PUBLIC

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

NHS Oxford Health NHS Foundation Trust

BOARD OF DIRECTORS' MEETING

Wednesday, 25 September 2024
09:00 – 12:20

Microsoft Teams virtual meeting

Agenda

INTRODUCTORY, STRATEGIC, REGULATORY & SYSTEM ITEMS	Purpose	Lead	Indicative Time
1. **#Hellomynameis** and apologies for absence	Welcome	Chair	09:00
2. Declarations and Register of Directors' Interests	Update	Chair	
3. Minutes and Matters Arising of the meeting held on 24 July 2024	Approval	Chair	
4. Trust Chair's report	Discussion	Chair	09:05
5. Chief Executive's report (supporting 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/)	Discussion	CEO	09:15
6. Corporate Affairs report including updates on: a. Legal, Regulatory and Policy; and b. Board Assurance Framework (strategic risks)	Information & Assurance	AD of Corp Affairs	09:25
7. Patient Journey – School Health Nursing Service and 0-19 Children's Services	Discussion	Chief Nurse	09:35[1]
8. Staff Story - Oxfordshire Talking Therapies service	Discussion	Chief People Officer	09:50
PERFORMANCE & SUSTAINABILITY			
9. Talking Therapies: outcome monitoring (how services have used outcome data to innovate and develop services) (presentation)	Discussion	Dr John Pimm /Jo Ryder/ Chief Medical Officer	10:05

[1] Timing to support attendance for the Patient Journey

10. Integrated performance and sustainability reporting: a. Integrated Performance Report (**IPR**); b. Quality & Safety Dashboard; and c. Finance report	Information & Assurance	Exec Team	10:25
10 minutes' break (if required)			11:00
11. Board Committees' update reports and recommendations from recent meetings:			
a. 3As reports (matters for Alert, Advice and Assurance) from Committees (see Reading Room for supporting Committee minutes and agendas; no 3As report expected from the People, Leadership & Culture Committee which has not met since the last 3As report presented to the July Board)	Discussion	C'ttee Chairs	11:10
b. Quality Committee recommendation: Safeguarding Service annual report	Approval	Assoc Director Social Work/ Chief Nurse and AY	
c. People, Leadership & Culture Committee recommendation: Medical Appraisal and Revalidation report[2]	Approval	Chief Medical Officer / Chief People Officer and MS	
d. Charity Committee recommendation: More Report on fundraising (private paper separately provided to the Board)	Discussion	RT	
RESEARCH & EDUCATION			
12. Research & Innovation report	Information	R&D Director and Assoc Director/ Chief Medical Officer	11:30
PEOPLE & QUALITY			
13. Mortality & Suicide Prevention report	Assurance	Chief Medical Officer	11:45
14. Patient Safety Incidents (**PSI**) report	Assurance	Chief Nurse	11:50
GOVERNANCE & REGULATORY			
15. Update report: Board Committee annual reports and Terms of Reference	Receipt and Assurance	AD of Corp Affairs	12:00
16. Corporate Registers: (i) application of Trust seal; and (ii) receipt of gifts and hospitality	Assurance	AD of Corp Affairs	

[2] Further to the recommendation from the People, Leadership & Culture Committee's 3As report to the July Board.

CONCLUSION & RESOLUTION TO CONDUCT PRIVATE BUSINESS

17. Any Other Business	-	Chair	12:10
18. Questions from the public and any governors or staff attending	-	Chair	
19. Review of the Meeting	-	Chair	
20. 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 12:20

Next meeting in public: 27 November 2024

READING ROOM/APPENDIX

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

21. 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/

22. Supporting information to the Corporate Affairs update report:
    a. Board Assurance Framework (strategic risks)

23. Minutes, agendas and supporting information from Committees:
    a. Audit Committee 03 September 2024
    b. Charity Committee on 04 September 2024
    c. Finance & Investment Committee on 09 May, 23 July and 17 September 2024
    d. Mental Health & Law Committee on 13 May and 16 July 2024
    e. Quality Committee on 16 July and 28 August 2024

24. Committee annual report, Terms of Reference and workplans (further to those provided to the July 2024 Board meeting):
    a. Finance & Investment Committee (annual report)
    b. Mental Health & Law Committee (Terms of Reference and workplan)
    c. Quality Committee (Terms of Reference and workplan)

Oxford Health
NHS Foundation Trust

(Agenda item: 2)

REGISTER OF DIRECTORS' INTERESTS

September 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 Calleva 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). Honorary member of the **Oxford University Department of Psychiatry**. Since 2023, has chaired the **Oxford Health Biomedical Research Centre**, the **Oxford & Thames Valley Applied Research Collaboration**, the **Oxford HealthTech Research Centre**, and is a board member of the **Oxford Academic Health Partners**, and the **Oxford & Thames Valley Health Innovation Network**.

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

		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.
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 and Senior Independent Director. 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.

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

[DRAFT] Minutes of a meeting held on Wednesday, 24 July 2024 at 09:00 Hybrid: Whiteleaf Centre (Conference Room), Aylesbury HP20 1EG and Microsoft Teams

Present:[1]

David Walker	Trust Chair (the Chair) (**DW**)
Grant Macdonald	Chief Executive Officer (**GM**)
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**) – *attending virtually over Microsoft Teams*
Chris Hurst	Non-Executive Director (**CMH**) – *attending virtually over Microsoft Teams*
Britta Klinck	Chief Nurse (**BK**)
Karl Marlowe	Chief Medical Officer (**KM**)
Ben Riley	Chief Operating Officer for Primary, Community & Dental Care (**BR**)
Philip Rutnam	Non-Executive Director (**PR**)
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 attendance[3] (in person or virtual):

Attendees/observers from Oxford Health NHS FT

Jane Appleton	Associate Director of Communications & Engagement
Andy Armsby	Ward Manager, Wallingford Community Hospital – *part meeting*
Laura Carter	Head of Strategy
Sarah Mather	Research Engagement and Research Clinic Liaison Manager
Kathy McKee	Health Care Assistant/Carer's Lead, Learning Disabilities – *part meeting*
Naomi Merritt	Community Research Delivery Team Leader
Rachel Miller	Patient Experience Lead for Learning Disability Services – *part meeting*
Benita Olivier	Professor of Rehabilitation (Oxford Brookes University), Co-Director: Centre for Healthy Living Research and Clinical-Academic (Oxford Health NHS FT)
Joe Smart	Head of Organisational Development
Hannah Smith	Assistant Trust Secretary (Minutes)

[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 66/24	**Apologies for Absence**	
a	Apologies for absence were received from: Rob Bale, Chief Operating Officer for Mental Health & Learning Disabilities; Mohinder Sawhney, Non-Executive Director; and (noted as on maternity leave) Amélie Bages, Executive Director of Strategy & Partnerships.	
BOD 67/24	**Patient Journey – Specialised Services, Forensic Learning Disability ward**	
a	The Chief Nurse introduced the Patient Experience Lead, the Health Care Assistant/Carers' Lead and the Carer, Celia, to the meeting. They presented their report and video presentation on Celia's reflections upon her son's decade long admission to the Forensic Learning Disability ward. Celia highlighted challenges with: being unfamiliar with the site and practices such as seclusion; staff recording of visits and understanding the purpose of keeping such recordings; the laundry system; understanding the relevant legal frameworks and medication; and being informed on how to access patient finance services. Celia praised the work of the Carers' Lead on the ward and the support she had provided to her and her son. Through working with Celia, potential actions had been identified to improve families' experiences in relation to: • information available for families of new patients; • reinforcing the importance of staff introducing themselves; and • list of items which can/cannot be given as gifts and guidance on food and other items allowed/not allowed on the ward.	
b	In discussion with Non-Executive Directors, the Chief Nurse and the Chief Executive, Celia explained: • challenges with bringing food onto the ward and health and safety precautions; and • that although she had not initially felt listened to, this had improved significantly such that families were now welcomed, allowed time to explain concerns and provided with much more information. She was grateful for the Carers' Lead and wished that this role had existed when her son had first been admitted	
c	The Chief Executive highlighted the significance and great improvements achieved by working and involving carers more closely and learning from incidents.	
d	**The Board thanked Celia (the Carer), the Patient Experience Lead and the Health Care Assistant/Carers' Lead and noted the Patient Journey.** *Celia, the Patient Experience Lead and the Health Care Assistant/Carers' Lead left the meeting.*	
BOD 68/24	**Staff Story – Staff Side and Wallingford Community Hospital**	
a	The Chief People Officer introduced Andy Armsby, Ward Manager who was also Vice Chair of the Trust's Staff Side and who brought experience from nursing, management, as a union representative and member of the Trust's LGBTQIA+ and staff equality network.	
b	In discussion with Non-Executive Directors and the Chief Executive, the Ward Manager: • emphasised the importance of clear avenues of career progression and opportunities for development and promotion in order to retain staff; • commented upon lack of investment in community hospitals compared to mental health wards and the importance of the right staffing models and parity between community hospitals and mental health wards in relation to staffing, especially the number of matrons, and rollout of e-prescribing; and • suggested that more regular and ongoing management training be more widely developed, noting that this was underway within community hospitals.	

c	**The Board thanked the Ward Manager, including for his advocacy and help over the years, and noted the Staff Story and the suggestions made.** *Andy Armsby, Ward Manager left the meeting*.	
BOD 69/24 a	**Register of Directors' Interests** The register was noted. No interests were declared pertinent to matters on the agenda.	
BOD 70/24 a b	**Minutes and Matters Arising of the meetings held on 22 May and 26 June 2024** The Minutes of the meetings were approved as a true and accurate record. Completion updates were provided in relation to: • item BOD 39/24(e) from the Chief Nurse in relation to the Carer's Story from the previous meeting. She reported that the Carer was continuing to work with the Trust and work was taking place to commission a 'working with families' psychosocial intervention course. The Quality Committee had also received an update on the Carers' Strategy; and • item BOD 46/24(d) from the Chief Finance Officer who confirmed that the Board would continue to receive twice yearly reporting against the Annual Plan but with more oversight at Board Committee level. The remaining actions due at that meeting were noted as complete (updates in the Summary of Actions document), with remaining actions not yet due.	
BOD 71/24 a b	**Trust Chair's Report** The Trust Chair took his report as read and added that the update from the Chair of the Buckinghamshire, Oxfordshire and Berkshire West System Recovery and Transformation Board would now be received at the Board meeting in private. **The Board noted the report.**	
BOD 72/24 a b c	**Chief Executive's report** The Chief Executive presented his report and welcomed the newly elected governors listed in the report, some of whom had been able to attend the most recent Council of Governors meeting on 12 June 2024 which had also been held at the Whiteleaf Centre in Aylesbury. He also drew the Board's attention to: • the annual staff awards ceremony; • the Service User Network (**SUN**) symposium, also hosted in Buckinghamshire, which brought together the growing number of SUNs nationally; and • the event hosted by Lindengate in Buckinghamshire for organisations, including the Trust with voluntary and community sector partners, to showcase their work to address health inequalities. The Board discussed differences in approaches towards addressing health inequalities between Buckinghamshire and Oxfordshire and the challenges in: (i) spreading and sharing innovations horizontally across the Trust's services and geography; and (ii) identifying resources and the right models to apply. Non-Executive Directors commented upon: (i) the importance of creating space for staff to share ideas and have time to think; (ii) insights which might be missed through focus upon aggregated data to assess operational performance; and (iii) the University of Oxford's work with OpenSAFELY (an open-source software platform for analysis of electronic health records data) which may support linking of different data sets to track outcomes and improve understanding of health inequalities. **The Board noted the report.**	

BOD 73/24 a b	**Corporate Affairs report** The Associate Director of Corporate Affairs presented the report and the recent regulatory and good practice guidance relevant to the work of the Trust, with the Trust's responses and ownership through the governance framework and key meetings. She highlighted: • NHS England's updated safeguarding accountability and assurance framework; • preparation for seasonal vaccinations; • the Speaking Up support scheme; • NHS Employers' diversity in health and care partners programme; and • NHS Providers' resource on making sense of health inequalities. **The Board noted the report.**	
BOD 74/24 a b c	**Integrated Performance, Quality and Sustainability reporting** ***Integrated Performance Report (IPR)*** The Chief Executive explained that the IPR had been redeveloped to improve alignment with the Trust's strategic ambitions, local and national performance requirements; the redeveloped report should also support a more progressive understanding of where performance may be going. The Board's comments upon the format of the report, at its Development Day in June, would continue to inform the development of the report over coming months and additional comments from Non-Executive Directors were noted in relation to: • restricting references to performance being 'significantly' better than the national average unless that performance had been statistically tested; • more direction towards the areas which the Executive wanted to highlight and analysis of data, especially in order to manage the volume of information available or to explain where changes may be due to improved data recovery coming out of the response to the clinical systems outage; and • developing more granular reporting to highlight the more difficult experiences for patients, such as the longest waiting times, not just reporting averages achieved. The Trust continued to perform well against the NHS National Oversight Framework metrics with the ongoing exception of inappropriate Out of Area Placements (**OAPs**). The Trust had developed a new set of metrics to monitor clinical performance and reporting against these would be introduced on a phased basis. The report also included an update on the project to support the recovery of reporting in response to the clinical systems outage; the last phase of the project was due to complete in August 2024. With the exception of two data gaps reported on the outage period and new system functionality, all other data items that were reportable before the outage would be reportable again by the end of August. In response to Geraldine Cumberbatch, the Chief Finance Officer explained that: (i) in relation to data gap 1 (outage period), data which had not been retrospectively entered would not now be reportable; and (ii) system functionality was still being constructed in order to address data gap 2. Lucy Weston added that the Finance & Investment Committee meeting the previous day had also explored the remaining data gaps and been assured that risk assessment of unreportable data would retrospectively be conducted and consideration of this would be built into business recovery processes. The Chief Executive was also assured that staff were receiving appropriate training in order to make optimum use of the new clinical information systems.	

	Quality & Safety Dashboard	
d	The Board discussed the information available through the Quality & Safety Dashboard on capacity issues in District Nursing. The Chief Nurse provided assurance that clinical harm reviews were taking place to prioritise District Nursing visits appropriately. The Chief Operating Officer for Primary, Community & Dental Care reported that the Executive had undertaken a deep dive into the District Nursing service in June and considered the situation and also the projects underway to redesign their duty system and handling of same-day requests, as well as the potential for using scheduling software. However, the service remained under pressure in Oxfordshire, had been impacted by the global CrowdStrike outage the previous week and could be impacted by any collective action by GPs. The Chief Finance Officer reported that the Trust had responded well to the global CrowdStrike outage and implemented business continuity plans quickly.	
e	In response to Lucy Weston, the Chief Operating Officer for Primary, Community & Dental Care confirmed that the Trust was part of a system-wide network to learn from other trusts with similar District Nursing services and was developing networking further.	
	Finance and Sustainability	
f	The Chief Finance Officer presented the Month 3 Finance Report. All key indicators were green-rated and risks and opportunities in the capital investment programme on slide 5 were evenly balanced.	
g	**The Board noted the report and welcomed the redeveloped format of the IPR.**	
BOD 75/24	**NMAHPP[4] Research Capacity & Capability Development Programme**	
a	The Chief Medical Officer introduced Professor Benita Olivier who presented on the proposed programme to develop research capacity and capability in NMAHPPs and wider healthcare staff as there was a notable lag in clinical research amongst NMAHPPs compared to the medical field. More high-quality research would support improved patient outcomes and enhanced quality of care. She explained the four projects which comprised the programme, starting with capturing research interest, engagement, capacity and capability before moving through to mapping research support activities and concluding with the identification of strategic and operational priorities for the development of research capacity and capability. She requested Board support and approval given the programme's potential long-term impact and the importance of buy-in from staff for its success.	
b	The Board discussed the relationship between Quality Improvement (**QI**) and research. Professor Benita Olivier noted that although there was overlap and QI was a form of research and a way of getting staff more comfortable with undertaking research, staff still seemed more daunted by involvement in research. The Chief Nurse added that despite the work of the Oxford Healthcare Improvement Centre in QI, it was necessary to develop the structures to help staff engage more in research and increase the translation of research into clinical practice; this programme was crucial to developing the infrastructure which the Trust needed for this. Non-Executive Directors commented positively upon the potential strategic importance of the programme to the development of the Trust, its priorities and identity and to support recruitment and retention by making more of the opportunities for research.	

[4] Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacists and Psychologists (**NMAHPP**)

c	David Clark added that QI projects counted as research for University of Oxford purposes; analysis of perceived blocks to research participation through this type of programme would be necessary in order to overcome these blocks.	
d	In response to questions from Philip Rutnam on funding and recurring costs to support the programme, the Chief Nurse and the Chief Medical Officer confirmed that some funding was already available for 15 NMAHPPs who were currently undertaking postgraduate degrees and work was taking place to increase support from the Biomedical Research Centre.	
e	**The Board endorsed and APPROVED the NMAHPP Research Capacity & Capability Programme.**	
BOD 76/24	**Research & Development/Innovation report**	
a	The Board discussed the report, commenting upon the thought-provoking research activity underway, Board input into the development of the report and querying whether future reporting could set out Trust input into the ongoing balance between mental and physical healthcare, pure and applied science as well as health sciences and the distinction between brain and mind.	**KM**
b	**The Board noted the report.**	
BOD 77/24	**Board Committees' update reports – matters for Alert, Advice & Assurance (3As)**	
a	The Board took as read the 3As reports from the Audit Committee and the People, Leadership & Culture Committee. Chris Hurst highlighted from the Audit Committee 3As report: (i) the review of the Annual Report & Accounts; and (ii) work to review the revised NHS Audit Committee Handbook from the Healthcare Financial Management Association, alongside feedback from the Audit Committee's self-assessment, the outcome of which may have wider relevance for the relationship of the Board with its Committees.	
b	The following verbal updates from recent or upcoming meetings were provided: • Lucy Weston highlighted that the Finance & Investment Committee had: conducted a strategic workshop on delivering value for money to the local population and achieving best outcomes for mental and community health delivery given current resources; and discussed updates in relation to Jordan Hill, the capital budget, data gaps further to the clinical systems outage and Annual Plan oversight; • Andrea Young highlighted that the Quality Committee had reviewed safer staffing reporting and been assured of the Trust's compliance; • the Trust Chair linked his report to the work of the Mental Health & Law Committee in considering mental health advocacy services appointed by the local authority. He paid tribute to the work of associate hospital managers, through whom detained patients had a right of appeal, and the support they received from the Mental Health Act and Information Governance team; and • Rick Trainor looked ahead to the next meeting of the Charity Committee which would be considering a report on potential long-term fundraising activities, some of which may be able to benefit the Warneford redevelopment project.	
c	**The Board noted the 3As updates from the Committees, with supporting minutes and agendas in the Reading Room.**	

BOD 78/24	**Equality, Diversity & Inclusion report (WRES & WDES[5])**	
a	The Chief People Officer and the Head of Organisational Development presented the report which demonstrated improvements across most indicators but for both ethnic minorities and disabilities: (i) a mixed picture in representation at different Agenda for Change bands; and (ii) deterioration in likelihood of entering formal disciplinary processes. The People, Leadership & Culture Committee had reviewed the findings and been apprised of the actions the Chief Executive and the Chief People Officer were taking in relation to ethnic minority staff being put forward to formal disciplinary processes; the Race Equality Staff Network was also involved.	
b	In response to challenge from Philip Rutnam that action planning and the Trust's focus was more developed for race equality than disability equality, the Chief Executive acknowledged that there had been less visible focus upon disabilities and especially those which were not related to neurodiversity. However, work was taking place with Disability Network chairs to address this and he also encouraged the Board to create an environment in which people could feel more psychologically safe to venture more discussion about themselves. The Chief People Officer confirmed that there would be more focus upon disability and the metrics around likelihood of disabled staff entering capability processes from Q2 (which had been delayed from prior periods).	
c	**The Board APPROVED the WRES and WDES reports and noted the progress which had been made with the majority of WRES indicators and WDES metrics.**	
BOD 79/24	**Patient Safety Incidents (PSI) report**	
a	The Chief Nurse reported on learning identified from 14 PSIs over the reporting period May – June 2024 and wider learning from the local incident response plan for the national Patient Safety Incident Response Framework (**PSIRF**) and a recently completed multi-agency domestic abuse related death review. The Trust Chair reflected upon a presentation from Buckinghamshire staff to Board members, as part of a site visit before this meeting, and the challenges this had highlighted in joint working with some external services.	
b	**The Board noted the report and was assured by processes and structure for the identification, review and learning from PSIs.**	
BOD 80/24	**Board Committees' annual reports**	
a	The Associate Director of Corporate Affairs referred the Board to the available Committee annual reports in the Reading Room and noted that updated Terms of Reference and work plans would be available in September, together with the annual report for the Finance & Investment Committee.	
b	**The Board received the available annual reports of its delegated Committees and noted that this would follow for the Finance & Investment Committee together with updated Terms of Reference and work plans.**	
BOD 81/24	**Modern Slavery Act Transparency Statement**	
a	The Associate Director of Corporate Affairs sought the Board's approval for the Modern Slavery Act Statement 2023/24 to be published on the Trust's website and support to foster a culture in which modern slavery was not tolerated in the work of the Trust or its suppliers. The Chief Executive would separately be provided with assurance against	

[5] Workforce Race Equality Standard (**WRES**) & Workforce Disability Equality Standard (**WDES**)

b	the actions/bullet points listed in section 5 of the statement (on Due Diligence, Risk Assessment and Management). **The Board APPROVED the Modern Slavery Act Statement 2023/24 for publication and supported the Trust to foster a culture in which modern slavery was not tolerated in any form.**	**BC/GD**
BOD 82/24 a	**Any Other Business/Questions** None.	
BOD 83/24 a	**Review of the meeting** No comments received.	
BOD 84/24 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: 13:16	

Summary of Actions from the Board meeting on 24 July 2024

Relevant Item	Action	Responsibility:
BOD 76/24(a)	**Research & Development/Innovation report** To consider more Board input into the development of the report and whether future reporting could set out Trust input into the ongoing balance between mental and physical healthcare, pure and applied science as well as health sciences and the distinction between brain and mind. **Status: *complete*** – *Chief Medical Officer meeting with Chief Executive and Trust Chair to develop this.*	**KM**
BOD 81/24(a)	**Modern Slavery Act Transparency Statement** To provide the Chief Executive with assurance against the actions/bullet points listed in section 5 of the statement (on Due Diligence, Risk Assessment and Management). **Status: *complete*** – *provided over email to the Chief Executive on 05 September 2024.*	**BC/GD**
Action from the meeting on 22 May 2024		
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. **Status: *complete*** – *discussed at the Quality Committee on 28 August 2024 and at a separate meeting between the Chairs of the Quality Committee and Finance & Investment Committee on 29 August.2024. Agreed that BAF 1.1 will be monitored through the Finance & Investment Committee rather than the Quality Committee.*	**AC/HeS**

Action 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)** 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: *complete*** *– discussed at the Quality Committee on 28 August 2024 and at a separate meeting between the Chairs of the Quality Committee and Finance & Investment Committee on 29 August.2024. Agreed that BAF 1.1 will be monitored through the Finance & Investment Committee rather than the Quality Committee.*	**HeS**
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**

PUBLIC

Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 4)

Board of Directors

25 September 2024

Trust Chair's report

For: Information/ Discussion

Executive Summary

The NHS has been awash with reports about its condition and prospects since its foundation and it is no disrespect to the latest – commissioned by the new government from Lord Darzi – to say it echoes the survey undertaken at the behest of Chancellor Gordon Brown by Sir Derek Wanless. The NHS could be put on a sustainable long term financial footing provided radical action were taken to prevent people becoming ill and needing healthcare. Prevention is the key word in all such projections – helping people become more responsible for their own health and removing or at least reducing the social and economic determinants of sickness and dependency.

The border counties between England and Scotland used to be known as the 'debatable lands', disputed by cattle rustlers and war lords. Prevention is our debatable terrain. Our Trust strives to help people referred in, their problems having been previously identified (usually by GPs). We have some teams which reach out, among them our district nurses, the Family-Nurse Partnership and 'assertive' mental health but we are not equipped to reach into people's lives to change the way they eat or behave, let alone how they are employed or (with some exceptions) bring up their children. We talk about addressing inequalities generated by race, gender and disability but what we mean is that we are trying to identify discrimination and injustice inside our services, among our staff and within the areas and communities we serve.

There is another tricky concept – community. People live in flats and houses, on streets, in places. Some identify strongly with neighbours, some with people of similar ethnicity or religion. But society is not organised in neat or even boundaried groups. People have multiple identities and none. The NHS possesses no means of manipulating social relationships. We often struggle even with the smallest units and could do more to understand our patients as members of families, which are sources of knowledge, assistance and dysfunction.

So 'prevention' implicates lots of other organisations and streams – advertisers of junk food, teachers, employers insisting on zero hours contracts, landlords, polluting motorists, charities and voluntary organisations, and behind them social classes and economic differences, stemming from inheritance, skills and good fortune. We can and should prevent where we can. Grant recently gave the example of a district nurse encountering a patient in her mould-encrusted home. Could she, should she pick up a scraper and by so doing reduce the chances of that patient becoming more unwell? But district nurses have an onerous case load and where do they find the time to sort out the myriad domestic problems that they may encounter? Aren't they the province of social workers, landlords, the Department of Work and Pensions and so on.

For political reasons Darzi was enjoined to stick to the NHS and not say much about local government or the wider picture. Which leaves the analysis cogent but the prescription thin. On the integrated care system tin it says 'population health management' and local government think tanks talk ambitiously of councils and mayors mapping needs and capacities in their areas. But councils, like the NHS, are limited in what they can or want to do, constrained by cash and their own often marginal roles within people's lives.

Yet the weight of the analysis by Darzi and all his predecessors is heavy. The present and future functioning of the NHS depends upon opening out a dialogue about health in its widest sense. We could and should do more to inform and push it – assuming our clinicians and other colleagues could find the time and energy to take a pace back from the day job. But we also have to accept – for all the public's continuing faith in the NHS – that we are a sickness not a health service. Someone else will have to do the preventing, albeit with our active support and stimulus.

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: Digital, Data & Technology; 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; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Business Continuity and Emergency Planning; Environmental Impact; and Major Projects

Report to the Meeting of the

Oxford Health NHS Foundation Trust

Board of Directors

25 September 2024

(Agenda item: 5)

Chief Executive's Report

Civil unrest

Over August the country experienced violent, racist riots, periods of civil unrest and protests. The acts and crimes committed were truly appalling and caused significant distress and anxiety for communities across the country and of course for our colleagues and the people we serve.

In response we focused on providing support for colleagues and patients affected and in put in place an emergency planning response to plan and prepare for any instances of civil unrest that could have affected Trust services and the safety of patients and staff, including relocating services from areas of risk.

In particular, I would like to thank colleagues from our race equality, and religion and spirituality networks who supported colleagues and their loved ones. The lasting message from colleagues is that as an organisation Oxford Health must be actively anti-racist in all that we do, acknowledge the impacts of racism in our own organisation, in the NHS and in the communities where we live, and be conscious in how we can perpetuate structural racism. The Chief People Officer Charmaine will update the board on how we bring greater intentionality and focus to our work in this area in the coming months.

Annual General Meeting

It was my pleasure earlier this month to speak at the Trust's Annual General meeting and Annual Members Meeting. The meeting - held at the Didcot Civic Hall on the 10th September - was chaired by David Walker and heard presentations from Trust services

as well as looking back over the previous year and the presentation of the Trust's Annual Report & Accounts 2023/24 and independent auditors report.

The evening captured the essence of the Trust - combining mental and physical health services and vital research into these areas - and demonstrated the continued passion and commitment demonstrated of our colleagues.

I would particularly like to thank our staff speakers – Dr Monty Lyman on the connection between mental and physical illnesses; Family Nurse Partnership colleagues Rhiannon Griffin and Helen Spencer on the important work of supporting first-time young mothers and their babies in getting a good start in life; Stephanie Oldroyd on the Buckinghamshire Primary Care Mental Health Hubs, with Michelle O'Sullivan and Cordy Williams on the work of the Service User Networks (SUN); and Katharine Smith & Deborah Mol on the Clinical Research Facility on their recent and forthcoming mental health research.

Minister for Health visit to Buckinghamshire Talking Therapies

Baroness Gillian Merron, Minister for Health with mental health in her portfolio, visited Buckinghamshire Talking Therapies in August to meet the team and learn about how the service is delivered. It was good to hear that she was very complimentary about the holistic approach taken by the team to treat the whole person and thanked for team for an enjoyable and though provoking visit. My thanks to all the team there and for taking the time out of their day for the visit.

Member of Parliament visit to Townlands Hospital

In a further visit to Trust services over August, recently elected MP for Henley and Thame, Freddie van Mierlo, visited the rapid access care unit at Townlands Hospital in Henley. He was keen to see what services are delivered from that site, reducing the need for people to be seen at an emergency department. He was also shown around the services provided there by Royal Berkshire Hospitals, showing how NHS organisations partner to provide a wide range of care and treatment. My thanks to the Trust staff at the Townlands site.

Adult speech and language therapy team gains national recognition

I was pleased to hear of the national interest in Oxford Health's speech and language therapy supporting adults service (ASALT). Last year this service received Better Care Funding to improve the management of swallowing difficulties (known as dysphagia) for people being looked after in care homes. The service receives around 265 referrals a month with 35% of these being from care homes. The funded pilot aimed to improve efficiency and to test new ways of working with four of Oxfordshire's care involved. The success of the pilot – which has now been rolled-out to many more care homes in

Oxfordshire – is generating interest from other NHS organisations to learn from its work. This is an example of the valuable innovative work undertaken by the Trust.

System-wide review of community nursing

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) is supporting a review of how community nursing works across its three counties, starting with a workshop of service leads in late September. The aim of this work is to help shape the future of community nursing across the ICB geography – which includes everything from district nursing to more specialist nursing services such as respiratory and heart failure – through the development of a long-term plan.

Oxford Health Charity & Volunteering

It has been a busy few months for the Trust's charity and volunteering teams with highlights including: summer arts activities including arts sessions at the Children and Adolescent Mental Health units in Oxfordshire and Wiltshire and intergenerational arts at Bicester Community Hospital (both funded by the charity); a new volunteer to career role in Speech and Language Therapy developed with the team at the Oxford Stroke Recovery Unit (at Abingdon Community Hospital); summer charity events including a 'Brush Party' for Oxfordshire and West Mental Health, the Newbury Inflatable runs, and a music event for the ROSY appeal in Eynsham; and the official opening of Lucy's Room at the Warneford site (providing a space for those receiving care where they can make and play music and receive music therapy sessions) – this will also mark the passing of Lucy's Room from the charity to the Trust following extensive family fundraising and support from the Trust's charity, Portakabin, Chiltern Rangers, the Trust's Estates team, and a wide range of volunteers.

Grant Macdonald, Chief Executive

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

Agenda item: 6

25 September 2024

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; and
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 July to 15 September 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

Lead Exec: Georgia Denegri, Interim 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*** *– 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 July to 15 September 2024 (NHSE, CQC, NHS Employers, NHS Providers, DHSC)

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	NHS England				
1.	**Improving the management of physical deterioration** The new prevention, identification, escalation and response (PIER) approach will enable the effective management of acute physical deterioration in health and care and will apply to all conditions, clinical settings and specialities. It views deterioration as a whole pathway which is supported by systems rather than only advocating a single strategy for identification. Acute physical deterioration is the rapid worsening of a patient's condition. It can be identified from changes in physiology, such as respiratory rate, blood pressure or consciousness, or more subtle signs, such as not eating and a patient or their family's concerns and observations around wellness, mental status or behaviour. Deterioration can occur in any health and care setting and is the common pathway in all emergency admissions, prolonged illnesses and deaths. **Link to website/document:** Read more about the PIER approach	15 July 2024	Physical health		For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	Listen to our podcast about acute physical deterioration				
2.	**ICB annual assessments** NHS published updated guidance describing the process of ICB annual assessment for 2023/24. It sets out the evidence NHSE is using to underpin assessments, expanded from 2022/23 to include Joint Forward Plans and Integrated Care Strategies, and the key lines of enquiry that will guide each section of the assessment **Link to website/document:** NHS England » Annual assessment of integrated care boards 2023/24 – supporting guidance	19 July 2024	ICB related		For information
3.	**Primary medical care policy and guidance manual** NHSE published updated Primary medical care policy and guidance manual which support the commissioning and contract management of primary medical care contracts. It is presented in four parts covering: commissioning and partnership working; contract management; when things go wrong; and general information **Link to website/document:** NHS England » Primary medical services policy and guidance manual (PGM)	19 July 2024 / 9 August 2024	ICB related		For information.
4.	**Emergency preparedness, resilience and response (EPRR)**	15 July 2024	EPRR	Georgia Denegri, Interim Associate	For information. The Trust's assessment will be reviewed

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	NHSE published the EPPR assurance process for 2024/25 which is due to be completed by Friday 27 December. This year's deep dive will focus on responses to cyber security and IT related incidents. **Link to website/document:** **NHS England » Emergency preparedness, resilience and response (EPRR) annual assurance process for 2024/25**			Director of Corporate Affairs	by the Board before it is submitted.
5.	**Emergency preparedness, resilience and response** NHSE issued a letter to ICBs and Trusts outlining the programme from 2024 to 2030 for routine, systematic testing. It confirms that from October, it will set 7 exercise themes for NHS organisations to exercise in turn, and asks that organisations work together to plan, exercise and report on their capabilities within each theme. **Link to website/document:** NHS England » NHS emergency preparedness, resilience and response exercise programme 2024 to 2030	19 August 2024	EPRR	Georgia Denegri, Interim Associate Director of Corporate Affairs	For information.
6.	**Guidance on intensive and assertive community mental health treatment**	26 July 2024	Community mental health treatment		For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	NHSE issued guidance about intensive and assertive community mental health treatment which is designed to support ICBs in reviewing their provision. It explains that system reviews should be used as an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, and in particular the specific actions services need to take to ensure people are receiving and engaging in the care they need. It confirms that NHS England regions will gather responses from local reviews by no later than Monday 30 September **Link to website/document:** NHS England » Guidance on intensive and assertive community mental health treatment				
7.	**Flu and COVID-19 autumn/winter vaccination programme** NHSE's autumn/winter 2024/25 letter confirms which members of the public will be offered vaccination and details plans for health and social care workers. It sets out the next steps, which include information on prioritisation, booking and outreach. The main flu and COVID-19 vaccination campaign will start on Tuesday 3 October.	19 August 2024	Vaccination programme	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	For information - underway

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	Link to website/document: NHS England » Flu and COVID-19 Seasonal Vaccination Programme: autumn/winter 2024/25				
8.	**Learning Disability Register** NHSE's patient information helps people to consider whether their child or someone they care for could be considered to have a learning disability and should be on their local GP practice's Learning Disability Register, to help them get the help they need. **Link to website/document:** **NHS England » Find out more about the Learning Disability Register – leaflet**	19 August 2024			For information
9.	**Maximising uptake of antenatal vaccinations** NHSE's letter outlines the role of maternity, community pharmacy and primary care services in advising pregnant women of their eligibility for vaccination against pertussis, flu, COVID-19, and RSV. The appendix provides further information and guidance on antenatal vaccinations. **Link to website/document:**	28/08	Vaccination - antenatal	Ben Riley, Chief Operating Officer for Community, Primary Health and Dental Care	For information

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	NHS England » Maximising uptake of antenatal vaccinations and the introduction of a maternal vaccine against respiratory syncytial virus (RSV) for infant protection this autumn and winter: letter				
10.	**Independent prescribing in Community Pharmacy Pathfinder Programme** From September 2026, all newly qualified pharmacists will be independent prescribers on the day of their registration. In preparation, as well as funding access to independent prescriber training, NHSE are running the Independent prescribing in Community Pharmacy Pathfinder Programme. This programme enables community pharmacist prescribers in pathfinder sites to deliver prescribing models as part of integrated primary care clinical services. Link to website/document: NHS England » Update on Independent Prescribing in Community Pharmacy Pathfinder Programme	29 August 2024	Pharmacists		For information
11.	**Death certification reforms**	29 August 2024	Death certification	Karl Marlowe, Chief Medical Officer	

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
	From Monday 9 September the Death Certification Reforms, including the statutory medical examiner system, are in effect. This marks the first major change to death certification in decades, ensuring all deaths in England and Wales are now independently reviewed by either a coroner or an NHS medical examiner. **Link to website/document:** Contact details for medical examiner offices in England National Medical Examiner's report for 2023.				
	NHS Employers				
12.	**International recruitment toolkit updates** NHS Employers has updated the international recruitment toolkit to reflect recent changes in international recruitment. It includes links to the latest tools and resources, including a webinar recording with North West London ICB on recruiting refugees. **Link to website/document:** International Recruitment Toolkit updates September 2024 | NHS Employers	29 August 2024	International recruitment	Charmaine De Souza, Chief People Officer	For information.
	CQC				

	Publication, summary, and link	Publication date	Area	Executive Lead(s) for action	Trust action(s)
13.	**National review of maternity services in England 2022 to 2024.** CQC published its national review of maternity services in England **Link to website/document:** **National review of maternity services in England 2022 to 2024 - Care Quality Commission (cqc.org.uk)**	19 September 2024			For information.
	Inquiries and Learning from other Trusts				
13.	**Nottingham attacks**	Panorama programme		Rob Bale, Chief Operating Officer, Mental	Work is under way and a report will be brought to the November Board meeting.
14.	**The hearings of two inquiries are opening at the end of September:** • **The Lambart inquiry** examining the deaths of mental health patients in Essex over a number of years • **The Thirlwall Inquiry**, examining the events surrounding the crimes of Lucy Letby at the Countess of Chester.				The Board will receive updates as appropriate.

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 September 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 19 August and 23 September 2024 reviewed updates on the BAF, whilst the Extended Leadership Team meeting on 02 September 2024 reviewed updates on the TRR and Directorate Risk Registers. The Extended Leadership Team meeting, which is also attended by senior managers from Directorates, approves 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 QC on 28 August 2024 and the FIC on 17 September 2024.

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

- BAF 1.1 on *Digital, Data and Technology* was confirmed for monitoring and oversight through the FIC (agreed at the QC meeting on 28 August 2024 and confirmed at a separate meeting between the chairs of the FIC and the QC on 29 August 2024). An updated version of BAF 1.1 was presented to the FIC on 17 September 2024 and is available as part of the BAF in the Reading Room. The Current Risk Rating is an overall high/orange-rating (risk score 12) although the Target Risk Rating has been reduced and there have been various updates to the assurances across Level 1 (reassurance), Level 2 (internal assurance) and Level 3 (independent assurance);

- BAF 1.5 on *Unavailability of beds/demand and capacity (Mental Health inpatient and Learning Disabilities)* and BAF 1.6 on *Sustainability of primary, community and dental care services* have been updated in relation to controls and mitigating actions but Current Risk Ratings remain unchanged at extreme/red for BAF 1.5 (risk score 15) and high/orange for BAF 1.6 (risk score 12);

- BAF 2.4 on *Culture,* BAF 3.7 on *Ineffective business planning arrangements*, BAF 3.13 on *Impact on the Environment* and BAF 3.14 on *Major Projects* have also been significantly updated in relation to controls and mitigating actions (and BAF 3.10 on *Information Governance and Cyber Security* is undergoing updates which will be available in the next iteration) although Current Risk Ratings remain unchanged at high/orange for BAF 2.4 (risk score 9), BAF 3.7 (risk score 12), BAF 3.10 (risk score 12) and BAF 3.13 (risk score 9) and extreme/red for BAF 3.14 (risk score 16); and

- BAF 4.1 on *Not maximising Research & Development potential* was subject to a deep dive at the QC meeting on 28 August 2024, with a more focused risk description and progress to reduce gaps against controls and assurances. The Current Risk Rating of moderate/yellow (risk score 6) remains unchanged.

PUBLIC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 7)

Board of Directors

25 September 2024

Patient and Family Journey with formerly School Health Nursing Service, now 0-19 Childrens Services

For: Information & Assurance

Executive Summary

The School Nursing Service moved to a new service model this academic year (2024/25), the case being presented took place within the previous model which was in place until July 2024 where school nurses were based in all secondary schools and further education colleges, with a separate team who looked after children in primary schools. School Health Nurses now work as part of a locality team (11 localities) comprising HVs, Community Public Health Nurses, community public health associates and school health care assistants

Following a contract change in September 2024, School Nursing, Health Visiting and Family Nurse Partnership merged to become part of the newly integrated 0-19 years Children & Young People Public Health Service aimed at providing seamless care from birth to 19 (whilst still in education).

School Health Nurses (SHN) are qualified nurses with an additional specialist qualification in the public health of children and young people- Specialist Community Public Health Nurse- School Nursing. They work in state schools across Oxfordshire but also offer support to children who are electively home educated, ensuring children with health conditions are well supported in school, they also provide individual and group/class advice & support on healthy lifestyle choices and harm minimisation; offer interventions and contribute to health promotion around emotional wellbeing as well as offering health reviews, support for families with complex needs, and work around safeguarding children and young people. They work closely with parents/carers as well as with partner agencies such as schools, colleges, social health care services, Mental Health Schools Team (MHST), Child and Adolescent Mental Health Services (CAMHS), GP's and other agencies.

There are 129,000 children and young people aged between 5-19yrs in Oxfordshire. 43 secondary schools, 252 primary schools and 5 colleges of further education. Whilst most of these children will receive a universal level of service, many will be referred by themselves, parents/carers, schools or other professionals and receive a more targeted or specialist level of support.

Workforce establishment for School Nursing taken from September 2023 Registered nurses WTE B7=6 B6 =30.97 B5 =7.2. Majority of band 5 and 6 work term time only.

EMIS is currently unable to provide robust data for school nursing but from academic year 21/22 Face to Face appointment with children and young people was on average 241/week and 3318 per term (3 x terms a year).

M is a 13yr old student (Yr 9) who has a chromosomal disorder that results in multiple health needs. He is autistic, has some learning needs (his levels are around Key Stage 1- early primary) and has an Education and Health Care Plan (EHCP). He transitioned to secondary school where his mother felt his health needs did not seem so well supported. He was the victim of bullying which left him hugely anxious about being in school. When M was referred to Tikki Harrold (SHN) in Sept 23, the relationship between school, parent and M had broken down, with communication between school and home only able to go via SENDIASS worker. SENDIASS provides impartial information, advice and support to parents and carers of children with special educational needs. M had not attended school since June 23 and had no intention of returning to the same school. He did, however, desperately want to be in education.

M's physical health needs at that time were around management of his asthma in school, his hearing impairment, mobility around school and joint pain, support with continence & self-care and management of his swallowing difficulties. Whilst his asthma was well supported by OUH, it appeared he had become a little lost to the OUH paediatric Gastroenterology and Urology teams. His emotional needs were around his very high anxiety levels, his suicidal feelings and the 'meltdowns' that he experienced.

Tikki was invited by M's school to attend a professional meeting 22.9.23 which is when M was 1st referred to the service. By end of Sept, Tikki had referred M to Community Paediatrics Physio and OT and liaised with the paediatric Gastroenterology team requesting a review. By mid-October Tikki had liaised with GP and a referral to Urology and Gastroenterology had been made. An individual health care plan was devised which ensured M's health needs were met in school and allowed M and his mother to feel more reassured. Key school staff were trained for M's personal care by Tikki. M worked with Tikki round his needle phobia which had prevented him from having his Human Papilloma Virus (HPV) vaccination. She was able to liaise with the School Aged Immunisation

Service, and with his mother's support, he was able to receive this in an out of school setting.

To help facilitate a rebuilding of the relationship with school, Tikki suggested a Team Around the Family (TAF) approach- see Early Help. This required completion of a strengths and needs (S&N) tool (an in-depth assessment exploring what is going well for the family and what help might be needed), setting of agreed goals and would ensure regular structured meetings. The S&Ns form should be completed in partnership with parent/child/school/health. Tikki completed the health element but unfortunately, due to educational staffing changes, the form was misplaced. This resulted in it being sent again to M's mother to complete herself. This is a very complicated form to fill in on a mobile phone. As most of the information required was already captured within Tikki's professional section, and the TAF was up and running, with the agreement of M's mother, Tikki returned this form to school for submission to the Locality Community Support Service.

After the initial referral Tikki visited M twice at home to get to know him, gain his trust and to complete a health needs assessment. On 11th Oct, to encourage M's integration back into school, she offered him and his mother a session with her in her room within the school. She had already explored the potential feelings he might experience and the strategies he could use to manage these. The meeting was timed so that M did not have to walk through the school when other students were moving between lessons. This session's primary aim was to get him into school and to help him see that if he used his calming strategies, he could manage. Through scaling his anxiety, M could see how it peaked but then slowly reduced.

Tikki continued to work on a one-to-one basis with M, in school, helping him to understand what was happening in his body when he felt anxious, exploring strategies around his anxieties, gently helping him increase his exposure to school and being away from his mother. In Feb 24 Tikki referred M to Mental Health School Team for some managing big feelings work. The request for service was initially declined, but she was able to strongly advocate for its appropriateness, and this intervention continues with M reporting he finds it helpful.

Outcome of SHN intervention: M's chronic health needs are being well supported by the appropriate teams. M has managed to have his HPV immunisation which he was previously too scared to have. M and his mother's relationship with school appears repaired. M appears more physically able to manage the school stairs which he feels is due to his physio exercises. M is now able to attend school for a daily hour long 1-to-1 lesson, whilst his mother waits in reception. On the days he sees Tikki, his mother is able to leave the school site. His visits to school are no longer filled with so much anxiety and he is enjoying his time there. This is all a significant improvement. The hope had been that M's

time in school would increase, but the school were unable to provide any further 1 to 1 teaching hours or a group environment where he feels safe, and there has been difficulty in finding M a place in a suitable alternative school.

Within the video, M and his mother talk about the excellent, flexible support they have received; the liaison Tikki undertook with school to ensure his health needs were met; the value they place on their School Health Nurse and the difference she has made to M's feeling of safety in school. M's mother talks positively about the frequent communication that took place between her and Tikki. M and his mother talk about not previously being aware of the SHN role, wanting more School Nurse provision in all schools and about the difficulties with the S&N's form.

At the start of each academic year, all SHN's offer to hold assemblies in school for the students to advertise the SHN role, but that is reliant on the student being present in school on that day to hear the information. To supplement this, we have now created a video explaining the role and how to access the service. This year it will be targeted at Yr 7s- just starting secondary school- but next year will be sent to all Yr 6 students to help prepare for transition. Schools will be asked to have this video visible on their website so all students can access. To increase the awareness for parents of primary aged children, a similar video has been created which includes some guidance on school readiness. In addition, SHN will work in collaboration with schools in areas of high deprivation to provide an in-person parents' session to help prepare for school entry.

Changes within the new contract should ensure school-aged children like M receive a targeted or specialist level of provision from the 0-19 years Children & Young People Public Health Service before difficulties arise within education. School Nurses will work closely with Primary schools aiming to identify any child who may need additional support around transition to secondary school, with Health Visitors identifying those who may need support at school entry with the new 4 year old review.

Primary and Secondary newsletters are emailed to all parents via the school and contain health promotion information that is age appropriate, and guidance on how to access the SHN. The process for accessing support has been simplified with the introduction of the new Single Point of Access (SPA), and the existing online messaging service for 11-19yr old children, ChatHealth, has been increased to all year round and now welcomes parental contact.

Strengths and Needs forms should not be completed by parents alone. The 0-19 years Children & Young People Public Health Service leadership team all hold specialist roles, one of which being Early Help which includes the S&Ns process. The completed forms are audited to ensure they are correctly completed, and staff are supported accordingly.

Governance Route/Escalation Process:

Nil

Statutory or Regulatory responsibilities

For assurance purposes.

Recommendation

This presentation is presenting the service users experience of the School Health Nursing Service.

Author and Job Title: Tikki Harrold- Clinical Education Lead and Specialist Community Public Health Nurse- School Nurse

Lead Executive Director: Britta Klinck Chief Nursing Officer - CNO

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/Priority 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).

PUBLIC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 8)

Board of Directors

25 September 2024

Staff Story

For: Discussion

Executive Summary

Today's staff story comes from Sarah Merritt. Sarah is a Team Manager in the Oxfordshire Talking Therapies service, and joined the Trust in this role at the start of January 2024. This is Sarah's first role in the NHS, having joined us from Thames Valley Police. She served in the police for 21 years, 15 of which were as a police officer. Her final role in the police was as a Neighbourhood Supervisor. She was Thames Valley Police Community Officer of the Year in 2019.

Sarah's experience as a manager and leader within the police enables her to bring a broader perspective to her management role at Oxford Health, and I hope that this provides the basis for a fruitful discussion from this staff story.

Recommendation

The Board is asked to receive this report, and take the opportunity to hear directly from Sarah 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

PUBLIC

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

(Agenda item: 10(a))

25 September 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 July 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 2024 and has made suggestions for improvement that will be included in the November 2024 six-monthly review for incorporation from the following financial year where appropriate.

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 July 2024 locally reported total bed day usage was 169 days (143 inappropriate OAP bed days in Buckinghamshire, and 26 inappropriate OAP bed days in Oxfordshire) – an increase of 25 bed days compared to June 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 dashboards throughout the IPR.

Service area	Total number of indicators	Total number of indicators reported in July 2024	Total number of indicators with reporting mechanism in development	Comments
Child and Adolescent Mental Health Services (CAMHS)	11	9	2	• Four week wait (interim metric – one meaningful contact within episode) – Buckinghamshire CAMHS above national target (61%) with 80.25% in July 2024 whilst Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire CAMHS services under national average with 56.16% and 52.47% respectively. • Oxfordshire CYP Eating Disorders services have achieved the national target (95%) in July 2024 for routine cases, while Buckinghamshire and Bath and North East Somerset, Swindon and Wiltshire CYP Eating Disorder services have not achieved the national target with 90% and 85.71% respectively. Bath and North East Somerset, Swindon and Wiltshire CYP Eating Disorder service achieved the national target (95%) for urgent cases, however, Buckinghamshire and Oxfordshire services have not with 33.33% and 85.71% respectively. Few factors contribute towards performance being under target: 1. Patients who choose to be seen outside of the timeframe are still counted as a breach, 2. Services are investigating referrals of 18-year-olds that cross-over with Adult Eating Disorder services.

Talking Therapies	15	12	3	All reported metrics have met set targets in July 2024 and are performing generally well consistently.
Adult and Older Adult Community Mental Health Services	8	2	6	Four week wait (interim metric – two contacts within episode) – Buckinghamshire and Oxfordshire adult and older adult community services performed above national average (32%) in July 2024 with 43% and 53.42% respectively.
Mental Health Urgent Care Services	6	6	0	• Both Oxfordshire and Buckinghamshire services are performing better than the national average (62%) against the 1-hour face to face response from Psychiatric Liaison service metric with 84.30% and 93.62% respectively. • 4-hour response time for very urgent referrals national average is exceeded by Buckinghamshire services, but not met by Oxfordshire services. • 24-hour response time for urgent referrals above national average across both Oxfordshire and Buckinghamshire. To note: not all activity undertaken in the urgent care pathway is represented in the Mental Health Urgent Care waiting standards reported in the IPR due to specific national definitions.
Adult and Older Adult acute/inpatient services	30	26	4	• Acute admissions with no prior contact with community services in year prior to inpatient admissions are higher than the national average across both Oxfordshire and Buckinghamshire services. • More than 80% of those discharged from mental health wards were followed up within 72 hours of discharges across both Oxfordshire and Buckinghamshire. There is a selection of indicators that are being baselined with a view to either set a target or a trajectory after few months of monitoring within this IPR sub-section.
Community Health Service, Primary Care & Dentistry	7	4	3	90.61% of patients attending Minor Injury Units in July 2024 were seen within 4 hours (national target – 78%).

(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.

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 this month.

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

Gap 1 (Outage period). **This is a permanent, non-recoverable gap**
The capture of data by services during the outage period was inconsistent both in terms of method and completeness. Therefore, anything that was not retrospectively entered into RiO/EMIS/Adastra relating to the outage period is not reportable and there is a permanent gap in the data. The Executive Team assessed the impact of the gap and took a decision for services **not** to undertake a comprehensive data entry exercise retrospectively. This is therefore a permanent, non-recoverable gap.

Data Gap 2 (system functionality). This is a recoverable gap
Data can only be reported if it is recorded in the clinical system. If the new clinical information systems do not yet have the functionality to enable the data to be recorded, the corresponding reporting does not exist. The implementation of new system functionality is a separate project to the reporting recovery project and is subject to its own prioritisation processes. However, it should be noted that the core data requirements were implemented as part of the initial system implementation and the outstanding data gaps (as per the table below) were deemed low risk.

Of the 8 outstanding data gaps last month, there are only 2 remaining data gaps (shaded yellow in the table overleaf) and both are due for completion by end of this month. Both are also deemed low risk.

Data item	Reason for gap	Assessment of impact	Mitigation/Status at end August 2024
Occupancy reporting in TOBI* **TOBI – Trust Online Business Intelligence platform*	Technical issues with counting number of beds available in data sources. In RiO this was due to incorrect configuration of the system i.e. too many beds built in the system and a need to change the warehouse to date stamp changes in bed number. For Community Hospitals a manual tool (Domino) needs to be used as the source for bed availability and this has proved complex to incorporate into the warehouse. This is in the process of being resolved by Business Intelligence team/Concept Analytics.	Low	**This is not a reporting gap.** Reporting has continued to be provided by Performance & Information based on manual reporting/recording processes mitigation for errors in bed availability, until TOBI* (automation) is available
National dataset: Primary Care Mental Health Teams (PCMHTs) outcomes (EMIS) data in Mental Health Services Data Set (MHSDS) & TOBI	Part of reporting recovery final elements	Low	**Work completed**. No longer a reporting gap
National dataset: PCMHTs general (EMIS) data in MHSDS	Part of reporting recovery final elements	Low	**Work completed**. No longer a reporting gap.
National dataset: True Colours outcomes data in MHSDS an TOBI	Part of reporting recovery final elements	Low	**Work completed** subject to final testing in September MHSDS window
National dataset: Urgent Community Response (UCR)/same day services waits data in Community Services Data Set (CSDS)	Part of reporting recovery final elements for UCR team and District Nursing. For other services that should be reporting this data their templates are yet to be developed in the clinical system (EMIS and Adastra)	Low	Work underway to develop reporting anticipated by **end of September 2024** at latest for services that have templates. Development of templates is part of the clinical systems optimisation project as prioritised by the Directorate.
0-19* contract reporting **0-19 is Healthy Child Programme*	Part of reporting recovery final elements. New service configuration and reporting requirements were only agreed April 2024, so this development was always planned to be at the end of the reporting recovery timeline.	Low	Work nearing completion – testing in progress

Mental Health physical health checks – Phase 1	Part of reporting recovery final elements	Low	**Work completed**. Please note, however, following rule changes within the Trust that were signed off by the Quality team in July, further work is required. This now forms part of business-as-usual process as is separate to reporting recovery.
National datasets: Mental Health out of area placements in MHSDS & TOBI	Unable to flow nationally or report in TOBI because the data capture has not been developed in the clinical system (RiO)	Low	**This is not a reporting gap.** **Reporting has continued to be provided by Performance & Information team** based on manually held information. Development of templates is part of the clinical systems optimisation project as prioritised by the Directorate.

It should also be noted that additional reporting (including those metrics marked as in development within the IPR) have continued to be developed alongside the reporting recovery project. **Overall, the reporting capability and outputs of the Trust will be better than before the outage.**

Outcome Measures-Reporting of outcome measures will be included within the IPR following the implementation within clinical directorates which is currently being rolled out in a phased approach.

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): September 2024

July 2024 data unless stated otherwise

Quality

People

Sustainability

Research

NHS
Oxford Health
NHS Foundation Trust

Contents

Oxford Health NHS Foundation Trust

Guide to the Integrated Performance Report

Oxford Health NHS Foundation Trust

The Integrated Performance report (IPR) provides and 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.

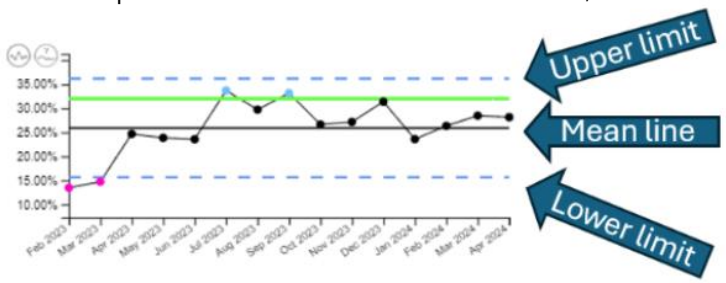
Clinical - these acknowledge business as usual activities to maintain performance. These are monitored against set thresholds, which will determine when further action should be taken. Reported on a monthly basis where applicable in Sections 1.1 and 1.2 of the IPR.

Guide to the Integrated Performance Report

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

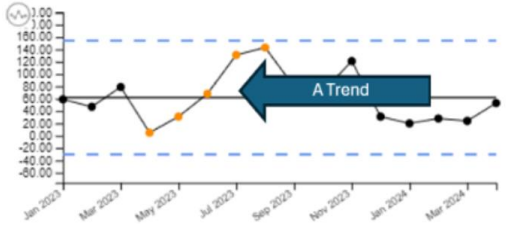
Statistical Process Charts (SPC) is an analytical technique that plots data over time. Such charts help identify variation i.e. what is 'different' and what is the 'norm'. Using these charts can help understand where focus might be needed to make a difference.

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.

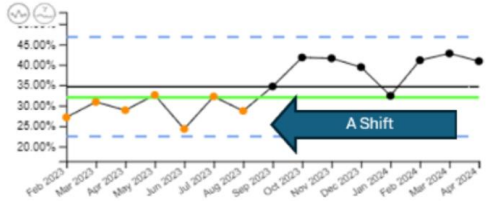


Green is the metric target line – only added to those graphs where target is applicable. Data points highlighted in pink are noted to be statistically different from the rest of the points (outside of the upper and lower control limits).

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.

Section 1.1
Clinical performance (National Mental Health Standards)

Oxford Health
NHS Foundation Trust

Mental Health Services – Child and Adolescent Mental Health Services – Summary dashboard (1/2)

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 reporting period	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)	*In development (estimated completion – Q2 2024. Status: technical development in testing)*				
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Buckinghamshire	61% National average	Jul-24	80.25%	↑	↑
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Oxfordshire	61% National average	Jul-24	56.16%	↓	↑
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	Jul-24	52.47%	↓	↑
National Objective	Waiting time standard for a meaningful contact & outcome measure	*In development (estimated completion - FY25. Status: technical development initiated; operational action needed to record in Electronic Patient Records)*				

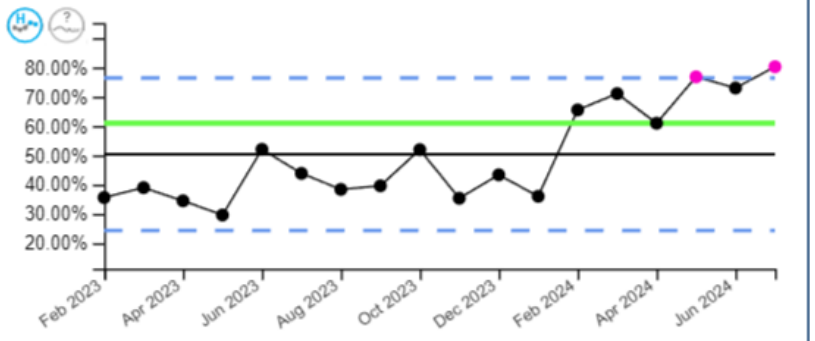
Mental Health Services – Child and Adolescent Mental Health Services – Summary dashboard (2/2)

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 reporting period	Better is
	Child and Adolescent Mental Health Services (CAMHS)					
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position)	95%	Jul-24	90.00%	↑	↑
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	95%	Jul-24	95.00%	→	↑
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Bath & North East Somerset, Swindon and Wiltshire (rolling 3 months position)	95%	Jul-24	85.71%	↑	↑
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Buckinghamshire (rolling 3 months position)	95%	Jul-24	85.71%	↑	↑
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire (rolling 3 months position)	95%	Jul-24	33.33%	↓	↑
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Bath & North East Somerset, Swindon and Wiltshire (rolling 3 months position)	95%	Jul-24	100.00%	↑	↑

Mental Health Services – Child and Adolescent Mental Health Services

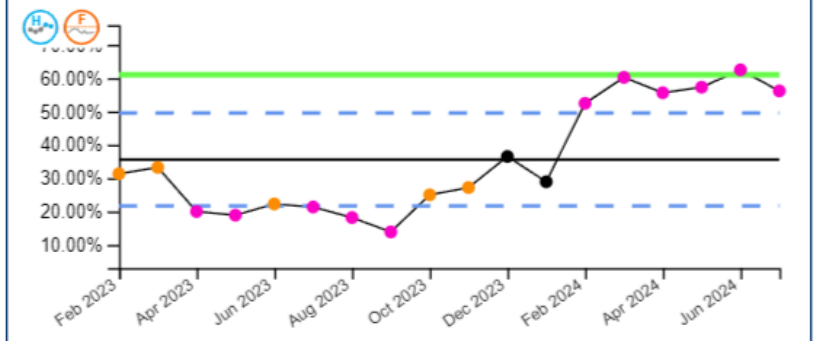
Children and Young People 4 Week Wait Interim Metric – Buckinghamshire



National Average: 61%

Month Year	Value	Numerator	Denominator
Jul 2024	80.25 %	455	567

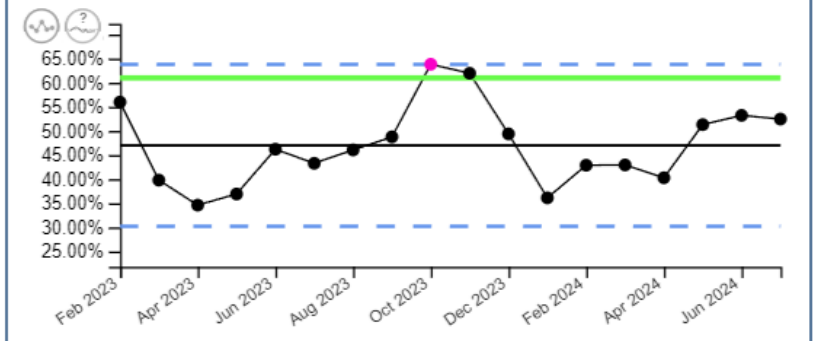
Children and Young People 4 Week Wait Interim Metric – Oxfordshire



National Average: 61%

Month Year	Value	Numerator	Denominator
Jul 2024	56.16 %	301	536

Children and Young People 4 Week Wait Interim Metric – Bath and North East Somerset, Swindon and Wiltshire



National Average: 61%

Month Year	Value	Numerator	Denominator
Jul 2024	52.47 %	202	385

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 July 2024 whilst Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire CAMHS are working towards achieving the national average.

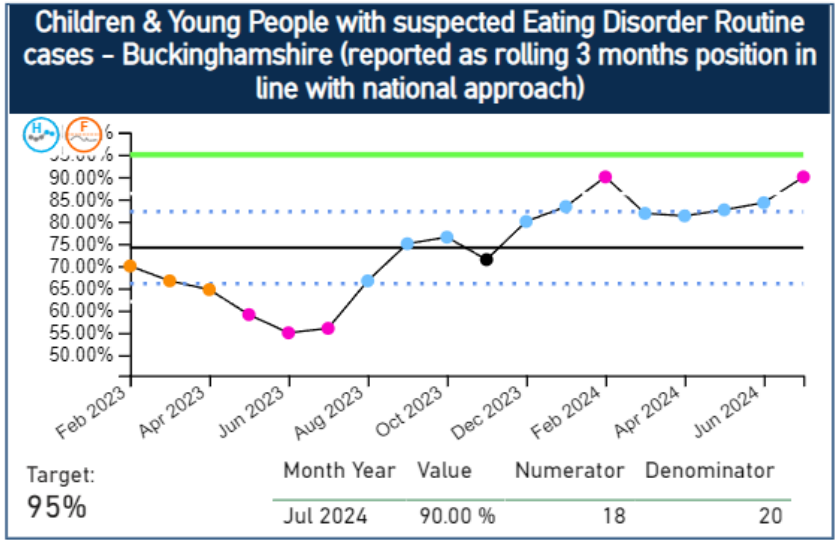
Meaningful contact is one that informs assessment and intervention, that is related to the identified/coded problem and is intended to assess or change feelings, thoughts, behaviour, or physical/bodily state. This may involve advice, support, or a brief intervention, help to access another more appropriate 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.

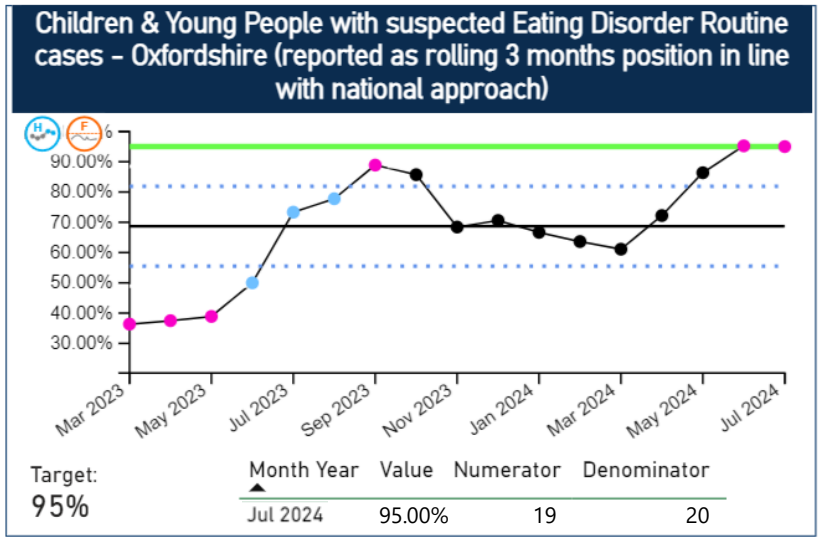
***SNOMED is a structured clinical vocabulary for use in an electronic health record.*

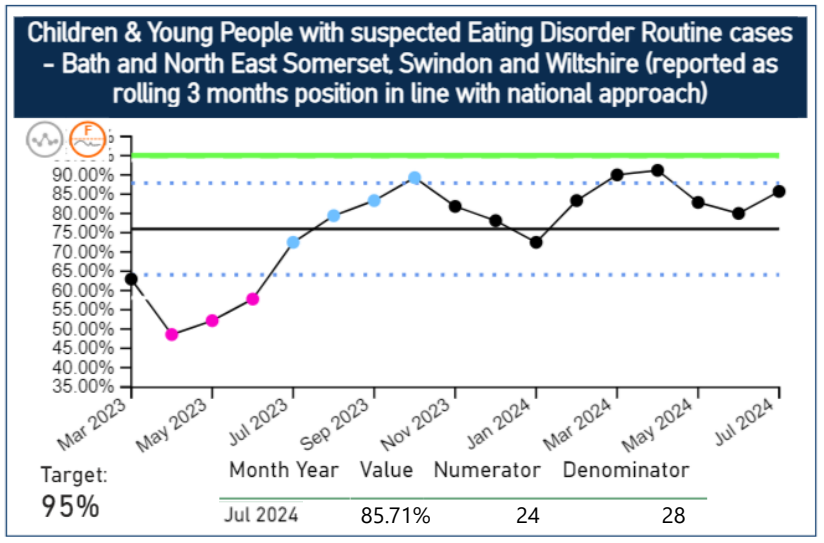
Actions

- Data recording guidance has been 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.
- Bath & North East Somerset, Swindon and Wiltshire CAMHS are reviewing their model of care with the aim of aligning it with the new non-urgent waiting time standards.

Mental Health Services – Child and Adolescent Mental Health Services







Summary This metric measures routine referrals seen within 28 days where the referral reason is "Eating Disorders" and age of patient is between 0 – 18 years. In order for the attended first appointment to count in the national waiting times, it must be outcomed and an appropriate SNOMED* intervention recorded. All providers are measured on a rolling 3-month position, so July 2024 performance includes May, June and July 2024 performance. Patients who choose to be seen outside of the 28-day timeframe will still be counted as a breach.
Eating Disorders referrals are not in scope of the Children and Young people (CYP) four (4) week wait measure.

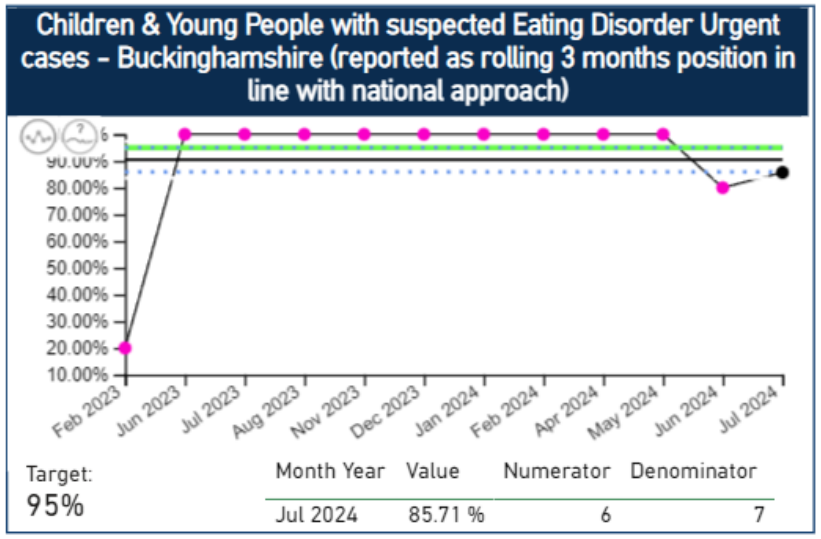
The national target for routine Eating Disorders to be seen within 28 days is 95%. Oxfordshire CYP Eating Disorders services have achieved the national target in July 2024, while Buckinghamshire and Bath and North East Somerset, Swindon and Wiltshire CYP Eating Disorder services have not achieved the national target. Six (6) out of seven (7) breaches were attributed to patient choice – all six (6) first appointments were offered within 28 days. One (1) breach is related to transitioning to adult services and is being investigated for data quality accuracy.

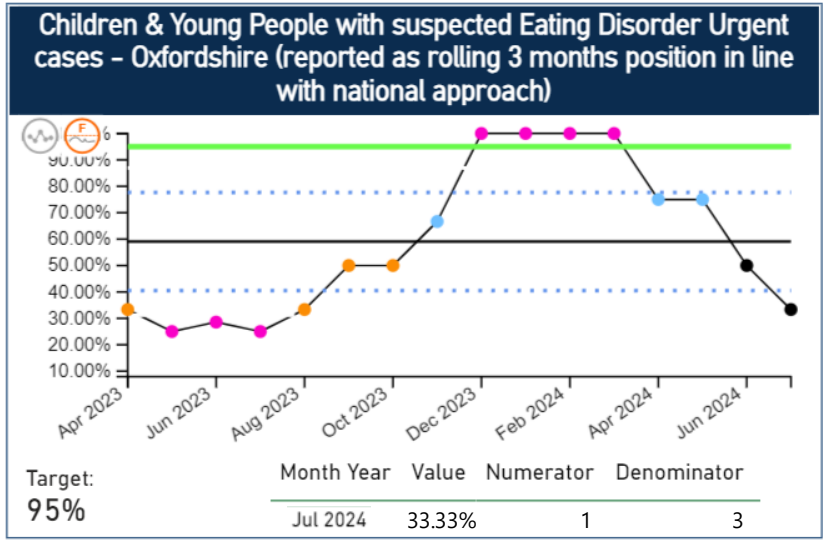
**SNOMED is a structured clinical vocabulary for use in an electronic health record.*

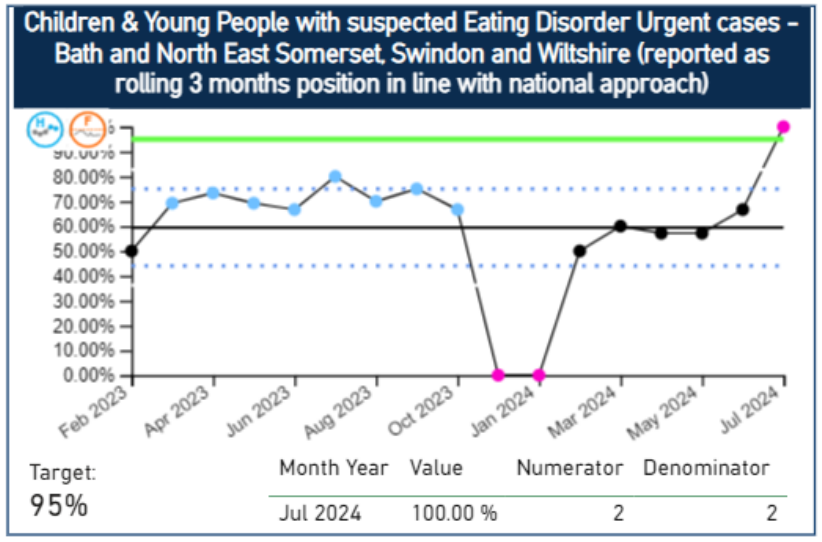
Actions

- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Every patient record indicating a breach is investigated to ensure appropriate intervention has been recorded.
- Services are investigating referrals of 18 year-olds that cross-over with Adult Eating Disorder services to review waiting times

Mental Health Services – Child and Adolescent Mental Health Services







Summary This metric measures urgent referrals seen within 7 days where the referral reason is "Eating Disorders" and age of patient is between 0 – 18 years. In order for the attended first appointment to count in the national waiting times, it must be outcomed and an appropriate SNOMED* intervention recorded. All providers are measured on a rolling 3-month position, so June 2024 performance includes May, June and July 2024 performance. Patients who choose to be seen outside of the 7-day timeframe will still be counted as a breach.
Eating Disorders referrals are not in scope of the Children and Young people (CYP) four (4) week wait measure.

The national target for urgent Eating Disorders to be seen within 7 days is 95%. Bath, North East Somerset, Swindon and Wiltshire CYP Eating Disorder service met the national target in July 2024 while CYP Eating Disorder services in Buckinghamshire and Oxfordshire have not. Two (2) out of three (3) patients were offered appointments outside of the timeframe (on day 7 and day 12 respectively). One (1) breach is related to transitioning to adult services and is being investigated for data quality accuracy.

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

Actions

- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Every patient record indicating a breach is investigated to ensure appropriate intervention has been recorded.
- Services are investigating referrals of 18 year-olds that cross-over with Adult Eating Disorder services to review waiting times

Mental Health Services – Talking Therapies – Summary dashboard

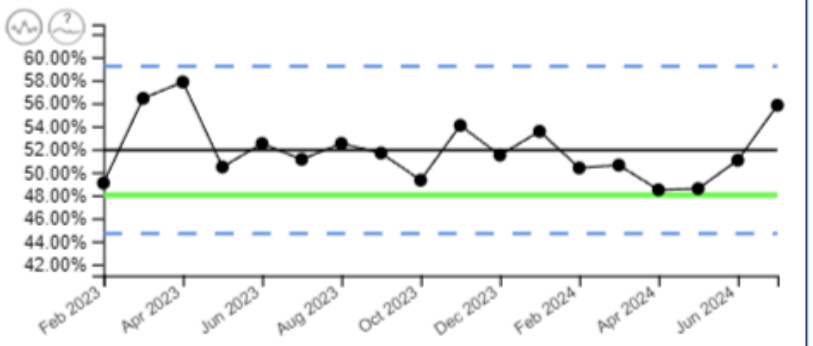
Narrative provided only for metrics under target (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Talking Therapies					
National Objective	Increase the number of adults and older adults accessing Talking Therapies treatment	*In development for Q2 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 Q2 FY25*				
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	48%	Jul-24	55.82%	↑	↑
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	46%	Jul-24	46.35%	→	↑
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	66%	Jul-24	70.83%	↑	↑
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	65%	Jul-24	66.12%	↓	↑
National Objective	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	75%	Jul-24	99.00%	↓	↑
National Objective	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	75%	Jul-24	99.86%	↑	↑
National Objective	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	95%	Jul-24	100%	→	↑
National Objective	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	95%	Jul-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%	Jul-24	2.13%	↓	↓
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%	Jul-24	4.09%	↓	↓
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%	Jul-24	56.73%	↑	↑
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%	Jul-24	51.22%	↑	↑
National Objective	Meet and maintain Talking Therapies standards - 50% 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 Q2 FY25*				

Mental Health Services – Talking Therapies

Metrics meeting target:

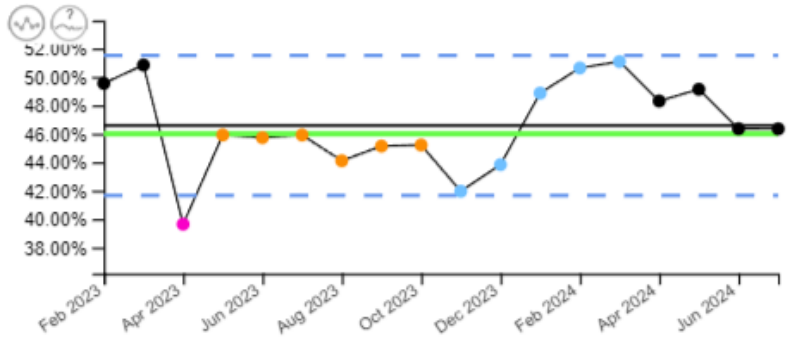
Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire



Target:
>=48%

Month Year	Value	Numerator	Denominator
Jul 2024	55.82%	307	550

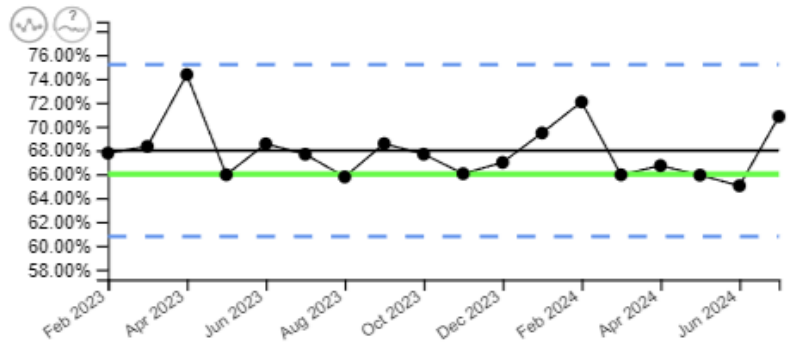
Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire



Target:
>=46%

Month Year	Value	Numerator	Denominator
Jul 2024	46.35%	324	699

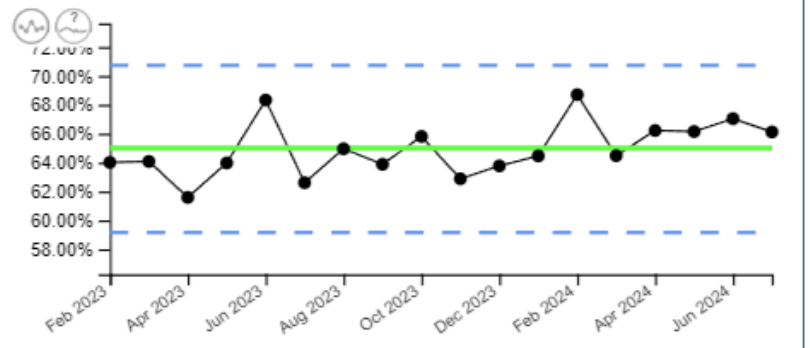
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Buckinghamshire



Target:
>=66%

Month Year	Value	Numerator	Denominator
Jul 2024	70.83%	425	600

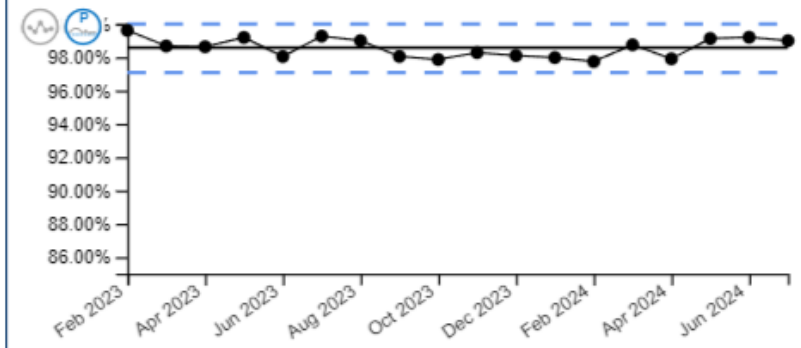
Reliable improvement rate for those completed a course of treatment adults and older adults combined - Oxfordshire



Target:
>=65%

Month Year	Value	Numerator	Denominator
Jul 2024	66.12%	484	732

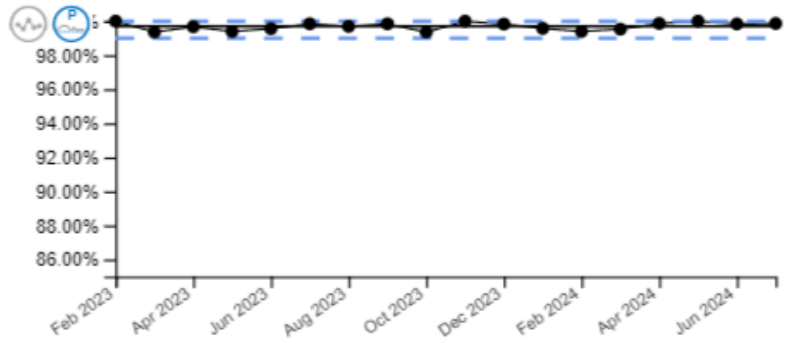
% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire



Target:
>=75%

Month Year	Value	Numerator	Denominator
Jul 2024	99.00%	594	600

% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire



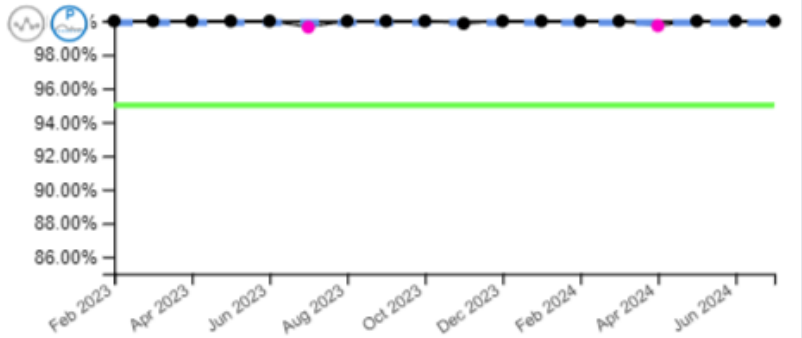
Target:
>=75%

Month Year	Value	Numerator	Denominator
Jul 2024	99.86%	733	734

Mental Health Services – Talking Therapies

Metrics meeting target:

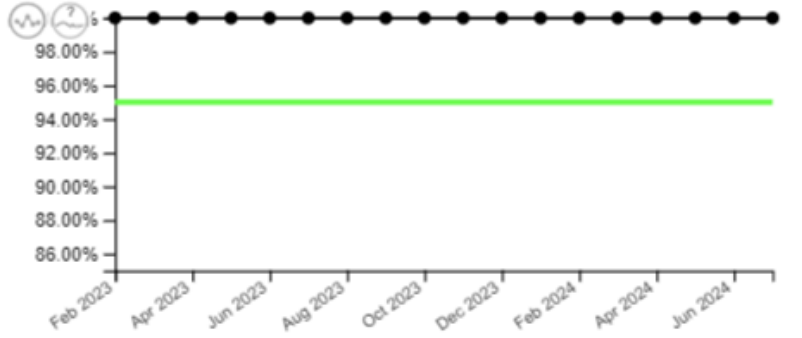
% of people receiving first appointment within 18 weeks of referral – Buckinghamshire



Target: >=95%

Month Year	Value	Numerator	Denominator
Jul 2024	100.00%	600	600

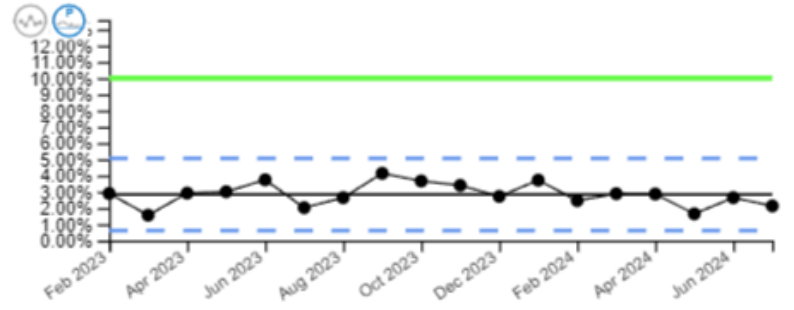
% of people receiving first appointment within 18 weeks of referral – Oxfordshire



Target: >=95%

Month Year	Value	Numerator	Denominator
Jul 2024	100.00%	734	734

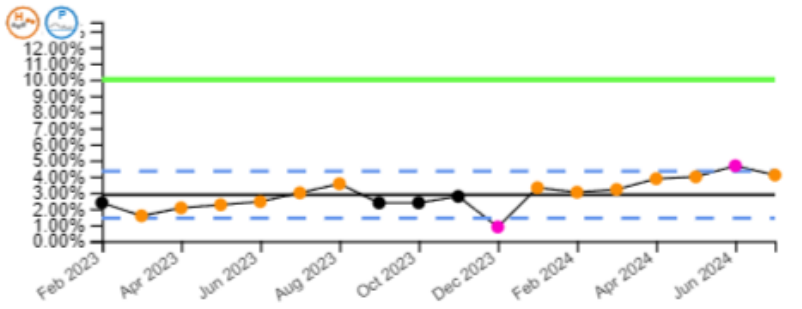
Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting no more than 90 days between treatments) – Buckinghamshire



Target: <=10%

Month Year	Value	Numerator	Denominator
Jul 2024	2.13%	14	657

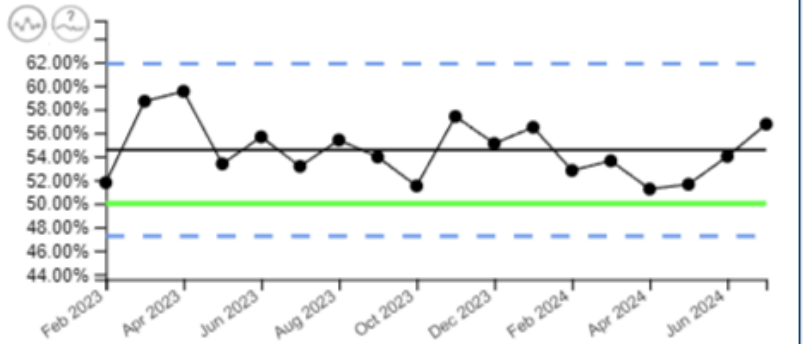
Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting no more than 90 days between treatments) – Oxfordshire



Target: <=10%

Month Year	Value	Numerator	Denominator
Jul 2024	4.09%	30	734

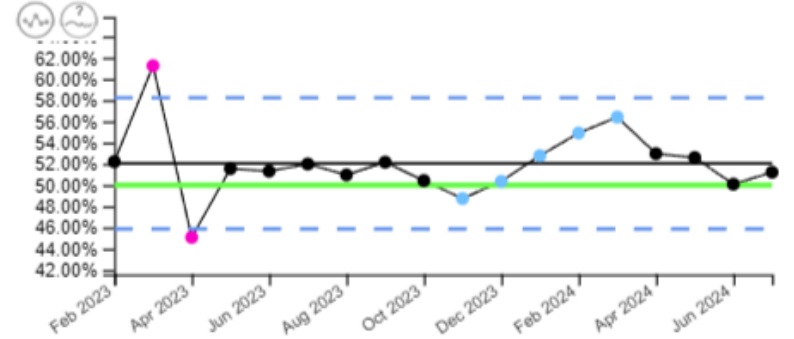
Meet and maintain Talking Therapies standards 50% Talking Thearpies recovery rate – Buckinghamshire



Target: >=50%

Month Year	Value	Numerator	Denominator
Jul 2024	56.73%	312	550

Meet and maintain Talking Therapies standards 50% Talking Therapies recovery rate – Oxfordshire



Target: >=50%

Month Year	Value	Numerator	Denominator
Jul 2024	51.22%	358	699

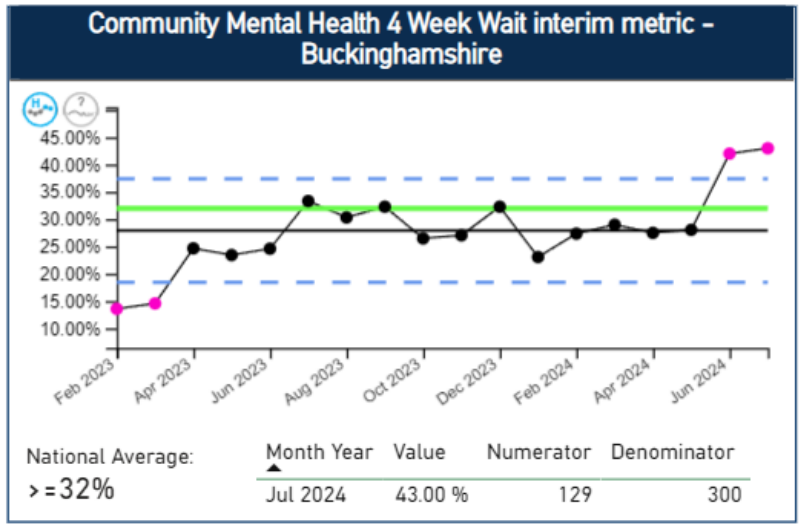
Mental Health Services – Adult and Older Adult community – Summary dashboard

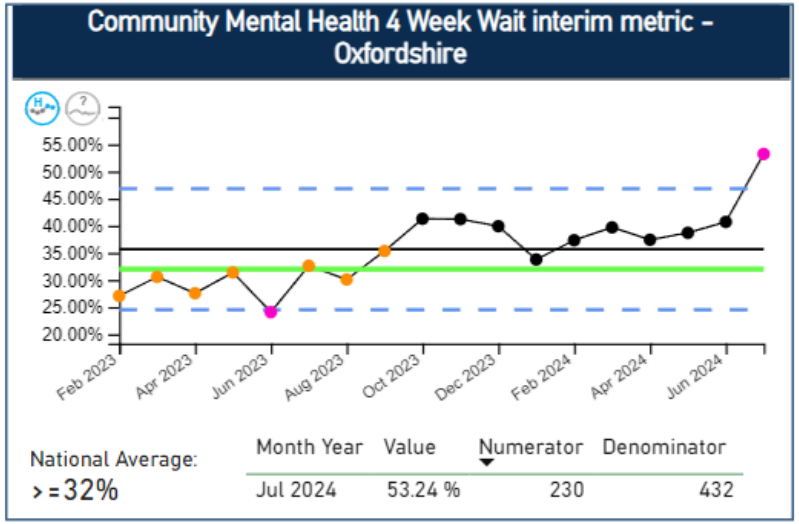
Narrative provided only for metrics under target or national average (value coloured in red below), narrative not provided for system measures:

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	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 – Q2 2024. Status: technical development in testing)*				
National Objective	4 week wait (28 days) standard (interim metric - two contacts within episode) - Buckinghamshire	32% National average	Jul-24	43.00%	↑	↑
National Objective	4 week wait (28 days) standard (interim metric - two contacts within episode)- Oxfordshire	32% National average	Jul-24	53.42%	↑	↑
National Objective Strategic Metric - Quality	Waiting time standard, care plan, outcome measure	*In development (estimated completion - FY25. Status: technical development initiated; waiting for national team to release code)*				
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 – Q2 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	*In development for Q2 2024*				
National Objective	Number of people accessing IPS	*In development (estimated completion – Q2 2024. Status: technical development in testing)*				
National measure	Recover dementia diagnosis rate (nationally reported system measure - Buckinghamshire)	63-64%	Jun-24	59.04%	↑	↑
National measure	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	63-64%	Jun-24	63.09%	↓	↑

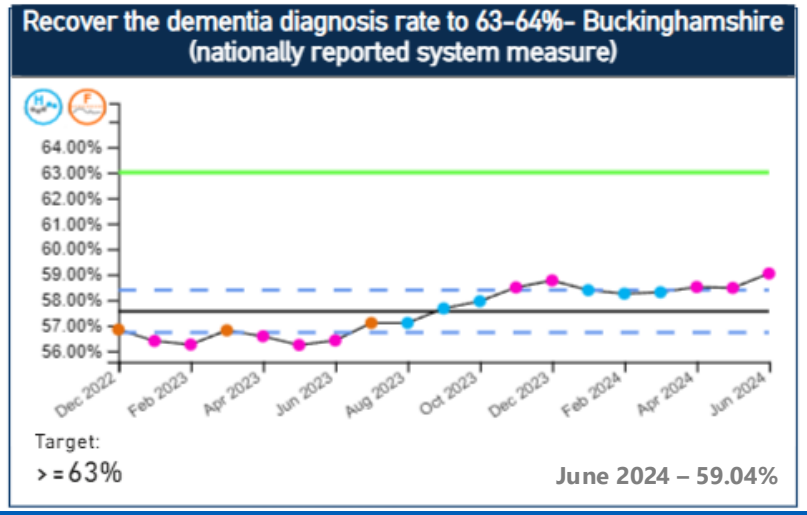
Mental Health Services – Adult & Older Adult Community

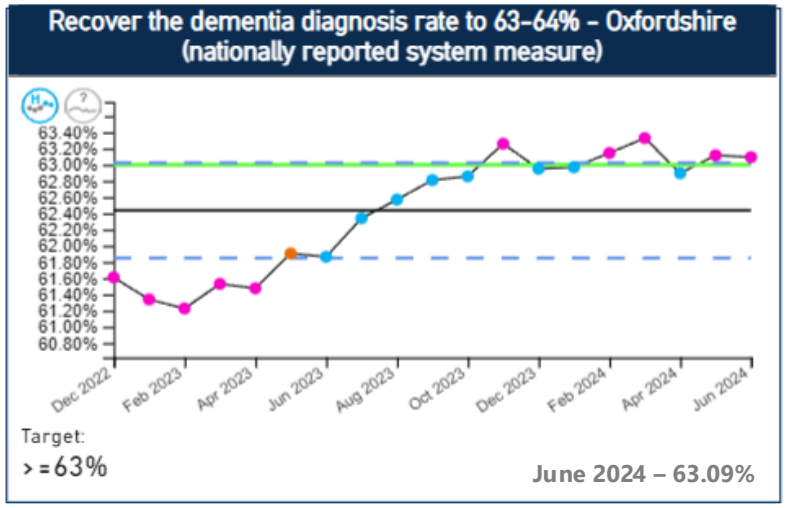
Metrics meeting national average:





System metrics:





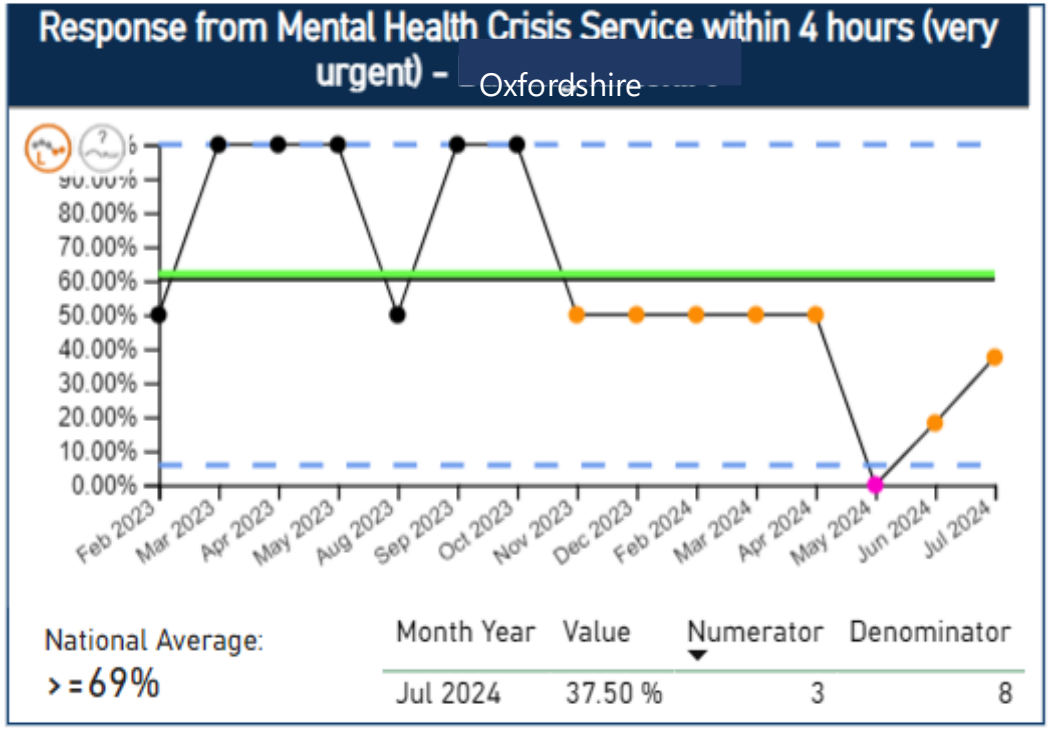
Mental Health Services – Urgent Care – Summary dashboard

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 reporting period	Better is
	Urgent Care					
National Objective	Response from Mental Health Psychiatric Liaison within 1 hour - Buckinghamshire	62% National average	Jul-24	93.62%	↑	↑
National Objective	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	62% National average	Jul-24	84.30%	↓	↑
National Objective	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	69% National average	Jul-24	100%	→	↑
National Objective	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Oxfordshire	69% National average	Jul-24	37.50%	↑	↑
National Objective	Response from Mental Health Crisis Service within 24 hours (Urgent) - Buckinghamshire	57% National average	Jul-24	60.74%	↑	↑
National Objective	Response from Mental Health Crisis Service within 24 hours (Urgent) - Oxfordshire	57% National average	Jul-24	69.23%	↑	↑

* National average over April – December 2023

Mental Health Services – Urgent Care



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.

The graph represents the Mental Health Crisis Service in Oxfordshire, which only operates full crisis service within Oxford City and North-East Oxfordshire and Home treatment service in North and West Oxfordshire; the rest of the county is covered by Community Adult and Older Adult Mental Health Teams. There is more activity undertaken within the Urgent Care pathway, however, due to specific national definitions such activity is not represented in Mental Health Urgent Care waiting standards - the Mental Health Helpline received 425 referrals, Street Triage received 88 referrals, the Night Team received 127 referrals, and a further 202 urgent and serious referrals received by the Community Adult and Older Adult Mental Health Teams in the month of July 2024 (however, the latter team works to a different response standard of 7 calendar days).

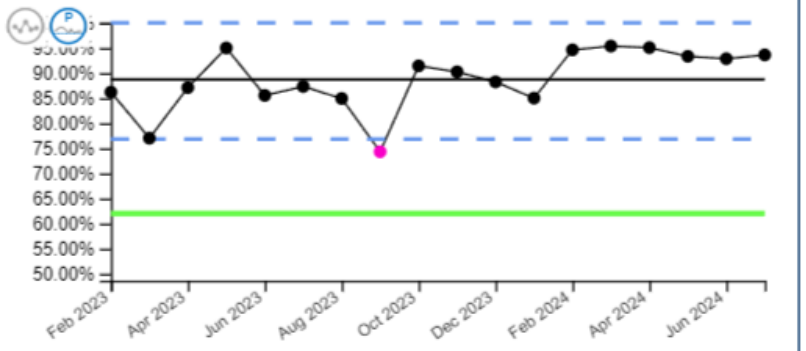
Actions

- 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

Mental Health Services – Urgent Care

Metrics meeting national average:

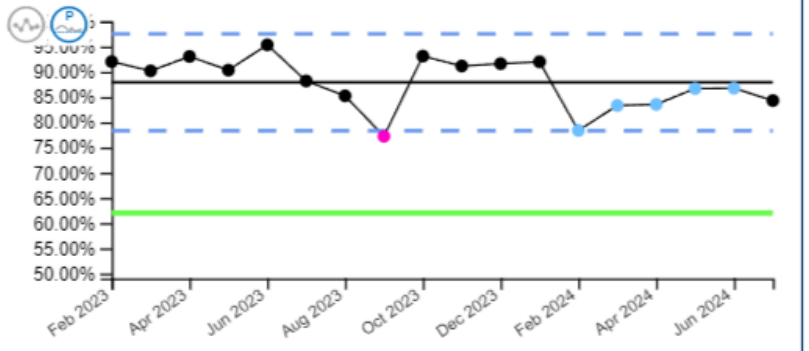
Response from Mental Health Psychiatric Liaison Service within 1 hour – Buckinghamshire



National Average:
>=62%

Month Year	Value	Numerator	Denominator
Jul 2024	93.62 %	88	94

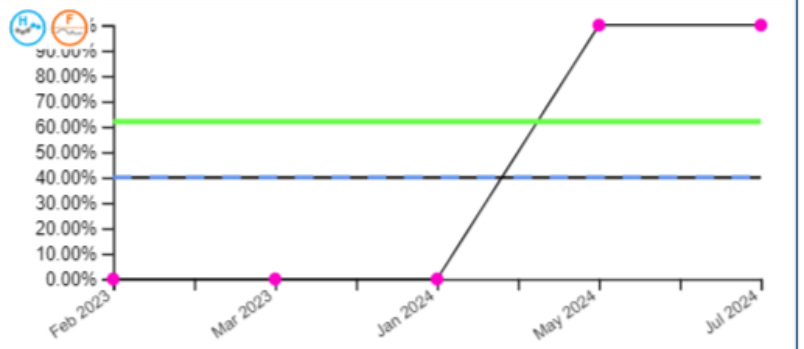
Response from Mental Health Psychiatric Liaison Service within 1 hour – Oxfordshire



National Average:
>=62%

Month Year	Value	Numerator	Denominator
Jul 2024	84.30 %	188	223

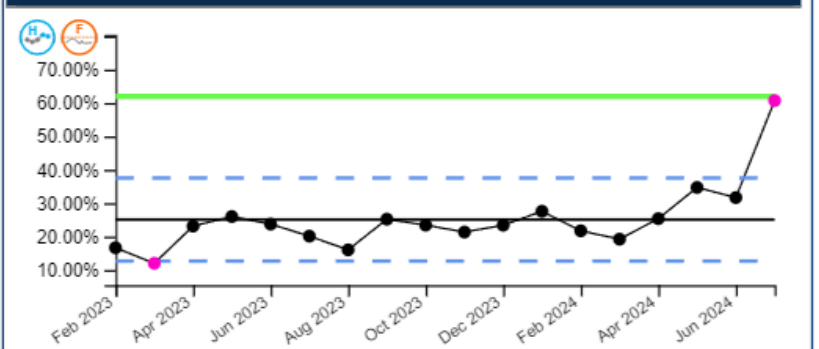
Response from Mental Health Crisis Service within 4 hours (very urgent) – Buckinghamshire



National Average:
>=69%

Month Year	Value	Numerator	Denominator
Jul 2024	100.00 %	4	4

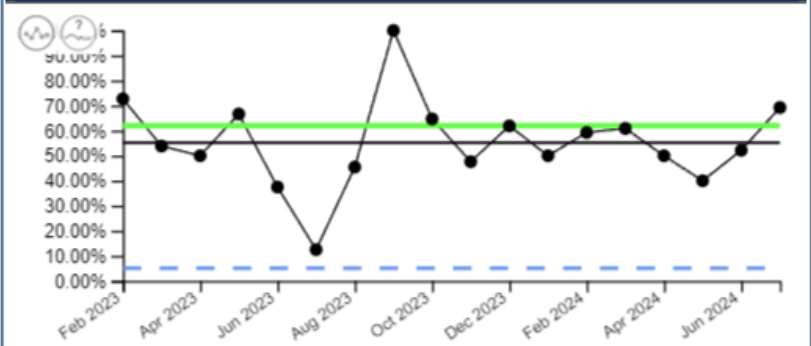
Response from Mental Health Crisis Service within 24 hours (urgent) – Buckinghamshire



National Average:
>=57%

Month Year	Value	Numerator	Denominator
Jul 2024	60.74 %	99	163

Response from Mental Health Crisis Service within 24 hours (urgent) – Oxfordshire



National Average:
>=57%

Month Year	Value	Numerator	Denominator
Jul 2024	69.23 %	18	26

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 reporting period	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 - rolling quarter - Adult (acute & Psychiatric Intensive Care Units) - Buckinghamshire	13% National average	Jul-24	19%	↓	↓
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 - rolling quarter- Adult (acute & Psychiatric Intensive Care Units) - Oxfordshire	13% National average	Jul-24	15%	↑	↓
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 - rolling quarter - Older Adult - Buckinghamshire	13% National average	Jul-24	17%	↑	↓
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 - rolling quarter - Older Adult - Oxfordshire	13% National average	Jul-24	15%	↑	↓
National Objective NOF	Rate per 100,000 population in adult acute beds with a length of stay over 60 days- Buckinghamshire	*In development (estimated completion – Q2 2024. Status: technical development in testing)*				
National Objective NOF	Rate per 100,000 population in adult acute beds with a length of stay over 60 days- Oxfordshire	*In development (estimated completion – Q2 2024. Status: technical development in testing)*				
National Objective NOF	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days- Buckinghamshire	*In development (estimated completion – Q2 2024. Status: technical development in testing)*				
National Objective NOF	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days- Oxfordshire	*In development (estimated completion – Q2 2024. Status: technical development in testing)*				
National Objective	72 hour follow up for those discharged from mental health wards - Adults - Buckinghamshire	80%	Jul-24	95.45%	↑	↑
National Objective	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	80%	Jul-24	84.85%	↑	↑
National Objective	72 hour follow up for those discharged from mental health wards - Older Adults - Buckinghamshire	80%	Jul-24	100.00%	→	↑
National Objective	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	80%	Jul-24	100.00%	→	↑

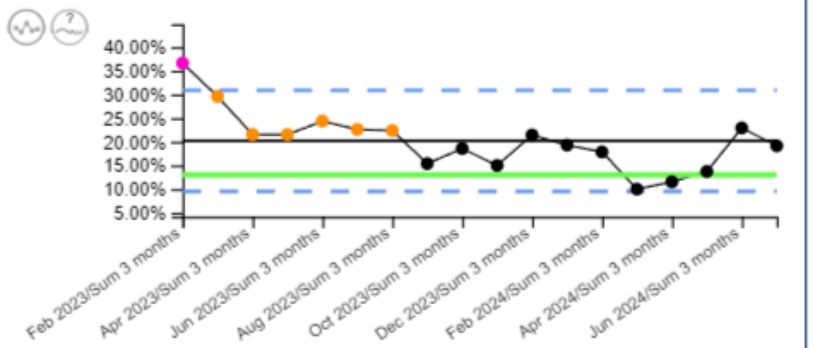
Mental Health Services – Acute / In-patients (Adults & Older Adults) – Summary dashboard (2/2)

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Acute / In-patients (Adults & Older Adults)					
	Inappropriate adult acute mental health out of area placements - snapshot last day month - Buckinghamshire	3	Jul-24	3	↓	↓
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Buckinghamshire		Jul-24	0	→	↓
	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Buckinghamshire		Jul-24	0	→	↓
	Inappropriate adult acute mental health out of area placements - snapshot last day month - Oxfordshire	5	Jul-24	1	↑	↓
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire		Jul-24	0	→	↓
	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire		Jul-24	0	→	↓
NOF	Inappropriate adult acute mental health out of area placements - beds days in month - Buckinghamshire	n/a	Jul-24	143	↑	↓
NOF	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Buckinghamshire	n/a	Jul-24	0	→	↓
NOF	Inappropriate older adult acute mental health out of area placements - beds days in month - Buckinghamshire	n/a	Jul-24	0	→	↓
NOF	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	n/a	Jul-24	26	→	↓
NOF	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	n/a	Jul-24	0	→	↓
NOF	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	n/a	Jul-24	0	→	↓
	% adult readmission within 30 days for mental health - Buckinghamshire	n/a	Jul-24	0%	→	↓
	% adult readmission within 30 days for mental health - Oxfordshire	n/a	Jul-24	0%	→	↓
	% older adult readmission within 30 days for mental health - Buckinghamshire	n/a	Jul-24	0%	→	↓
	% older adult readmission within 30 days for mental health - Oxfordshire	n/a	Jul-24	0%	→	↓
	Average number of clinically ready for discharge patients per day - Buckinghamshire	n/a	Jul-24	7	↓	↓
	Average number of clinically ready for discharge patients per day - Oxfordshire	n/a	Jul-24	6	↓	↓

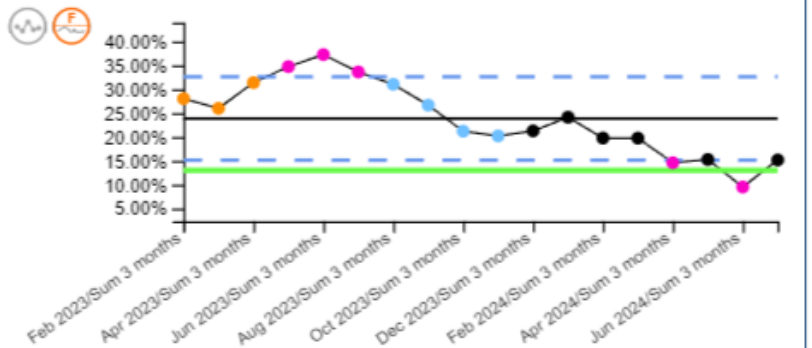
Mental Health Services – Acute / In-patients (Adults & Older Adults)

Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) – Adult (acute & PICU) Buckinghamshire (reported as rolling 3 months)



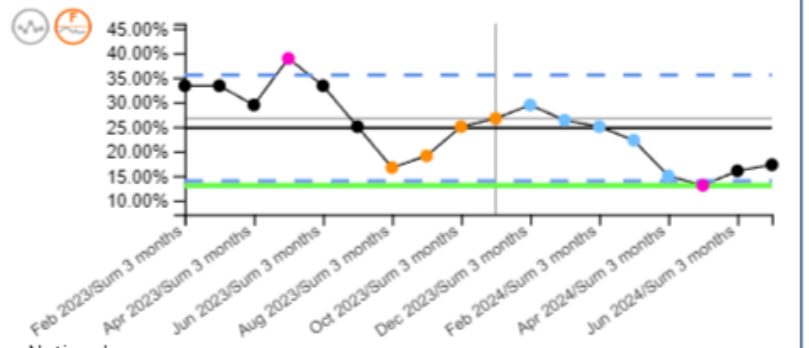
National Average:	Month Year	Value	Numerator	Denominator
<=13%	Jul 2024	19 %	9	47

Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) – Adult (acute & PICU) Oxfordshire (reported as rolling 3 months)



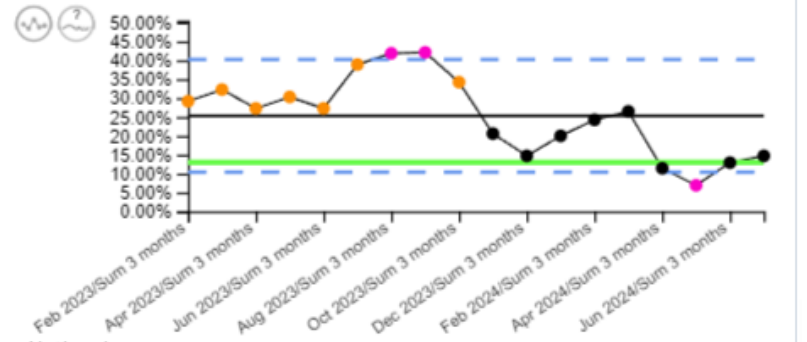
National Average:	Month Year	Value	Numerator	Denominator
<=13%	Jul 2024	15 %	12	79

Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) – Older Adult Buckinghamshire (reported as rolling 3 months)



National Average:	Month Year	Value	Numerator	Denominator
<=13%	Jul 2024	17 %	5	29

Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of older adult acute admissions with no prior contact) – Older Adult Oxfordshire (reported as a rolling 3 months)



National Average:	Month Year	Value	Numerator	Denominator
<=13%	Jul 2024	15 %	5	34

Summary

This metric monitors the rate of acute admissions with no previous contact in the reporting period (as per national definitions contact 48 hours prior to admission is excluded from this measure). Acute admissions are defined by the type of hospital bed used in the admission; the Trust monitors Adult Acute & Psychiatric Intensive Care Unit (PICU) and Older Adult admissions separately. All providers are measured on a rolling 3-month position, so July 2024 performance includes May, June and July 2024 performance. Nationally on average 13% of acute admissions are of patients who have not had prior contact with community mental health services in a year prior to an admission to an inpatient unit. In Buckinghamshire, such admissions were at a higher rate than the national average in the month of July 2024.

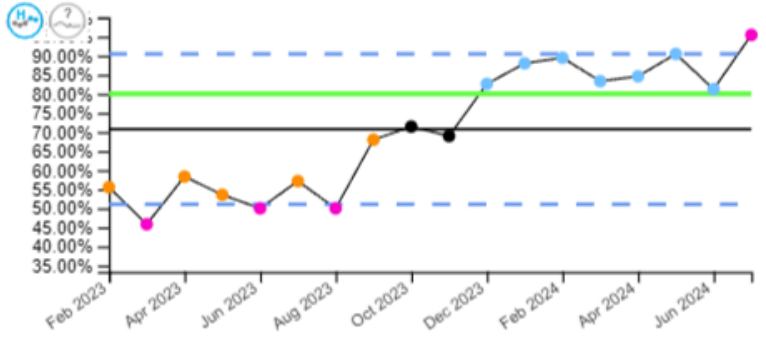
Actions

Continuous review of patients admitted without prior contact to establish whether such patients represent an unmet need within the community.

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

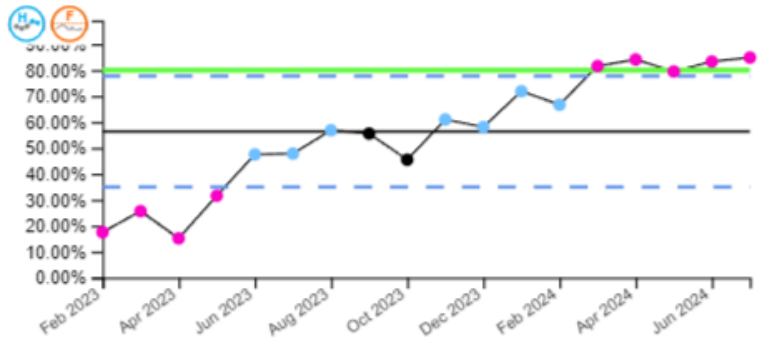
Metrics meeting target, being baselined or with target yet to be confirmed:

72 hour follow up for those discharged from mental health wards – Adult Buckinghamshire



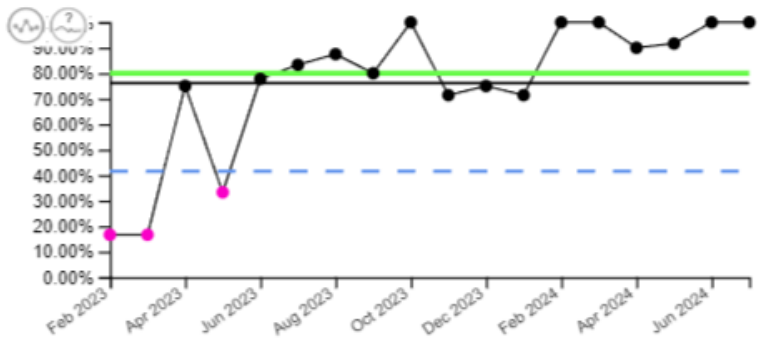
Target:	Month Year	Value	Numerator	Denominator
>=80%	Jul 2024	95.45%	21	22

72 hour follow up for those discharged from mental health wards – Adult Oxfordshire



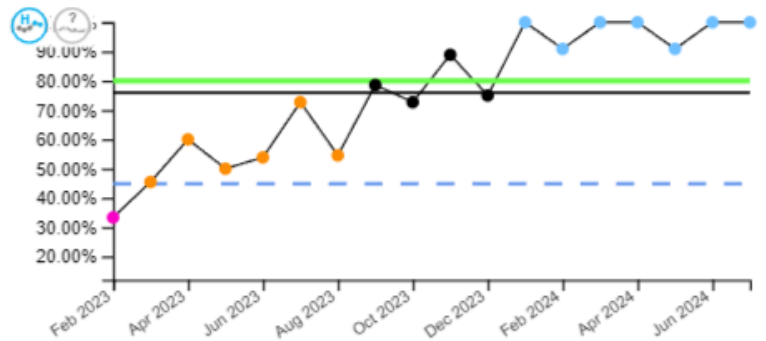
Target:	Month Year	Value	Numerator	Denominator
>=80%	Jul 2024	84.85%	28	33

72 hour follow up for those discharged from mental health wards – Older Adult Buckinghamshire



Target:	Month Year	Value	Numerator	Denominator
>=80%	Jul 2024	100.00%	11	11

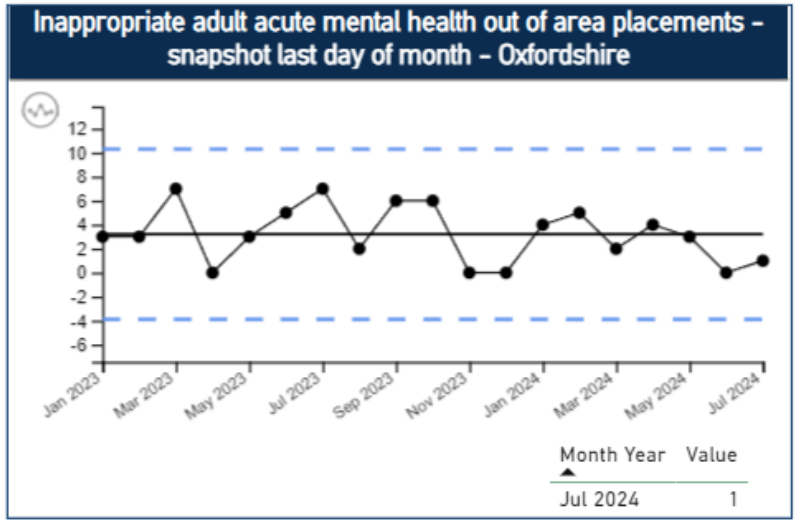
72 hour follow up for those discharged from mental health wards – Older Adult Oxfordshire

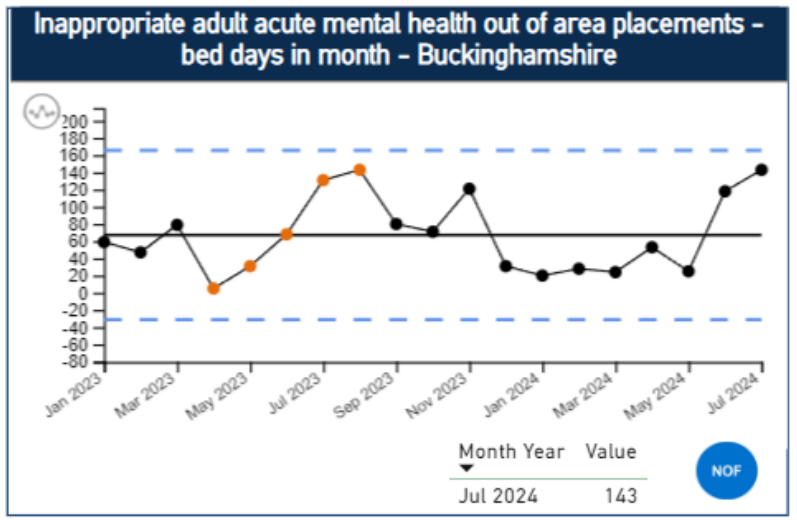


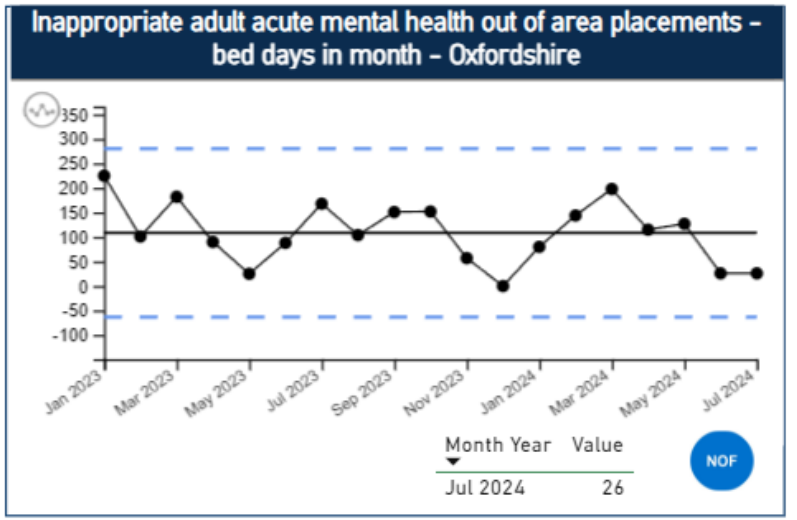
Target:	Month Year	Value	Numerator	Denominator
>=80%	Jul 2024	100.00%	13	13

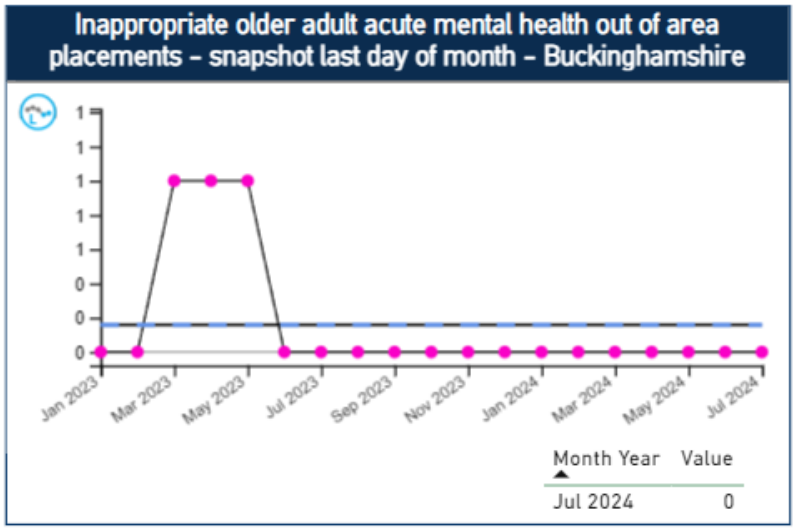
Mental Health Services – Acute / In-patients (Adults & Older Adults)

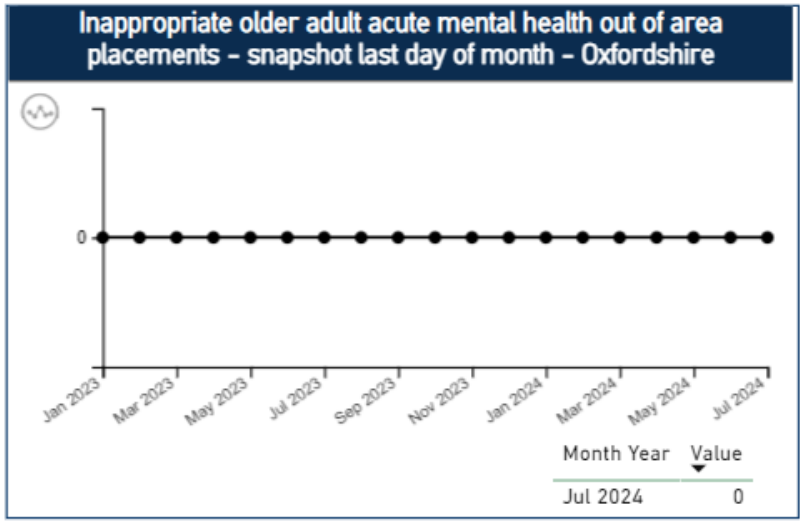
Metrics meeting target, being baselined or with target yet to be confirmed:

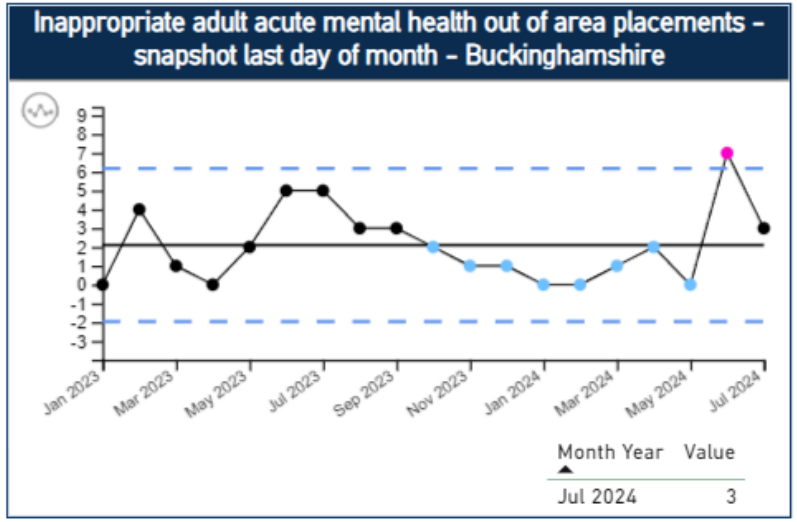






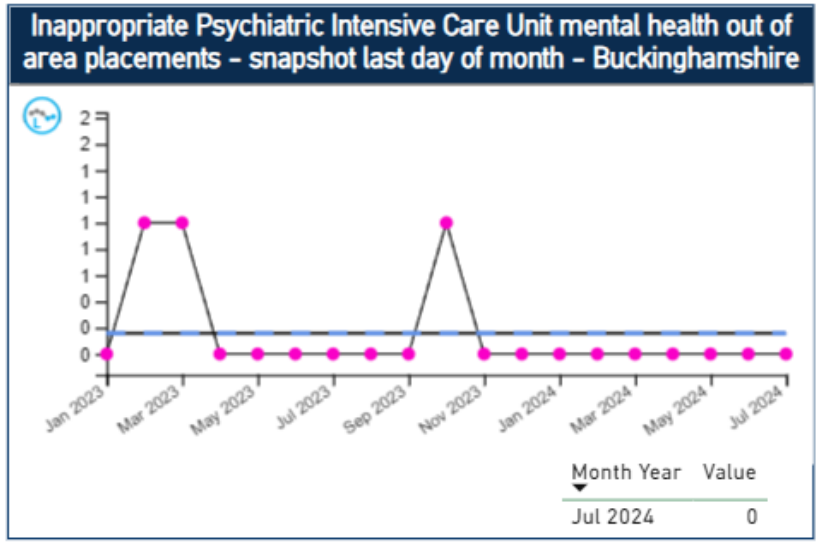


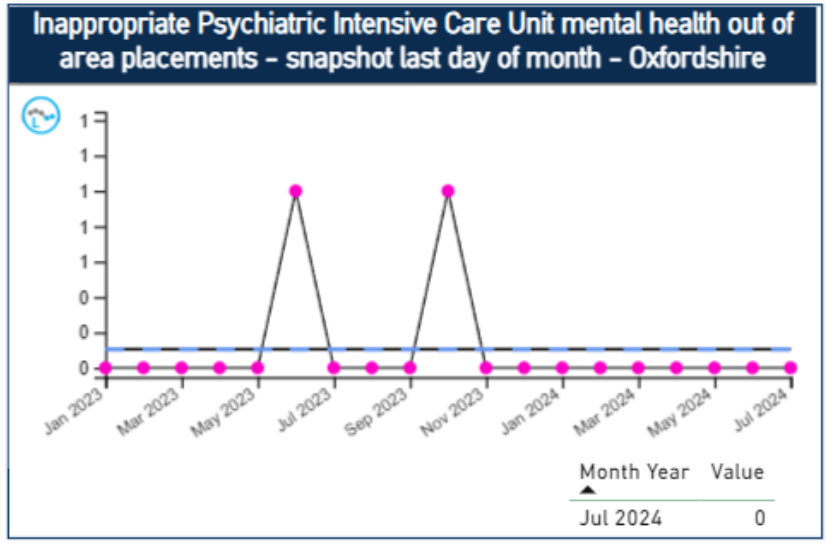


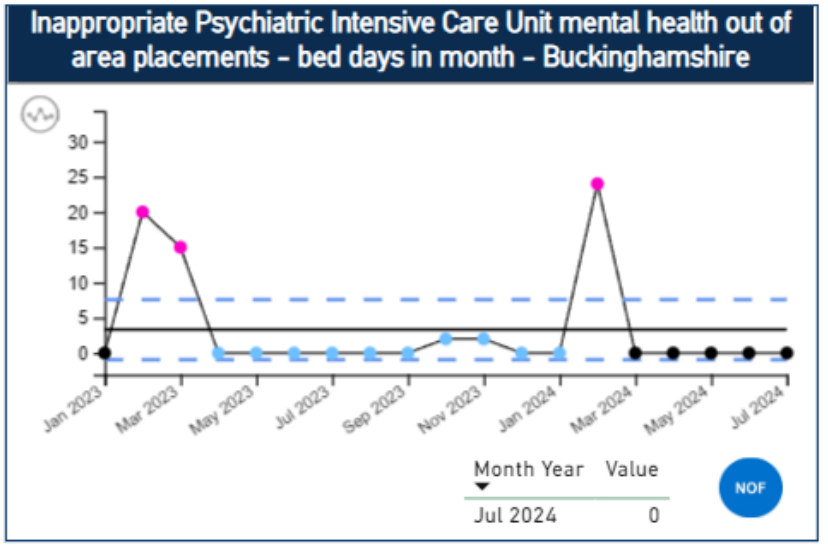


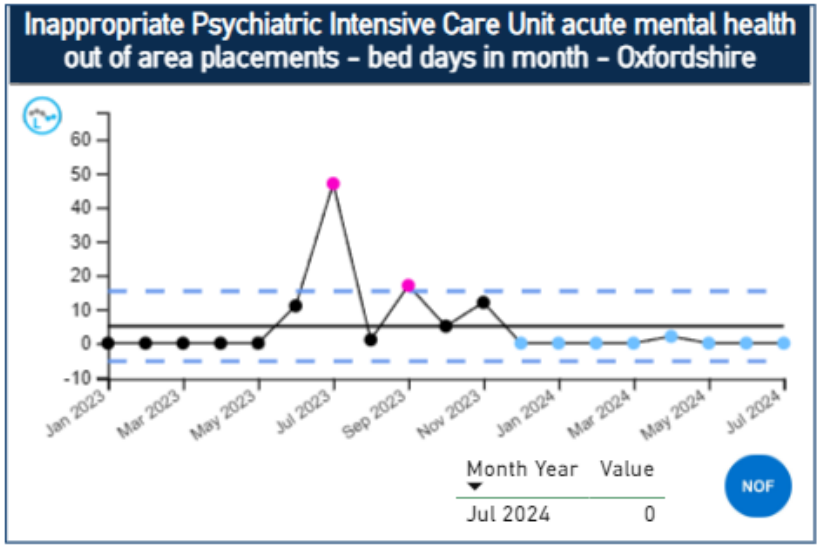
Mental Health Services – Acute / In-patients (Adults & Older Adults)

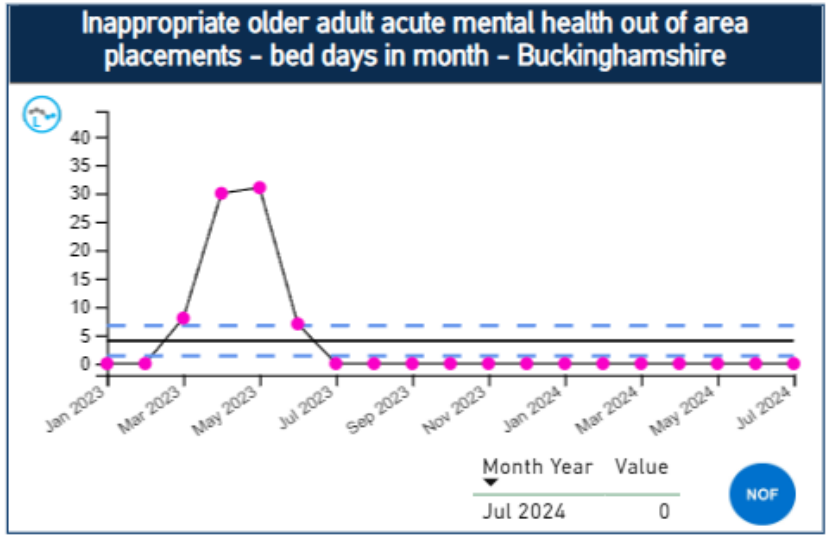
Metrics meeting target, being baselined or with target yet to be confirmed:

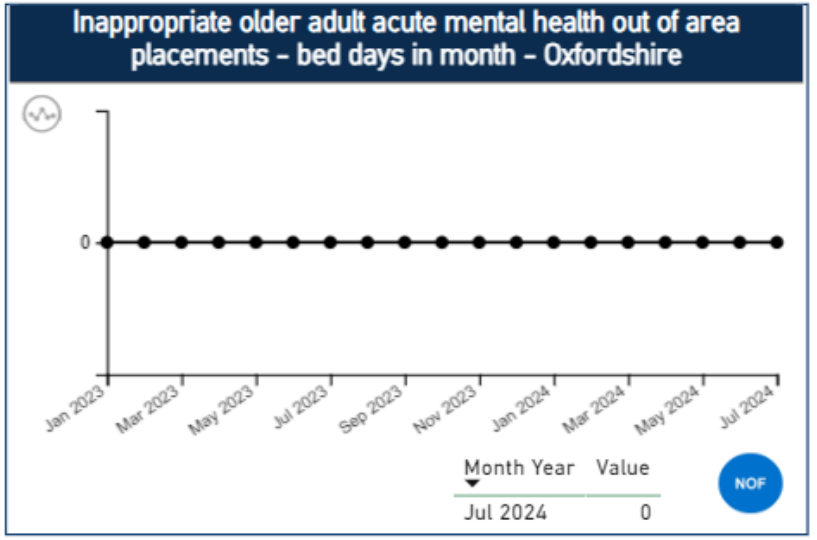








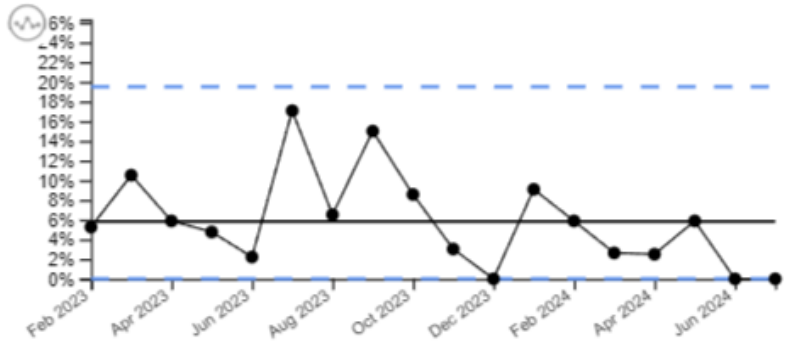




Mental Health Services – Acute / In-patients (Adults & Older Adults)

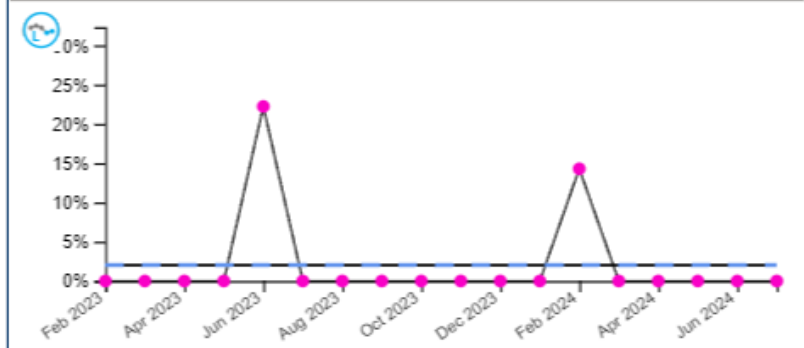
Metrics meeting target, being baselined or with target yet to be confirmed:

% adult acute readmissions within 30 days for mental health services - Oxfordshire



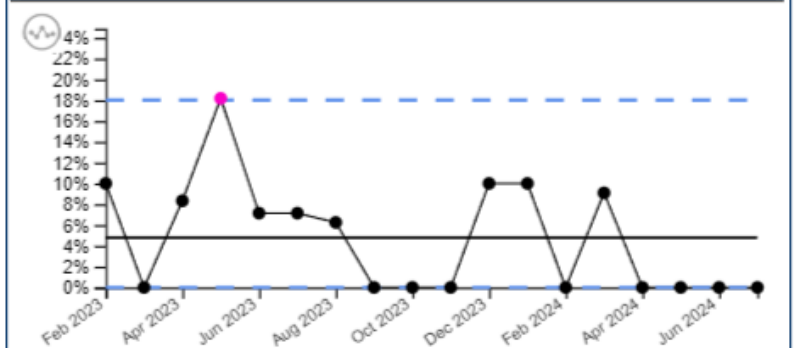
Month Year	Value	Numerator	Denominator
Jul 2024	0 %	0	27

% older adult readmissions within 30 days for mental health - Buckinghamshire



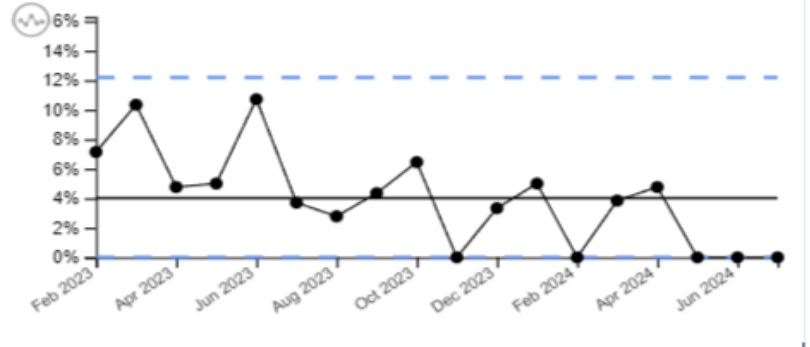
Month Year	Value	Numerator	Denominator
Jul 2024	0 %	0	11

% adult acute readmissions within 30 days for mental health services - Oxfordshire



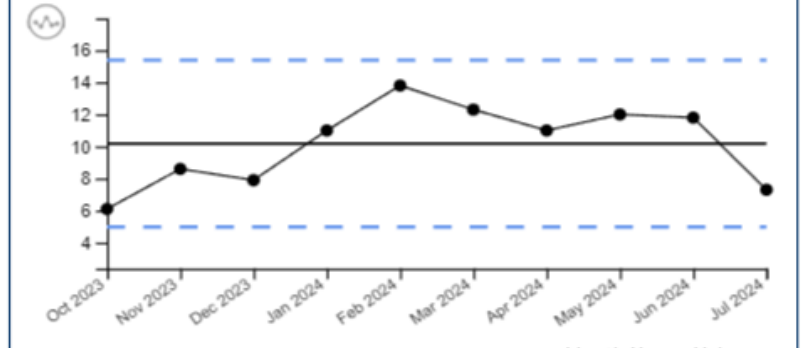
Month Year	Value	Numerator	Denominator
Jul 2024	0 %	0	14

% adult readmissions within 30 days for mental health - Buckinghamshire



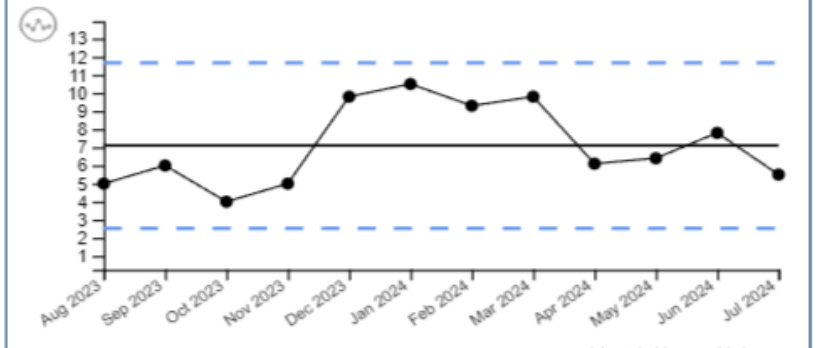
Month Year	Value	Numerator	Denominator
Jul 2024	0 %	0	20

Average number of clinically ready for discharge patients per day - Buckinghamshire



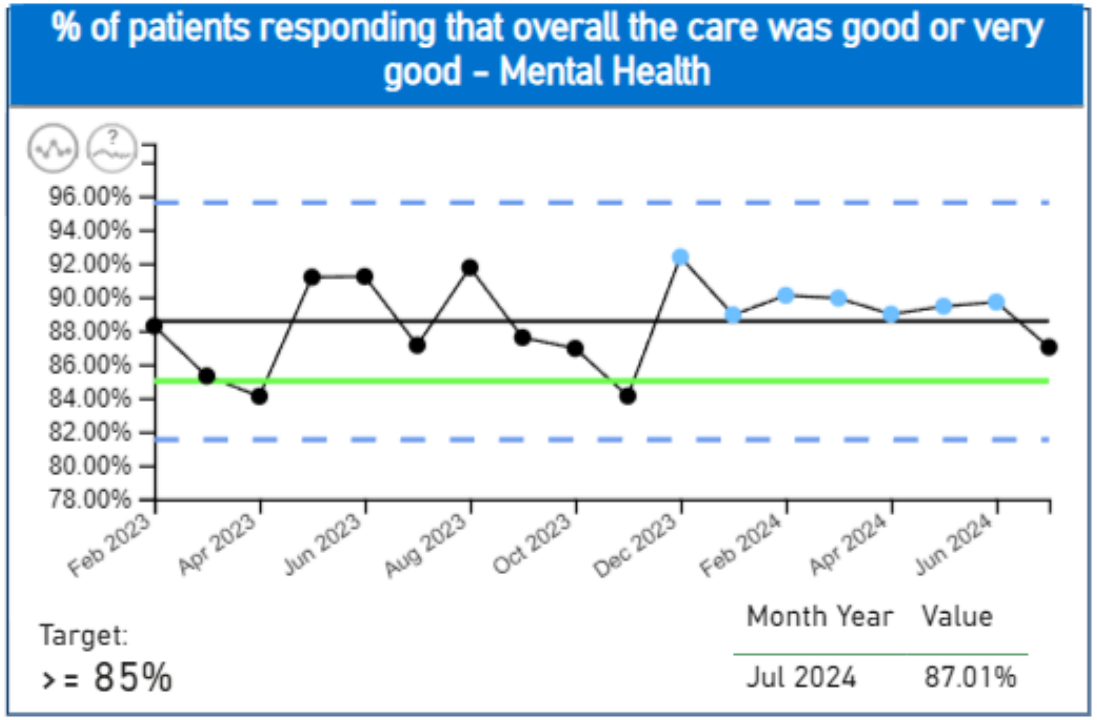
Month Year	Value
Jul 2024	7

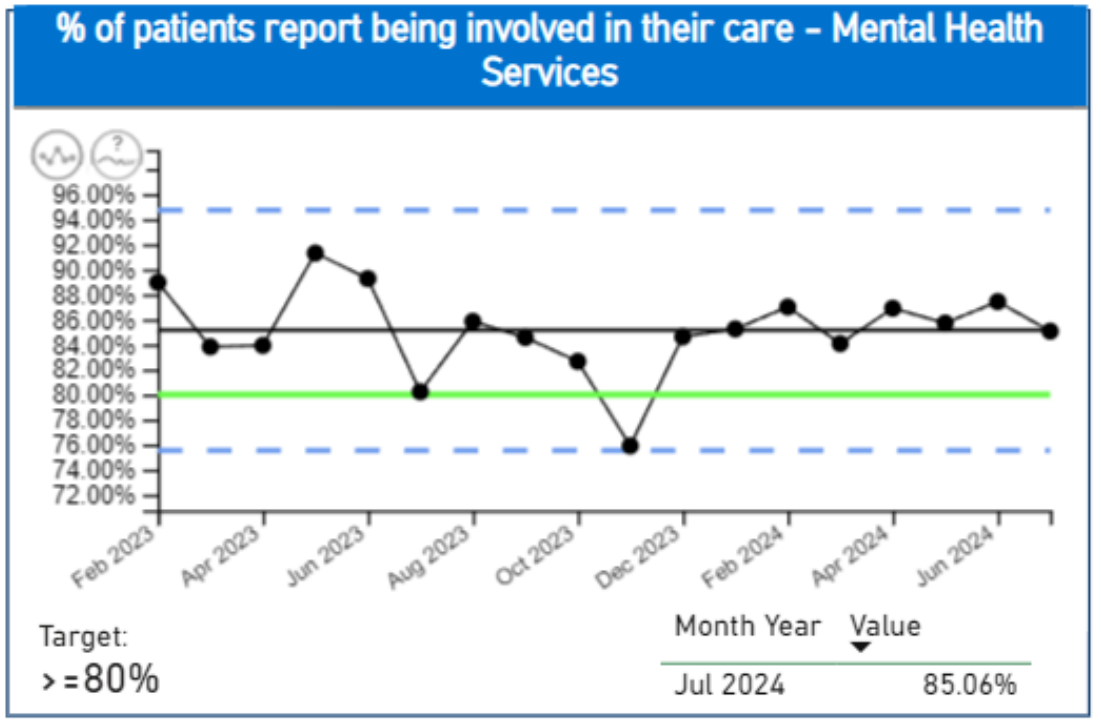
Average number of clinically ready for discharge patients per day - Oxfordshire



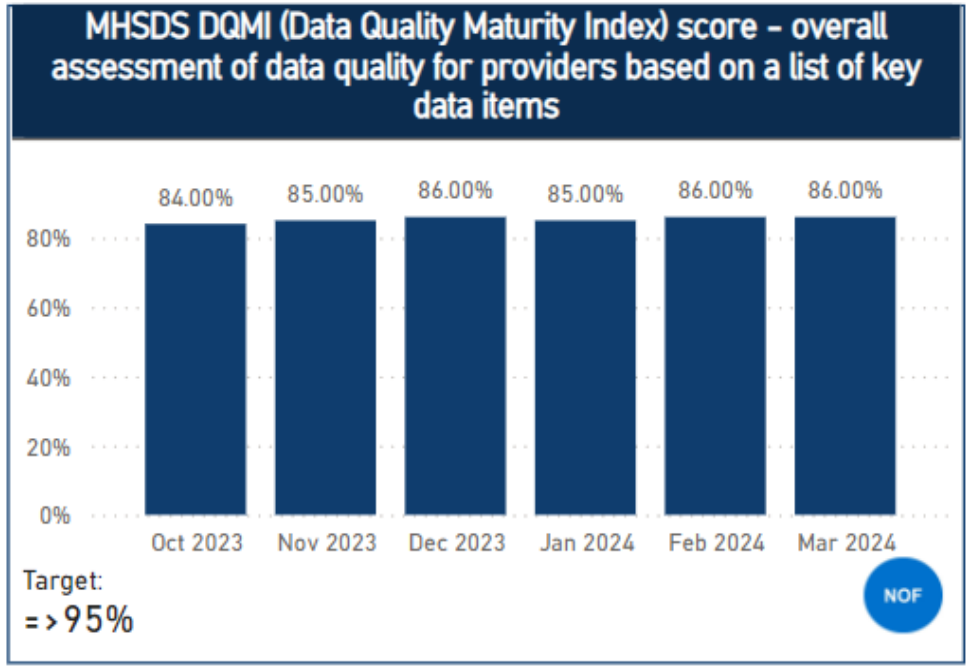
Month Year	Value
Jul 2024	6

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





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



Summary

The Trust's Data Quality Maturity Index (DQMI) position has been impacted by the reporting outage and move to new clinical system. Additionally, a new version of Mental Health Services Data Set (MHSDS) was introduced in June 2024. The Performance & Information team are now reintroducing systems to routinely review DQMI performance and identify areas for improvement.

Actions

- Following a review of MHSDS DQMI Performance & Information have identified those actions which can be addressed by configuration/dataset changes and those that need service improvements. These actions will be taken forward as appropriate.

Section 1.2
Clinical performance (Community Health Service, Primary Care & Dentistry)

Oxford Health
NHS Foundation Trust

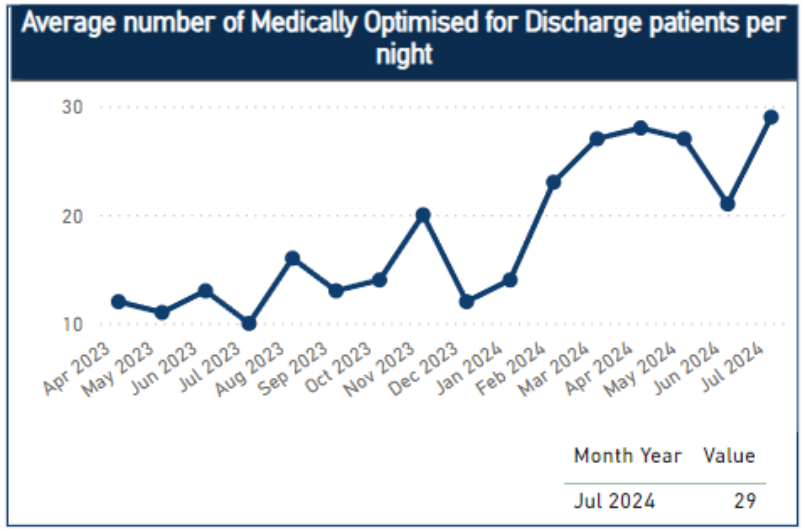
Community Health Service, Primary Care & Dentistry – Summary Dashboard

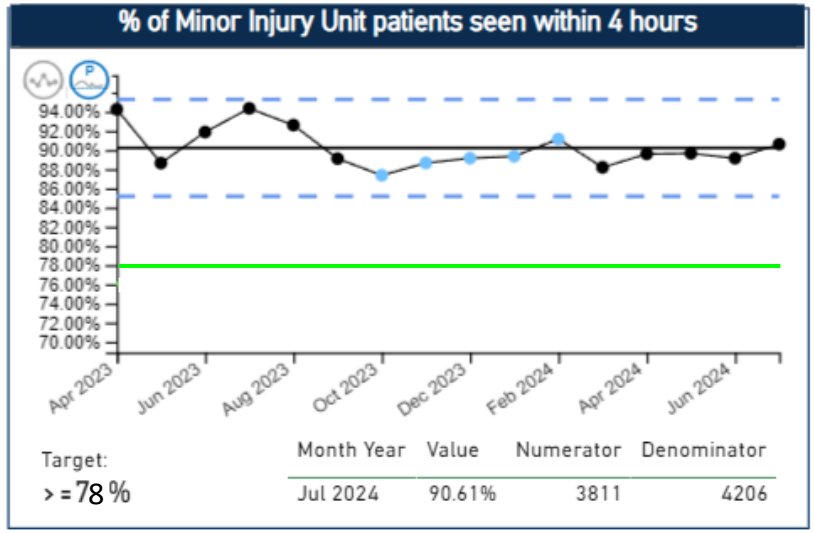
Narrative provided only for metrics under target (value coloured in red) – none in July 2024. Please note that narrative for system measures will not be provided as these are monitored at Integrated Care Board (ICB) level and figures are provided to Trust Board for information only.

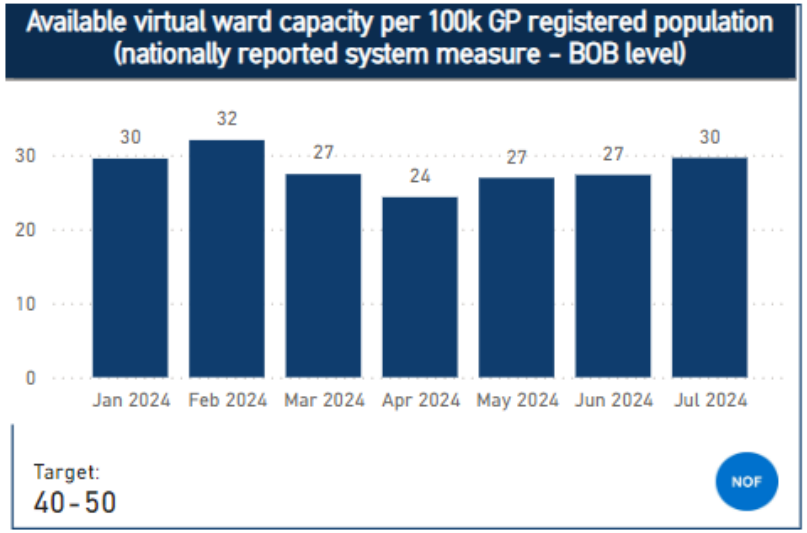
Type of metric	Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Average Length of Stay in Community Hospitals by basket of care	*In development for FY25*				
	Average number of Medically Optimised For Discharge (MOFD) patients per night	Baseline	Jul-24	29	↑	↓
National Objective	% of Minor Injury Unit patients seen within 4 hours	78%	Jul-24	90.61%	↑	↑
National Objective	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	*In development for FY25*				
NOF National Objective	Proportion of patients discharged from hospital by pathways	*In development for FY25*				
NOF	Available virtual ward capacity per 100k head of population (nationally reported system measure - Buckinghamshire. Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level)	40-50	Jul-24	30	↑	↑
NOF National Objective	Virtual ward occupancy (nationally reported system measure - Buckinghamshire. Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level)	TBC	Jul-24	93.22%	↑	↑

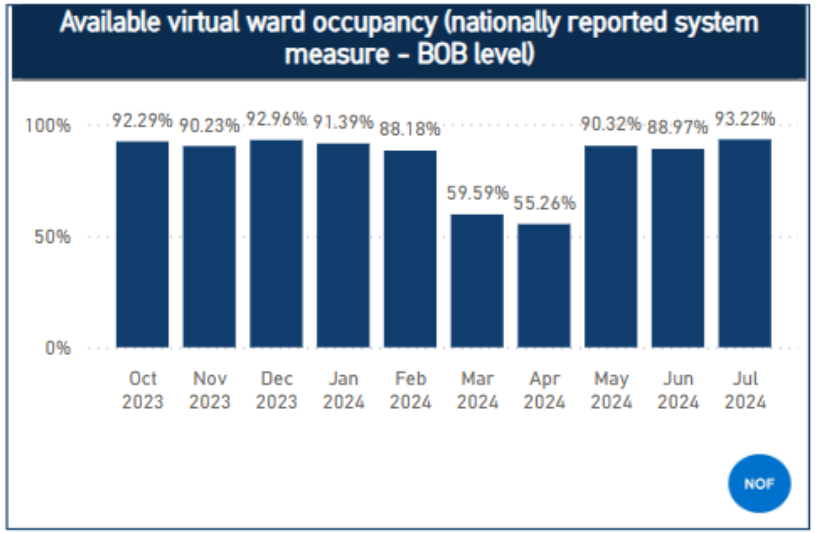
Community Health Service, Primary Care & Dentistry

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



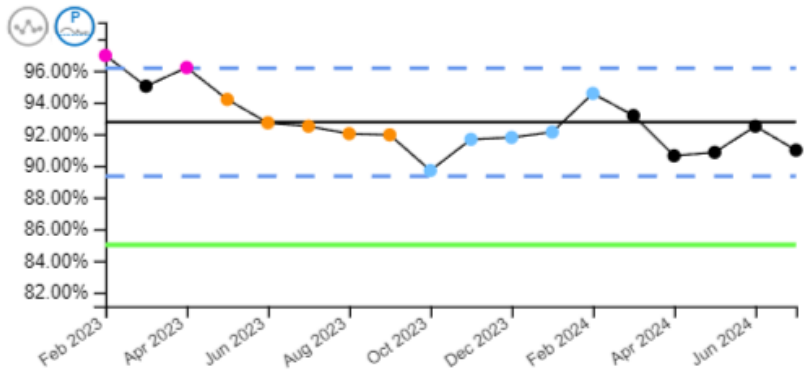






Community Health Service, Primary Care & Dentistry In-Year Strategic metrics – For Information only

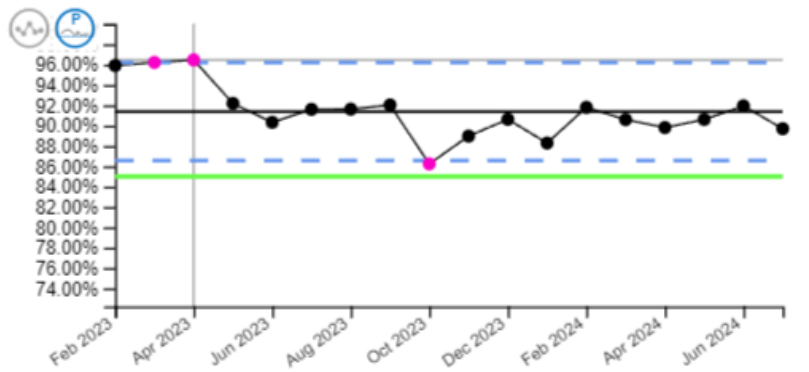
% of patients responding that overall the care was good or very good – Community Health Service, Primary Care & Dentistry



Target:
>=85%

Month Year	Value
Jul 2024	90.98%

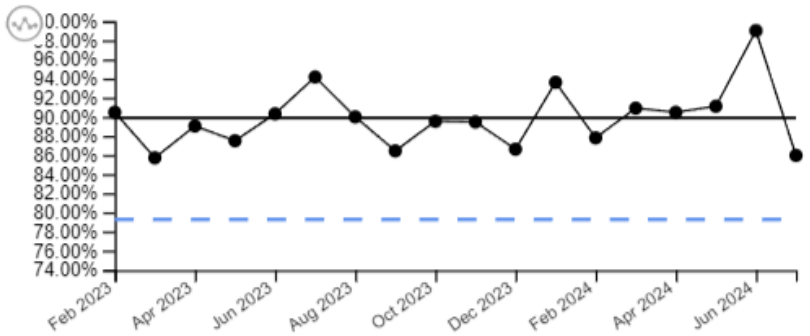
% of patients report being involved in their care – Community Health Service, Primary Care & Dentistry



Target:
>=85%

Month Year	Value
Jul 2024	89.70%

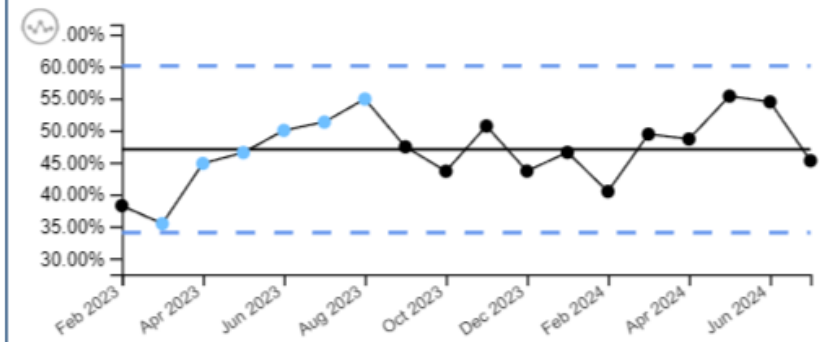
% of out of hours palliative care referrals responded to within 30 mins: the time from receipt of the call from 111 to the start of the telephone consultation was within 30 mins



Target: tbc -
Baselining

Month Year	Value	Numerator	Denominator
Jul 2024	85.96%	98	114

% of out of hours palliative care referrals responded to within 60 mins: the time from completion of that triage call to the start of the home visit consultation was within 60 mins



Target: tbc -
Baselining

Month Year	Value	Numerator	Denominator
Jul 2024	45.26%	43	95

Section 2

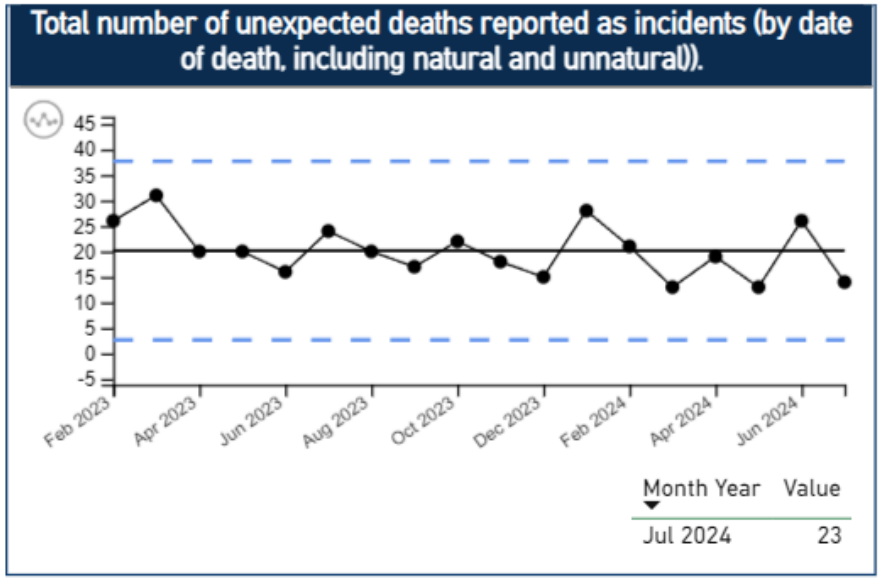
Quality
People

Quality - Deliver the best possible care and health outcomes

Quality – Summary Dashboard

Type of metric	Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Total number of patient incidents (all levels of harm)	TBC	Jul-24	1367	↑	n/a
	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)	TBC	Jul-24	23	↓	n/a
	Number of suspected suicides	TBC	Jul-24	4	↓	n/a
	Total number of incidents involving physical restraint	TBC	Jul-24	182	↑	n/a
	Total number of complaints and resolutions	TBC	Jul-24	106	↑	n/a
	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	TBC	Jul-24	299	↑	n/a
Strategic Metric - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint)	Less than 16 per month	Jul-24	7	↓	↓
Strategic Metric - Quality	Reduction in use of seclusion (number of incidents involving seclusion)	Less than48 per month	Jul-24	29	↓	↓
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 Q2 FY25. Status: Technical development in progress*				

Quality

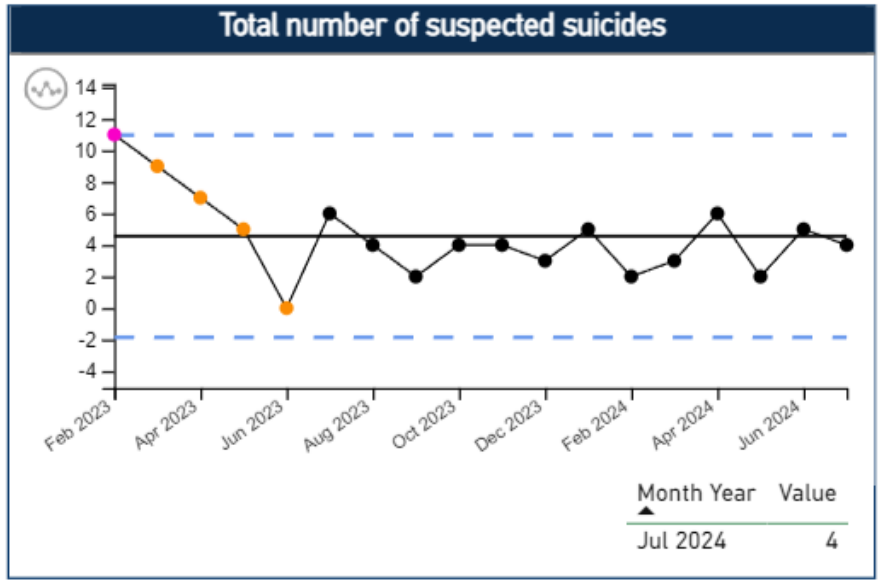


Summary, highlights, actions

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.

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 scrutiny 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 Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (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 non-coronial deaths from 9th September 2024.



Summary, highlights, actions

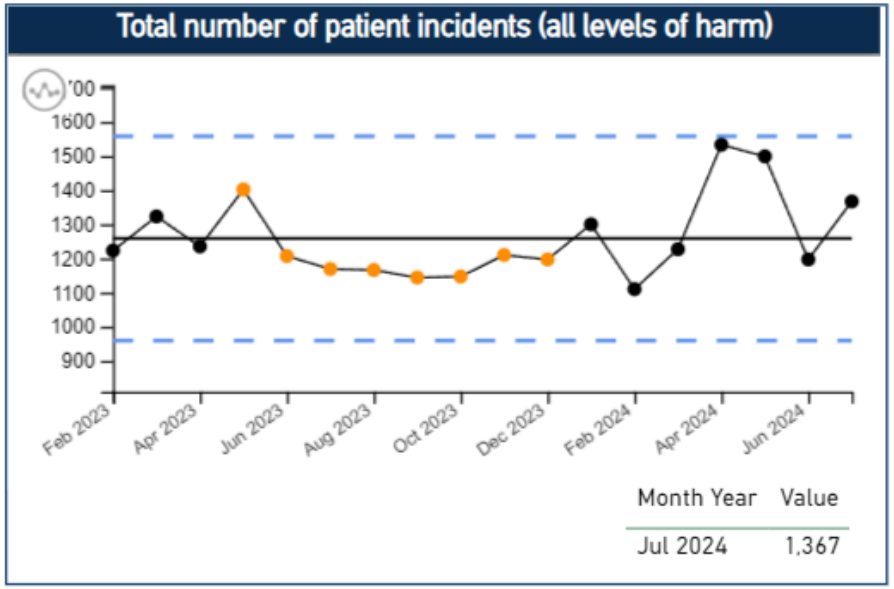
All suspected suicides are identified in real-time daily and reviewed. Most will have an incident learning huddle completed with the clinicians involved in addition to the offer of psychological support to staff and family liaison support to bereaved relatives.

There were 41 confirmed/suspected suicides for open and discharged patients in the last 12 months (9 suicides in Q1), this includes patients who have been seen at any point in time by Trust services. 23 patients were open at the time of their death to Oxford Health's services and 29 patients were open/seen within 12 months of their death. A higher number of suicides relate to males (28 males/13 females). The Thames Valley Real Time Surveillance System shows that for about half of all suspected suicides in the population the person was known at some point in time to Oxford Health's services.

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.

The Trust has lots of activities planned to recognise and raise awareness around World Suicide Prevention Day on 10th September.

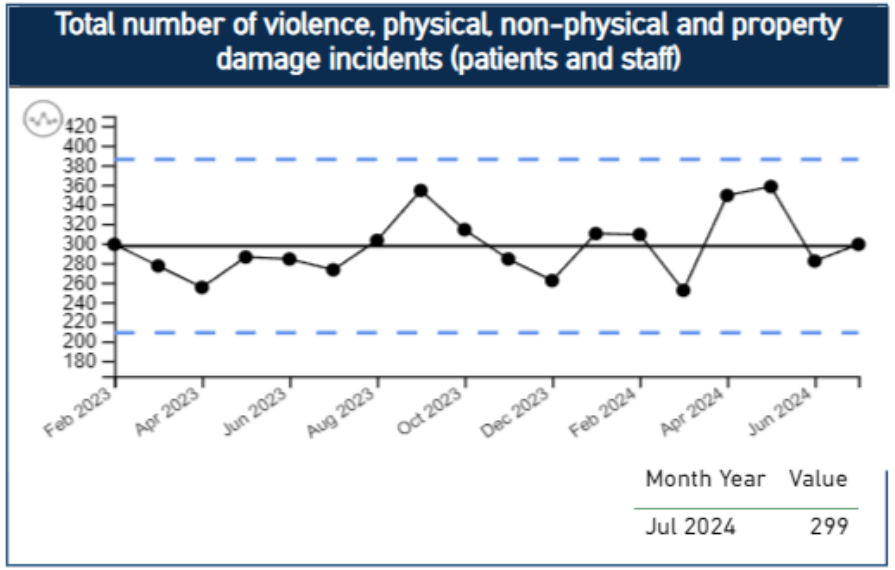
Quality



Summary, highlights, actions

During July 2024 most incidents related to self-harm, particularly patients striking-self or tying ligatures without using a point on a mental health ward. This is followed by verbal abuse patients towards staff and then medicine administration/supply. Most incidents were reported by the 2 Eating Disorder wards, a Forensic ward and a Child and Adolescent Mental Health ward. A small number of patients were involved in the incidents. 52% of incidents resulted in no harm/near misses and 39% minor harm. The 4 severe harm incidents were broken down as; 2 patients with serious self-harm incidents (1 inpatient and 1 community setting), 1 related to concerns from a family about the care provided by a care agency to a palliative patient in their home (a safeguarding alert was raised and followed up) and 1 was a treatment delay for a palliative patient in the community.

The increase in incidents in April and May 2024 related to the 3 Child and Adolescent Mental Health wards including the new Psychiatric Intensive Care Unit (PICU) mostly involving a small number of young people engaging in on-going high risk self-injurious behaviour. The increase in incidents correlates with an increase in use of physical interventions (see next slide for more details). The senior matrons and Associate Director of Nursing have reviewed the incidents and use of physical interventions across the wards.

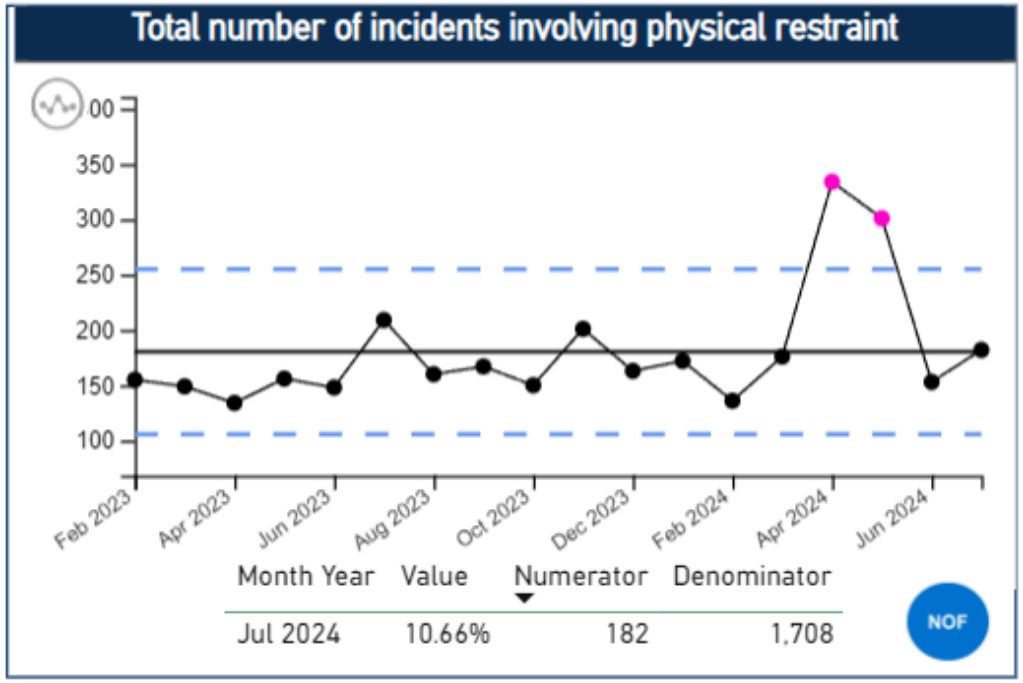


Summary, highlights, actions

There is no noticeable change over time in the number of violent incidents reported. The majority of incidents are on our mental health inpatient wards, particularly the forensic wards, and relate to violence from patients to staff with no injury, verbal abuse by patients to staff or threat of violence by patients to staff.

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 continues to reduce the use of restrictive practice.

Quality



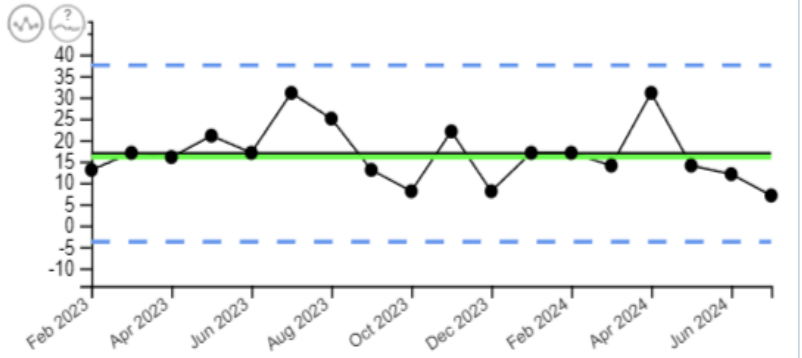
Summary, highlights, actions

There has been a small increase in restraint from 153 in June to 183 in July, involving 58 patients across 22 wards. The course group for incidents involving restraint is mainly Self harm (n=75), Violence (n=71) followed by Health (n=23). There were 18 incidents of restraint for administration of intramuscular injection (IM) medication and 5 for nasogastric (NG) feeding.

The areas with the highest use in July 2024 were Child and Adolescent Mental Health inpatient units (Marlborough House – 33 and Highfield – 19) and Adult Psychiatric Intensive Care Unit (Ashurst - 19). The use of physical restraint significantly increased in April and May 2024 compared to the previous 12 months, this was largely attributable to two Child and Adolescent Mental Health services, Highfield and Meadow wards. Both of these units saw a significant reduction in June 2024 which has been maintained in July 2024. Meadow (Psychiatric Intensive Care Unit for young people) has reduced to 8 episodes of restraint and Highfield to 19 in July 2024.

Quality

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



Target: in year	Target: in month	Month Year	Value	FYTD value
<188	<16	Jul 2024	7	64

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. In July 2024 the most common cause was Violence (4 incidents) and Health (2 incidents). The prone position is used mostly to administer immediate medication via intramuscular injection (IM) followed by seclusion exit procedure.

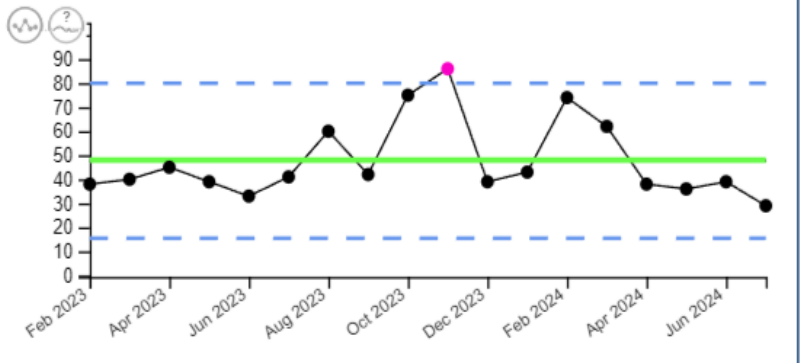
Highlights

The graph shows the use of prone by month for all wards over the last year. The Trust can demonstrate a sustained reduction is use of prone restraint since 2021. However, during April 2024 this increased above the trend line with 31 uses of Prone. The reduction in May and June has been maintained with further reduction in July to 7 episodes of prone restraint.

The 7 episodes of Prone in July involved 6 patients were spread across 5 wards. 5 episodes were to enable administration of IM medication and 2 unintentional led by patient.

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)



Target: in year	Target: in month	Month Year	Value	FYTD value
<575	<48	Jul 2024	29	142

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

An increase in the use of seclusion is noted since August 2023, this is largely attributable to a patient on Evenlode ward 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 June 2024 there were 13 seclusion episodes for this patient. There has been a reduction in the number of seclusion episodes for this patient due to longer periods of seclusion.

July 2024 saw the lowest number of seclusion in the last 18 months - 29 episodes of seclusion across 8 wards, involving 17 patients. The highest use of seclusion within the month was on Evenlode (8 episodes), Ashurst Psychiatric Intensive Care Unit (8 episodes).

Quality

Note: Recent changes to the Complaints procedure introduced the following terms: rapid resolution complaint (previously known as concern) and low/high level complaint. The above graph shows a combined figure of early resolution, rapid resolution complaints and low/high level complaints since the change was introduced in April 2024.

Summary, highlights

The Trust continues to value all complaints and concerns raised to use these as opportunities to make improvements. We monitor key themes identified within complaints, alongside information from other sources of feedback such as Patient Safety Incidents, Legal Claims, Inquests and HR investigations. Discussions to triangulate the information takes 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. The Trust introduced the new national complaints standards at the beginning of April 2024.

In July 2024 there were fifty-two (52) rapid resolution complaints, twelve (12) low level complaints and two (2) high level complaints. This is a slight reduction from the previous year when we received fifty-four (54) concerns (rapid resolution complaints), fourteen (14) low level complaints and four (4) high level complaints. The top teams with three complaints were Oxfordshire's Adult ADHD (Attention Deficit Hyperactivity Disorder), Adult Mental Health Team Oxon South, Child and Adolescent Mental Health Oxon Getting More Help North, Minor Injury Unit Abingdon and Wintle (adult female acute) Ward in Oxford. There were forty (40) early resolutions in July 2024.

In terms of compliments, there were 262 compliments across the Trust in July 2024, which is a reduction when compared to July 2023 when 311 compliments were received. The numbers broken down by directorates are as follows: Buckinghamshire Mental Health - 40, Oxfordshire and Bath and North East Somerset, Swindon and Wiltshire Mental Health - 141, Community Health Service, Primary Care and Dentistry - 73, and Corporate Services - 8.

Actions :

- Early resolution: - work with teams to ensure service and team manager are contacting individuals within 72 hours to try to resolve issues at this stage.
- Rapid Resolution: - continue to engage with services to work towards completing these cases within the 15 working day deadline and responding to complainants in writing.
- Extensions process; continue 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: - reintroduction of complaints panels to provide a greater overview of current situation within services, review quality and focus on learning.

People - Be a great place to work

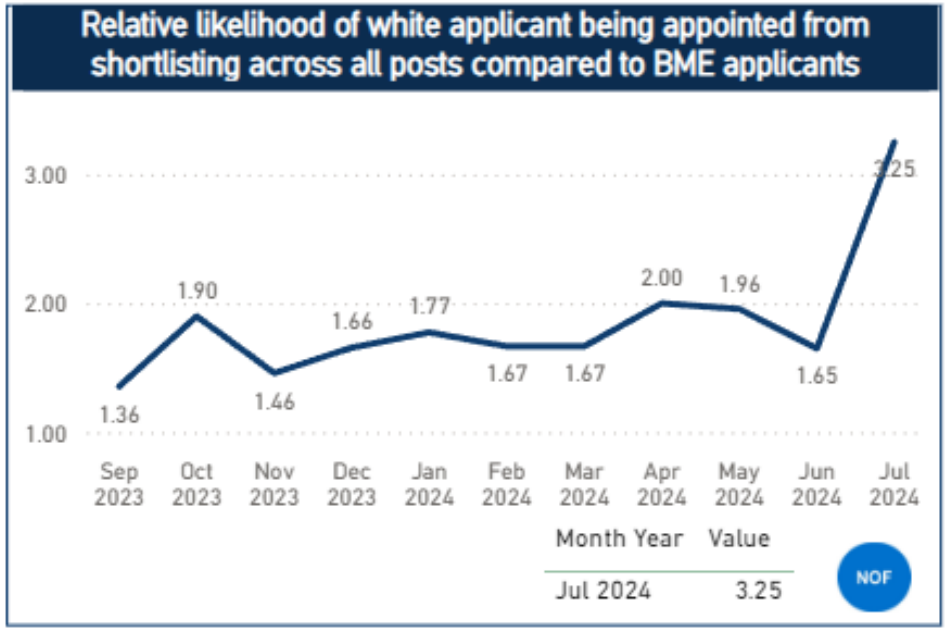
Oxford Health
NHS Foundation Trust

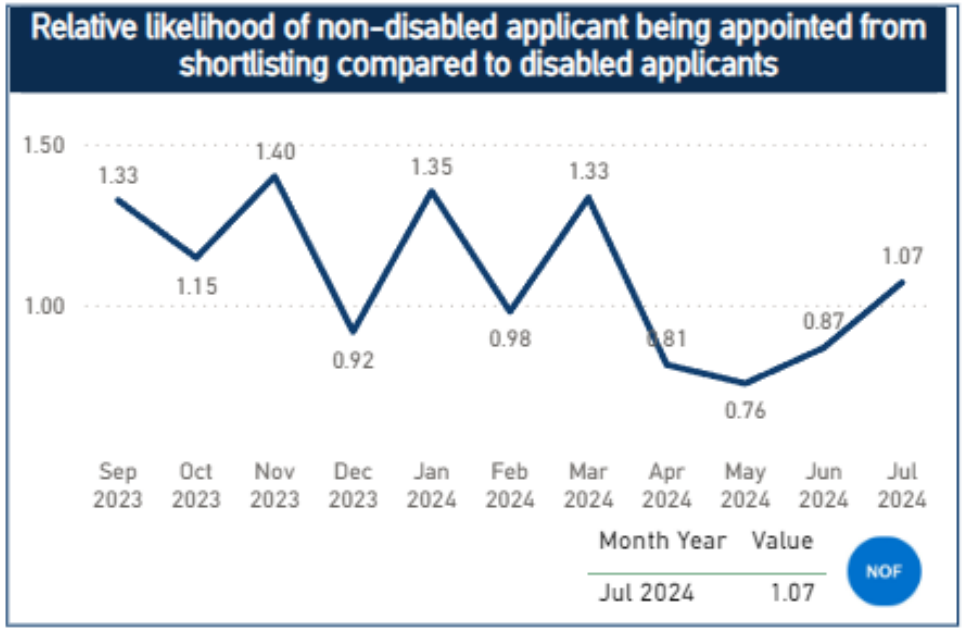
People metrics – Summary Dashboard

Type of metric	Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
NOF	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	TBC	Jul-24	77.79%	↑	↑
NOF	Reduce staff sickness to 4.5%	4.5%	Jul-24	5.58%	↑	↓
	PDR compliance	95%	Jul-24	95.51%	↑	↑
NOF	Reduction in vacancies	9%	Jul-24	13.62%	↑	↓
	% of early turnover	14%	Jul-24	14.31%	↑	↓
	Statutory and mandatory training compliance	95%	Jul-24	88.94%	↑	↑
	Clinical supervision completion rate	95%	Jul-24	80.68%	↑	↑
	Management supervision rate	95%	Jul-24	75.83%	↑	↑
NOF	Staff leaver rate	n/a	Jul-24	7.16%	↑	↓
NOF	Relative likelihood of white applicant being appointed from shortlisting across all posts compared to Black, Asian and Minority Ethnic (BME) applicants	n/a	Jul-24	3.25	↑	↓
NOF	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	n/a	Jul-24	1.07	↑	↓
Strategic Metric - People NOF	Reduce agency usage to meet target (% of agency used)	6.50%	Jul-24	7.48%	↑	↓
Strategic Metric - People	Reduction in % labour turnover	14%	Jul-24	11.93%	↓	↓
Strategic Metric - People	% of staff completing Quality Improvement Training Level 1	*In development for FY25. Status: plan to make part of statutory training from July 24 onwards (initiated). Technical development initiated for wider 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%	Jul-24	24.02%	↑	↑
Strategic Metric - People NOF	Black, Asian and Minority Ethnic (BAME) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	19%	Jul-24	12.89%	↑	↑

- 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.

People





Summary

- The relative likelihood of white applicants being appointed from shortlisting compared to Black, Asian and Minority Ethnic (BAME) applicants has increased by 1.6 from 1.65 in June 2024 to 3.25 in July 2024. The higher the ratio, the more likely White applicants are to be appointed than BAME applicants. A ratio under 1 indicates that BAME applicants are more likely to be appointed than White applicants and vice versa. A ratio of 1 indicates equal likelihood for both groups.
- The relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants has increased by 0.20 from 0.87 in June 2024 to 1.07 in July 2024. The higher the ratio the more likely Non-Disabled applicants are to be appointed than Disabled applicants. A ratio of 1 would indicate equal likelihood for both groups.

Actions

Race Equality:

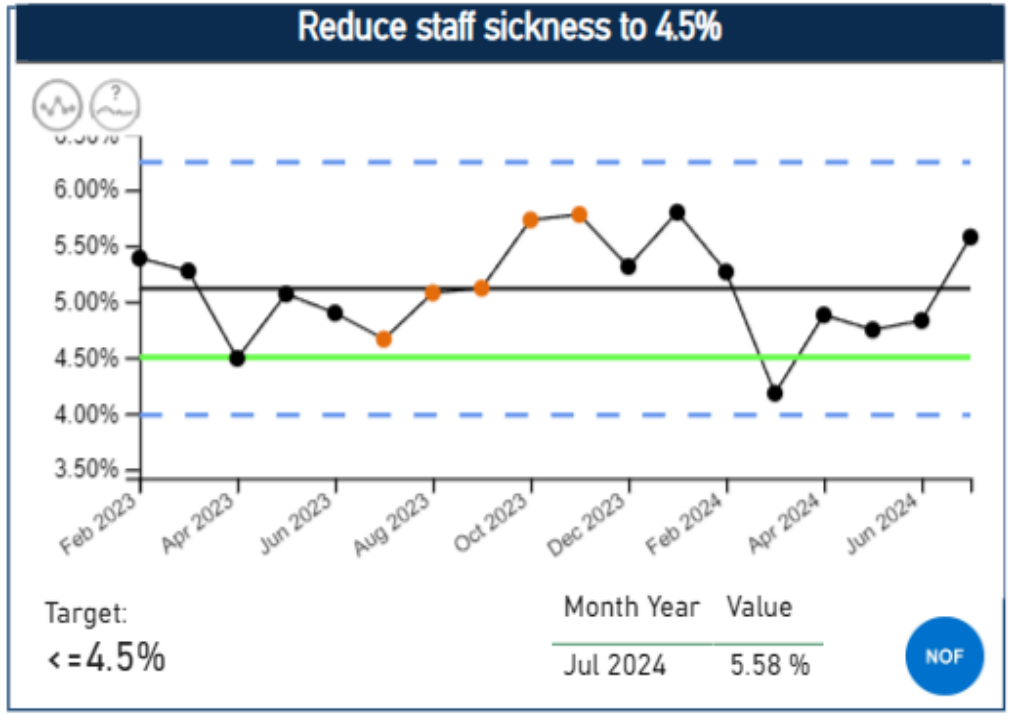
- Proposal paper to recruit Inclusion Reps from all the directorates to sit on all interview panels for Band 8c and above has been drafted – awaiting outcome.

Disability Equality:

- The re-accreditation of the Level 2 Disability Confident submission to the DWP was completed on 13/08/24 – awaiting results.

Caring, safe and excellent

People



Summary

The sickness absence increased from 4.83% to 5.58%. with a 2% increase in Forensic services and an outbreak of infectious gastroenteritis in Evenlode (medium secure ward in Oxford).

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/Migraine, Covid 19 confirmed, Gastrointestinal and Anxiety/Stress non-work related.

Actions Sickness Absence

The Human Resources (HR) Operational teams continue to regularly to review the management of individual sickness absence cases where individuals have been identified as having higher levels of absence. The HR Operational Teams also focus 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. Absence management training being delivered in larger services where there are new line managers. We are also working on virtual e-learning sessions to make accessing training modules and materials easier for managers. Work to ensure a smooth transition from Goodshape to managing absence through the e-rostering system is underway with training sessions for managers beginning in September.

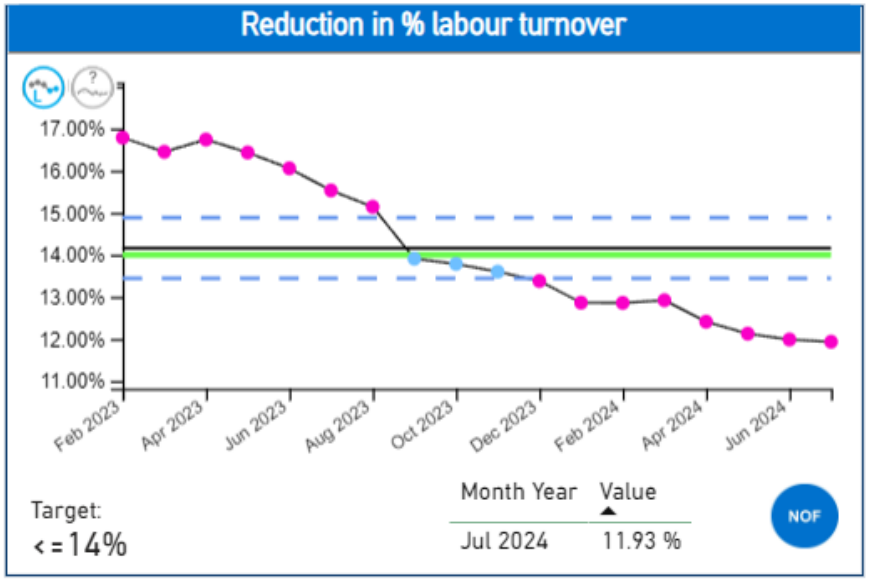
Actions Occupational Health/ Well being

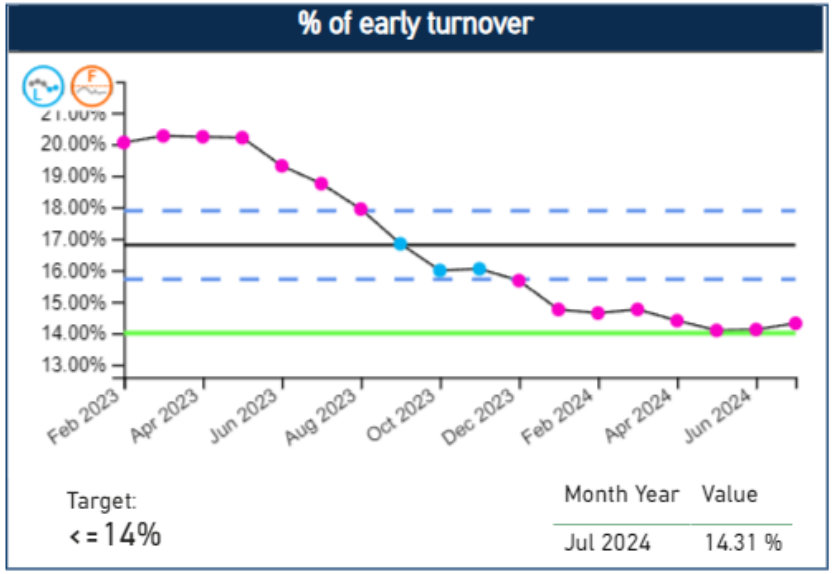
The Occupational Health team undertook 222 management referrals, 8 self-referral, 2 ill health retirement applications and 91 reviews during July. Of the 45 management referrals relating to Musculo-skeletal (MSK) causes, 13 were attributed to work-related issues and 10 were referred on for physiotherapy. 33 physiotherapy treatment sessions were undertaken in relation to MSK issues impacting work. From a stress perspective (both attributed to work and non-work-related causes) 28 referral appointments were completed (20 for perceived work stress), 5 were referred on for Staff Psychology Service assessment.

Other activities included processing 285 work health assessment questionnaires, 90 of which needed a follow-up appointment, 8 case conferences, 3 workstation specialist advice/assessment and 11 management of blood borne virus incidents. Attendance at Quality Sub Committee to present updated Management of Clinical Sharps Injuries and Exposure to Blood/High Risk Body Fluids/Needlestick Injuries which has now been ratified.

The Staff Psychology Service received 6 new referrals during July and completed 15 initial consultations plus 48 ongoing treatment sessions. Reflective sessions were also offered to a specific team. It should be noted that there was a gap in staffing during July due to fixed -term contract end and return from maternity leave of one of the team.

People





Summary

Staff turnover decreased from 11.99% to 11.93% and remains below the 14% target. Early labour turnover has slightly increased from 14.11% to 14.31%

The early turnover of Black, Asian and Minority Ethnic (BAME) staff (18.1%) is considerably higher than turnover of white staff (13.5%) 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 several 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 carried out a thorough data analysis during the month of August to identify hotspot areas that will have the highest impact on turnover. The findings and recommendations will be shared at the September People Steering Group for sign off.

The recurring theme throughout the data analysis is 'early turnover' and this needs to be addressed, particularly the gap in early turnover of white staff and BAME staff and the early turnover of BAME male staff in band 3 roles.

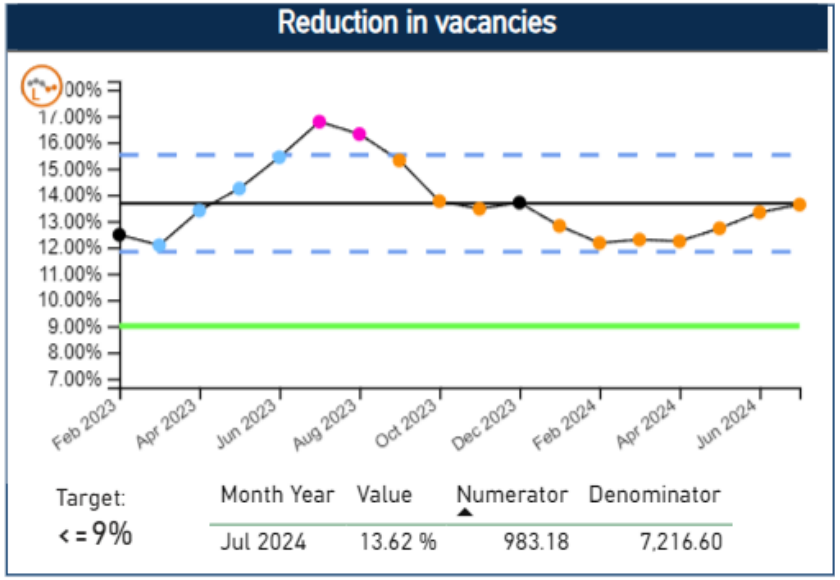
The following work will be undertaken in the coming months to improve staff engagement and data quality and to better understand the experiences of our new starters so that we can make the necessary improvements.

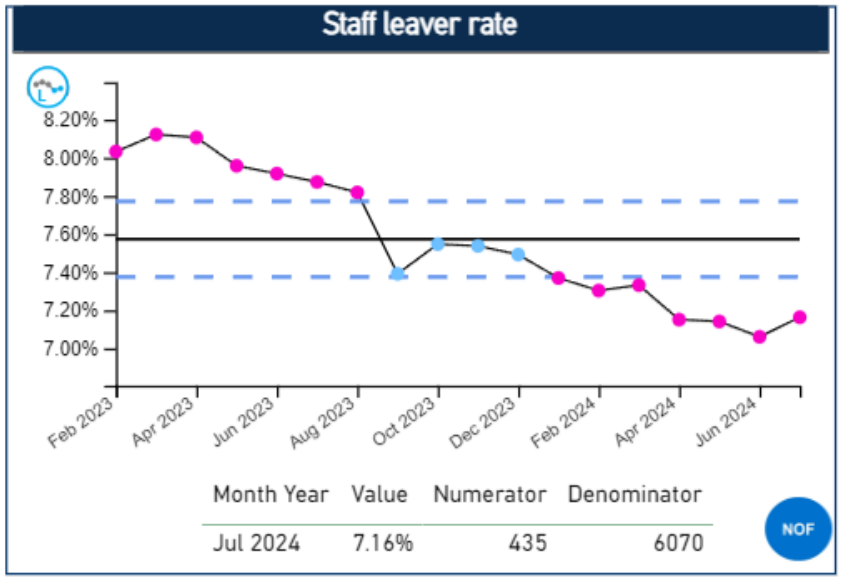
- Launch of a new Quality Improvement (QI) project – New Starter Experience & Reduction of Early turnover – this area remains a high impact area and root causes need to be identified to inform future improvement work

- Full review of exit process; to include manager leaver form, Exit Interviews, stay conversations and local exit interviews; the data we have is limited and of poor quality (this needs to be better if we are to really understand why staff are leaving)

The People Promise Manager has identified 'flexible working' as a key area that needs improvement . A QI project will be launched in September to identify root causes and improvements.

People





Summary

The vacancy rate has increased from 13.33% to 13.62%; 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 high cost-of-living and lower compensations. Staff shortages due to leave and turnover within the recruitment team along with limitations with recruiting tools is impacting on staff recruitment.

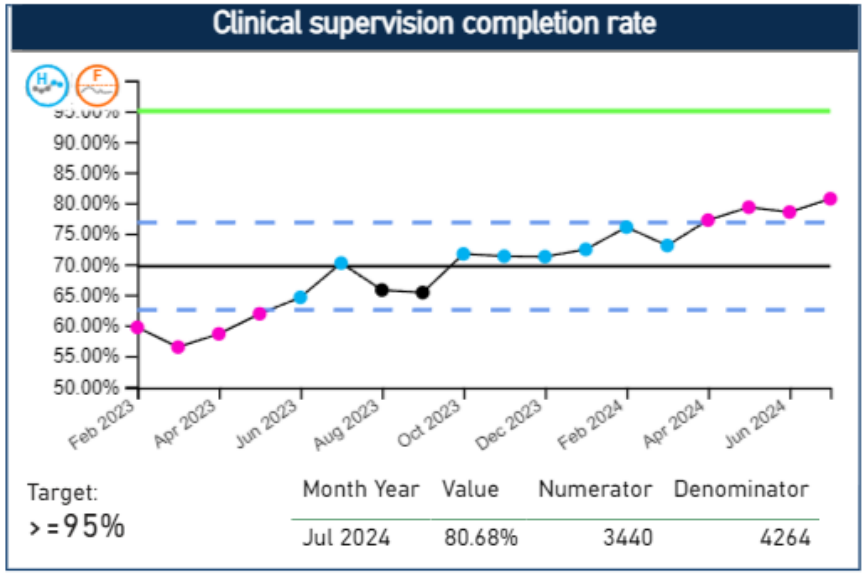
Actions:
The Trust budgeted establishment has continued to increase, month on month, from 6,945FTE in July 2023 to 7,216 in July 2024, an increase of 271 new posts created within the last year, with 30 new posts (budget Full Time Equivalents) created between June 2024 and July 2024.

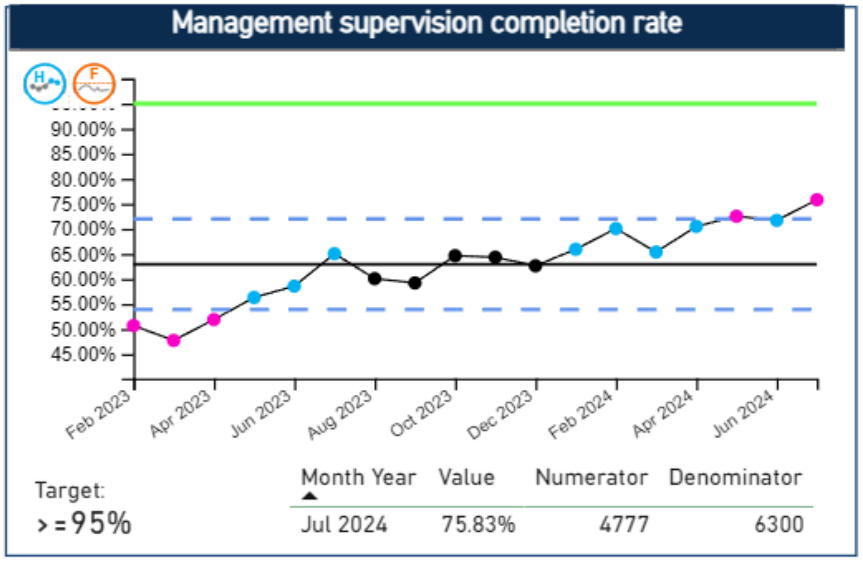
The recruitment transformation Quality Improvement project is ongoing, based on survey feedback gathered in the discovery phase, the project team are now reviewing application requirements with a view to adding a range of application forms to TRAC (recruitment management system), these will be based on the application needs of each staff group, tailored to remove barriers to entry and removing avenues for bias creep. The project group have been asked to pause on technology options to improve accessibility and inclusivity in the application and shortlisting stage, this had included technology to support the application process, improving the quality of applications, improving the candidate experience and in turn increasing the volume of quality applications.

Recruitment events slow down during the summer holiday period, however a wide calendar of events is planned for the rest of the calendar year, this includes Recruitment Roadshows throughout November, open-day and assessment centre events for nursing and Healthcare Assistant (HCA) recruitment, along with numerous University and local external recruitment events.

Priorities:
- A re-organisation of the Resourcing team is in progress with the consultation launch on Monday 2nd September, the proposed new structure will move the Trust towards a Talent Acquisition model.
- New technology developments to compliment this structure, to include on-line ID checking meaning most candidates will no longer need to attend Littlemore to conduct an identity/right to work check and a TRAC upgrade allowing forms to be complete and signed online (on any device) have been paused while we undertake a wider assessment of HR system change to allow for work to be planned.

People





Summary

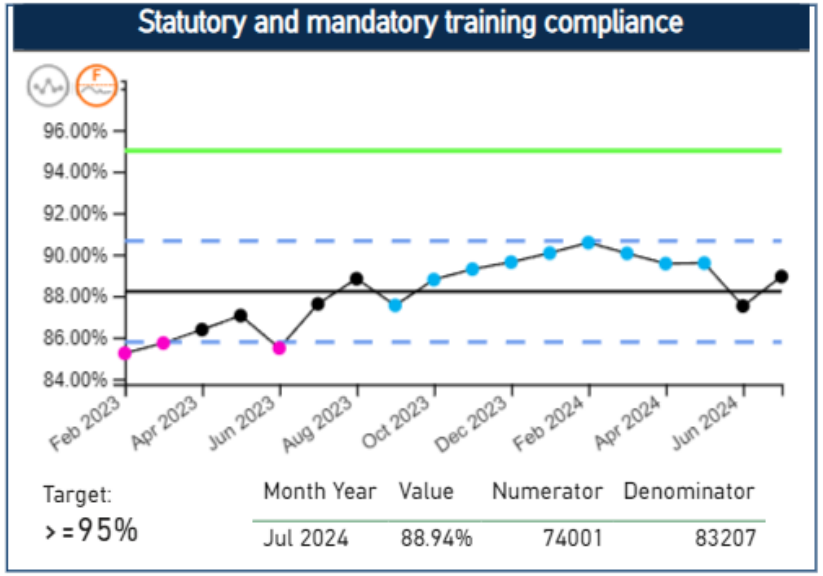
Good quality and regular management and clinical supervision is essential for ensuring that we provide high quality patient care and that we support staff in relation to their professional development and wellbeing. Whilst improvement has been slow there has been an upward trajectory of both clinical and management supervision since January 2023. This Clinical supervision has increased from 78.5% to 80.7%. this is the first time over 80% has been achieved. Management supervision rate has also increased from 71.7% to 75.8%.

Action

- The Supervision steering group has now stopped, and oversight of supervision has been moved to the Education Strategy group – updates from the initial stages of the Quality Improvement (QI) project to be presented for discussion/decision in next meeting on October 22nd.

- The Head of Learning and Development and the Deputy Chief Nurse have started a QI project with current actions being completed:
  - review of other Trust supervision policy to determine best practice/approach to take.
  - review of other Trust compliance rates to determine if Oxford Health are in line with what other Trusts consider to be achievable compliance rates.
  - review staff survey questions relating to supervision to ensure that all changes are in line with these.

People



Summary

The percentage of Statutory and Mandatory training modules reported as complete at the end of July has increased from 87.51 % to 88.94%. Individuals who have not completed their training may not have the skills and knowledge to carry out their role safely.

Staff report that at times due to ongoing staffing pressures, they are not being released to attend but that the access to training is better and they are clear on the requirements for statutory and mandatory training. Work continues to correct anomalies in job roles to ensure accurate training is allocated to each staff member as this remains an issue. There are 8 pieces of Mandatory training that have a compliance rate above 90%. Head of Learning and Development is engaged with the National NHS England (NHSE) project to align all Statutory & Mandatory (S&M) training for easy passporting. Trust has submitted mapping against Core Skills Training Framework (CSTF) for approval through NHSE programme and has been identified as Trust of progressive practice in their approach to Statutory and Mandatory training.

Actions

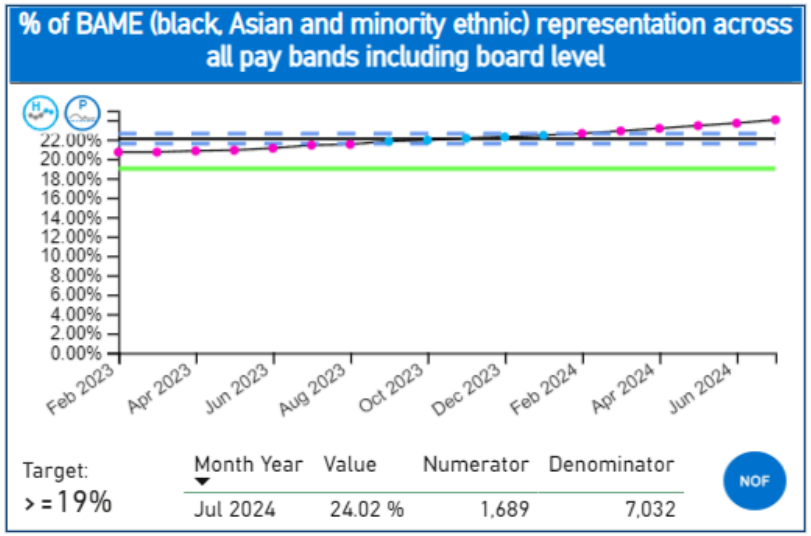
The overall position for Statutory and Mandatory training has improved and all the directorates in the Trust are circa 90% completion which demonstrates the continued commitment to supporting staff to complete this. There is a clear understanding of the risks and barriers which are resulting in the training subjects that are noticeably below expected compliance rates. Plans are in place to address these, and they are being monitored by the risk register. Compliance for statutory and mandatory training was reported to Quality and Clinical governance sub-group in August.
The most recent report highlighted and actioned:

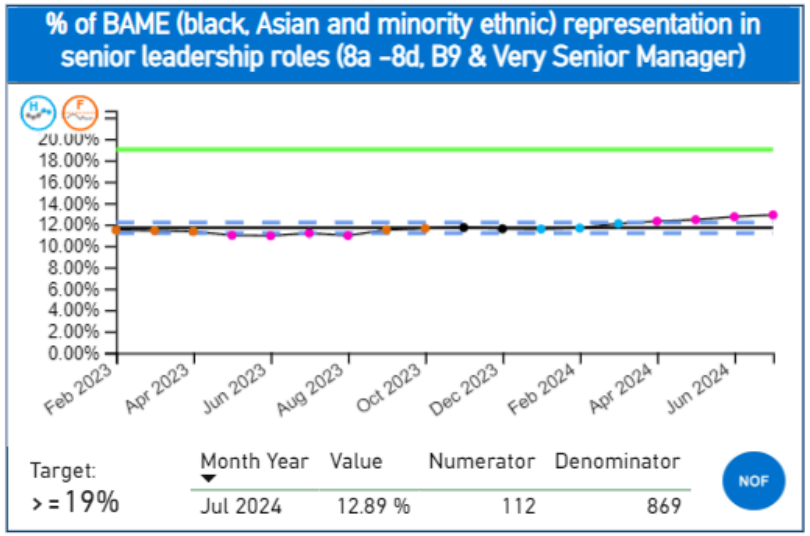
- Compliance for training is improving in all subjects with some areas of improvement since being included in Statutory and Mandatory training requirements such as The Oliver McGowan training (currently at 86.8%) which demonstrates the overall drive to improve compliance rates.

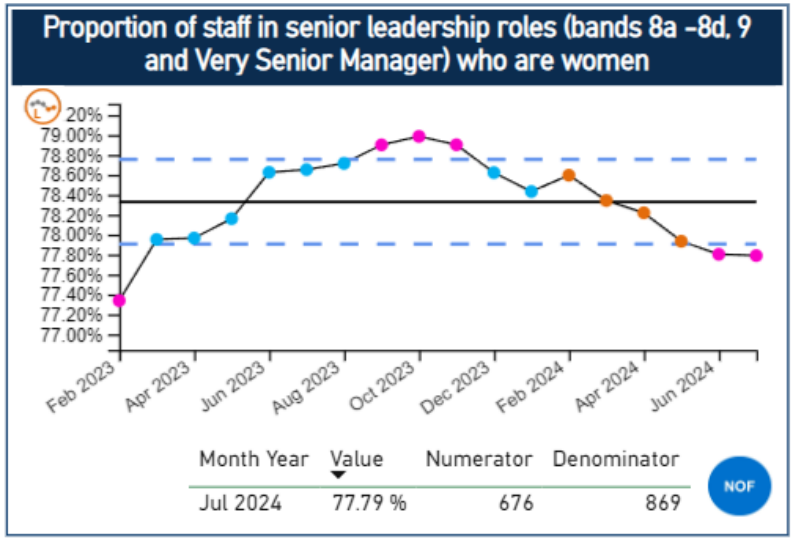
Assurances for training modules below 90%:

- Conflict Resolution – Lower compliance can be attributed to an error in the training set up in the Learning & Development system resulting in the provision for non-clinical staff having no recertification. This has been corrected but did highlight a high % of non-compliant staff. Training is easily accessible through e-learning and facilitated virtual classroom and attendance is very good.
- Infection Prevention and Control - Lower compliance can be attributed to change in provision for non-clinical staff in line with new best practice standards to now include a 3 yearly recertification where previously there was no recertification, did negatively impact on compliance rates. These are being monitored and compliance steadily improving and expected be above 90% in the next 3 months.
- Resus – Changes to resus training agreed and now being scheduled. Issues with regards to access to training room in Buckinghamshire still ongoing.
- Level 1 Oliver McGowan – newly introduced training this financial year – compliance rates steadily improving.

People







Summary

- There has been an increase of +0.34% in the representation of Black, Asian and Minority Ethnic (BAME) staff across all pay bands in July 2024 reporting period.
- There has been an increase of +0.17% in the representation of Black, Asian and Minority Ethnic (BAME) staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in July 2024 reporting period.
- There has been a slight decrease of -0.1% in the representation of Female staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in July 2024 reporting period.

Actions

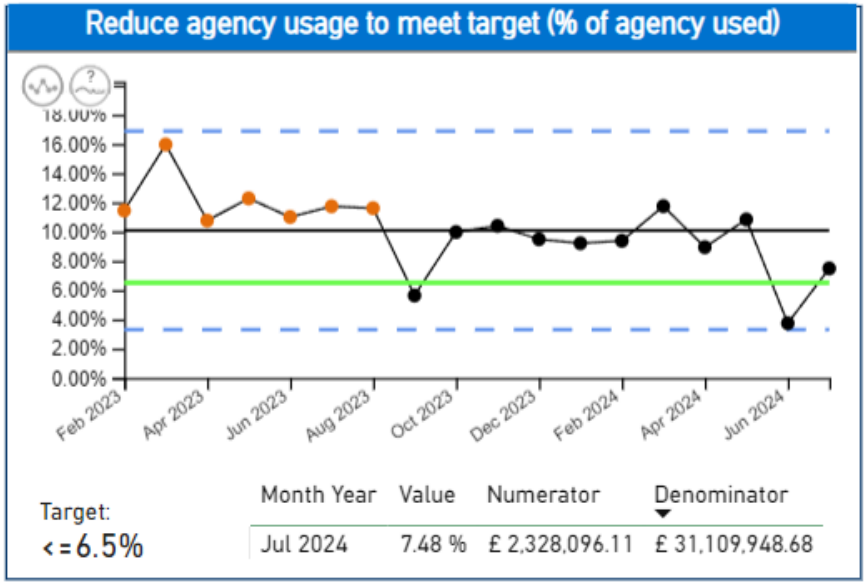
All three above metrics will be worked on under High Impact Action 2 to secure diverse and fair representation of staff in the workforce in line with inclusive recruitment and talent management principles. We will also draw on the analysis of the NHS Workforce Race Equality Standard (WRES) 2024 data 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

Update:

- Project proposal paper to recruit Black, Asian and Minority Ethnic (BAME) staff from every directorate to become 'Inclusion Representatives' has been drafted to action the decision to mandate Inclusion Representatives for Band 8C and above roles.
- Work underway within the Human Resources and Learning & Development functions to define talent and succession planning more clearly to understand what interventions are a priority.

People



Summary

Overall, total agency spend in July was £2,328K (7.5% of total pay bill) or 1.7% above July budget of £2,289k.

Agency Actuals June 2024 - the month 3 agency figure is low because it includes a £1m correction to month 2. The month 2 figures included £1m related to Financial Year 24 which has subsequently been reported in the amended version of the Financial Year 24 accounts following the completion of the audit. The true spend for May was £2.485m, 7.7% of pay and for June was £2.134m 7.0% of pay.

In July 63% of our temporary staffing shifts (based on hours) were filled by bank workers; 31% were filled by agency workers and 6% were unfilled
Agency Spend as a % of Temporary Staffing was 46.3% (£2,328K) and Bank was 53.7% (£2,696k).

Highlights, updates, actions

Managed Service Provider Update

NHS Professionals (Agenda for Change):

The Healthcare Assistant (HCA) change to agency cascade as reported last month has seen the shift fill rate HCA's continue to improve week on week without any negative impact to overall fill rates ensuring patient safety. Unfortunately, the automated process NHS Professionals (NHSP) created deliver these changes is not working and we have therefore implemented a manual process through IDM to ensure we can maintain this approach. We are continuing to contact all substantive HCA's who are not already registered with NHSP inviting them to join the bank, posters have been supplied to the wards for their break rooms and the message on the intranet page advising of these changes contains the link for joining the bank.
Bank workers in the School Immunisations team were transferred across from Oxford Health to NHSP on 1st August 2024, documentation is being checked and training profiles are being created to enable them to undertake shifts at the start of the new school term.

ID Medical (AfC):

There are currently 115 lines of work in place across the Trust which has reduced by 135 from 250 since 1 January 2024. The number of lines of work at price cap are 58, phase 1 has reduced from 54 to 43 and phase 2 have reduced from 9 to 4. The temporary staffing team are continuing to support teams in migrating agency workers to the bank and substantive roles, to date 24 agency workers have migrated to the bank, 19 agency workers and 26 bank members have joined the Trust on a substantive basis. There are 17 workers who are awaiting start dates for their substantive role and 6 who are going through the pre-employment check process. The temporary staffing team are continuing to support the services with reducing the number of retrospective shifts that are being requested. We are closely monitoring and taking action with services who are logging retrospective shifts, although there has been an increase of 33 retro shifts with 1,525 in July and 1,492 in June.

ID Medical (Medical):

The GP Out of Hours service continues to report savings based on the negotiated rates achieved in conjunction with ID Medical, in October we will consider the option of insisting GP's move to a Direct Engagement contract which would release further savings based on reduced VAT payments.
In mental health, ID medical are continuing to work closely with Associate Medical Directors in the successful replacement or rate reduction on existing medics and the introduction of lower cost workers to new requirements. The Medical Agency Management meeting is considering the option of insisting all medics move to a Direct Engagement contract which could realise a saving of c£1m per annum based on the current workforce due to reduced VAT payments.

Section 3
Strategic dashboard

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.

Oxford Health NHS Foundation Trust

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

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

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
	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
Research	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

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%		F
	CYPED Urgent cases that wait 1 week or less from referral	Feb 24	95.0%	0.0%		F
	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	L	
	Estimated Diagnosis rate for people with dementia	Mar 24	66.7%	62.2%	H	F

Talking Therapies Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Talking Therapies: Treated within 6 weeks	Apr 24	75.0%	97.0%		P
	Talking Therapies: Treated within 18 weeks	Apr 24	95.0%	100.0%	H	P
	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%	H	P

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.

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.

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

25 September 2024

(Agenda item: 10(b))

Quality and Safety Dashboard
For Information

Executive Summary
The information in the Quality and Safety Dashboard is up to 31st July 2024. The purpose of the dashboard is to bring together data and soft intelligence to help identify wards/teams that might be struggling and need more support.

From reviewing a range of activity, quality and workforce indicators the below wards and community teams are highlighted by exception as flagging with an area of concern based on the position in July 2024 and a review of any trends from the last 3 months (May-July 2024). Waiting time information is included in the report.

The language used to highlight teams struggling has been changed from this month to;
- Enhanced Support (previously known as alert status)
- Early Warning (previously known as to keep a watching eye).

The thresholds for escalation have been reviewed and strengthened, detailed further in the main body of the report.

See accompanying excel sheet for the full detailed dashboard for the inpatient wards. For the community teams a range of indicators are also reviewed with any teams identified by exception below.

The following wards/community teams have been highlighted, split into 2 groups; Enhanced Support and Early Warning. Those highlighted in BLUE were identified in last month's Dashboard.

Highlighted wards/teams by exception:

	Enhanced Support (previously known as alert status)	**Early Warning** (previously known as to keep a watching eye)
Inpatient Wards	• CAMHS Highfield • Sapphire, stepped up from early warning • Kestrel • Kingfisher (see table 5 for detail)	• Wintle • Ashurst PCIU • Cotswold House Oxford • Meadow Unit CAMHS, downgraded from enhanced support last month • CAMHS Marlborough House, downgraded from enhanced support last month • Cherwell • Sandford • Ruby • Wallingford community hospital ward

	Enhanced Support (previously known as alert status)	**Early Warning** (previously known as to keep a watching eye)
		• Linfoot community hospital ward • Abbey Community Hospital ward • Watling • Kennet • Evenlode {to see reason for highlighting go to section 5)
Community Teams	• Oxon North and West AMHT • Bucks Chiltern AMHT (East and West), in early warning last month • Oxon City and NE AMHT • District Nursing (see table 6 for detail)	• Podiatry • Children's Integrated Therapies • Bucks Memory Clinic service • Bucks OA South CMHT • Bucks Aylesbury CMHT • Oxon South AMHT • Oxon Perinatal service • Swindon CAMHS (to see reason for highlighting go to section 6)

The report includes further detail about each of the teams at enhanced support and early warning levels, including the mitigations and actions being taken.

In addition, to the teams/wards highlighted there are a number of areas with a significant number of vacancies, although for the majority the quality indicators reviewed are not showing any concerns. For all wards the minimum staff fill rates are being met. In community teams agency/locums are being used to maintain safe staffing levels. The teams with high vacancies, 30% or above, are listed in the report to show a complete picture for all clinical teams. There are a series of recruitment and retention initiatives being taken to tackle those teams with higher vacancies.

Governance Route/Approval Process
The Dashboard is a regular paper, developed with input from the Clinical Directorates and discussion at the Quality and Clinical Governance Sub-Committee in August 2024.

Statutory or Regulatory responsibilities
We are required to report on the inpatient staff fill rates to Trust Board members which has been delegated to the Quality Committee, see accompanying excel sheet for detail at ward level.

Recommendation
The Board is asked to note the report and the actions being taken to support the teams highlighted.

Author and title: Jane Kershaw, Head of Patient Safety
Lead Executive Director: Brita Klinck, Chief Nurse

Main report.

1. Introduction

The information in the Quality and Safety Dashboard is up to 31st July 2024. The purpose of the dashboard is to bring together data and soft intelligence to help identify wards/teams that might be struggling and need more support.

From reviewing a range of activity, quality and workforce indicators the below wards and community teams are highlighted by exception as flagging with an area of concern based on the position in July 2024 and a review of any trends from the last 3 months (May to July 2024).

See the accompanying excel sheet for the full detailed dashboard for the inpatient wards. For the community teams a range of indicators are also reviewed with any teams identified by exception below. As shared in the last monthly report, shortly the inpatient ward dashboard will be available in TOBI and refreshed automatically each month. A similar dashboard for teams in the community will also be developed in TOBI.

Indicators

Below are the list of indicators included in the dashboard across four domains.

	Inpatient Wards	Community Teams
Workforce Domain	Day Reg Fill Rate (target more than 85%)	
	Day Unreg Fill Rate (target more than 85%)	
	Night Reg Fill Rate (target more than 85%)	
	Night Unreg Fill Rate (target more than 85%)	
	Nursing Associates - Day Shift Hours worked	
	Nursing Associates - Night Shift Hours worked	
	Agency % total pay (target less than 10.4%)	Agency % total pay (target less than 10.4%)
	Vacancies % (target less than 9%)	Vacancies % (target less than 9%)
	Total Turnover % (target less than 14%)	Total Turnover % (target less than 14%)
	Sickness % (target less than 4.5%)	Sickness % (target less than 4.5%)
Safe Domain	Number of staff injuries (all types of causes) with actual harm of moderate or above	
	Number of patient incidents with moderate or above harm (1 or less)	Number of patient incidents with moderate or above harm (1 or less)
	Most common sub-group group for reported incidents (patient and staff)	Most common sub-group group for reported incidents (patient and staff)
	Number of incidents of AWOLs (detained patients - unescorted, escroted or escape from ward) [this is Falls for Community Hospital wards)	
	Medicine Incidents resulting in harm (minor harm or above. Excludes patient refused)	
	Number of pressure ulcers developed in service (categories 1-4, deep injury & unstageable. Includes where there are no lapses in care)	Number of pressure ulcers developed in service (categories 1-4, deep injury & unstageable. Includes where there are no lapses in care)
	Number of Incidents under the PSIRP between Dec 2023-Feb 2024 (note. SI criteria no longer exists)	Number of Incidents under the PSIRP between Dec 2023-Feb 2024 (note. SI criteria no longer exists)
	Unexpected deaths (natural and unnatural) incl. within 2 days of inpatient stay	Unexpected deaths (natural and unnatural)
	Number of physical restraint episodes (less than 10)	
	Number of prone restraints (1 or less)	
	Number of seclusion episodes (less than 4)	
	Number of uses of LTS (less than 2)	
Effective Domain	Median Length of Stay YTD 23/24 incl leave (discharged patients)	Waiting times and Referrals reviewed instead
	Number of Admissions in Month	
	Bed occupancy in month excluding leave	
	Clinical Supervision (target more than 95%)	
	Overall Mandatory Training performance (target more than 95%)	Overall Mandatory Training performance (target more than 95%)
	Fire Response Training (target more than 95%)	
	Resus Training (target more than 95%)	
	PEACE Training (target more than 95%)	
Experience Domain	Number of formal complaints (2 or more)	Number of formal complaints (2 or more)
	Number of informal concerns (2 or more)	Number of informal concerns (2 or more)
	Formal surveys received via IWGC in month- yes or no (no will be flagged)	Formal surveys received via IWGC in month- yes or no (no will be flagged)

Changes to the dashboard going forward

The language used to highlight teams struggling has been changed from this month to;

- Enhanced Support (previously known as alert status)
- Early Warning (previously known as to keep a watching eye).

The thresholds for escalation have been reviewed and strengthened, detailed below.

The majority of indicators (22/33) have a target so are individually rated. Every indicator is equally weighted, although there is recognition that the workforce domain indicators are interlinked for example vacancies and use of agency staff.

The expected response to the escalation levels are summarised below;

Table 1.

Escalation level	When is a Team/ward Identified (Escalation Threshold)	Response
Early Warning (previously known as to keep a watching eye)	• 1 indicator is red rated and 1 indicator is amber rated across at least 2 of the 4 domains. This is a guide and a clinical Directorate might identify a team for Early Warning from soft intelligence. • A red rating of high vacancies on their own without concerns in fill rates will not identify a ward/team. • A red rating of fill rates will be considered in relation to safe staffing levels across reg/unreg staff and bed occupancy. This will not automatically lead to a ward/ team being identified. • A team/ward at Enhanced Support level can be stepped down to Early Warning if agreed by the Directorate Clinical Director/Associate Director of Nursing. An explanation and the actions being taken will be shared in the Dashboard with the next Quality and Clinical Governance sub-group.	• Monitoring led by the clinical Directorate level through their clinical governance structure. • If a ward/team has been at Early Warning level for 3 consecutive months they will be moved to Enhanced Support unless there is an explanation which will be shared in the Dashboard with the Quality and Clinical Governance sub-group. (this starts from June 2024)
Enhanced Support (previously known as alert status)	• 2 indicators are red rated across at least 2 of the 4 domains. This is a guide and a clinical Directorate might identify a team for Enhanced Support from soft intelligence. • A team/ward at Early Warning level for 3 consecutive months unless there is a clear explanation (this starts from June 2024).	• Clinical Directorate to identify actions being taken. • Actions being taken to be reported in the Dashboard and reviewed by the Quality and Clinical Governance sub-group. Additional support can be requested. • There may be a request for a more detailed presentation/deep dive at the next Quality and Clinical Governance sub-group meeting to look at the impact of the actions being taken.

2. Summary of highlighted wards/community teams

The following wards/community teams have been highlighted, split into 2 groups; Enhanced Support and Early Warning. Those highlighted in BLUE were identified in last month's Dashboard.

Table 2.

	Enhanced Support (previously known as alert status)	**Early Warning** (previously known as to keep a watching eye)
Inpatient Wards	• CAMHS Highfield • Sapphire, stepped up from early warning • Kestrel • Kingfisher (see table 5 for detail)	• Wintle • Ashurst PCIU • Cotswold House Oxford • Meadow Unit CAMHS, downgraded from enhanced support last month • CAMHS Marlborough House, downgraded from enhanced support last month • Cherwell • Sandford • Ruby • Wallingford community hospital ward • Linfoot community hospital ward • Abbey Community Hospital ward • Watling • Kennet • Evenlode {to see reason for highlighting go to section 5)
Community Teams	• Oxon North and West AMHT • Bucks Chiltern AMHT (East and West), in early warning last month • Oxon City and NE AMHT • District Nursing (see table 6 for detail)	• Podiatry • Children's Integrated Therapies • Bucks Memory Clinic service • Bucks OA South CMHT • Bucks Aylesbury CMHT • Oxon South AMHT • Oxon Perinatal service • Swindon CAMHS (to see reason for highlighting go to section 6)

3. Teams with High Vacancies (July 2024 data)

In addition, to the teams/wards highlighted there are a number of areas with a significant number of vacancies, although for the majority the quality indicators reviewed are not showing any concerns. For all wards the minimum staff fill rates are being met. In community teams agency/locums are being used to maintain safe staffing levels. The teams with high vacancies, 30% or above, are listed below to show a complete picture for all clinical teams.

There are a series of recruitment and retention initiatives being taken to tackle those teams with higher vacancies.

Table 3.

Areas with High Vacancies - 30% or above (data source Finance)	
Inpatient Wards	Community Teams
• Wintle 31.8% (improved) • Ashurst 29.4% (worse) • CAMHS Meadow PICU (new unit from Nov 2023 – same) • Sandford 32.1% (worse) • Bicester community hospital ward 33.1% (worse) See accompanying excel sheet for the full detailed dashboard for the inpatient wards which includes fill rates by shift.	• Mental health in reach service into Prisons Bullingdon (50%, worse from last month) and Huntercombe (32.2%, same as last month) • Oxon City and NE AMHT 34.6% (improved) • Oxon mental health hubs – Abingdon, City East and Banbury. • Oxon maternal mental health 67.8% (same) • Oxon CAMHS getting help North 38.9% (same) • Oxon CAMHS getting help South 44.3% (worse) • Oxon CAMHS Crisis 39.7% (worse) • Oxon CAMHS LD/ASD Hospital@Home 63.3% (improved) • Bucks Aylesbury AMHT 37% (improved) • Bucks Chiltern East AMHT 47.7% (improved) • Bucks Chiltern West AMHT 35.1% (improved) • Bucks PIRLS 32.8% (improved) • Bucks SCAS & Street Triage 83.3% (worse, although small team of 5 staff) • Bucks OA South CMHT 52.9% (same) • Bucks Memory clinic service 38.1% (worse) • Bucks CAMHS LD 36.5% (same) • Bucks CAMHS ED 29.8% (same) • Podiatry 33.9% (improved) [there is a national shortage of podiatrists and a small numbers of places being offered to training students] • Dental special care and paediatric dentistry • Children's Community Nursing West 30.6% (same) • Luther Street Medical Centre 32.1% (worse)
In addition there are a number of separate medical/doctor professional cost centres across the learning disability service, adult and older adult mental health teams and wards with very high vacancies. Locums are being used whilst recruitment initiatives are being used.	

4. Inpatient discharges followed in line with the national requirements

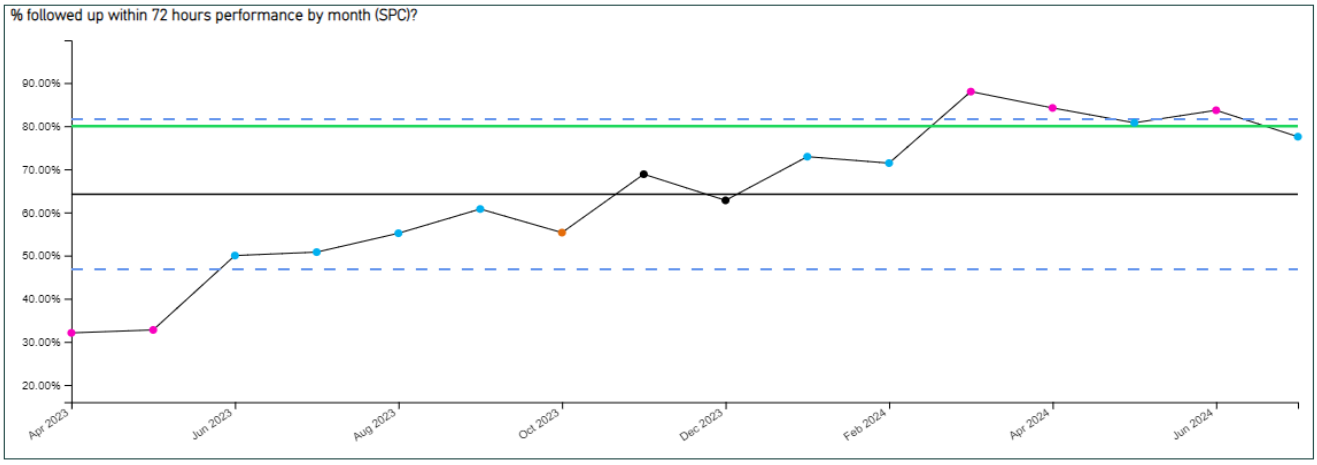
In July 2024 **84%** of eligible discharges (n=83) the patient was followed up within 72 hours (national indicator) and 82% within 48 hours (local indicator). The 72 hour follow up performance overtime by directorate is below. Note the beginning of the time period on the SPCs in early 2023 is based on incomplete data due to the PAS outage when the Trust was working under business continuity followed by a data recovery period.

The information is based on nationally set rules for reporting. A follow up is based on an attended follow up within a number of days (not hours), this can include a telephone contact, video call or F2F meeting. Discharges to acute hospital settings are excluded but discharges to care/nursing homes are still 'eligible' to be included in the reporting. One of the specifications is to not include the day of discharge as a possible follow up day, this might be confusing for example Joe Bloggs may be discharged on a Monday, then the community team go and see him same day and this does not count as a follow up contact, which needs to be from the next day (Tuesday), counted as day 1 or the day after (Wed), counted as day 2 to be within 48 hours. The other challenge for teams relates to patients on S17 leave, as once a patient is discharged they need to be followed up within 24/72 hours.

There are daily mechanisms in place to monitor patients discharged for follow up by the community team and oversight of performance.

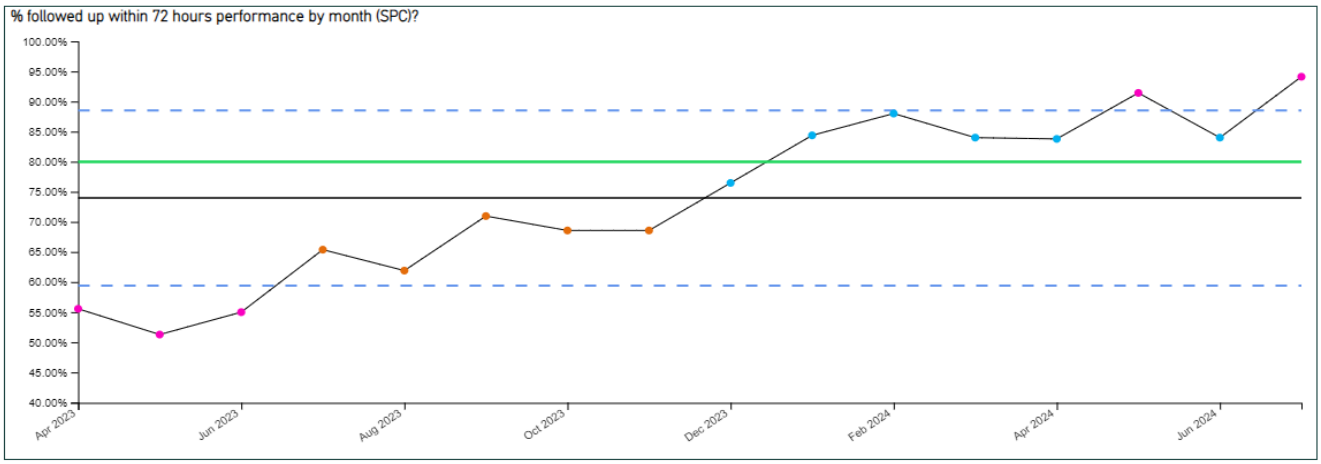
Oxon (based on commissioner)

April-July 2024 eligible discharges 207 and performance for 72 hour follow up **81%.**



Bucks (based on commissioner)

April-July 2024 eligible discharges 131 and performance for 72 hour follow up **88%.**



5. Wards Highlighted at Enhanced Support Level

There are four wards identified at Enhanced Support;

- Kingfisher
- Kestrel
- Sapphire
- CAMHS Highfield

Further details are on the next page, table 5, with the mitigations and actions being taken.

In addition the following teams/services are identified at an Early Warning level;

Table 4.

Directorate	Ward	Reason for highlighting
Oxon and BSW Mental Health	Wintle	High vacancies, sickness, low supervision, high complaints
	Ashurst PCIU	High vacancies, sickness, use of restraint & seclusion, low supervision no patient feedback
	Cotswold House Oxford	High vacancies and turnover, sickness, use of restraint, low supervision and mandatory training, high complaints & no patient feedback
	Meadow Unit CAMHS	Downgraded from enhanced support last month. High vacancies, agency use, turnover, sickness, low supervision & low mandatory training
	CAMHS Marlborough House	Downgraded from enhanced support last month. Workforce indicators, high use of restraint, low supervision, mandatory training & no patient feedback.
	Cherwell	High vacancies, sickness, high use of restraint, low supervision & no patient feedback
	Sandford	High vacancies, high use of restraint & low supervision
Bucks Mental Health	Ruby	High vacancies, agency use, sickness & low mandatory training
Primary, Community and Dental Services	Wallingford community hospital ward	High vacancies, turnover, sickness, low supervision & mandatory training
	Linfoot community hospital ward	Registered staff fill rates, sickness & low supervision
	Abbey Community Hospital ward	High turnover and sickness, low supervision & mandatory training
Forensic Mental Health	Watling	High sickness, low supervision & no patient feedback
	Kennet	High vacancies, turnover, sickness, high use of LTS & low supervision
	Evenlode	High vacancies and sickness, high use of restraint & seclusion – although for 1 patient

Wards identified as needing Enhanced Support

Table 5.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
Kestrel and Kingfisher (Thames House)	Yes	• Concerns raised by the Provider Collaborative following a quality visit to 5 forensic wards on 5th July 2024. Summary of key concerns; challenges within the nursing team dynamics and MDT working, senior leadership presence on the ward, reflective practice is not fully embedded, coordinated safeguarding arrangements, impact on therapeutic timetable for patients, care plans not person centred, medication administration and storage, gaps in physical healthcare. • High vacancies, 25% Kestrel and 27% Kingfisher. Staff fill rates good on Kestrel and lower on Kingfisher but this is intentional due to lower bed occupancy. • High sickness on Kestrel 11.4%. • 2 informal concerns raised on Kestrel. No patient feedback gathered on either ward in month.	A quality improvement plan is being implemented and monitored by the Provider Collaborative.
CAMHS Highfield	Yes	• High vacancies 25% (reduction from last month at 34%), high agency use, turnover and sickness. • High use of physical restraint. • Low performance against mandatory training (81%).	In terms of vacancy rates the position is improving with 4 new HCA and 2 new RMNS having joined the team in the past month and a further 4 to start in the next 2 months. Restrictive practice data has significantly reduced during the last 4 week period. Ongoing work focussing on restrictive practice across the CAMHS wards will continue to monitor this. The training data is at 81%, there have been 6 new starters to the team who have yet to complete training which relates to some of this as there is no longer the 3 months grace period for new starters.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
Sapphire ward	No	• High vacancies 19.9%, although fill rates are good. • High sickness 10.7%. • High use of prone restraint, 3 times in 1 month for 2 patients for immediate IM. • Clinical supervision low 53%. • No patient feedback collected in last month.	Although vacancies are high this overall is an improving picture in terms of nursing staff. Slight increase this month due to the Ward Manager moving on. Several new starters due in September and October 2024. Sickness: 4 staff on long term sickness. Prone restraint: both of those patients needed PICU care and have been transferred to appropriate care settings. Clinical Supervision now at 90%, recent improvement. Patient feedback has been a focus across the teams using peer support workers to help which has seen an improvement. Sapphire have new PSW in post who will support the team to improve feedback.

6. Community Teams Highlighted at Enhanced Support Level

Reported on by exception from a review of key activity, quality and workforce indicators.

Four teams/services have been highlighted which are particularly struggling,

- Oxon North and West AMHT
- Bucks Chiltern AMHT (East and West)
- Oxon City and NE AMHT
- District Nursing

Table 6 provides further details with the mitigations and actions being taken.

In addition the following teams/services are identified at an Early Warning level;

- Podiatry (reason: high vacancies, waits for treatment, number of complaints/concerns)
- Children's Integrated Therapies (reason: waits for treatment and number of complaints/concerns)
- Bucks Memory Clinic service (reason: high vacancies, low clinical supervision and waits for treatment)
- Bucks OA South CMHT (reason: very high vacancies and sickness for more than 2 months)
- Bucks Aylesbury CMHT (reason: high vacancies and complaints)
- Oxon South AMHT (reason: 3 serious patient self-harms and 7 complaints in 3 months, mostly in July 24)
- Oxon Perinatal service (reason: psychology staffing in the team, limited investment so not able to implement national model)
- Swindon CAMHS (reason: high vacancies, waiting times for assessment and treatment and 2 MP queries and 2 informal concerns in the last 3 months)

Waiting times

National Targets

The performance for the following services with national waiting targets are reported in the integrated performance report to the Board of Directors monthly, so are not repeated here. Services/metrics include;

- Adult community mental health teams making 2 contacts for routine referrals within 4 weeks
- All referrals to the EIS must have an attended contact within 14 days.
- Children community mental health teams making 1 contact for routine referrals within 4 weeks
- Adult mental health urgent care teams (crisis teams/SPA) having contact for very urgent referrals within 4 hours and urgent referrals within 24 hours
- Adult and children mental health psychiatric liaison teams responding to acute referrals within 1 hour
- CAMHS referrals for support with an eating disorder urgent seen within 7 days and routine within 28 days
- All ages referrals with reason of suspected autism seen within 91 days.

Data Quality

Data on patients waiting is now available in TOBI to support teams to improve the data quality. Caution needs to be used if using TOBI data alone without a check with the local team/service.

There has been significant work to improve the data quality for waits particularly for CAMHS Neuro Diversity and Adult ADHD Services in Bucks and Oxon, by the end of August 2024 the work will be completed. The same work is needed across all services to have reliable central data on number of patients waiting and length of time of waits. At the moment the focus is on waits from referral to first contact (assessment). There is scoping work to possibly use the RiO waiting list function and to expand the work to look at waiting times through the system such as waiting for a primary worker, waiting from an assessment to treatment.

The Trust's Business services team meet monthly with the children, adult and older adult mental health services to review the patients who are waiting which is driving up data quality and improving the accuracy of data available on TOBI. This work is to start in the Primary, Community and Dental services from September 2024.

Complaints

From May-July 2024 there were 33 concerns, complaints or MP queries raised relating to waiting times and access; 11 in May, 11 in June and 11 in July.

Out of the 33, most related to Bucks CAMHS Neuro Diversity pathway (n=7) and the Oxon CAMHS Neuro Diversity pathway (n=8). Demand and capacity work has been completed with a plan for a more efficient assessment model. However there are still challenges with the recruitment into psychology posts, the number of referrals continuing to grow and a lack of building space to implement the new assessment model. Internal monitoring and support is in place including; monthly performance meetings, harm minimisation group, monthly meetings with commissioners and weekly performance reports to commissioners.

The Adult ADHD services in Bucks and Oxon paused new referrals from April 2024 due to demand being greater than capacity, to enable the clinical team to work through the waiting list and reviews. Quality Impact Assessments have previously been shared with the sub-group members in relation to pausing new referrals. Rob Bale, Executive Managing Director, is overseeing the work and reviewing progress regularly. A number of issues are starting to be raised as the pause continues, for example no one is commissioned to provide annual reviews and GPs may stop prescribing without support. A harm minimisation plan is in place and there are ongoing discussions with ICB about the model for the service going forward.

Services highlighted with waiting times/delays in response

Services are working incredibly hard however for a mixture of challenges, which vary by service, the following services have higher waiting times as unable to meet demand. The information is based on patients recorded as currently waiting who have breached any national/local targets. Note the data quality issues mentioned above which are still being worked through.

Each service is locally managing their waiting list, often manually and regularly reviewing those patients waiting and re-prioritising by patient need, as well as putting mitigating actions in place to reduce risks and harm to patients.

- Children's integrated therapy service – speech and language, physiotherapy and OT
- Podiatry – particularly struggling with follow up appointments within expected timescales
- Bladder and bowel children's and adults
- Nutrition and dietetics
- The District Nursing service are delaying about 350 visits per day due to a lack of capacity, there is on average a 28%+ gap between capacity and demand for the service, and referrals are increasing.
- Dentistry affecting both children and special care adults needing general anaesthetic procedures due to limited access to theatre space. The current waiting period for children is 15 months and there are 232 children waiting. Some additional weekend theatre sessions will be available from Sept 2024 which will help to reduce the waiting list and time.
- Oxon CAMHS Neuro Diversity (manual data shows 3526 patients waiting, mean time 81 weeks. High number of complaints received about the waiting time)
- Oxon Adult ADHD Services (manual data shows 2567 patients waiting, mean wait 84 weeks)
- Oxon Memory clinic services
- Oxon adult community eating disorder service
- Bucks CAMHS Neuro Diversity (manual data shows 3352 patients waiting, mean time 81 weeks. High number of complaints received about the waiting time)
- Bucks Adult ADHD Services (manual data shows 1194 patients waiting, mean wait 60 weeks)
- Bucks Adult Autism (manual data shows 454 patients waiting, mean wait 66 weeks)
- Bucks Memory clinic services
- Oxon and Bucks Complex Needs Service, although some of the waits relate to the service model based on group treatment, resulting in a delay in assessment and treatment.

Community teams identified as needing Enhanced Support

Table 6.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
Oxon North and West AMHT	No	• Vacancies high 24.8% and similar to last month. Higher in the Witney team for clinical staff at about 56%. Risk with reliance on agency staff who can leave with no notice leaving patients unallocated and pressures on existing staff. Risk in relation to delays in treatment. • Sickness in July 24 was at 12.9%, compared to 9.3% the previous month. • Clinical supervision in July 24 at 54% • Patient harm; 3 serious self-harm incidents and 2 suspected suicides in the last 3 months May-July 24. • 2 PSIRP cases (identified May and July 24) in relation to involving families and delay in treatment. • 4 complaints/concerns raised between May-July 24.	No real changes in recruitment, one post offered/adverts currently out. Recent loss of agency staff unexpectedly has further impacted on the team meaning caseloads need reallocating to existing staff who already have high caseloads. Seeking CVs and interviews via ID medical to support agency recruitment. Reviewing caseloads within MDT. QI work due to start to focus on review of FACT board model. Support effective allocation. Working with HR re sickness monitoring for some staff. Clinical supervision has improved in the last few weeks to 78%, main issue was staff not recording, current missing supervisions are due to annual leave and sickness. Incidents and complaints discussed in leadership meetings, and action shared. Ongoing service development work within one part of the team (Witney) due to some challenges within the MDT and cultural dynamics. This is the team that is holding more vacant posts and loss of agency workers. SLT team members are joining the weekly local leadership team meetings to offer support.
Bucks Chiltern AMHT (East and West)	No	• Vacancies high, East 47.7% and West 35.1%. • Sickness high in July 2024, 40.3% • Patient harm: 2 suspected suicides. • 2 PSIRP cases identified in May 24 relating to patients being missed/lost in handover/follow up between teams. • 4 complaints/concerns raised between May-July 24.	Vacancies still continue to be a struggle but there has been some good engagement from recruitment events with some new starters in the pipeline and conversion of long line agency workers into substantive posts. Early stages with teams looking at culture and the principle of no wrong door, Service Managers engaged in leading a joint way forward across care pathways.
Oxon City and NE AMHT	Yes	• The team is made up of 3 sub-teams, there are different challenges in each team. Overall the teams have high vacancies (34.6% July 24 similar to previous months) combined with increased demand particularly	Deep dive presentation to Quality Committee members in July 2024.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
		for urgent referrals. Risk of patients being missed/not contacted regularly and delayed treatment. • Patient harm; 1 serious self-harm incident and 2 suspected suicides in the last 3 months May-July 24. • 7 complaints/informal concerns in 3 month period May-July 2024 re: discharge, communication and treatment.	Improvement in recruitment and a focus on retention. Reducing agency employments, some agency staff moving into substantive posts. SLT members to continue to attend leadership team meeting to monitor actions already identified and to support sustaining improvements, including an earlier response to issues as identified. The team now needs time to embed the changes, new staff starting, team away day planned. Head of organisational development and team are keen to support team development. Exercise underway to process map referral/triage processes with support from the OHI team.
District Nursing	Yes	• Growing demand is exceeding capacity and current available resources. National Community Nursing Safe Staffing Tool results for 2023 demonstrates an average 28% gap (60+ WTE staff) in available capacity vs demand. On average 750-800 visits are completed each day, however 350+ visits are being delayed due to a lack of capacity. The service carries a caseload of around 7,000 patients. • Patient harm: 23 moderate and above incidents in the last 3 months May-July 24, most relate to pressure ulcers developed in service. All pressure ulcers are reviewed to understand if there were any lapse in care provided. 1 PSIRP case was identified in the last 3 months related to a delay in treatment. • 12 complaints/concerns raised between May-July 24 (5 received in June and July), mostly about communication/information and care provided.	Detailed presentation to the Executive Team in June 2024. Short term plan us to focus on managing a safe service and supporting the workforce. A clinical prioritisation framework is in place to prioritise care. Series of QI projects to improve capacity and manage demand, including same day urgent response, centralisation of the duty desk, anti-coagulation caseload, ambulatory clinics and insulin delegation. As well as innovations to support retention (career progression framework) and staff wellbeing. Monthly meetings in place with BOB ICB commissioner/GP leads to monitor situation. Longer term plans are also underway to support managing the significant gap between capacity and demand.

For Information

Finance Report
August 2024 (Month 5), FY25
Report to Board of Directors

Contents

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 £2.2m deficit – on plan
- Forecast £2.7m deficit – on plan

Capital Expenditure
- £1.6m underspend YTD
- £2.5m forecast overspend

Risks £7.1m
Opportunities £16.1m
Net £9.0m upside

Cash
- Actual £87.5m, £3.6m behind plan

Key messages:

1. Financial risk remains around the PFI exit payment until a final agreement is reached, with a likelihood any impact crystalises in capital rather than impacting the Trust revenue position. The PFI provider has approached RICS (Royal Institute of Chartered Surveyors) to appoint an independent valuation arbitrator, as per the lease terms. It will be several months for this process to run its course.

2. Capital is forecasting an overspend of £2.5m. To address this, the Digital team are seeking additional funding, and the Estates team are stopping or slowing down projects to bring the spend back into balance. Finance are also considering whether any Digital spend budgeted as capital can be covered in the revenue position.

3. We are reporting both year to date and full year forecast revenue positions more or less to plan. There are no significant risks to this and more opportunities than risks.

1. Income Statement

INCOME STATEMENT	Month 5				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	44.4	43.4	-1.0	-2.3%	217.0	213.6	-3.4	-1.5%	521.6	514.2	-7.4	-1%
Other Operating Income	10.2	10.8	0.6	6.1%	49.2	55.7	6.5	13.3%	125.0	134.6	9.6	8%
Operating Income, Total	**54.6**	**54.2**	**-0.4**	**-0.7%**	**266.1**	**269.3**	**3.2**	**1.2%**	**646.6**	**648.8**	**2.1**	**0%**
Employee Benefit Expenses (Pay)	34.0	31.0	3.1	9.0%	161.4	155.5	5.9	3.6%	386.1	382.0	4.1	1%
Other Operating Expenses	19.4	22.4	-3.0	-15.5%	98.9	110.0	-11.2	-11.3%	246.5	255.5	-9.0	-4%
Operating Expenses, Total	**53.4**	**53.4**	**0.1**	**0.1%**	**260.3**	**265.6**	**-5.3**	**2.0%**	**632.7**	**637.6**	**-4.9**	**-1%**
EBITDA	**1.2**	**0.9**	**-0.3**	**-28.7%**	**5.9**	**3.8**	**-2.1**	**35.8%**	**13.9**	**11.2**	**-2.7**	
Financing costs	1.6	1.2	0.4	25.7%	7.9	5.7	2.2	38.0%	16.6	13.5	3.1	18%
Surplus/ (Deficit)	**-0.4**	**-0.3**	**0.1**	**-16.2%**	**-2.0**	**-2.0**	**0.1**	**3.7%**	**-2.6**	**-2.3**	**0.3**	
Adjustments	0.0	0.0	0.0	0.0%	-0.2	-0.2	0.0	0.0%	-0.1	-0.1	0.0	0.0
Adjusted Forecast Surplus/ (Deficit)	**-0.4**	**-0.4**	**0.1**	**-14.7%**	**-2.2**	**-2.2**	**0.0**	**1.2%**	**-2.7**	**-2.4**	**0.3**	
Amounts held for unknown risks										-0.3	-0.3	
Forecast Surplus/ (Deficit)									**-2.7**	**-2.7**	**0.0**	

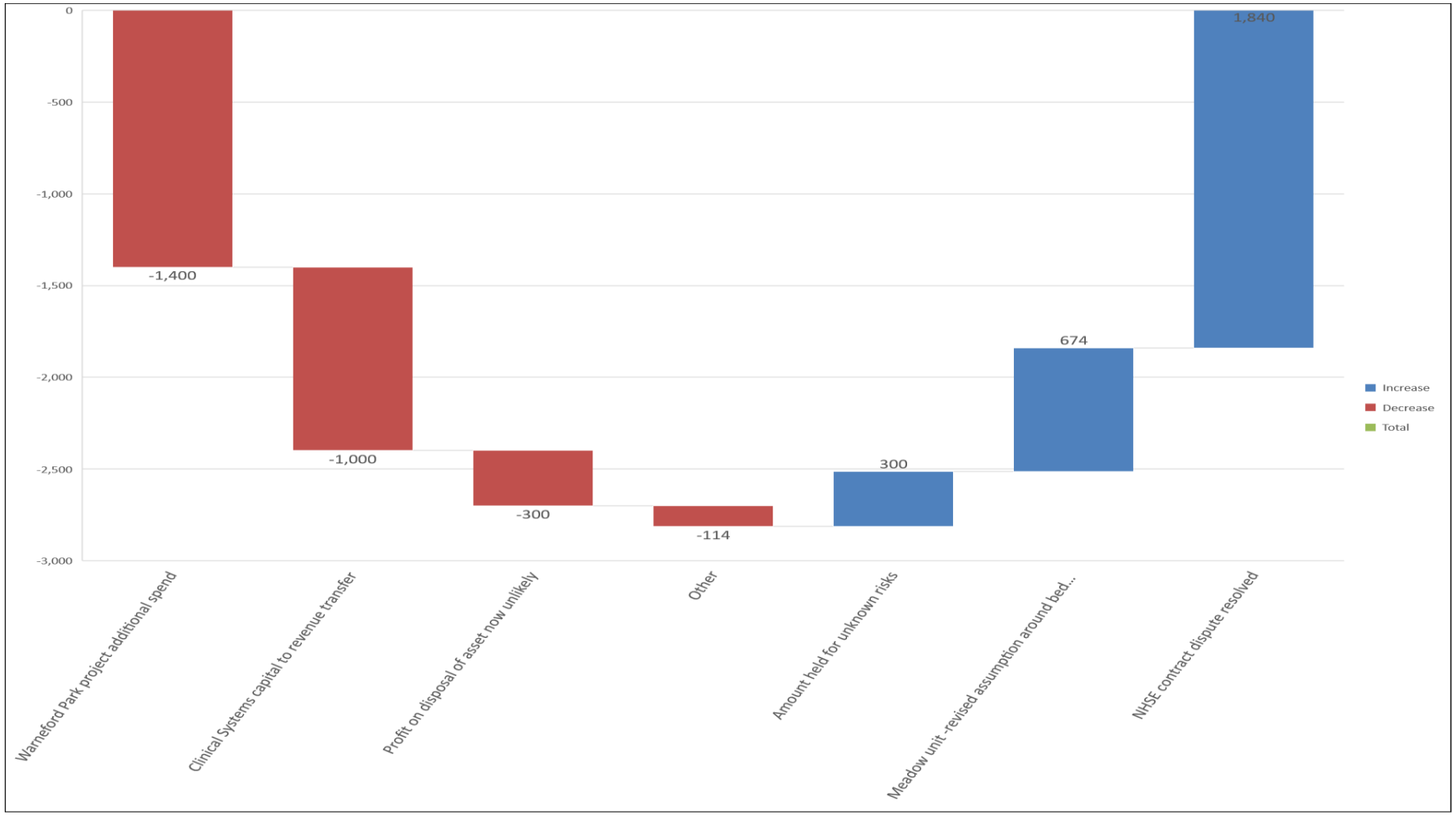
The YTD position at month 5 is a deficit of **£2.2m** which is on plan. EBITDA is £2.1m adverse to plan, offset with a favourable variance of **£2.2m** on Financing cost, due to higher than planned interest receivable (**£0.3m**) and lower than planned PFI interest costs following the decision to change the accounting treatment for the PFI exit settlement from a prior period adjustment to a provision (**£1.1m**) and lower than planned depreciation costs (**£0.8m**).

The YTD favourable variance on income (**£3.2m**) is driven by **£4.7m** higher than planned sales in Oxford Pharmacy Store. This is offset by a **£1.3m** adverse variance on Provider Collaboratives where income has been matched to spend and a net **£0.2m** adverse across other areas.

The YTD adverse variance on expenditure (**£5.3m**) is due to higher cost of sales in Oxford Pharmacy Store (**£4.8m**), an overspend on mental health out of area placements (**£1.2m**) and an overspend on Learning Disabilities out of area placements (**£0.7m**). These are offset with a favourable variance on Provider Collaboratives (**£1.3m**) and a net favourable variance of **£0.2m** across other areas.

The forecast is a **£2.7m** deficit which is on plan. This includes **£0.3m** on top of the base forecast held for unknown risks.

2. Forecast movement from previous month



3. Forecast Risks & Opportunities

Risks	£'000	Likelihood
Audit/Balance Sheet year-end risks	3000	Medium
Increase in agency	2000	Medium
Mental Health OAPs	1000	Medium
Meadow Unit income	600	Medium
Learning Disabilities OAPs increase	500	Medium
	7,100	

Opportunities	£'000	Likelihood
Provider Collaborative underperformance gain share	3,750	Medium
Audit/Balance Sheet year-end opportunities	3,000	Medium
Underspend on SDF investment	1,000	Medium
Modern Equivalent Asset Valuation	1,000	Medium
VAT on IT licenses	1,000	Medium
Additional income from BOB ICB	731	Medium
Extension of Forensic EPCs	596	Medium
Further agency reductions	460	Medium
Discharge of Learning Disabilities OAPs	430	Medium
Release of bad debt provision	300	Medium
Meadow Unit Income	300	Medium
Income in Oxford Institute of Clinical Psychology Training	200	Medium
Release of Wellbeing Day provision	1,169	Low
Release ED NHSE loan	850	Low
Review of old accruals	700	Low
Discharge of Learning Disabilities OAPs	341	Low
Revenue element of sale of Shrublands	300	Low
	16,127	

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

There are **£7.1m** of risks and **£16.1m** of opportunities to the forecast. This gives a forecast range of between **£16.1m** better than plan and **£7.1m** worse than plan.

There are currently no risks and opportunities with a high likelihood.

£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	Full Year	Full Year	Forecast Outturn
Upside Forecast	2,700	18,827	16,127
Downside Forecast	2,700	-4,400	-7,100

Forecast range - high likelihood risks and opportunities £'000	Full Year	Full Year	Forecast Outturn
Upside Forecast	2,700	2,700	-0
Downside Forecast	2,700	2,700	-0

4. Capital Investment Programme

Project Names	(B) Latest Budget £,0	(C) Profiled Budget £,0	(D) Actual Expenditure £,0	(C-D) Variance £,0	FY25 Outturn To Date (E) System Commt's £,0	(F=D+E) Actual Plus Commt's £,0	(B-F) Variance £,0	FY25 Estimated Outturn (G) Estimated Forecast £,0	(B-G) Variance £,0	
Estates - Projects Carried Forward	2,043	674	765	(91)	404	1,169	875	1,894	149	☺
Estates - Transformational Projects	5,282	1,825	288	1,537	631	919	4,363	6,493	(1,211)	☹
Estates - Operational	1,975	131	56	75	782	838	1,137	1,864	111	☺
Oxford Pharmacy	117	49	-	49	-	-	117	117	-	
Grand Total - All Estates	9,418	2,679	1,109	1,570	1,745	2,854	6,564	10,297	(880)	☹
IT Capital	227	95	-	95	365	365	(138)	299	(72)	☹
IM&T Clinical Systems	2,242	790	853	(63)	78	930	1,312	3,022	(780)	☹
Grand Total - IM&T	2,469	884	853	31	443	1,296	1,173	3,321	(852)	☹
PFI	-	-	-	-	-	-	-	-	-	
Grand Total	11,887	3,563	1,962	1,601	2,260	4,222	7,666	13,689	(1,802)	☹

Funding Sources	Latest Funding
Total Funding Available	11,195

Net Funding Surplus /(Deficit) vs Budget	(692)	☹
Net Funding Surplus /(Deficit) vs Est. Outturn	(2,494)	☹

The Trust spent **£1,962k** (£1,623k M1-4) on its core capital programme to the end of August, **£1,601k** behind plan.

£1,398k of leased assets were capitalised as 'Right of Use Assets' in the first 5 months of FY25.

The capital plan is forecasting a **£1.8m** overspend against budget and **£2.5m** overspend against available funding.

The Estates team review of this year's capital programme and priorities has already reduced the net forecast outturn by **£1.4m** from M3, and this includes the **£1.6m** forecast overspend against the Jordan Hill project.

The Frontline digitalisation funding shortfall and potential PFI exit payment also present a risk to the capital forecast.

5. PFI Exit Settlement Risk

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

Valuation work has been completed and shared by both parties and the PFI provider has approached RICS (Royal Institute of Chartered Surveyors) to appoint an arbitrator.

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.

6. Directorate Financial Performance Summary

	Month 5				Year-to-date				Forecast			
	Plan	Actual	Variance	Variance	Plan	Actual	Variance	Variance	Plan	Forecast	Variance	Variance
Directorate	£m	£m	£m	%	£m	£m	£m	%	£m	£m	£m	%
Oxfordshire & BSW Mental Health	10.4	10.4	0.0	0.0%	49.9	49.7	0.2	0.0%	120.6	121.5	-1.0	-1%
Buckinghamshire Mental Health	4.8	4.6	0.2	4.6%	24.0	23.3	0.7	3.0%	58.1	57.9	0.2	0%
Forensic Mental Health	3.0	2.6	0.4	13.0%	13.4	13.6	-0.3	-1.9%	32.1	33.1	-1.1	-3%
Learning Disabilities	0.5	0.5	0.0	-6.9%	2.4	2.9	-0.5	-20.8%	5.8	6.5	-0.7	-12%
Provider Collaboratives	-1.1	-1.1	0.0	0.0%	-4.1	-4.1	0.0	0.0%	-9.8	-9.8	0.0	0%
MH Directorates Total	**17.5**	**16.9**	**0.5**	**3.1%**	**85.5**	**85.4**	**0.1**	**0.1%**	**206.7**	**209.2**	**-2.5**	**-1%**
Primary Community & Dental	8.5	8.2	0.2	2.6%	41.1	40.7	0.4	0.9%	97.0	98.6	-1.6	-2%
Corporate	5.6	5.8	-0.2	-3.1%	28.4	28.5	-0.1	-0.3%	68.1	71.7	-3.6	-5%
Oxford Pharmacy Store	-0.1	-0.1	0.0	-14.3%	-0.2	-0.4	0.2	-71.1%	-1.0	-1.0	0.0	0%
Research & Development	0.1	0.0	0.0	87.6%	0.3	0.0	0.2	96.6%	0.7	0.4	0.3	42%
Covid-19 Costs	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0	
Reserves	1.4	3.3	-1.9	-129.8%	5.8	9.0	-3.2	-55.1%	14.7	10.8	3.9	27%
Block Income	-34.2	-35.1	0.9	-2.6%	-166.7	-167.0	0.3	-0.2%	-400.1	-400.9	0.7	0%
EBITDA	**-1.2**	**-0.9**	**-0.3**		**-5.8**	**-3.8**	**-2.1**		**-14.0**	**-11.2**	**-2.8**	
Financing Costs	1.6	1.1	0.4	28.2%	7.9	5.7	2.2	27.6%	16.6	13.5	3.1	18%
Adjustments	0.0	0.0	0.0		0.2	0.1	0.1		0.1	0.1	0.0	
Adjusted (Surplus)/Deficit	**0.4**	**0.3**	**0.1**		**2.2**	**2.0**	**0.1**		**2.7**	**2.4**	**0.3**	

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.

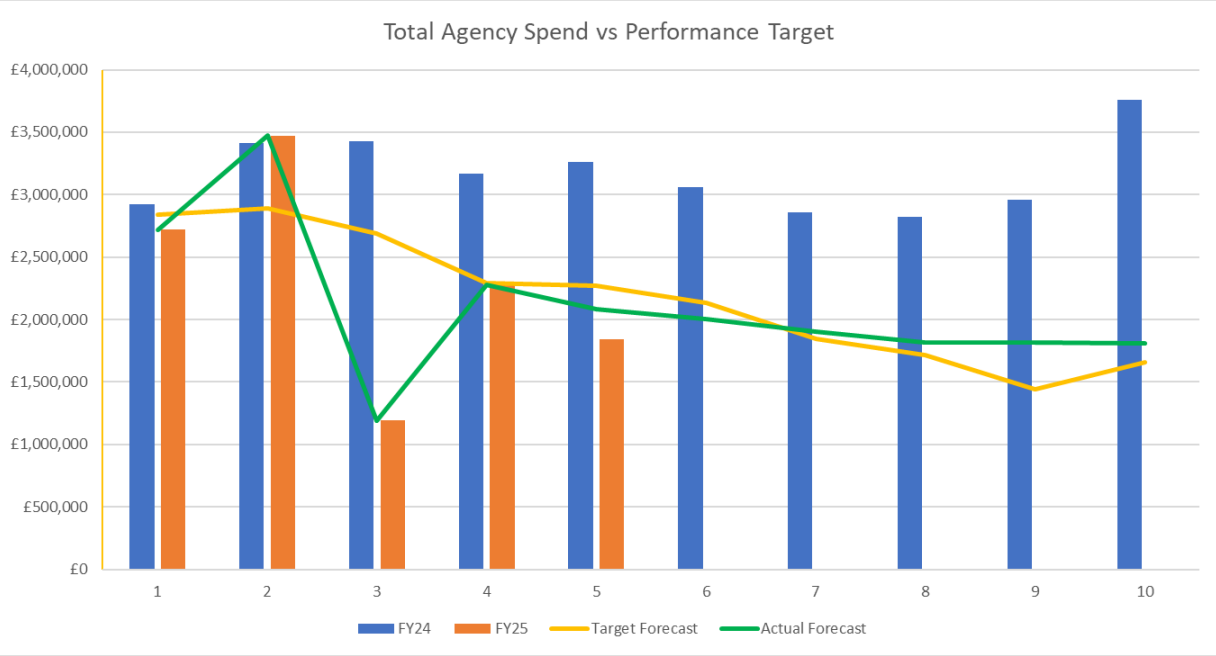
7. Provider Collaboratives Financial Performance Summary

	Month 5			Year-to-date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Secure	7.9	15.7	(7.8)	39.7	39.2	0.5	95.2	94.1	1.1
CAMHS	2.4	4.4	(2.0)	12.1	11.0	1.1	29.0	26.3	2.6
Adult AED	0.8	1.6	0.0	3.9	3.9	0.0	9.3	9.3	0.0
Provider Collaboratives Total	**11.1**	**21.6**	**(9.7)**	**55.6**	**54.0**	**1.6**	**133.4**	**129.6**	**3.8**

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) position is **£1.6m** favourable to plan YTD and forecast to be **£3.8m** favourable to plan. It is reported as breakeven in the Trust overall position in line with the principles of the PC to reinvest savings into services.

8. Agency Analysis



	FY24 April - August	FY25 April - August	Change from FY24
Medical	£6,444,629	£5,191,435	-£1,253,194
Nursing	£8,320,296	£5,537,331	-£2,782,965
AHP/HSS	£1,061,056	£630,237	-£430,819
Admin & Clerical	£338,918	£68,158	-£270,760
Estates	£38,487	£22,779	-£15,708
Total	**£16,203,386**	**£11,449,940**	**-£4,753,446**
FY24 VC's & FY25 Retros	£13,909	£100,285	£86,376
Prior year/Finance adjustments	-£25,029	£0	£25,029
Total Reported	**£16,192,267**	**£11,550,226**	**-£4,642,041**

YTD Target Forecast vs Actual Spend M5			
Staffing Type	**FY25 Target Apr- Aug**	**FY25 Actual Apr - Aug**	**FY25 Variance Apr - Aug**
Agenda for Change	£7,804,545	£6,358,790	£1,445,755
Medical	£5,174,002	£5,191,436	-£17,434
Total	**£12,978,547**	**£11,550,226**	**£1,428,321**

In Month 5 temporary staffing was **15%** of the Trust total pay bill with Agency at **6%** and Bank at **9%**.

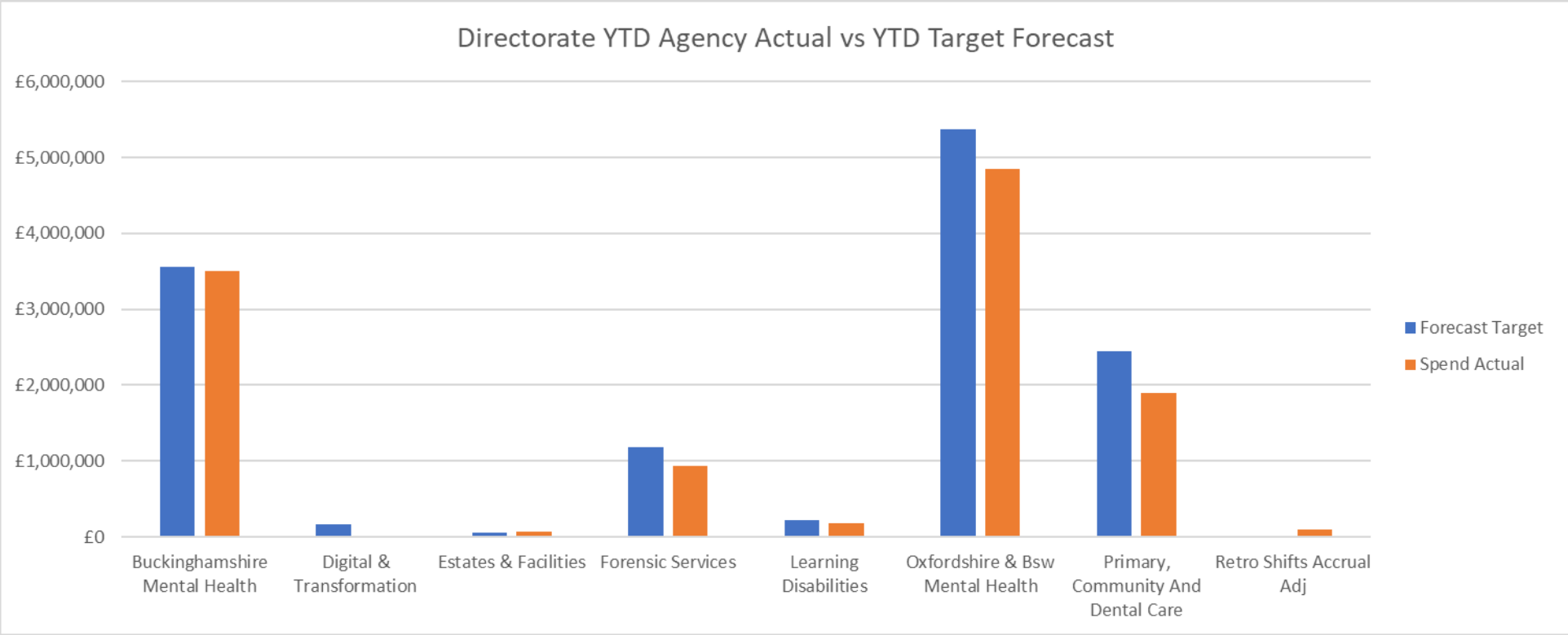
Included in the month 2 figures is **£1m** of agency cost related to FY24 which was reversed in month 3 as the FY24 accounts have been amended to reflect this.

The Trust has submitted a plan to BOB ICB and NHS England to spend a maximum of **£25.4m** on Agency in FY25.

Year to date agency spend, is **£1.4m** better than plan and **£4.6m** better than the same period in FY24.

The total Trust forecast spend is **£25.3m** which is **£0.1m** better than the target.

Agency Analysis Continued



Directorates have been allocated targets to reduce agency spend in line with the submitted plan of **£25.4m.**

An additional **£0.1m** was accrued in month 5 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 5.

Directorate targets were revised in month 4 to reflect all submitted plans for Agency WTE reductions in FY25.

9. 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 FY25 contract requirements (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	371	371	891
	Non-Pay - Estates and Premises transformation	770	770	1,848
	Non-Pay - Other	15	15	36
	Pay - Agency - reduce the reliance on agency	2,078	2,078	5,068
	Non-Pay - Service re-design	4,315	4,315	10,356
	Pay - Establishment reviews	5,885	5,885	14,124
Total Non-Recurrent		**13,434**	**13,434**	**32,323**
Non-Recurrent Total	Income - Non-Patient Care	295	295	708
	Non-Pay - Corporate services transformation	35	35	84
	Non-Pay - Digital transformation	404	404	969
	Non-Pay - Estates and Premises transformation	210	210	504
	Non-Pay - Fleet optimisation	5	5	12
	Non-Pay - Service re-design	95	95	228
	Pay - Establishment reviews	855	855	2,052
	Pay - Service re-design	1,345	1,345	3,372
Total Recurrent		**3,244**	**3,244**	**7,929**
Grand Total		**16,678**	**16,678**	**40,252**

Cost Improvement Programme (CIP) Cont.

Internally, as well as the **£6.2m** FY25 contract requirement, 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**.

£6m 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. The remaining balance for the year is being met through non recurrent vacancies while recurrent plans are being developed.

There is a risk of **£1m** on the delivery of CIP target in the Primary, Community & Dental directorate primarily due to delays in the planned CIP schemes. The directorate is trying to mitigate this in year as much as possible.

£'000							
Directorate	**CIP Target**	**Fully Developed**	**Plans In Progress**	**High Risk**	**No Plans**	**Expected Slippage**	**Total**
Primary Community & Dental	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%

10. Statement of Financial Position

Statement of Financial Position at 31 August 2024

31 Mar 24 £'000		31 Jul 24 £'000	31 Aug 24 £'000	Movement In-Month £'000	Movement YTD £'000	
	Non-current assets					
7,013	Intangible Assets	7,070	7,063	(7)	50	
216,328	Property, plant and equipment	214,940	214,507	(433)	(1,821)	
33,133	Finance Leases	32,810	32,373	(437)	(760)	
1,125	Investments	1,125	1,125	0	0	
412	Trade and other receivables	412	412	0	0	
651	Other Assets	653	653	0	2	
258,662	Total non-current assets	257,011	256,134	(877)	(2,529)	①
	Current Assets					
3,184	Inventories	5,159	4,979	(181)	1,794	②
21,722	Trade and other receivables	24,413	23,149	(1,265)	1,427	③
200	Non-current assets held for sale	200	200	0	0	
85,628	Cash and cash equivalents	90,598	87,534	(3,064)	1,906	④
110,734	Total current assets	120,371	115,861	(4,509)	5,127	
	Current Liabilities					
(77,857)	Trade and other payables	(82,024)	(77,911)	4,113	(54)	⑤
(2,614)	Borrowings	(2,499)	(2,453)	46	161	
(4,019)	Lease Liabilities	(4,061)	(4,061)	0	(42)	
(16,518)	Provisions	(16,368)	(16,358)	11	160	
(24,222)	Deferred income	(30,468)	(30,064)	404	(5,842)	⑥
(125,230)	Total Current Liabilities	(135,420)	(130,847)	4,573	(5,617)	
	Non-current Liabilities					
(12,049)	Borrowings	(12,049)	(12,049)	0	(0)	
(21,814)	Lease Liabilities	(21,167)	(20,688)	479	1,126	⑦
(6,545)	Provisions	(6,604)	(6,604)	0	(59)	
(1,500)	Other Liabilities	(1,517)	(1,500)	17	0	
(41,908)	Total non-current liabilities	(41,337)	(40,841)	496	1,067	
202,258	Total assets employed	200,625	200,308	(318)	(1,951)	
	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	
4,438	Income & expenditure reserve	2,803	2,486	(318)	(1,952)	⑧
202,258	Total taxpayers' equity	200,625	200,308	(318)	(1,951)	

1. Non-current assets have decreased by £2.5m YTD. This is represented by capital additions of £3.4m (including £1.4m of leased assets – mainly Unipart) less cumulative depreciation of £5.9m
2. Inventories have increased by £1.8m YTD and decreased by £0.2m in-month. The initial increase was due to a new infusion drug line being sold by OPS following a distribution agreement with NHSE/Sandoz. Inventory levels of c£5m expected to be steady state going forward.
3. Receivables have increased by £1.4m YTD and decreased by £1.3m in-month. Most of the increase in year is due to an increase in prepayments of £3.1m less a net reduction in outstanding debt & accrued income of (£1.5m) . The in-month decrease is largely driven by a net reduction in outstanding debt and accrued income.
4. The cash balance has increased by £1.9m over the year and decreased by £1.9m in-month. The increase in-year is largely driven by deferred income (£5.8m) and offset by a reduction of (£3.8m) in working capital balances and lease liabilities.
5. Trade and other payables have decreased by £4.1m in year. This is due to a net decrease in trade payables and accrued expenditure. This swing in accruals and payables is not an untypical monthly movement. This is reflected in a decrease in cash in-month as well.
6. Deferred income has increased by £5.8m in year and decreased marginally in month. Most of the increase can be attributed to the Provider Collaborative £1.2m, SDF income £0.9m, Learning Disability & Autism £1.8m, NHSPS £1.0m and other £0.9m
7. Non-current lease liabilities have decreased in year and in-month. YTD capital repayments against existing and new leases of £2.5m have been offset by new leases totalling (£1.4m).
8. The £1.9m downward movement in year reflects the Trust's reported deficit in year.

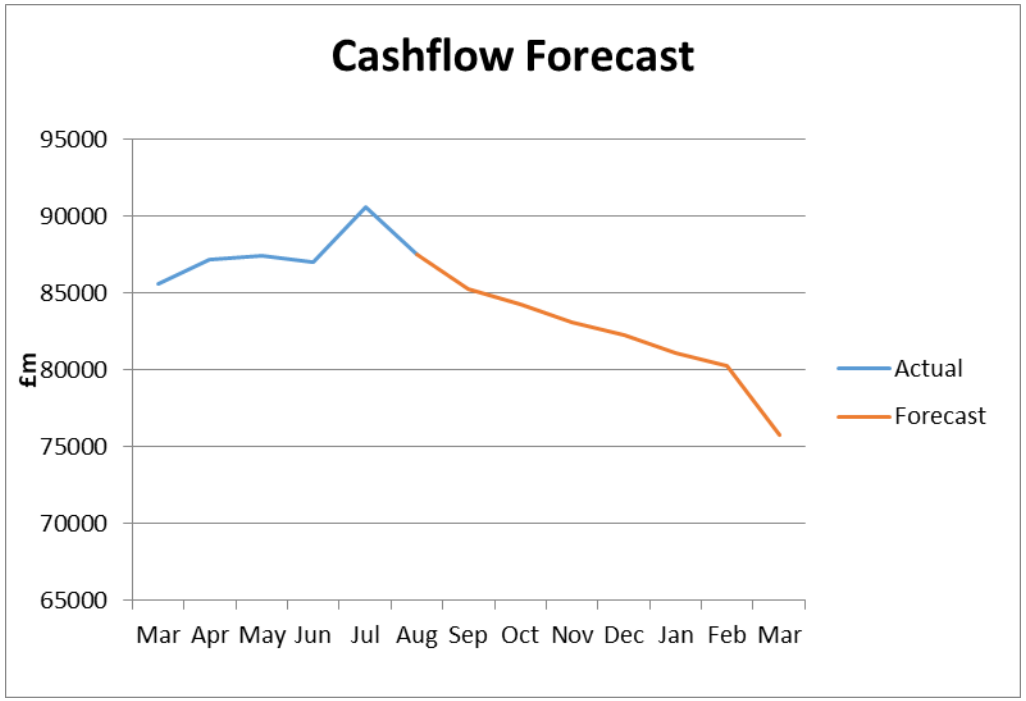
11. Cash Flow

STATEMENT OF YEAR TO DATE CASH FLOWS

	Actual £'000	Plan £'000	Variance £'000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations	(2,135)	(1,962)	(173)
Operating surplus/(deficit)	**(2,135)**	**(1,962)**	**(173)**
Non-cash income and expense:			
Depreciation and amortisation	5,902	6,373	(471)
(Increase)/Decrease in Trade and Other Receivables	(783)	0	(783)
(Increase)/Decrease in Inventories	(1,794)	(2,415)	621
Increase/(Decrease) in Trade and Other Payables	1,231	11,204	(9,973)
Increase/(Decrease) in Deferred Income	5,842	0	5,842
Increase/(Decrease) in Provisions	(113)	(31)	(82)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**8,150**	**13,169**	**(5,019)**
Cash flows from investing activities			
Interest received	2,390	2,199	191
Purchase of Non Current Assets	(5,744)	(5,948)	204
Net cash generated from/(used in) investing activities	**(3,354)**	**(3,749)**	**395**
Cash flows from financing activities			
Capital element of lease rental payments	(2,483)	(4,085)	1,602
Capital element of Private Finance Initiative Obligations	(201)	0	(201)
Interest paid	0	(226)	226
Interest element on leases	(192)	(105)	(87)
Interest element of Private Finance Initiative obligations	(14)	(15)	1
Net cash generated from/(used in) financing activities	**(2,890)**	**(4,431)**	**1,541**
Increase/(decrease) in cash and cash equivalents	1,906	4,989	(3,083)
Cash and Cash equivalents at 1st April 2024	**85,628**	**86,148**	**(520)**
Cash and Cash equivalents at 30 August 2024	**87,534**	**91,137**	**(3,603)**

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 August was **£87.5.m** (£90.6m in July).
- The cash forecast is for £75.8m at the 31 March.



12. Working Capital Indicators

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	13	
Debtors % > 90 days	5.0%	13.2%	
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	80.4%	
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	91.1%	
Cash (£m) - per year-end forecast	75.8	87.5	

Summary Notes

- Debtor days ahead of target.
- Debtors % over 90 days is below target, due to unpaid invoices. These are mainly various ICB's £268k, Salary overpayments £312k, Central & NW London £117k, NHSE £79k, Connect Health £112k, University of Oxford £107k and other £192k.
- NHS BPPC (Better Payments Practice Code) below target.- 2 Southern Health invoices for £4.4m not paid in time. .
- Non-NHS BPPC (Better Payments Practice Code) marginally below target.
- Cash better than year-end target.

PUBLIC

Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(a))

Board of Directors

25 September 2024

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

Executive Summary

The agenda of the Committee's most recent meeting - on September 3 of this year - is available for information in the Reading Room.

From the Committee's scrutiny of 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:

- Under "any other business", the committee discussed the potential implications of NHS England's recent decision to move the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board (ICB) into its "Investigation & Intervention" regime.
- The committee considered the merits of forging stronger relationships across the assurance arrangements of local provider trusts and with the ICB's audit committee. It concluded this matter would merit a broader board discussion.

To Advise (to monitor)

The Board is asked to note that:

- The Trust's internal auditors (KPMG) alerted the committee to some slippage in the timing of planned internal audit reviews over the summer.

After discussion and questioning, the committee was re-assured by the auditors that:

- The resources required to ensure the planned reviews are carried out before the year end will be committed to achieve this; and that
- The change in the timing of individual reviews will not have any "knock on" consequences for achievement of the overall audit plan for 2023-24 *[NB - the committee noted that there will be need to thoughtfully phase the demands placed on some Trust staff who will be required to provide support to more than one audit review]*; and that
- This initial slippage will not adversely impact on the reliance external audit is able to place on the work of internal audit at the year end, when it carries out its work.

The committee has asked the CFO and audit team to keep committee members briefed on the progress being made to bring the plan "back on track" in between its meetings.

- After concluding its formal business, the committee moved into a workshop session to discuss the contents of the recently published and updated HFMA NHS Audit Committee Handbook. The session went very well and surfaced some important areas for further discussion and work. A brief note of these outputs is to be prepared and shared with board members in the next few weeks.

For Assurance (to note)

The Board is asked to note the following:

- The Committee received and noted the final version of the External Auditor's Annual Report for 2023/24, which included the auditor's commentary on Value for Money arrangements[1]. The contents of the report were consistent with the pre-final draft which had been discussed at the Committee's previous meeting and shared with the board with the draft accounts on June 26. The assessment of the Trust's Value for Money arrangements did not raise any matters of concern.
- The 2023-24 accounts closure process and year-end audit are considered to have gone well by all parties but, as in past years, will be reviewed by the

[1] Which had not been available at the time the Audit Committee and Trust reviewed the Annual Accounts and Annual Report

Trust's finance and the external audit staff to identify any further scope for improvement. The outcome of this review is to be brought to the committee's December meeting.

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: Digital, Data & Technology; 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; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Business Continuity and Emergency Planning; Environmental Impact; and Major Projects.

PUBLIC

Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(a))

Board of Directors
25 September 2024

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

Executive Summary
The Charity Committee met on 4 September 2024 and considered the attached agenda.

For Alert (may require discussion)

- Having considered the More Report on future fundraising by the Charity (which included a recognition of substantial improvements in the Charity and its management in recent years), the Committee recognised the potential to expand substantially the money raised for specific projects as well as for the Warneford Project. The Committee recommended that fundraising efforts be substantially increased. The Committee also backed the Report's conclusion that, in order to realise these ambitions, further investment in staffing would be necessary in the form of a Senior Development Executive. The Committee recognized that senior management commitment would also be required and that the Trust Board should be advised of its recommendations. The Committee therefore agreed to engage in dialogue with senior management and the Trust Board on these matters.

To Advise (to monitor)
The Committee wish to advise the Board that:

- The annual impact report and annual financial report were presented in draft form for approval.
- The total income for the year increased by £46,000 to £345,000. The total expenditure for the year April 2023 – March 2024 reduced by £28,000 to £524,000. It was noted that expenditure was still significantly higher than income. However, the investment portfolio performance improved over the course of the year, compared to the significant loss experienced in the previous financial year.
- The Committee approved, with minor amendments (including the insertion of a statement indicating that the Charity is not content with annual significant net decreases in its assets and is seeking to improve its financial position) the draft impact and financial reports.
- After scrutiny by the external auditors the reports will then return to the Charity Committee at its next meeting of the 4th of December for a final sign off. After they will go to the Corporate Trustee (i.e. the Trust Board) who are meeting mid-December The reports will then be submitted to the Charity Commission, which has a deadline of 31st January 2025.
- The Committee noted the management accounts for April, May, and June 2024 which showed a modest surplus of income over expenditure albeit a decrease in the total funds available to the Charity. Various improvements in reporting are in train.
- With regard to investment options, the Committee agreed - having decided that a deposit account approach was preferable to the current investment account - that all of the Charity's money and investments be transferred to a BankLine account, which would minimize risk, save the current cost of investment advisers, provide unlimited protection, yield a good interest rate and allow flexible spending. The Charity will continue to review all potential providers.
- The Committee noted significant progress in relation to a number of the KPIs – concerning engagement and involvement, for example - of the agreed Charity Strategy for the year.
- The Committee noted a continuing flow of grant requests and decisions. The Charity has also been successful in some of its own applications for grants.

For Assurance (to note)
The Committee wish to assure the Board that the Committee continues to take seriously the need to improve financial performance.

Recommendation
The Board is asked to note and discuss as it sees appropriate. The Board may also wish to take a view, perhaps in principle, on the recommendations – as commended by the Charity Committee – of the More Report.

Author and Title: Rick Trainor
Chair, Charity Committee

Meeting of the Oxford Health Charity Committee – Governance

Wednesday 4th September 2024 1.30pm – 2.45pm via. Microsoft Teams

Apologies to Charlotte Evans (charlotte.evans1@oxfordhealth.nhs.uk)

AGENDA

	Agenda Item	Lead	Indicative Time
1	**Welcome and apologies for absence**	RT	1.30pm
2	**Declarations of interest/related party transactions**	RT	1.35pm
3	**Minutes of the Meeting on 1st May 2024** (1) **and Action Updates** (2)	RT *CCG 003i_24 & CCG 003ii_24*	1.40pm
4	**Annual Impact Report (draft) and Annual Financial Report (draft)**	JP/MW *CCG 004i_24, CCG 004ii_24 & CCG 004iii_24*	1.50pm
5	**Financial Management Accounts**	MW *CCG 005_24*	2pm
6	**Future Investment Support**	MW *CCG 006_24*	2.10pm
7	**Legacies and Inactive Funds**	JP *CCG 007_24*	2.20pm
8	**More Partnership Report**	JP *CCG 008i_24 & CCG 008ii_24*	2.30pm

9	**Any Other Business/Close** - External Members	RT	2.40pm

Date of Next Meetings:

- 4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting.

Attendance – Governance Sub-group

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024	May 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓	✓
Non-Executive Director	*Chris Hurst*		*Chris Hurst*	*Chris Hurst & David Clark*	Non-Executive Director	*Chris Hurst*	*Chirs Hurst*
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	✓	✓ *& Claire Dalley*			Mark Waring/Ellyn Carnall		

Meeting of the Oxford Health Charity Committee – Development

Wednesday 4th September 2024 2.45pm – 4pm via. Microsoft Teams

Apologies to Charlotte Evans (charlotte.evans1@oxfordhealth.nhs.uk)

AGENDA

	Agenda Item	Lead	Indicative Time
1	**Welcome and apologies for absence**	RT	2.45pm
2	**Declarations of interest/related party transactions**	RT	2.50pm
3	**Minutes of the Meeting on 7th May 2024** (1) **and Action Updates** (2)	RT *CCD 003i_24 & CCD 003ii_24*	2.55pm
4	**Charity Strategy Update**	JP *CCD 004_24*	3.00pm
~~5~~	~~**Requests £10k+**~~ ~~- **Bicester Air-Conditioning**~~	~~SM/SR *CCD 005_24*~~	~~3.05pm~~
6	**Impact Reporting**	ME/JP *Presentation*	3.15pm

7	**Fundraising Update**	ME/JP *Presentation*	3.25pm
8	**More Partnership Report**	JP *CCD 008i_24 & CCD 008ii_24*	3.35pm
9	**Philanthropy Development**	VR/PM *CCD 009_24*	3.45pm
10	**Any Other Business/Close** - **Lucy's Room Update**	JPh/MW	3.55pm

Date of Next Meetings:

- 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	*Chris Hurst*		*Chris Hurst*	*Chris Hurst*	Non-Executive Director	*Chris Hurst*	*Chris Hurst*
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	✓	✓ *& Claire Dalley*		✓	Mark Waring/Ellyn Carnall	✓	✓

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Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(a))

Board of Directors

25 September 2024

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

Executive Summary

The Quality Committee continues to meet five times a year and has considered an agenda, which is available in the Reading room together with the minutes of the last meeting held on 16 July 2024.

In relation to matters previously alerted to the Board, specifically our focus on services with a shortage of substantive nursing, medical and therapy staff, the report below will advise members of the outcome of our deep dive into the City and North East Adult Mental health team. The Committee continues to receive updates on work underway to mitigate the significant shortfall in District Nursing capacity, including transformation work. This service has no vacancies but continues to be underfunded against demographic trends, with approximately 350 visits deferred daily. The position is well known to the ICB who are involved in risk assessment and the development of a prioritization framework. Very high-risk patients, including end of life, medication administration and urgent interventions are being protected.

For Alert (may require discussion)

There are no further alerts.

To Advise (to monitor)

The Committee wishes to advise the Board that we have undertaken a deep dive into staffing and quality issues in the **Oxford and North East Oxfordshire Adult**

Mental Health team led by the Oxfordshire and BSW Mental Health Senior leadership team. The service has been flagging on the dashboard for vacancies and some quality alerts (complaints) for over 2 years. The situation is well known to the leadership team who presented an honest and robust assessment of the service. The position currently is that recruitment has improved, attention has now turned to retention and to team working including a standardized approach to patient assessment and caseload management. They are also focused on clinical supervision. A consultant in the team reported positive job satisfaction in her role. We agreed to review progress with the OxBSW leadership team in November. The Committee was confident that the team were well versed in the challenges and necessary changes required.

The Committee is also advising the Board that following an observable upward trend in use of **restrictive practice in the Child and Adolescent wards (CAMHS) including the Psychiatric Intensive Care unit** there would be a detailed review for the next meeting to understand what is driving the position.

The Committee also discussed the current performance on **72-hour review of patients suffering mental health illness post discharge.** Data collection on this is still relatively new (less than 3 months) and performance improving but is showing Ox/BSW just falling below the national standard of 80% of patients. Executives and the CEO confirmed that our expectation should be 90% of patients being reviewed in 72 hours. By way of context a visit on the same day of discharge does not count towards this metric.

For Assurance (to note)

The Committee wish to assure the Board that we received the statutory six-month staffing review which confirmed the Trust achieved the required care hours per day per patient with one exception, Linfoot ward in Witney Community Hospital. The exception is understood and being addressed.

The Committee also approved the Quality Account for 2024/25 and agreed to accept recommendations from the Oxfordshire Health Overview and Scrutiny.

We also received an update, now fully automated, on clinical audit activity in the Trust and can confirm compliance with all national audit requirements.

In the light of recent interest and clarity of expectations of all Trusts in tackling health inequalities we were pleased to receive a very detailed report and

presentation from the Bucks mental health team on their comprehensive work plan, recognizing that data quality underpinned all this work. They evidenced improvements in access to talking therapies and will be focusing on tackling variations in outcomes by ethnic group.

The Committee approved the Trust Legal Proceedings Policy (and commended its clarity). The Committee also reviewed its Terms of Refence and endorse these for Board approval.

Recommendation

The Board is asked to confirm that it is assured with action underway to manage clinical risk and to note compliance on statutory matters, including safe staffing.

Author and Title: Andrea Young, Non-Executive Director.

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: Utilising Digital, Data and Technology; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Sustainability (Community Oxfordshire).

   2) People - Be a great place to work
   Strategic risk themes: Succession Planning, Organisational and Leadership Development; Culture; Retention; and Adequacy of Staffing.

   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; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; 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: Research and Development potential.

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Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(a))

Board of Directors

25 September 2024

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

Executive Summary

The Quality Committee continues to meet five times a year and has considered an agenda on 28 August, which is attached, together with the minutes of the last meeting, in the reading room.

In relation to matters previously alerted to the Board I would draw attention to the two **principal escalations on our Quality dashboard which remain the shortage of substantive staff and timely access to treatment and services across the Trust.** All shifts are filled with temporary staff, so care hours are assured, and patients on long waiting lists are clinically reviewed on a regular basis.

For Alert

The Committee has no issues to alert.

To Advise (to monitor)

The Committee wishes to advise the Board that the following issues have been reviewed and remain under monitoring by the Quality Committee.

We received, as requested at the previous meeting, a deep dive into the use of **restrictive practice on the Child and Adolescent (CAMHS) inpatient wards**, this includes the two General Adolescent Units in Oxford (18 bedded unit at the Highfield) and Swindon (12 bedded unit at Marlborough House), and the

Meadows unit (PICU), currently open to 4 patients. Restraint was identified as the most frequently used type of restriction applied, causes of increased use of restraint include prevention of self-harm (commonly head banging), naso-gastric feeding for patients with eating disorders and increasing acuity amongst patients (driven by reduced bed availability within the Thames Valley collaborative, long waits for service, post covid delay in care), coupled with community capacity shortfalls making discharges more difficult. Spikes in incidents are frequently linked to individual patients rather than absolute numbers on the wards. Ward culture is aimed at reducing restrictive practice using creative care plans, personal behavior plans, de-escalation and weekly monitoring including participation in the Reducing Restrictive practice workstream where best practice is shared, and training has been disseminated. The committee will review progress on a quarterly basis via the Positive and Safe subcommittee.

As required by NHS England in the 24/25 Priorities guidance we have undertaken an **initial review into our discharge arrangements for patients with serious mental illness,** especially those patients who require intensive community treatment and follow up but where engagement is a challenge. To date we have confirmed with the Integrated Care Board (ICB) that we do not use Did Not Attend (DNA) status as a reason to discharge patients. The second task is to complete a comprehensive schedule identifying our level of compliance with each area of practice. This section is due for submission at the end of September. The Committee confirmed that although this work is not yet complete our risk assessment and potential gaps are well understood- the exercise is welcomed by both mental health directorates in shining the light and remediating pathways in assessment, continuity of care and in crisis response, with the aim of increasing standardization of best practice, specifically in developing more assertive practice. The committee will review in November and recommend that this is presented to the full board in December.

The Committee received an update from the **Trust's Mental Health and Learning Disabilities Inpatient Transformation Programme Board,** co-chaired by an Expert by Experience. The initial phase of the programme is to bring coherence to all the improvement work across inpatient care and to adopt the Culture of Care standards promoted by NHS England. The work is being developed across the Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Mental Health Provider Collaborative. This transformation work is taking place in the context of community MH services development and focusses more sharply on the purpose and outcomes expected from an inpatient stay. It is

recommended that this is also shared with the Board in December. This work flows usefully into the redevelopment of facilities at the Warneford Hospital.
Finally, the Board is advised that enhanced monitoring is in place for **Thames House, Forensics Directorate by the Adult Secure Provider Collaborative** following quality concerns. There is proactive engagement with the leadership team with an improvement plan in place being monitored monthly.

For Assurance (to note)

The Committee wish to assure the Board that we have received the **Annual Report into Safeguarding Services (23/24)** and noted increased multi agency working, increase in mental capacity act reviews and the appointment of a lead manager at OHFT and improvements in access to and take up of training.

We also received the Trust's **Inquests and Claims Annual Report for 23/24** which highlighted an increase in fees and an increase in inquests -potentially still residual cases held over from lockdown periods. However, the Trust has fewer claims arising from inquests and no coronial letters. Sadly, coroners in Bucks and Oxon are reporting an increase in inquests for suicide, it is too soon to determine if this is an upward trend or the impact of increasing total inquests (denominator issue).

The Committee reviewed the strategic risks it has a lead responsibility for and made no changes to ratings, but noted further mitigations and controls added to **BAF risk 1.5 relating to mental health inpatient capacity and BAF risk 1.6 relating to Primary and community services sustainability.**

The Committee reviewed **the Trust Policy Register** and was informed about work underway to bring the only two outstanding policies to final sign off. We approved the **Governance of Policies and Procedural Documents Policy.**

We received a report setting out the **Trust's response to NHS England's letter on maintaining focus and oversight on quality of care and experience in pressurized services, with focus on Urgent and Emergency Care.** The Committee is satisfied that within available resources our teams are engaged in appropriate leadership, quality improvement and monitoring work. We agreed that a Trust Board visit to an urgent care setting should be undertaken within the

next 12 months and a patient story on experience in our urgent care services should also be scheduled in the next 12 months.

Recommendation

The Board is asked to consider the report and confirm that it is assured with improvement actions being taken to address quality and safety concerns.

Author and Title: Andrea Young, Non-Executive Director and Chair of Quality 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: Utilising Digital, Data and Technology; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Sustainability (Community Oxfordshire).

   2) People - Be a great place to work
   Strategic risk themes: Succession Planning, Organisational and Leadership Development; Culture; Retention; and Adequacy of Staffing.

   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; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; 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: Research and Development potential.

PUBLIC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(a))

Board of Directors

25 September 2024

Report from Finance and Investment Committee on matters to Alert, Advise or Assure

Executive Summary

The Finance and Investment Committee continues to meet five times a year, most recently on 17 September and considered an agenda, which is attached.

In relation to matters previously alerted to the Board, PFI exits risks were highlighted in the July 2024 verbal report and an update is provided below.

For Alert (may require discussion)

The Committee wish to alert the Board that:

- **BOB ICS** – NHSE have confirmed that the risk rating of the system now requires it to enter its Investigation and Intervention regime. The ICS has produced a new financial recovery plan (FRP) that prioritises achieving the planned FY25 deficit of £60m, with the ICS body and two acute providers being the main risk to delivery. Closer financial scrutiny and control will inevitably result, with additional controls already put in place.
- **Capital FY24 budget** – there is a risk we will overspend our capital allocation, which will impact the system capital envelope. As previously highlighted, increased Jordan Hill refit costs put pressure on an already over-committed capital programme for FY25. Existing capital budgets have been revised and rephased, but a forecast £2.2m deficit remains with further pressure from the PFI exit cost. The system has appealed to providers for support in adjusting spend allocations and the Trust remains committed to reducing costs further wherever possible, without impacting patient safety or statutory compliance.
- **Warneford Park Programme** – a separate paper is coming to this meeting suggesting a rephasing of the budget to achieve planning submission this

financial year, resulting in a request for Board approval of £0.9m additional spend in the current financial year. FIC recommend approval.

To Advise (to monitor)

The Committee wish to advise the Board that:

- Work has progressed to articulate the Trust's approach to achieving the best **value** for its public funding, with high level themes for our ambition set out. More detailed work will now be co-produced with patients and staff to set a vision for the Trust to work towards.
- The **Medium Term Financial Plan** for the Trust is at risk of a recurrent £13m deficit annually for FY 25-7 if the ICS withdraw a number of funding streams classed as 'non recurrent', some of which are actually part of Trust running operational spend. There are several opportunities to improve this position, which the Trust is proactively addressing, but it is likely that a break even position will remain challenging, requiring strategic decisions to be made.
- There is hope that this medium/long term position might improve following **Lord Darzi's report** from the Independent Investigation of the National Health Service in England. It highlights the trend of NHS spending being increasingly diverted to hospitals over the last decade, fuelled by political pressure to reduce acute waits and recommends that the 10 year plan lock funding into general practice, mental health and community services expansion.
- **Green Plan 2** (2025-8) is under development to deliver the progress against Net Zero requirements set out by the NHS Standard Contract. This will come to Board later this year/early next year, once plans have been finalised.
- **PFI exit** – the transfer of the building and TUPE staff happened seamlessly this month after much detailed planning and an arbitration process has been entered to agree the final transfer value. It is hoped this exit payment will be settled before year end, but may stretch into FY26, both of which would affect ICS capital positions (as set out above). Further fire surveys are being conducted to establish the full extent of what is required to bring the buildings in line with statutory compliance and any required remediations will be expedited.
- **Frontline digitisation** – the Trust has challenged NHSE's decision to reduce funding by excluding the two main clinical systems (RIO and EMIS) from the programme. Alternative sources of funding are being sought and the scope has been reduced and rephased, although a forecast £1.2m overspend remains. Critical implementation work continues at pace, including the implementation of EMIS in the podiatry service (removing use of complex spreadsheets), electronic prescribing in EMIS and the development of Hope App in collaboration with Oxford and Toronto Universities.

EMIS was affected by the global CrowdStrike IT issue, requiring business continuity protocols over three days to provide critical clinical information until resolved, when data was retrospectively added to the system to avoid gaps. Work continues to address identified data issues resulting from the malicious cyber attack in 2022. All data recorded on templates outside affected clinical systems was uploaded to new clinical systems as unstructured data, so is available clinically but will remain unavailable for reporting. Identified gaps in new system functionality were mapped, addressed according to risk and will be completed this month.

- **Estates deep dive** – comprehensive work is being undertaken to take stock of operational and financial performance, including reviews of internal controls, compliance, workforce and contracting. Opportunities to take a more strategic approach to procurement and contract management, enhance technical support, improve training, ensure consistency between procedures and practices and construct budgets from zero bases will be addressed over the next two years, providing a firm foundation for the Trust wide Estates Strategy.
- **Terms of Reference** have yet to be revised in line with Board and sub committee discussions, so resolution of the remit of FIC remains unconfirmed.

For Assurance (to note)

The Committee wish to assure the Board that:

- The Trust is reporting to plan for **FY25 revenue budgets** (both on current actual and full year forecast performance), albeit that risks and some opportunities to forecasts remain.
- **BAF risks** 1.1 (Utilising digital, data and technology to drive quality, efficiency, economy, research and innovation) and 3.10 (Information Governance and Cyber Security were reviewed, challenged and enhanced, including consideration of increasing the risk rating of 1.1 (to 12, amber).
- The **Treasury Management** and **Inquests and Claims Annual Reports** for FY24 were received – Quality Committee will want to pick up learnings identified in the latter report.
- The **Treasury Management Policy** was approved and options for investment of surplus cash were discussed.

Recommendation

The Board is asked to discuss the items for alert and note the items for advice and assurance.

Author and Title: **Lucy Weston**
Chair of Finance and Investment Committee

PUBLIC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(b)

Board of Directors

25 September 2024

Safeguarding Service Annual Report 2023/2024

For: Assurance and Approval

Executive Summary

The Safeguarding Service provides support to staff via core work and interfaces with partners across the health and social care system.

It has been a productive 2023/24, we have continued to develop the safeguarding service structure, embedding more integrated adult and children work and introducing an adult/children joint named nurse/professional post.

There has been a drive to embed safeguarding further into Trust's governance processes, with a focus on taking forward recommendations and learning identified from Safeguarding Adult Reviews/Child Safeguarding Practice Reviews.

Directorate safeguarding committees have been established in most directorates with the purpose of providing assurance, identifying good practice and supporting services to improve.

The new MCA Lead has made a significant impact in the Trust with the breadth of work increasing as the role embeds.

Safeguarding training levels have improved significantly from 2022/23 with some directorates achieving training requirements for level 3 safeguarding children.

Continued work is underway to achieve target levels for level 3 safeguarding adults training.

The Trusts' input into the Multi Agency Safeguarding Hub (MASH) has been a priority in 2023/24. Audits have been improved to provide evidence of consistency and quality assurance across the MASHs.

Challenges in 2023/24 have included development of the new patient record systems, transformation in partner agencies and building new relationships.
Implementation of statutory guidance *Working together to safeguard children 2023* has been a focus of safeguarding children's boards/partnerships. There is a focus on shared responsibility and partnership working across the whole system of help, support and protection and strengthening multi-agency safeguarding arrangements and how the local authority, integrated care boards and police work together.

This report provides the Trust Board with an overview of the activity of the Oxford Health NHS Foundation Trust Safeguarding Service.

1. Statutory or Regulatory responsibilities

The report provides assurance that the Trust is compliant with its statutory duties and CQC Regulation 13 'Safeguarding service users from abuse and improper treatment'. The Trust has a statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. Under the Care Act 2014 the Trust has a responsibility to work co-operatively with partners to ensure the welfare of adults at risk.

2. Assurance processes

The safeguarding service participated in multiagency audit work as part of its role as members of the Safeguarding Partnerships/Boards or in partnership with other health providers. An audit program is in place within the safeguarding service and members of the team have been part of the Trust peer review program.

The Trust received positive feedback in the joint targeted area inspection (JTAI) in Buckinghamshire which looked at the multi-agency identification of risk and need across the local partnership.

3. Governance Route/Escalation Process

This annual report was presented at the Safeguarding Committee on the 17th July 2023.

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.

This report relates to or provides assurance and evidence against the Strategic Objective(s) of the Trust, see link below:

http://intranet.oxfordhealth.nhs.uk/strategy/

Recommendation:

The Board is asked to confirm that it is assured that there are systems in place to protect service users from abuse and improper treatment.

Author and Title: Lisa Lord, Head of Safeguarding
Elizabeth Navrady-Wilson, Deputy Head of Safeguarding

Lead Executive Director: Britta Klinck, Chief Nurse

Safeguarding Annual Report Summary 2023/2024

Oxford Health NHS Foundation Trust

Key Achievements

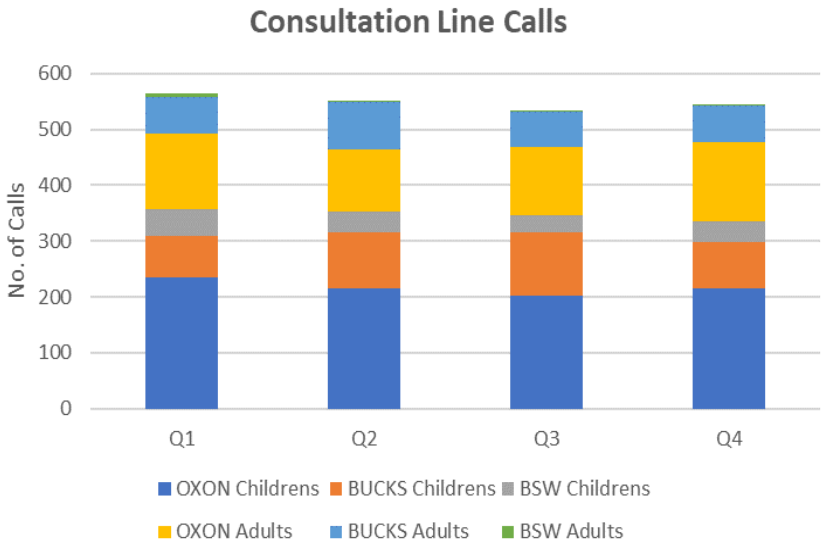
MCA Lead in place and making significant impact in the Trust.
Improved safeguarding training figures and easier access. Introduction of combined Adult and Children Safeguarding Level 3 training course.
More face-to-face sessions/supervision/training/meetings.
Embedding Strengths and Needs assessments with teams in Oxon.
Embedding CSPRs and SARs learning reviews in Trust processes.
Improved governance processes in MASHs across geographical areas.

Challenges This Year

Vacancies and covering additional work.
Trust organisational changes.
Input into the development of new patient record systems.
Transformation of partner organisations and building relationships.

Challenges for the year ahead

Implementation of statutory guidance: Working Together 2023
Consistency of Safeguarding Service offer across the Trust's geographical areas.
The increase in SARs and CSPRs, embedding the learning.



Staff Support

Delivered 85 online/face to face safeguarding training sessions.

Delivered 220 safeguarding children supervision sessions to staff.

Clinical staff contacted the safeguarding service for advice and support on 2,195 occasions.

Monthly safeguarding newsletter

Support with writing court reports in 16 cases.

Multi-agency working

Processed 8,904 Multi-Agency Safeguarding Hub information shares.

Attended 617 MASH strategy meetings.

Attended 58 Multi-Agency Risk Assessment Conferences and involved in safety planning for 52 people open to OHFT services.

Prevent Lead helped safeguard 97 individuals. Prevent training improved through correct staff training matrices.

Processed 100 information shares for Multi-Agency Public Protection Arrangements.

Supported 77 child death review processes.

Support for National Referral Mechanism panel pilot.

Priorities 2024/25

Mental Capacity Act

Neglect

Domestic Abuse

Learning and Development

Safeguarding Adult Reviews/Child Safeguarding Practice Reviews

MCA/Legal Literacy

New Trust wide role created June 2023

Training development and delivery successfully implemented.

Guidance and specialist advice on Mental capacity Act (MCA) and Deprivation of Liberty safeguard (DoLs) available for all Trust staff. Breadth of work increasing as role embeds.

* Prevent Programme aims to tackle the causes of radicalisation.
* Channel meeting- multi-agency approach to identify and support individuals at risk of being drawn into terrorism.
* National Referral Mechanism – a framework for identifying victims of human trafficking or modern slavery and ensuring they receive appropriate support.

Safeguarding Children and Adults

Annual Report 2023/24

 # Think Family

SUPPORTING AND ENABLING STAFF TO KEEP ADULTS, CHILDREN AND FAMILIES SAFE

Authors: Lisa Lord- Head of Safeguarding, Elizabeth Navrady-Wilson- Deputy Head of Safeguarding

Contents

1 Introduction

The Safeguarding Service support staff in dealing with complex safeguarding concerns. In 2023/24 local authorities continued to report high level of referrals to both adult and children's social care. This is alongside continued increase in demand for services, staff turnover and service transformation internally and in some partner agencies. The complexity of cases is reflected in the concerns discussed with staff on the safeguarding consultation lines, through discussion at safeguarding supervision and direct support to staff who are managing complex cases.

The Trust is regulated by the CQC and must demonstrate compliance with Regulation 13. The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, including unlawful deprivation of liberty.

The Trust has a statutory duty under Section 11 of the Children Act 2004 to make arrangements to work together with other partners locally including education providers and childcare settings, to safeguard and promote the welfare of all children in their area. Under the Care Act 2014 the Trust has a statutory duty to work co-operatively with partners to ensure the welfare of adults at risk.

The aim of the Safeguarding Service is to provide high quality advice, training and support to practitioners across the Trust to keep children safe and safeguard adults with care and support needs. Safeguarding should be integrated into people's day to day practice. The Safeguarding Service also has a key role in working with partners representing the Trust in multi-agency fora including Safeguarding Adult/ Children Boards and Partnerships.

This report provides the Trust Board with an overview of the activity led by the Oxford Health NHS Foundation Trust Safeguarding Service and identifies the progress and accomplishments made within the Trust during 2023/24 and provides details regarding the key safeguarding priorities for the year ahead. It explains the structure of the safeguarding children and adult teams, and how they work in partnership with other Trust services and local agencies to influence positive change and support the most vulnerable in society.

2 Safeguarding Service Priorities for 2023/24- We Said-We Did

Further development of the role of Oxford Health in the Multi-agency Safeguarding Hubs (**MASH**) across Buckinghamshire, Oxfordshire and Wiltshire.

Work on building relationships and governance frameworks within Bucks MASH saw a significant increase in requests for information shares from mental health. Regular audit meetings have taken place to identify learning.

Oxon MASH- Governance frameworks re-introduced and the introduction of MASH audits.

Introduction of a quarterly dip sample audit of health information shares. This has promoted consistency of quality across health information shares.

Processes now in place for safeguarding service to manage information share requests from Swindon and Wiltshire.

Promoting knowledge base of the **Mental Capacity Act** in Oxford Health re 16 and17 year olds. Introduction of the new post for the Mental Capacity Act Lead

New MCA lead has made significant progress with MCA-training including reviewing the training package and improving training figures from 54%- 76%.

Introduction of meetings with local authorities to review DoLs authorisations.

Introduction of MCA intranet pages.

Development of electronic patient record DoLs and MCA forms.

Staff support via consultation/supervision.

Promoting “think family” and the “early help” agenda for children and supporting the development of processes in services.

Embedding of Strength and Needs early help assessment with teams in Oxon.

Development of *Adult mental illness and the impact on children that they care for* guidance and plan to roll out workshops for adult mental health and children’s social care.

Promote learning from child safeguarding practice reviews (**CSPR**) and safeguarding adult reviews (**SAR**s) and embedding the process to provide oversight within Oxford Health.

Embedding of learning and actions from CSPR & SARs into trust processes including monitoring of actions.

Involvement of Quality Leads and Quality Improvement team to have oversight of learning.

Working with the Oxford Health directorates and Learning and Development to provide safeguarding training that is consistent with the Intercollegiate Documents re the roles and competencies for healthcare staff in Safeguarding.

This includes the introduction of a learning passport to support the recording and evidencing of training/competence as required by the Intercollegiate Documents.

Developed 3 new training packages.

Introduction of adult & children workshop.

Supporting neglect simulation training.

Supporting multi-agency child exploitation training.

Safeguarding stand at induction.

More face-to-face sessions.

Improvement in training figures.

3 Safeguarding Priorities 2024/25

These priorities will be included in the Safeguarding Service workplan, and actions monitored quarterly and reported to the Safeguarding Committee.

The organisational priorities for the Safeguarding Service are:

- **Mental Capacity Act**
    - Promoting knowledge base of the Mental Capacity Act in Oxford Health re 16- and 17-year-olds.
    - Embedding work already started on patient electronic record forms for MCA, DoLs and best interests' decision record.
    - Continued focus on improving MCA training figures.
    - How to make MCA relevant to individual teams so they have confidence in their practice.

- **Neglect**
    - Promoting neglect to have all age focus.
    - Promoting awareness of tools to recognise and respond to neglect.
    - Engage, support and lead multi-agency work around neglect.
    - Equipping our staff with the knowledge and skills.
    - To include tools within IT systems.

- **Domestic abuse**
    - Promote awareness of domestic abuse and processes to staff.
    - Increase staff cultural awareness and older adult domestic abuse.
    - Education on the use of appropriate language when asking about domestic abuse.

- Encourage services to include in their priorities.
- Explore streamlining information from partner agencies for domestic abuse multi-agency meetings.
- Greater clarity about domestic abuse board sub-groups- role/function and information flow.
- Identify a member of the team to have a focus on driving domestic abuse work forward and maintain work plan.

- **Learning and development**

  - Demonstrate impact of training, evidence “so what”.
  - Improve capturing and reporting training evaluation from staff.
  - To increase knowledge and embed use of the Learning Passport.
  - Learning from safeguarding reviews- how can we improve getting learning to teams.
  - Multi-agency training- support to develop and deliver training.
  - Explore options of training delivery.
  - Quality assurance of trainers and training packages.

- **Safeguarding Adult Reviews/Child Safeguarding Practice Reviews**

  - Strengthen sharing learning from safeguarding reviews with safeguarding service for wider sharing.
  - Sharing chronologies and attendance at rapid reviews for team development and learning.
  - Building confidence of using Ulysses for monitoring actions from safeguarding reviews.
  - Continue to embed internal action planning with services.
  - Share actions and learning with directorate quality leads to monitor actions via governance processes.
  - Embed sign off process of safeguarding reviews via Exec Patient Safety Incident sign off meeting
  - Promote learning from child safeguarding practice reviews (CSPR) and safeguarding adult reviews (SARs) in governance meetings, training, consultation line, newsletter and supervision.

4 National context

4.1 Key national guidance

New national guidance is available for the areas below. The guidance has been highlighted in governance meetings. Training, policies, and procedures have been reviewed in relation to any changes.

Consultations took place this year on Information Sharing Advice for Practitioners; Working Together to Safeguard Children; Mandatory reporting of child sexual abuse: call for evidence. The safeguarding service coordinated the Trust response to these consultations.

4.1.1 Prevent

New Prevent Duty Guidance was published in September 2023 **Prevent duty guidance: England and Wales (2023) - GOV.UK (www.gov.uk).** This guidance came into effect on 31st December 2023. The key implications for Oxford Health are:

- Those with Prevent-specific responsibilities should refresh their training at least every two years.
- Healthcare professionals with Prevent responsibilities will have a good understanding of extremist ideologies as a key driver of radicalisation and should complete any required ideology training.
- Any Prevent referral must make the link with an ideology.
- The Trust Prevent Lead should attend annual CTLP risk and threat briefings delivered by the police or NHS England Regional Prevent Coordinator and cascade any relevant information to staff within the organisation to enable them to better understand the local context.

4.1.2 Working Together to Safeguard Children December 2023

https://assets.publishing.service.gov.uk/media/65803fe31c0c2a000d18cf40/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

Working together statutory guidance was published in Dec 2023. There are workshops in 2024/25 organised by safeguarding boards/partnerships to consider the implications of these changes on partners.

Summary of the changes include:

- A new chapter “Shared Responsibility” with a focus on strong multi-agency partnership working across the whole system of help, support and protection and effective work from all agencies with parents, carers and families.
- Multi-agency safeguarding arrangements strengthening how LA, ICBs and police work together.
- Renewed focus on how organisations and agencies provide help support, safeguarding and protection.
- Changes to Prison and Probation sections to strengthen and clarify processes and responsibilities for child safeguarding.
- Clarified expectation of keeping in touch with care leavers over 21 years and non-mandatory reporting of care leavers deaths up to age 25.
- Finally factual changes have been made to child death reviews in line with legislation, statutory and operational guidance.

4.1.3 Sexual Safety Charter

4th Sept 2023, NHS England launched the Sexual Safety in Healthcare- organisational charter.

https://www.england.nhs.uk/long-read/sexual-safety-in-healthcare-organisational-charter

Work has been completed to evidence how we are meeting the 10 principles and to identify any gaps. The trust health and well-being team pulled together this information and presented this information at the ICB people's steering group at the beginning of April 24. The work completed in the Trust was recognised as good practice by other areas and asked to be shared. It is expected that signatories will implement principles by July 2024.

A meeting is convened with representatives from health & well-being, Deputy Chief Nurse, safeguarding service, Associate Directorate of Nursing looking at how to take forward this work, where it will sit and membership of the group.

4.1.4 Child Safeguarding Practice Review Panel - Annual Report 2022/23- January 2024

Child Safeguarding Practice Review Panel: annual report 2022 to 2023 - GOV.UK (publishing.service.gov.uk)

National reviews and thematic analysis commissioned by the Child Safeguarding Practice Review Panel during 2022/2023

- National child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson (CSPRP, 2022c)
- Multi-agency safeguarding and domestic abuse.
- Bruising in non-mobile infants
- Safeguarding children with disabilities in residential settings

6 practice themes were highlighted:

- Effective leadership and culture supporting critical thinking and professional challenge.
- Giving central consideration to racial, ethnic, and cultural identity and impact on the lived experience of children and families
- The importance of a whole family approach to risk assessment and support
- Recognising and responding to the vulnerability of babies
- Domestic abuse and harm to children – working across services.
- Keeping a focus on risks outside the family

Further 6 practice themes introduced:

- Parenting capacity and children with disabilities and health needs
- Children with complex mental health needs
- Parental mental health and parenting capacity
- Children not in school
- Young carers
- Working with Gypsy, Roma and Traveller communities

It is recognised the report takes place in an ever-evolving environment that affects safeguarding practice. Inclusive of changing policy landscape, increase complexity needs in families and major recruitment and retention pressures.

5 Inspections

There has been inspection activity for local authorities in most of the geographical areas the Trust delivers services, and the Trust was included in the inspection in Buckinghamshire in 2023/24.

The Safeguarding Service has been involved in the Trust CQC preparation and has developed an assurance tool for services to identify areas of strength and development.

5.1 Joint Targeted Area Inspection- January 2024 -Buckinghamshire

Ofsted announced on 8th January a joint targeted area inspection (JTAI) in Buckinghamshire. This inspection looked at the multi-agency identification of risk and need across the local partnership and commentary on the safeguarding partnership.

Joint targeted area inspection of the multi-agency response to identification of initial need and risk - GOV.UK (www.gov.uk)

OHFT received positive feedback from inspectors and partners on the effectiveness and quality of support offered by CAMHS and the support given to children by their schools and the street triage service when struggling with their emotional and mental health. Also, social workers within adult mental health teams were recognised as supporting transition for young people moving to adult services safely and effectively.

Areas of improvement included consolidation of performance data, effectiveness of the safeguarding partnership, multi-agency training, involving education in formulating partnerships strategic direction, quality, timeliness and consistency of social work assessments and information sharing between partner agencies involved in safeguarding children.

As a result of the findings the ICB along with partners created an action plan to address some of the areas of improvement. This will be submitted to OFSTED by Buckinghamshire council as principal authority at the end of June 24.

The progress of the action plan will be reviewed not only by the Bucks Safeguarding Children Partnership but also the ICS System Quality Group and ICS Safeguarding Committee.

Item 5.1 Report - Buckinghamshire JTAI

5.1.1 OFSTED- Area SEND inspection of Oxfordshire Local Area Partnership Inspection July 2023- Oxfordshire

The outcome of the inspection found there were widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership needed to address urgently.

A monitoring inspection will be carried out within approximately 18 months. The next full reinspection will be within approximately 3 years. As a result of this inspection, HMCI requires the local area partnership to prepare and submit a priority action plan (area SEND) to address the identified areas for priority action.

A transformation program is in place which includes multi-agency involvement.

50228374 (ofsted.gov.uk)

5.1.2 OFSTED- Inspection of Oxfordshire Local Authority Children's Services February 2024

The outcome of the inspection was the experiences and progress of children and young people in Oxfordshire are good across all aspects of the inspection framework. Comprehensive partnership working was noted across early help, and good attendance by partners at child protection meetings. Long waits to access child and adolescent mental health services in the county was noted.

50228374 (ofsted.gov.uk)

5.1.3 Inspection of Swindon Borough Council Local Authority Children's Services July 2023

The Outcome of the inspection for overall effectiveness was inadequate.

Since Ofsted's last inspection in 2019, there has been a significant deterioration in the quality and impact of services for children in Swindon. There are pockets of strong practice, notably with disabled children, those on the edge of care, those who are privately

fostered and by the virtual school. However, too many children are left with unassessed needs and risks and plans that drift, and they experience too many changes of social worker. The local authority has not developed sufficiently strong working relationships with partner agencies in all areas to create a coherent approach to meeting all the needs of the children for whom it has a statutory responsibility. There is a fragmented approach which has led to some needs, in particular the mental health and well-being needs of children, not being prioritised as effectively as they could be.

A transformation program is in place which includes multi-agency involvement.

50227724 (ofsted.gov.uk)

5.1.4 Inspection of Wiltshire Council Local Authority Children's Services September 2023

The outcome of the inspection was that all aspects of care for children across Wiltshire were outstanding or good.

Children living in Wiltshire benefit from high-quality services that make a positive difference to their lives. Since the time of the last inspection in 2019, when services were judged to be good, political, corporate and children's services leaders have focused successfully on strengthening existing services further, including through investing in new preventative services and specialist teams. While levels of need have risen in much of the country, this investment, particularly in preventative services, has helped to ensure that the level of need for children's services remains stable and services are meeting more children's needs well. The quality of the services provided to children in care is much improved and the quality of support to care leavers is a standout strength. Services for children in need of help and protection have improved in many areas, including private fostering, early help, support to children on the edge of care and support to children at risk of extra familial harm. While continuous improvement and consistently good support has been provided to the vast majority of children, the support provided to the small number of vulnerable children aged 16 and 17 who are homeless or at risk of homelessness is not effective.

50235241 (ofsted.gov.uk)

5.2 Children We Care For- Phoenix Team

Initial Health Assessments

The team's ability to be able to offer a child their statutory initial health assessment (IHA) has significantly improved since October 2023 due to the overall reduction in the number of children becoming looked after by the local authority and increased medical capacity in the service. However, there are still delays in the actual completion of the Initial Health Assessments due to a variety of factors:

It took an average of 11 days to receive consent for the health assessment, with a range from 2 to 28 days for Q4 (14 days for Q3). This information is essential for the assessment to proceed, wider health information to be gathered and to progress referrals.

Appointments cancelled at short notice due to illness, carers unavailable to bring the child to the appointment or child unwilling to initially attend, etc.

Children placed out of area often experience additional delays due to capacity in the receiving area and the additional information requirements which can take a longer period of time to collate.

Review Health Assessments (RHA)

Children placed within Oxfordshire receive their health assessments within statutory timescales. Minor exceptions will include children who decline to have a health assessment or unplanned events such as staff/child ill health.

Children placed outside of Oxfordshire continue to experience delays in receiving their health assessment. A decision is made based on the individual needs of the child as to whether an assessment should take place on TEAMS or whether it would be better to be seen locally. The latter is often preferable as the receiving health team are aware of the relevant local services and facilities.

Overall, the main causes of delay for children requiring their review health assessments are as listed below;

Reduced capacity out of area-37%

Delay receiving information requested from Social Care Team-33%

An escalation process is in place via the Independent Reviewing Officers so that delays in response to requests for information can be highlighted and actioned within Children's Social Care.

2023/24 has continued to see a steady flow of unaccompanied children arriving in Oxfordshire either through the National Transfer Scheme or spontaneous arrivals. Unaccompanied children (UC) arriving in the UK are an increased risk group for blood borne infections (BBIs) including Hepatitis B, Hepatitis C, HIV and syphilis as well as increased risk from either active or latent tuberculosis.

Other medical conditions such as anaemia and helminth infections are also common and a full blood count is recommended as part of routine screening by the Royal College of Paediatrics and Child Health (Refugee and asylum seeking children and young people-guidance for paediatricians).

Previous audits in 2017 and 2019 revealed that blood borne infection screening was completed by GPs for less than 50% of children despite actions taken to improve and clarify the required health actions. A revised multi-agency (TB Nurse Clinic and the Local Authority Unaccompanied Children's Team) screening pathway for tuberculosis and blood born infections alongside a full blood count has resulted in significant improvements in the number of children who have received screening enabling treatment and advice to be promptly received.

6 Safeguarding Service

The safeguarding adult and children's teams are one service within the Corporate Nursing & Clinical Standards Directorate. This reflects the trust wide nature of its work and supports improved integrated working across adults and children and the cross-cutting public protection work such as domestic abuse, modern slavery and prevent.

The safeguarding service is in regular attendance at directorate governance meetings with safeguarding being a standard slot on agendas.

2023/24 has seen directorates having more of a focus on safeguarding with the introduction of directorate safeguarding committees/meetings in three clinical directorates and discussion around introduction in the fourth. These provide a forum for directorates to consider their safeguarding practice, concerns and escalations to provide assurance to the Trust Safeguarding Committee.

6.1 Accolades

The MCA Lead – Amy Allen represented the Trust at the NHS SE MCA celebration event in November in London. We presented alongside the MCA Lead at Berkshire Healthcare and the BOB Designated Nurse for Safeguarding Adults (Oxfordshire).

The Prevent Lead- Paula Har represented the Trust at the NHS SE Prevent celebration event in December in London. The Prevent training for Nurse Cadet Apprenticeship was recognized as innovation in practice. The training is being shared with the Home Office.

Emma Merchant received an accolade from the Oxfordshire Safeguarding Childrens Board for her development and delivery of the multi-agency Child Exploitation Training.

Lisa Lord, Elizabeth Navrady-Wilson, Anita Owen- Safeguarding Service, Andy Fitton Head of CAMHS received an accolade from the Bucks Safeguarding Childrens Partnership Exec group for support with organization and input for the JTAI inspection in Feb 24.

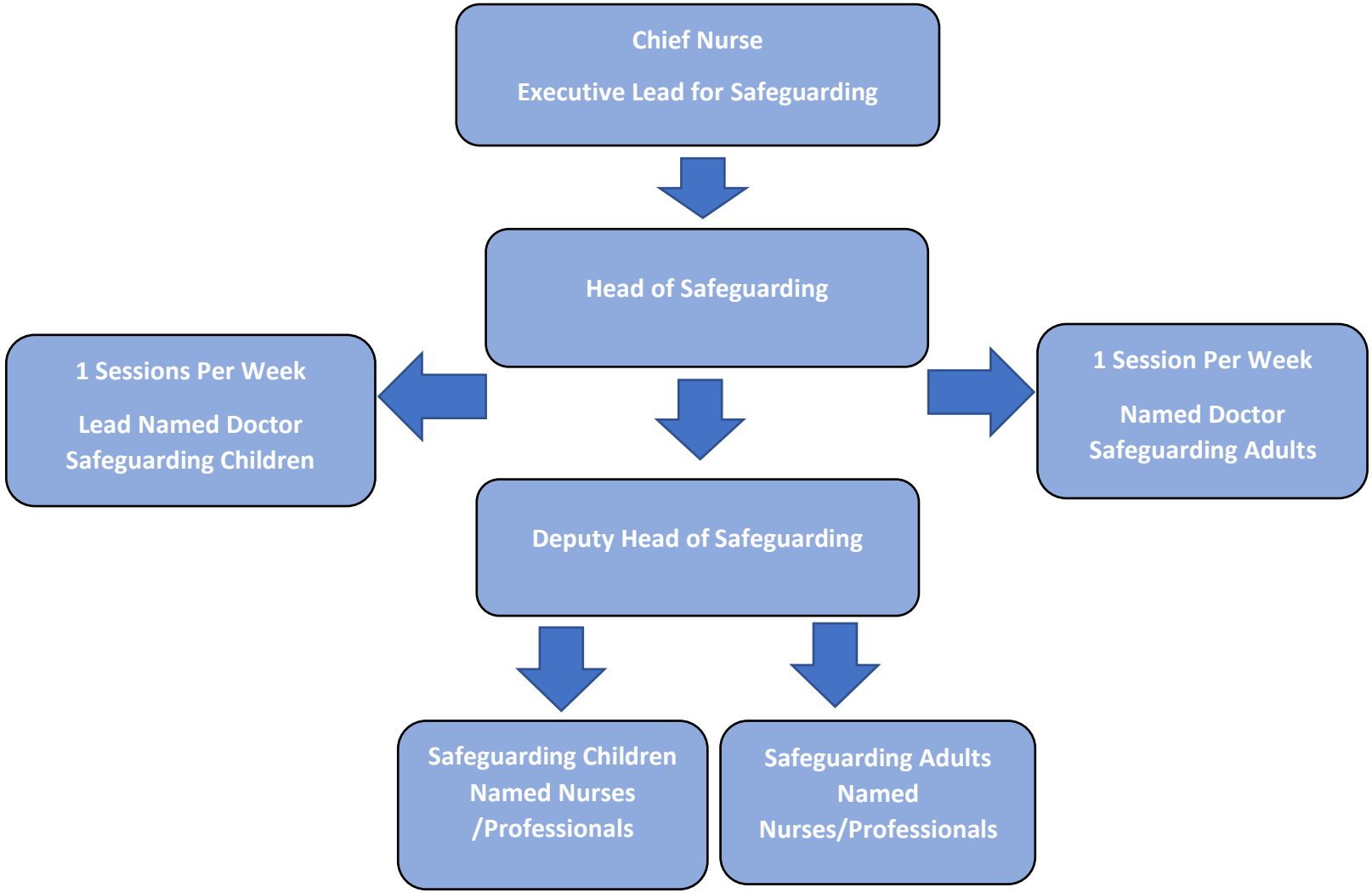
6.2 Safeguarding Service Structure

In 2023/24 the safeguarding service was led by Head of Safeguarding and the Lead Named Doctor, reporting to the Chief Nurse. For the safeguarding of individuals, accountability remains with the clinical staff. The safeguarding teams do not carry caseloads.

The Safeguarding Service covers the five Local Safeguarding Children Boards/Partnerships (LSCB/LSCP) (Oxfordshire, Buckinghamshire, Bath and North-East Somerset, Swindon, Wiltshire) and two Local Safeguarding Adults Boards (LSAB) (Oxfordshire and Buckinghamshire).

The Social Care Professional Leads (Social Worker Leads employed by Oxford Health) provide safeguarding adult advice and support as part of their social care function but sit outside of the safeguarding service.

See the structure chart below.



7 Safeguarding Activity/ Core Work

7.1 Adult Activity

Safeguarding adult activity is core work for all clinicians. The Safeguarding Adult Team provides additional and timely support through telephone consultation and review of incidents notified to the team.

Key indicators of effective safeguarding are consultations, the number of referrals made to the local authorities and requests for information from the local authority as part of their further enquiry under s.42 of the Care Act 2014 (known as section 42 enquiries). Together this activity information demonstrates that the Trust has processes in place to prevent harm and clarify concerns, take actions to protect people and that services are accountable for actions taken (or not taken) and that it is working in partnership with other agencies.

	2022/23	2023/24
Telephone Consultations	678	803
Referrals to local authorities	230	178
s.42 enquiries undertaken	22	11

The figures do not include any s.42 enquiries delegated to Oxford Health by the local authorities as part of the s.75 of the National Health Services Act 2006 agreements in place, whereby responsibilities of the Local Authority are delegated.

This information reflects the increase in consultations to the Safeguarding Service across all services. It illustrates that the staff are sensitive to concerns about service users. Each contact will be about considering how harm or further harm can be prevented and demonstrates that the clinical services place value on their discussions with the safeguarding service.

The outcomes of the Care Act s.42 enquiries are not always shared with Oxford Health although this communication has improved during the past year. There is a task and finish group with the local authority in Oxfordshire to look at resolving some of the areas that have been raised by the Community Directorate.

7.1.1 Safeguarding Adults Incidents 2023/24:

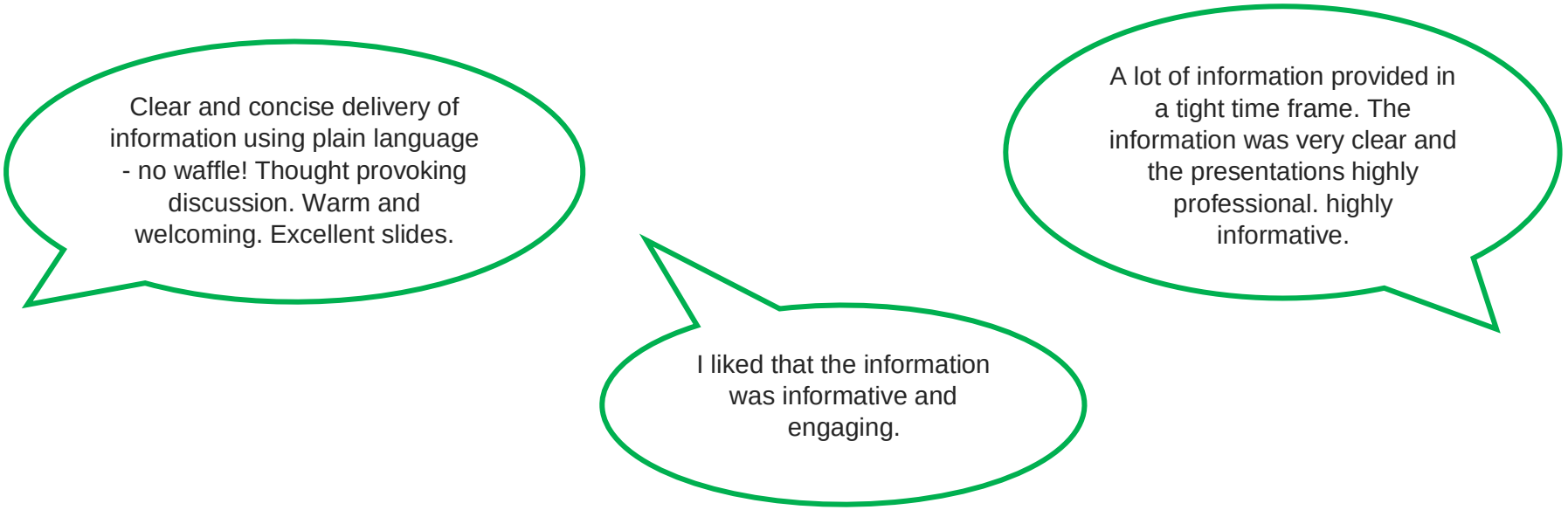
The total number of Adult Safeguarding Incidents reported in 2023/24 was 687. The Safeguarding Service review safeguarding incidents and contact the staff member reporting the incident if required. The main themes are:

Area	Total number	Main Themes
Bucks Mental Health	**79**	**Violence (16), Self-Harm (10), Admission/ Discharge (10)**
Community (Includes minor injuries and out of hours)	**301**	**Health (69), Skin Integrity (45), Violence (36), Communication/Confidentiality (31), Fall Related (12), Self-Harm (11), Admission/Discharge (11)**
Oxon & West Mental Health	**111**	**Violence (26), Self-Harm (18), Health (14)**
Specialised Services	**150**	**Violence (68), Sexual (17)**

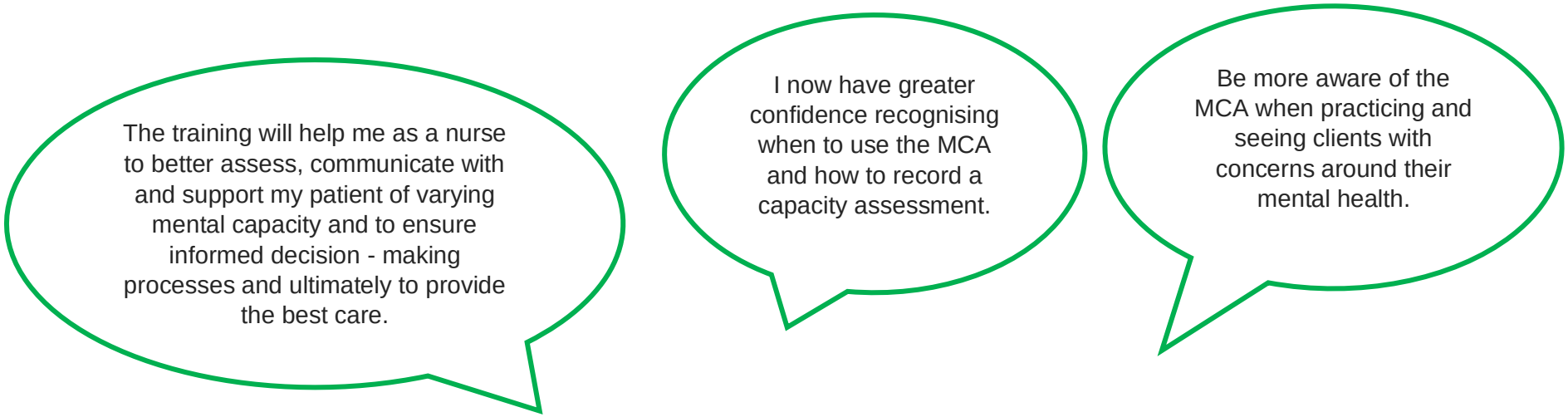
7.2 Mental Capacity Act

The new role of Mental Capacity Act Lead was created in June 2023 encompassing training development and delivery, refreshed guidance and specialist advice on the Mental Capacity Act and Deprivation of Liberty safeguards (DoLS). This is a Trust wide role offering support across all Directorates via email, Teams and telephone consultations. The consultations between July 2023 and March 2024 were mostly from Oxfordshire Social Care Teams with a small number from Buckinghamshire, the breadth of work is now increasing as the role embeds.

The training offer includes MCA induction and refresher courses across all directorates and disciplines. The course content has been completely refreshed and updated to reflect changes in case law and policy. Compliance with this mandatory training has improved significantly, particularly within the Community Hospital workforce. Bespoke training is also offered to teams on request responding to individual need. The improvements to the training packages have been well received and very positive on the whole.



The evaluation form asks how attendance at training will impact practice:



As the role becomes more embedded the number and complexity of consultations is increasing with an additional function supporting Court of Protection work. In addition, attendance at Safeguarding Supervision sessions is increasing awareness and developing knowledge. Written guidance is now available on the Trust Intranet for all staff. Links and networks continue to build across the BOB system promoting shared learning and partnership working.

7.3 Children activity

The safeguarding children team's core work is supporting staff in managing highly complex cases through training, supervision and consultation. Another significant area is representing the Trust in multi-agency working. In addition, the Safeguarding Children Team support staff who are providing reports or attending the family courts. This year, 18 staff have been supported to write court reports compared to 16 last year.

The information below gives an overview of the core areas of work undertaken by the Safeguarding Children Team.
Safeguarding supervision sessions have increased as we now offer supervision to more services.

There has been 1 allegation against staff in Oxfordshire in the past year, none of which proceeded to a formal investigation. There was 1 allegation in BSW which did not proceed to a formal investigation. There has been 1 allegation in Buckinghamshire which proceeded to formal investigation. All allegations are referred to the local area designated officer (LADO) for independent consideration of further investigation.

Previously referrals made by Oxford Health staff to Children's Social Care were captured via Carenotes electronic patient record. As a result of the IT outage in 2022 alternative electronic patient record systems were introduced. Work is in place to develop this function but is yet to be implemented within all new electronic patient record systems.

7.3.1 Safeguarding Childrens Incidents

Incidents that are identified as safeguarding are shared with senior members of the Safeguarding Service for review and followed up by the named nurses as required. Themes are collated and reported to the safeguarding committee as shown in the report below. Concerns regarding self-harm, communication, dog bites and violence have featured in 2023/24.

Reporting of these concerns as incidents is positive as it demonstrates issues are identified and action taken. Examples of this include:

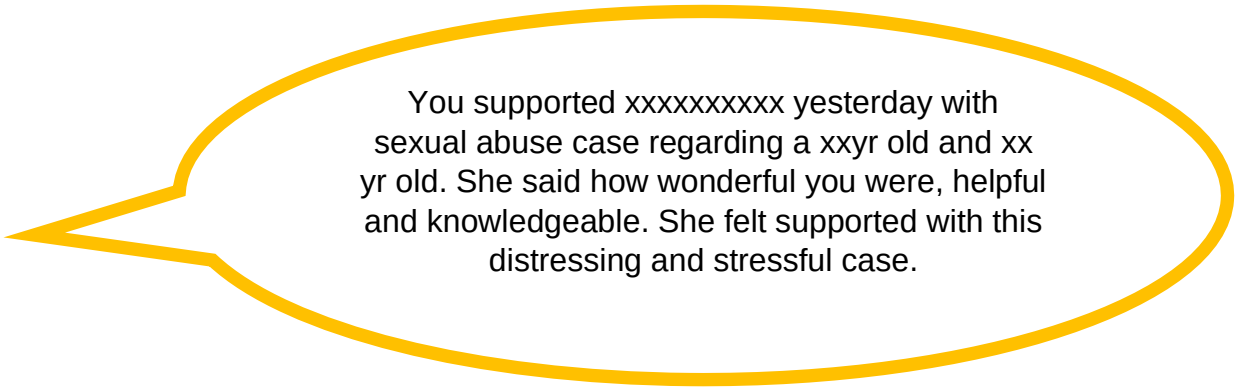
- Increase in presentation to minor injuries units (MIU) of self-harm has led to a piece of work with CAMHS to strengthen referral pathways.
- Data is shared from MIUs with the police-Thames Valley Together on serious violence as part of the implementation of serious violence duty.
- Data is now shared from MIUs with the Oxfordshire domestic abuse Board on number of incidents of domestic abuse to inform development of domestic abuse delivery plan.
- Dog bite protocol being reviewed with partners to improve time taken to report to police and children social care.
- Increase in reporting of communication issues with partners to have oversight of any system difficulties which may require escalation.

Safeguarding Incidents involving children 2023/24:

Area	Total number	Themes
Bucks Mental Health	**14**	**Self-Harm (3), Violence (3), Communication/Confidentiality (3), Medication Incident (2), Admission/Discharge (2)**
Community (Includes minor injuries and out of hours)	**146**	**Communication/Confidentiality (35), Health (34), Self-harm (16), Violence (16),**
Oxon & West Mental Health	**55**	**Communication/Confidentiality (13), Self-harm (12), Violence (9), Admission/Discharge (5), Death (3), Health (3), Sexual (3), security (2)**
Specialised Services	**5**	**Violence (4), Sexual (1)**

7.4 Safeguarding consultations

Individual advice and consultation are available from the Safeguarding Children Team to all trust staff by telephone via a dedicated consultation line number and/or by face-to-face contact. This is available 9-5, Monday – Friday.



In 2023/24 there were 1380 calls to the consultation line, a decrease of 77 calls on the previous year. There has been a decrease in calls from the mental health teams but an increase from the community directorate. This may be due to the local authority in Oxfordshire - Locality Community Support Service (LCSS) withdrawing the no names consultation service and transformation within some community services. Anecdotally it is reported that CAMHS staff are accessing advice from specialist roles such as clinical interface and transitions in Oxfordshire.

Consultations regarding emotional abuse continue to be the category with the highest number of calls, with domestic abuse, neglect and physical abuse following. The Safeguarding Service now collect number of calls relating to indecent images as this was noted as a theme. However, the number of calls remains low-12 in 2023/24.

Safeguarding Children Consultation Line Data

	Oxon & South West Mental Health	Bucks Mental Health	Community Health	Specialised Services	Other/Partners	Total
2022/23 Total	**758**	**393**	**275**	**14**	**14**	**1457**
2023/24 Total	**648**	**316**	**406**	**5**	**5**	**1380**

7.5 Training

Training Course	2023/24
Children Safeguarding Level 3	12
Adult Safeguarding Level 3	12
Combined Children's and Adults Level 3 (new in 2024)	4
MHA/MCA and MCA bespoke	31
Junior Doctors Training	5
HCA Clinical Induction	12
Induction Stand	12
Total	88

The Safeguarding Service is providing training both through MS Teams and face to face. It is anticipated that we will continue to provide training in this way. E-learning is available for some courses. The requirements for safeguarding training in relation to both children and adults are outlined in the intercollegiate documents (Adult Safeguarding: Roles and Competencies for Health Care Staff. First edition: August 2018 and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: January 2019). Safeguarding training is regularly reviewed to reflect national guidance, learning from reviews and the roles

and competencies intercollegiate documents for adults and children. Level 2 children and adults is now delivered via Health Education England eLearning package. Level 2 induction training for Health Care assistants is delivered face to face classroom session.

Level 3 children's training package is delivered either virtually or face to face. The package incorporates pre course self-directed learning which includes subjects such as domestic abuse, exploitation, and contextual safeguarding, going forward this will be included within the main training and the pre-course learning removed. The learning is consolidated during the course delivery which expands on the subjects and integrates theories, policy and case studies focusing on neglect. The package is updated to reflect recent learning from local and national CSPRs and reviews.

Level 3 Adult has been updated for 2024 and now is delivered face to face or via MS Teams. This uses a case study approach as a basis to consider safeguarding subject such as neglect, domestic abuse and exploitation whilst encouraging delegates to 'think family'. Capacity in Level 3 courses has increased to reflect the increased numbers of staff required to access Level 3 Safeguarding courses.

In line with the 'think family' approach the safeguarding team have developed an **Adult and Child level 3 Workshop**, a safeguarding day. This day was developed to ensure that staff who may not have ready access to online learning and capacity to complete pre-course learning have opportunity to attend. The day is based on scenarios to encourage multidisciplinary discussion and debate. The day encourages professional curiosity and focuses on themes such as domestic abuse, neglect and exploitation, subjects relevant to both adult and children.

Key learning from Child Safeguarding Practice Review (CSPR)/ Safeguarding Adults Reviews (SARS)/Rapid reviews is included in the training packages. The packages are regularly reviewed and updated to include recent changes in guidance or information.

7.6 Evaluation of training

Evaluations are compiled using a mixture of Teams forms, informal feedback and learning and development evaluation. The same form is used for all 3 packages to aid comparison. Feedback from these sessions has been very positive with practitioner valuing the real time safeguarding learning focus. Examples from course evaluation

Feedback on how the training will impact practice:

"Improve my awareness in keeping people safe"

"Will help me to ensure young persons safety"

"Better knowledge "

Training levels have improved for 2023/24. The booking process has been improved and the safeguarding adult training package has been refreshed and the requirement for pre course eLearning has been removed to increase accessibility of the course. The development of the level 3 safeguarding day has improved course choice to appeal to a range of staff groups.

Multiagency training

The safeguarding team have been involved in delivering Multiagency training and are part of the OSCB training pool. A package of training about child exploitation has been developed and delivered for the OSCB.

7.7 Supervision

Area of Work	Number completed 2022-2023	Number completed 2023-2024
Safeguarding Children Supervision sessions	**210**	**220**

Safeguarding supervision is central to promoting robust safeguarding practice. It offers professionals a safe space to consider and reflect. Working Together to Safeguard Children 2023 states: 'Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family'. The Safeguarding Service Children's Team provides safeguarding supervision in line with the Trust Safeguarding Children policy which recommends that staff attend a minimum of 3 sessions per year.

The service currently offers supervision to 85 groups across clinical services and has seen a 24% increase in groups offered across the Trust this year. This increase is driven by demand from service managers recognising the value of protected time for safeguarding supervision for their staff. These groups are offered both virtually and in person, supporting accessibility to supervision in line with the Trust policy. The safeguarding service and senior managers are in the process of considering how supervision will be offered to the new 0-19 community service that has been restructured and rolled out from April 24.

The safeguarding service are also in the process, of liaising with learning and development, to enable service managers to have oversight and access to data on numbers of staff attending safeguarding supervision for their service.
A supervision audit is currently underway to ascertain the quality of safeguarding supervision offered to teams.

Members of the Safeguarding Adults Team undertake clinical supervision with teams and individuals on a 4 – 8 weekly basis. In addition, supervision is provided for specific safeguarding issues on an ad hoc basis. This may be by appointment or through the consultation line at a time when individuals are working through complex issues. The adult team have supported supervision provided to the Perinatal Service in Buckinghamshire.

Forums for the community mental health teams have been set up in Buckinghamshire which have used a supervision approach to allow for reflection on safeguarding issues. These forums are not counted in the supervision sessions provided.

- **Community Hospitals**

Supervision sessions have been initiated monthly as a result of a root cause analysis. All community hospital staff are invited and attend as they are able. A session may cover current safeguarding themes, and issues around the Mental Capacity Act, including Deprivation of Liberty. A request was made by the District Nurse Clinical Development Leads to join this and some great conversations between Community Hospital Nurses and District Nurses reflecting the similarity of concerns from both services are being brought to the sessions.

- **District Nurses**

The district Nurses have requested safeguarding supervision following a complaint, this is being followed up and consideration how this can be delivered so it is equitable to all the teams, given the geographical spread of teams. This is now in place for Band 7's DN, CTS and Specialist Services. They have been divided into 4 groups and they are monthly.

- **Community Development Leads (DN team managers) (CDL)**

A group of CDLs (including specialist nurses) meet every 6-8 weeks for supervision. This is a longstanding arrangement and is positively evaluated by members of the group. Other CDLs have successfully joined the supervision sessions set up for the community hospitals.

- **Individual Supervision**

There are times following significant events when people request ad hoc individual supervision to reflect on the event (safeguarding implications). There are two separate individuals currently who are accessing this option.

- **Mental Health Inpatient units for Oxford and Buckinghamshire**

A monthly drop-in session is in place all staff from the inpatient units have been invited to attend and these sessions may cover issues related admission, discharge or disclosures. Aspects of the Mental Capacity Act and or Deprivation of Liberty. We also discuss practice and process around safeguarding.

- **Complex Needs**

Supervision is set to begin in June for this staff group and this is for staff across Oxfordshire and Buckinghamshire services.

7.8 Audits

The Trust Safeguarding Service audit framework moved to reflect the think family approach being championed across the Trust in its audit programme from 2021-22. Audits recorded within AMAT (Audit Management and Tracking electronic system) across all directorates are reviewed for safeguarding activity being monitored in the audit tools. A number of scheduled audits across all directorates did not occur in 2023-24 and were suspended due to transformation projects for the new electronic patient record systems implemented in 2022. Data to complete the audits was not easily accessible and priority was given to documentation process for patient care delivery. The 2024-25 Audit programme aims to be able to review more competed audits as data confidence is increased with the new electronic patient record systems in place. Safeguarding audits stipulated to be completed in the 0-19 pathway contract have been confirmed.

The safeguarding service participated in multiagency audit work as part of its role as members of the Safeguarding Partnerships/Boards or in partnership with other health providers. The safeguarding service have been part of the Trust peer review program.

Learning from Safeguarding Service audits is shared with staff through the Safeguarding Service newsletter; governance reports; training and supervision sessions.

7.8.1 Trust wide

Trust audits reviewed included:

- **Care Planning Approach Audit – Community Mental Health Services**

The Care Programme Approach (CPA) audit identified that questions asked by the practitioner about the service users' ability to carry out caring responsibilities has increased from 66% to 81% from last year's audit.

Audit findings show that practitioners are documenting dependents names and ages on the service users' records. This has improved from 51% in 2022 to 75 % in 2023. Both findings indicate that practitioners are using a Think family approach across their practice.

- **Health Visitors Documentation**

The Health Visiting Documentation audit identified specific safeguarding actions.

Key Successes include:

There is a factual description of the child in language a parent /career would understand and using the assessment framework recorded within the clinical notes - 99% (99% in 2022 audit)

Health needs of a child subject to a TAF/CIN/CPP been clearly documented to demonstrate the role of Health Visiting team - 97% (96% in 2022 audit)

Key Concerns include:

Safeguarding form has been opened - 70% (34% in 2022 audit)

Safeguarding spreadsheet been reviewed and updated within the last month - 77% (94% in 2022 audit)

The child's record document and clarify emerging themes about the needs of the child from their perspective - 88% (100% in 2022 audit)

Within the last year it is documented which tools have been used for assessing and identifying risk such as assessment framework, DASH etc. - 88% (100% in 2022 audit)

It has been documented that the clinical records of siblings have been reviewed for historic DVA events in families receiving a specialist service as per the safeguarding SOP - 88% (100% in 2022 audit)

The safeguarding service is working with the 0-19 service to monitor audit action plan.

7.8.2 Safeguarding Service Audits

Completed Audits 2023-24	Safeguarding Service Action Taken
February 2024 **Audit to consider Risk following retractions of Oxon. MASH health shares before completion.** **Aims/objectives:** The aim of this audit was to understand what the risks to both children and health practitioners are when MASH enquires are retracted from the health tray in Liquid Logic before they can be processed. We are aware that Children's Social Care make their safeguarding decisions based on the information from partner agencies within MASH and possibly their own actions in contacting health professionals they believe to be involved. This, however, does not provide an overview of all health involvement and the associated risks. **Key successes** • Only small numbers of cases are retracted, high risk cases are processed in a timely manner with full information shares. **Key concerns**	When Mash enquiries are removed from the Health Tray, risk is identified. If retraction of cases begins again, a plan will need to be implemented to minimize risk to children and practitioners. • Retraction numbers are to be requested from the Local Authority three monthly to check this. • Discuss with the Local Authority regarding their inaccurate reporting of retracted cases. • Meeting with LA to share results of this audit.

• Risk is missed when a MASH enquiry is not completed and entered into the clinical records. Children have been seen by professionals and risk not discussed. • Local Authority retraction information is not always correct. Numbers of retractions are smaller than previously thought. • If actions are carried out by partner agencies, this is not known to health professionals and therefore, can't be supported or challenged. **Key actions** • Retraction's have stopped since October 23, numbers of MASH enquiries have reduced, and staff are processing all enquiries in a timely manner. • Data regarding incorrect reporting of retractions requires sharing with the Local Authority. • An action plan will be required if retractions commence again.	
August 2023 Oxon MASH No Further Action Case Review An audit was requested to look at 10 MASH (Multiagency Safeguarding Hub) enquires that were submitted by Oxford	• Practitioners to understand the Early Help offer including the strength and needs form.

Health Foundation Trust (OHFT) practitioners that resulted in the outcome of No Further Action by Oxfordshire Children's Social Care (CSC). Consideration was to be given to the origin of the referrals to establish if there was a learning need and to understand why 'No Further Action' was being reached. • **Key successes** Threshold of needs document is being used by staff. None were of poor quality, some lacked depth, but concern was clearly stated. • **Key concerns** Early Help support should be considered before a MASH enquiry. Consider if as a Trust, we are challenging outcomes CSC. • **Key findings** Early Help was not always considered when risk was identified in families/children. Some MASH enquires lacked supporting information to help our partners understand the risk that we were observing. Practitioners recognised risk for children and demonstrated they were listening to parental concern.	• The Early Help E learning and Early Help skills session training is available on the OSCB training directory. Training to be promoted again by the safeguarding service to teams via governance meetings and the safeguarding newsletter. • Increase the use of strength and needs form. • Review safeguarding consultation line spreadsheet quarterly to review how many strengths and needs forms have been recommended to be completed at the time of the consultation to evidence promotion of the strength and needs form by the safeguarding service. • Practitioners to know how to make a good referral to CSC. • Information on how to make a good referral is on the safeguarding pages of the Intranet. To share this information again in the Safeguarding Newsletter. • Trust webinar to include a safeguarding slot this will incorporate signposting to the Intranet pages and information on how to make a good referral.

May 2023 An audit of Oxfordshire and Buckinghamshire MASH information shares was completed and scoping of the Swindon, Wiltshire and Bath and North East Somerset MASH's actioned. **Key successes** • There is clear sharing of children and parents/carers details including NHS numbers with MASH. • MASH shares are GDPR compliant by using initials to identify adults other than family members in the home. • Contact details relating to the practitioner involved with the child, young person or adult is shared with MASH. • It is clear which practitioner was sharing the MASH enquiry. • The safeguarding risk identified in the MASH enquiry is being addressed by health shares in Oxon. **Key concerns** • Not all MASH enquires are being added to all the health records in Oxon. • In Oxon, there are three record systems to move between for each family member, and more data bases to be read should it be necessary.	Staff who are part of MASH processing in Oxon and Bucks are to have approx. 3 MASH shares reviewed by their manger. • Documentation on all records examined. • Check consent is recorded. • Check for current risk assessment or Care plans being shared. Check analysis has been included for bands above band 4. At staff one to ones, 3 mash shares are to be assessed. • Review, and update MASH SoP's • When changes in processes occur, SoP's to be reviewed. Add to Bucks SoP the use of initials of related adults rather than use of full name. • Agree processes in Swindon, BaNES and Wiltshire MASH. • Agree an OHFT Standard Operating Process for Swindon, Wiltshire and BaNES

• Consent is not always documented. • Risk assessments and care plans are generally shared appropriately, however, Bucks shares, we were less good at this. • We do not currently have oversight of the MASH information shares for BaNES, Swindon and Wiltshire. • The safeguarding risk identified in the MASH enquiry is being analysed 40% of the time in Bucks information shares. **Key actions** • The safeguarding service is supporting a project in 2023-24 in regard to information governance processes around MASH information shares in BaNES, Swindon Wiltshire to be robust and in keeping with other geographic areas. • Consent needs to be documented on all shares. • Records to be assessed at one to ones.	

7.8.3 Multi-Agency Audits

Safeguarding training resources have been reviewed to ensure learning from audits is reflected in training content. Safeguarding supervision sessions have focused on aspects of learning identified in the multiagency findings.
The Safeguarding Service have supported the following multi-agency audits:

- **Oxfordshire**

  Development of a Multiagency Audit for MASH was supported in 2023-24. Audit programme commences in 2024.

  Child Protection Case Conference attendance and report submission record review was completed in February 2024 and reported to the Task and Finish Group: Continual Improvement of CP Conferences in Oxfordshire

  Findings

  - 130 children discussed at Conferences across Q2.
  - 13 children identified where OHFT invites not identified- Data provided advised they were.
  - One invite went to worker who was on leave.
  - Conferences attended for 20 children.
  - Apologies given for 51 children.
  - Conferences not attended for 36 children.
  - Reports submitted for 65 children.
  - 11 children identified where Social Worker was advised before Conference there had been no school health nursing involvement since last Review Child Protection Conference (RCPC) so OHFT staff would not be attending as no involvement. Not reflected in conference minutes – advised No participation.

  Observations

- Attendance by AMHT and Perinatal team noted.
- Identified in records review invites not sent to some services who had significant involvement with the child- community therapy services, Children bowel and bladder service.

Recommendations for Partnership

How services involved with the child are identified to be invited to Initial Child Protection Conference (ICPC) and Specifically RCPC when families are being worked with and the opportunity to know the child's network should have been established.

Review by Conference administrators of "blanket" list to conferences as inaccuracies were noted and those people did not attend conference when there was no rational for them to attend.

OHFT action plan

Review of documentation process for invites, attendance and report submissions to be discussed with clinical teams after Q4 2023-24 data is reviewed.

The Oxfordshire Adult Safeguarding Board has not requested any multiagency audits in 2023-24.

- **Buckinghamshire**

The Safeguarding children team have supported multiagency MASH audits. This raises the profile of mental health amongst the multiagency team. Actions for OHFT have included following up cases to ensure appropriate intervention is initiated for the child. Internal MASH audits has supported changes to OHFT information sharing processes and improvement seen in the analysis provided and contribution to decision making sections of the returns.

There have been no audits requested from the Buckinghamshire Adult Safeguarding Board.

- **Banes Swindon and Wiltshire**
  - The safeguarding children team participate in monthly MASH audits in Swindon. No OHFT actions have been identified in 2023-24.
  - BANEs Mock Joint Targeted Area Inspection Youth Violence Audit was supported in November 2023.
  - Swindon Safeguarding Partnership Children Living with Neglect audit supported May 2023. Learning identified was included in the Swindon Safeguarding Partnership Neglect Strategy, Neglect tool kit and guidance which was published in February 2024.
  - Wiltshire Integrated Front Door/MASH-CAMHS referral and response audit October 2023 – Concluded that referrals reviewed were well documented which comprehensively addressed the concern history and strengths. CAMHS responses to information requests were of a good quality with recommendations for the family supported. Area for development identified was lack of explicit connection made between child's menta health and safeguarding concerns by CAMHS staff; missing information regarding the impact of parental animosity on mental health and insufficient CAMHS involvement in Early Support Assessments.
  - Information on parental conflict has been provided via the safeguarding newsletter and in supervision sessions to support staff understanding of parental animosity on a child's lived experience. Guidance on making a good referral has been updated on the safeguarding service webpage.

An internal audit of BSW referrals has been scheduled for completion in 2024-25.

8 Policy and Procedures

The following policy updates were completed in 2023/24:

Prevent Policy CP46 – changes to reflect Prevent Duty Guidance 2023.

The Safeguarding Service supported the update of the Buckinghamshire Safeguarding Children Partnership guidance on- The Impact of adults with mental illness on children they care for.

The Safeguarding Service supported the development and publication of the Swindon Safeguarding Partnership Neglect Strategy, guidance and toolkit.

9 Multi-agency Working

9.1 Multi-agency Safeguarding Hub (MASH)

The risks associated with the IT outage in August 2022 have resolved. Information from the previous patient electronic system has been transferred to the new systems which has improved the number that require accessing for information. Safeguarding Service have improved quality assurance processes by quarterly dip sampling health information returns. This has resulted in consistency of analysis in returns across geographical areas.

Area of work	Number completed 2021-22	Number completed 2022-23	Number completed 2023-24
MASH enquiries processed	Oxon: 4726 (average 18/day)	Oxon: 7356 (average 29/day)	Oxon: 6867(average 27/day)
	Bucks: 638 (253 open cases)	Bucks: 459 (average 2/day) (213 open cases)	Bucks: 2027(average 8/day) (959 shares sent) *

*changed from reporting cases 'open' to 'shares sent' to include cases with historical information

Area of work- 2023-24	Oxfordshire	Buckinghamshire
Strategy meeting requests received		**955**
Strategy meetings attended **Strategy meetings – share only*** **Not always attended due to subjects currently not open to the Trust but known historically.**	**305**	**312**

9.1.1 Oxfordshire

Oxfordshire MASH numbers which have been processed by MASH health team have reduced by 7% in 2023/24. There has been pressure points this year with staff vacancies, but these posts have now been recruited to.

The reduction in request for information shares may be due to the introduction of the Strength and Needs early help assessment form. The expectation is the introduction of the Strength and Needs form would see a reduction in referrals that did not meet the level of significant harm.

The health information exchange (HIE) has been introduced to Oxfordshire County Council (safeguarding children) it is already in place for safeguarding adults. This gives access to a summary of information from GPs, OUH and Royal Berkshire Hospital MASH reports that they are accessing HIE. Due to the IT outage for the Trust, information is only available from August 2022. The Trust is linking with the ICB system which will feed into HIE. Until this is in place Trust information will not be current.

Family Help Hub has been introduced (currently a pilot) by the local authority and report seeing a positive impact of this service. Referral to children's social care that do not meet threshold of significant harm, are going to Family Help Hub and will not go via the MASH health team for an information share.

MASH audits are to be introduced in the coming year.

9.1.2 Buckinghamshire

The number of cases processed in Buckinghamshire MASH by the Safeguarding Service has increased significantly by 4 times previous number of shares. 47% of requests for information have current or historical involvement.

The safeguarding service contribute to the monthly multi agency MASH Audit. Dip sample audits take place quarterly by the Safeguarding Service looking at quality of health returns to MASH. The Safeguarding Service representative is now attending the daily meeting with Bucks Health Care Trust, Police and Children's Social Care to plan strategy meetings.

9.1.3 BSW

Wiltshire MASH - the Safeguarding Service took over responsibility for information sharing to the MASH in March 2022. Information share requests have been lower than expected in 2023-24. This will be raised with the MASH manager. The CAMHS clinician retained responsibility for joint decision making where a mental health concern is present, attending complex strategy discussions and planning and delivering bespoke training sessions to the MASH team.

Swindon MASH- the Safeguarding Service took over responsibility for information sharing to the MASH in Dec 2023. Requests have been lower in number than expected. This has been raised at the MASH operational group and strategic group.

BANES - do not operate a MASH as the front door, there is a system in place for duty CAMHs clinician to link with the children's social care teams. The Safeguarding service are now collecting data on MASH activity in Swindon and Wiltshire.

9.2 Safeguarding Adult Reviews

Safeguarding Adult Review (SAR) is a process through which the safeguarding board partners can identify lessons about the way local professionals and agencies work together to benefit adults with care and support needs. All SARs are by their very nature complex.

In Oxfordshire and Buckinghamshire during 2023/24 there were SARs completed that explored the issues for people with whom services had difficulty engaging. There is a tension between individual autonomy and duty of care. Services need to be clear about the legal framework in which they work as well employing expert communication skills within the boundaries of the service provision. SAR Ian in Oxfordshire built further on the information from the thematic review of the death of people who were homeless which was completed in 2020/21.

The SARs can be accessed on the website of the local safeguarding adult's board.

9.2.1 SARs and Rapid Reviews undertaken in 2023/24 with Trust service involvement:

Area	Rapid review completed	Published SARs	Completed &/or awaiting publication	Ongoing SARs
Oxfordshire	**0**	**0**	**4**	**3**
Buckinghamshire	**0**	**0**	**2**	**3**
BaNES	**0**	**0**	**0**	**0**
Swindon	**0**	**1**	**0**	**0**
Wiltshire	**0**	**0**	**0**	**0**

9.2.2 Learning Identified from 2023/24

There was only one safeguarding adults review completed in 2023. The learning identified from this review included:

- Provision of services for people with autism against the national and local strategies.
- Accessible and timely advocacy.
- Neurodiversity training in place for staff.
- Making safeguarding personal.
- Use of health passports.
- Audit use of pre-birth assessments.
- Review current practice on high-volume ‘revolving door’ admissions and subsequent case management.
- Review of supporting families after a death or serious incident.

9.2.3 Implementing learning from SARs

- Introduction of the Bucks Autism Reasonable Adjustments Service (BARA) providing consultation and support to staff.
- All community mental health teams were involved in a tabletop exercise to go through the green light audit tool and develop an action plan which was led by the Buckinghamshire Autism Reasonable Adjustment Team (BARA).
- Perinatal Team’s Consultant Psychiatrist shared the MBRRACE Report with Team Members in November 2021 and also circulated the summary on 12th November 2021.
- High intensity user complex case panels are taking place in Buckinghamshire and feedback is positive.
- Family Liaison Service in place to support families after a death.

- Staff are completing the Oliver McGowan training, and it is part of staff essential training. This training is available to staff to understand autistic traits.

9.3 Child Safeguarding Practice Reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers.

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed.

Serious harm includes (but is not limited to) serious **and/or** long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development.

Activity around child safeguarding practice reviews and outstanding actions are included in quarterly reporting.

9.3.1 Child Safeguarding Practice Review (CSPR) Activity Which Has Involved Trust Services

In 2023/24 we have seen a decrease in child safeguarding practice reviews commissioned.

However, the rapid review process where safeguarding partners promptly undertake a rapid review of the case which involves gathering facts, discussing immediate actions, identifying improvements, and deciding next steps. When the rapid review is completed, a decision is made by those present whether a child safeguarding practice review should be commissioned. This decision

along with supporting information is sent to the National Child Safeguarding Practice Review Panel who confirm if they agree and any comments or suggestions. The table below shows the rapid response and CSPR activity over the past year.

In 2023/24 the Safeguarding Service has been embedding a process to track actions from CSPRS on the incident reporting system Ulysses. Also meeting with directorates to agree actions achievable for the Trust that are in line with the action plans signed off for CSPRS. In 2024/25 the safeguarding service will further embed this process to include safeguarding adult reviews and Section 42s enquiries. Discussion is underway regarding sign off for safeguarding reviews and in what forum this will be through to ensure consistency and integration of safeguarding processes and learning.

9.3.2 CSPRs and rapid reviews undertaken in 2023/24 with Trust service involvement:

Area	Rapid review completed	Published CSPRs	Completed &/or awaiting publication	Ongoing CSPRs	Partnership review
Oxfordshire	1	0	0	0	1
Buckinghamshire	0	1	2	1	0
B&NES	0	0	1	0	0
Swindon	0	0	0	0	0
Wiltshire	0	0	0	0	0

9.3.3 Learning Identified from CSPRS 2023/24

- Early identification of neglect, abuse and exploitation.
- Understanding behaviour as a means of communicating emotional distress.
- The need for a trauma informed approach.
- The importance of a questioning and curious response to what parents tell us.
- Children are safer when in education.
- Broad implementation of the Neglect Strategy and associated practice tools.
- Understanding the potential impact of transitions.
- Presenting problems can often deflect practice attention away from a more holistic consideration of children's needs, and from direct communication with them.
- Multi-agency prebirth guidance is to be understood and applied by all relevant practitioners, which mandates prebirth assessments to be completed on families where children were previously removed.

9.3.4 Implementing learning from CSPRs

The Safeguarding Children Team has been actively involved in sharing learning from CSPR both internally and in conjunction with the LSCB/LSCPs. This has included, informing service development and changes in practice, promoting awareness of themes of learning, highlighting specialist services to partners. Some examples are listed below.

- 0-19 service developing pathway for complex families.
- Multi-agency task and finish group reviewed Oxfordshire pre-birth guidance and plan in 2024/25 to roll out training to services on purpose of pre-birth assessments and inclusion of good quality information to improve risk assessment and care planning.

- Personal assistant (PA) for children we care for to attend 0-19 service meetings to promote understanding of their role and closer working relationships.
- Information on Child and Adolescent Harmful Behaviour Service (CAHBS) shared with partners and attended children social care meeting to raise awareness of the service.
- Oxfordshire Safeguarding Children Board (OSCB) child sexual abuse resources page shared with Bucks Safeguarding Children Partnership (BSCP) policies and procedures group to consider including on partnership intranet page.
- Trust MASH operating procedure amended to ensure that CAHBS are contacted for consultation and a referral considered as part of strategy discussions involving child to child sexual abuse.
- CAMHS processes to consider a referral to CAHBS in cases of peer-on-peer sexual abuse.
- Review of current CAMHS documentation audit/core clinical standards to capture child's lived experience and voice which will inform care planning and interventions.
- Parental conflict hot topic in safeguarding newsletter, included in safeguarding level 3 joint and clinical risk assessment and management training, resources shared with CAMHS via governance meetings and supervision.
- Identify what work/training is being undertaken across the trust with regard to trauma informed practice.
- Document shared with staff to support use of trauma informed language when documenting on children's patient record and to include questions in documentation audit that considers use of language.
- Promoting OSCB trauma training to staff.
- Incorporating local and national themes in level 3 safeguarding children training.
- Embedding Early Help processes via supervision, consultations and resources and working with multi-agency partners.
- The learning from reviews is included in a monthly safeguarding children newsletter/update and shared at governance and locality meetings.

- The Safeguarding Service has shared child sexual abuse training delivered by child sexual abuse centre to heads of service to consider including in recommended staff training.

10 Child Death Review Process

10.1 Trust involvement in Child Death Review process

The safeguarding service co-ordinates the child death review process for the Trust when a child dies or if family members are known to our services and represent the Trust on the Child Death Overview Panel (CDOP) across all Trust geographical areas. There is also representation from the safeguarding service at the Trust Mortality review meeting to give feedback on themes of child deaths and any modifiable factors. In turn any learning from the Mortality review meeting is fed back to the CDOP meeting.

10.2 Data Breakdown 2023-24

In 2023-24 OHFT supported CDOP process for 77 children. (2022-23 89 children 2021-22 OHFT 92 children; 2020-21 61 CDOP cases)

Due to cross border services being accessed by families in south Oxfordshire and south Buckinghamshire, the Trust support CDOP requests from Berkshire so support to families can be maximised.

Area	CDOP cases reviewed 2022-23	Known to OHFT services 2022-23	CDOP cases reviewed 2023-24	Known to OHFT services 2023-24
Berkshire	12	0	18	0
BSW	8	3	5	1
Bucks	32	1	25	3
Oxon	37	26	29	24

Death by CDOP category reported 2023-24			
Area	**Expected death**	**Unexpected death**	**Neonatal**
Berkshire	5	6	7
Banes	0	2	0
Swindon	0	1	0
Wiltshire	0	1	0
Bucks	10	5	10
Oxon	4	14	11

1 case in Swindon was an unknown cause of death due to CDOP reporting processes.

Age range of children reviewed 2023-24	Expected death	Unexpected death	neonatal
under 12 months	5	4	28
1 to 5 (1 unknown)	5	4	0
6 to 10	3	5	0
11 to 15	5	6	0
16 to 18	1	10	0
unrecorded	0	2	1

- **Oxfordshire**

	2021-22	2022-23	2023-24
Oxon CDOP Cases reviewed by OHFT	33	37	29
Neonatal	11	9	11
Known to Community Services	21	26	21
Known to Mental Health services	2	2	3
Unknown to OHFT services at time of death	9	10	5

- **BaNEs, Swindon and Wiltshire (BSW)**

	2022-23	2023-24
BSW CDOP cases reviewed	8	4
Not known to OHFT	5	4
Open to CAMHS at time of their death	3	0

- **Buckinghamshire**

	2022-23	2023-24
Bucks CDOP cases reviewed 2022-23	32	25
Neonatal	8	10
Known to CAMHS	1	1
Family known to AMHT	0	2
Not known to OHFT	31 (8 neonatal)	22 (10 neonatal)

- **Berkshire**

Berkshire CDOP cases reviewed	25
Child or family member known to OHFT	0

10.3 Joint Agency Review (JAR) Meetings

Joint agency review meetings (JAR) are only called when a child dies unexpectedly. Neonatal and expected deaths do not have JARs within their CDOP pathway.

In Buckinghamshire the JARS are coordinated by the Buckingham Healthcare Trust Paediatric service. OHFT staff are not always invited to attend the meetings.

In BSW the Safeguarding service attend the JAR. A CAMHS manager may also attend. JAR meetings are also attended in BSW when the child is not known to services to support actions for children attending the same school/ leisure activities who may be affected by the death of the child. The process for being invited to attend the JAR meeting has improved in Swindon. Work is occurring with the designated Doctor for CDOP for BSW ICB to ensure consistency of OHFT support to CDOP process in Wiltshire and BaNES.

The decision who should attend the JAR is made in collaboration with service leads and the Safeguarding Children Team. Factors taken into account in deciding who attend the JAR are the needs of the member of staff who know the family; the time and availability of people to attend the JAR as they need to occur within days of the child passing to offer the best support to the family and any additional internal processes being followed as a result of the child death.

10.4 Child Death Review Meetings (CDRM)

Meetings were re-established in 2022 after a pause during the Covid pandemic, but not called for all cases. The Community Children Nursing team and Integrated therapies services supported CDR meetings lead by specialist teams i.e. oncology rather than the CDOP designated doctor. It was agreed in 2023 that OHFT Safeguarding Service would chair CDRM meetings for children known to CAMHs but no acute health services. One CDRM meeting has been chaired in 2023-24.

10.5 Child Death Overview Panel (CDOP) Meetings

Panel meetings occur quarterly and are the final stage of the local CDOP processes. The Oxon and Bucks panel have combined to reflect ICB alignment of processes.

Panel Meetings are not attended in BSW.

Within the Oxon Bucks CDOP panel completed reviews there were 3 modifiable factors identified relating to baby's sleeping arrangements. One of these factors was attributed to co-sleeping, which is a reduction from the previous year. The Health Visiting service and perinatal services were provided with updated national guidance and co-sleeping resources, including supporting fathers to facilitate psychoeducation support to families related to co-sleeping.
There were 2 identified maternal BMI related factors, both in extreme premature births.

There were 2 close relative marriages identified and, in both children, there were chromosomal abnormalities. Smoking and substance misuse was identified in 7 cases reviewed. Other modifiable factors included Domestic Abuse (1), Environmental/Public Access (1), Deprivation (1) and No Education (1).

Interagency communication remains the most frequent theme arising from reviews. The value of early, proactive planning, involving acute, community and palliative care teams has been clearly demonstrated during the year with examples presented of excellent coordinated care, especially within the palliative care services.

The cultural support offer to families in the immediate bereavement phase has been identified by panel as limited for non-Christian faiths in the review year. The accessibility, for professionals, of specialist faith leaders has been restricted by limited key communication links being available. All services have agreed to review their local offer, to ensure it is equitable and meets the family needs. The CDOP Panel has agreed to keep cultural needs as an area of focus for reviews in the coming year.

10.6 Thematic Reviews

Thematic reviews were introduced when CDOP processes were updated in 2018. The reviews are supported at a regional level.

OHFT have not attended any thematic review events in 2023-24.

11 Partnership Working

Collaboration and working with partners is essential and a key part of the core work of the Safeguarding Service. This is through the Safeguarding Boards/Partnerships and sub-groups and other multi-agency forums.

Key pieces of work in addition to the areas below include work on developing a multi-agency template for case conferences; reviewing and revising pre-birth guidance; developing guidance for staff who work with adults with mental health issues who are parents/carers; Review of the Dog Bite Policy, Bruising Policy for mobile children and developing training with partners and supporting research.

11.1 Neglect Work

Neglect continues to be a priority for all of the LSCB/LSCPs covering the Trust's services.

11.1.1 Oxfordshire

As part of the OXON Neglect strategic plan, Oxford Health has continued to produce an action plan, that is updated every quarter and presented at the OSCB Neglect Strategic Meetings by a member of the children facing part of the safeguarding service.

The key priorities for 2023/4 are educational neglect, a joint theme across the partnership and also nationally. Data indicates for children on a neglect plan, severe absence is increasing.

There has been a focus on how practitioners can identify children that have low attendance, non-attendance and follow up those children whose families have chosen to be home educated. There is an educated at home alert on electronic records and CAMHS and school Health nurses play an integral part in multiagency support for these families.

The use of the strengths and Needs form continues to be promoted in supervision and on the consultation line and Neglect cases are being detected earlier through these assessments. Data collection is in progress, and it is hoped that the new Early help portal from Children social care will make this easier.

Health visitors across Oxfordshire community services are being trained to use and be train the trainer in the Graded care profile.

A new Early Help board has been set up to prioritise early help work across Oxfordshire and the identification of neglect early to improve outcomes for children and families. A member of the safeguarding team attends this group with a focus on reviewing the current Early help strategy and how it can be improved.

11.1.2 BSW

Swindon Safeguarding Partnership Neglect Subgroup continues to be supported. The Safeguarding Service facilitated a session during the Swindon Safeguarding Partnership (SSP) Spotlight event on Neglect in March 2024. The Neglect Strategy, Neglect toolkit and guidance has been shared with clinical teams when it was launched in February 2024. SSP opted to end their use of The Graded Care Profile in 2023.

Wiltshire local authority are partners in the implementation of the NSPCC'S Graded Care Profile 2 (GCP2) and partners including CAMHS currently feed into the implementation group. Multi agency training is offered to all agencies and CAMHS staff have been encouraged to attend this.

BANES do not currently use a specific tool, but staff are aware of the trust use of the Neglect tool and are encouraged to use this as appropriate.

12 Public protection Work

12.1 Prevent

The Counter-Terrorism and Security Act 2015 contains a duty on specified authorities to have due regard to prevent people from being drawn into terrorism. The Government's strategy, CONTEST, is the framework that enables the government to organise this work to counter all forms of terrorism. The Prevent programme depends on leadership and delivery through a wide network of partners which includes health organisations. Channel panels continue to take place virtually. Information is being shared by the Trust Prevent lead as required. The Trust Prevent lead sits within the safeguarding service and the safeguarding service has a deputy Prevent lead to ensure cover for Channel meetings. The Prevent Boards in Oxfordshire and Buckinghamshire are attended by the Head of Safeguarding and by the Prevent Lead in BSW. Prevent training figures have improved in 2023/24 as the correct prevent training is now included on staff training matrices.

Prevent training has also been designed and delivered face to face to Nurse Cadets aged 16-18, this is well received, and there is good engagement in the session.

Area of work	Number of PREVENT information requests completed	Open to services	Referrals from Oxford Health
Oxfordshire	47	13	4
Buckinghamshire	34	8	2
BSW	14	6	0
Out of Area	2		

12.2 Domestic Abuse

The safeguarding service recognises that domestic abuse continues to be one of the top reasons from staff to the consultation to the safeguarding service. However, the numbers of referrals from the Trust into Multi-agency risk assessment conference (MARAC) remain at a low level.

A domestic abuse working group which has membership from services across the Trust has been established since February 2019. The aim of the group is to be aware of work being undertaken around domestic abuse as a Trust and ensure a co-ordinated consistent response that links with national guidance and local areas strategic plans and safeguarding board priorities.

The focus of the work in 2023-24 has been to increase skills and knowledge of the champions with learning sessions being supported by police colleagues related to Claire's law and a national speaker related to legal orders which can be used in domestic abuse safety planning. Meetings continue to be held quarterly to support to Domestic Abuse Champion. The Champions supported their clinical teams to identify changes in working practice around domestic abuse identification and management.

12.2.1 Domestic Abuse Adults DASH Checklist for Adults, and Domestic Abuse Children and Young People (CYP) DASH Checklist

The Domestic Abuse DASH Checklist for Adults, and Domestic Abuse DASH Checklist for CYP was available in Mental Health and Community Health Carenotes from October 2021. EMIS and Rio transformation programme work has been supported to ensure resources are available in current electronic patient record systems.

The DASH checklist assesses risk associated with domestic abuse and is also part of the process of referral to the multi-agency risk assessment conference (MARAC). MARAC is a multi-agency meeting to ensure there is a safety plan around victims considered at high risk from domestic abuse.

12.2.2 Domestic Abuse Strategic Board and Operational Groups

There is representation from the safeguarding service at the Oxfordshire domestic abuse operational group, BaNES Domestic Abuse Partnerships subgroup.

A new Domestic Abuse Act ("the Act"[1]), was enacted in parliament in April 2021 and confers additional responsibilities on County Councils within England. This includes appointing a Domestic Abuse Partnership Board with prescribed membership. Representation from the Trust in 2023/24 is by the Head of Safeguarding. There is additional representation from the safeguarding service on the operational groups. Oxfordshire and Buckinghamshire DA Boards are finalising their strategy and needs assessment and refreshing and developing the delivery plan.

12.2.3 Multi-agency risk assessment conference (MARAC)

The safeguarding service is involved in supporting MARAC meetings in all geographical areas. Health staff attend MARAC to contribute to safety plans around those experiencing domestic abuse, with an aim for people to make changes and reduce their personal risk.

[1] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

There is a representative from the safeguarding team on the Buckinghamshire and Oxfordshire MARAC steering group. BSW deliver children's mental health services only and the input into MARAC processes relates to children in the family who may be open to CAMHs services.

MARAC referrals made by the Trust

	2022/23	2023/24
Oxfordshire	4	2
Buckinghamshire	1	0
BSW	0	0

12.2.4 Multi-Agency Task and Coordination (MATAC)

There is Safeguarding Service oversight of the cases discussed at Oxfordshire MATAC's (North, City and South) to provide safeguarding information. These are meeting where perpetrators and their families are discussed in order to disrupt their behaviour. Information is shared about known risks within the families. They are not at the risk level for MARAC but have frequent contact with the Police. Information sharing agreements are in place for both counties. Buckinghamshire meetings are attended by the team manager of the Early Intervention Service and in discussion with the team manager it was felt that the Safeguarding Service was not needed to attend, but any escalation or issues with the MATAC meetings would be shared with the Safeguarding Service. MATAC happens monthly in the North, City and South of Oxfordshire.

The Safeguarding service does not support MATAC meetings in Buckinghamshire.

12.2.5 Multi-agency public protection arrangements (MAPPA)

	2022/23	2023/24
Multi-Agency Public Protection Arrangements (MAPPA) information shares	34	15

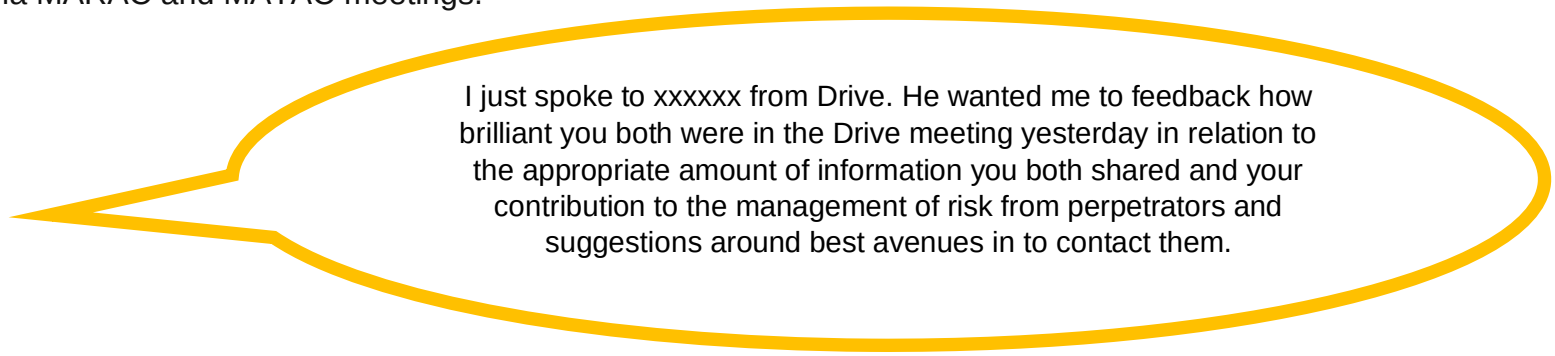
There is representation at MAPPA by adult mental health and safeguarding adult team as required. The safeguarding children team review the agenda in Oxfordshire for any children of those people under MAPPA and provide information to support risk planning as appropriate. The MAPPA process within the safeguarding team has been reviewed and a procedure put in place. The Safeguarding service has supported the OHFT MAPPA task and finish group who are supporting the MAPPA lead review the MAPPA policy and processes across OHFT.

12.2.6 Domestic Abuse Perpetrator Panel (DAPP) and DRIVE program

The Safeguarding Service is involved with supporting monthly DAPP meetings in Oxfordshire, Buckinghamshire and Milton Keynes. Health staff support through the proportionate and relevant sharing of information relating to the perpetrator/victim/children which can be used within the processes to identify need and assist in the facilitation of a management plan and also contribute to the decision making around a perpetrator's suitability for The Drive program.

The Drive program is an innovative domestic abuse intervention that aims to reduce the number of child and adult victims by disrupting and changing perpetrator behaviour delivered by Cranstoun.

The panel and program are in their infancy, with the first panel meetings occurring in February 2024. Perpetrators are referred into DAPP via MARAC and MATAC meetings.



12.2.7 Female Genital Mutilation (FGM)

In Oxfordshire, the Trust is represented at a “no names” multi-agency FGM meeting. This meeting discusses cases where a risk assessment has been completed and establishes if multiagency involvement is required to support the victim or family. This was initially monthly, moved to bi-monthly, but this year has become case driven as the numbers of women and girls identified as being at risk or a victim continues to reduce. Cultural and legal changes in practice in the countries of origin is leading a shift away from FGM.

10 cases were discussed at the no names FGM meeting from April 23-March 24. Only one case required an alert adding to clinical records, the remaining 9 required no further action by Oxford Health, as plans were in place, or male babies were delivered.

Reporting of FGM to the Department of Health has been disrupted following the Carenotes Outage. Department of Health reporting recommenced in Quarter 3 2023-24. In the coming 12 months, we will be able to identify risk of FGM through the Safeguarding Children's Form as it is now embedded into EMIS and Rio.

Multi-agency training is available in Oxfordshire and BSW for Trust staff to attend.
No cases of FGM were reported to Trust staff in Buckinghamshire or BSW. Safeguarding children process would be followed if cases were reported.

12.3 Serious Violence

The Government's Serious Violence Strategy sets out the government's response to serious violence and recent increases in knife crime, gun crime and homicide. The Strategy advocates a Public Health approach with a focus on early intervention, safeguarding and disruption activities with young persons under the age of 25 years.
In all Trust geographical areas providers offer suggestions, additions, and issues that they want to see as part of the strategic planning for the next year in relation to reducing serious violence. The Safeguarding Service representative promotes any local events that require dissemination.

12.4 Child Exploitation

The Trust are engaged at a strategic and operational level to respond to child exploitation. A senior member of the safeguarding team attends the partnership subgroups and cascades information across the trust via the newsletter and operational governance meetings. In most countries there has been a review of exploitation tools.

12.4.1 Oxfordshire

Missing and Exploited Panel meetings continue to take place monthly in North, City and South. The panel meetings are being attended by CAMHS team managers, team manager Phoenix team and the Specialist Nurse for Exploitation.

The Specialist Nurses within the Phoenix Team continue to address the health needs of children and young people who are at risk of exploitation and fall under the YJES. A senior member of the safeguarding team delivers supervision to this team to discuss complex cases. The children on the caseload often have a complex presentation which includes involvement in significant youth violence coupled with a risk of criminal exploitation.

A member of the Safeguarding team attends the OSCB Exploitation subgroup. The key priorities for this group for 2023/24 are Harm outside the home and contextual safeguarding. Low attendance at school and Exploitation is also a focus across the county. Information regarding this is shared with School health nurses and CAMHS.

National Referral Mechanism Pilot

The pilot study in Oxfordshire continues to run and there is no clear end date at this time. It has been successful as cases are being heard in a timely manner.

A named nurse is the representative at the modern slavery network meeting and this information can be cascaded to

practitioners across the trust if relevant via the Trust safeguarding newsletter.

12.4.2 Buckinghamshire

CAMHs attend Multi-agency Child Exploitation (MACE) meetings fortnightly. There was a change in September 2023 with the safeguarding team representing at these meetings.

Numbers of cases open to CAMHs and discussed at the MACE meeting are shared with Bucks Safeguarding Children's Partnership.

The exploitation and modern slavery sub-group is attended by the safeguarding service. Serious violence partnership meets as a separate meeting and is attend by the Safeguarding Service.

12.4.3 BSW

The 'Pan Wiltshire criminal exploitation' sub-group is attended by members of the safeguarding service.

In BaNES there is safeguarding representation at the sub-group, and we were part of the development of a new exploitation tool for health staff.

13 Appendix 1

Glossary	
CAMHS	**Child and Adolescent Mental Health Services**
CDOP	**Child Death Overview Process**
CSE	**Child Sexual Exploitation**
DRIVE	**The Drive program is an innovative domestic abuse intervention that aims to reduce the number of child and adult victims by disrupting and changing perpetrator behaviour delivered by Cranstoun.**
FGM	**Female Genital Mutilation**
ICB	**Integrated Care Board**
Intercollegiate Documents	**This refers to two documents developed by the Royal Colleges. There is one document for roles and responsibilities in safeguarding adults and one for roles and responsibilities in safeguarding children. They have been accepted by the NHS as the competency framework for safeguarding.**
LSAB	**Local Safeguarding Adults Board; Under the Care Act 2014 every local authority area has a safeguarding adults board in place. Its functions as set out in the Care Act are:** • **assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance** • **assuring itself that safeguarding practice is person-centred and outcome-focused** • **working collaboratively to prevent abuse and neglect where possible**

	• ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred • assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.
LSCB/P	**Local Safeguarding Children Board/Partnership**
MAPPA	**Multi-Agency Public Protection Arrangements**
MARAC	**Multi-Agency Risk Assessment Conference**
MASH	**Multi-Agency Safeguarding Hub**
MATAC	**Multi-Agency Tasking and Co-ordination**
Prevent	**This is the term used to describe working with and responding to people who appear to be radicalised.**

PUBLIC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 11(c))

Board of Directors

25 September 2024

Annual Medical Appraisal and Revalidation Report

For: Approval

Executive Summary

- This report is presented for assurance that the statutory functions of the Responsible Officer are being appropriately and adequately discharged.
- The report notes that the Trust is compliant, and that progress has been made against last year's action plan.

Governance Route/Escalation Process

- This report has previously been considered by People, Leadership and Culture Committee before presentation at Full Board for approval.
- There is a brief update on progress made against priorities since PLC reviewed the annual report in July, as required by new reporting requirements by NHSE.
- From next year, the report will be replaced by an annual report for "Quality assurance of professional standards processes for doctors".

Statutory or Regulatory responsibilities

The Framework of quality assurance for responsible officers and revalidation published in 2014 was reviewed in 2019 and further slimmed down post-pandemic. The annual Board report, combined with statement of compliance, are required as annual reporting to NHSE.

In previous years, the Board has discussed the Trust's approach to Local Clinical Excellence Awards (LCEAs) alongside this annual report. The new Consultant pay deal has removed the contractual entitlement to access an annual LCEA, with that

funding realigned to the remuneration for the new Consultant payscales. There is no need, therefore, to consider this matter this year, as Trusts will no longer run local review processes.

Recommendation

The Board to approve the report, support the actions suggested and makes the Statement of Compliance (Appendix 1) for submission to the Tier 2 Responsible Officer at NHS England.

Author and Title: Dr Kezia Lange, Deputy Chief Medical Officer, Professional Standards
Lead Executive Director: Dr Karl Marlowe, Chief Medical Officer

Annual Medical Appraisal and Revalidation Report 2023/24

1. Purpose

1.1. This report is presented to the Trust Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Trust Board on progress since the 2022/23 annual report; to highlight current and future issues and to present action plans to mitigate potential risks.

2. Background

2.1. Medical revalidation was launched in 2012 to strengthen the regulation of doctors, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical profession.

2.2. The purpose of medical revalidation is to assure patients and the public that doctors are up to date and fit to practice.

2.3. Each doctor must have a Responsible Officer who oversees a range of processes including annual appraisal, and who makes, at five yearly intervals, a recommendation to the General Medical Council (GMC) regarding the doctor's revalidation.

2.4. The Responsible Officer is appointed by the Board of an organisation termed a Designated Body, to which a doctor is linked by a Prescribed Connection. This link is created when a contract of employment, (substantive, locum or honorary), is agreed between the doctor and the Designated Body.

2.5. Designated Bodies have a statutory duty under the Responsible Officer Regulations to support their Responsible Officers in discharging their duties. It is expected that provider Boards will oversee compliance by:

2.5.1. Ensuring that the Responsible Officer is provided with adequate resources to fulfil the obligations of the role.

2.5.2. Monitoring the frequency and quality of medical appraisals in their organisations.

2.5.3. Checking that there are effective systems in place for monitoring the conduct and performance of their doctors.
2.5.4. Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
2.5.5. Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.6. Compliance with these regulations forms part of the Care Quality Commission's surveillance model.

2.7. The last annual report was submitted for the year 2022/23. This report covers the period 1 April 2023 to 31 March 2024.

3. Governance

3.1. The current Responsible Officer (Dr Karl Marlowe, Chief Medical Officer) was appointed by the Trust Board on 10 May 2021 in line with statutory requirements. The Chief Medical Officer is supported by a medical appraisal/revalidation advisor (appointed in January 2023 as part of the medical workforce team) and a medical lead for appraisal/revalidation who was appointed at the end of 2021.

3.2. Progress and compliance with the regulations was previously monitored by submission of quarterly reports and the Annual Organisational Audit to NHS England, but these were stepped down at the start of the pandemic. The annual board report serves to quality assure the process within Oxford Health and there remains the requirement to submit this, with the Statement of Compliance, to NHS England on an annual basis.

3.3. The number of doctors with a prescribed connection to OHFT (Oxford Health Foundation Trust) increased over the last year from **195** to **237**. Of these, **22** were clinical academics jointly appraised under the Follett principles with academic and NHS appraisers.

4. Policy and Guidance

4.1. The Medical Appraisal and Revalidation Procedure document that was substantially out of date. The Medical Appraisal and Revalidation Policy has been drafted and is awaiting final feedback and ratification.

4.2. In the interim, supporting information of guidance for doctors was updated in February 2023 and circulated to all doctors being appraised for 23/24, with specific reference to gathering evidence across the whole scope of practice. Updates were also provided to take into account the GMC's updated 'Good Medical Practice' guidance which came into effect in early 2024. The Terms of Reference for the Responsible Officer Advisory Group (ROAG) have been implemented and actively adhered to.

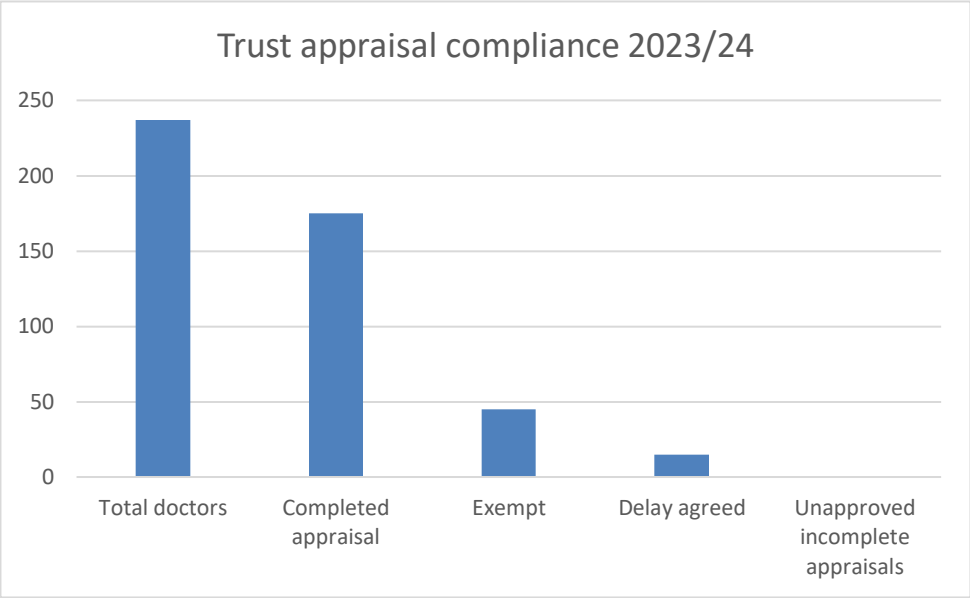
5. Challenges in 2023/24

5.1. There were significant delays to appraisals and revalidation after processes were suspended during Covid, but these effects have largely been dealt with.

5.2. The effect of increasing workloads and difficulty recruiting staff has impacted on appraiser recruitment and retention, and doctors' ability to set aside the appropriate time to undertake getting supporting information for appraisal.

5.3. Additional pressure from the recurring national strike action has impacted on appraisals with some having to be postponed as well as delays in the completion of paperwork and subsequent submission.

6. Medical Appraisal



6.1. There were **237** doctors with a prescribed connection to the Trust in 2023-2024. **175** successfully completed their appraisal. **15** have agreed delays and **45** were exempt due to Maternity Leave/Sick Leave or New Starter Exemptions. **2** Doctors left the Trust without completing their appraisal. There were **no** letters of non-engagement issued in 2023/2024.

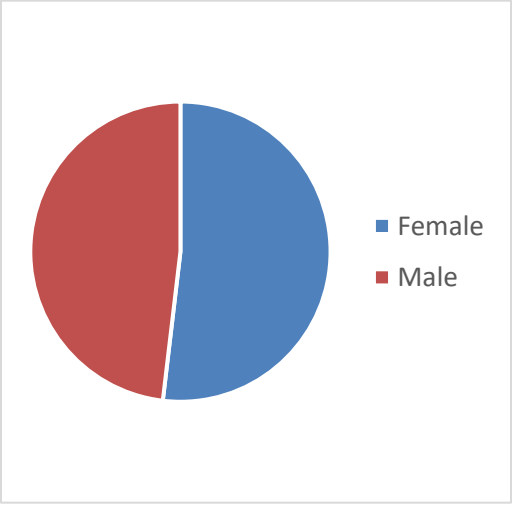
Appraisal Year	Overall compliance (those connected and not exempt, and completed/booked)
2012 - 2013	77%
2013 - 2014	99%
2014 - 2015	99%
2015 - 2016	100%
2016 - 2017	97%
2017 - 2018	99.4%
2018 - 2019	100%
2019 - 2020	99%
2020 - 2021	99%
2021 – 2022	94%
2022 – 2023	96%
2023 – 2024	**96%**

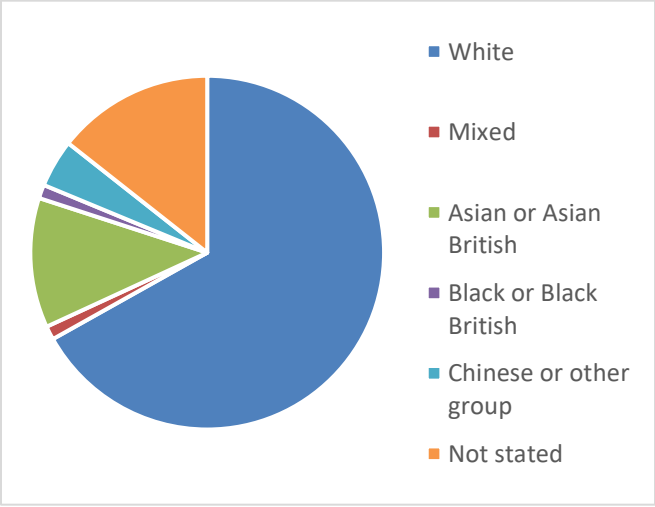
6.2. A continued challenge in 2023/2024 was meeting the target set by NHS England of returning completed appraisal documentation within 28 days of the appraisal meeting, but this is slowly improving. Please see yearly figures below:

Appraisal Year	% of doctors submitting the completed documentation within 28 days
2015 - 2016	80%
2016 - 2017	80%
2017 - 2018	83%
2018 – 2019	82%
2019 – 2020	83%
2020 - 2021	58%
2021 – 2022	86%
2022 – 2023	70%
2023 – 2024	**77%**

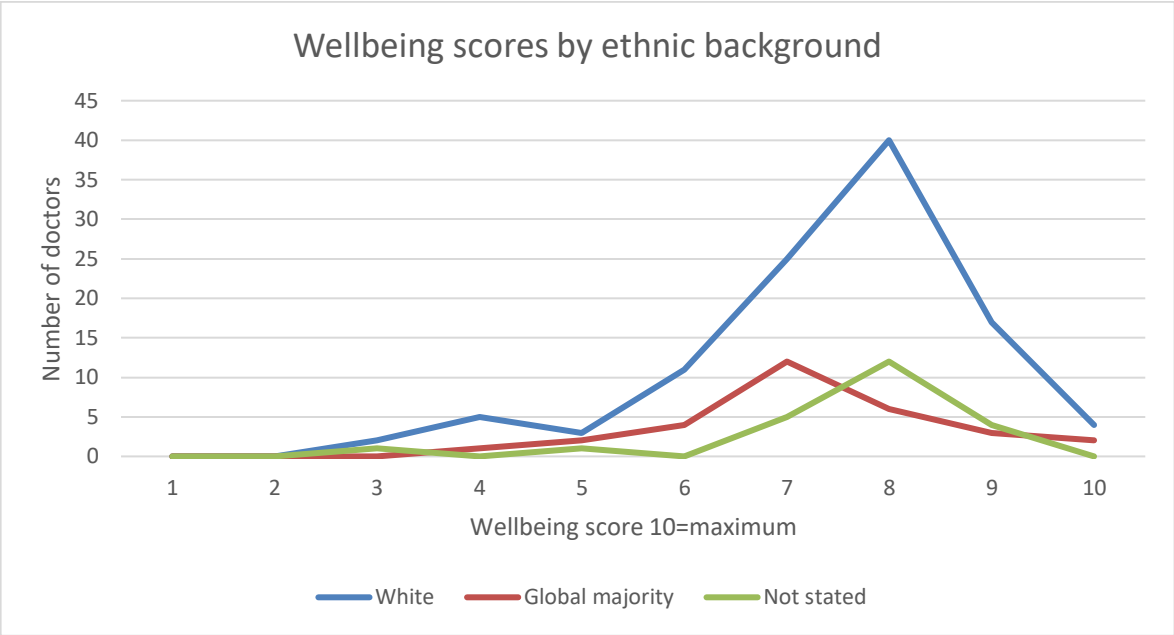
6.3. At final close out of the appraisal year on 31st May 2024, **15** appraisals remained incomplete but none of which were due to non-compliance. There are delays in obtaining clinical director reports which require input by PALS/patient safety regarding complaints and serious incidents involving the appraisee.

6.4. Completed appraisals provide a snapshot of doctors employed by the Trust as consultants, SAS (staff and specialist grade) and locally employed doctors.





When completing their appraisal documentation, doctors are asked what their overall 'wellbeing score' is (ranked from 1 – most negative to 10 – most positive):



6.5. Appraisers

6.5.1. Appraiser capacity continued to be a challenge during 2023/24. Appraiser capacity was increased by employing two recently retired consultants to undertake a number of paid appraisals. The medical lead for appraisal also undertook a high number of the appraisals.

6.5.2. Although recruitment of new appraisers has taken place, some doctors' appraisals were delayed as allocation of an appraiser took time.

6.5.3. Four new appraisers (two academic and two NHS) have undertaken training.

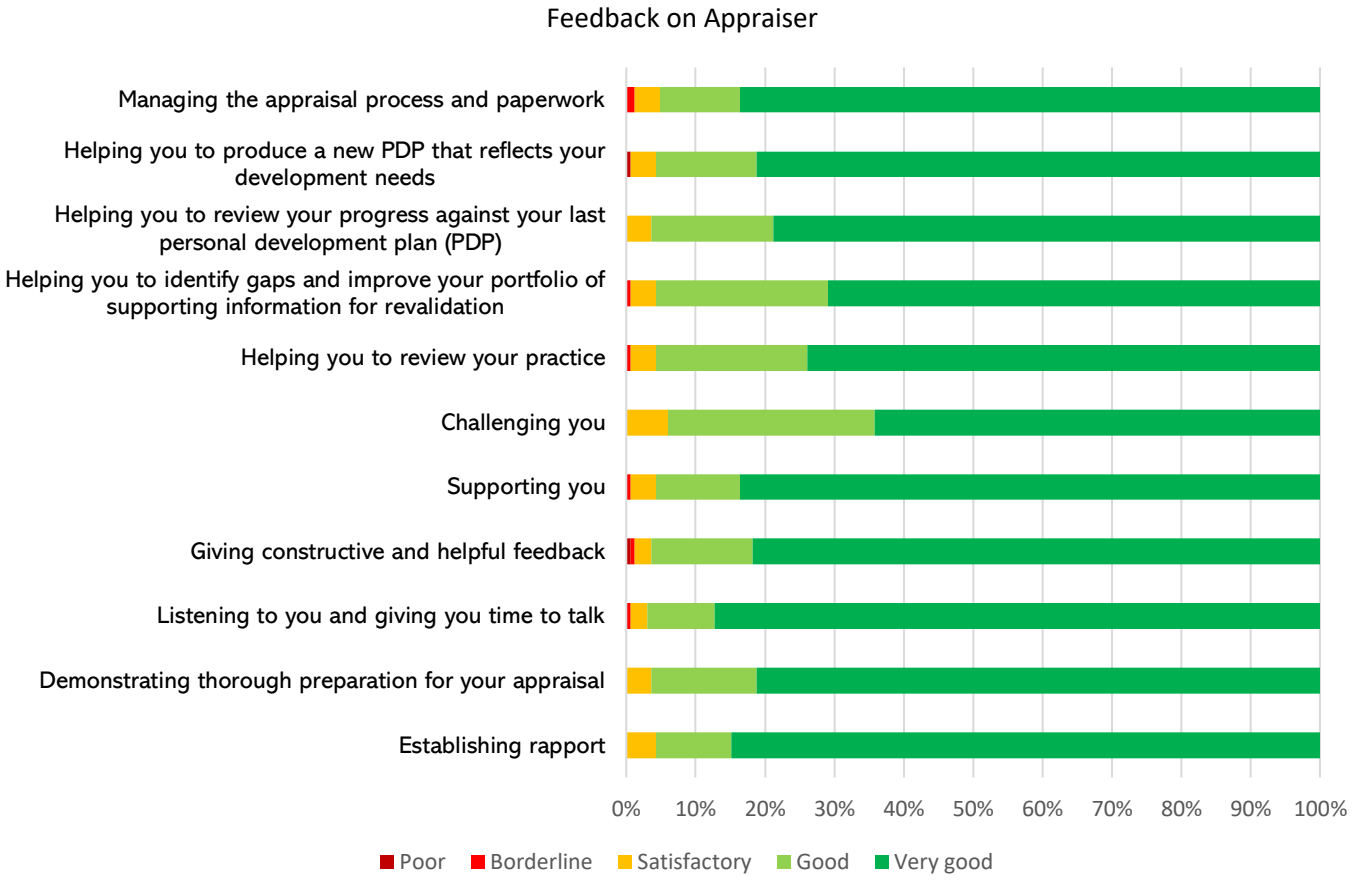
6.5.4. The new job planning policy was agreed in the middle of the last appraisal year which includes an allocation of 0.3PA for 5-6 appraisals plus associated training (which can be job planned in existing job plans or paid as an additional responsibility) funded by the central medical budget. As doctors have started to do their job planning under the new policy, **17** appraisers have taken up this offer (which will increase the

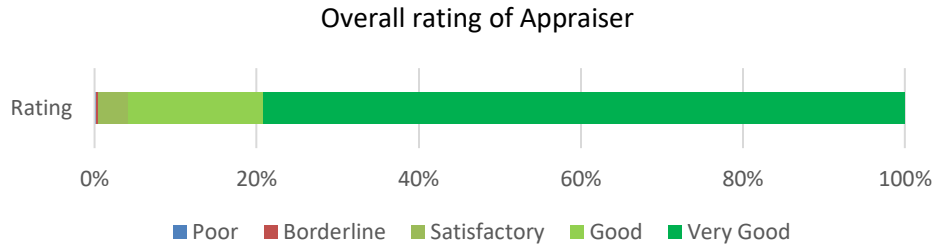
number of appraisals done/year for most) and more doctors are considering taking up this offer.

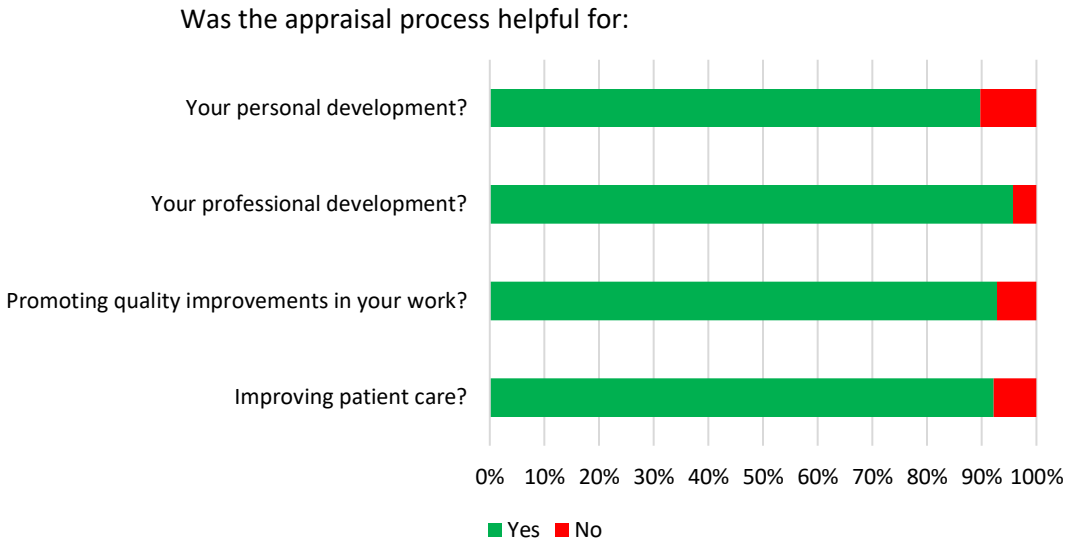
6.5.5. Another successful appraiser training event was held in January 2024, having been deferred from September 2023 due to medical industrial action. The event was well attended with positive feedback having been received and utilised to plan the next event scheduled for September 2024.

6.6. Quality assurance

6.6.1. As part of the implementation of the new electronic appraisal system appraisee feedback has now been made mandatory. This is reported monthly at ROAG, and feedback was presented at the appraiser's training event.







6.6.2. Due to the work done to implement the new electronic software and ensure all doctors and appraisers were using this successfully, the quality assurance of appraisals has not yet been completed. There is agreement that the PROGRESS tool will be used and this was discussed with appraisers at the appraiser training event.

7. Medical Revalidation

7.1. Monthly ROAG (Responsible Officer Advisory Group) meetings were set up in line with GMC guidance to assure the revalidation recommendation process, and to provide advice to the RO where a significant concern has been raised about a doctor. GMC guidance suggests that a NED be appointed to provide support to the ROAG, and this was facilitated by David Walker.

7.2. Revalidation recommendations

7.2.1. During 2023/24, **53** revalidation recommendations were made. **6** deferrals were approved, with reasons including sickness absence and on-going difficulties in collecting 360 patient feedback. There was **1** request made for second deferral due to long-term sickness absence which was agreed by the GMC employment liaison adviser. That doctor has subsequently had successful revalidation.

8. Recruitment and Engagement Background Checks

8.1. The Medical HR (Human Resources) Team is responsible for ensuring that all necessary pre- and post-recruitment checks are completed in full and for taking any required action, including dealing with start dates, or withdrawing offers of employment, where the responses to these checks are not satisfactory. Checks include but are not limited to:

a. Identity check
b. Qualification check
c. GMC Conditions / Undertakings and past history
d. Ongoing GMC / MPTS / NCAS investigations
e. Disclosure and Barring Service (DBS) check
f. Appraisal History
g. Employment References
h. Language Competency

8.2. The Head of Medical Workforce has undertaken a local audit to provide assurance that appropriate checks are in place for the 35 substantive appointments that have been made in mental health services since August 2023. This audit involved a review of 10 files, chosen at random. No significant concerns were raised as a result of these checks, but some opportunities for improvement were identified, including bring in greater consistency in the way in which documents are stored on files, and introducing a peer to peer quality assurance process within the medical HR team before a doctor's file is signed off as compliant.

8.3. The medical appraisal/revalidation advisor is responsible for sending MPIT (transfer of information) forms to previous responsible officers to obtain any significant information relating to fitness to practice, and this has been done for all new starters in 2023/24.

9. **Monitoring Performance, Responding to Concerns and Remediation**

9.1. Concerns about a doctor's performance or conduct are managed under the Trust's Procedure for Handling Concerns related to Conduct, Capability or Health of Medical and Dental Practitioners. There are regular meetings between the RO and GMC Employment Liaison Officer and all concerns are discussed with NHS Resolution Practitioner Performance Advice. The terms of reference of the ROAG, which advises the RO on revalidation decisions and management of concerns raised about doctors, is now embedded into the agreed monthly meeting with minutes taken as a record of the discussion/decisions made.

9.2. During 2023/24 appraisal year, **12** doctors were discussed where concerns had been raised. Of these, **3** were locum doctors, **1** was on a sessional contract and **2** were doctors-in-training. **One** locum doctor and both doctors-in-training had GMC investigations. There were **no** MHPS investigations, and two improvement letters were sent.

10. **Summary of risks**

10.1. Appraiser capacity – by the end of the 24/25 appraisal year, it is hoped that we will have sufficient capacity of appraisers to meet demand, and that we will rely less on additional paid appraisers.

10.2. Policies need to be finalised to ensure transparency of processes and to embed necessary quality assurance processes.

10.3. Supporting information for appraisals – provision of accurate information from PALS/patient safety to inform the CD reports accurately.

10.4. New electronic appraisal system – the current software solution does not deliver on every aspect required for the appraisal and revalidation process however, measures have been put in place to mitigate this.

11. Progress against last action plan 2023/24

Objective	Action	Progress
Resolve issue of appraiser capacity	1. Review how the new job planning policy affects take-up of more appraisal work. 2. Improve retention by network events and investigate other avenues of support.	The situation continues to improve with uptake of the appraiser contract, and it is hoped that by the end of the 24/25 appraiser year that we will have sufficient appraiser capacity. Appraiser refresher events are going well
Review Trust procedures and processes	1. Review Trust Procedure for medical appraisal and revalidation 2. Re-start quality assurance of medical appraisals 3. Review medical HR procedures regarding starters/leavers and honorary contracts.	The appraisal and revalidation policy is drafted and awaiting final feedback and ratification Quality assurance (audit using PROGRESS tool) has started Good progress has been made regarding medical HR processes, with improvement opportunities identified through local audits.. The honorary contract process has been reviewed, and the general recruitment team are learning from the good practice used within the medical honorary contract processes.
Improve quality of supporting information	1. Review how information regarding complaints/PSI can be reported easily to CDs for appraisal purposes 2. Ensure that the medical revalidation intranet page is kept up to date. 3. Process user friendly guide for the use of the electronic system and how to complete the online form.	This continues to be a challenge to obtain timely, accurate, objective information regarding complaints/PSI for doctors' appraisal Information has been provided for all users of the new Allocate system and this is an area of on-going development and improvement.

12. Proposed action plan for 2024/25

Objective	Action	Expected outcome
Resolve issue of appraiser capacity	Encourage medical line managers to discuss becoming an appraiser with a wider group of consultants and SAS doctors.	To reduce the need for additional paid appraisals by the end of the appraisal year. To have sufficient capacity to ensure all new medical recruits can be promptly allocated an appraiser.
Review Trust procedures and processes	Finalise and ratify the Medical appraisal and revalidation policy. Develop transparent policy regarding responsibilities for bank and honorary contract holders.	Improve transparency and consistency of processes.
Quality assurance	Complete audit of appraisal outputs using PROGRESS tool. Provide feedback to appraisers individually using audit and appraisee feedback information. Ensure audits of background checks for new medical staff are done and acted upon.	Improve quality of appraisal outputs and identify training needs for appraisers. Ensure safeguarding and legal requirements consistently met for all new medical starters.
Improve quality of supporting information	Continue discussions with PALS and PSI team on how to obtain accurate, timely and objective information to support appraisals.	Improve assurance of safe working to the RO for revalidation and that complaints/PSI are reflected in appraisals.
Engagement and wellbeing of doctors	Continue to monitor use of software and identify issues and ease of use. Keep risk register up-to-date regarding software used.	Ensure that when we mandate use of a software solution for doctors, that it is fit for purpose and does not lead to extra work/stress.

13. Update since action plan commenced in July 2024 (PLC report)

13.1. There are now only 5 outstanding appraisals from 23/24 due to agreed delays

13.2. There have been a further 3 new appraisers appointed (although one has resigned)

13.3. Quality assurance audit and individual appraiser feedback has commenced

13.4. The medical appraisal and revalidation policy has been agreed with only minor changes by the LNC and will shortly be signed off.

13.5. We have an agreed way forward to have assurance of PSI and complaints reporting into appraisals.

14. Recommendation

The Trust Board to:

Receive this report, note the content, and note that it will be shared with the Tier 2 Responsible Officer at NHS England.

Note the Statement of Compliance (Appendix 1) confirms that Oxford Health NHS FT (Foundation Trust), as a Designated Body, is in compliance with the regulations and that the Chief Executive will sign this on behalf of OHFT following the Trust Board Meeting.

Author: Dr Kezia Lange, Deputy Chief Medical Officer, Professional Standards
Lead Executive Director: Dr Karl Marlowe, Chief Medical Officer

Appendix A

Designated Body Annual Board Report and Statement of Compliance

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

1A – General

The board/executive management team of Oxford Health NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No action
Comments:	Dr Karl Marlowe, Chief Medical Officer remains Responsible Officer for the Trust.
Action for next year:	No action required

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Initiate recruitment drive once incentive options are ratified by Committee. Initiate quality assurance process.
Comments:	Since ratification of the job planning policy offering paid/job planned incentive to the Appraiser role, existing Appraisers have opted to exercise this option and new appraisers have been recruited. This has enabled the service to have greater resilience, but fragility remains given potential retirement of staff

Action for next year:	Focus on Appraiser retention and expansion with implementation of areas for improvement arising from the recommenced quality assurance process

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Medical HR to actively monitor the implementation process of all medical starters/leavers to ensure it is robust and fit for purpose.
Comments:	The honorary contract process is under active review with the process being simplified under a set of new criteria. Medical HR processes continue to be reviewed to ensure fit for purpose whilst ensuring adherence to current legislation. Prescribed connection is reviewed monthly to ensure the list is accurate and Trust compliant with statutory responsibilities
Action for next year:	Medical HR to continue to monitor procedures to ensure that they are fit for purpose and compliant with current legislation.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Scrutinise and review of quality assurance schedule to monitor Trust compliance by conducting due diligence of the appraisal process.
Comments:	ROAG oversight monthly meetings diarised with minutes recorded. Performance report produced and presented to ensure compliance with legislation.
Action for next year:	Continue with monthly/quarterly performance reports but to include EDI (Equality, Diversity & Inclusion) data. Ensure all policy documents are up to date and ratified accordingly.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	No action
Comments:	No peer review planned but this could be considered with neighbouring Trusts.
Action for next year:	No action

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Review information to ensure more accessible and accurate, and continue with the appropriate signposting to enable 1:1 advice on Trust processes and documentation is provided, where required.
Comments:	New medical HR processes in place to ensure that short-term placement Doctors are identified at the point of appointment and have the necessary access to support their developmental requirements. Training for medical line managers to ensure support in place for LED's and locum doctors.
Action for next year	Continue on-going work on developing induction protocols for newly appointed doctors including locums and LED's.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Review how information regarding complaints and PSI can be more robustly reported to CD's to inform the appraisal process
Comments:	Clinical Director statements continue to document complaints and significant events, however national changes to the PSIRF (Patient Safety Incident Response Framework) process and PALS notification have delayed efforts to simplify the process but work continues on this. Advice and guidance to doctors via the intranet pages has been reviewed and updated to ensure accuracy. Advice to appraisers and appraisees about feedback from whole scope of practice (including medicolegal work).
Action for next year:	Finalise review of how information regarding complaints and PSI can be more robustly reported to CD's to inform the appraisal process.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	No action
Comments:	Through the appropriate use of the ROAG meeting any issues/concerns are addressed and action/s taken with a record being kept in the form of minutes.
Action for next year:	On-going active monitoring.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Continue to review Trust Policy for Medical Appraisal on receipt of updates being issued by NHS England and/or GMC (General Medical Council).
Comments:	The previous outdated procedure document has been reviewed and revised into a formal Trust Policy document considering significant changes to systems and process which is now ready for ratification.
Action for next year:	Continue to review Trust Policy for Medical Appraisal on receipt of updates being issued by NHS England and/or GMC.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Provide oversight as to the incentive costs for the provision by recording total PA's accredited to the Appraisers for their service by means of data recording from the electronic job planning system
Comments:	We have continued to pay a small number of recently retired consultants to provide extra appraiser capacity this year. The new job planning policy which allows a clear tariff for appraisals has already resulted in new recruitment and an increase in the number of appraisals appraisers are undertaking. The system remains somewhat fragile with predicted retirements reducing appraiser numbers.
Action for next year:	Continue to provide oversight on the PA incentive provision from the electronic job planning system. Continue with appraiser recruitment to

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	maintain required capacity. Review requirement for extra short-term capacity purchase.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Quarterly Appraiser newsletter to be issued to enable Appraisers to be kept up to date on updates that impact on the appraisal service.
Comments:	Another successfully appraiser refresher training event took place with positive feedback with another event planned for September 2024. Newsletter to be created. Appraisers invited to Senior Clinical Leaders Conference event in May 2024.
Action for next year:	Quarterly Appraiser newsletter to be issued to enable Appraisers to be kept up to date on updates/matters that impact on the Appraisal Service. Schedule next appraiser training event for 2025/26 appraisal year.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Monthly update reports to be provided to the ROAG for oversight of the appraisal service provision. Review of appraisers' work to be re-started.
Comments:	Annual Board Report submitted outlining relevant developments/issues along with oversight by the ROAG. Feedback from appraisees is now mandatory and is contained within the Board report. Quality assurance of appraisers' work will be commenced this year with PROGRESS tool identified and discussed in appraiser training.
Action for next year:	Continue with monthly/quarterly performance reports to ROAG. Monitor Appraiser performance via monthly reports and audit tool.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	No action

Comments:	With the oversight from monthly ROAG meetings staff revalidation recommendations have been made in a timely manner, with outcomes being communicated following the decision having been made.
Action for next year:	No action

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No action
Comments:	The RO notifies the GMC via their online portal with the Appraisal Lead contacting the doctor with the recommendation decision during/follow the monthly meeting followed by the Medical HR Advisor updating the electronic appraisal system
Action for next year:	No action.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	No actions
Comments:	Confirmed – there are robust clinical governance frameworks throughout the organisation for all clinicians.
Action for next year:	No action

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	To continue to work with the leads for patient safety to ensure robust process to ensure correct information is provided for appraisal purposes

Comments:	Confirmed, but as previously commented, PALS and patient safety information should be made more readily and robustly available to clinical directors to include in the mandatory supporting information for Appraisals, this is still under review. Doctors continue to be required to provide a 'clinical director's report' which represents an objective view of conduct and performance.
Action for next year:	To continue to work with the leads for patient safety to ensure robust process to ensure correct information is provided for appraisal purposes within the Just and Restorative Culture framework.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No action
Comments:	We continue to improve the reporting systems into appraisal, currently this is the remit of the medical line manager who assures the appraiser of governance aspects of the appraisee's work.
Action for next year:	To continue to work with PALS and PSI team to improve objective reporting into appraisals.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	No action
Comments:	Confirmed
Action for next year:	The MHPS policy is to be updated as the 'Managing concerns about doctors' policy.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Annual reports to be compiled and reviewed by ROAG prior to submission to the Board
Comments:	Concerns discussed on monthly basis at ROAG and reported to the Board in annual report as part of quality assurance.
Action for next year:	No action

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No action
Comments:	MPiT register kept for recording the information transfer between organisations.
Action for next year:	No action

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	No action
Comments:	Practices are in line with MHPS policies.
Action for next year:	Add EDI data into ROAG reporting and reflect on data produced.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	No action
Comments:	Clinical effectiveness groups have been set up and wider governance/training issues are regularly disseminated to medical and other staff where relevant. There is a clear HR process about updating policies and procedures to ensure they are in line with national updates. An example is adjusting relevant policies to take into account the Just and Restorative Culture learning.
Action for next year:	No action.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	No action
Comments:	The Trust has a well-developed PDR process which is actively monitored and quality assured for AfC staff, alongside the appraisal system for doctors. Dentists have a similar arrangement and report into ROAG annually that this has taken place for all dentists.
Action for next year:	No action

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	**No action**
Comments:	The Head of Medical Workforce has undertaken a local audit of checks held. No concerns were raised as a result of these checks, but some opportunities for improvement were identified which are highlighted as actions for next year below
Action for next year:	Bring greater consistency to the way in which documents are stored on files, and introduce a peer to peer quality assurance process within the medical HR team before a doctor's file is signed off as compliant

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	**No action**
Comments:	Within the last year, the Trust has established new, and fully recruited to, associate medical director and medical lead roles.This has provided greater stability in our culture and environment, creating better conditions in which clinical care can flourish and be continually enhanced. Clincal effectiveness groups meet regularly across professions and the Trust has committed to the Just and Restorative Learning Culture, introducing the Patient Safety Incident Response Framework which supports a culture of learning and clinical excellence.
Action for next year:	**No change**

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	**No action**
Comments:	We have several staff networks focused on supporting and giving greater voice to staff members with protected characteristics, and are currently focused on embedding a Restorative, Just and Learning Culture across the Trust. EDI and protected characteristic data is collected for all staff where concerns are raised and this is reported regularly to the board to ensure that there is consistency and transparency in processes.
Action for next year:	No change

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	**No action**

Comments:	We have Freedom to Speak Up Guardians in place, who have good reach across the organisation. We have a separate policy and process for Whistleblowing. We Board level champions for both FTSU and Whistleblowing, to whom we provide ongoing assurance, and receive constructive challenge, to ensure that our mechanisms are robust, and support our learning culture. There is an on-going programme considering merging our speaking up policies and frameworks (FTSU and Whistleblowing) in line with both the guidance from the National FTSU Guardian's Office, and our ongoing development of our Restorative, Just and Learning Culture.
Action for next year:	No change

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	No action
Comments:	Feedback is sought and a formal complaints procedure exists but the new 'Managing concerns about doctors' policy (currently being written) will make this process more explicit.
Action for next year:	No change.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	No action
Comments:	All case-management cases have this data collected by central HR functions but it has not been separately collected for doctors, but this process has started this year and will be able to be reported in the next year.
Action for next year:	Report parity data in ROAG meetings for discussion.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	**No action**
Comments:	RO and medical lead for appraisal regularly attend network meetings and there is regular communication and benchmarking with neighbouring Trusts.
Action for next year:	No change.

Section 2 – metrics

Year covered by this report and statement: **1 April 2023 - 31March 2024** .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	217

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**175**
Total number of appraisals approved missed	**62**
Total number of unapproved missed	**0**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	59
Total number of late recommendations	0

Total number of positive recommendations	53
Total number of deferrals made	6
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	**16**
Total number of trained case managers	**2**
Total number of new concerns registered	**10**
Total number of concerns processes completed	**8**
Longest duration of concerns process of those open on 31 March	**22 months**
Median duration of concerns processes closed	**6.8 months**
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**3 referred (not by us)**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	28
Number of new employment checks completed before commencement of employment	0

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	-

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

Objective	Action	Progress
Resolve issue of appraiser capacity	1. Review how the new job planning policy affects take-up of more appraisal work. 2. Improve retention by network events and investigate other avenues of support.	The situation continues to improve with uptake of the appraiser contract, and it is hoped that by the end of the 24/25 appraiser year that we will have sufficient appraiser capacity. Appraiser refresher events are going well
Review Trust procedures and processes	1. Review Trust Procedure for medical appraisal and revalidation 2. Re-start quality assurance of medical appraisals 3. Review medical HR procedures regarding starters/leavers and honorary contracts.	The appraisal and revalidation policy is drafted and awaiting final feedback and ratification Quality assurance (audit using PROGRESS tool) has started Good progress has been made regarding medical HR processes, with improvement opportunities identified through local audits. The honorary contract process has been reviewed, and the general recruitment team are learning from the good practice used within the medical honorary contract processes.
Improve quality of supporting information	1. Review how information regarding complaints/PSI can be reported easily to CDs for appraisal purposes 2. Ensure that the medical revalidation intranet page is kept up to date.	This continues to be a challenge to obtain timely, accurate, objective information regarding complaints/PSI for doctors' appraisal Information has been provided for all users of the new Allocate system and this is an area of on-going development and improvement.

	3. Process user friendly guide for the use of the electronic system and how to complete the online form.	

Actions still outstanding

On-going discussions about how to produce individualised complaints/PSI information in new structures taking into account Just and Restorative Culture of Learning from incidents and current reporting software.

Quality assurance – re-starting audits of appraisal outputs.

Finalising medical appraisal and revalidation policy.

Appraiser capacity improving but still not fully at capacity.

Current issues

New electronic appraisal system – the current software solution does not deliver on every aspect required for the appraisal and revalidation process however, measures have been put in place to mitigate this.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Objective	**Action**	**Expected outcome**
Resolve issue of appraiser capacity	Encourage medical line managers to discuss becoming an appraiser with a wider group of consultants and SAS doctors.	To reduce the need for additional paid appraisals by the end of the appraisal year. To have sufficient capacity to ensure all new medical recruits can be promptly allocated an appraiser.
Review Trust procedures and processes	Finalise and ratify the Medical appraisal and revalidation policy.	Improve transparency and consistency of processes.

	Develop transparent policy regarding responsibilities for bank and honorary contract holders.	
Quality assurance	Complete audit of appraisal outputs using PROGRESS tool. Provide feedback to appraisers individually using audit and appraisee feedback information. Ensure audits of background checks for new medical staff are done and acted upon.	Improve quality of appraisal outputs and identify training needs for appraisers. Ensure safeguarding and legal requirements consistently met for all new medical starters.
Improve quality of supporting information	Continue discussions with PALS and PSI team on how to obtain accurate, timely and objective information to support appraisals.	Improve assurance of safe working to the RO for revalidation and that complaints/PSI are reflected in appraisals.
Engagement and wellbeing of doctors	Continue to monitor use of software and identify issues and ease of use. Keep risk register up-to-date regarding software used.	Ensure that when we mandate use of a software solution for doctors, that it is fit for purpose and does not lead to extra work/stress.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Overall this has been a successful year with the implementation of our electronic appraisal system, improving quality assurance, and improved appraiser capacity. There is on-going improvement work in all of these areas as outlined above.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Oxford Health NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

(Agenda item: 12)

25 September 2024

Research and Development/Innovation Report

For information

This report covers recent activity related to the Research and Development (R&D) Senior Management Team (SMT) and Research Office under the direction of Professor Vanessa Raymont, R&D Director. The National Institute for Health and Care Research (NIHR) Oxford Health (OH) Biomedical Research Centre (BRC) is reported separately, and a detailed OH-BRC update was submitted to the Board in July 2024.

VR clinic/gameChange: gameChange VR, an automated therapy for treating severe agoraphobic avoidance in psychosis, has been approved by NICE for use within the NHS and progress continues apace with the planning and adaptation phases of an implementation roadmap for the VR clinic. In support of this, a project team across Oxfordshire and Buckinghamshire is engaging with primary and secondary care teams in OHFT to understand local mental health needs and identify pilot sites for the clinic's implementation. Collaborations with pilot sites will focus on developing infrastructure for identifying, assessing, and treating patients, while also addressing potential health and digital inequalities to ensure inclusivity. Coordination with the Clinical Systems Transformation Team will ensure regulatory approvals are met before its 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 across the NHS.

Initial pilot sites (City & NE Oxford AMHT and Aylesbury AMHT) have been identified and Professor Daniel Freeman has been successful in a funding application to the NIHR i4i and OLS Real World Evidence Call, subject to minor amendments. This funding will enable a 'a real-world' wait list randomised controlled trial (RCT) of gameChange VR for patients with the most severe mental health difficulties.

Neu Health Service Evaluation: In collaboration with colleagues from the University of Oxford and a commercial spin out company from OH-BRC, staff from OH R&D and the Older Adults Community Mental Health team are in the process of setting up a service evaluation project of a new digital application. The company (Neu Health) have developed an innovative digital platform to support patients and their carers in monitoring the patient's symptoms, which can provide rapid feedback to patients and their clinicians, potentially providing options for digital follow up prompting targeted face-to-face appointments. Initially

trialed in patients with Parkinson's Disease, Neu Health have expanded the platform to include patients with Mild Cognitive Impairment (MCI). Oxford Health NHS FT (OHFT) will partner with Neu Health to offer the platform to patients for a six-month period and will be the first Trust in the country to evaluate the platform in this patient group. Although the aim is to assess the acceptability and feasibility of the platform to patients, carers and NHS staff, the collaboration offers a unique opportunity to explore potential new patient pathways. Given recent advancements in dementia treatment, coupled with the ongoing development of a lumbar puncture clinic at OHFT's Clinical Research Facility (CRF), the Neu Health collaboration is perfectly timed to shine a light on the changing needs of this population and services. The Neu Health platform has opened the door to new areas of service development which, if successful, will be an important exemplar of OHFT's ability to take forward its own translational research through the research pathway and into the NHS.

Oxford **P**revention and **E**arly detectio**N (OPEN) Service:** NICE guidelines and the NHS Access and Waiting Time (AWT) standards recommend the provision of specialised assessment, individual and family psychosocial interventions, and support for comorbid conditions to young people meeting criteria for an At-Risk Mental State for Psychosis (ARMS). However, currently there is no dedicated service for people with an ARMS in OHFT. In response to this, the OPEN service has been set up to meet this unmet need, providing specialist services for adolescents and young adults across Oxfordshire with an ARMS. The team's remit is to identify, assess, and treat people aged from 14-35 years with ARMS to ameliorate current symptoms and problems, and improve long-term outcomes, such as the risk of later progression to psychosis. The service has been designed to support and reduce burden on OHFT existing services (EIS, CAMHS, CMHT, Keystone hubs) by providing specialist advice, reducing waiting lists and caseloads. Data suggest the programme is well-accepted by service users and is clinically and cost effective. Plans are well-developed to submit a fully costed bid for funding to OHFT later this financial year.

Mental Health Mission: Phase 1 (£43 million over 5 years) of the Mental Health Mission (MHM) is managed and led by the Mental Health Translational Research Collaboration (MH-TRC), hosted by Oxford Health. Governance for the mission is through established OH BRC governance structures, which continues to work well. Reputational benefit from the mission continues to flourish, with the recent award of £18 million for the Mood Disorders Research Clinic Network, which included funding for 7 new sites. The competition ran over the Summer, with 16 applicants and 7 successful sites identified. These sites provided a good geographical spread, covering all but one Research Delivery Networks (RDNs) in England, 2 sites in Scotland and 1 site in Wales. Most of the workstreams and demonstrator sites remain on track with their objectives. Additionally, a seed-corn award competition was run in the Spring, with 10 awards of up to £40k made

New appointments: Rachel Upthegrove, Professor of Psychiatry and Director Designate of the NIHR OH BRC joined the University of Oxford in August 2024, where she is working to manage the transition to Director ahead of Professor Geddes stepping down from the role in November 2024. Since May 2023 Professor Upthegrove has been Chair of the NIHR Mental Health Translational Research Collaboration (MH TRC), which manages the Office for Life Science's Mental Health Mission (MHM). Given the reputational and financial importance of both infrastructures to Oxford Health, Professor Upthegrove's appointment will be key to developing and shaping the strategy to successfully rebid for their continued funding.

Dr Martin Batty also joined the Trust in August 2024, taking over from Bill Wells as Head of R&D. Martin's appointment will help shore up leadership in R&D, working closely with Vanessa Raymont and the Senior Management Team.

Author: Professor Vanessa Raymont
Lead Executive Director: Dr Karl Marlowe

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

(Agenda item: 13)

Board of Directors

25 September 2024

Mortality & Suicide Prevention Report

Aim of report

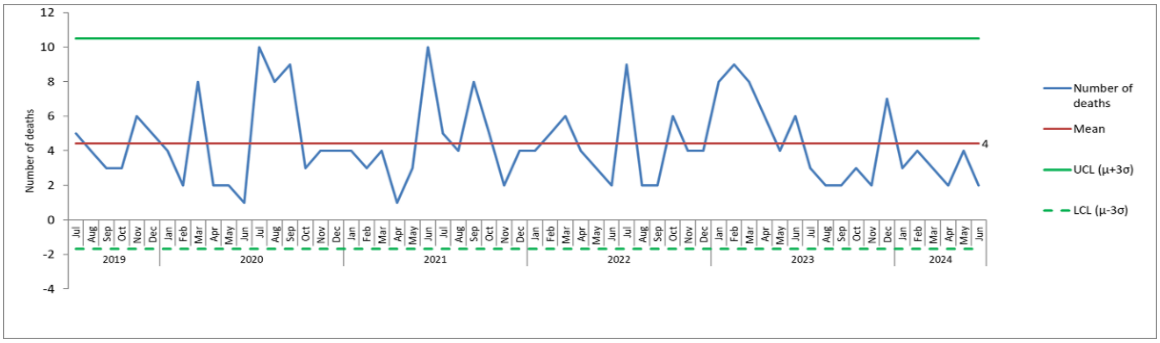
This report is to for information purposes to provide a 6 monthly update to the Board on specific suicide prevention activity within the Trust.

Data

Recent ONS national figures for suicides for England and Wales registered in 2023, indicate an increase compared with 2022 (6,069 deaths/11.4 per 100,000 compared with 5,542 deaths/10.7 per 100,000). This is the highest rate since 1999. Possible explanations for this increase include the economic climate, and the importance of including finances in assessments. We are working to include a money worries section on the RIO risk assessment page to support assessment documentation.

Locally, there have been 41 confirmed/suspected suicides for open and discharged OHFT patients in the last 12 months (9 suicides in Q1), this includes patients who have been seen at any time by trust services. 23 patients were open at the time of their death to OHFT services. A higher number of suicides of men (28 males/13 females). We have seen a lower number of deaths by month between Feb-June 2024. The Thames Valley Real Time Surveillance System shows that for about half of all suspected suicides in the population the person was known at some time to OHFT services.

Number of confirmed/suspected suicides



Suicide Prevention Steering Group

The Trust suicide prevention steering group has been extended to include representation from Oxfordshire and Buckinghamshire public health teams to facilitate partnership working. OHFT also has robust representation on the Oxon, Bucks and BSW public health multi-agency suicide prevention groups and the Thames Valley Suicide Prevention and Intervention Network to ensure sharing of intelligence and alignment with local need and national strategy.

Clinical services

The current focus is the National Confidential Inquiry 10 Ways to Safety NCHISH-banner px (manchester.ac.uk) and annual reports NCISH | Annual report 2024: UK patient and general population data 2011-2021 (manchester.ac.uk).

Self assessment against the NCISH 10 ways to safety toolkit has been carried out and steps taken to ensure this is included in directorate quality SMT meetings to identify and plan improvement where indicated. Trust suicide data from the last 5 years has been compared with data from the NCISH 2024 annual report to enable comparison and identify areas of strength and need. A Trust infographic has been developed (see appendix) and Bucks and Oxon/BSW specific infographics are in development. This exercise will be carried out annually following publication of NCISH reports to enable directorates to monitor changes and prioritise areas.

Training & Learning

Suicide prevention and awareness training for qualified staff has been increased to two face to face days to enable attention to the necessary skills for effective assessment and management of suicide risk. The mandatory clinical risk assessment and management training for qualified staff will be extended to a full day from April 2025 to enable more scenario and discussion, to build confidence in risk formulation.

A series of online tutorials have been developed to assist clinicians navigate the risk assessment page in RIO, which are due to be launched during patient safety week on 19th September.

Training for unqualified staff members is an area for development.

A conference was held World Suicide Prevention Day, 10th September, with a focus on working with clinical populations. This was well attended and resulted in helpful learning resources which are be available for all staff via the Trust suicide prevention page. In addition, a Webinar focused on adapted safety planning for autistic adults attracted 300 staff and again the recording and associated links will be available to staff via the suicide prevention intranet page.

Research
The RAPID trial RAPID TRIAL – Remote Approaches To Psychosocial Intervention (psychosisresearch.com) is ongoing.

A NHSE systematic review of research investigating mental health problems, self-harm and suicide among mental health nurses is ongoing.

A funded research study investigating the spiritual needs of people bereaved by suicide is in the design phase.

A collaboration with a US team to implement and validate the suicide competence assessment is ongoing (ethical approvals are being applied for).

Governance Route/Escalation Process
This six monthly update report will be presented at the meeting of the Quality and clinical governance sub committee group on 26th September 2024.

Recommendation
The Board is asked to confirm that it is assured with progress.

Author and Title: Karen Lascelles, Nurse Consultant
Lead Executive Director: Karl Marlowe CMO

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*

   1) Quality - Deliver the best possible care and health outcomes
   Strategic risk themes: Utilising Digital, Data and Technology; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Sustainability (Community Oxfordshire).

   4) Research and Education – Become a leader in healthcare research and education
   Strategic risk themes: Research and Development potential.

Report to the Meeting of the
Oxford Health NHS Foundation Trust

Board of Directors

(Agenda item: 14)

25 September 2024

Patient Safety Incidents reviews July and August 2024
For: Assurance

Executive Summary
It is crucial that we learn from every incident and near miss that happens to identify and address system issues to continually improve the safety of care. We transitioned and started working under PSIRF from 4th December 2023. The documents setting out our approach and local incident response plan have been published and are available here Patient Safety Incident Response Framework (PSIRF) - Oxford Health NHS Foundation Trust.

The report focuses on the period July and August 2024 following on from the last report. Five reviews within our new local incident response plan have been identified in the period:

- 2 Unexpected unnatural death (suspected suicide).
- 1 Sepsis death.
- 1 significant self harm
- 1 missed fracture

The key areas of learning we have identified from the 5 PSI reviews completed in July and August, is summarised within the report. Learning is shared in various ways and formats with clinical teams, ward/team managers, senior clinicians, as well as through a series of Trust-wide forums. The key Trust-wide forums are; the Weekly Review Meeting, weekly Executive Director patient safety panel, monthly Quality and Clinical Governance Sub-Committee, quarterly Quality Improvement and Learning Forum and the quarterly Quality Committee.

Governance Route/Escalation Process
The Trust has a series of weekly and monthly patient safety forums which review the details of the information summarized in this report.

Recommendation
For the Board to be assured regarding the current processes and structures for the identification, review and learning from patient safety incidents.

Author and Title: **Victoria Harte, Patient Safety Service Manager**

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 – 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 clinical care and health outcomes

1.0 Patient Safety Incident reviews

As part of the national Patient Safety Strategy around developing a safer culture, safer systems, and safer patient care was the development of the Patient Safety Incident Response Framework (PSIRF). This was a welcome but significant change in how we think and behave in relation to developing how we learn and improve from patient safety incidents. The Trust transitioned and started working under PSIRF from 4th December 2023, following support from the ICB, Provider Collaboratives and BOB ICS system Quality Forum. A summary of our approach and new way of working under the PSIRF as well as our new local incident response plan is published on the Trust's website and available here Patient Safety Incident Response Framework (PSIRF) - Oxford Health NHS Foundation Trust.

Following the last report there have been five reviews identified meeting our new incident response plan (local safety areas we identified to focus on), in total this takes us to 41 reviews under PSIRF from 4th December 2023 to 31st August 2024. These 41 reviews have taken various learning response forms for example thematic reviews, incident learning huddles, observational audits, system reviews, in-depth investigations, appreciative injury, and work using the Triangle of Care tool developed by the Carers Trust. We have found we have been able to identify and start learning quicker with 21 out of the 41 reviews already completed. These are some of the early benefits we have seen with the implementation of PSIRF. All the incidents declared within the 'Serious Incident Framework' have been completed. So all current investigations underway are within PSIRF.

The recent patient incidents under PSRIF identified in July and August 2024 are described below;

- 2 Unexpected unnatural death (suspected suicide).
- 1 Sepsis death.
- 1 significant self harm
- 1 missed fracture

2.0 Completed Investigations and Learning

Internal PSIRP reviews

We use a systems-based methodology to identify and act on learning. A summary of the key actions from the investigations and reviews completed in May and June 2024 is shared below.

Learning is shared in various ways and formats with clinical teams, ward/team managers, senior clinicians, as well as through a series of Trust-wide forums. The key Trust-wide forums are; the Weekly Review Meeting, weekly Executive Director patient safety panel, monthly Quality and Clinical Governance Sub-Committee, quarterly Quality Improvement and Learning Forum and the quarterly Quality Committee. Individual actions from each review are monitored centrally with progress against these reported through various reports and forums.

There were also a number of good practice identified from these reviews. To note a few:

- good system working with excellent communication between AMHT and GP and the family.
- Team commended on the care delivered.

Improvement area	Action(s)
Discharge planning and involving family	The ward has added to discharge checklist contact with family, to aid in prompting this to occur.
Discharge process in CAMHS team	Strengthened process to ensure summary of care, care plan/safety plan. Also sharing these with other professionals involved in care.
Structure of MDT meetings in CAMHS team	Reviewing structure and process to identify and discuss key changes in care plans.
Involvement and information to patient during triage	Process altered to ensure patients are involved in triage, and also informed of outcome.
Communication/engaging with patients on waiting list	Check points being added for young people on waitlist.
Documentation and plans regarding alteration of observation level	The rational for alteration of observation level should be discussed and agreed. Also documented in notes. The ward are discussing this learning to ensure all aware of what to do.
Timeliness of discharge letter being sent to GP	Importance of letters being sent within 7 day timeframe discussed in business meeting. Monitoring through audit planned.
Communicating progress on rolling out Primary Care Mental Health Hubs	Information regarding the progress of setting up PCMH's sent across Oxon Mental Health Directorate, including which areas have a PCMH and what GP surgeries they are aligned with.
Attendance at Criminal Justice and Mental Health Panel (CJMH)	Review being completed regarding attendance and cascade to teams and service managers.
Environment of 136 suit was not suitable for patient – placed in other area on ward.	Review the S136 suite environment and facilities and whether these are suitable for patients with physical health needs including wheelchair users.
A number of reviews had highlighted the challenges of multiple electronic patient record systems	This is known issue – finding of reviews are being fed into system development forums.

<u>PSII completed following suspected homicide.</u>

A suspected homicide of a person happened in February 2024. The perpetrator was known to mental health services. This is a externally commissioned Domestic Abuse Related Death Review being completed. The internal PSII review has been completed for this case and will feed into this external review. The internal review highlighted several areas of learning, all have been captured into action already take or improvement plans with associated action plan. When the external review has been completed the review, its finding and action plan will be published.

PUBLIC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

Agenda item: 15

Board of Directors

25 September 2024

Update report: Board Committee annual reports and Terms of Reference

For: Receipt and Assurance

Executive Summary

Further to the report to the Board meeting on 24 July 2024, the annual report of the Finance & Investment Committee is now available together with the updated Terms of Reference for the Quality Committee and the Mental Health & Law Committee. Committee annual reports summarise performance and the work each committee considered during the year. The detail is available in the Reading Room if required. The Board is reminded that, at its previous meeting in July, it already received the annual reports of the: Audit Committee; Quality Committee; People, Leadership & Culture Committee; Mental Health & Law Committee; Charity Committee; and the Warneford Park Programme Board.

Background

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.

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 report of the Finance & Investment Committee and the Terms of Reference for the Quality Committee and the Mental Health & Law Committee.

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: Digital, Data & Technology; 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; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Business Continuity and Emergency Planning; Environmental Impact; and Major Projects.

Oxford Health NHS Foundation Trust

(Agenda item 16(i))

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

25 September 2024

Corporate Registers: Application of Trust Seal

For: Information and Assurance

Introduction

The Common Seal of the Trust is affixed to documents under the authority of the Board of Directors in accordance with its Standing Orders. A Register of Seals is maintained by the Director of Corporate Affairs & Company Secretary.

Standing Orders require, pursuant to section 9, that a report of all seals is made to the Board. The Trust's Board of Directors receives reports of all seals, its last report being presented on 27 March 2024. This report provides information about the application of the Trust's seal between 19 February 2024 and last entry 16 September 2024.

The Board of Directors is invited to note that the following documents were sealed during this period:

REGISTER OF SEALING

Details	Seal No.	Signatory	Date
Revisionary lease for Clock House, Abingdon. Lease terms between Dove Developments Limited and Oxford Health NHS FT. Commencement 25th December 2024 to 25th December 2029. Yearly rent £58,000.	409	Grant Macdonald, Chief Executive Kerry Rogers, Director of Corporate Affairs	18/03/2024

		& Company Secretary	
New lease for Murray, Jordan Hill Business Park. Lease terms between the Chancellor Masters and Scholars of The University of Oxford and Oxford Health NHS FT. Commencing from completion of the lease for 20 years, expiring in 2044. Yearly rent £408,699 p.a. excl VAT.	410	Grant Macdonald, Chief Executive Kerry Rogers, Director of Corporate Affairs & Company Secretary	18/03/2024
New lease for Kingfisher House, Wantage, OX12 9YN. Units 2 & 18 and Licence of Alterations. Lease terms between Kings Park Leisure Limited and Oxford Health NHS FT. Commencing from completion of the lease for 5 years, expiring in 2029. Yearly annual rent for both premises £42,000 p.a. (excl VAT).	411	Grant Macdonald, Chief Executive Heather Smith, Chief Finance Officer	25/03/2024
Sales contract and transfer deed (TRI) for disposal of Shrublands, High Wycombe aka Haywood House. Contract between Oxford Health NHS Foundation Trust (seller), Property Matters Albion LTD (PMA) and Nearton End Ltd (Buyer). Sale price £500k with timetable of completion to take place 3 weeks after exchange of contracts.	413	Grant Macdonald, Chief Executive Heather Smith, Chief Finance Officer	22/07/2024
Lease renewals for Unit 42-44a and Unit 46 Sandford Lane. Lease commencement 1st April 2024 for a term of 5 years. Annual rent of £62,751 per annum excl. of VAT. Lease between Sandford Lane oxford Limited and Oxford Health NHS Foundation Trust. Option to give 3 months' notice and ext at break date 18 months after signature i.e. in 2025.	414	Grant Macdonald, Chief Executive Heather Smith, Chief Finance Officer	08/07/2024
Renewal lease for exclusively demised offices and a new licence for shared consulting rooms for OUH family planning services. Terms agreed will extend their occupation until 2029 whilst incorporating a rolling break that can be served at any time. Lease/licence terms: landlord is Oxford Health NHS Foundation Trust, tenant is Oxford University	415	Grant Macdonald, Chief Executive Heather Smith, Chief Finance Officer	28/08/2024

Hospitals NHS Foundation Trust. Term backdated to 1st April 2024 for 5 years, expiring 31st March 2029. Yearly rent £24.5k excl. VAT.			
OUH renewal lease at Rectory Centre 949895 and lease of part of the Rectory Centre, Rectory Road, Oxford, OX4 1BU. Lease commencement 1st April 2024 to 31st March 2027 (OUH) and to 31st March 2029 (part of Rectory Centre). Yearly rent of £60,000 p.a. exc VAT (OUH) and of £106,000 p.a. exc VAT (part of Rectory Centre). 6 months written notice at any time.	416	Grant Macdonald, Chief Executive Heather Smith, Chief Finance Officer	16/09/2024

Recommendation

The Board is asked to note this report.

Author and Title: Nicola Gill, Corporate Governance Officer
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*** *– this report relates to or provides assurance and evidence against the following Strategic Objectives/Priorities*

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

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

Oxford Health NHS Foundation Trust

(Agenda item 16(ii))

Report to the Meeting of the Oxford Health NHS Foundation Trust Board of Directors

25 September 2024

Corporate Registers – Gifts, Hospitality & Sponsorship

The Board is asked to note the following Corporate Register:

- Entries in the Register of Gifts, Hospitality & Sponsorship since the last report presented to the Board on 22 May 2024.

GIFTS AND HOSPITALITY (ACCEPTED)

	Details	Individuals	Est. Value	Date Reported
1	Received a glass of wine and light lunch provided at the Laing family home.	Heather Smith, Chief Finance Officer	Unknown	15/05/2024
2	Dinner in London with the Good Governance Institute which cost approx.. £70 per head.	Andrea Young, Non-Executive Director	Approx.. £70 per head	03/06/2024
3	Dinner provided by the Good Governance Institute whilst attending a seminar	Grant Macdonald, Chief Executive	Unknown	20/06/2024
4	Received the following from Jessie Bellinger, 3M local rep.	Ifan George, Senior Dental Officer	Approx.. £109	24/07/2024

	Scotchbrand adhesive sample 1.5ml RRP £40 Filtek Bulk Fill sample 1g x 2 £12.50 each Supreme Flowable 1g x 2 £16 each 5 small capsules of composite £12.50			

GIFTS AND HOSPITALITY (DONATED INTO THE TRUST CHARITY)

	Details	**Individuals**	**Est. Value**	**Date Reported**
5	£10 cash received from patient to member of the team who was leaving the Trust. This was donated to the Trust Charity on 01/07/2024.	Charis Smith, District Nursing Locality Lead	£10	02/01/2024
6	£25 Costa voucher received from patient. This was donated to the Trust Charity on 14/05/2024.	Sarah Buckingham, Specialist in Special Care Dentistry	£25	01/04/2024
7	£20 Lush gift card/voucher received from patient. This was donated to the Trust Charity on 17/06/2024.	Fiona Clements, Counselling Psychologist, Adult Community Eating Disorder Service	£20	26/04/2024
8	Received £50 cash as a gift from a patient. This was donated to the Trust Charity on 05/06/2024.	Neil Carver, Specialist Practice Educator	£50	28/05/2024

GIFTS AND HOSPITALITY (INVESTIGATION/BREACHES)

Cases are under investigation, if vouchers have been accepted from patients/families then there will have been a breach of policy and this will be discussed with staff who will be

reminded of the guidance to follow.[1] However, if possible to decline or redirect the vouchers to the Trust's Charity then this will be done as an alternative.

	Details	**Est. Value**	**Date Reported**
	None during the reporting period.		

SPONSORSHIP

	Details	**Individuals**	**Est. Value**	**Date Reported**
	None during the reporting period.			

Recommendation
The Board is invited to note this report.

Author and Title: Nicola Gill, Corporate Governance Officer
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*** *– no Strategic Objectives/Priorities apply to this report.*

[1] NHS England guidance – gifts of cash and vouchers to individuals from patients/families/service users should always be declined https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf

BOARD ASSURANCE FRAMEWORK FULL VERSION SEPTEMBER 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)** **MONITORING COMMITTEE**	**RISK**	**CURRENT RATING**	**TARGET**	**MOVEMENT**	**REVIEW Date**
1. Quality - Deliver the best possible care and outcomes						
1.1	Chief Finance Officer Finance & Investment Committee	**Utilising digital, data and technology to drive quality, efficiency, economy, research, and innovation** A failure to utilise and engage with digital, data and technology to drive quality, efficiency, economy, research, insights, analytics and innovation, resulting in poorer patient outcomes and experience, lack of insights to support decisions, lower return on investments, lack of insights driving quality improvements, lack of innovations.	12	6	↑	17/09/24 17/09/24
1.5	Chief Operating Officer for MH & LD Quality Committee	**Unavailability of beds/demand and capacity (Mental Health inpatient and Learning Disability)** 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	8	↔	21/08/24 28/08/24
1.6	Chief Operating Officer for Primary Care & Community Quality Committee	**Sustainability of the Trust's primary, community & dental care services** 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.	12	9	↔	13/08/24 28/08/24

2. People - Be a great place to work						
2.3	Chief People Officer People Leadership and Culture Committee	**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 10/07/24
2.4	Chief People Officer People Leadership and Culture Committee	**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.	9	4	↔	13/09/24 10/07/24
2.5	Chief People Officer People Leadership and Culture Committee	**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 10/07/24
2.6	Chief People Officer People Leadership and Culture Committee	**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.	16	9	↔	01/07/24 10/07/24

3. Sustainability - Make the best use of our resources and protect the environment						
3.1	Executive Director of Strategy & Partnerships 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.** 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.	12	9	↔	02/07/24 28/08/24
3.4	Chief Finance Officer Finance & Investment	**Delivery of the financial plan and maintaining financial sustainability** 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.	16	12	↔	19/06/24 17/09/24
3.6	Director of Corporate Affairs & Co Sec Audit Committee	**Governance and decision-making arrangements** 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.	8	4	↔	19/03/24 23/04/24
3.7	Executive Director of Strategy & Partnerships Finance & Investment	**Ineffective business planning arrangements** 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.	12	6	↔	21/08/24 17/09/24

3.10	Chief Finance Officer Finance & Investment	**Information Governance & Cyber Security** 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.	12	9	↔	08/03/24 17/09/24
3.12	Director of Corporate Affairs & Co Sec Emergency preparedness, resilience and response committee (sub-group to Executive Management Committee) and Audit Committee	**Business continuity and emergency planning** 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.	9	9	↔	16/02/24 23/04/24
3.13	Chief Finance Officer Finance & Investment	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.	9	3	↔	21/08/24 17/09/24
3.14	Chief Finance Officer Finance & Investment	**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; non-delivery of required savings, unplanned expenses, delays and wasted resources.	16	6	↔	12/08/24 17/09/24
4. Research & Education - Become a leader in healthcare research and education						
4.1	Chief Medical Officer Quality Committee	**Not maximising the Trust's Research and Development (R&D) potential.** Not maximising the potential 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.	6	3	↔	13/08/24 28/08/24

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

Date added to BAF	10 February 2022
Monitoring Committee	Finance & Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	17/09/24
Risk movement	↑
Date of next review	December 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**4**	**3**	**12**
Target risk rating	**3**	**2**	**6**
Target to be achieved by	March 2026		

Risk Description:

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

Key Controls	Assurance	Gaps	Actions
Implementation of the Trust Digital Strategy Revised improved Governance across Digital, Data and Technology within the Trust and across the ICS. Programme and project management of Frontline Digitisation strategic programme. Embedding the development and use of TOBI (Trust Online Business Intelligence) data from ward to Board level. Engagement with Data Platforms for direct care, insights, including population health insights and analytics. Collaboration with Oxford University and other health research organisations and networks to support	**Level 1: reassurance** Digital Strategy Implementation Plan review to ensure delivery by 2026. Right governance to facilitate clinical engagement in the digital programme of works. Exec oversight of Frontline Digitisation programme. Integrated Performance Report to Board to provide assurance around Trust performance and data Utilisation of data for insights and analytics to support direct care, service improvements and population health analytics. Digital Data and Technology Governance pulling together all	GAP: Due to the cyber-attack on the clinical systems supplier and subsequent 5-month outage in 2022, clinical data was captured outside of clinical systems in an unstructured format. As the new systems were implemented, they were only basic systems initially capturing basic clinical data. 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. GAP: Lost opportunities to develop data insight, population health analytics, system interoperability, health innovations due to the focus being on recovery from the outage. Outcome measure data lacking.	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. Data recovery programme overseen by Trust CEO. Business Continuity Working Group to ensure any future data gaps are relevant and agreed ACTION: Ensure the Trust engages to focus on realising the benefits of the data analytics platforms with links to the optimisation programme and Truecolours.

innovation, quality improvements and commercial development. Utilisation of Oxford Healthcare Improvement (OHI) Centre skills and resources to support data insights, analytics and service improvements. Optimisation Programmes of Trusts new EPRs to ensure the right data is captured at the point of care. Data Quality Programme to ensure good quality data is captured at the point of care. Co-production and user engagement in all developments, optimisations and implementations. Horizon scanning to ensure right choices are being made.	elements into the Digital, Data and Technology Strategy Board meetings, feeding into the Executive Committee and Board. Innovation Pipeline to facilitate oversight, prioritisation and resources for Trust digital innovations. Digital Clinical Safety Group supported by CCIO to provide assurance re clinical data. Digital Leadership Team now including CNIO to facilitate clinical engagement and oversight. Artificial Intelligence (AI) Strategic Group to facilitate innovative AI projects leveraging efficiencies. Digital, Data and Technology Skills and Workforce Group within the Trust, ICS and Regional to focus on upskilling the digital data and technology champions and wider digital skills. Data, Analytics and Research Group within the Trust and ICS to facilitate use of data platforms. Level 2: internal Digital programme highlight reports for Digital Data and Technology Board.	GAP / OPPORTUNITY: Interdependency on other NHS organisations for data platforms such as Federated Data Platform, Shared Care Record, Secure Data Environment. 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 not 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. GAP: Target architecture not set out, to identify any Technology and Infrastructure gaps. GAP: Transparency over support, service and availability and relationship management. GAP: Lack of strategic approach to ensure the value of the Trust's data is	ACTION: Ensure resources are applied to engage with the programmes around external data platforms. 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 alongside the ICS and regional groups. ACTION: Focus on facilitating the digital recording of patient outcome measures across the Trust. ACTION: Engage with patients and research team around "Count me in". ACTION: Engage with BRC Data Science Theme team ACTION: Support digital innovations from idea to implementation using agile methodology. ACTION: Enabler 2 work on corporate services transparency and responsiveness, to include digital and technology.

	Data Quality Group focussing on key data quality issues. Information Management Group Digital Update. Finance and Investment Committee oversight of Frontline Digitisation Programme. Integrated Performance Report to Board. Internal Trust Digital Assurances – Cyber Security, Infrastructure Assessment, Clinical Safety, Information Governance. Level 3: independent NHSE Mandatory Clinical Data Reporting. CQC Inspections. Patient/carer feedback, incl. 'I Want Great Care' results. Use of NHSE Digital Maturity Framework "What Good Looks Like" to measure Trusts Digital Maturity improvement aligned to the Digital Programme of works. Internal audit reviews KPMG assurance of Frontline Digitisation programme governance. Knowledge sharing with Berkshire Healthcare digital teams as part of Mental Health Provider Collaborative and with ICS counterparts.	being realised and to drive data insights.	

	NHSE digital assurance framework DTAC [for assessing products]. Performance against national NHS Oversight Framework indicators [for services].		

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
Monitoring Committee	Quality Committee
Executive Lead	Chief Operating Officer for Mental Health & Learning Disabilities
Date of last review	09/07/24
Risk movement	↔
Date of next review	December 2024

	Impact	Likelihood	Rating
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** - Staffing reports performance reports via oversight with collaborative IPR as well Clinical oversight via Directorate monthly Senior Management Team (SMT) meetings and Exec, daily	1) Newly commissioned opened PICU not working to capacity due to lack of staff.	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

	monitoring SITREP reviews.		People, Leadership & Culture Committee). Ongoing Development of hospital at home CAMHS.
2) Adult eating disorder collaborative.	**Level 2: internal** - 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;	2) Staffing level challenge, delays in accessing.	2) Adult Eating Disorder (ED) service to extend and develop Day Hospital and Hospital at Home offerings; with aim to reduce need for T4 admission for ED treatment.
3 Timely access to beds for patients with Learning Disabilities	**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. 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.	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. Routine monitoring of OAPS by LD team which has dedicated case manager role who has oversight of all admissions
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; National review and roll of MH Operational		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,	4. 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

Pressures Escalation Level (OPEL) framework which has clear set of escalation to support access to local beds MH provider collaborative working across Buckinghamshire, Oxfordshire and West Berkshire to support and transform services, 3 key work programs: 1: Mental Health Crisis & Urgent Care – Community 2.3 Year Adult Inpatient Transformation 3. Localising Mental Health Services		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).	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 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 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. 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. Review of OEPL framework undertaken, once finalised nationally to be implemented across services Directorate SLTS engaged with Provider collaborative programme. Work commenced on all programmes, monitored by PC board

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
Executive Lead	Chief Operating Officer for Primary Care and Community
Date of last review	13/08/24
Risk movement	↔
Date of next review	December 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**4**	**3**	**12**
Target risk rating	**3**	3	**9**
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 and resolve gaps in staffing.	**Level 1: reassurance** **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	•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, specialist heart failure service). • 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 (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	*Short-term:* 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

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	(OILB). ICB-level 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).	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. There have been unexpected delays to the FY24 Estates work programme delaying on our ability to increase the capacity and sustainability of	discussed with LNC colleagues shortly. 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. *Longer-term:* 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. The Estates and Operational Directorate Teams are reviewing the sites and services affected by the delays to the works programme at

		services in the UEC pathway into FY25. This has impacted particularly on: The Oxford City Community Services Hub project – a rescheduling of the expected Jordan Hill development completion date to March 2024 has in turn delayed the service transformation timeline to bring together multiple children's and adult's service teams into a single North Hub The works to expand the Minor Injuries Unit at Witney Community Hospital have been delayed until FY26 due to insufficient capital funding in FY25 to complete the works. A review is underway to identify and manage immediate pressures on the MIU clinical space and patient waiting areas, to mitigate the increased patient attendances. NB. This issue impacts on the ability of the service to meet the national 4-hour ED performance target reported to Board. The works to develop a single expanded reception, waiting area and improved patient flow for the Urgent Care Centre and GP OOH clinics at The Fiennes Centre,	The Fiennes and Witney CH to agree a mitigation plan. This will manage any short-term service delivery risks until the works can be completed next financial year. The financial impacts of the City Hubs project and timeline changes largely fall on the Trust's capital programme and have been considered within this programme and reviewed at CPSC and FIC. There will be a modest impact on revenue which will be managed through usual financial monitoring and planning processes. 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 of April 2024; performance data should be available in the next few months. 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. This issue impacts on the ability of the service to meet the national 4-hour ED performance target. Performance against the 4-hour ED targets and the implementation of agreed mitigations plans will be reported to Board This will be monitored and managed through the usual financial and planning processes 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

		Banbury, have been postponed until FY26 due to insufficient capital funding in FY25 (the Trust's UEC capital funding bid to NHSE for this site was declined). This will in turn delay proposals to operationally integrate these services to reduce duplicated existing costs and improve patient experience and service sustainability.	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
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	4	16
Current risk rating	**3**	**4**	**12**
Target risk rating	2	2	4
Target to be achieved by			

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-	**Level 1: reassurance** -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	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	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;

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 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	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 perception of leadership development; - Yearly staff appraisals; PDR compliance rate was 91% in year 1 following successful implementation of PDR season. 2nd year 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	training figures achieved to date remain consistently strong. Aggregated compliance reporting of statutory and mandatory training mask success and risk areas. 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	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 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

- Implementation of a Trust wide approach to Leadership development under the NHS Leadership Academy 'Our Leadership way' framework	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.	f. There is a need for a clear segmented retention plan created in response to People Promise self-assessment – this is now being formulated.	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 tool which identified 'We work flexibly' as area most important to staff to focus retention plan.
		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.	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. Equality and Diversity. The WRES and WDES are monitored against national benchmarks and areas variation are reviewed and action plans developed.	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 QI race programmes will look like in light of the March 2024 WDES and WRES data. OWNER: Head of OD
		i, No formal succession planning/talent process in the Trust for clinical and non-clinical staff	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
		j, Leadership	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

	Impact	Likelihood	Rating

Executive Lead:	Chief People Officer
Date of last review	13/09/24
Risk movement	↔
Date of next review	December 2024

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; - Delivery of the NHS equality, diversity and inclusion (EDI) improvement plan by delivering all 6 of the High Impact Actions (HIA)	**Level 1: reassurance** -- 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	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	**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

- 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.	via take-up of Trust's model through BOB ICS.	element being below the national median. The score for **'we are safe and healthy'** is in line with the national median. Sexual Safety Charter 10 principles analysed, and gaps identified.	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 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.

		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.	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 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. Project Approach to delivery of the High Impact

		Delivery of the NHS equality, diversity and inclusion (EDI) improvement plan by delivering all 6 of the High Impact Actions (HIA) - Health	Actions which are monitored by the EDI Steering Group. On the 5th of September meeting the latest results are: 18 High Impact Actions are due to be completed and the current status is: • 9 are complete • 9 are pending • All HIAs have owners and estimated delivery dates

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	↔
Date of next review	September 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**3**	**12**
Target risk rating	3	3	9
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;	**Level 1: reassurance** - 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);	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	– 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.

- 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	- 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.	on staff leaving due to promotion. No specific work focusing on BAME early turnover/turnover.	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 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 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 member ship 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 collaborate with SE Temp Staffing Collaborative.			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:

			• 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
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	02/07/24
Risk movement	↔
Date of next review	October 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**3**	**12**
Target risk rating	4	2	8
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 **Level 2: internal** - Reporting through: Executive Management Committee; Strategic Delivery Group and Trust Board. **Level 3: independent** - ICS-level and Place-level emerging governance for Mental Health, Learning Disability and Autism (MH, LD&A) and Community	**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 **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. 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
Executive Lead	Chief Finance Officer
Date of last review	19/06/24
Risk movement	↔
Date of next review	September 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**4**	**16**
Target risk rating	4	3	12
Target to be achieved by	2027		

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** - 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.	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). FY25 plans currently remain a deficit. Owner: Chief Finance Officer b) Deliver plans to reduce agency spend further in FY25.

- 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 **Level 3: independent** - Internal Audit reviews including annual review of financial controls; - External Audit review pf financial statements; - Monthly reporting to, and monitoring by, NHSE and the Integrated Care Board (ICB).	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

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	↓
Date of next review	June 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**2**	**8**
Target risk rating	2	2	4
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, governance and assurance framework and performance	**Level 1: reassurance** 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** - Annual Governance Statement reviewed by Audit Committee and	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. The gap has been exacerbated by the clinical outage from which the Trust has not yet fully	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. Enabler 1 – Operating Framework – simplifying description of governance

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; - Maintenance of key Trust registers (e.g. declarations of interest,	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 Assurance Framework, Risk and Quality Governance and the Feb	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	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 and attuned to the system

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	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.	(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. *Gap & Action Closed*. 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
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	21/08/24
Risk movement	↔
Date of next review	December 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**3**	**12**
Target risk rating	3	2	6
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 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.**	**Level 1: reassurance** 1 year cycle of strategy development completed with Trust Board resulting in first iteration of Strategy Delivery Plan **now finalised. Trust Strategy Governance to oversee the progress of the Strategy Delivery Plan.** **Level 2: internal** Integrated Performance Report to the Board in public revised with focus on delivery against the strategic objectives via the strategic dashboard and performance against	a) Service Change and Delivery (SCAD) Team disestablished (Oct 2023) following consultation process and resources now embedded in directorates.	**a) Following disestablishment of SCAD team, develop new reduced central approach for Change and Programme Management oversight and implement.** Change Management Group continues to develop a central model to change identification and management. Project and Programme best practice frameworks reviewed for Trust wide approach. Change management approach and project and programme framework to be presented to the

Annual Planning process for FY24/25 (jointly led by Finance and Strategy and involving: Performance & Intelligence, HR, Capital, and Business Services team) is now completed. Final draft of the 24/25 Annual Plan to be submitted to the Trust Board in May 24 for sign off.	key performance measures. 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 October 24 to develop strategic planning and set strategic priorities for the coming year. **Level 3: independent**	b) Data outage means that planning work for 2024/25 did not include a robust and systematic trajectory-setting process for all directorates and objectives are not as SMART as required.	Executive Leadership Team in October 24. Strategic PMO manager recruited as of April 2024 to provide a strategic portfolio management process and project and programme framework to support delivery of the Trust's strategic objectives. OWNER: Exec Director of Strategy & Partnerships and relevant Executive Leads for each delivery area. b) An annual Plan has been finalised for 2024/25, with limited quantitative measures included. The process has been further reviewed and iterated for 25/26 with further work required to make the 25/26 plan more quantitative. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. Track delivery of 2024/25 Annual Plan and report to the Board (bi-annually). Progress against trajectories will be included in the IPR. Board to be updated on the progress of the 24/25 Annual Plan in November 24. Strategic Delivery approach in place to identify and align strategic programmes of work to current Strategy Delivery Plan and report to Trust's Leadership and Board.

			Corporate Strategy Governance now established. 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 OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer.
		c) ICS Planning process established but not well developed over 2024/25 planning round which limited the ability to progress national planning quickly and effectively.	c) Support development of an ICS Planning process Collaborative process was in place for National planning 24/25 (Mental Health activity). Continue to work collaboratively with ICB to track and review (on a monthly basis) the alignment of priorities, MH trajectories and support to system goals. (link with BAF risk 3.1). Engagement in the ICB led 24/25 planning review to improve collaborative planning for 25/26. (link with BAF risk 3.1). OWNER: Exec Director of Strategy & Partnerships.
		d) Workforce Planning function and leadership is a gap. e) Need to clarify performance processes, resources, and leadership.	d) Workforce Planning approach and leadership to be identified. OWNER: Executive Team e) Proposal for Performance processes, resourcing and leadership is being developed.

		f) 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.	IPR iterated to reflect Strategy development and performance work. **f) 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
Executive Lead	Chief Finance Officer
Date of last review	08/03/24
Risk movement	↔
Date of next review	March 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
Current risk rating	**4**	**3**	**12**
Target risk rating	3	3	9
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 risked assessed using standard Data Protection Impact Assessment (DPIA) tool;	**Level 1: reassurance** - Information Management Group (IMG); - Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group **Level 2: internal** Finance & Investment Committee receives reports from IMG	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	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

- 'Third Party Cyber Security Assessment' (checklist & questionnaire) developed, to provide a systems requirement specification and to ensure any new Information Systems being 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	- Monitoring of IG training attendance; - Incident management and response process (enhanced to meet DSPT requirements) - NHS Digital Data Security and Protection Toolkit (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);	cyber security not compromised. The clinical system outage, which resulted from the failure with third 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	support the recovery of reporting (project runs May 2023 - January 2024); the priority is to enable prompt recovery of reporting whilst 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. **OWNER: Head of Clinical Systems** 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 are 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.

Scanning, Microsoft Defender Advanced Threat Protection); - Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit 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		risks from poor cyber security behaviours. Desktop Third Party Software Patch 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.	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 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
Executive Lead	Director of Corporate Affairs & Company Secretary
Date of last review	13/02/2024
Risk movement	↔
Date of next review	August 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	3	15
Current risk rating	3	3	9
Target risk rating	3	3	9
Target to be achieved by			

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	**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		

and learning from Covid-19 pandemic; - 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: 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	Standards. 2023 Full compliance 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 **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		

service (tactical), key staff with operational 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.	protection toolkit. All four assertions relating to 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
Date of last review	21/08/24
Risk movement	↔
Date of next review	December 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	3	4	12
Current risk rating	3	3	9
Target risk rating	3	1	3
Target to be achieved by	2032		

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, for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2032, for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036, could lead to: a failure to meet Trust and System wide objectives, reputational damage, loss of contracts with commissioners, contributing 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 Green Plan reporting; - Procurement Policy – sets out sustainability commitments required by suppliers;	**Level 1: reassurance** - Monitoring of deliverables by Sustainability Manager **Level 2: internal** - 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; - FY24 saw a 17% reduction in carbon emissions when compared to the 2020-baseline year. Annual target of 5% reduction when compared to FY22 not met due to	Trust not meeting annual carbon budget FY24 (-2.5% increase in consumption against target of 5% reduction in carbon emissions). GAP: current resource may be insufficient to implement Green Plan. GAP: Green Plan Capital & Revenue Budget to achieve Net Zero targets	Review Annual Business Mileage and consider long term plan to transfer mileage into more sustainable modes of travel. QI Project OWNER Quality improvement team /Sustainability Manager Complete analysis of resource requirements to implement Green Plan 2 Action Plan Owner Sustainability Manage Develop Heat decarbonisation plan for the Estate which will include 10-year investment plan for the

- Green Energy Supplier for electricity via CCS, - New Developments in accordance with NHS Net Zero Buildings Guidance	increase in Business mileage. **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.		retained estate to achieve Net Zero Carbon. OWNER Sustainability Manager 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.

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	12/08/24
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:

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 in place for most strategic programmes and ~~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. Strategic PMO manager recruited to from April 2024 to provide a strategic portfolio management process and project and programme framework to support delivery. Project and Programme Management Reference Group established with representation across the Trust to co-design and implement the programme and programme framework. Change management group established to review how change is managed and to set up clear and consistent process to manage change across the Trust.	**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 has now been ~~being~~ introduced in FY24 for Execs (bi-monthly), FIC and Board (bi-annually); 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. Executive Sponsors in place for all strategic programmes across the Trust. **Level 3: Independent**	a) Portfolio oversight now in place but this will take time to become 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. f) Capacity and skills in the Financial Management team to support major projects	a) Board, Committee and Exec to continue 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. In addition, the newly established change management group has representation across the Trust and will establish a Trust wide approach to managing change. 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. f) Development of the Finance Business Partner roles to be able to provide financial support to major projects Owner: Chief Finance Officer

	- Internal audit reviews. - KPMG assurance over Frontline Digitisation programme. - ICB representation at Digital and Data Strategy Board.		

Strategic Objective 4: Become a leading organisation in healthcare research and education

4.1: Not Maximising the Trust's Research and Development (R&D) potential

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Chief Medical Officer
Date of last review	13/08/24
Risk movement	↔
Date of next review	December 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	3	3	9
Current risk rating	**3**	**2**	**6**
Target risk rating	3	1	3
Target to be achieved by			

Risk Description:
Not maximising the potential 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	**Level 1: reassurance** **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);	GAP: Following the clinical system outage in August 2022 the issues with migration and recording of diagnosis within RIO have now resolved and RI now have the ability to produce accurate recruitment lists. Diagnosis migration issues are also resolved. 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	RIO 'Research contact preference' form and 'Research approaches and participation' form are in the final stages of development and testing, expected to go live by September 2024. A new team is being added to RIO teams pick list named 'Research team'. The addition of the 'Research team' to the RIO teams pick list will facilitate the documentation of clinical trial activities for

Committee and Partnership Board; - Oxford Applied Research Collaboration Oxford and Thames Valley (OxTV) (ARC); - 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	- Annual Statement of Expenditure Reports are submitted to DH for the BRC, CRF, ARC and MIC - 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;	strategy, awaiting new research forms in RIO and the ability for appointment letters with CMI leaflet attached, to be sent direct from RIO. When CMI service resumes, it will require a relaunch to staff and patients. We have no date for this to be resolved. CMI is being led by a Hon Consultant Psychiatrist • Research and Development and an Academic Clinical Fellow - Forensic Inpatient Ward via the BRC Data Science Theme. This project is ongoing. R&D are considering an additional senior project management role to support the delivery of this project. GAP: CMI forms have been built and are now being tested. These will allow patients research contact preference details and approaches and participation in research to be recorded in RIO. This will also support 'Count me in' (CMI) when relaunched. 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.	participants who do not have an existing RIO record. This enhancement allows for the inclusion of a progress note, the uploading of essential documents such as consent forms and participant information sheets, and the recording of activities in the newly created 'research contact preference' and 'research approaches and participation' forms. 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. Further work is being conducted to establish the clinics' ongoing needs in relation to both clinical and research databases. This work is being carried out with the CIO to support clinics in ensuring they are meeting national and internal Information

development of the research element of NMAPS.		GAP (Controls): R&D Strategy in development. Includes Monitor and Improve study set-up times, support early adoption of innovation to reduce waiting lists and increase productivity, Review / re-launch "Count me in". Develop a future proof strategy to sustain, grow and support the development of Research Focused Clinics. Facilitated by clinical academic posts, this work will feed into the wider growth of such post throughout the Trust. A scoping report of Research Focused Clinics' opportunities has been conducted and disseminated. For example, the ARMS (OPEN) clinic provides a unique opportunity to provide early intervention, treatment and route into research for a large group of patients, with potential cost saving benefits to the Trust. There is a gap in funding provisions for this service.	Governance guidelines. The clinics present a unique opportunity to develop new patient pathways, facilitate translational research and support the Trust's strategy. R&D have established communication routes to update relevant stakeholders of progress. R&D are assisting with developing a business case to secure ongoing funding for a vital service.

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 know 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

Oxford Health NHS Foundation Trust

Meeting of the Audit Committee

Tuesday, 03 September 2024
13:30-16:00[1]
Microsoft Teams virtual meeting (live video streaming – invitation only)

Apologies to Hannah Smith, Assistant Trust Secretary, hannah.smith@oxfordhealth.nhs.uk

AGENDA

			Start time	Allocated (mins)
1.	Welcome and Apologies for Absence[2]	CMH	13:30	10
2.	Confirmation of items for Any Other Business	CMH		
3.	Minutes of the Audit Committee Meeting on 19 June 2024 and Matters Arising (paper 03/AC)	CMH		
4.	Committee workplan (see overview plan at the end of this agenda)	CMH		
	External Audit			
5.	External Auditor's annual report (final) to support the 2023/24 External Audit process and including commentary on Value For Money arrangements (paper 05/AC)	EY	13:40	15
	Internal Audit			
6.	Internal Audit progress report (paper 06/AC)	KPMG/ PM/HeS	13:55	15
	Counter Fraud			
7.	Counter Fraud progress report (paper 07/AC)	KPMG/ HeS	14:10	15

[1] 13:00-13:15 Non-Executive Directors only pre-meeting;
13:15-13:30 Auditors pre-meeting; and
13:30 main meeting starts.

[2] Apologies from: None from Committee members, apologies from Neil Thomas (KPMG)

Governance & Assurance

8. Single Action Tender Waivers report (paper 08/AC)	HeS	14:25	5
9. Losses & Special Payments report (paper 09/AC)	HeS	14:30	5
10. Agency fee structures (ID Medical) update (paper 10/AC)	PM/CDS/ HeS	14:35	10
Auditors and Counter Fraud to leave *5 minutes' break if needed*		14:45	5

Contract review

11. Internal and External Audit update (paper - private 11/AC)	HeS	14:50	15

Any Other Business

12. Any Other Business (oral discussion)	CMH	15:05	10
13. Questions from observing Governors (oral discussion)			
Meeting Close		15:15	

Committee Workshop session

14. Update of HFMA NHS Audit Committee Handbook and Audit Committee self-assessment (paper 14/AC)	CMH	15:15	30
15. Review of the Meeting and Workshop (oral discussion) a. any escalations to the Board or any risk escalations to the Trust Risk Register or Board Assurance Framework; b. any points to raise from the private pre-meetings; and c. content and behaviours.		15:45	
Workshop Close		16:00	

Date of next meeting: 03 December 2024 09:00-12:30

Oxford Health
NHS Foundation Trust

Audit Committee – overview plan for 2024/25[3]

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
INTERNAL AUDIT									
Internal Audit progress report, action tracker and review reports	KPMG	x	x	x	x	x	x	x	x
Internal Audit Plan	KPMG	x					x		
Internal Audit annual report and Head of Internal Audit Opinion	KPMG		[x]	x				[x]	x
EXTERNAL AUDIT									
External Audit progress report	Ernst & Young	x	x	x	x		x	x	x
External Audit Plan and Informing the Audit Risk Assessment	Ernst & Young	x					x		
External Audit – Audit Results Report on the financial statement audit (including draft letter(s) of representation)	Ernst & Young			x					x
External Audit Value For Money/ 'Auditor's Annual' report	Ernst & Young			x					x
COUNTER FRAUD									
Counter Fraud progress report	KPMG	x	x		x	x	x	x	
Counter Fraud Work Plan and Risk Assessment	KPMG	[x]	x				x		
Counter Fraud annual report	KPMG		x					x	
YEAR-END & FINANCE REPORTING									

[3] Summarises the Committee's more detailed Work Plan

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
Timetable for Annual Report & Accounts	Finance / Heather Smith	x					x		
Financial Statements and Accounts	Finance / Heather Smith		x	x				x	
Going Concern Statement	Finance / Heather Smith		x	x				x	
Annual Report and Annual Governance Statement	Corporate Governance / Georgia Denegri		x	x				x	
Losses & Special Payments Report	Finance / Heather Smith	x			x		x		
Single Action Tender Waivers Report	Finance / Heather Smith	x			x		x		
RISK MANAGEMENT									
Board Assurance Framework and Trust Risk Register report and/or deep dive. Forward look: • April 2024 – Governance & Decision-Making; and Adequacy of Staffing • June 2024 – Financial Plan	Brian Aveyard/ Neil McLaughlin / Hannah Smith / Georgia Denegri	x	x	x	x	x	x	x	
OTHER ASSURANCE FUNCTIONS AND MANAGEMENT REPORTING									
Assurance from Committee Chairs on themes previously identified in audits	NED Committee Chairs	x	x		x	x	x	x	
Clinical Audit update report	Claire Forrest/Angela Ward/Karl Marlowe					x			
Clinical Audit annual report	Claire Forrest/Angela Ward/Karl Marlowe		x					x	
Cyber Security (*Encrypt'Send Secure')*	IT/Heather Smith	x			x		x		
Whistleblowing arrangements (invite Whistleblowing Champion NED – Philip Rutnam)	HR (Jill Castle/Zoe Moorhouse)/ Heather Smith			[x]	~~x~~	~~[x]~~			

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
Emergency Planning annual report	Emergency Planning/ Georgia Denegri				[x]	x			
POLICIES & STRATEGIES									
Standing Financial Instructions (on a 2 years cycle, last done 2023 – next due 2025)									
Scheme of Delegation	Corporate Governance / Georgia Denegri								
Risk Management Policy	Neil McLaughlin / Hannah Smith / Georgia Denegri		~~x~~		x				
Counter Fraud Policy	Finance & KPMG								
GOVERNANCE									
Minutes	Corporate Governance	x	x	x	x	x	x	x	
Audit Committee annual report	Corporate Governance		x	x				[x]	
Quality Committee annual report	Corporate Governance				x				
Charity Committee annual report	Charity				x	[x]			
Other Committee annual reports may be more optional/depending upon when/if called for – all will in any event always be available as part of Board packs									
OTHER REQUESTED ITEMS									

Minutes of the

Oxford Health Charity Committee – Governance Meeting

Wednesday 4th September 2024 01.30-02.45pm, 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)
Ben Cahill (BC)	Deputy Director of Corporate Affairs
Charmaine Desouza (CD)	Chief People Officer
Michelle Evans (ME)	Development Manager – Oxford Health Charity
Angie Fletcher (AF)	Deputy Chief Nurse
Chris Hurst (CH)	Non-Executive Director
Chris Langridge (CL)	Oxford Health Charity Administrator
Julie Pink (JP)	Head of Charity & Involvement
Olga Senior (OS)	External Non-Voting Member
Michael Williams (MW)	Financial Controller

Guests – present for relevant agenda item:

N/A	N/A

Apologies:

Jane Appleton (JA)	Associate Director of Communication & Engagement
Amelie Bages (AB)	Executive Director of Strategy & Partnerships
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Britta Klinck (BK)	Chief Nurse
Grant Macdonald (GM)	Chief Executive
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care
David Walker (DW)	Chair - Oxford Health NHS FT

1	**Introductions and Apologies**	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. The meeting was confirmed to be quorate.	
2	**Declarations of interest**	
	No new declarations of interest were received pertinent to matters on the agenda of today's meeting.	
3	**Minutes of the Meeting on 7th May 2024 and Action Updates**	
	The minutes for the Governance Charity Committee Meeting on 7th May 2024 were accepted as an accurate record of the meeting. It was raised that under the diagram for item 7 it should state OS commented not OD. This will be amended. There were no further comments or amendments to be made, and the minutes were formally approved subject to the amendment. In regard to matters arising, please see separate action tracker. There are currently the following outstanding actions: • Investment Report – Michael Williams (MW) updated that we can now have access to an electronic report download, which means we can avoid the lengthy manual reporting. This electronic report download was all that was needed. **This action can now be closed.** • Investment Portfolio Proposal – This is on the agenda for discussion today. • Risk Register – RT advised the risk register will be coming to the committee on an annual basis, or as any other business if there is a new risk. **This action can now be closed.** • External Members – Julie Pink (JP) advised this process is now ongoing. **This action is to remain open.** RT thanked Olga Senior (OS) for her work for 8 years as an external member to the Charity Committee and said how valuable her perspective has been. OS will continue as one of the Mental Health Act Managers for the Trust which she has done since 2015.	
4	**Annual Impact Report (Draft) and Annual Financial Report (Draft)**	
	The annual impact report and annual financial report were presented in draft form for approval before going to the external auditors for an independent review. JP gave an overview of the draft annual impact report. The report covers 2023/2024 by month, and larger appeals that have had significant development including ROSY and Lucy's Room. There is a short introduction to the strategy, an overview of spend, what the future looks like and where our thanks lie in terms of support from organisations throughout the year. JP thanked Michelle Evans (ME) and Chris Langridge (CL) for their work on this report. The report will also include the impact report as a standalone document	

	once approved, and this will be utilised to send to those who have made donations and to encourage future donations and support grant applications. JP encouraged comments from attendees. Charmaine Desouza (CD) encouraged the team to think broadly about what stakeholders could benefit from seeing this, including governors, internal staff, patient groups and partners such as MIND. OS also encouraged including local MPs, universities, Trusts in other boundaries (not just key partners in Oxfordshire and Buckinghamshire) as well as public sector services included police and fire services. The draft annual impact report was approved as a standalone impact report and as part of the annual report. MW gave an overview of the draft annual financial report. This covers an introduction to the charity, statutory background, governance arrangements as well as financial statements and notes to the accounts. The statement of financial activity/incoming expenditure account is on page 12. The total income for the year increased by £46,000 to £345,000. The total expenditure for the year reduced by £28,000 to £524,000. It was noted that expenditure is still significantly higher than level of income. The investment portfolio performance improved over the course of the year compared to the significant loss experienced in the previous financial year. There was a net decrease in value of investments of £87,000 from last year to the end of that financial year (March 2024). Clarification was provided around this – the investment portfolio performance has improved over the course of the year, but some investments were dis-invested to support the day-to-day running of the Charity. Therefore the value of the investments has decreased over the year. Cash has increased by nearly £100,000 over the year. It was explained that most of this is related to the ROSY account and reflects a build-up of cash over the year as the respite care invoices were not paid this financial year and were settled in April 2024. OS requested a note to be added around the delay in payments for the ROSY invoices as this could be concerning for a member of the public to view a build-up of cash. JP gave further information about the delay and indicated that there have been discussions with the CCN team regarding invoicing for ROSY which seemed to take longer than expected, and when the finance team were instructed to invoice, they invoiced in April even though the decision had been made in the year. Overall, the net funds/assets have decreased by £157,000. RT commented that the Charity Commission might be worried about funds going down so it should be noted that as a committee we did not think going down by 1/6 of our assets every year was something we would want to continue with, and the committee was looking at ways to improve investment management. It was agreed that a note be added, for	

	transparency and clarification, stating the charity is actively considering steps that would mitigate the downward pressure on our resources. The suggested comments around ROSY invoicing and investment management to be added to the draft financial report. **ACTION MW.** With the amendments noted above the Committee approved the financial report. With the agreed amendments the draft impact and financial reports will now go to external auditors for an independent review. The reports will then return to the Charity Committee at the next meeting of the 4th of December for a final sign off. After this it will go to Corporate Trustee who are meeting mid-December. MW and Danielle Manning will then submit to the Charity Commission, which has a deadline of 31st January 2025.	**MW**
5	**Financial Management Accounts**	
	MW presented the financial management accounts for the first 3 months of the current financial year, April, May and June. In terms of income expenditure, the Charity received just over £100,000 in the first quarter and incurred expenditure of £83,000, representing a surplus for charity in the first quarter. The income for the first quarter can be compared to the previous income figures for the last 3 years, and whilst the income trends do not look like we are back to our 2021/2022 figures, the direction of travel is positive and may exceed what happened in the last financial year 2022/2023. The investment line shows a £35,000 loss in the first quarter. MW has requested to re-review this figure after the meeting and update the committee out of session as this may have been miss-reported. **ACTION MW.** The Charity had no legacy income during the first quarter, compared to £71,000 for the last financial year. Looking at the balance sheet, the total funds available to the Charity have decreased in the first quarter. There are figures around the invoices for ROSY which have now been paid. Staffing costs show £67,000 with £45,000 for ROSY staff. OS commented that the first quarter expenditure is predominantly on salaries and not much for any beneficiaries as such. JP will look into this as it is not clear if this is to do with timings or the new process for requests from April 2024. It may be that no invoices came through during this quarter but there was left over invoices from the previous approach. **ACTION JP.** MW agreed that this could have been due to an overspill or cut off from the last financial year. There is a fund analysis for bigger funds and level of income, as well as a list of funds that have been closed and individual fund balances across the whole of the Charity that have commitments. It was also noted that the team have lost their Community Fundraising	**MW** **JP**

	Officer, who left in August. This is currently going through the recruitment process, but the team are conscious of the impact this vacancy may have on fundraising income. Suggestions were made about how this recruitment might be expedited. MW was asked how does the financial management accounts perform against expectations? MW advised that these figures look positive, and JP agreed that there are areas of budgeting and forecasting for the whole year which will be introduced and help to provide better transparency. It was noted restricted income is relatively low compared to previous totals around ROSY. JP is in discussions with the CCN team as this is a continued risk for ROSY funded positions, which is being actively monitored. There has been a very large donation recently for ROSY so things may turn around in the coming quarter, but income is still lower than expected at this stage. The Committee noted the management accounts and the subsequent discussion.	
6	**Future Investment Support**	
	The Committee had asked to be updated on charity investment options and management of those going forwards. A Charity Investment Options paper was previously presented to the Charity Committee in May 2024. It was agreed subsequently, at an out of session Committee meeting on 25 July 2024, to present a range of deposit focused investment options (instead of current investment arrangements) and to make a recommendation to the Committee going forward. The Committee favoured a deposit account approach over other options because of the need for a safer alternative to investment for its surplus cash over market focused investments. If the investments are disinvested, this will generate annual saving of £6,700 in relation to LGT's management fee (the current investment arrangement). It was agreed the Committee are concerned about volatility of the current arrangements and prefer to look seriously and urgently at options within the category of a deposit account approach. At the meeting it had been agreed to explore these in a systematic way, adding a couple of extra options, such as the Charity Deposit Platform and the option of using the Trust's existing financial mechanisms. MW advised that based on analysis and balance of financial return, accessibility, safety and minimising disruption the best option would be a call or current account with Lloyds. However, there is a compensation cap in the event of the bank failing limited to £85,000. MW noted that call accounts are quite unique in that withdrawals can be made at any time, and funds can be managed more actively to maximise the returns. Some cash can be kept in a current account for daily receipts and payments, but kept to a minimum to meet immediate needs, with the rest of the cash in a call account to maximise return.	

	There is also the option of a BankLine current account, which has an unlimited compensation cap in the event of the bank failing. There was discussion around the National Loan Funds deposit arrangement, but it was noted that money would need to be deposited for a specific term, and the Charity would not have access to the funds for whatever the term is. OS had previously mentioned the Charity Deposit Platform, which has been included in the list of options but they do charge an account fee. CD highlighted the risk with the call account with the compensation cap, when some options offer unlimited protection (BankLine, National Loan Funds). It was agreed that the Committee felt more comfortable with unlimited protection. MW advised that BankLine rates are competitive and offer an excellent service – the Trust currently uses BankLine and the interest rate on the current account is currently 4.89%. However, there is potential for disruption with switching bank accounts. There was discussion that it would be worth the one-off disruption for the security that BankLine offers, and because of the responsibility around stewardship of resources. It was noted BankLine is part of the government banking service. Following the discussion, it was agreed that all of the Charity's money and investments could be transferred to a BankLine account, with benefits of unlimited protection, a good interest rate and the ability to spend. MW also noted that over time the Charity should continue to review all providers. The Committee is asked to note the information provided in the report and discussion and the agreement in favour of the charity investment option. It was agreed to transfer all money and investments (including money in the current Lloyds Account) to a BankLine current account. It was clarified that this sort of financial decision sits with the Committee, and the Corporate Trustee will be informed of the decision made. **ACTION MW.**	**MW**
7	**Legacies and Inactive Funds**	
	Information was provided on the current inactive funds and legacies, which are being worked through by the Charity team and solicitors as appropriate. JP advised there has been a decrease as part of a long-term piece of work. There are 8 legacy funds with a new fund being added and 2 closed as spent. There are currently 7 inactive funds which is a decrease from previous reports. There are no new inactive funds. The new legacy fund related to CAMHS in Oxon; this has been a lengthy process that ME has worked through with solicitors as it was for a hospital we no longer own. JP highlighted that there is now a new process, and the team are working tightly with the fund advisors to ensure things are moving forward and	

	legacies/funds are being spent. There have also been a couple of highlighted that we may potentially be able to use within the research grant programme as discussed in the May Charity Committee Development meeting. An update will be provided on this at the December Charity Committee Development meeting. The Committee noted the information provided in the discussion.	
8	**More Partnership Report**	
	RT summarised The More Partnership Report which was commissioned before he became Chair of the Charity Committee. RT had met with the authors of the report in August and did not have any amendments to suggest for the report. RT had also met with Grant Macdonald to discuss his perspective on the report. An assumption built in to the report is that there has been real progress in relation to the Charity and its management over recent years. The key recommendation of the report was that a serious attempt should be made to expand substantially the fundraising ambition of, and returns to, the Charity, for both specific projects and the Warneford Project, and that realising these ambitions would make it essential to appoint a senior development manager. OS felt it was great to see the report and highlighted a point around the commitment of senior staff within the Trust. It was noted some members have never attended a Charity Committee meeting. If there is no commitment or support from senior staff, the Charity will not succeed in realising the ambitions of the report. RT agreed that this was part of the reason he met with Grant Macdonald. RT advised that Grant Macdonald is broadly comfortable with the recommendations, but that this needs to be looked at by the Trust Board (at least by way of note) and by senior executives. It was agreed for a report/paper to go to the senior executives supporting the recommendations from the More Partnership Report in order to assist dialogue on these issues. **ACTION JP/BC.** JP advised there was a business case for a senior development manager previously through the strategic approach for business case requests, but this was not successful. There was no further feedback other than there was not enough money available. It was noted that there is not the existing infrastructure and that investment is needed to fulfil the ambitions of the More report. The committee would support any cases made to the senior executives and Trust board, noting that significant additional staffing is required. CH commented that previously the fundraising and charitable work has been seen as valued, but not understood or appreciated. To be successful we need to be really clear about what we are trying to achieve and the difference it will make. It was noted that the Director of Corporate Affairs has left and there has been a gap, which means the charity is missing a champion on the board.	**JP/BC**

	The committee enthusiastically recommend expansion of future fundraising and staffing to the Executive Team and Trust Board, noting the importance of senior management commitment and funding of the senior development manager post would be needed to succeed. This item will also be discussed at the later Development Meeting. It was advised that the More Partnership Report will be circulated to everyone who took part in interviews. The PowerPoint created by JP to summarise the report will be circulated with the draft charity committee minutes within the next couple of weeks. **ACTION CE.** Having agreed to support the recommendaitons of the More Report, the Committee is asked to note the information provided in the papers and discussion.	**CE**
9	**Any Other Business/Close**	
	External Members As above, RT thanked Olga Senior (OS) for her work for 8 years as an external member to the Charity Committee and said how valuable her perspective has been.. JP will be working with Ben Cahill (BC) and the communications team to contact governors regarding new external members. JP has also liaised with OS to include her viewpoints in those discussions. **ACTION JP.**	**JP**
10	**Date of Next Meeting(s)**	
	- 4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting.	

Attendance – Governance Sub-Group

	Nov-23		Feb-24	May-24	Sep-24
Lucy Weston	✔	Rick Trainor	✔	✔	✔
Non-Executive Director	*Chris Hurst and David Clark*	Non-Executive Director	*Chris Hurst*	*Chris Hurst*	*Chris Hurst*
Amelie Bages		Amelie Bages			
Marie Crofts		Britta Klinck	*Rose Hombo*	✔	*Angie Fletcher*
Kerry Rogers	✔	Kerry Rogers/Georgia Denegri from May 2024	✔	✔	*Ben Cahill*
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		Mark Waring/Ellyn Carnall/Jeremy Philpott			

Minutes of the

Oxford Health Charity Committee – Development Meeting

Wednesday 4th September 2024 02.45pm-04.00pm, 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)
Ben Cahill (BC)	Deputy Director of Corporate Affairs
Charmaine Desouza (CD)	Chief People Officer
Michelle Evans (ME)	Development Manager – Oxford Health Charity
Angie Fletcher (AF)	Deputy Chief Nurse
Chris Hurst (CH)	Non-Executive Director
Chris Langridge (CL)	Oxford Health Charity Administrator
Julie Pink (JP)	Head of Charity & Involvement
Jeremy Philpot (JPh)	Interim Director of Estates & Facilities
Olga Senior (OS)	External Non-Voting Member
Mark Waring (MW)	Head of Estates Transformation & Strategic Developments

Guests – present for relevant agenda item:

Philip McGuire (PM)	Professor of Psychiatry, University of Oxford

Apologies:

Jane Appleton (JA)	Associate Director of Communication & Engagement
Amelie Bages (AB)	Executive Director of Strategy & Partnerships
Ellyn Carnall (EC)	Operational Support Officer
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Britta Klinck (BK)	Chief Nurse
Grant Macdonald (GM)	Chief Executive
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care
David Walker (DW)	Chair - Oxford Health NHS FT

1	**Introductions and Apologies**	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. The meeting was confirmed to be quorate.	
2	**Declarations of interest**	
	No new declarations of interest were received pertinent to matters on the agenda of today's meeting.	
3	**Minutes of the Meeting on 7th May 2024 and Action Updates**	
	The minutes for the Development Charity Committee Meeting on 7th May 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: • Oxfordshire Health Services Research Grant – Julie Pink (JP) advised there are some legacy funds that have been identified that could drawn upon in support of this grant. JP is meeting with Kate Saunders about this and then will come back to the meeting in December with a plan of action following support for the grant in the May meeting. Action to remain open.	
4	**Charity Strategy Update**	
	JP provided an update on the first quarter performance for 24/25 and the action plan for 24/25 in relation to the Charity Strategy 23-28. There are the same KPIs including ones around meaningful impact. The process around collecting feedback and impact reporting has changed during the year so these KPIs may need to be revised. The process is now more bespoke to each project and will help to produce a better level of impact reporting, especially for larger projects. The KPIs around engagement and involvement show a positive start to the year, with a number of new volunteers and more activity in relation to charity events. There are a further 4 events planned in the autumn. Communication channels are increasing. Data will need to be reviewed from Donorfy regarding engagement and involvement, including contactable supports. In terms of research focused funding, there has been £6,000 approved funding and £94,000 funding waiting for approval as part of a development programme proposed for nurses.	

	There is a KPI around increasing annual fundraising income, and this will be closely monitored due to the loss of the Community Fundraising Officer within the team. The Committee is asked to note this information provided in the papers and discussion.	
5	**Requests £10k+**	
	Bicester Air-Conditioning This item was not discussed at today's meeting as not all the information was received to submit a paper in time. This item will be deferred to the Charity Committee meeting in December or circulated to Committee members outside of the meeting to prevent any delay and upset to the family as this is being funded by a legacy (given to the Bicester League of Friends) and has already taken some time to progress. **ACTION CE.**	**CE**
6	**Impact Reporting**	
	ME provided a summary of project and impact reporting. There were 30 requests in the period during the April/Spring window for a total of £55,000. 17 of these were approved, 4 are currently held for a review and 9 were declined. During the July/Summer window there were 47 requests for a total of £98,300. 19 of these were approved, 14 are currently held for a review and 14 were declined. These figures are not cumulative with Spring and Summer windows and requests held being kept separate. Reasons for requests being declined included: • Team/staff wellbeing initiatives • Conference attendance that Learning and Development couldn't fund • Background work hadn't been completed (discussion with estates). • Not meeting charity remit • Activity on sites where estates work is planned or underway Funding requests being approved have included: • Trip to Cotswold Wildlife Park for complex needs services • Meditation and wellbeing activities for carers • Memorial bench and mural • Projects on young people mental health wards for workshops over the summer Approved fundraising requests to be included in project and impact reporting in the future. **ACTION ME.** Recent projects/specific appeals have included: • OSRU's Summer of Sports	**ME**

	• Physical Health Groups for clients of the Oxfordshire Early Intervention Service • A Live Music Concert at the Warneford Chapel • Wellbeing Activities in Carers' Week • Communities of Communities Forum attendance for Bucks and Oxon service users In terms of engagement, social media platforms X (Twitter), Facebook and LinkedIn have had an increase of followers. In regard to X and some NHS organisations removing themselves from this platform, the Charity is currently continuing to use X but is liaising closely with the communications team in case the external situation changes. The website and intranet are updated regularly, with 333 staff members visiting the intranet over the last 90 days. Emily Tammam, a staff membe,r has shared her story about the passing of her daughter and has been raising funds for a cuddle cot to support other families in this situation. This story was picked up by The Telegraph and £2,770 has been raised so far. 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 £1,000 from Chown Charitable Trust for the ROSY Appeal and £8,5000 from South Oxfordshire District Council for an arts and nature project at Didcot Community Hospital. There is a grant application for £75,000 being reviewed/under consideration with the Veterans Foundation to support the development of the veteran service user engagement with the Armed Forces Network. There were two unsuccessful grant applications from Oxfordshire Community Foundation for the Better Mental Health Grant and the Department for Environment Food and Rural Affairs for the Sustainable Healthcare Grant. There are difficulties with the Oxfordshire Community Foundation and the criteria of Trustees. RT suggested challenging this decision and JP has raised a query but would appreciate help with a corporate letter. JP will speak to Georgia Denegri about this. Olga Senior (OS) will also speak to some contacts that she knows and find out if they have previously	

	supported the Oxford University Hospitals Charity. **ACTION JP/OS.** Work continues to go on with grant applications and these will be reported to the committee at each meeting. There have been fundraising activities including: • Blenheim 7k • Oxford Contemporary Music Concert • Bike Oxford • Wilderness Festival (including being added as a recognised charity when buying tickets for 2025) • Community fundraisers including a bingo event and a Speyside Way Trek • Corporate fundraisers including MVKelly to undertake a fundraiser for ROSY and completing a 3 Peaks Challenge In terms of appeals, an update was given on Lucy's Room, which will be opening officially on 5th October, and the Charity is now in the final stages of handover. Mark Waring (MW) provided an update: the Charity has started the internal fit out for a small office area and a larger open plan area for group activities. Contractors have started and the work will finish by the end of September. There is also ongoing work around the outside area to tidy this up, the new path and ramp to the entrance door are in. There are conversations ongoing around pinpoint alarms and CCTV being completed as a charitable donation. There are future fundraising activities arranged with a 2024 poster created to help engage with staff. Activities include: • Brush Party in September • Inflatable Fun Run on 28th September • ROCKIN' SHOP Music Event on 29th September • The Oxford Half in October with 41 participants It was also noted about becoming a MuchLoved Charity Partner, which is an online tribute platform. The Charity has now partnered with them, which means the Charity now has more functions, receives notifications of tribute pages (so we can get more information) and hase the ability to reach out to the family. The Charity will also have branded pages enabling family members to ad funeral pages. There is also MicroHive (which was formerly known as Pennies from Heaven). This is an opt-in initiative to enable Trust staff to donate the pennies from their monthly pay packet to the Charity. This has been approved by the Corporate Trustee, and there is now ongoing coordination with payroll, HR systems and HR onboarding. There will be a	**JP/OS**

	communications campaign devised with a plan to launch Trust-wide in Autumn. Information was also provided on legacies, which are being worked through by the Charity Team and solicitors as appropriate: • Burridge legacy for ROSY • A will with a legacy for Oxfordshire Early Intervention in Psychosis The Smee & Ford legacy notification service will mean we are notified if we get a match. They have so far identified 6 potential matches. 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	**More Partnership Report**	
	This item had been discussed, in depth, at the earlier Governance Meeting. The Report highlighted that substantial additional money could be raised to benefit the Trust through the Charity and fundraising activities. The Governance Meeting had recommended accepting the recommendations of the report for attempting to raise substantial additional funds, and backed the Report's suggestion that in order to accomplish this goal significant additional expenditure would be required, including on a senior development manager. The Governance Meeting had enthusiastically accepted the recommendations of the Report and would communicate accordingly with the senior executive and the Trust Board. No one present at the Developoment Meeting expressed dissent from the recommendaitons supported at the Governance Meeting.It was advised that the More Partnership Report will be circulated to everyone who took part in interviews. The Committee is asked to note the information provided in the papers and discussionI.	
9	**Philanthropy Development**	
	Philip McGuire (PM) joined the meeting and discussed with the committee the philanthropy development following discussions with More Partnership. PM was interviewed by More Partnership as part of their work for the report discussed above. PM advised they discussed research clinics, which are staffed by clinical academics employed by the University who have had clinical training but also research	

	expertise. A number of these research clinics have been set up over the last few years in Oxford Health. More Partnership were interested in Open, which is a new for Oxford Health service to prevent people/young adults (student age) from developing mental health conditions. This is an early detection service and so prior to early intervention services. NICE guidelines state that all mental health Trusts should provide a service that meets this need. There was discussion around mental health services being most developed and how prevention is most likely to be possible in terms of health impact. OS asked about how this service is funded, including any NHS funding as if it is so important, it should be funded by the NHS rather than the charity. PM advised that in an ideal world it would be funded by the NHS as it is expected by the NICE guidelines which state it is mandatory for an early detection and intervention service to be provided by mental health Trusts. However, in reality very few services provide these services due to a lack of funding. It is also wrongly perceived as not important because the individuals are not acutely unwell and not an emergency, so it is felt there are more important things to fund, such as services individuals who are acutely unwell. Oxford Health currently fund £80,000 a year which is not enough. The forward vision is to try and set up a service, demonstrate that it is worthwhile, useful and helpful, so that the NHS and the Trust would see that it is worth funding. Angie Fletcher (AF) asked if other Trusts have piloted these services with additional funding: could we make a case using their success without us having to set a service up to prove relevance and importance? PM advised that we could draw on experience and evidence, but there may be differences depending on catchment area and location etc that make impact feasibility. RT suggested thatthat, as part of the recommendations of the More Report, this Open service should be considered as a fundraising commitment if we broaden our fundraising ambition and have more staffing/resources. It was agreed that it is an important and useful service. It will be kept on the list of recommendations in the More Partnership Report, and the comments made at today's meeting about how to approach the service taken on board if the recommendations in the More Partnership Report are accepted and implemented.	

	It was advised that the More Partnership Report will be circulated to everyone who took part in interviews, including PM.	
9	**Any Other Business/Close**	
	Lucy's Room Update As discussed above, Lucy's Room will be opening officially on 5th October, and we are now in final stages of handover. Mark Waring (MW) provided an update, we have started the internal fit out for a small office area and a larger open plan area for group activities. Contractors have started and the work will finish by the end of September. There is also ongoing work around the outside area to tidy this up; the new path and ramp to the entrance door are in. There are conversations ongoing around pinpoint alarms and CCTV being completed as a charitable donation. **External Members** As above, RT thanked OS for her work for 8 years as an external member to the charity committee and noted how valuable her perspective has been. OS will continue as one of the Mental Health Act Managers for the Trust which she has done since 2015.	
10	**Date of Next Meeting(s)**	
	4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting	

Attendance – Development Sub-Group

	Nov-23		Feb-24	May-24	Sep-24
Lucy Weston	✔	Rick Trainor	✔	✔	✔
Non-Executive Director	*Chris Hurst*	Non-Executive Director	*Chris Hurst*	*Chris Hurst*	*Chris Hurst*
Amelie Bages	✔	Amelie Bages			
Marie Crofts		Britta Klinck	*Rose Hombo*	✔	*Angie Fletcher*
Kerry Rogers	✔	Kerry Rogers/Georgia Denegri from May 2024	✔	✔	*Ben Cahill*
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	✔	Mark Waring/Ellyn Carnall/Jeremy Philpott	✔	✔	✔

Meeting of the Oxford Health NHS Foundation Trust
Finance and Investment Committee

Minutes of a meeting held on
Thursday 09 May 2024 at 09:00
Via Microsoft Teams Virtual Meeting

Present:
Core members and attending Board members included in quorum

Lucy Weston	Non-Executive Director (**LW**) (the Chair)
Rob Bale	Executive Managing Director for Mental Health & Learning Disability Services (**RB**)
Georgia Denegri	Associate Director of Corporate Affairs (**GD**)
Grant Macdonald	Chief Executive (**GM**)
Dr Ben Riley	Executive Managing Director for Primary, Community & Dental Care (**BR**)
Philip Rutnam	Non-Executive Director (**PR**)
Heather Smith	Chief Finance Officer (**HeS**)
David Walker	Trust Chair (**DW**)

In attendance:

Brian Aveyard	Risk, Assurance and Compliance Manager (**BA**)
Ben Cahill	Deputy Director of Corporate Affairs (**BC**)
Laura Carter	Head of Strategy (**LC**) - *part meeting*
Simon Cook	Warneford Park Programme Director (**SC**) - *part meeting*
Charmaine De Souza	Chief People Officer (**CDS**) - *part meeting*
Nicola Gill	Corporate Governance Officer (**NG**) (minutes)
Alison Gordon	Head of Financial Management (**AG**) - *part meeting*
Peter Milliken	Director of Finance (**PM**) – *part meeting*
Jeremy Philpot	Interim Director of Estates and Facilities (**JP**) – *part meeting*
Hannah Smith	Assistant Trust Secretary (**HaS**) – *part meeting*
Priya Thompson	Head of Strategy (**PT**) – *part meeting*

Governor Observers:

Vicki Power	Staff Governor

1. a b	**Apologies for Absence** Apologies were received from members and attending Board members: Amelie Bages, Executive Director of Strategy and Partnerships; and Britta Klinck, Chief Nurse. The Chair welcomed all to the meeting and confirmed it was quorate.	

2.	**Minutes of the Meeting held on 12 March 2024 and Matters Arising**	
a	The minutes at FIC 23/2024 of the Finance and Investment Committee meeting held on 12 March 2024 were approved as a true and accurate record once amended to note the Chief Finance Officers amendments following the meeting.	
	Matters Arising	
b	The Committee noted that the following action was complete: • 3(f) – Annual Planning & Budget setting – embedding quality priorities and highlighting temporary staffing: included in the Plan for this agenda; • 4(b) – Deep Dive into Board Assurance Framework (BAF) 3.4: on agenda; • 4(e) – Update on the reframed BAF 1.1: on the agenda; • 6(e) – Oxford Clinic Private Finance Initiative (PFI): on the agenda; • 7(a) – Business Case Review: on the agenda; and • 15(e) – Review of board committee cover sheets: to be discussed when review has been undertaken.	
c	The Committee noted that the following actions were still in progress: • 4(c) – set of risk categories created from the 28 February Board workshop to be used to inform/add to the existing BAF risks – to be embedded and brought to July's meeting; • 4(d) – Request for a deep dive into the Oxford Pharmacy Store (OPS) licence – to be brought to an autumn meeting and include a post implementation look at the warehouse move and benefits realisation; and • 12(d) – Warneford Park Programme deep dives – dates to be confirmed.	
3.	**Annual Planning & Budget setting**	
	Annual Plan and oversight arrangements	
a	The Head of Strategy presented the paper at FIC 24/2024 noting it was being presented to the Committee for review and endorsement and was seeking the Committee's recommendation to go to the May Board of Director's meeting for final approval. She explained that the Annual Plan would be tracked and monitored to ensure issues were escalated and priorities adjusted if required. A review against progress of the overall Annual Plan will be shared with the Board twice a year The Executive team would maintain a regular review of progress against the overall Annual Plan.	
b	David Walker voiced concerns about the achievability outcome measures Regarding 'Patients receiving effective care' he questioned whether a baseline had been established for measuring movement change during 24/25? Laura Carter responded that this measure had caused a lot of conversation and was something the programme was trying to identify. Her understanding was that currently there was not the level of reporting to enable them to identify baseline targets which is why the baseline measure in the report was being seen.	
c	The Chair and other NEDs asked about the targets as set out in the paper including how realistic they were to achieve, how they were informed by outcome measures, and their coverage of key areas of work within directorates. It was noted that there was the need for a shared clarity of what was trying to be achieved and over what timescale.	
d	Laura Carter spoke about how change was managed in the organisation, noting that part of the work being undertaken was looking at the shared consistency of governance, reporting and how programmes are working and looking at how this can be managed in a more consistent way. A Change Group has been set up which will be ongoing and focussing on change in major projects and programmes within their directorates.	

e	***Budget*** The Chief Finance Officer presented the FY25 Financial Plan & Budget Update and provided the following overview: • Slide 2 shows that in March we were showing a £16.5m deficit, caused by the removal of COVD funding in a large part. That deficit has now reduced to £4.3m, partly to extra funding and the Trust committing to two lines of Additional Non-Recurrent Cost Improvement Programme (CIP) providing approximately £6.3m of stretch; • Slides 3 and 4 provide the background to the detail; • Slide 5 shows the Capital Plan and flagged that the target for agency was stretching if we end up with it. The caveat was this based on the planning assumption, first analysis undertaken shows it is broadly achievable at a stretch. Numerous savings from the programme have not been factored into the plan so to that extent the plan is resilient to failing to meet this. The ceiling has not been agreed with NHSE or Integrated Care Board (ICB) yet so is a work in progress; • Slides 8 and 9 cover the CIP plans. She explained that a more ambitious CIP plan had been set and this showed the proposal of how they would be met; • Slides 10 and 11 shows information on the Mental Health Investment Standard and System Development Funding; • Slides 12 shows the budget setting update; • Slide 13 shows what other providers are doing; and • Slides 14-15 show the financial controls put in place by the Trust.	
f	David Walker sought clarity on the current arrangements with the ICB and was this now fixed or still in an iterative process. The Chief Finance Officer confirmed it was iterative. He asked about the realise of the ambitious CIPs and asked if we were committing to something we know will not be realised. The Director of Finance responded that the true CIP figure was shown on slide 8 and felt confident these could be delivered, especially in the mental health services adding that the Trust was in a good place on CIPs in terms of delivering genuine recurrent savings that do not directly impact into services being provided.	
g	***Mental Health & Community Directorate spotlights*** The Executive Managing Director for Primary, Community & Dental Care shared his presentation on Primary, Community & Dental Care – Financial Plan Summary highlighting: • Baseline budget for PCDC Directorate for FY25 = £97m; • Approximately 90% of the budget is for pay costs, approximately 10% for non-pay costs; • A £2.55m (2.7%) reduction to the baseline budget has been applied from April, incorporating a FY25 CIP allocation (£2.1m) and the undelivered FY24 CIP (£0.8m); and • This reduction was provisionally allocated to pathways in proportion to budget size.	
h	**Plan Priorities for FY25** Operational CIPs: Unused budgets £460k, non-pay £230k, Ward efficiencies: £150k • More effective community ambulatory care and inpatient pathways (£1.4m); • Reducing fragmentation in UEC pathway and new medical workforce model (up to £700k); • Developing a sustainable Community Nursing model (manage growth in existing budget); and • Community care coordination hub / SPA (improving productivity).	

i	The Executive Managing Director for Primary, Community & Dental Care concluded by providing an update on delivering the Transformation programme including programme framework and the transformation team.	
j	The Chair commented that it was an impressive, multi-year, long term approach to delivery of care, efficiency and effectiveness that addresses current challenges whilst looking at opportunities to deliver care better in tandem.	
k	The Executive Managing Director for Mental Health & Learning Disability Services noted that through the annual plan the various priorities for the directorates which had clearly identified some of their financial priorities and challenges. Some of this is about investment going forward to consolidate some of the mental health framework changes over the last two years. In addition, there is a focus on ensuring the directorate does not overspend on out of area placements (OAPs) along with agency spend discussions have taken place within directorates also. There has been some investment through the provider collaboratives in Forensic which has allowed them to prioritise and continue to fund their specialist community forensic teams.	
l	Mental health wards tend to run at an overspend due to the unpredictable nature of staffing levels they need and whilst a degree of flexibility is built into the budget's acuity can change. His sense was the directorate was in a better place than it had previously been and had seen an incremental improvement over the last 3 years in budget management.	
m	**The Committee noted the reports and update.**	
4.	**Financial Management** ***Financial Report M12***	
a	The Chief Finance Officer took the paper at FIC 25/2024 as read noting that the previous year had gone well with improvements seen with financial culture, budget management, and budgets matching to spend.	
b	Philip Rutnam noted that whilst the Trust's activity level went up the balance sheet had shrunk slightly and asked about the asset impairment, what was that and why. He noted that on provider collaboratives the CAMHS space had underspent by 30% relative to budget and the disconnect between the underspend and the significant service pressures.	
c	The Chief Finance Officer responded that the impairment was the annual valuation of assets/estate looking at the market value or depreciated replacement costs. On cash, she noted the need to keep coming back to as some of the provider collaborative underspends were driving some of these. Regarding Tier 4 CAMHS underspend, the Director of Finance explained that this had happened in previous years also relating to historic underspends. The Taplow Unit closed over a year ago, the Meadow Unit had opened but was not at full capacity yet so not spending the money it will when fully functioning (approx. £3m). There was a plan to fully utilise the funding. The Executive Managing Director for Mental Health & Learning Disability Services concurred that there were various potential plans to invest in services such as day services in Buckinghamshire and Gloucestershire.	
d	Philip Rutnam noted that this was potentially a strategic issue and the sensitivity of the fact we have the money and was important therefore to be able to turn that into delivery plans.	

	Analytical Review of Financial Accounts Year End	
e	The Chief Finance Officer took the paper at FIC 26/2024 as read nothing this had already been to the Audit Committee.	
	Capital Report M12	
f	The Chief Finance Officer took the paper at FIC 27/2024 as read noting that the issue of slippage had been flagged in the report, in terms of the implications on our capabilities to both deliver and forecast. The level of implications for FY25 were still being assessed. She highlighted that the Jordan Hill lease had been signed and that increasing service charges had been agreed with our tenants (OUH & Response) to improve cost recovery.	
	Estates Update	
g	The Interim Director of Estates and Facilities took the paper at FIC 28/2024 as read noted that a programme was currently being implemented to look at the major items for the next 3 months alongside reviewing the strategic aspects and building a road map which will take longer. He needed to work through the dependencies to enable a timescale and programme pulled together which he was currently working on.	
h	The Chair reflected on the compliance side and items that had been identified as falling off the radar and something in the control environment that allowed escalation routes or oversight to not have acted as back up control to pick them up and would be interested to know how this control environment could be improved. The Interim Director of Estates and Facilities confirmed he was looking at compliance and having a team to address some of these issues.	
	IM&T Update	
i	The Chief Finance Officer presented the paper at FIC 29/2024 noting that on page 2 on frontline digitisation funding they had been able to mitigate against the risk of not receiving the money by bringing forward spend to this year as much as possible. The other mitigation in the report, on page 4, is the Trust had now received a full and final settlement from Advanced in respect of the outage caused by the cyber-attack. Lastly, she noted that the Trust was continuing to pursue the remainder of the frontline digitisation funding along with other funding sources to further mitigate risk and maximise what can be achieved.	
j	The Chief Finance Officer commented on the content of what the team was doing and highlighted the roll outs and improvements across RiO, EMIS, Truecolours and some of our infrastructure with Wi-Fi improvements.	
k	Philip Rutnam asked if the contract now in place offer a higher level of financial assurance in relation to compensation if the other systems, we use suffer a loss of service due to cyber-attacks. The Chair asked about the level of assurance we have over their own controls and have talked in the past about procuring third party assurance from key suppliers in terms of resilience. The Chief Finance Officer confirmed that this had been undertaken in house. Regarding the new contracts we get the highest level of assurance around cyber resilience and there is a process for this. The gap is in the legacy existing contracts where the resource has not been available to review this. This is now being undertaken but it still a top risk in the cyber report. In terms of financial risk, the Chief Finance Officer agreed to speak to her team and get a breakdown of the top IT contract and compensation arrangements and send the outcome to Philip Rutnam and the Chair.	**HeS**
l	**The Committee noted the reports.**	

5.	**Major Projects** ***Warneford Park Programme Update***	
a	Simon Cook took the report at paper FIC 30/2024 as read noting the intended programme spend for this year (tranche 3b) of £1.6m, April – August 2024 inclusive. He noted there were options beyond this tranche of spend as listed in the cover note and the decision would need to be made by July 2024 of which option to take. The Annual Committee report included in the pack of papers will go to the Board of Directors in May which will include the latest risks in more detail. He also highlighted they had included more depth into the progress at the Chair's request.	
b	Simon Cook spoke about the complexity of the project which they were currently navigating whilst the research building was being developed. He explained it had moved from a period of relative dormancy in terms of its design development in March this year and had been stimulated by interaction with the council and planners who are now giving it attention along with JV spending money into developing the design. There are implications for the Trust regarding this design and the key considerations are included in the pack of papers. It is likely they will want to come back to the committee to set out the implications and choices open to the Trust.	
c	Committee discussions followed regarding the planned overspend and the phasing of this along with overall costs. Concerns were expressed around the perception of this and whether the overspend should be spread over a longer time period. The Chief Finance Officer noted that different components were driving the overall costs and increase and explained that a management piece was currently being undertaken to ensure costs are correct. She highlighted that if planning were achieved in March 2025, it would create opportunities to next year so there is a need to look in the round at what is best value overall. Simon Cook noted that if we were to pause now then we would delay the programme with the consequence of a significant cost increase and disruption.	
d	The Chair requested that when the report came back in July it included assurance around the effectiveness of the clinical model and development and how each of the workstreams were working together.	
	Oxford Clinic PFI Exit – Sept 24	
e	The Interim Director of Estates and Facilities took the paper at FIC 32/2024 as read noting the work currently being undertaken to agree the final settlement figure with Project Co. Project Co have responded and have pushed back on the approach we want to take on the condition survey, but we will go back and discuss this with them. A Project Board had now been established which was working well.	
f	The Chief Finance Officer provided an update on the valuation received and the exploration of reducing the value in our negotiations. They were thinking about what deductions should be made for the condition of the asset as well as looking at the profit basis. Once we have our version of the cost valuation, we will compare notes with Semperian to gain a clearer understanding of the valuation. In terms of accounting treatments, the paper included in the Annex sets out how the conclusion was reached. KPMG and national advice were taken and agreed it was corrected, meaning our FY24 outturn is to plan in both revenue and capital. She highlighted that there was a risk to next year which was still being worked through as NHSE were rowing back on using ISF16 in budgets. She concluded that we were through FY24 but not FY25 yet.	
	Improving Quality Reducing Agency benefits realisation update	

g	The Chief People Office took the paper at FIC 33/2024 as read and noted that at M12 we had come in 10% above the NHSE ceiling in relation to agency spend for FY23/24. This was higher than expected and reported previously to the committee due to unexpected demand for agency in M12. This was being investigated. That aside, she emphasised that more than £6m was saved when looking at the Agenda for Change categories. Medical had moved in the wrong direction which had offset some of the benefits which could have been seen. Targets for 24/25 were being set in relation to agency and they will be reinforcing a bank first approach along with driving down rate cards being set regionally in relation to agency.	
h	The Chair noted the positive moves in the right direction.	
	The Committee took a five-minute break from 11:22 to 11:27	
	Business Case Review	
i	The Director of Finance took the report at paper FIC 31/2024 as read explaining that following a lack of clear process and policy around completion of business cases in the Trust, and learning from recent experience, the Trust Chief Finance Officer had sought to undertake a review to set up a clear process, documentation, and support structure for the completion of business cases within OHFT.	
j	A review had been undertaken by Ben Marriott, an economist on secondment from DHSC to check through all the Trust processes and documentation. He engaged a wide range of stakeholders as part of this review to seek views from all relevant staff. This review formed the basis of the proposed changes and updates listed in the paper.	
k	Philip Rutnam commented that in terms of thresholds it was very financially orientated and suggested that a criterion might be included enabling strategic oversight/scrutiny. He noted the 'on financial criteria,' 'capital' and 'revenue' and asked what the revenue meant, was it annual and whether clarity was needed for the minimum and whether whole life costs might be relevant.	
l	The Director of Finance noted the comment on clarity for whole life costs and would think this through. On the first point, following feedback that it was too complicated they had simplified it but may need to consider how to put the detail back in but in an uncomplicated way.	
m	The Chair suggested some support for staff on how you define a project might be useful.	
n	The Chair reflected that the document was financially dominated and if we were looking to engage staff in the organisation that might not be as familiar with these processes it was still quite complicated, how could we make it more user friendly.	
o	**The Committee noted the reports.**	

6.	**Operational & Strategic Risks** ***Deep Dive BAF 3.4 Delivery of the financial plan***	
a	The Chief Finance Officer presented the report at paper FIC 34/2024 noting that she had taken on a range of different feedback alongside reflecting on the progress in recent years when producing the paper. The important focus should be on the gaps and the red rating was correct. This also considers our underlying value for money with agency and CIPs requiring more development and need to be delivering on agency reduction. There also needs to be a proper long-term plan for cost improvement and productivity. She noted this had been quite a substantial re-write and had not been through any consultation and was a starting point.	
b	David Walker questioned the Integrated Care System (ICS) risk and how explicitly this should be written. The Chair felt this was an elevated risk, some of which was in our control and some of it which was not and felt the ICS fell into the not within our control area. The Chief Finance Officer would reflect this in an update.	
c	CIPs were discussed at length and the need for it to be captured here. Further discussions regarding CIPs to take place at the July meeting.	
d	The Chair asked whether there was a shared sense that this risk rating seemed appropriate and what was our expectation of reducing the risk downwards and over what timescale. The Chief Finance Officer responded that it was economic political context along with our capability to manage ourselves and be confident we are getting best value with a timeframe of 2027.	
	BAF 3.14 Major Projects	
e	The Chief Finance Officer noted this risk turned to be more of a re-write than anticipated and thanked colleagues for their work on this. She felt the key to good programmes was the leadership of the programmes and capability of delivering it. Strengthening the capability where people are managing the risk felt like the right approach. She highlighted the gaps in terms of portfolio oversight and felt this was a key risk. Change management approach was important and was already deeply embedded within our most important enabler. Estates was picked out due to capability challenges being faced by them and was a large share of the capital budget and should be discussed in this space. Lastly, methodology, this has been developed and guidance will be published and communicated by August 2024.	
f	Philip Rutnam suggested including the patient and carer perspective into this overview. The Chair concurred.	
g	**The Committee noted the reports.**	
7.	**Information Governance, Financial Governance & Other Matters** ***Information Management Group (IMG) 3As report***	
a	The Deputy Director of Corporate Affairs took the report at paper FIC 35/2024 as read. The Chair requested that acronyms were explained fully in reports.	
	FIC Draft Annual Report/Workplan/ToR	
b	The Chair recommended that the reports at paper FIC 36/2024 were brought back to the July meeting. The Associate Director of Corporate Affairs noted that following a meeting of the Chairs where these papers would be reviewed and then updated, they would go to the July Board.	

c d	The Chair welcomed this and asked for comments/feedback on the Annual Report. **The Committee noted the reports.**	
8. a	**Any Other Business (AOB)** None.	
9. a	**Brief reflections on today's meeting** The Chair requested those present email her with any reflections on the meeting. She also requested that the meeting on 23 July be held in person to aid discussion.	
Meeting close: 12:05 **Date of next meeting**: 23 July 2024 09:00 -12:00 in person in the Ascot Room, Littlemore.		

Meeting of the Oxford Health NHS Foundation Trust
Finance and Investment Committee

Minutes of a meeting held on
Tuesday 23 July 2024 at 09:00
Ascot Room, Littlemore Mental Health Centre, Sandford Road, Oxford, OX4 4XN

Present:
Core members and attending Board members included in quorum

Lucy Weston	Non-Executive Director (**LW**) (the Chair)
Georgia Denegri	Associate Director of Corporate Affairs (**GD**) - *part meeting via MS Teams*
Dr Ben Riley	Executive Managing Director for Primary, Community & Dental Care (**BR**)
Heather Smith	Chief Finance Officer (**HeS**)
David Walker	Trust Chair (**DW**)

In attendance:

Grant Macdonald	Chief Executive (**GM**)
Sue Butt	Transformation Director (Primary, Community and Dental Care) (**SB**) - *part meeting*
Ali Corfield	Programme Director Clinical Systems & Interim CIO (**AC**) - *part meeting via MS Teams*
Lindsay Fenn	Senior Programme Manager, Warneford Park Programme (**LF**) – *part meeting*
Nicola Gill	Corporate Governance Officer (**NG**) (minutes)
Alison Gordon	Head of Financial Management (**AG**) – *part meeting*
Vivek Khosla	Consultant, Forensic Services (**VK**) – *part meeting*
Peter Milliken	Director of Finance (**PM**) – *via MS Teams*
Claire Page	Head of Performance and Information (**CP**) – *part meeting*
Jeremy Philpot	Interim Director of Estates and Facilities (**JP**) – *part meeting*
Sam Robinson	Clinical Nurse Lead (**SR**) – *part meeting*
Priya Thompson	Head of Strategy (**PT**) – *part meeting*
Mark Underwood	Head of Information Governance (**MU**) – *part meeting*
Paul Vincent	Head of Costing (**PV**) – *part meeting*

Governor Observers:

Anna Gardner	Lead Governor– *part meeting*

1. a b	**Strategic approach to Value for Money Workshop** The Chief Finance Officer shared the presentation to guide the discussion regarding the strategic approach to Value for Money. **Action: Paper on language and vision for value to be co-created with clinical, non-clinical staff and patient groups and linking to Quality Improvement.**	
	Break 10:30-10:40 (10 minutes)	

2. a b	**Apologies for Absence** Apologies were received from members and attending Board members: Rob Bale, Executive Managing Director for Mental Health & Learning Disability Services and Philip Rutnam, Non-Executive Director. The Chair welcomed all to the meeting and confirmed it was quorate.	
3. a b	**Minutes of the Meeting held on 09 May 2024 and Matters Arising** The minutes at FIC 37/2024 of the Finance and Investment Committee meeting held on 09 May 2024 were approved as a true and accurate record. ***Matters Arising*** The Committee noted that the following actions were still in progress: • 4(c) – set of risk categories created from the 28 February Board workshop to be used to inform/add to the existing BAF risks – to be embedded and brought to a future meeting; • 4(d) – Request for a deep dive into the Oxford Pharmacy Store (OPS) licence – to be brought to an autumn meeting and include a post implementation look at the warehouse move and benefits realisation; and • 12(d) – Warneford Park Programme deep dives – dates to be confirmed.	
4. a b c d	**Annual Planning** ***Annual Plan and oversight arrangements*** The Head of Strategy took the paper at FIC 38/2024 as read highlighting that it set out the executive level review of the various components of the plan and the role of this committee in relation to that. The view was this committee would oversee the financial elements of the plan, but it was not intended that it would look at the delivery or performance management which would be looked at by the Board. The Chair noted that although the report covered the committee's role in the plan it was missing the role that sub committees play in the oversight of the plan. She also felt that Enabler 2 should come to this committee but could not see in the paper the plan for this. She acknowledged that whilst some of the strategic programmes sit within sub committees for those that did not clarity was needed on where they should sit and if not then the rationale behind the decision. **Action: The Associate Director of Corporate Affairs and Chief Finance Officer to produce a list showing what Board and sub committees oversee.** **The Committee noted the report.**	**GD/ HeS**
5. a	**Financial Management** ***Financial Report M3*** The Chief Finance Officer took the paper at FIC 39/2024 as read noting that at M3 the Trust was reporting exactly to plan both YTD and as a forecast. This was because any improvements against plan were being held in reserve in case of the need to contribute to any PFI exit settlement for the Oxford Clinic. £2.7m was currently forecast to be available for this purpose. The risks and opportunities around this were set out in the power point and were evenly balanced and was our clearest assessment of where we are on revenue currently.	

b	The Trust was conducting the usual Quarterly review process to determine whether budget allocations need to be reviewed but that process was at the early stages currently.	
c	David Walker asked about the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board. The Chief Finance Officer noted she was concerned about BOB as they continue to struggle with competing pressures including its own reorganisation, financial capability and financial pressures. The Trust had continued to provide support, seconding the Director of Finance 3.5 days a week for several months, to resolve some of their issues and to develop a plan and a grip on reporting. We must consider that it was eminently likely that the national outcome framework for Level 4 of heightened intervention might begin to happen and were operating to that context. The Director of Finance commented that the next month would be a critical one for the Integrated Care System (ICS) in terms of NHS England intervention. Oxford Health's position was that we were a stable area of the ICS and need to shield ourselves as much as possible. We want to avoid the ICS being put into oversight Level 4 and that having an impact into how we deliver our services.	
d	The Chair commented about the direction of the ICS and this financial process dragging the ICS seemingly into a transactional, backward-looking organisation which was the precise opposite to what the opportunity was. Not only had we lost the opportunity we had been burdened with extra administrative pressures. Were there any opportunities for the systems leaders to start to change this. The Chief Executive highlighted that the concern for the Trust was next year as the ICS may try to move money away from us and we need to be prepared for this.	
e	The Chief Finance Officer highlighted that Agency was going better than planned and Cost Improvement Programme (CIP) slightly worse than planned but this was being looked at and services were aiming to identify offsetting CIPs.	
f	The Chief Finance Officer reminded those present that the Warneford Programme was not a Capital Programme at this stage. The Trust's capital budget this year was predominantly Jordan Hill, estates transformation work, generally Health & Safety work and digital programmes. We over committed on digital due to Frontline digitisation taking some of the funding back and we over committed on Estates due to slippage in previous years. She noted that the slippage from last year was much higher than that factored into the plan; higher quotes had been received on Jordan Hill and higher expenditure on other projects. The intention is not to overspend but to secure additional headroom should we need it. She noted that recovering the VAT on the Meadow Unit and selling the Shrublands property were benefits.	
g	On the PFI exit payment, the Chief Finance Officer noted that we were anticipating our paper setting out what the exit payment should be. The Regional Finance Director has acknowledged the risk while reminding us that the system should aim to manage any revenue consequences.	
h	On financial culture, the Chief Finance Officer felt that financial control and financial management was now well-embedded, with positive reports received from external and internal auditors. The intention this year was to shift focus towards a deeper attention to value for money and longer-term sustainability planning. A month Services and Financial Sustainability Group has been established, chaired by herself and the Chief Executive, to challenge ourselves on these issues, alongside improving the technical management of CIPs. The workshop at the start of this meeting will likely provide helpful framing for this work.	

	Extra item	
i	The Chief Finance Officer explained Oxford University Hospitals (OUH) was requesting a short term £10m loan arrangements from the Trust to cover a working capital shortfall in the last week of August (27 August to 3 September) and September (25 September to 2 October) 2024. OUH's assumption is that if cash is needed in later months, it will be due to non-delivery of its I&E plan and at that point OUH will see PDC revenue support from NHS England.	
j	OUH is seeking to avoid use of revenue support PDC regime unless it misses its I&E plan. This is because the regime is administratively onerous and brings with it a reduction in delegated autonomy. NHS England will not confirm how long this reduced delegation lasts for after a time limited use of revenue support PDC.	
k	The Trust considers Oxford University Hospitals to be low risk and part of a Government Department i.e. the NHS.	
l	Discussion ensued regarding the pros and cons of supporting this request.	
m	**The Committee AGREED to support the request by OUH.**	
	Capital Programme Sub Committee 3As report	
n	The Chief Finance Officer noted the affordability position and capability issues within the estates team, to be discussed at the September meeting. Jordan Hill and PFI updates on specific challenges have been raised with the Chair.	
	Review of National Reference Costs – draft return	
o	The Head of Costing took the report at paper FIC 41/2024 as read. The Chief Finance Officer noted this was a return the Trust had to complete and had been difficult due to the data gaps. This is what will be reported on national databases and over time we will get back other reference costs and know how we compare to others. However, the aim is to have the equivalent for the trust as a whole in terms of our services, so the service line version of the costing will come back and be something the committee can use to see how cost to activity level is changing over time. The Chair questioned whether the root causes around some of the issues noted in the commentary would be brought back as these raised the questions but not the answers.	
p	**Action: The Chief Finance Officer requested that Talking Therapies and CAMHS be taken as an action and investigated further, then bring a fuller explanation back to the Committee.**	**HeS/ RB**
q	**Action: The Chair requested a paper reviewing the 6 keys points raised so the committee could understand what the learning was and whether there was any learning to extrapolate and implement.**	**PV**
r	**The Committee APPROVED the submission of the reference costs.**	
s	**The Committee noted the reports.**	

6.	**Major Projects** ***Warneford Park Programme Update***	
a	The Senior Programme Manager took the report at paper FIC 42/2024 as read. The Chief Finance Officer noted that funding sourcing and planning were currently on track. She commented that constructive feedback from the Council had been received on the planning application.	
b	The Senior Programme Manager noted that Tranche 3b had been approved in May and was almost completed. She highlighted that they were at a decision point now in terms of other options for the profile spend for the rest of the year which were: 1. Continue as planned to end of Tranche 3b and complete the first Public Consultation in September. Pause the programme and exercise option to remain under £2M spend threshold and then mothball spend until the end of April (FY25). Total spend until end of September 2024 is **£1,505,873** 2. Continue with September consultation and Design Freeze (October) but make decision in July to pause the Programme at the end of October. This will allow us to complete the public consultation and design freeze milestones, and then mothball spend until the end of April (FY25). This option also allows us to remain under the £2M threshold. Total spend until end of October 2024 is **£1,754,283** 3. Maintain trajectory for a March 2025 planning submission date. This includes critical path milestones of Design Chill, First Public Consultation, Design Freeze, Environmental Impact Assessment, Planning submission. This allows us the option to pause after the design freeze if required. The decision point is October, with a ramp down period to December. Important to note that this option commits us to a minimum spend of £2.5M, which is an increase of £500k in this year's profile. *Total Spend to end of December is **£2,500,000**. Predicted spend to end of March 2025 is **£3.4M** as presented at 1st of May.*	
c	The recommendation was to proceed with Option 3, with the opportunity to pause in October. Not proceeding with Option 3 will delay the programme and increase the overall programme cost and remove the option of a planning submission date in this financial year. It is recommended to proceed with Option 3 to maintain the Programme given that the September consultation and Design Freeze are on the critical path. Option 3 still allows for a pause in October pending feedback from the consultation and if we are unable to meet the Design Freeze milestone.	
d	On 3 July 2024, the WPIB Board supported the recommendation to maintain the option to meet planning submission date in March.	
e	Members of the committee sought clarification on the figures and risks which may arise. The Chief Finance Officer provided clarification on the figures. David Walker noted the need to consider in the planning application the current discussions taking place about the transport infrastructure in the City of Oxford and the proposed changes this would bring.	
f	**The Committee APPROVED the additional funding.**	
g	Vivek Khosla, Consultant, Forensic Services and Sam Robinson, Clinical Nurse Lead introduced themselves. The Chair noted the importance of clinical involvement in this project and asked what the clinical prominence had been to date.	
h	Sam Robinson confirmed that they had been involved in the project from the start working with the different pathways to look at the current issues, complications with the	

	current estates and impacts on deliverability. Mixed workshops were held for each of the pathways with a range of clinicians and experts by experience, these promoted thought on how we build on the good services we have now, what aspirations did we have in terms of environment to help us achieve the outcomes that we need from modern mental health care. There had been thoughtful engagement from across the clinical spectrum to how the environment can help. They were also keen to learn from other people's experiences and as such have looked at hospital builds across the UK and visited a hospital in Denmark to see how they have used their environment to improve health outcomes. A wealth of information has been gained through this in terms of what is needed from this hospital going forwards.	
i	The Chair asked if there was consideration about how clinical pathways might change. We have heard from patient stories the importance of relationships in treatment and continuity of relationships, the conceptualisation around a lifecycle of care rather than treatments within individual interventions or locations. Has our thinking around models of care changed. Vivek Khosla noted this was a crucial point and when they engage with staff they think about the here and now and the opportunity is to shift their thinking to what they might be doing in the future. They are trying to use this as an influence on directorates to start thinking about how we want to deliver care. Part of the conversations taking place are looking at how we change what we do, not just the building but what happens inside the building. The Chair challenged whether this might change the way the building looks. Vivek Khosla responded that there would be the opportunity to evolve the design parameters within the inside of the building and flexibility was key to the design. The Chief Executive noted the need for space for ambulatory care and not to underestimate the challenge ahead.	
	Jordan Hill Update	
j	The Transformation Director (Primary, Community and Dental Care) took the report at paper FIC 43/2024 as read noting that during the financial process, in terms of the fit-out contractor they undertook additional due diligence. The bids received were reviewed and the most capable and competent supplier was identified who can undertake the work this financial year negating the doubling up of revenue costs. Alongside that some additional management requirements have been looked at to reduce risk regarding specialist fit-out regarding podiatry and dental. The next steps regarding deliverability would be, presuming finances agreed this week, that we would then have a triangulation meeting session next week with the designers, the appointed fit-out contractor and ourselves to walk through value engineering. Potentially some costs have been identified that could be value engineered out. This meeting would then drive what the revised programme would look like.	
k	The Transformation Director (Primary, Community and Dental Care) spoke about the engagement of clinical teams in the project noting that this had been strong from the start of the project.	
l	David Walker asked about the transport plans and was there anything at corporate level that could be done to assist. The Executive Managing Director for Primary, Community & Dental Care noted that they had recently met with the new transport team, they spoke about following up and had attended the Blackbird Leys workshop. Medium to long-term we would need to think about our model around home visiting and modes of transport to do that. The Chair noted the need to revisit public transport.	
m	The Chair asked about the budget overspend noting it was a significant overspend and whether alternatives had been looked at, that perhaps considers podiatry staying where it is if that is the high-cost element of the re-fit or bariatric care, and other teams move into a hub to make that a more cost-effective real estate. Why were we happy that this	

	significant increase in cost represents value for money. The Transformation Director (Primary, Community and Dental Care) noted that our current building estate around Oxford City, most are not owned by the Trust so very much transient ownership and Jordan Hill would ensure surety of estate.	
n	The Chief Executive asked what podiatry and dentistry would be provided at Blackbird Leys. The Transformation Director (Primary, Community and Dental Care) noted there would be no dentistry, but podiatry would come into Blackbird Leys.	
o	The Chief Finance Officer noted the programme was seeking £1.946m in total. This committee were being asked to recommend it to Board for approval.	
p	**The Committee RECOMMENDED Board approval the additional spend on the caveat that we re-visit how these projects are handled and decision making and thinking about Blackbird Leys in a different light as a result.**	
	Oxford Clinic PFI Exit – Sept 24	
q	The Interim Director of Estates and Facilities took the paper at FIC 44/2024 as read. He noted that it was going well and there were some key meetings due to take place in the coming weeks. Work was being undertaken to identify the outstanding amounts the Trust was owed which will help inform the final financial negotiation agreement.	
r	**The Committee noted the reports.**	
7.	**Information Governance, Financial Governance & Other Matters**	
	Data gaps and data quality assurance report	
a	The Head of Performance and Information took the paper at FIC 45/2024 as read. She highlighted the report outlined where the Trust was with the reporting recovery and provided an update around data quality and data quality assurance activities which were underway.	
b	The Chair asked about risk, the extent to which in deciding which data would be attempt to be recovered or backdated a risk assessment had been undertaken which had decided which areas were or were not a priority for including in scope and the longer-term impact on both quality issues and reporting issues that might result from that. Therefore, we know what the risk was from having those data gaps in a long-term scenario. The Head of Performance and Information responded that there were two of these. Data Gap 1 relates to the outage period and data which was not entered into the clinical information systems. Discussions occurred at the various steering groups and the digital and data strategy board decisions taken on what was at the time pragmatic and achievable. Due to the nature of how the data was saved it was agreed that just the documents would be uploaded onto the systems so that clinically the data was there but from a reporting perspective the data was not necessarily available.	
c	The Chair noted that potentially the risk analysis piece had not been undertaken on the data gaps the Trust has and our planning will remain in perpetuity, we my not have analysed at a Trust level the impact of what that might be. The Chief Finance Officer confirmed that for Data Gap 1 that was the case but for Data Gap 2, relating to system functionality there were 8 items identified which had risk assessments and mitigations put in place. The Chair requested this information be circulated to the committee.	
d	The Chair requested that management pick up the risk around the first point. The Chief Finance Officer noted this could be discussed but noted the reality was there would not be the option of going back to that period in 2022 and re-creating a record now.	

e	The Head of Performance and Information highlighted that work was being undertaken reviewing the Trust's business continuity process and felt that looking at the risk would be beneficial to incorporate into the future process. She did not feel that there was any remedial action that could be taken at this stage.	
f	The Chair noted that at the Exec meeting the previous day they had discussed how remarkable the Trust's reaction had been to this incident and should explore ways of sharing our preparedness of this with other services.	
g	The Chair noted she hears at Quality Committee the narrative around risk associated data gaps and the impact on quality and she hears there is an answer to this but perhaps it is not being widely shared in terms of the narrative.	
h	The CDIO noted this came up yesterday following the EMIS outage over the weekend and the clinical services were challenging why we did not have a solution to why we had not got a solution to automatically put the data back into our clinical systems following an outage. That solution is incredibly challenging to develop, we do not have one. One of the lessons learnt from this recent outage is to clearly communicate that to our staff. To develop something to capture and transfer automatically information from business continuity plans into clinicals systems is very difficult. This will be looked at but will take time. The Chair noted the sharing of what data services felt was critical to them to deliver a safe service is the bit to prioritise and have a conversation around the options. The CDIO noted this was being undertaken currently but felt it was clear to be very clear what their capability was in an outage back to business.	
	Procurement Report incl Single Action Tender Waiver (SATW) The Head of Procurement took the paper at FIC 46/2024 as read.	
i j	The Chair requested that the next iteration of the report to include risk and the analysis of such so the committee could understand where the residual risks were and the impact of these might be. The Head of Procurement agreed to include this information in the next report.	
	Information Management Group (IMG) 3As report The Head of Information Governance took the report at paper FIC 47/2024 as read.	
k	The Chair asked about the first point in escalation around paper records still outstanding, noting she had escalated this at the previous Board meeting. He explained they were well advanced and under control but felt it was worthy of note in the governance. He noted there had been issues over the weekend with mobile EMIS due to the CrowdStrike event.	
l	The Chair requested that the Chief Finance Officer provide an update at the Board meeting the following day on the impact of the CrowdStrike event.	
m	The Chair requested an update about the risk around 'paper' as they had been told at Board meeting that the paper issue was not a risk. The Head of Information Governance felt the only noted risk is a practice one due in part to the fact that District Nurses use records in patient homes and when a patient dies and they are required after death then the family dispose or them or they disappear, that is the risk. There is a risk of that confidential information being in the wrong environment or not being accessible for the coroner or other purposes. The Chair sought clarification that this pre-existed system outages and was in hand. He confirmed it was and that mobile EMIS would assist with this.	

n o p	***FIC Draft Annual Report/Workplan/ToR*** The Chair took the paper at FIC 48/2024 as read. The Associate Director of Corporate Affairs requested that the ToR were looked at outside of the meeting so that they would be ready along with the workplan and annual report to go to the September Board meeting. **The Committee noted the reports.**	
8. a	**Policies** • **Investment Policy** The paper at FIC 49/2024 was taken as read. **The Committee APPROVED the Investment Policy.**	
9. a	**Any Other Business (AOB)** The Chief Finance Officer noted the delay in the Oxford Pharmacy Store (OPS) move to the new warehouse on prudent safety grounds and that the cost remained within budget.	
10. a b	**Brief reflections on today's meeting** The Chair noted that it had been agreed with the Chief Finance Officer that they look at financial reporting and what comes to the committee as it was reasonably impenetrable in terms of volume and focus on key messages. The Chief Executive commented that he felt having a workshop prior to the main meeting might not be the best solution and perhaps a stand-alone workshop would work better.	
Meeting close: 12:44 **Date of next meeting**: 17 September 2024 09:00 -12:00 via Microsoft Teams		

Meeting of the
Finance and Investment Committee

Tuesday, 17 September 2024
09:00 – 12:30
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 23 July 2024 and Matters Arising (paper – FIC 50/2024)	LW		5
3.	**Estates Deep Dive** (paper – FIC 51/2024) *TO FOLLOW*	JP	9:05	25
4.	**Green Plan/Sustainability Strategy – progress reporting** (paper – FIC 52/2024)	KA/RB HeS/JU	9:30	20
5.	**Financial Management**			
	• Financial Report (revenue and capital) – M4 (paper – FIC 53/2024)	PM/HeS	09:50	40
	• Capital Programme Sub Committee 3As report (paper – FIC 54/2024)	HeS		
	*Supporting information: Capital Programme Sub-Committee minutes and agenda (to note) - see **Reading Room/Appendix (papers – RR/App 15/2024)***			
	• Medium Term Financial Plan (paper – FIC 55/2024)	HeS/PM/ AG		
	• The articulation of our ambition around value (paper – FIC 56/2024)	HeS		
	• Analysis of reference cost variances (paper – FIC 57/2024)	HeS/PM/ PV		
	Break 10:30 – 10:40 (10 minutes)			
6.	**Major Projects**			
	• Warneford Park Programme update (paper – FIC 58/2024)	SC/HeS	10:40	45
	*Information to note: Warneford Park Internal Programme Board minutes and agenda - see **Reading Room/Appendix (papers – RR/App 16/2024)***			
	• Oxford Clinic PFI Exit – Sept 2024 (paper – FIC 59/2024)	JP/PM/ MW/HeS		
	• Frontline Digitisation Update inc data gaps assurance (paper – FIC 60/2024)	AC		

[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

7. **Operational & Strategic Risks** (paper – FIC 61/2024) • Update on BAF risks 1.1 & 3.10	HeS/BC/ BA/HaS	11:25	25
8. **Information Governance, Financial Governance & Other Matters**			
• Treasury Management annual report (paper – FIC 62/2024)	MW/HeS	11:50	25
• Inquests and Claims (Legal) annual report (paper – FIC 63/2024)	NMcL/ GD		
• FIC ToR and Annual Report (paper – FIC 64/2024)	LW		
9. **Policies** • Treasury Management Policy (*renewal 30.09.24*) (paper – FIC 65/2024)	PM	12:15	5
10. Any Other Business: *to include matters referred to FIC from other sub committees*	LW	12:20	
11. Brief reflections on today's meeting	LW		
Meeting Close		12:30	

Date of next meeting: 12 November 2024 09:00 - 12:00 via Microsoft Teams virtual meeting

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted -

12. Capital Programme Sub-Committee minutes and agenda: June 2024 (to note) (papers – RR/App 15/2024)

13. Warneford Park Internal Programme Board minutes and agenda: July 2024 (to note) (paper – RR/App 16/2024)

FIC Attendance 2024/25

FIC - Core members (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Jan-25	Mar-25
Rob Bale	✓	Apols				
Amélie Bages*	Apols	Apols				
Philip Rutnam	✓	Apols				
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	✓	x				
Peter Milliken	✓	✓				
Priya Thompson	✓	✓				
Hannah Smith		x				

* = 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 (*minutes)*

Item	**Discussion**	**Action**
1. a b	**Welcome and Apologies for Absence (GC)** The Chair welcomed members of the Committee and confirmed the meeting was quorate. Apologies were received from Britta Klinck, Chief Nurse.	
2. a b	**Minutes of previous meeting held on 29 February 2024 and Matters Arising (GC)** The minutes of the meeting held on 29 February 2024 were approved as a true and accurate record. **Matters Arising** No matters arising.	
3. a	**Trends in Mental Health Act (MU)** 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.	
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. h=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.	**MU**
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 mangers 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 mangers 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 brough back to the next meeting to be approved.**	
6. a	**Patient Participation Group and PALS update (RH)** 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:**	

	• 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.	
f	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.	
g	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.	**RH/MU**
h	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.	**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 b	**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 it 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. 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** **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 VoiceAblilty 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

MINUTES of the Mental Health & Law Committee meeting held on Tuesday 16 July 2024 at 0900 hrs via Microsoft Teams

Present:	
David Walker (**DW**) acting Chair	Trust Chair
Karl Marlowe (**KM**)	Chief Medical Officer
Georgia Denegri (**GD**)	Associate Director of Corporate Affairs
Mark Underwood (**MU**)	Head of Information Governance
Rob Bale (**RB**)	Executive Managing Director for Mental Health & Learning Disabilities

In attendance:	
Nicola Gill (**NG**)	Corporate Governance Officer (*minutes*)
Amy Allen (**AA**)	Mental Capacity Act and LPS Lead
Rose Hombo (**RH)**	Deputy Director of Quality
Leanne Dunkley (**LD**)	Corporate Governance Officer (*minutes)*

Item	**Discussion**	**Action**
1.	**Welcome and Apologies for Absence (GC)**	
a	The Chair welcomed members of the Committee.	
b	Apologies were received from Britta Klinck, Chief Nurse, Daniel Mercier Associate Director of Social Work and Social Care, Geraldine Cumberbatch, Non-Executive Director and Committee Chair and Grant Macdonald, Chief Executive.	
2.	**Minutes of previous meeting held on 13 May 2024 and Matters Arising (DW)**	
a	The minutes of the meeting held on 13 May 2023 were approved as a true and accurate record.	
b	**Matters Arising** **The Committee noted that the following actions have been completed:** • committee Terms of reference-on the agenda for today; • Invite Executive Managing Director for Mental Health and Learning Disabilities to future meetings-LD completed, attending today; • Mental Health Act Policy review-on today's agenda; and	

	• The Trust Chair to raise concerns with council re VoiceAbility contract-contact has been made. **Therefore, these actions could be closed**.	
c	The following action remains: • Committee Chair to discuss offline with Deputy Director for Quality and Head of Information Governance to consider reports -to stay open.	**GC/RH**
3.	**Trends in Mental Health Act (MU)**	
a	The Head of Information Governance took the presentation, Trends in Mental Health Act report at paper MH&LC 13/2024 as read, which provides an update on mental health act activity over Q1 and Year to Date (YTD). He highlighted: • places of Safety (POS) continue to be used as an admission facility, 47 adults and 3 young people over Q1; • in Buckinghamshire, 1 young person detained under section 2 for 5 days in POS; • no invalid detentions; • 11 lapses in detention, 8 of which had run their course, no decision to move onto section 3, One Community Treatment Order (CTO) not renewed and 2 Section 3's ran their course; • 3 nearest relative discharges, 2 of which were barred by responsible clinician; • mental health act office processing 48 managers hearings and 72 mental health tribunal's; • 150 tribunals have been completed in Q1; • risk with Second Opinion Appointed Doctors (SOAD) pending, resulting in the use of section 62 by responsible clinicians; • Friday saw the lowest level of leave of detained patients at 2 which is a change over the past 4 years; and • CQC visit at the Meadow Unit this week, verbal feedback positive, with no actions overdue.	
b	The Mental Capacity Act and LPS lead asked in relation to the CQC improvement actions regarding consent to treatment and recording of capacity, has guidance been provided as to what they are expecting. The Southeast regional group has proposed setting up a task and finish group to put together a checklist, including common pitfalls that could be used, as it not appropriate to document it all the time.	

c	The Head of Information Governance noted that it is very general guidance but will go through the reports and pull out any detail that would be applicable.	
d	The Chair noted that it could be an opportunity to articulate and be positive and consider how CQC activity could be improved for the sake of patient care, as they are open to practical solutions.	
e	The Chief Medical Officer is keen that a letter is articulated to the CQC regarding the capacity consent to treatment, as the Act says that we assume capacity and have to assess for capacity or lack of capacity based on time and place and decision being made, which is the opposite of what is happening during CQC visits, who are reporting that there is no prove a person has capacity.	AA/KM
f	The Chair noted that it would also be worth copying this to the DASH enquiry team as well.	
g	The Associate Director of Corporate Affairs added that there are ongoing engagement meetings between the CQC and Chief Nurse, which alongside the letter would be a good forum to discuss this with them.	
h	The Head of Information Governance noted that from a recent report it mentioned concerns regarding assessments of mental capacity, as in 4 sets of notes it was documented that a person did not have capacity, however there was no evidence of these assessments, therefore need to ensure that we back up when people do not have capacity.	
i	The Chair asked in relation to POS, have any effects been seen following the revision of the Polices approach to mental health, ahead of an upcoming meeting with the Police commissioner? The Head of Information Governance noted that there has been an impact and will identify for the next meeting any specific cases, however there is reluctance to help with Absent Without Leave (AWOL) patients.	
j	The Chief Medical Officer noted that his experience is that there is an overuse of the section 136, and questioned whether the utilisation of POS as an admission be benchmarked, as opposed to using it as a POS, would be useful to build that story considering the human rights aspect. Is there anything that needs to be done in relation to the number of CTO's which has been consistent since 2019, as the triangulation of data, the extended leave under section 17 has reduced, but that is not reflected in the number of CTOs, as the new government will be reviving the new Mental Health Act, and CTO's will have a maximum of 12 months.	

k	The Head of Information Governance noted that this was not unusual when compared to national figures, it could be related to leave and those who are difficult to engage with.	
l	The Chair noted that with the political landscape changing if we felt pressure to support the recovery of the Wesley reforms, to push it up the agenda, now would be the time to do some lobbying for this.	
m	The Chair summarised that the trends presented are stable and sought assurance that there was nothing untoward happening under these trends that could be a concern.	
n	The Head of Information Governance commented that there were no concerns in relation to the Act being used and implemented lawfully. The Trust is now significantly better at providing information to individuals detained under the act, which is reported at the weekly safety review and the number of invalid detentions is related to the act rather than clinical decisions, so no concerns at present, however, need to continue to challenge its implementation and consider alternative ways to deliver care, as 85% of mental health inpatients are detained under the mental health act. **The Committee Noted the Update**	
4.	**Trust Risk Register update (KM)**	
a	The Chief Medical Officer took the paper tabled at MH&LC 13/2024 as read which provides the Committee with information regarding TRR risk 1033 (Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)), noting this refers to the Deprivation of Liberty changing to Liberty Protection Safeguarding (**LPS**) and the Trusts ability to implement that. This did not go through last parliament and there has not been an increase in resource requirement, therefore this risk could be closed as no longer relevant, and could be brought back should it become relevant. The reason that this was such a significant risk was the Trust as an NHS provider would have taken responsibility and be the designated body for it.	
b	The Mental Capacity Act and LPS lead supported the removal of this risk from the risk register noting that the Mental Health Act was talked about on the new parliament, but not the liberty protection safeguards, so unlikely to happen any time. The Trust has robust measures in place, and everything being completed regarding mental capacity act compliance is with a view to transfer and implement that in regard to LPS if required.	

c	The Head of Information Governance added that the authorisation process is broken at local authority level, the Trust is doing what they would be doing if LPS was in place.	
d	The Chair asked whether there is any likelihood of this legislation being rapidly represented under the new parliament. The Chief Medical Officer felt that it would not be this legislation, it may be the autonomy component of the new Mental Health Act, which gives greater protection to the induvial, making decisions and the LPS went in parallel with this. The New Mental Health Act would have a lot more protection of autonomy of the individual subject to the Mental Health Act, if this was to be implemented it requires significant resource allocation, so would not be done quickly. **The Committee supports the removal of this risk from the TRR and will be presented to the extended Executives meeting and to The Board to support this**.	
5.	**Mental Health and Law Committee Draft Annual Report.**	
a	The Chair took the annual report at MH&LC 14(i)/2024 as read and asked the members for comments/amendments.	
b	The Chief Medical Officer commented that more attention to human rights and the implementation of the Mental Health Act should be included. Rights are considered as part of the trends in Mental Act paper that the Committee receives at each meeting and as part of the capacity.	
c	The Mental Capacity Act and LPS lead added that rights are considered and discussed when reviewing the POS data, which is discussed most meetings.	
d	The Head of Information Governance added that the Committee receives reports that evidence that consent is obtained in line with the Mental Health Act and highlights any issues such as the availability of SOAD. The right to a fair trial around tribunal's and ensuring that patients receive the correct information during this process is also reported. Complaints are discussed regularly in relation to the Mental Health Act and consent to treatment. At the weekly safety meeting the privacy of the person and respect and dignity of the person in relation the environment is discussed along with restraint and seclusion, which would be escalated to the Committee.	
e	The Executive Managing Director for Mental Health and Learning Disabilities added that the Trust has Mental Health Act CQC visits which look at a wide range of things, that we respond to. The trends and themes from those visits, which provides assurance as they are an external body	

	review our services and practice in this area, so could consider adding a summary of those visits and the themes from them. The advocacy section feels brief, which there are problems with at present, however, is there data on how many patients are accessing advocacy services and what the feedback from those accessing this external service is.	
f	The Chair concluded that if there is any useful data on the Advocacy service that it could be added in to the draft report, as there have been concerns regarding the access to advocacy service highlighted to this Committee.	
g	The Chief Medical Officer asked for clarity in relation to ethnicity data on page 4, is the wording correct or do we need to add some evidence or highlight that the information has been interrogated. On page 10 there is mention of the Co-Pact study, which relates to advocacy, which is not usually the committee to receive this sort of presentation and have started to develop this and have invited VoiceAbility and POWER to attend the Committee.	**LD**
h	The Head of information Governance confirmed the statement is true, Leanne to add that the data has been interrogated and then recirculate the updated draft to Committee members offline for further comments.	
	Terms of Reference (ToR):	
i	The Associate Director of Corporate Affairs noted that she had sent through this morning an updated version of the Terms of Reference which will be circulated after the meeting. These have been put into a new template; however, the content of the ToR has not changed. She asked whether the Committee wanted to spell out what duties it was looking at, as at present the workings of the Committee are quite general.	
j	The Chief Medical Officer highlighted that the content of the ToR was similar to the previous ToR that was approved at the last meeting, other than adding the role of the Executive Managing Director for Mental Health and Learning Disabilities to the membership and removed the Chief Nurse, and questioned whether the Mental Capacity Act and LPS lead should be included as a member of the Committee. He felt that the duties of the Committee did not need expanding at present.	
k	The Executive Managing Director of Mental Health and Learning Disability questioned whether community services were covered through this Committee as there was no community representation, as there is a vast number of people under the deprivation of liberties within that service. The Chair questioned as to who that might be to provide the community	

	representation? It was suggested it could be a service director or clinical director.	
l	The Chief Medical Officer highlighted that the utilisation of the Mental Capacity Act in the community hospital setting has been reviewed, which was an area that had previously not had much light shone on it. Now have a fantastic training programme covering the community directorate so would not suggest increasing the membership of the Committee at present.	
m	The Mental Capacity Act and LPS lead commented that the community is such a vast directorate, with many teams and different disciplines that getting the right representation would be difficult.	
n	The Chair commented that historically the concern has been how information is disseminated, so having the Chief Medical Officer and Executive Managing Director of Mental Health and Learning Disabilities as members of the Committee addresses this concern. The Committee workings need to remain focused, as it is an important subject matter and as members of the Committee is about concentrating the conversations.	
	The Committee agreed to not expand the duties of the Committee on the ToR and to add the Mental Capacity Act and LPS lead as a member. Leanne to add and circulate via email outside of the Committee.	**LD**
o	**Committee Workplan**	
p	The Chair noted that as there are concerns regarding the rights of patients and the access to advocacy services, which is discussed and reviewed through the Committee's standard reports, is not stated explicitly in the workplan.	
q	The Head of Information Governance added that there has been challenges of individual's under DoLS which causes issues in the social care teams and has a financial aspect attached seeking legal advice, is this tracked here or elsewhere.	
r	The Mental Capacity Act and LPS lead highlighted that this was discussed with the Trust Solicitor and Risk Manager last year in terms of court protection work, as challenges to DoLS is one aspect of that, which could be brought here as part of the Mental Capacity Act and DOL's update report and could include challenges to DoLS, court protection advice around section 49 reports, which is increasing.	

	The Chair summarised that as this relates to legislation and there is an upward trend noted then the Committee should be sighted on this. **The Committee Approved the Workplan**.	
6. a	**Patient Participation Group and PALS update:** The Deputy Director for Quality provided an oral update, highlighting: • 229 complaints received last year; • Q1, 36 Rapid resolution complaints received; • implementing the new complaints standards, which focuses on rapid resolution to prevent escalations and improve the experience for the complainer; • 15 low level and 1 high level complaint, mostly around CAMH's children services; • themes remain similar around level of care, communication, staff attitude and behaviour, poor sharing of information between teams and agencies and waiting times and access to services; • waiting times is one of the quality priorities for the next year; • 300 compliments received in the last quarter; these are difficult to track as not electronically captured so considering alternative way to collate the data; • 6 voices pathways running, one in each directorate and the BOB neurodivergent voices across the ICB; • Mental Health Partnerships and Outcome measures work all have patient and carers representation; • looking to increase the numbers of patient involvement, to ensure that we are hearing from a diverse group; • the Physical health programme around smoking cessation services and the QUIT programme with the Royal College of Psychiatry; • the Suicide prevention programme has been very beneficial, with service users and staff collaborating and new training for staff; • The Patient, Carer Equality Race Framework (PCERF), is being rolled out; • in CAMH's there is the unlock project, which is coming to an end, has 3 aims to deliver, which was to increase young peoples feedback, to create a young peoples board and to reach out to as many schools as possible, awaiting the outcome report from this project; • mental health advocacy issue has now been taken over by the Associate Director of Social Work and Social Care, and there has been positive improvements with most of the providers. • currently 3 providers covering the Trust, POWER cover adult and children's services in Buckinghamshire and BaNEs and have just started to submit their reports, which is working well. There are	

	good relationships and engaged commissioners in Buckinghamshire. • VoiceAbility is the Oxfordshire provider, however they do not cover children's services; • Community Connect are the children's services provider, their contract does not cover Independent Mental Health Advocates (IMHA), which has been raised with the commissioners, as this is a service gap, which was picked up in the recent CQC mental health act visit and will be in the report from this; • PAL's clinics have been set up as a mitigation for the lack of IMHA in Oxfordshire's children's services; • For next meeting should have some reports from the providers to show the work they are doing;	
b	The Chief Medical Officer sought conformation that the Advocacy issue is being taken forward and that an update could be provided at the October Committee meeting.	
c	The Head of Information Governance commented that it is extraordinary that there has been an advocacy provider commissioned that are not able to provide a statutory requirement, which needs to be resolved quickly.	
d	The Chair noted that he would be happy to approach the leadership of the County Council again as this is a statutory function that is not being fulfilled, resulting in a gap that is not of our making.	
e	Following a question regarding the advocacy service in Swindon, where there are young people's wards, The Head of Information Governance informed the Committee that Advocacy service in Swindon is provided by Swindon and Marlborough Advocacy (SAM), who do seem to be effective and accessible.	
f	The Executive Managing Director for Mental Health and Learning Disabilities suggested that the Trust should suggest alternative option to cover the gap such as using POWER, who previously provided advocacy services in Oxfordshire including children and young people or SAM could provide the cover that Community Connect are not being commissioned to provide. **The Committee noted the update**	
7.	**Mental Capacity Act Policy Review**	
a	The Mental Capacity Act and LPS lead presented the reviewed Mental Capacity Act policy, acknowledging that it is a lengthy policy. The format	

	has been changed to follow the process in the act and the training that is provided, and frequently asked questions have also been included.	
b	The Chief Medical Officer noted that the assumption of capacity is clearly defined within the policy, which could be used to write a letter to the CQC in regard of process of assessing capacity. He asked for clarity around the new legislation, regarding what has changed. The Head of Information Governance explained that the interface between the mental health act and the mental capacity act is huge. There is an eligibility criteria for the use of DoLS and if ineligible should you be using the mental health act, so clarity has been added to the policy to support ward's when considering DoLS.	
c	The Chief Medical Officer noted that this has always been a muddy area on older adult mental health wards, where the mental health act tended to be used.	
d	The Mental Capacity Act and LPS lead noted that DoLS in an inpatient setting is difficult, from September running a separate mental capacity act training for medical staff, which will allow 2 hours to focus on the complexities and discuss the interface between mental health act, mental capacity act, DoLS and case law.	
e	The Chair asked is there an equivalent process in terms of nursing staff to keep up to date in this complex area. The Deputy Head of Quality noted that there is mandatory training for nursing staff, although one of the difficulties is the application of knowledge gained from the training, it is difficult to assess the effectiveness of the training. Considering delivering bitesize training to have more impact and impart more knowledge for frontline workers, noting that the responsibility of training agency staff does not lie with the Trust.	
f	The Head of Information Governance added that the Mental Health Act and LPS lead has been delivering bespoke focused training to community hospital inpatient staff, which is now at 82%, which is a forum where DoLS issues rest. The Mental Capacity Act and LPS lead commented that the training for the community hospitals has been tailored for them and the client group they serve, there is a question as to whether we should be offering tailored training to other wards and teams, which could be done.	
g	The Deputy Head of Quality and Mental Capacity Act and LPS lead agreed to take this to the Education and training group, as there is gap for	

	inpatient mental health wards. There are lots of learning and development practitioners who could support and deliver some of the bitesize training.	
h	**The Committee Approved the Policy.**	
i	**Mental Capacity Act and DoLS update** The Mental Capacity Act and LPS Lead took her report at MH&LC 15/2024 as read, highlighting: • 3 requests of DoLS in Buckinghamshire inpatients unit authorised; • Buckinghamshire Council triage DoLS request differently to Oxfordshire, priorities any requests from mental Health Wards; • 1 of these is an ongoing situation in which court protection are involved, which could be brought here; Buckinghamshire Council are leading the work in this case as it regarding discharge from hospital; • Community hospitals in Oxfordshire are assessing them, working with matrons to ensure that there is robust assurance regarding reviewing DoLS. **The Committee noted the update**.	
8.	**Use of Force Act update:**	
a	No report received	
9.	**Mental Health Managers Story**	
a	The Chief Medical Officer informed the Committee that a report was not available for this meeting and the Head of Information Governance would invite a Mental Health Act Manager to present at the October Committee meeting.	**MU/KM**
b	The Chair added that he met with Mental Health Act managers recently who expressed concerns that there was not non-executive presence as observers in hearings.	
10.	**Inpatient Mental Health Survey** The Chief Medical Officer informed the Committee that the survey is not yet available. The Deputy Head of Quality noted that last year's survey has been published and there is an action plan that is being worked through. The papers have just been signed off for a secondary team to complete this	**RH**

	year's survey, which is just about to start. The survey will be brought to this Committee to consider the mental health act legislation.	
OTHER BUSINESS		
8. a b	**Any other business** None **Actions**: The Deputy Head of Quality and Mental Capacity Act and LPS lead agreed to take this to the Education and training group, as there is gap for inpatient mental health wards. There are lots of learning and development practitioners who could support and deliver some of the bitesize training.	
9. a	**Meeting Review (ALL)** none	
10. a	**Meeting Close** There being no other business the meeting closed at 10:28 hrs.	

The next meeting is scheduled to be held on Tuesday 15 October 2024 at 13:00 hrs via Microsoft Teams

Meeting of the Oxford Health NHS Foundation Trust Quality Committee

[DRAFT] Minutes of a meeting held on Tuesday, 16 July 2024 at 09:00

virtual Microsoft Teams meeting

Present[1]:

Andrea Young	Non-Executive Director (Committee Chair) (**AY**)
Rob Bale	Executive Managing Director for Mental Health and Learning Disabilities (**RB**)
Britta Klinck	Chief Nurse (**BK**)
Karl Marlowe	Chief Medical Officer (**KM**)
Georgia Denegri	Associate Director of Corporate Affairs (**GD**)
David Walker	Trust Chair (**DW**)
David Clark	Non-Executive Director (**DC**)

In attendance[2]:

Grant Macdonald	Chief Executive (**GM**)
Brian Aveyard	Risk Assurance and Compliance Manager (**BA**)
Lynda Dix	Associate Director of Nursing, Forensic Services (**LD**)
Leanne Dunkley	Corporate Governance Officer (**LCD**) (minutes)
Juliet Hunter	Public Governor (**JH**)
Hannah Smith	Assistant Trust Secretary (**HS**)
Rose Hombo	Deputy Director of Quality (**RH**)
Jane Kershaw	Head of Patient safety (**JK**)
Angie Fletcher	Deputy Chief Nurse (**AF**)
Rami El-Shirbiny	Clinical Director Forensic Services (**REL**)
Michael Marven	Chief Pharmacist and Clinical Director for Medicines Management (**MM**)
Pete McGrane	Clinical Director, Community Services (**PM**) deputising for Ben Riley
Claire Forrest	Head of Clinical Standards (**CF**)
Sophie Behrman	Consultant Adult Mental Health Assessment and treatment Team City (**SB) Observer**

[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.

Victoria Harte	Patient Safety Service Manager (**VH**)
Katrina Anderson	Service Director Oxon & BSW Mental Health (**KA**)
Ashley Harvey	Oxford Health Improvement Manager (**AH**)
Julia Marren	Infection Prevention and Control Nurse (**JM**)
Tasmin Irving	Head of Service Adult Directorate Management Team (**TI**)
John Pimm	Clinical Lead, Buckinghamshire Psychological Therapies Pathway (**JP**)
Partha Ghosh	Senior Locality Lead, Buckinghamshire Talking Therapies (**PG**)
Tina Malhotra	Clinical Director, Adult Mental Health Assessment & Treatment Team South (**TM**)

1.	**Apologies for Absence**	**Action**
a	Apologies for absence were received from Lucy Weston, Non-Executive Director.	
b	Apologies for absence were noted from the following regular attendees: Daniel Mercier, Associate Director of Social Work and Social Care; Lola Martos, Interim Clinical Director, Oxon and BSW Mental Health Services.	
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.	
b	The minutes at QC 34(i)/2024 Minutes of the Quality Committee (**QC) on the 02 May 2024** were confirmed as a true and accurate record, subject to amending section 3F to say vacancies in community mental health teams.	
c	***Matters Arising*** The Committee noted that the following actions were on the agenda and could therefore **be closed**: 3b (j) Patient Safety Partners-an update is included as part of the PSI report today; 3a (b) City Adult Mental Health Teams-plan of support and mitigations; 3(o) Safe Staffing Report; 6(b) Quality Account (Quality Priorities); 8 (e) Quality Governance of Oxford Pharmacy Store-is now scheduled in workplan; and 9(f) BAF 3.1 Failure to Engage in shared planning and decision making at a system and place level and work collaboratively with partners.	
d	The Committee noted that the following actions remained open: 6(a) Discharge arrangements for Mental Health Patients following NHS England planning Guidance; 3(c) Restrictive Practice/Rapid Tranquilisation and Prescribing- this is understanding rapid Tranquilisation and whether it is used in a supportive practice and how it is recorded-an update to be brought to the September meeting. Being looked at in	**RB/KM** **BK**

	positive and safe committee and a deep dive into CAMHS restrictive practice was presented at July QCG-SG , paper to be shared to members; 3(b)k Deep Dive into Patient Safety Incident report to review effectiveness of change/mitigations -verbal update to be provided in November and full report following a full year implementation i.e. February 2025; 9(d) Learning from Patients-map where and how feedback is collected and collated to come as part of the next report in November; 15(e) Quality Governance System including Ward to Board Governance-to be brought back to the November meeting, showing reporting arrangements below directorate level; 3(e) Resuscitation Training-Timeline is not included this month, there are changes coming out from resus council. An update to be available in September; 9(f) BAF 1.1 (Triangulating Data and learning to drive Quality Improvement) meeting to decide which committee takes ownership of this risk scheduled for August so update at September meeting; 5(d) Mental Health, Learning Disability & Autism Inpatient Quality Transformation Programme Progress Report-scheduled for September; and 6(c) Patient and Carer Race Equality Framework (PCREF) full report due in September.	**JK** **RH** **GD/BC** **AY/LW** **KP/RB** **RH**
SAFETY		
3.	**Quality and Clinical Governance Group (QCG) 4 July 2024 - escalation report**	
a	The Chief Nurse took the report QC 35(i)/2024 as read, and highlighted the following key issues: • deep dive into restrictive practice which compared data across the Trust's CAMHS units, alongside national data (although difficult to obtain meaningful relevant national data), which showed OHFT is in line with other CAMHS units, however there are big differences between 2 units; • Highfield unit, which has the highest restrictive practice use, include NG feeds (about 41% of all restrictive practice was related to NG feeds), with the number of patients requiring them increasing over the past 6 months; • no increase in restrictive practice due to self-harm this remains the highest cause group; • improvement projects are underway in managing restrictive practice in all the CAMHs wards including the reduction of rapid tranquilisation, prone restraint and seclusion of young people.; • a deep dive into the model of care and staffing model on the Meadow PICU unit, was received by the Quality Sub Group. Staffing remains challenging, it was acknowledged that there is some good work taking place despite a lack of experience of CAMHs PICU in the staff group; • Meadow unit have had their first CQC Mental Health Act Inspection. Verbal feedback received was positive in terms of care planning, clinical model, environment and staff compassion. There were some issues identified relating to medication forms and access to hot drinks, awaiting full report; • there was a reduction in restrictive practice following the discharge of 2 patients from the Meadow unit; These 2 patients had displayed frequent self-harming behaviours largely in the form of headbanging requiring frequent intervention to prevent harm;	

	• challenges have continued with access to the Independent Advocacy Service. There is now a new provider, however they have declined to come into CAMHS wards as they are not commissioned to do so and do not feel they have the necessary skills. This has been escalated to the local authority who commission the service. To mitigate this, PALS clinics have been put in place. The CQC inspector has also raised this with the local authority; and • CAS alert remains open regarding risk of entrapment/falls relating to medical beds/trollies and bed rails with 5 out of the 7 actions completed. Whilst overdue, it is a similar picture to surrounding Trusts in relation to patients who receive prescribed equipment in the community, the completion of risk assessments has been hampered by the cyber outage of NRC our equipment provider.	
b	In relation to the reduction of restrictive practice following the discharge of two patients, DC asked how we would know that we are having an impact on restrictive practice across the system overall regardless of individual patients. The Chief Nurse noted that most of the data regarding restrictive practice was accessible for the ward, so they can identify those trends and exclude outliers or certain patients when reviewing the data to establish quality improvement projects and evaluate their impact. There were ongoing discussions taking place, on different ways to review and report the data to gain as much insight as possible.	
c	The Chief Medical Officer commented that consideration of different measures for PICU units has been discussed extensively. Length of time between incidents is being used as a measure as rate counting appeared less meaningful. The teams are receiving support from the national and Trust quality improvement team, looking at the information quite uniquely and this is being reported into the positive and safe committee. Another measure is considering staff satisfaction and well-being in the setting, which can be triangulated with incidents and use of restraints.	
d	**The committee noted the report and assurances provided.**	
	Rami El-Shirbiny joined the meeting	
	a) Quality and Safety Dashboard	
a	The Chief Nurse took the report QC 35(ii)/2024 as read, noting the following escalations: • the shortage of substantive nursing staff, although fill rates remained good this did have an impact on quality. Potential for harm for podiatry patients in terms of time waiting and the ongoing inability to recruit podiatrists and Speech and Language therapists (SLT), who are considering how they can work differently to meet the demands on their service; and • timely access to services and long wait times in terms of potential for patient harm in District Nursing teams. Demand is currently outstripping resource leading to cancelled visits and high risk of patient harm. A strategic review has been commissioned across BOB ICB to determine recommendations for future funding of DN services. A number of QI projects are under way in the service to ensure efficiency and as far as possible patient safety. The committee	

	acknowledged this work is overseen by the Executive team. Patient harm reviews are frequently carried out.	
b	In response to the Chair's request for an update on the work in the community Heart Failure Team, the Clinical Director for Community Services noted that while the initial headline figure was concerning, further detailed work is ongoing which has so far revealed learning but a less concerning picture. The delay in accessing the service was not thought to have contributed to any deaths. Currently four cases with life limiting illness, were being reviewed in relation to their end-of-life care. There was additional work being completed alongside that which mirrored some of the work taking place in district nursing, however the shortfall in service means some people are receiving very limited care.	
c	In response to a further query by the Chair, the Clinical Director for Community Services said that the Trust is the only provider of community heart failure, with OUH providing the mainstay for assessment and diagnosis and admission in the deteriorating patient. The Trust's job is to triage these patients based on urgency. NICE guidance suggests that if a person is triaged as urgent, they should be seen within 2 weeks, currently the wait for those with less urgency is 13 weeks, which as of today was closer to six weeks; this was not ideal but an improving picture. Focus was on ensuring that the prioritisation and triage are adept. The matrix and support for this service was not right, so now there is greater clinical oversight and a tighter grip on the waiting list and associated risk, utilising the EMIS system to help review waiting lists. A new patient leaflet is being drafted to provide safety netting advice and there is more work to be done on what information is sent to patients waiting to be seen.	
d	The Chief Executive added that this was discussed in the regular Executive to Executive meetings with the OUH, considering whether we have the right model and staff to serve the population, which was felt to be correct. The heart failure team work in an integrated way and have reviewed the service openly in a manner that improves safety.	
e	The Clinical Director for Community Services noted that there had been concerns in the team as to how deaths were recorded, so the process has changed and all deaths now go through a Mazar screening, which does take time as staff are having to look across three different systems to collate the information.	
f	The Chair asked in relation to the teams piloting True Colours, what is the initial feedback on this platform. The Chief Nurse advised that the pilot was not yet far enough along, however True Colours is the platform on which we are providing some of the outcome measures, which is completely different now to what it used to be. It is a helpful platform for delivering lots of tools.	
g	The Executive Director for Mental Health and Learning Disability noted that this is being used as platform in CAMHS, and pilots are going live this month across adult and older adult teams, the feedback from this will support the roll out and ongoing review.	

h	DC noted that it was positive to see this pilot happening, as the Trust only collected data on 2% of all young patients, putting us at the bottom nationally, and queried if the True Colours would help with his reporting and if so when it would be available. The Chief Executive responded that the 2% was historic data from pre-outage, and no new data has been collected. True Colours data would be included in the integrated performance report going forwards. The Trust's paired outcomes for CAMHS were similar to neighbouring Trusts' and similar to pre-outage reporting. Current effort was to recover the data, and there was now a clearer pathway for this information flow.	
i	The Chief Nurse reported on a visit to Thames House from the provider collaborative, following concerns raised relating to the care of a complex patient. The exercise was useful with several positives identified along with some areas of improvement. It was noted that there was good leadership on the ground but more support was required in relation to this patient's distress and highly abusive behaviour. A response to the report and action plan would be overseen by the Quality and Clinical Governance Sub-Group.	
j	In response to a query by the Chair, the Executive Managing Director for Mental Health and Learning Disability confirmed that no wards were pausing admissions due to vacancies at present across the CAHMS adult and older adult wards.	
k	On the 72 hours follow up post discharge, DC noted the graph showed the impressive progress the Trust is making in this area. The Chief Nurse commented that this should be improved further and that work was required to achieve over 80%. Closer scrutiny and interrogation of when it was not achieved would be monitored by the Quality and Clinical Governance Group.	
i	**The Committee noted the report.**	
	b) Patient Safety Incident Report (PSI):	
a	The Head of Patient safety took the report as read, which showed good progress against the national Patient Safety Incident Response Framework (PSIRF) and covered: • incidents identified under the Patient Safety Incident Response Plan; • a review across all incidents regardless of level of harm; • oversight of current reviews underway; • an update on Incident Learning Huddles; • external/ System reviews; • internal Thematic Reviews; • learning from completed reviews; and • an update about the Patient Safety Partner roles.	
b	She highlighted that the second review with ICB and NHS England was positive and showed the impact of the PSIRF approach in improving the patient safety culture and engagement with patients, families and staff. She recognised that more work was required for the change principles to be fully embedded across the organisation and reported that she had been asked to share the Trust's approach on national forums. The	

	report showed the safety areas the Trust was currently focusing on and the wider incident data that sits below which is used to identify the emergent areas requiring attention. The Trust had taken a novel approach regarding patient safety partners by appointing two part time patient safety partners with lived experiences of using Trust services to work in the patient safety team on an 18-month fixed term contract. This arrangement recognised and valued partners' lived experience, set regular hours for involving them in more substantial pieces of work, and allowed rotation of people with new perspectives regularly. Detail on their achievements to date was included in the report. The Chief Nurse added that the Trust's approach appeared to be more successful than of neighbouring Trusts' which were trying to recruit volunteers to these roles. It was hoped that it would also provide enhanced learning.	
c	**The committee noted the report.**	
	c) Safe Staffing Report-6 monthly review.	
a	The Chief Nurse took the report QC 37/2024 as read, which provided data over the past 6 months (December 2023 to end May 2024), including variations between planned and actual staffing and break down per directorate, as well as information contributing to staffing levels and ongoing work to plan for future levels of staffing. She highlighted: • details of fill rates across all inpatient areas - 49,000 shifts requested and only 471 were not filled, which gave a fill rate of 99%; • the care hours per day per patient (which is a national tool to ensure there are safe staffing levels to meet the needs of the patients), provided assurance to the Committee that in all except one area, care hours per day per patient was met and exceeded; • reduction in incident reporting due to staffing, likely due to better links with NHS Professionals; and • two incident reports suggesting moderate harm were reviewed and the wrong box was ticked, there was no harm incurred	
b	The Chief Nurse further highlighted the developments over the next 6 months. The Trust was currently in the process of implementing two acuity tools – the Mental Health Optimal Staffing Tool (MHOST) across mental health wards and the Safer Nursing Care Tool (SNCT) across community hospital wards, which are evidenced tools used to calculate the clinical staff requirements based on patients' needs (acuity and dependency) and assist in making decisions about optimal staffing levels across wards.	
c	Regarding Linfoot ward, which reports actual Care Hours Per Patient Day (CHPPD) sitting below planned, the Clinical Director for Community Services clarified that it is a community hospital ward in Witney specialising in general rehabilitation and includes bariatric rehabilitation beds, where there have been staffing changes, which is why it is just below. The directorate are well sighted on this and assured about the safety of the staffing numbers.	
d	Summarising the discussion, the Chair noted that this is a statutory report considered by the Committee every six months for assurance and commented that the acuity tools	

	will be helpful in supporting the work of the People Leadership and Culture committee (PLC) who are looking into where there is over establishment, as this may be due to the acuity of the patients and the complexity of their needs. So, it will be helpful to review the data more comprehensively at PLC and QC.	
e	The Chief Executive commended the high-quality report, which has provided the assurance required. However, he pointed out that the CAMHS PICU reported 52.77 care hours per day per patient and would suggest there are more than 2 nurses per patient per day, which should be reviewed. The Chief Nurse agreed and noted that discussions had taken place at the Quality and Clinical Governance Group as part of a deep dive looking at the staffing and bed occupancy.	
f	**The Committee noted the report and issues escalated from the Quality and Clinical Governance Group.**	
	d) Quality Account 2023/2024 and Quality Priorities 2024/2025	
a	The Chief Nurse took the report at QC 38/2024 as read, which provided a clear picture of the quality of care provided by the Trust, as well as the huge range of quality improvement, research and innovation work undertaken by the Trust. The quality account gives detailed insights into the following: • the Trust's activities over the previous year; • the potential areas where improvements in the quality of services are needed; • the objectives for improvement for the coming year 2024-25; • the quality priorities for 2024 -25; and • the extent to which the Trust has been involving patients and carers who use its services, as well as staff, in determining these priorities for improvement.	
b	She noted that this year's report has now been published but moving forward there is opportunity to change how the information is presented in a transparent and easy read format, as it is no longer a requirement to publish it in a particular format. Next year's priorities were included at a high level and progress against those will be reported to the Committee, ensuring that they align with the strategic objectives. She invited comments on how the Committee would like to see the information presented in the future.	
c	The Chief Medical Officer noted that the Trust's quality objectives for the next 12 months were presented at page 17, which include rolling out PSIRF, using TRIM and reducing restrictive practice with background on how that is measured and reported. Also contained within the report is the Oxfordshire Joint Health Overview and Scrutiny Committee's (JHOSC) recommendations starting at page 79, of which there were five that the Trust is required to accept or reject. One of the recommendations relates to out of area placements which he suggested should be accepted, along with the other recommendations. The Chief Executive added that this issue was being reviewed and discussed daily.	
d	In terms of its format, the Chair commented:	

	• on the range of improvements which, in the context of the Trust's resources and the social climate were impressive and suggested that the Trust could share this information more widely and accessibly in a simpler format; • the report would benefit from a better balance in presenting the range of mental health services with community services provided; and • adding feedback from what people say about our services in a visual way with graphs and diagrams.	
e	The Chair also asked for greater transparency in the monitoring of priorities not achieved or partly achieved by the Committee instead of these being monitored at operational level and the Committee not being able to easily track progress. Regarding the Trust's response to the recommendations of the JHOSC, she took soundings from the Committee and was content to agree them.	
f	DC noted that when objective 6 (to measure and capture outcomes in our mental health services) was discussed at Board, it was agreed to have a section on outcomes monitoring as to where we are and what we are continuing to do. The Chair commented that this would form part of the new strategic objectives for 2024/25, however if this was going to be reported quarterly, the measure and target would need to be identified clearly. The reporting of strategic objectives will be six monthly at full public board meetings.	
g	**With the above comments, the Committee accepted the JHOSC recommendations and agreed the Trust's 2024/25 quality priorities.**	
4.	**Quality Compliance & Regulation Update** **CQC Compliance & Regulation**	
a	The Chief Nurse took the report QC 39/2024 as read, which provided an overview of the work underway relating to CQC preparedness activity and future planned areas of work, and CQC engagement activities including meeting with inspectors and new relationship manager. She highlighted that Q1 was focused on CQC preparedness as it had been five years since the last inspection, and the Trust had new staff members that did not have previous experience from inspections. This was a big piece of work led by the Interim Deputy Chief Nurse and the Head of Clinical Standards to ensure that there are robust structures in place to evidence how the Trust governance and oversight works. This was the first part of the Trust's journey to excellence, considering the oversight of clinical standards and how compliance can be evidenced. The work had been well received by staff, who want to understand more about CQC inspections. There had been a lack of consistency in our engagement with CQC lately, the Trust now has a new point of contact.	
b	**The Committee noted the report.**	
5.	**Safety of the Physical Estate**	

	No paper had been received and the Chief Nurse would be following this up. This was raised at the Quality and Clinical Governance Group where alternative methods of assurance were reviewed and no concerns were noted. The ligature assessments and the safe environment assessments had been completed. The report should be available for the next Committee meeting. **The Committee noted the update.**	
6.	**City Adult AMHT update**	
a	The Chair welcomed Katrina Anderson and Tasmin Irving to the meeting and explained that the Committee had asked for a presentation following concerns regarding stubborn recruitment issues which were included in the quality and safety dashboard and safety concerns raised by a Consultant. The Committee wanted to understand the issues the team faced and to determine the level of assurance regarding safety and risk. The Chief Executive and the Executive Director for Mental Health and Learning Disabilities had provided reassurance that the team managed risk well, although there was a longer-term burden.	
b	KA noted that recruitment was not at present a major concern as the service had been successful in recruiting, however there seemed to be something deep rooted within the service in that every time concerns were raised, the Senior Leadership Team would swoop in to provide support and put measures in place but once stabilised and they stepped back, one of the sub-teams would end up close to crisis. It was believed that a lot of the issues related to processes and how staff interact within their own teams and with the primary care mental health teams. To help understand this further a detailed process map was being developed by the end of August to identify blockages in the processes, which at times were due to staffing but not always.	
c	In response to the Chair's query on whether there was any indication through the process mapping about the cause of the variation reported within the sub teams, TI commented that one of the issues related to the mixture of longer serving staff and new staff, so the new staff needed to be embedded and changes to internal processes to be stopped. The aim was to establish set standards across the board and reduce variation, e.g. in relation to the keystone hubs, some staff were unsure of what they can offer, so some teams made referrals whereas other held on to patients as they did not feel the hubs could manage that level of needs and risk.	
d	The Executive Managing Director for Mental Health and Learning Disabilities noted that there is some clear structured information on the teams contained within the presentation. It is a busy service that covers high morbidity areas, which added a level of complexity. The success in recruitment meant that there are new staff members that require ongoing support and supervision into systems and processes. He informed the Committee that he is a consultant within the service but has not been involved in this review. Regular meetings taking place with the team leaders showed that confidence within the teams was growing. There was now more structure in the admin teams which helped to provide a more consistent approach. So, there were numerous factors, however, the need was now to move away from firefighting and say this is the process	

	we are following, which teams are now doing more consistently, identifying core needs and what can be done differently going forward.	
e	The Trust Chair asked for assurance that we are getting to the root of the problem, considering the various improvement projects over the year did not seem to have been fruitful in terms of long-term improvement. The Chief Executive pointed out that there was up to 30% vacancy rate of key roles in some teams which indicated that recruitment remained an issue. KA acknowledged it was a problem but not the only problem.	
f	SB who was observing the Quality committee meeting on the day and who is also a consultant within the team, commented that this was a fun place to work with a lot of people working hard. Recruitment was less of a problem compared to retention. For example, in the Willow team staff did not stay in post longer than 6 months, which meant that the team was always changing, and this was taking away from clinical time firefighting to induct and train new staff. Environmental issues were often identified in exit questionnaires; however the culture played a huge part and a cultural shift was required to achieve the long-term goals. So, anything to help with retention would be beneficial.	
g	The Chief Nurse reflected that over the years this team felt like they were firefighting most days to just keep safe and manage on a day-to-day basis, which must be draining for staff. She commented that it is the team relationships that help to retain staff, even in difficult times, and wondered what support the team could get to ensure they have the time out from the everyday work to forge those relationships, bond as a team and build resilience.	
h	The Chair wondered whether the team needed some additional resources for 18 months to allow for team development and support the process mapping exercise and queried what they would find helpful moving forward. Echoing SB's comment, KA noted it was difficult to build a team when there was high staff turnover, so maybe away days could be facilitated when there was a substantive team in place, however this required headspace to be done effectively. There was the question of whether to consider doing something more drastic. Currently the assessment and treatment pathways were being merged to reduce gaps and offer the same interventions across the pathway, increasing staff knowledge and confidence. Consideration was given to having one big team rather than 3 sub teams, which was tried previously and did not work, so any suggestions were welcome. The suggestion regarding away days and retention support were helpful to consider.	
i	Noting the significant difference between sub teams regarding waiting lists for assessment, DC queried what were the differences in each sub-team's approach to assessment. SB explained that junior doctors completed the assessments in the Willow team as there hadn't been an assessment team for over a year. Someone from the Aspen team was moving over to fill this gap, however this felt like just moving the problem rather than resolving it longer-term. DC commented that this indicated that it was staff capacity rather than procedures that differed. It was confirmed that referrals received were the same across teams, however there was not an assessment lead to	

	oversee this in the Willow team. TI added that there had been a push this week to resolve the un-outcomed appointments, (episode of care data not completed) as there were over 400 in the city team, which in turn affected the figures on number of patients being seen, so hopefully there would be more accurate data moving forward, hopefully within the next 2 weeks.	
j	The Executive Managing Director for Mental Health and Learning Disabilities noted that this approach needed to be across all services. It was about how to generate the energy and enthusiasm to constantly challenge and ask the right questions. He advocated that we keep listening to people in a framework that is structured and responsive, rather than knee jerk reactions. This needed to be the blueprint for supporting all teams.	
k	The Chief Nurse commented that staff dynamics have a direct impact on quality of care, mortality and outcomes for patients, therefore it was important to have a strategy for supporting teams managing busy and complex services. An organised approach to facilitate good team working was required.	
l	The Chair summarised that the detailed presentation and discussion showed there was good analysis and the issues were understood. It would be good to hold onto the work the SLT was carrying out and hear again in November what decisions were taken and progress made. She prompted the SLT to accept the offers of support and additional resources. If the focused attention and interventions paid off regarding retention and waiting times, it could form a template with potential to be used in other services. There was QI support available to help with this, which could then be shared with other services.	
m	The Chief Executive noted that as there had been a patient safety concern raised, an analysis of incidents should be completed and compared with other areas, noting that these are highly volatile and change over time.	
n	**The Committee noted the update.**	
	KA and TI left the meeting. *RH joined the meeting.*	
CARING, RESPONSIVE & EFFECTIVE		
7.	**Service deep dive including:** **a. Quality Improvement annual oversight and spotlight presentation.**	
a	<u>Gloves Qi project</u> JM shared slides regarding the initiative to reduce inappropriate non-sterile glove use and improve patient safety. The inappropriate use of non-sterile gloves, encourages staff to miss hand hygiene opportunities, increases risk of transmission of infection and skin irritation. It also impacts on sustainability and the environment. Overall aim of the initiative is to protect staff and patients, however, there had been some resistance as staff felt it was mainly for financial reasons.	

	Wallingford is a pilot site for this study. The glove audit data and the number of gloves supplied to the service, showed that Wallingford had an increase in glove use, which when interrogated it transpired it was due to the ward also ordering for the outpatient department, which was now back to full capacity. A spike in the alcohol-based hand gel use was noted, which was due to a project to have hand rub at the point of care. The hand hygiene audits completed across the Trust came back between 90-100%, however this did not correlate with the product use across the Trust, so it was being investigated further. JM concluded there was still a long way to go so collaboration with the QI teams continued and a roadshow to engage staff and promote the project had just been completed. The challenge of this project relate to human behaviour and culture and leadership.	
b	The Chief Nurse thanked JM for her presentation and the fantastic QI project which has with huge impact on patient safety, the environment and financial benefits. The Managing Director for Community services added it is misplaced infection control, and that it is about returning to basics of good infection control standards.	
c	<u>QI 2024/25 plan</u> AH took the report and presentation slides QC 41/2024 as read, which provided an overview of the Trust's planned quality improvement (QI) activity for 2024/25, including key areas of focus and key strategic methods for supporting the Trust on its Journey to Excellence and next steps. Key highlights from the presentation were: • the work continued building on strong foundations with well-established improvement hubs; • in 2024, there were 434 staff, patients and carers trained; • there were 278 QI projects in progress linked to the identified priorities, with teams taking stronger ownership; • 40% of QI work involved service users and carers which was an increase from 18% the previous year and plans to increase further; • engagement to get staff on board included Trust wide webinars, talking about what people are trying to do and learning from things that did not go so well; • focus this year was on capability building and training, as well as getting the training accredited. Senior colleagues were being asked to allocate an advocate for QI and ensure QI features as a standard item on meeting agendas; • focus on bottom-up approach in supporting projects alongside a top-down approach where areas are identified that improvement is required closely linked to patient safety; • close links with research and building guide to publications, in the form of posters to be shared in public areas; and • linking with the green sustainability plan to help achieve the Trust's goals using QI approach.	
d	The Chief Medical Officer added that a key focus next year is co-production driving QI and utilising a scale up approach, so that we are not doing too many things all at once.	

e	The Chair commended the QI work noting that this is a great strength of the Trust. The work has become extensive and the question to ask ourselves in 2-3 years' time will be how this has impacted on the care we provide and what evidence we can draw on. **The Committee noted the presentation and report.**	
8.	**Clinical Effectiveness update:** **a) Clinical Effectiveness Group**	
a	The Chief Medical Officer took the report QC 42/2024 as read. The group oversees and monitors the implementation of Clinical Improvement initiatives across the Trust and reviews and approves significant service transformation.	
b	The Deputy Chief Medical Officer reported that there is excellent engagement with the ICB leads joining on the Clinical Effectiveness Group.	
c	The Chair asked for clarification if the Trust have written to Primary Care and they have not replied within 14 days, was it assumed they were accepting the shared care plan? The Chief Pharmacist & Clinical Director for Medicines Management confirmed that this was in relation to shared care protocols in prescribing between secondary care and primary care; and that there is national guidance on active acceptance rather than assumed acceptance. The Trust has worked on assumed shared care but there was a push to standardise this across the ICB, however in the absence of electronic prescribing this was an interim compromise that has been agreed across the ICB. The Chair accepted that if this was the agreed path, the Trust will go with it, noting however that it does have risk associated with it.	
	b) Clinical Audit update	
d	The Associate Director of Quality took the paper QC 43/2024 as read which provided an overview of Clinical Audit and NICE activity, developments and progress against the clinical audit annual plan for Q1.	
e	The Chief Medical Officer noted that clinical audit and NICE activity were monitored through the CEG in alignment. Work continued on NICE guidance where there were gaps. There is ICB representation in the group, so when a decision is made not to follow through a guidance in full, it is proactive rather than a passive decision, which is supported by the Southeast Region who also attend and observe.	
f	In response to the Chair's query when the review of the overdue guidance was planned to be completed, the Head of Clinical Standards noted that 12 pieces of guidance have not been entirely reviewed across the whole Trust, however they have been reviewed with the directorates and mitigations have been put in place so there is no impact on patient care or treatment. The review would be completed over the next few weeks.	
g	In response to DC's query to what extent does the clinical audit team feel that the Trust will be able to evidence that patients receive NICE recommended care, following NHS England's statement, the Deputy Chief Nurse noted that there are key areas across the Trust where the implementation of NICE guidance and recommendations is measured	

	so the Trust can evidence it delivers care in accordance with NICE guidance in these areas. This is reported as part of the annual report.	
h	**c) Medicines Management report** The Chief Pharmacist & Clinical Director for Medicines Management took report QC 44/2024 as read, which provided a quarterly update and escalations from the two medicines management subgroups along with key regulatory and assurance updates. He highlighted: • availability of multi dosing systems in the community, which has been added to the risk register, and working with partners and Trusts in the ICS to reduce unnecessary use of these systems and make them available to patients who would benefit from them; • change in legislation means pharmacy technicians are now able to work under a PDG, which gives the opportunity to review and change staffing models; and • Oxford Pharmacy Store (**OPS**) has now received its licenses, so will operate from the new site in August.	
i	**The Committee noted the updates and reports.**	
	HS, JP, LR, LC and GP joined the meeting.	
Policies and Governance		
9.	**Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF)**	
a	The Assistant Trust Secretary took report QC 45/2024 as read which provided: • information and updates to support a deep dive into BAF 3.1 (shared planning and partnership working); • an overview/update on the BAF and Trust Risk Register risks within the Committee's remit, noting there were no major updates at this meeting as the Committee had recently carried out deep dives into BAF 1.5 (lack of local admission beds due to demand outstripping capacity) and 1.6 (sustainability of the Trust's primary, community and dental care services).; and • an update that a decision on Committee ownership of BAF 1.1 (utilising digital, data and technology) was not yet available and therefore a more detailed update was requested for September, with a potential update on BAF 4.1 (failure to realise the Trust's Research and Development potential) after the New Head of Research and Development has started in post.	
b	Laura Carter, Head of Strategy, had joined the meeting to present an update on BAF 3.1 (shared planning and partnership working) and support the deep dive, and introduced Lisa Reynolds, Associate Director for Mental Health and lead on partnership working for the BOB Provider Collaborative. BAF 3.1 focuses on making sure the Trust is engaging in shared planning and decision making across the system and working collaboratively to deliver the transformation of services. The risk has been updated since October. In terms of controls, some additional posts have been put in place, including the Head of Strategy role who has been leading on the support to national planning for ICB trust	

	place and additional roles in the Thames Valley dental partnership. In terms of evidencing assurances, the governance has been strengthened.	
c	The Chair acknowledged that the risk descriptor, controls and mitigations have been significantly enhanced in since the last time it was reviewed, with a lot of work underway to address gaps in controls, including through this year's planning progress at ICB level. Working under financial pressure it does force system level resolution, however despite all the work the rating for the risk remained at 12, which is the same as it was 12 months ago, indicating that all the additional resources put in place have not reduced the risk.	
d	LS noted that there are weekly meetings with the ICB since January to conclude the national planning round and the Trust will be engaged in the ICB level review of the 2024/25 planning round. She commented she was not clear on the process for changing the risk rating and thus she had left it as previously. The Chair explained that it is usually for the Director or their deputy to recommend what they believe the risk be rated based on the additional controls and risk mitigations and whether the impact or likelihood scoring has changed, suggesting the likelihood score may have changed for this risk. The Chief Executive counter-argued that sometimes our closeness to partners could pose different problems due to the challenges they face, therefore it means our likelihood may be less, but the impact could be higher due to the challenges our partners face.	
e	The Associate Director of Corporate Affairs confirmed that the Executive lead is the risk owner, and it is for them to propose the revised score and take it to the Executive team to balance and agree the score that is put forward to the Committee. This would be going to the Executive Team the coming Monday. The timings of when risks are considered by the Executive before being brought to a committee needed better aligning as sometimes, as in this case, it came to the Committee before it has been to Executive. With regard to the rating, the Chief Executive commented that a lot of work has taken place in a context of a more turbulent environment, and it felt the risk sits appropriately in an amber place.	
f	The Chair concluded that the risk score would remain 12 and the Committee would plan when it would be brought back after being considered by the Executive Team. She further noted that the review date needed to be updated and thanked Laura for the detailed information.	**HS**
g	BAF 4.1 would be updated by R&D for the next committee meeting in September.	
h	The Clinical Director for Community Services asked for clarity on whether the document was a work in progress with lots of strikethrough of text or is going through ratification. The Head of Strategy explained that was how it was asked to be written, with new additional information in Red and it has been through The Executive Managing Director of Mental Health and Learning Disability and Sue, so has been checked at both sides. The Assistant Trust Secretary added that in the covering report there are no track changes, it is presented as a clean version of the update of BAF 3.1. It is in the accompanying appendix 1, with the overview in detail of all of the risks, which is a mark up version of updates on all the Quality Committee Risks to show changes over time.	

	The Committee noted the update and assurances provided. *LC/ LR left the meeting*	
10.	**Health Inequalities -Quality Improvement.**	
a	The Chief Medical Officer commented that health inequalities is one of the Trust's strategic priorities and directorates have been looking into it as part of the operational planning. He introduced John Pimm, Clinical Lead and Parth Ghosh, Senior Locality Lead from the Buckinghamshire Talking Therapies service, whose team is quite advanced with looking at this.	
b	JP took the report QC 46/2024 as read which provided an overview of advancing and embedding a directorate approach to tackling health inequalities. He explained that Bucks Talking Therapies has been looking at health inequalities for 5 years, to engage some of our communities that were less well represented, which has been successful in terms of sustained increase in access and working on experience and outcomes, which led to the suggestion to take that approach across the directorate. A 6-month task and finish group was set up, to engage with each of the pathways around inequalities and what they could be thinking about, which Partha was seconded to work on for 6 months. The report presented what the group achieved and the plans for the next 12 months.	
c	PG highlighted from the presentation the key outputs achieved, the next steps and the priorities over the next 12 months. These include data quality, as this has been poor so utilising the dashboard and toolkit to look at how we can improve data completeness systematically and a specific QI project at the Gateway team, which will improve data quality through the system and will be reaudited in 12 months.	
d	The Chair noted that data quality is fundamental for all this work, however if there are many different initiatives, it may be difficult to progress them all.	
e	DC commented that data quality varies across the Trust, so the projects that are identified in directorates will be different as they were all starting at different points. He asked, in relation to the Bucks Talking Therapies Service where a recovery rate of 45% for White ethnicity and 35% among the Asian population was reported in the annual report, if this would be an area of focus for next year. JP confirmed that the difference between recovery rates in different communities along with access rates, have been identified as priorities. Priority of access rate have increased considerably and are above other services. Recovery rates do fluctuate month on month, but data has been improving.	
f	The Chief Medical Officer added that this is an example of people using data to inform their own service development to address access and think about outcomes, moving beyond ethnicity and considering deprivation indices. Teams were looking how they are demonstrating this. The ethnicity data varies between services, and it will become clearer as services improve data collection and utilise it to develop health inequality work within their teams and services.	

g	The Chief Nurse commented that this dashboard which should now be available across the Trust will be beneficial for all teams and services and will be helpful for the Patient Carer Equality Race Framework (PCREF).	
h	The Chair thanked the team for a clear and well written report.	
i	**The Committee noted the report**	
11.	**Friends, Family and Carers Strategy-6-month progress report.**	
a	The Deputy Director of Quality took the report QC 47/2024 as read, which provided an oversight of performance against the 3-year strategy, which includes strategy implementation and measures, the current position and an update on embedding the triangle of care. She highlighted: • one of the overarching aims for the strategy is the work around embedding the triangle of care, which if it is not achieved, the Trust's Family and Friends rating position will not change from current rating 2. This required a lot of work, co-production and time, with limited resources; • there are differences across the Trust in relation to the Triangle of care model; focus and priorities has been on the mental health directorate, which has resulted in the learning disabilities and forensic services falling behind, and it is different for community services; • she assured the Committee that the 2 main measures have been met; an indicator regarding staff training, had not yet been agreed; • training for patients and carers for co-production will add another layer to consider how to roll out across the organisation; • there is a lot of involvement work happening at different levels, which do not all progress as QI projects; and • all major transformation projects have involvement of patients, carers and family along with Experts by Experience.	
b	The Chief Nurse commented the need to start considering the next three years, what difference it makes to patients, carers and families and how that is monitored and reviewed against measures to create change.	
c	The Chair highlighted that this is good progress especially in terms of the culture shift and the Trust will be able to move to 3 stars when the Triangle of Care is completed.	
d	**The committee noted the report.**	

12.	**Legal Proceedings Policy (for approval)** The Chair noted that the policy is clear with a good summary of changes made to the policy. The Chief Medical Officer added that this links with the Mental Health Act policy that was approved in the Mental Health and Law Committee that morning. **The Committee approved the Legal Proceedings policy.**	
13.	**QC workplan, Annual Report and ToR** The Chair took the report QC 49/2024 as read, noting that further work was needed on the Workplan to clarify some items. **The Committee approved its annual report and terms of reference for submission to the Board.**	**GD/BK/AY**
14.	**Quality Governance System including Ward to Board** The Associate Director of Corporate Affairs updated that the work in capturing the ward to board governance structures across directorates had not been completed. The high level arrangements were included in the operating framework. In response to the Chair's query on timeframes, the Chief Executive noted that a draft would be available at the November meeting of the committee.	**GD/GM**
15.	**AOB** No other business was discussed.	
16.	**Review of the meeting**	
	Meeting closed at 16:03 **Date of next meeting:**	

Oxford Health NHS Foundation Trust

Meeting of the Quality Committee

Wednesday, 28 August 2024
09:00 - 12:00
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	09:00
Minutes and Matters Arising			
2. a. Minutes of the meeting of the Quality Committee on 16 July 2024 (paper – QC 50(i)/2024) b. Matters Arising/action log (paper-QC 50(ii) /2024) c. Discharge arrangements for patients with severe mental illness (paper QC-50(iii)/2024 and QC-50(iv)/2024)	*To confirm & report matters arising*	AY	09:05
Safe			
3. Quality and Clinical Governance Sub-Group (QCG-SG) escalation reporting including: a. Quality and Safety Dashboard (paper – QC 51/2024)	*For assurance*	JK/BK	09:10
b. Positive and Safe- restrictive practice/Rapid Tranquilisation and prescribing (paper-QC 52/2024) (Blanket Restriction policy-RR/App 08/2024)	*For assurance*	LD/AF	
~~4. Service Deep Dive~~ ~~a. Update on Strategy (2022-2027) and service development in Learning Disability service (oral update)~~	*For assurance*	KP/RB	09:40
b. ~~Learning Disabilities & Autism Services-access to healthcare annual report 2023-2024~~ (paper-QC 53/2024)	*For assurance*	KP/RB	10:15
5. Safety of the Physical estate oral update by Britta	*For Assurance*	JP/HS/BK	10:25
6. Inquest & claims annual report 2023/2024 (paper-QC 54/2024)	*For Assurance*	NM/GD	10:35
7. Safeguarding annual report 2023/2024 (paper-QC 55/2024)	*For assurance*	LL/DM/BK	10:40

[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.

Effective			
8. Clinical Effectiveness updates: a. Clinical Effectiveness Group (CEG) report (paper – QC 56/2024) b. Medicines Management report (paper – QC 57/2024) • *For supporting detail: CEG minutes & action log in the **Reading Room/Appendix (papers – RR/App 09/2024)***	*For assurance* *For assurance*	RM/KM MM/KM	10:50
Break 5 Minutes			**11:10**
Caring & Responsive			
Nothing tabled			
Quality Improvement			
09. Mental Health Inpatient Transformation Programme (paper QC58/2024)	*For assurance*	BT/AF/ RB	11:15
Research			
10. Research & Development update (governance aspects) (paper QC 59/2024)	*For assurance*	VR/KM	11:25
Strategies and Policies			
11. Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) (paper – QC 60/2024)	*To discuss & for assurance*	BC/GD	11:35
12. Provider Collaboratives (paper-QC 61/2024)	*For assurance*	KD/BK	11:40
13. Trust Policy Register (paper-QC 62/2024)	*For assurance*	BC/GD	11:45
Governance and Risk Management			
14. Ensuring Quality & Safety in pressured UEC services (paper-QC-63/2024)	*For assurance*	BR	11:50
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	11:55
16. Review of the meeting		AY	11:55
Meeting Close		AY	12:00

Date of next meeting:
Thursday, 7 November 2024 09:00-12:00 Face to Face venue to be confirmed.

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	✓	*Britta Klinck deputised*	*x (Britta Klink deputised)*	✓	*Britta Klink*
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	✓	✓			
Grant MacDonald	✓	✓			
Karl Marlowe	✓	✓			
Ben Riley	✓	✓			
Heather Smith	✓				
Georgia Denegri	✓	✓			
Attending Board members (voting & non-voting included in quorum)					
Amelie Bages*	*Mat*	*mat*			
Charmaine DeSouza	*x*	*x*			

David Walker	✓	✓			
Lucy Weston	✓	x			
David Clarke		✓			

Oxford Health NHS Foundation Trust

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	
SAFE							
Quality and Clinical Governance Sub-Committee escalation report including Quality and Safety Dashboard *(to include positive and safe each month and May meeting to include ToR and work plan)*	Jane Kershaw/Britta Klinck	*X (ToR & workplan included)* ✓	*x* ✓	*x*	*x*	*x*	
Directorate/Service area 'deep dive' *(Presentation)*	Rob Bale/Ben Riley	*X 0-19 service* ✓	*X✓ City Adult AMHT*	*X Learning Disabilities*	*X*	*X*	
Quality Account (quality priorities) *(May meeting includes annual report)*	Angie Fletcher/Britta Klinck	*X* ✓			*X*		
Patient Safety Incident Report (PSIs) *(Learning from Deaths Report, to include mortality and homicide reviews)*	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)*	Claire Forrest/Britta Klinck	*X* ✓	*X ✓ Well led guidance*	*X*	*X*	*X*	
Director of Infection Prevention & Control (IPC) – IPC annual report	Helen Bosley/Britta Klinck	*X* ✓					
Safety of the physical estate – annual report *Ligature update (BK/MC)*	Jeremy Philpot/ Heather Smith		*X Deferred to Sept*	*x*			
Learning Disabilities & Autism Services – access to healthcare annual report	Kirsten Prance/Rob Bale			*X*			

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Inquests & Claims – annual report	Neil McLaughlin/ Georgia Denegri			*X*			
Safeguarding annual report	Lisa Lord/Daniel Mercier/Britta Klinck			*X*			
Oxford Pharmacy Store (OPS) *(quality assurance report around the governance and quality of medicines regulation in OPS)*	Mark Byrne/Heather Smith	*X (review of programme)* ✓			X		
EFFECTIVE							
Clinical Effectiveness Group (CEG) *(RR minutes from CEG group, new NICE guidance)*	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*	
CARING & RESPONSIVE (patient & carer experience)							
Experience and Involvement report *(update on strategy)*	Rose Hombo / Britta Klinck				*X*		
PCREF Framework *(update on strategy)*	Rose Hombo/Britta Klinck		X *Deferred to sept*	x	*X*		
Complaints & PALS annual report	Rose Hombo/ Britta Klinck	*X* ✓					
QUALITY IMPROVEMENT							
Health Inequalities - Quality Improvement (smoking cessation/SMI Health checks/ dashboarding waiting list for Index of Multiple deprivation/ethnicity data)	Karl Marlowe		*X* ✓				
Quality Improvement Spotlight presentation (developing capability and the impact on staff and patients)	Angie Fletcher/Britta Klinck	*X Review of programme* ✓	*X* ✓ *Plan for the year*		*X (projects)*	*X (projects)*	
Mental Health Inpatient transformation programme	Bill Tiplady/Angie Fletcher/Rob Bale			*X*			

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
RESEARCH							
Research & Development update (Governance aspects)	Vanessa Raymont/Karl Marlowe			x			
STRATEGIES & POLICIES							
Nursing Strategy	Angie Fletcher/ Britta Klinck				*X*		
Learning from Patients, Family & Carers *update on strategy*	Rose Hombo/Britta Klinck	*X* ✓			*X*		
Allied Health Professionals Strategy	Sam Rigg/Britta Klinck					X	
Learning Disability Strategy (2022-2027)	Kirsten Prance/Rob Bale		X Deferred to Sept	x			
Suicide Prevention Strategy	Karen Lascelles/ Karl Marlowe						
Trust Policies *(as and when – new policies for approval and certain policies for review)*							
Legal Proceedings Policy	Neil McLaughlin/DoCA		X ✓				
GOVERNANCE & RISK MANAGEMENT							
Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF*) review each one at each meeting*	Ben Cahill/Georgia Denegri	*X* ✓	*X* ✓	*X*	*X*	*X*	
Minutes of the Quality Committee	Georgia Denegri	*X* ✓	*X* ✓	*X*	*X*	*X*	
Integrated Governance Framework 2024-2025 Developing Quality Governance (schematic showing ward to board and testing its effectiveness in deep dives and quality management)	Georgia Denegri/Ben Cahill	*X* ✓		X Defer to November	x		
Provider Collaboratives	Karen Drabble/Britta Klinck	*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	
		✓					
Partnership update	Laura Carter/Amélie Bages		X ✓		X		
Trust Policy Register	Ben Cahill/Georgia Denegri	*X*		X			
Annual Planning Process	Laura Carter/Amelie Bages					*X*	
ANNUAL REVIEW OF COMMITTEE EFFECTIVENESS AND TERMS OF REFERENCE							
Terms of Reference annual review	Andrea Young/Britta Klinck/Georgia Denegri						
Quality Committee annual report	Andrea Young/Britta Klinck/Georgia Denegri	*X* ✓	~~X~~ ✓				
OTHER REQUESTED ITEMS							
Number of Items on Agenda		21	*17*	*15*	*18*	15	

Note

NHSE/ issues for QC oversight *reviewed March 24*

- Children & Young People (on May agenda)
- Learning from Deaths (in PSIRF report)
- Resuscitation (Quality dashboard)
- Security Management – Violence & Aggression (currently in PLC agenda)
- Palliative and End of Life Care (TBC)

- Safeguarding (Sept agenda, and review through learning/PSIRF)
- Sexual Safety (TBC)
- Well-led guidance (July)

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

Finance & Investment Committee
17 September 2024

Finance and Investment Committee Annual Report 2023/24
For Approval

Executive Summary
The Annual Report summarises the performance and work programme of the Finance and Investment Committee during the period 01 April 2023 to 31 March 2024.

Overview from FIC Chair

Focusing on the domains of financial strategy, planning, management, investment and accounting policy, FIC continues to balance it's oversight between performance, internal control environments and the culture required to deliver these successfully.

Whilst there has been a change in Chair of the committee during the year, rigorous focus has been maintained on these areas, whilst ensuring new perspectives and reflections are considered.

Governance Route/Approval Process
The Finance and Investment Committee is asked to review and approve the Annual Report for presentation to the Board of Directors. The Audit Committee will also receive a copy of the Finance and Investment Committee's Annual Report and take an overview of its work. The Annual Report informs an update to the Finance and Investment Committee Terms of Reference, Appendix 1.

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 Committee is requested to approve the Finance and Investment Committee's Annual Report, overview workplan and revised Terms of Reference.

Author and Title: Nicola Gill, Corporate Governance Officer
Contribution: Lucy Weston, Non-Executive Director & FIC Chair
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:*
   - *Sustainability – Make best use of our resources and protect the environment; and*
   - *Strategic risk themes: Delivery of the financial plan and maintaining financial sustainability; Ineffective business planning arrangements; Information governance and cyber security; Business solutions in a single data centre; The Trust's impact on the environment; and Major capital projects.*
3. ***This report satisfies or provides assurance and evidence against the requirement of the following Terms of Reference of the Finance & Investment Committee**:*

Capital Investment

- *consider and approve all capital expenditure proposals, acquisitions, and disposals within the authorities delegated to the Committee by the Board of Directors, under the Trust's Scheme of Delegation: critically scrutinise all business cases over £500k; approve business cases (over £500 less than £2.0 million); and make recommendations to the Board of Directors on approval over £2.0 million;*
- *approve all PIDs for schemes over £2.0 million;*
- *approval of any forecast variation of £100-£500k of the approved budget for a capital development in line with the Budgetary Control Policy;*
- *annually review the Capital Programme and make a recommendation to the Board of Directors to approve;*
- *review the governance arrangements for the capital investment programme by request from the Audit Committee on the basis of a recommendation arising from an assurance report;*
- *monitor delivery of the capital investment programme through quarterly progress reporting from the Capital Programme sub-committee;*
- *receive and consider evaluation reports for capital schemes over £2.0 million;*
- *receive an annual report from the Capital Programme sub-committee on the performance of project delivery; and*
- *agree and monitor the work of the Capital Programme sub-committee and review annually its terms of reference, performance and effectiveness within the Integrated Governance Structure.*

Financial Strategy

- *critically review the Financial Strategy (the Long Term Financial Plan), Estates Strategy and ICT Strategy (delivery against the Global Digital Exemplar programme) with a recommendation to the Board of Directors on approval. Receive annual progress reports on the anniversary of their approval and review recommendations on variations to strategy. Approve supporting strategies relating to these key strategies; and*
- *recommend changes in financial strategy, as and when considered appropriate, in the following areas: resource management; LDP; capital structure; borrowing; interest exposure; tax planning; and investment.*

Financial planning and budgeting, financial management and financial performance

- *discuss and review medium term financial plan, annual budget, and annual efficiency plans for submission to the Board of Directors;*
- *review in-year financial performance, forecasts, and financial risk, on behalf of the Board, ensuring that appropriate action is identified and take to mitigate emergent risks at the earliest opportunity; and*
- *oversight of aggregate financial risk across the portfolio of financial reporting, including Estates, Information Management & Technology and other investments.*

Efficiency and value for money

- *receive an annual report from the Director of Estates and Facilities on securing VFM; and*
- *monitor the delivery of annual cost and performance improvement plans, ensuring that action is identified and taken to deal with any slippage in the plan, wherever possible.*

Cash management and investment of funds

- *approve any financing or use of financial instruments within its delegation;*
- *be empowered to delegate its authority to the Chairman or the Chief Executive within the limits contained in the Trust's Scheme of Delegation; and*
- *review compliance with financing agreements and covenants and the operation of treasury management policies including setting benchmarks for assessing the Treasury function's performance, and annually reviews performance against those benchmarks.*

Accounting policies

- *consider any changes to accounting policies before the Audit Committee scrutinises the statutory accounts.*

Finance and Investment Committee Annual Report 2023/24
For the period 01 April 2023 to 31 March 2024

The Finance and Investment Committee (**Committee**) is the principal sub-committee of the Board with responsibility to ensure the effective planning and scrutiny of financial matters and decisions. The Committee provides assurance to the Board on a comprehensive governance framework covering the Trust's finances, including the capital programme, and that the Trust can demonstrate Value For Money (VfM). The committee has oversight of the financial, estates and ICT strategies and their delivery, including plans to develop the financial culture and capability of the Trust. The committee also assures the Board on matters of annual planning, budgeting and performance, including the approval and delivery of capital investment, on financial and treasury management, including risk management and on any changes in accounting policies. The committee further monitors Trust procurement and any commercial operations.

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 September 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, which also details 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. Business transacted by the Committee

Set out below is the remit of the Finance and Investment Committee as outlined in the current ToRs. The fulfilment of the Committee remit is supported by the Finance and Investment Committee overview plan for 2023 – 2024, Appendix 3, which details frequency of reporting and business transacted over the reporting period. Notes below will support any highlight or exception reporting to information detailed at Appendix 3.

3.0 Capital Investment:

3.1 To consider and approve all capital expenditure proposals, acquisitions, and disposals within the authorities delegated to the Committee by the Board of Directors, under the Trust's Scheme of Delegation: critically scrutinise all business cases over £500k; approve business cases (over £500k and less than £2.0 million); and make recommendations to the Board of Directors on approval of schemes above £2.0 million.

A Warneford Programme update was presented at every meeting for oversight and to monitor progress of the development and quality assurance of the emerging business case through its various stages provided by the Programme Director. Copies of the internal Warneford Park Project Board minutes were available in the Reading Room at every meeting. The Conditional Options Agreement (COA) was signed by the Trust, the University of Oxford and Ian Laing on

18 December 2023. The contract was exchanged and the £1.5m premium paid to the Trust on 20 December 2023.

A business justification for additional capital funds for a new warehouse fit-out for the Oxford Pharmacy Store (**OPS**) was presented at the September 2023 meeting. The costs had increased further due to delays in lease negotiations and agreement for a power upgrade as well as changes to the scope of the project in order to benefit from local system and national opportunities. The Committee supported the additional capital funds for the new warehouse fit-out.

The Committee reviewed business cases for the Primary, Community & Dental Care Transformation – Oxford Estates Project and Community Mental Health Framework Hub at the November 2023 meeting. The business case for Primary, Community & Dental Care Transformation recommendation was approved by the Committee to recommend the business case, and associated investments and delegations, to the Board of Directors. The Committee approved the capital expenditure, noting the revenue implications for the Community Mental Health Framework Hub.

At an Extraordinary meeting in June 2023 the Committee were presented the Frontline Digitisation Business Case which they recommended for approval by the Trust Board at its June 2023 meeting. It also received the Development of Warneford Park Business Case – Economic Model update which it approved. The Committee noted the update to the Jordan Hill Business Case at this meeting also.

3.2 To approve all Project Initiation Documents (PIDs) for schemes over £2.0 million

There were no new PIDs for schemes over £2.0 million presented for approval in the reporting period.

3.3 To approve any forecast variation of £100k-£500k of the approved budget for a capital development in line with the Budgetary Control Policy

The Committee received and scrutinised rolling financial updates at all meetings in the reporting period via the Financial Report.

At the May 2023 meeting the Chief Finance Officer sought approval from the Committee to have permission to vary the approved FY24 plan submissions by up to £5.0 million, on the condition that any changes would be neutral in net terms to the Trust's overall financial plan. This was an additional request, pending post meeting approval of the revised plan. She explained that this flexibility was required to enable the final Plan to be aligned with the outcome of the current discussions with the ICS regarding the balance of revenue to capital funding to be provided. She added that there was the possibility of an additional £3.0 million contribution to the Trust's pressures if the ICS received additional income. Quorate approval of the revised FY24 plan was achieved following the meeting.

3.4 To annually review the Capital Programme and make a recommendation to the Board of Directors to approve

The Committee received and approved (July 2023) the Capital Programme Sub Committee (CPSC) Annual Report covering the reporting period 01 April 2022 – 31 March 2023 (FY23). The Report summarised the performance and programmed work of the CPSC during the period specified. The Finance and Investment Committee received the minutes of the CSPC at each of its meetings for information.

There were no material matters that the CPSC wished to bring to the attention of the Committee that had not already been dealt with during the period.

The Chief Finance Officer presented Capital Planning FY25 (March 2024) and sought approval of the Committee. The Committee approved the plan.

3.5 To monitor delivery of the capital investment programme through quarterly progress reporting from the Capital Programme sub-committee

A Capital Programme Financial update (Estates, IT, and Transformational projects) was received at each meeting reporting on YTD spend against budget and progress made in delivering the programme and an overview was included in the Financial Report from November 2023. Separate update reporting was received at each meeting for the Capital Programme Plan Estates schemes and Information Management & Technology (**IM&T**).

3.6 To receive and consider evaluation reports for approved capital schemes over £2.0 million

Projects detailed at 3.1 over £2.0 million were noted as requiring approval by the Board.

3.7 To receive an annual report from the Capital Programme sub-committee on the performance of project delivery

A Capital Programme Board Annual Report, incorporating the work of the sub-committee was received July 2023, reference 3.4.

3.8 To agree and monitor the work of the Capital Programme sub-committee and review annually its terms of reference, performance and effectiveness within the Integrated Governance Structure.

The latest available CPSC minutes were available in the Reading Room/Appendix at each meeting. The CPSC ToRs were approved by the Committee, July 2023 and work being undertaken in reviewing CPSC processes reported at 3.4.

4.0 Financial Strategy and Culture:

4.1 To critically review the Financial Strategy (the Long-Term Financial Plan), including the plan to develop the Financial Culture and capability of the Trust. Critically review the Estates Strategy and ICT Strategy Receive annual progress reports and review recommendations on variations to strategy. Approve supporting strategies relating to these key strategies

A summary of the YTD financial position to plan was presented at all meetings for oversight and scrutiny.

An Estates project update was presented at 4 out of the 6 meetings including a Deep dive at the March 2024 meeting where it was noted that to enable the operational effectiveness of the department, a departmental review and restructure would be required. This would translate into effective financial management with clearer accountability, as budget would align to the structure and contracts would be managed appropriately. The development of an Estates Strategy would follow in due course.

An IM&T update report was received at each meeting. In September 2023 the Chief Finance Officer highlighted the progress being made with Frontline Digitisation Strategy and the optimisation of the new clinical systems implemented since the clinical system outage. In addition, further to the successful pilot of an electronic Prescribing and Medicines Administration (**ePMA**) system on a number of wards, a larger scale rollout is planned.

4.2 To recommend changes in financial strategy, as and when considered appropriate, in the following areas: resource management; LDP; capital structure; borrowing; interest exposure; tax planning; and investment

The review of National Reference Costs did not take place during the reporting period due to no activity data being available owing to systems outage from the cyber-attack.

5.0 To ensure effective Financial planning and budgeting, financial management and financial performance:

5.1 To discuss and review medium term financial plan, annual budget, and annual efficiency plans for submission to the Board of Directors

The Annual Planning process FY23/24 including budget setting was presented at the May and July 2023 meetings. From January 2024 the Annual Planning process including budget setting focussed on FY 24/25.

The medium term plan was presented at the July and September 2023 meetings.

5.2 To review in-year financial performance, forecasts, and financial risk, on behalf of the Board, ensuring that appropriate action is identified and take to mitigate emergent risks at the earliest opportunity

Financial reports were presented at all meetings providing ongoing updates on financial performance and forecasting.

5.3 oversight of aggregate financial risk across the portfolio of financial reporting, including Estates, Information Management & Technology, and other investments

The aggregate financial risk was incorporated in the Financial Report for integrated oversight and Estates and IM&T risks were considered in updates provided at each meeting.

An update on Operational and Strategic Risks was presented at each meeting in the reporting period. The Committee reflected at the end of each meeting on any matters arising in the meeting or known external factors whether strategic or operational which may pose a risk or necessitated an update in the status of the risks allocated and monitored by the Committee.

A Deep dive into Major Capital Projects (BAF 3.14) resulted in the risk rating to remain unchanged with the option for it to be reduced in the near future when measurable benefits could be seen to be delivered and embedded such as the IQRA programme (July 2023). At the same meeting a Deep dive into Information Governance & Cyber Security (BAF 3.10) also took place. A new risk on the TRR (Failure of the Trust to ensure organisational wide Supply Chain Resilience) was approved at the September 2023 meeting. At the meeting in November 2023 the Chair suggested that provider collaborative risks could feature more substantively in the TRR and perhaps the BAF. Noting the change in Chair of the Committee from January 2024 the Chair requested a pause on requests for risk deep dives. At the meeting in January 2024 the risks surrounding the Oxford Clinic PFI were discussed. It was also agreed at this meeting that the Oxford Pharmacy Store (OPS) risk be removed from the register. At the March 2024 meeting it was noted that BAF 1.1 had been reframed to focus on digital, data and technology and realising the benefits of this.

6.0 Efficiency and value for money:

6.1 To receive an annual report from the Director of Estates and Facilities on securing Value for Money (VfM)
The Capital Programme Board Annual Report presented (July 2023) included an update on securing VfM for FY23 and VfM was an intrinsic aspect in the procurement/delivery process.

The Committee received a procurement update in 3 of the 6 meeting with reporting on Single Action Tender Waivers being incorporated at the same time.

7.0 To ensure effective Cash management and investment of funds:

7.1 To approve any financing or use of financial instruments within its delegation
None during the reporting period.

7.2 To empower to delegate its authority to the Chairman or the Chief Executive within the limits contained in the Trust's Scheme of Delegation
No instances during the reporting period.

7.3 To review compliance with financing agreements and covenants and the operation of treasury management policies The Treasury Management Annual Report was presented (September 2023) with the Treasury Management Policy.

8.0 Accounting policies:

8.1 To consider any changes to accounting policies before the Audit Committee scrutinises the statutory accounts
The following Policies were presented and approved -

- Treasury Management Policy (September 2023)

9.0 Other Business Transacted

- Information Management Group Highlight and Escalation Report presented at 5 out of the 6 meetings
- Thames Valley Prisons Integrated Mental Health Service Partnership Contract (May 2023)
- Strategic dashboard draft proposal (September 2023)
- Provider Collaborative update (November 2023)
- Inquest and Claims (Legal) annual Report presented (November 2023)
- Oxford Clinic PFI (March 2024)

10.0 Committee Effectiveness

- Has the Committee's membership been effective (range, skills, frequency of attendance, contribution)?
  - Yes
  - Yes, particularly now that membership has been reviewed and strengthened.
  - No concerns – from the meetings attending broad discussions and contributions.
  - Yes
  - Yes, but some queries over the detail of Estates and IT. We are thinking about IT governance and query need for more visibility at Board.
  - Yes, the committee has been well attended by NEDs and core executives and I believe has been effective overall. It draws on the appropriate range of skills, experiences, and professional advice in going about its work.

- 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?
  - In part, the Committee looks carefully at financial management and is alert to risk. The Committee has an ambition to look more at performance and value for money but has been hampered by data gaps following the cyber outage.
  - Yes, although I don't believe the assurance needs of the organisation are stated explicitly. The committee provides insight and constructive challenge on a regular basis and there is a strong culture of constructive challenge being welcomed.
  - Yes
  - Yes, on challenge I think insight could be improved but from execs into committee not the committee as such.
  - Yes, but lately the committee – along with the board – has been somewhat marginalised by the BOB ICS financial crisis, with lots of bilateral executive discussion out of the Board's and FIC's line of sight.

- Yes, I consider the annual work plan to set out the relevant areas of business for the committee. From time to time, unforeseen matters do arise, and I believe the committee has shown itself to be alert to the need to respond to such matters and flexible in its use of time (without distorting its overall priorities). I believe the committee does constructively challenge both executive recommendations and the deliberations of the Board, as and when it considers it to be appropriate.

- 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?
  - Yes
  - Yes, this having been further articulated with the arrival of a new Chair.
  - Yes, and it continues to evolve and develop.
  - Yes
  - Not yet for 2024-25.
  - This is something that it keeps under ongoing review. Members are routinely asked to confirm their satisfaction with, for example, the quality of papers, the allocation of committee time and the overall conduct of business at the end of each meeting.

- Does management fully brief the Committee in relation to key risks, assurances, gaps in controls/assurances in a timely fashion?
  - Yes
  - Yes, there is a good, shared understanding of risks, although the BAF is not used as a live document to manage those risks, instead tending to be considered retrospectively. Gaps in controls and assurances are picked up ad hoc on identification and addressed in a timely manner, although I am not aware that the committee routinely considers the control/assurance framework for completeness.
  - Yes
  - Not sure you can ever fully brief, but it is done to a good enough standard.
  - Yes
  - In general, I would say 'yes'. However, it is important to recognise that members of the committee need to continuously test the voracity and completeness of the assessments it is presented with to be effective.

- Do the Committee's papers and meetings (length and frequency) support the Committee to perform its role effectively?
  - Yes. It feels like the right pattern of meetings. Papers could be streamlined which is being planned.

- Yes, although consistency of papers could be improved to ensure all papers are focussed on analysis/insight and resolution rather than transactional narrative. There is also an opportunity to improve the ability of the committee to look forwards (identifying underlying positions, future trends, early warnings, risk etc) rather than back.
- Yes, but papers assume a level of financial literacy and knowledge of acronyms.
- Yes
- Yes
- Yes, I believe they do generally. However, there will be occasions when members challenge the information provided and/or ask for additional or alternative analysis – this is a central part of the committee's effectiveness.

- 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. Extra time is given where needed.
  - Yes
  - I am relatively new to the committee but yes discussions are appropriate with relevant actions to monitor/assure etc.
  - Yes
  - Yes
  - Yes, I believe it does. There are times when the committee will 'drill down' on issues/numbers, or scrutinise areas of potential concern, which are subsequently confirmed to be of insignificant in scale, or risks that are very unlikely to crystalise. Notwithstanding this, the committee must be free to pursue the matters it considers may be of concern when it is presented with recommendations.

Appendix 1 – Finance and Investment Committee, Terms of Reference (September 2023)
Appendix 2 – Finance and Investment Committee, attendance 2023-2024
Appendix 3 - Finance and Investment Committee, overview plan 2023-2024
Appendix 4 – Finance and Investment Committee, Draft overview plan 2024-2025
Appendix 5 – Finance and Investment Committee, Draft Terms of Reference April 2024

Oxford Health
NHS Foundation Trust

Mental Health & Law Committee
Terms of Reference

Contents

1. Purpose

1.1 The Mental Health & Law Committee is established to:

- Provide assurance to the Board over the Trust's ethical and lawful application of all legislation governing the care provided to its service users and engagement with carers, friends, and family;
- Provide a forum for consideration of matters with a wide ethical and social impact (separate from clinical ethics) such as:
  - Population Health;
  - Health and Social care; and
  - Research and Development.
- Monitor, review, and report to the Board the Trust practice in relation to:
  - European Convention on Human Rights (Human Rights Act 2008)
  - Mental Health Act 1983;
  - Mental Capacity Act 2005;
  - Deprivation of Liberty Safeguards;
  - Care Act 2014; and
  - other related legislation, case law and practice

2. Constitution

2.1 The Board has established a committee known as the Mental Health & Law Committee (previously known as the Mental Health Act committee), as a standing assurance committee of the Board.

2.2 The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation of Powers and may be amended from time to time. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2.3 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders of the Board and other policies of the Trust.

2.4 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.

2.5 These Terms of Reference, which will be published on the Trust's website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

3. Authority

3.1 The Committee is authorised by the Board to:

3.1.1 Investigate any activity within its Terms of Reference.

3.1.2 Seek any information it requires within its remit, from any employee or member of the Board (who are directed to co-operate with any request made by the committee) within its remit as outlined in these Terms of Reference.

3.1.3 Commission any reports it deems necessary to help fulfil its obligations.

3.1.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the Board for obtaining legal or professional advice.

3.1.5 All procedural matters in respect of conduct of meetings shall follow the Board's Standing Orders, Scheme of Delegation and Reservation and/or Trust Constitution as required.

Limitations of Authority

3.2 The Committee shall be delegated the power of the Board of Directors to require the attendance of any member of the Trust staff.

3.3 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.

3.4 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 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.

4. Duties and responsibilities

4.1 The Committee is responsible for providing assurance to the Board of Directors of the Trust's compliance with relevant legislation and case law relating to clinical care;

4.2 The Committee will monitor the Trust's provision of patient care and carer engagement in an ethical manner;

4.3 The Committee will promote Trust-wide education on human rights, ethics and legal matters;

4.4 The Committee will monitor coherent internal and external communication around Trust values, ethics and human rights;

4.5 The Committee will receive reports from the MHA/MCA Legislation Group

4.6 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. This will include the implementation of the Liberty Protection Safeguards;

4.7 Keep under review the work of Associate Hospital Managers;

4.8 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;

4.9 Oversee the Trust's response to recommendations from CQC Mental Health Act visits, to ensure progress on action plans and to provide strategic thinking around recurrent themes and areas for improvement;

4.10 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;

4.11 Monitor the provision of adequate guidance, information, education and training on mental health legislation to staff, service users, carers and other stakeholders;

4.12 Monitor the application of Human Rights principles and frameworks across the Trust and draw attention to any shortcomings. In particular:

(a) Checking that patients receive information regarding their rights, especially at key points such as prior to a 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 Advocate (IMHA).

(b) Checking that patients are given the opportunity to be involved in planning their care.

(c) Ensuring assurance that the application of the Mental Health Act and the Mental Capacity Act within the Trust does not disproportionately affect or disadvantage any groups as set out in the Equalities Act.

(d) Checking that, especially as regards the use of segregation and restraint, the principle of the application of the least restrictive option is always followed.

5. Other functions

5.1 The Committee will consider matters referred to it by the Board, the Audit Committee or any other Board Committee.

5.2 The Committee will refer relevant risks or other matters to appropriate Committees for information or mitigation and will oversee appropriate risks delegated to it from the Board.

5.3 The Committee can request a report on any subject or issue relevant to its Terms of Reference.

6. Membership and attendance

6.1 The Mental Health & Law Committee membership will be appointed by the Board and consist of:

- Two Non-Executive Directors, one of whom will be the Chair of the Committee
- Chief Medical Officer (Executive lead) or a nominated Deputy
- Chief Operating Officer for Mental Health and Learning Disabilities
- Director of Corporate Affairs
- Mental Health Act/Legislation Manager; and
- Head of Information Governance
- Deputy Director of Quality-Nursing and Clinical Standards

6.2 The Trust Chair, Chief Executive, other Non-Executive Directors and up to three governors at each meeting have standing invitations to attend any meeting.

6.3 The Board will review the membership of the Committee annually to ensure that it meets the evolving needs of the Trust. The Committee membership 2024/25 is presented at the Appendix.

6.4 An Executive or Non-Executive member of the Committee may nominate a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. In the case of an Executive member that deputy could either be another Executive Director of the Trust or some other deputy as appropriate. The Non-Executive Director members of the Committee may nominate any other Non-Executive Director of the Trust as their deputy to attend meetings in their absence. A deputy should be nominated only in exceptional circumstances for a particular meeting, and in such circumstances would count towards the quorum for the meeting.

6.5 The Committee may invite non-members to attend, in a non-voting capacity, all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair of the Committee.

6.6 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.

6.7 Attendance at the meeting may be by videoconferencing at the discretion of the Committee Chair.

6.8 Committee members are required to:

- Attend at least 75% of meetings, having read all papers beforehand.
- Act as 'champions', disseminating information and good practice as appropriate.
- If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

7. Frequency of meetings

7.1 Meetings shall be held not less than four times per financial year.

7.2 The frequency of meetings can be varied at the discretion of the Chair of the Committee.

7.3 An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

8. Calling meetings

8.1 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.

8.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.

8.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Quoracy

9.1 The quorum for the committee is four members, to include at least one Non-Executive Director and at least one Executive.

9.2 Attendance will be monitored as part of the committee's annual report to the Board and will be reported in the Trust's Annual Report.

9.3 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

9.4 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

10. Decision making and voting

10.1 The Committee must have regard to guidance issued by NHS England, the Care Quality Commission, and will also have regard to NHS policy and best practice.

10.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

10.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

10.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

10.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

10.6 Where committee members unable to attend a meeting have nominated a deputy to attend in their place, 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.

11. Behaviours and Conduct

<u>Benchmarking and guidance</u>

11.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example guidance issued by the Government, the Department of Health and Social Care, NHS England, Care Quality Commission, and the wider NHS in reaching their determinations.

Conflicts of interest

11.2 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the Trust's policies and procedures. This will be recorded in the minutes.

11.3 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

Trust values

11.4 Members will be expected to conduct business in line with the Trust values and objectives and the principles set out by the Board.

11.5 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Code of Conduct.

11.6 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

11.7 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

11.8 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

Equality and diversity

11.9 Members must demonstrably consider the equality and diversity implications of decisions they make.

12. Accountability and reporting arrangements

12.1 Meetings of the Mental Health & Law Committee will be formally recorded and once approved, submitted to the Board at the next opportunity.

12.2 After each meeting of the Committee, the Chair of the Committee will make a report (in the form of 3As – Alert/Advise/Assurance) to the next meeting of the Trust Board and draw to its attention any issues that require its particular attention or require it to take action. Where the Chair of the Committee considers appropriate, s/he will escalate immediately any significant issue to the Chief Executive or Chair.

12.3 The Chair of the Committee will submit an annual report of the work of the Committee to the Board to include reports on frequency of meetings, members' attendance, any recommendations to address non-attendance or changes to membership, and business conducted by the Committee (cross referenced to its remit). The purpose of the Annual Report is to ensure that the Committee is working to its terms of reference and has appropriate membership.

13. Administrative support

13.1 The Committee will be supported administratively by the Director of Corporate Affairs or their nominated member of his/her team, whose duties in this respect will include:

13.1.1 Agreement of the agenda with the Committee Chair and lead Executive Director, collation and distribution of papers at least one week before each meeting.

13.1.2 Good quality minutes are taken in accordance with the Standing Orders, produced within ten working days of a meeting and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

13.1.3 Action points are taken forward between meetings.

13.1.4 An annual work programme summarising those items to be considered during the year is provided to the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

13.1.5 Providing support to the Committee Chair and members as required.

14. Review of committee effectiveness and terms of reference

14.1 The Committee will undertake an annual self-assessment of its performance against its annual work programme, membership, and compliance with its Terms of Reference. This self-assessment will form the basis of its annual report to the Board.

14.2 The Committee's annual report will include details of its governance cycle, meeting dates, a summary of the business conducted, membership attendance, and whether meetings were held in quorum.

14.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval**.**

Date approved:	25 September 2024
Approved by:	Board of Directors
Next review date:	May 2025

Document management and revision history

Version	Date	Summary of changes
1.0	April 2022	Approved by the Board of Directors
1.1	xx May 2024	Reviewed by the Committee
1.2	July 2024	No material changes. TOR transferred onto new template and good practice governance clauses added for consistency across all committees terms of reference.

Appendix

Mental Health & Law committee membership 2024/25

Non-Executive Director (Committee Chair)	Geraldine Cumberbatch
Non-Executive Director	David Walker
Chief Medical Officer (executive lead)	Karl Marlowe
Chief Operating Officer for Mental Health & Learning Disabilities	Rob Bale
Director of Corporate Affairs	
Regular attendees:	
Mental Health Act/Legislation Manager Head of Information Governance	Mark Underwood
Deputy Director of Quality-Nursing and Clinical Standards	Rose Hombo

Oxford Health NHS Foundation Trust

Mental Health & Law Committee – overview plan for 2024 - 2025

Item	Owner(s) or function	Q1 18 April 2024	Q2 16 July 2024	Q3 15 October 2024	Q4 February 2025
Standing Items					
Minutes of the Previous meeting	Corporate Governance Officer	y	y	y	Y
Trust Risk Register update	Mark Underwood/Neil McLaughlin/Brian Aveyard	y	y	y	*y*
Trends in Mental Health Act • Mental Health Act Managers • Adequacy of guidance/training on MHA legislation • BAME information • Index of multiple health disparities (ethnicity/gender/location)	Mark Underwood	y	y	y	y
CQC Activity/Compliance	Mark Underwood	Y	y	y	y
Highlight Report Positive & Safe • Use of force update • Restrictive practice	Britta Klinck-needs changing as no longer member	Y	y	y	y
Terms of Reference	Karl Marlowe	Y			Y
Legal & Regulatory update	Director of Corporate Affairs	Y	N	N	
Annual Report	Geraldine/Karl/ Director of Corporate Affairs	Y	N	N	y
Patient Participation Group update	Rose Hombo	Y	y	y	y
PALs update	Rose Hombo	Y	y	y	y
Other Requested Items					
Mental Health Managers Staff Story	Britta Klinck (needs changing)		y		
Inpatient Mental Health Survey	Karl Marlowe		Y		
True for us reports	Director of Corporate Affairs		y		y
Deprivation of Liberties update	Amy Allen	y	y	y	y
Patient Carer Race Equality Framework					

Item	Owner(s) or function	Q1 18 April 2024	Q2 16 July 2024	Q3 15 October 2024	Q4 February 2025

Oxford Health
NHS Foundation Trust

Quality Committee
Terms of Reference

Contents

1. Purpose

1.1 The Quality Committee is established as a committee of the Board of Directors (the Board) of Oxford Health NHS Foundation Trust (the Trust) to scrutinise the robustness and provide assurance to the Board that there is an effective system of quality governance and internal control across the clinical activities of the organisation, that supports the Trust to deliver its strategic objectives and provide excellent care.

2. Constitution

2.1 The Board has established a committee known as the Quality Committee as a standing assurance committee of the Board.

2.2 The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation of Powers and may be amended from time to time. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2.3 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders of the Board and other policies of the Trust.

2.4 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.

2.5 These Terms of Reference, which will be published on the Trust's website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

3. Authority

3.1 The Committee is authorised by the Board to:

3.1.1 Investigate any activity within its Terms of Reference.

3.1.2 Seek any information it requires within its remit, from any employee or member of the Board (who are directed to co-operate with any request made by the committee) within its remit as outlined in these Terms of Reference.

3.1.3 Commission any reports it deems necessary to help fulfil its obligations.

3.1.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the Board for obtaining legal or professional advice.

3.1.5 All procedural matters in respect of conduct of meetings shall follow the Board's Standing Orders, Scheme of Delegation and Reservation and/or Trust Constitution as required.

<u>Limitations of Authority</u>

3.2 The Committee shall be delegated the power of the Board of Directors to require the attendance of any member of the Trust staff.

3.3 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.

3.4 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.

4. Duties and responsibilities

Quality and Clinical Governance Assurance

4.1 The Quality Committee will:

4.1.1 Oversee and monitor the delivery of the annual strategic objectives and programmes assigned to it.

4.1.2 Oversee the development and implementation of the Trust's clinical strategy.

4.1.3 Oversee the development and implementation of the Trust's quality priorities.

4.1.4 Oversee the operation of the Trust's quality governance systems and processes at a corporate and directorate level to:

(a) Promote safety and excellence in patient care

(b) Identify, prioritise and manage risk arising from clinical care on a continuing basis

4.1.5 Oversee the Trust's processes to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation and that learning is disseminated within the Trust and beyond if appropriate.

4.1.6 Receive and approve the annual Clinical Audit programme.

4.1.7 Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work, to the extent that it applies to matters within these Terms of Reference.

4.1.8 Approve the Trust's annual Quality Account before submission to the Board.

4.1.9 Oversee data and trends in patient safety, experience, and outcomes to provide assurance to the Board on performance and undertake 'deep dives' as appropriate at the discretion of the Committee.

4.1.10 Receive reports from the Mental Health & Law Committee (MH&L) as the MH&L considers appropriate regardless of itself being a Board Committee.

Regulatory Compliance

4.2 The Quality Committee will:

4.2.1 Assure itself that all regulatory requirements relating to the Care Quality Commission's fundamental standards of quality and safety are complied with, with proven and demonstrable assurance, and that immediate and effective action is taken where there is variation.

4.2.2 Promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care and compliance with the requirements of the Duty of Candour.

4.2.3 Consider and receive assurance on any published external reviews which relate to the Trust's services within the scope of the committee.

4.2.4 Oversee the ratification of clinical policies and any other formal clinical documents where mandatory compliance is required.

Clinical Risk Management

4.3 The Quality Committee will:

4.3.1 Support the work of the Audit Committee by monitoring progress against actions to mitigate quality and safety risks on the Board Assurance Framework and Trust Risk Register in line with the Boards' risk appetite.

4.3.2 Ensure that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation:

- To ensure the Trust incorporates the recommendations from external bodies as well as those made internally
- To ensure those areas of risk within the Trust are regularly monitored and that effective Disaster Recovery Plans are in place
- To assure that there are processes in place that safeguard children and adults
- Agree additions, deletions, and changes in risk rating to clinical risks on the Board Assurance Framework and Trust Risk Register proposed by the executive.

5. Other functions

5.1 The Committee will consider matters referred to it by the Board, the Audit Committee or any other Board committee.

5.2 The Committee will ensure effective interface with the Audit Committee, and with the Executive led Quality and Clinical Governance Group and Trust Mortality Group, to assure itself of the co-ordination of risk management processes across the Trust, both clinical and non-clinical

5.3 The Committee will 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.

5.4 The Committee will 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 Boards

5.5 The Quality Committee will receive the Terms of Reference of the Quality and Clinical Governance Group and oversee its work, receiving and reviewing at each of its meetings an escalation report 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 Group will be brought to the Quality Committee through the provision of papers consistent with the guidelines for committee papers.

5.6 The Quality Committee will receive an annual report from the Quality and Clinical Governance Group on its performance and effectiveness within the integrated governance framework.

5.7 The Committee will refer relevant risks or other matters to appropriate Committees for information or mitigation and will oversee appropriate risks delegated to it from the Board.

6. Specific responsibilities

6.1 The Quality Committee will receive reports on the following issues:

- Quality and Clinical Governance Group escalation report, including Quality and Safety Dashboard
- Patient Safety Incident Reports (including mortality and homicide reviews)
- Learning from incidents and deaths
- Safeguarding children, young people and adults
- Infection, Prevention and Control
- Clinical audit
- Board Assurance Framework and Trust Risk Register – clinical and safety risks
- Regulatory updates and compliance with national requirements and standards, including CQC, NICE, NHS Resolution (formerly NHSLA), Local Authority such as SEND, OFSTED, etc and MHAC
- Briefings on legal and key national policy developments
- Quality improvement
- Patient and carer experience, including complaints and PALS
- Health and safety matters with a clinical or quality dimension, including safety of the physical estate
- Presentations/deep dives in services

- Pharmacy/medicines management
- Physical health

6.2 The Quality Committee can request a report on any subject or issue relevant to its Terms of Reference.

6.3 The Quality Committee will consider the following annual reports before being submitted to the Board:

- Infection Prevention and Control annual report (statutory)
- Patient and Carer Experience (including complaints) annual report (mandatory)
- Safeguarding Annual Report (statutory)
- Quality Account (statutory)
- Health and Safety (including fire, security and welfare) annual report (statutory)
- Pharmacy annual report (mandatory)
- Research and Development annual report
- Learning from Deaths report

6.4 The Quality Committee will be responsible for overseeing the following strategies:

- Clinical strategy
- Experience and Involvement Strategy for Patients, Service Users and Carers
- Family, Friends and Carers strategy
- Dementia strategy
- Quality Account priorities
- Pharmacy strategy (tbc)
- Nursing strategy (quality elements)
- Allied Health Professionals strategy (quality elements)

7. Membership and attendance

7.1 The Quality Committee membership will be appointed by the Board and consist of:

- At least three Non-Executive Directors, one of whom will be the Chair of the Committee
- Chief Nurse (Executive lead)
- Chief Medical Officer
- Chief Operating Officer for Mental Health and Learning Disabilities
- Chief Operating Officer for Community, Primary Care and Dental Care
- Director of Corporate Affairs

7.2 The Trust Chair, Chief Executive, other Non-Executive Directors and up to three governors at each meeting have standing invitations to attend any meeting.

7.3 The Board will review the membership of the Committee annually to ensure that it meets the evolving needs of the Trust. The Committee membership 2024/25 is presented at the Appendix.

7.4 An Executive or Non-Executive member of the Committee may nominate a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. In the case of an Executive member that deputy could either be another Executive Director of the Trust or some other deputy as appropriate. The Non-Executive Director

members of the Committee may ~~will be entitled to~~ nominate any other Non-Executive Director of the Trust as their deputy to attend meetings in their absence. A deputy should be nominated only in exceptional circumstances for a particular meeting, and in such circumstances would count towards the quorum for the meeting.

7.5 The Committee may invite non-members to attend, in a non-voting capacity, all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair of the Committee.

7.6 Regular attendees, who are not voting members unless formally deputising and exercising the vote of their principal, include: the five Clinical Directors from each of the clinical service directorates; and the Deputy Chief Nurse.

7.7 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.

7.8 Attendance at the meeting may be by videoconferencing at the discretion of the Committee Chair.

7.9 Committee members are required to:

- Attend at least 75% of meetings, having read all papers beforehand.
- Act as 'champions', disseminating information and good practice as appropriate.
- If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

8. Frequency of meetings

8.1 Meetings shall be held not less than four times per ~~annum~~ financial year.

8.2 The frequency of meetings can be varied at the discretion of the Chair of the Committee.

8.3 An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

9. Calling meetings

9.1 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.

9.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.

9.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

10. Quoracy

10.1 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.

10.2 Attendance will be monitored as part of the committee's annual report to the Board and will be reported in the Trust's Annual Report.

10.3 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

10.4 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

11. Decision making and voting

11.1 The Committee must have regard to guidance issued by NHS England, the Care Quality Commission, and will also have regard to NHS policy and best practice.

11.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

11.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

11.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

11.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

11.6 Where committee members unable to attend a meeting have nominated a deputy to attend in their place, 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.

12. Behaviours and Conduct

Benchmarking and guidance

12.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example guidance issued by the Government, the Department of Health and Social Care, NHS England, Care Quality Commission, and the wider NHS in reaching their determinations.

Conflicts of interest

12.2 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the Trust's policies and procedures. This will be recorded in the minutes.

12.3 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

Trust values

12.4 Members will be expected to conduct business in line with the Trust values and objectives and the principles set out by the Board.

12.5 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Code of Conduct.

12.6 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

12.7 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

12.8 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

Equality and diversity

12.9 Members must demonstrably consider the equality and diversity implications of decisions they make.

13. Accountability and reporting arrangements

13.1 Meetings of the Quality Committee will be formally recorded and once approved, submitted to the Board at the next opportunity.

13.2 After each meeting of the Committee, the Chair of the Committee will make a report (in the form of 3As – Alert/Advise/Assurance) to the next meeting of the Trust Board and draw to its attention any issues that require its particular attention or require it to take action. Where the Chair of the Committee considers appropriate, s/he will escalate immediately any significant issue to the Chief Executive or Chair.

13.3 The representative Non-Executive member of the Quality Committee appointed to the Audit Committee shall draw specific attention to any issues that require notification to the Audit Committee.

13.4 The Quality Committee may work with the Audit Committee specifically when issues arise in relation to the Audit Committee's role in maintaining effective systems of governance, risk management and internal control within the Trust.

13.5 The Chair of the Committee will submit an annual report of the work of the Committee to the Board 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.

14. Administrative support

14.1 The Committee will be supported administratively by the Director of Corporate Affairs or their nominated member of his/her team, whose duties in this respect will include:

14.1.1 Agreement of the agenda with the Committee Chair and lead Executive Director, collation and distribution of papers at least one week before each meeting.

14.1.2 Good quality minutes are taken in accordance with the Standing Orders, produced within ten working days of a meeting and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

14.1.3 Action points are taken forward between meetings.

14.1.4 An annual work programme summarising those items to be considered during the year is provided to the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

14.1.5 Providing support to the Committee Chair and members as required.

15. Review of committee effectiveness and terms of reference

15.1 The Committee will undertake an annual self-assessment of its performance against its annual work programme, membership, and compliance with its Terms of Reference. This self-assessment will form the basis of its annual report to the Board.

15.2 The Committee's annual report will include details of its governance cycle, meeting dates, a summary of the business conducted, membership attendance, and whether meetings were held in quorum.

15.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Date approved:	xx September 2024
Approved by:	Board of Directors
Next review date:	May 2025

Document management and revision history

Version	Date	Summary of changes
1.0	24 October 2014	Approved by the Board of Directors, 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.
1.1	28 January 2015	Presented with revisions approved by the Board on 28 January 2015.
1.2	25 February 2015	Further revision to increase membership of Non-Executive Directors to take effect from 01 March 2015.
1.3	27 September 2017	Further revision to provide for the Committee to be chaired by a Non-Executive Director other than the Trust Chair.
1.4	14 July 2022	Approved by the Board with revisions approved by Quality Committee
1.5	13 July 2023	Presented with revisions approved by Quality Committee on 13 July 2023.
	02 May 2024	Presented to the Quality Committee on 02 May 2024 with revisions for approval – deferred.
1.6	xx July 2024	Revisions presented in new committee terms of reference template; clarification of committee purpose, duties and responsibilities; addition of clauses regarding behaviours and conduct (benchmarking and guidance, conflict of interests, Trust values, equality and diversity) and non-material revisions to governance clauses in accordance to Standing Orders.

Appendix

Quality committee membership 2024/25

Andrea Young	Non-Executive Director (Committee Chair)
David Walker	Non-Executive Director
David Clark	Non-Executive Director
Lucy Weston	Non-Executive Director
Britta Klinck	Chief Nurse (executive lead)
Karl Marlowe	Chief Medical Officer
Rob Bale	Chief Operating Officer for Mental Health & Learning Disabilities
Ben Riley	Chief Operating Officer for Community, Primary Health and Dental Care
	Director of Corporate Affairs

Oxford Health
NHS Foundation Trust

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	
OPENING STANDING ITEMS							
Welcome and apologies	Andrea Young	X	X	X	X	X	X
Declaration of interests	Andrea Young	X	X	X	X	X	X
Minutes of previous meeting and matters arising	Andrea Young/Britta Klinck/ Leanne Dunkley	X	X	X	X	X	X
Action log	Andrea Young/Britta Klinck/ Leanne Dunkley	X	X	X	X	X	X
SAFE							
Quality and Clinical Governance Sub-Committee escalation report including Quality and Safety Dashboard *(to include positive and safe each month and May meeting to include ToR and work plan)*	Jane Kershaw/Britta Klinck	X *(ToR & workplan included)* ✓	x	x	x	x	
Directorate/Service area 'deep dive' *(Presentation)*	Rob Bale/Ben Riley	X *0-19 service* ✓	X *City Adult AMHT*	X *Learning Disabilities*	X	X	
Quality Account (quality priorities) *(May meeting includes annual report)*	Angie Fletcher/Britta Klinck	X ✓			X		
Patient Safety Incident Report (PSIs) *(Learning from Deaths Report, to include mortality and homicide reviews)*	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)*	Claire Forrest/Britta Klinck	X ✓	X *Well led guidance*	X	X	X	
Director of Infection Prevention & Control (IPC) – IPC annual report	Helen Bosley/Britta Klinck	X ✓					

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Safety of the physical estate – annual report *Ligature update (BK/MC)*	Jeremy Philpot/ Heather Smith		*X* *Deferred to Sept*	*x*			
Learning Disabilities & Autism Services – access to healthcare annual report	Kirsten Prance/Rob Bale			*X*			
Inquests & Claims – annual report	Neil McLaughlin/ Georgia Denegri			*X*			
Safeguarding annual report	Lisa Lord/Daniel Mercier/Britta Klinck			*X*			
Oxford Pharmacy Store (OPS) *(quality assurance report around the governance and quality of medicines regulation in OPS)*	Mark Byrne/Heather Smith	*X* *(review of programme)* ✓			X		
EFFECTIVE							
Clinical Effectiveness Group (CEG) *(RR minutes from CEG group, new NICE guidance)*	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*	
CARING & RESPONSIVE (patient & carer experience)							
Experience and Involvement report *(update on strategy)*	Rose Hombo / Britta Klinck				*X*		
PCREF Framework *(update on strategy)*	Rose Hombo/Britta Klinck		X Deferred to sept		*X*		
Complaints & PALS annual report	Rose Hombo/ Britta Klinck	*X* ✓					
QUALITY IMPROVEMENT							
Health Inequalities - Quality Improvement (smoking cessation/SMI Health checks/ dashboarding waiting list for Index of Multiple deprivation/ethnicity data)	Karl Marlowe		*X*				

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Quality Improvement Spotlight presentation (developing capability and the impact on staff and patients)	Angie Fletcher/Britta Klinck	*X* *Review of programme* ✓	*X* *Plan for the year*		*X* *(projects)*	*X* *(projects)*	
ANNUAL PLAN STRATEGIC PROGRAMMES							
Patient and Carer Race Equality Framework (see above under Caring & Responsive)	Rose Hombo/ Britta Klinck						
Patient Experience and Involvement Strategy (see above under Caring & Responsive)	Rose Hombo/ Britta Klinck						
Learning Together for a Safer Tomorrow	Jane Kershaw/ Britta Klinck						
Journey to Excellence	Angie Fletcher/Britta Klinck						
Mental Health Inpatient and Community Improvement Programme • MH Inpatient Transformation Programme • Community MH Framework OxBSW • Community MH Framework Bucks	Rob Bale/ Bill Tiplady & Angie Fletcher Rob Bale/ Katrina Anderson Rob Bale/ Donna Clarke			X			
Provider Collaboratives and Strategic Partnerships • BOB MH Provider collaborative • Oxford Health / OUH partnership • Thames Valley Community Dental Partnership	Rob Bale & Amelie Bages / Lisa Reynolds Grant Macdonald/Sue Butt Ben Riley/Ros Mitchell						
Provider Collaboratives	Karen Drabble/Britta Klinck	*X* ✓	*X*	*X*	*X*	*X*	
Partnership update	Laura Carter/Amélie Bages		X ✓		X		
RESEARCH							

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Research & Development update (Governance aspects)	Vanessa Raymont/Karl Marlowe			x			
STRATEGIES & POLICIES							
Nursing Strategy	Angie Fletcher/ Britta Klinck				*X*		
Allied Health Professionals Strategy	Sam Rigg/Britta Klinck					X	
Learning from Patients, Family & Carers *update on strategy*	Rose Hombo/Britta Klinck	*X* ✓			*X*		
Learning Disability Strategy (2022-2027)	Kirsten Prance/Rob Bale		X Deferred to Sept	x			
Suicide Prevention Strategy	Karen Lascelles/ Karl Marlowe						
Trust Policies *(as and when – new policies for approval and certain policies for review)*							
Legal Proceedings Policy	Neil McLaughlin/DoCA		X				
GOVERNANCE & RISK MANAGEMENT							
Operational and Strategic Risks - Trust Risk Register (TRR) and Board Assurance Framework (BAF) *review each one at each meeting*	Ben Cahill/Georgia Denegri	*X* ✓	*X*	*X*	*X*	*X*	
Operating Framework – ward to board governance (graph showing ward to board and testing its effectiveness in deep dives and quality management)	Georgia Denegri	*X* ✓		X Defer to November	x		
Trust Policy Register	Ben Cahill/Georgia Denegri	*X*		X			
Annual Planning Process	Laura Carter/Amelie Bages					*X*	
ANNUAL REVIEW OF COMMITTEE EFFECTIVENESS AND TERMS OF REFERENCE							

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Terms of Reference annual review	Andrea Young/Britta Klinck/Georgia Denegri						
Quality Committee annual report	Andrea Young/Britta Klinck/Georgia Denegri	X ✓					
OTHER REQUESTED ITEMS							
Number of Items on Agenda		21	*17*	*15*	*18*	15	

Note

NHSE/ issues for QC oversight *reviewed March 24*

- Children & Young People (on May agenda)
- Learning from Deaths (in PSIRF report)
- Resuscitation (Quality dashboard)
- Security Management – Violence & Aggression (currently in PLC agenda)
- Palliative and End of Life Care (TBC)
- Safeguarding (Sept agenda, and review through learning/PSIRF)
- Sexual Safety (TBC)
- Well-led guidance (July)