funding						Increased funding identified for 24/25 financial year. Decision point in Q1 24/25 to confirm trajectory.
JV	19/03/2023	There is a risk that OCC does not accept that the planning application excludes the listed buildings for the college.						Further engagement with OCC to explain rationale for why a detailed application is not possible at this stage. Agreement to planning conditions which require consent for the listed buildings to be given prior to the new buildings of the college being developed.
P&D	07/05/2024	Biodiversity Net Gain target of 20% is going to be difficult to achieve						Review BNG baseline and take advice from RSK on how best to achieve BNG requirements.

**Appendix 1: Warneford Park (Internal) Programme Board
ToR**

**Oxford Health NHS Foundation Trust
Warneford Park (Internal) Programme Board
Terms of Reference**

1. Constitution

The Board of Directors has resolved to establish a Committee of the Board to be known as Warneford Park (Internal) Programme Board.

Warneford Park (Internal) Programme Board is a time limited Committee of the Board of Oxford Health NHS Foundation Trust.

Warneford Park (Internal) Programme Board has no executive powers other than those specifically delegated in these Terms of Reference.

Introduction

The Warneford Park Campus Development Programme is driven by a unique collaboration between Oxford Health NHS Foundation Trust, the University of Oxford and Ian Laing a philanthropic developer.

The Strategic Objectives agreed with our partners for the wider programme are to:

- **Improve brain healthcare outcomes** through research that is outstanding at a global level and world-leading in its output and impacts, including through translation and innovation.
- **Provide simplified access** to high quality mental health care through an exceptional new hospital complex that embeds the 'least restrictive' approach to care.
- **Create an outstanding environment for healthcare, research, innovation, and education** that attracts and retains talented staff and students from multiple different backgrounds and disciplines, and that increases the benefits from colocation.
- **Realise the full benefits of collaboration** between mental healthcare and research, including through a long-term partnership between the University of Oxford and the Trust.
- **Attract partners who contribute to the long-term success** of the programme and the realisation of its objectives including commercially.

- **Ensure that the programme can adapt appropriately**
to change over time, through a flexible and adaptable infrastructure that enables long term delivery of the programme objectives.

Key benefits of this scheme for the Trust include but will not be limited to:

- Improved service user and staff experience
- Better therapeutic services and interventions
- Reduction in length of stay
- Flexible healthcare
- Reduction in out of area placements
- Better links to the community
- Improved quality of the estate, ensuring fit for purpose accommodation
- Improvement of the Warneford site efficiency and effectiveness
- Delivery of an integrated mental health and brain research campus to improve mental health services.

2. Purpose

The Warneford Park (Internal) Programme Board is responsible for delivering the Trust's component to the Warneford vision. It will deliver SOC, OBC and FBC documentation, as directed by the Trust Board and undertaking wider activity to secure the necessary public funding. It will be responsible for developing clinical and estate solutions, appropriate enabling strategies (if required) through its work streams and leading on the planning application. The Warneford Park (Internal) Programme Board is to develop plans for and deliver the WP Hospital programme, managing risks.

Warneford Park (Internal) Programme Board is responsible for two key workstreams within the wider Warneford Park (External) Programme Board. The purpose of the wider programme is for the Warneford Partners to oversee the development and submission of a planning application and obtain funding for the provision of a new mental health hospital, integrated research facility and new postgraduate college on the Warneford Park site.

3. Accountability

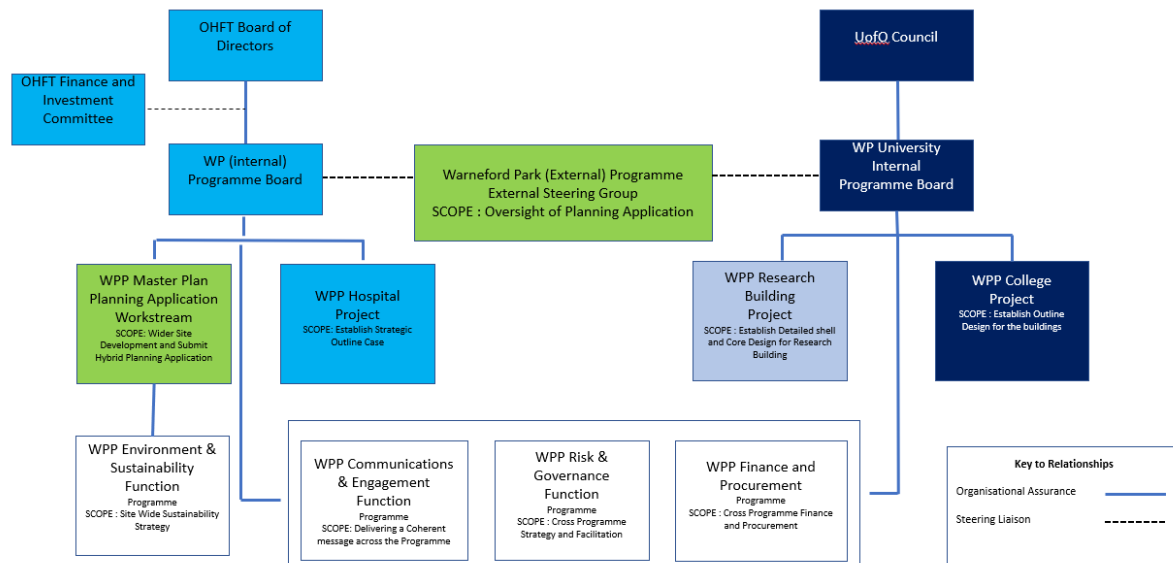
The Warneford Park (Internal) Programme Board is ultimately accountable to the OHFT Board of Directors and is to report to the Trust's Finance and Investment Committee monthly.

The structure Chart Below show the Organisational assurance to the relevant parties.

The Warneford Park (Internal) Programme Board is required to report progress, issues, and risk to the Warneford Park External Programme Board throughout the process.

The Warneford Park External Programme Board is chaired by Philip Rutnam, a non-executive director of OHFT, and comprised of representatives from OHFT, UofO and Ian Laing who are key stakeholders and who will oversee the delivery of the wider WPP Masterplan and ensure effective collaboration and joint working.

The structure chart below shows the organisational assurance and responsibility to the relevant parties.



4. Responsibilities

The Warneford Park (Internal) Programme Board will:

- Provide structure and rigour on behalf of the Trust / Programme Board for delivery to scope, time and budgets and the management of financial risks and resources.
- Establish and manage the work streams as appropriate to ensure delivery.
- Ensure the production and submission of a planning application for the wider Warneford Park Programme.
- Ensure the service design fits with the Trust's strategic direction, such that the new hospital design is fit for purpose and makes efficient use of space within an affordable financial envelope.
- Ensure that the service design is evidence based, innovative, and delivers highly efficient and productive services that facilitate the provision of high quality and safe care for patients and staff and are responsive to feedback from stakeholders.
- Identify and delivery the project's investment objectives, benefits, and critical success factors.
- Identify and approve the benefits realisation plan and ensure baseline measures are identified and collected.
- Ensure the completion of a Strategic Outline Case (SOC), and subsequent business case stages, which will be approved by the Trust Board of Directors, prior to submission to NHS England.
- Identify, record, and manage risks and mitigations that may affect the Programme. Review risk on a regular basis and escalate when appropriate to

the Trust Board of Directors and the Warneford Park (External) Programme Board as appropriate.

- Identify key stakeholder groups relevant to the project. Ensure involvement of and engagement via stakeholder groups is maintained during all stages of the project.
- Seek and obtain funding for the New Hospital, including philanthropy, and support the funding strategy for the wider Warneford Park Programme.
- Via the Communications and Engagement Workstream, develop communications, branding and fundraising strategies associated with the Project and overall Programme.

5. Warneford Park (Internal) Programme Board Programme of Work

The Warneford Park (Internal) Programme Board will design and maintain a programme of work, within the constraints of the Warneford Park Programme, against which it will report.

6. Authority

Warneford Park (Internal) Project Board is authorised by the OHFT Board of Directors to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any director, officer, or employee.

In order to fulfil its remit, the Warneford Park (Internal) Project Board may obtain whatever professional advice it requires and require executives and senior managers to attend meetings. External advice should combine quality and judgement with independence.

7. Membership

Key Roles

The Warneford Park (Internal) Project Board is established by the Senior responsible Owner (SRO). The prime purpose of the Board will be to drive the Programme forward and deliver its outcomes and benefits. Project members will provide resource and specific commitment to support the SRO, who is accountable for the successful delivery of the Programme.

The Warneford Park (Internal) Programme Board is established by the Chief Executive of the Trust and will be deputy-chaired by the Senior Responsible Owner (SRO). The prime purpose of the Board will be to drive the Programme forward and deliver its outcomes and benefits. Project members will provide resource and specific commitment to support the SRO, who is accountable for the successful delivery of the Programme.

Role	Member	OHFT Trust Position
Chair	Grant MacDonald	Interim CEO
SRO / Deputy Chair	Heather Smith	Chief Finance Officer
MH Lead	Rob Bale	Interim Exec MD for MH & Learning Disabilities
Medical & Research Lead	Dr Karl Marlowe	Chief Medical Officer
Clinical Lead	Britta Klinck	Chief Nurse
Estates Lead	Jeremy Philpot	Interim Director of Estates and Facilities

Governance & Charity	Kerry Rogers	Director of Corporate Affairs & Company Secretary
Comms Lead	Alison Barnes	Senior Communications & Stakeholder Engagement Manager Transformation NHS South Central West CSU
Clinical Lead (Psychiatry)	Vivek Khosla	Consultant, Forensic Services
Clinical Lead (Nursing)	Samantha Robinson	Clinical Nurse Lead, Nursing and Clinical Standards
Expert by Experience	Aideen-Niamh O'Neill	Expert by Experience
Chair of WPEP Board	Philip Rutnam	OHFT Non-Executive Director
Project Director	Simon Cook	Consultant – Cherwell Consulting
Design Lead	Nigel Porter	Consultant – Glanville Group
Project Manager PMO	Lindsay Fenn	Senior Programme Manager – Warneford Park Programme

8. Frequency of meetings

Monthly (alternating between in person and Teams)

9. Procedures and Quorum

To be quorate five members must be present including:

- Chair or deputy chair
- Medical or clinical lead
- Project director or project manager

The Chair and SRO will be expected to attend 80% of the meetings. Other project board members will be required to attend a minimum of 80% of all meetings and where applicable, may nominate a deputy.

The Warneford Park (Internal) Programme Board can expect to co-opt as necessary, external advisors and/or the heads of departments when discussing areas of the operation that are the responsibility of that head or require external guidance or advice. Workgroup representatives may also be invited to attend as required.

The Warneford Park (Internal) Project Board will be supported by the Assistant Project Manager under the oversight of the Director of Corporate Affairs & Company Secretary to ensure consistency with Board Committee governance.

An agenda will be issued, and minutes will be taken and an annual workplan will be agreed, as necessary.

10. Reporting Mechanism

The Warneford Park (Internal) Project Board will be accountable to both the Trust Board of Directors and will report and escalate as necessary to the Warneford Park (External) Board. Approved minutes of the meetings will be received by the Finance and Investment Committee.

The outcomes of the meetings will be presented to both boards by the Chair, or their nominated deputy, who shall draw to the attention of the boards any issues that require disclosure or require executive action.

An action tracker will also be produced to monitor key actions and record progress and closure of those actions.

11. Lead Time for Papers and Minutes

Papers shall be circulated seven days in advance of the Warneford Park (Internal) Project Board or by agreement with the Warneford Park (Internal) Project Board Chair. Minutes and actions shall be distributed within ten days of a meeting.

12. Standing Agenda

Standing agenda items are as follows, amendments to the agenda should be notified to project management team, 7 working days before the meeting.

- Apologies
- Previous Minutes
- Actions
- PMO Programme
- Clinical Workstream
- Research & Development
- Change Management
- Funding Campaign
- Philanthropy
- Comms
- Planning
- Commercial and Legal
- Business Case
- Budgeted
- Governance
- Any Other business

Programme specific adjustments as identified in the forward agenda plan.

Review of these Terms of Reference

Terms of Reference will be reviewed six-monthly to ensure fit for purpose as the Project develops.

Approved: [Feb 2024]

Review Date [Planning Submission] Aug 2024