PUBLIC

Please notify attendance and send questions to Kerry Rogers, Director of Corporate Affairs & Company Secretary, on kerry.rogers@oxfordhealth.nhs.uk

Oxford Health NHS Foundation Trust

BOARD OF DIRECTORS' MEETING

Wednesday, 31 January 2024
09:00 – 11:50

POWIC Conference Room, Warneford Hospital site, Oxford OX3 7JX
(and Microsoft Teams – hybrid virtual and in person)

Agenda

INTRODUCTORY ITEMS	**Paper/ Reading Room**	**Purpose**	**Lead**	**Indicative Time**
1. **#Hellomynameis** and apologies for absence	-	Welcome	Chair	09:00
2. Patient Story - Thames Valley Forensic Mental Health Service	BOD 01/2024	Discussion	Chief Nurse	09:05
3. Register of Directors' Interests	*RR/App 01/2024*	Update	Chair	09:20
4. Minutes and Matters Arising of the meeting held on 29 November 2023	BOD 02/2024	Approval	Chair	
STRATEGIC, REGULATORY & SYSTEM				
5. Trust Chair's report	BOD 03/2024	Discussion	Chair	09:25
6. 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/)	BOD 04/2024	Discussion	CEO	09:35
7. Corporate Affairs report including updates on: a. Legal, Regulatory and Policy; b. Board Assurance Framework (strategic risks); c. Charity and Involvement impact and updates; and d. Communications and Engagement	BOD 05/2024 *RR/App 02/2024*	Information & Assurance	DoCA/ CoSec	09:50

PERFORMANCE, PEOPLE & SUSTAINABILITY				
8. Wantage Community Hospital update (see Reading Room for supporting information)	BOD 06/2024 *RR/App 07/2024*	Information	Exec MD for Primary, Community & Dental	10:00
5 minutes' break (if required)				10:20
9. Integrated performance and sustainability reporting: a. Integrated Performance Report (**IPR**); and b. Finance report	BOD 07/2024 *RR/App 03/2024*	Information & Assurance	Exec Team	10:25
10. Board Committees' update reports and recommendations from recent meetings:				11:10
a. 3As reporting/oral updates (matters for Alert, Advice and Assurance) from Committees with meetings since November 2023 (see Reading Room for supporting Committee minutes and agendas, note that 3As reports for October-November 2023 meetings already provided to the November 2023 Board for the Audit Committee, Charity Committee, Finance & Investment Committee, People, Leadership & Culture Committee and the Quality Committee)	BOD 08/2024 *RR/App 04-06/2024*	Discussion	C'ttee Chairs	
QUALITY				
11. Allied Health Professionals strategy	BOD 09/2024	Information	AD for AHPs/ Chief Nurse	11:15
12. Patient Safety Incidents (**PSI**) report	BOD 10/2024	Assurance	Chief Nurse	11:30
CONCLUSION & RESOLUTION TO CONDUCT PRIVATE BUSINESS				
13. Any Other Business	-	-	Chair	11:40
14. Questions from the public and any governors or staff attending	-	-	Chair	
15. Review of the Meeting	-	-	Chair	
16. 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				11:50

Next meeting in public: 27 March 2024

READING ROOM/APPENDIX

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

17. Register of Directors' Interests (paper - RR/App 01/2024)

18. 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/

19. Appendices to the Corporate Affairs update report (paper - RR/App 02/2024):
    a. Legal, Regulatory & Policy update; and
    b. Board Assurance Framework (strategic risks)

20. Integrated Performance Report (**IPR**) - supporting information:
    Safety & Quality Dashboard (paper - RR/App 03/2024)

21. Meetings, minutes, agendas and supporting information from Committees:
    a. Audit Committee on 21 November 2023 (oral update - 3As report for the November 2023 meeting already provided to the November 2023 Board for the Audit Committee)
    b. Charity Committee on 22 November 2023 (oral update)
    c. Finance & Investment Committee on 16 November 2023 and agenda for 23 January 2024 (paper - RR/App 04/2024)
    d. Mental Health & Law Committee on 17 October 2023 (oral update)
    e. People, Leadership & Culture Committee agenda for 17 January 2024 (paper - RR/App 05/2024)
    f. Quality Committee on 09 November 2023 (paper - RR/App 06/2024)

22. Wantage Community Hospital - supporting information (paper - RR/App 07/2024)

Oxford Health NHS Foundation Trust

Report to the Meeting of the
Oxford Health NHS Foundation Trust

Board of Directors

BOD 01/2024
(Agenda item: 2)

31st January 2024
Thames Valley Forensic Mental Health Service

For: Information

Summary of the story

This patient story focuses on the need for services to be better at listening to families and carers, and the serious consequences that can occur when this does not happen. It raises the question – can we reduce the number of people needing to use our services simply by being better at listening?

It challenges us to consider how much we value the voice of those outside of our clinical teams – whether that be the patient, the family, or members of the public, and how we can change our culture and working practices to do this better.

This patient in question would like to be anonymous but has ask the patient experience lead from this pathway to tell their story.

The patient describes his journey with the forensic services who treated him as."
"The care was outstanding; the team has been good to me. They have shown me the way and it was down to me to follow that way.
They helped me to realise that whatever has happened in the past I need focus on being the best person I can be today, and they helped me to do that."

About the service

Our forensic mental health service provides accommodation, treatment and support for men and women who have been diagnosed with severe mental health

problems and are considered to pose a risk to the public. We have a number of secure inpatient settings, referred to as "forensic".

We are the NHS provider of secure services for Oxfordshire, Berkshire, Buckinghamshire and Milton Keynes.

We provide a full range of inpatient services across this area, including:

- two medium secure units
- two low secure units
- a secure unit for women
- an open pre-discharge facility.

We also have a Specialist Community Forensic Team which provides coordination of the patient journey through the service as well as follow up and after care for patients after they have been discharged from inpatient services.

We provide mental health support to a range of prison settings, such as Bullingdon Prison, Her Majesty's Prison (HMP) Grendon and the Close Supervision Centre at HMP Woodhill.

Our service, and our reputation as a provider as well as a base for research and academic achievement, is growing fast with an ability to offer services to other NHS trusts across England.

Meeting of the Oxford Health NHS Foundation Trust Board of Directors

BOD 02/2024
(Agenda item: 4)

Minutes of a meeting held on 29 November 2023 at 09:00 Microsoft Teams virtual meeting

Present:[1]

David Walker	Trust Chair (the Chair) (**DW**)
Grant Macdonald	Chief Executive Officer (**GM**)
Amélie Bages	Executive Director of Strategy & Partnerships (**AB**)*
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (**RB**)
David Clark	Non-Executive Director appointee of the University of Oxford (**DC**)
Marie Crofts	Chief Nurse (**MC**)
Geraldine Cumberbatch	Non-Executive Director (**GC**)
Charmaine De Souza	Chief People Officer (**CDS**)
Chris Hurst	Non-Executive Director (**CMH**)
Karl Marlowe	Chief Medical Officer (**KM**)
Ben Riley	Executive Managing Director for Primary, Community & Dental Care Services (**BR**)
Kerry Rogers	Director of Corporate Affairs & Company Secretary (**KR**)*
Philip Rutnam	Non-Executive Director (**PR**) - *part meeting*
Mohinder Sawhney	Non-Executive Director (**MS**)
Heather Smith	Chief Finance Officer (**HeS**)
Rick Trainor	Non-Executive Director (**RT**)
Lucy Weston	Non-Executive Director (**LW**)
Andrea Young	Non-Executive Director (**AY**)

In attendance[2]**:**

Attendees from Oxford Health NHS FT

Jane Appleton	Associate Director of Communications & Engagement
Lianne Bowes	Freedom to Speak Up Guardian - *part meeting*
Rita Bundhoo-Swift	Freedom to Speak Up Guardian - *part meeting*
Ben Cahill	Deputy Director of Corporate Affairs
Emma Croft	Head of Allied Health Professions, Mental Health & Learning Disabilities - *part meeting*
Leanne Dunkley	Corporate Governance Officer (Minutes)
Angie Fletcher	Associate Director of Quality Improvement (**QI**) & Clinical Effectiveness - *part meeting*
Claire Forrest	Head of Clinical Standards & Excellence - *part meeting*
Nicola Gill	Executive Project Officer - *part meeting*

[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 17 (from April 2022), quorum of 2/3 with a vote is 11

[2] An officer in attendance for an Executive but without formal acting up status may not count towards the quorum – Standing Orders 3.12.2

Rose Hombo	Deputy Director of Quality
Elaine Jones	Executive Officer to CEO and Chair - *part meeting*
Emma Leaver	Service Director - Primary, Community & Dental Services - *part meeting*
Susan Marriott	Executive Assistant - *part meeting*
Karen Pinel	Senior Children's Allied Health Professionals Clinical Lead - *part meeting*
Nicole Robinson	Patient Engagement & Involvement Lead - *part meeting*
Hannah Smith	Assistant Trust Secretary (Minutes)
Kathryn Stevenson	Specialist Lead, Children's Occupational Therapist - *part meeting*
Priya Thompson	Head of Strategy - *part meeting*

Governor Observers

Carolyn Mason	Appointed Governor, representing Oxford Brookes University
Paul Ringer	Appointed Governor, representing AGE UK Oxfordshire
Vicki Power	Staff Governor

BOD 101/23	**Welcome, #Hellomynameis and Apologies for Absence**	
a	The Trust Chair welcomed members of the Board present and staff, governors and observing members of the public. The Board and those in attendance at the start of the meeting introduced themselves (#Hellomynameis).	
b	There were no apologies for absence.	
c	The Trust Chair noted that the meeting in public would be followed by a private meeting of the Board, to transact confidential items, but he would as usual provide an update to the Lead Governor afterwards.	
BOD 102/23	**Register of Directors' Interests**	
a	The Trust Chair referred to the updated Register of Directors' Interests at RR/App 54/2023. No interests were declared pertinent to matters on the agenda.	
BOD 103/23	**Minutes of the Meeting held on 27 September 2023**	
a	The Minutes of the meeting held on 27 September 2023, at BOD 69/2023, were approved as a true and accurate record.	
	Matters Arising	
b	The Board noted that the following actions were in progress but not yet complete: • BOD 93/23(l) – workshop on effectiveness of Speaking Up arrangements to take place in early 2024; • BOD 95/23(j) - Risk workshop to take place in early 2024; and • BOD 77/23(k) – targets for the Experience & Involvement Strategy 2023-25 to be re-evaluated.	

BOD 104/23	**Trust Chair's Report and system update**	
a	The Trust Chair took his report, at BOD 70/2023, as read. In addition to his report, he highlighted yesterday's Peer Support Worker Graduation Event, noting that this had been a joyous occasion for him and the Chief Executive to attend and would enable the new Peer Support Workers to use their lived experience to support others.	
b	**The Board noted the report.**	
BOD 105/23	**Chief Executive's Report**	
a	The Chief Executive presented his report at paper BOD 71/2023 and highlighted: • his thanks to all staff involved in responding to the emergency evacuation at the Fulbrook Centre following the power outage on 09 November 2023. Staff across the organisation had been involved in managing the situation safety and promptly to evacuate and rehouse approximately 50 patients from the two Mental Health wards and the City Community Hospital; • that the Trust had been successful in tendering for 0-19 services in Oxfordshire and the next few months would be spent developing the revised integrated care model further; • the opening of the new Keystone Mental Health & Wellbeing Hub in Abingdon, where he had met again with Peer Support Workers who were keen to make this unit a success and improve health outcomes and access; and • the opening of the Meadow Unit, an 8-bed Psychiatric Intensive Care Unit (**PICU**) for young people, at the Warneford site. The PICU had been opened with due care and caution and currently had 2 young people.	
b	The Chief Executive concluded by thanking the Chief Nurse and, on behalf of the Board, wishing her well in her new role as Chief Nurse for the Gloucestershire Integrated Care Board (**ICB**).	
c	Rick Trainor referred to page 2 of the report and the inspection into Oxfordshire services for children with Special Educational Needs and Disabilities (**SEND**); he asked about the timeframe to develop the priority action plan. The Chief Executive replied that the action plan had been developed with partners and submitted as part of the inspection process, but it could still be developed and refined; initial feedback had been to make it more specific and work was taking place to provide more focus on the outcomes. He would also be meeting with the independent chair to this process, Steve Crocker, to further discuss refinement of the action plan.	
d	**The Board noted the report.**	
BOD 106/23	**Corporate Affairs update report**	
a	The Director of Corporate Affairs & Company Secretary presented the report at paper BOD 72/2023, with supporting material available at RR/App 55/2023. She reminded the meeting that this report set out the universal picture of the Trust's strategic risk profile whilst the Committee 3As reports, at BOD 76/2023, provided further detail of	

	the most recent Committee discussions which would amplify oversight of risk for the Board. She added that the Executive would also be meeting next week to discuss the Trust's risk profile and, potentially, risk appetite. She also highlighted from the report: • the volume of activity across Communications, Involvement and Engagement and the Charity, Involvement & Volunteering. • legal and regulatory updates including: (i) NHS Providers' annual state of the provider sector survey; and (ii) the Care Quality Commission's (**CQC's**) State of Care 22/23 report, noting that the snapshot of the issues facing NHS leaders which these provided was also consistent with the themes contained in the Board Assurance Framework and the Trust Risk Register; • although the Mental Health Bill, to reform the Mental Health Act, was not being brought forward by the government at this time, the Trust's Mental Health & Law Committee had paid close attention to the spirit of the anticipated changes and was overseeing developments accordingly to amplify individual rights and liberties, including a review of advocacy arrangements for Learning Disability & Autism services; and • the importance of understanding organisational cultures, behaviours and practices and the risks of closed cultures and cultural failings, as demonstrated in the CQC inspection reports linked to in Addendum A/'true for us' of the Legal, Regulatory and Policy update at RR/App 55(i)/2023. She noted the particular cultural and logistical challenge of behaving as a single organisation whilst operating across a number of different sites. *Philip Rutnam joined the meeting*.	
b	The Trust Chair commented upon the risks and potential impact upon individuals of one-word judgements made by regulators following inspections of organisations. He noted that it was positive that the recent CQC reports demonstrated more subtly than this and that it was possible to identify areas for improvement without affecting the organisation's overall score.	
c	**The Board noted the report.**	
BOD 107/23	**Annual Plan 2023/24 mid-year review and update**	
a	The Executive Director of Strategy and Partnerships took the report at BOD 73/2023 as read and explained that the aim of the annual planning process was to empower operational teams to be pro-active in annual planning and coordinate the approaches of Finance, HR/workforce, operational and corporate teams to optimise the services being delivered. She noted that the report was a mid-year progress report on the FY23/24 Plan; the Board would receive further updates which would also include the Corporate Directorate.	**AB**
b	The Executive Director of Strategy and Partnerships took the meeting through the presentation and highlighted that: • the Mental Health & Learning Disabilities Directorates had seen overall good progress against their objectives but with some challenges relating to recruitment and ensuring the flow of finance for contracts; and	

	• the Primary, Community & Dental Care Directorate had launched a Community Services Transformation Programme which would gain pace from Q3 onwards.	
c	The Trust Chair asked how the Annual Plan and its projects could be meaningful in the daily lives of staff delivering services. The Executive Director of Strategy and Partnerships replied that the coordinated and structured approach helped to increase transparency, including for the Council of Governors and the Trust's partners, and supported teams to work better together in a structured way. The Executive Managing Director for Primary, Community & Dental Care Services added that there would be direct and tangible positive impacts for staff: • if the Trust could deliver on the Community Services Transformation Programme, especially as this had been developed from the bottom-up and had a strong 'people' theme with planned improvements around recruitment, retention and how the Trust was as an employer; • through the roll out of IT digital solutions, as already demonstrated by the impact of the rollout of the EMIS system and the improved links with primary care; and • through the plans being developed with Estates.	
d	David Clark, from his perspective as a clinical advisor to NHS England, added an alert from the Treasury's Autumn Statement 2023 relating to a substantial funding uplift to expand NHS Talking Therapies services. He recommended that the Trust start planning to apply for the first wave of funding, for which it would need to demonstrate that the service already had the right staff in place. The Trust Chair and the Executive Director of Strategy and Partnerships thanked him and noted that the Talking Therapies Team would be involved.	
e	Philip Rutman referred to the report, at slide 17, and the 4 red-rated priorities for the Forensic Services Directorate in relation to Local Workforce Strategy, review of the Delivery of Care, scoping for future provision of specialist services and the Intensive Intervention & Risk Management Service. He asked for assurance that these items were being addressed with sufficient vigour and confidence. The Executive Managing Director for Mental Health, Learning Disabilities and Autism replied that there were regular reviews of the service's strategy and performance (with one due next week) along with ongoing oversight of the service; he was assured by what the service was delivering and would review the ratings in the Annual Plan as the red-ratings may not be reflective of the activity currently taking place.	**RB**
f	Further to queries from Andrea Young, the Executive Director of Strategy and Partnerships noted that: • an Executive review of corporate services had commenced and would be complete by March 2024. Optimising corporate services was one of the key enablers to support the Trust's Strategy development work; and • thematic reporting across directorates should be available from March.	
g	Mohinder Sawhney welcomed the work taking place to develop thematic analysis across directorates from March. She also encouraged the Board to consider how to triangulate data across different sources, for example in relation to how comparative	

	data in this mid-year review of the Annual Plan at BOD 73/2023 corresponded with data in the Integrated Performance Report (**IPR**) at paper BOD 75/2023. She commented upon how the Annual Plan data for the Forensic Service demonstrated no green-rated priorities whilst the Forensic Service also led the table in the IPR on vacancy and turnover rates. The assurance provided above by the Executive Managing Director for Mental Health, Learning Disabilities and Autism had been helpful but it would also have been useful and more digestible for the Board if this analysis had taken place earlier. The Chief Nurse recommended caution when using RAG ratings as these could be simplistic; for example the Neurodevelopmental pathway in Oxfordshire was green-rated due to good progress with planned actions but there were still long waiting lists for this service and those two positions may not correlate well with each other from an external perspective.	
h	Mohinder Sawhney referred to the SEND inspection report, discussed at item BOD 105/23(c) above, and noted that it would be useful to reflect upon any specific learning for the Trust, once considered by the Quality Committee.	
i	Mohinder Sawhney also asked about the strikingly lower than contracted rates of bed occupancy in Eating Disorders and Forensic Services, which was contributing to the overall £0.7 million adverse position for Mental Health directorates. The Chief Executive replied that lower bed occupancy across Trust wards was not necessarily a negative and this could be a positive indicator if the Trust was supporting patients into less restrictive settings. Culturally, the Trust also needed to move away from a growth mindset towards an improvement mindset and to start addressing this as part of its planning for next financial year. David Clark commented upon a greater focus on quality and noted that the Treasury's Autumn Statement was explicit on expanding the NHS Talking Therapies workforce in order to maximise outcomes for patients by providing more therapy sessions.	
j	The Trust Chair commented upon the cultural shift which would be required to evolve from a growth to improvement mindset and looked forward to ideas upon how to embed that approach in 2024/2025.	
k	**The Board noted the report.**	
BOD 108/23	**Research & Development (R&D) report**	
a	The Chief Medical Officer presented the report at BOD 79/2023 which provided an update on: (i) the Biomedical Research Centre (**BRC**) in its first year of implementation; and (ii) the governance of the Mental Health Mission (**MHM**), with assurance that appropriate governance processes were in place. The Trust's BRC Steering Committee, chaired by the Chief Medical Officer, would act as the key committee for MHM reporting to the Board and the National Institute for Health and Care Research (**NIHR**).	
b	The Trust Chair reiterated the importance of academic research in supporting clinical need and improving the interventions and therapies that could be offered to patients. Whilst commending the Chief Medical Officer's involvement, he asked how other Board colleagues could also become involved in R&D governance and BRC leadership.	

c	The Chief Medical Officer replied that although only one directorate (Forensic Services) had included R&D amongst their objectives, the aim was for all directorates to identify an R&D objective. Work was also taking place to develop more clinical academic posts which would support more delivery of innovations from early stage research.	
d	Mohinder Sawhney noted that she had been delighted to attend the BRC showcase event on 04 October 2023 and gain an oversight of developments so far. However, not many Trust colleagues had been in attendance at the event and she wanted to encourage more frontline clinical staff to participate in R&D and for the Trust's distinctive experience to be more present at such events.	
e	Mohinder Sawhney referred to page 5 of the report and asked for more detail on the BRC underspend. The Chief Medical Officer explained that 3-4, out of 12, themes were underspent as they were behind in recruitment to posts to deliver the research; this was being addressed as it was important for themes to deliver against plan and any unallocated spend would otherwise revert to the NIHR.	
f	The Chief Finance Officer agreed with the importance of mainstreaming learning and research and creating the right culture for this. The Annual Planning process was helping to bring R&D considerations into operational teams. She also acknowledged the work of the Chief Nurse's teams and their strategic approach to sharing learning across the organisation from clinical audits, Quality Improvement (**QI**) and R&D. The Chief Nurse noted that the Trust still had work to do in order to improve the translation of research into clinical practice, especially from a Nursing and Allied Health Professionals (**AHP**) perspective. However, she noted that both the Nursing Strategy and the AHP Strategy were being reworked at present and R&D was a common theme in both. The Chief Medical Officer emphasised the importance of linking R&D activity with QI and noted that if a team was experiencing service delivery issues, local and national research would be reviewed for learning and there would be consideration of how to apply QI methodologies to implementation.	
g	David Clark also offered the Chief Medical Officer his support and experience in translating research into practice. The Chief Medical Officer added that thought was also being given to how to involve the Board more in R&D as a delivery mechanism for service change and transformation, not just its governance. The Chief Executive added that he and the Trust Chair would also be attending a meeting with the R&D team and could start considering this.	
h	Andrea Young commented upon the importance of developing a pipeline of research Nurses and AHPs and for the organisation to be able to support these through bursaries and part-time research opportunities which fitted in with their career development; she noted that the Trust needed more structure to this.	
i	**The Board noted the report.**	

BOD 109/23	**Winter Resilience Plan and Community Services Transformation Programme**	
a	The Executive Managing Director for Primary, Community & Dental Care Services presented the report at BOD 74/2023 which provided updates on: the 2023/24 Winter Resilience Plan; (ii) the structure and workstreams for the Community Services Transformation Programme; and (iii) the resources now in place for the Transformation Programme. He explained that the Winter Resilience Plan and the Community Services Transformation Programme were linked as the plans in place for winter were also part of the ongoing long-term Transformation Programme. ***Winter Resilience Plan***	
b	Further to the details in his report, he confirmed that high-impact priority interventions from national urgent and emergency care recovery plans had been factored into the Trust's local plans. The Trust had also continued to build on its systems for responding to events and surges in pressure. In particular the 2023/24 Winter Resilience Plan had delivered: (i) a local escalation daily reporting dashboard – for daily reporting on bed states, pressures and any escalations to the Trust, Oxford University Hospitals NHS FT (**OUH**), primary care, social care and ICB partners; and (ii) a Transfer of Care Hub together with OUH and adult social care teams to help match patients to available beds and reduce delayed discharges. Over the past few months this has significantly reduced delayed discharges and over the summer delayed discharges were down to single figures, whereas last year there were up to 50 delays at any one time. ***Community Services Transformation Programme (CSTP)***	
c	System working across partners remained a dominate theme in the CSTP and the Trust was continuing to develop the Single Point of Access (**SPA**) to support a more integrated approach to Health and Social Care in Oxfordshire. A partnership between the Trust and OUH had also been agreed to provide a consistent countywide Hospital at Home service to support adults and older adults in their own homes, launching in December 2023. Work had also started to establish Integrated Neighbourhood Teams, further to the Fuller Stocktake report on primary care integration; these teams would focus on preventative care for individuals living with multiple health conditions.	
d	He explained that the CSTP was operating with the following workstreams (as set out in more detail in the report): Start Well (for children and young people); Live Well (adults); and Age Well (older adults with complex needs including frailty). Transformation Leads had been appointed for each of these workstreams and reported to Sue Butt, Transformation Director for Primary, Community & Dental Care.	
e	The Chief People Officer noted that the CSTP would impact upon staff (for example in relation to rosters, location and nature of work) and success of the CSTP would require early engagement with staff; she confirmed that this engagement with staff was about to commence with a Union meeting tomorrow. ***Q&A***	

f	Andrea Young supported the direction of travel set out in the report and the shared ways of working with other local organisations. She noted that the Quality Committee could also have a role in ongoing oversight of the CSTP. She asked whether the Board needed to formally sign-off on the Winter Plan. The Chief Executive replied that the Buckinghamshire, Oxfordshire and Berkshire West (**BOB**) Integrated Care Board (**ICB**), rather than the Board, needed to assure NHS England on Winter Planning. The Chief Medical Officer added that the Board's support would, however, be important to show commitment to the team and the principle of partnership working, especially at a time when there were significant waiting lists.	
g	Philip Rutnam asked: (i) about the level of risk associated with this winter season (whether this could relate to COVID-19, flu or other viruses); (ii) what mitigations were in place; and (iii) the wider system's capacity to deal with a higher level of challenge if assessment of the risks for this winter season were underestimated. The Executive Managing Director for Primary, Community & Dental Care Services replied that, although waiting lists were significant in acute and urgent care services, overall services and the wider system was better placed than last year and better at working collectively together. There could be emerging risks around the build-up of respiratory infections and relatively low vaccination rates, which could have been impacted by people becoming 'vaccine tired' after the efforts of the past few years, and there was the potential for a surge in respiratory illness to be challenging.	
h	**The Board noted the report.**	
BOD 110/23	**Integrated Performance Report (IPR)**	
a	The Executive Director of Strategy & Partnerships introduced the report at paper BOD 75/2023, accompanied by supporting material at RR/App 56/2023, which provided: i. a summary of performance against the NHS National Oversight Framework and Southeast regional performance including Provider Collaborative performance; ii. Directorate highlights and escalations from the Executive Managing Directors; iii. delivery of the Trust's Strategic Objectives using the Objective Key Results (**OKRs**) and with narrative from Lead Executive Directors; iv. the Finance report; and v. the Quality & Safety Dashboard, showing quality and workforce indicators, at RR/App 56/2023.	
b	She highlighted: • good overall performance against the NHS Oversight Framework except for the increase in inappropriate Out of Area Placements (**OAPs**); • removal of completion of Personal Development Reviews (**PDRs**) due to the good improvement trajectory; • some inconsistency in reporting of agency targets had been identified. Therefore, for the purposes of this meeting, the most accurate financial position at Month 7 could be found in the finance report at paper BOD 75(iii)/2023; and • the Board's recent work to refresh the OKRs and define meaningful metrics to report in the IPR, with a view to developing a new format for the IPR in 2024.	

c	She provided an update on the ongoing impact of the clinical systems outage from August 2022, which had resulted from a failure with third party supplier-hosted patient record systems. Although some data remained unavailable to report, it had become possible to restart national reporting of some Mental Health data and progress was being made to restart reporting on inpatient and community services data. The IPR to the next meeting should have more reporting available but there would still be data gaps, to be phased out gradually, in relation to: when data had not been entered retrospectively; and where the Trust was still in the process of embedding new clinical systems and switching on functionality (until systems were fully functional, some data may not be captured). ***Directorate highlights and escalations from the Executive Managing Directors***	
d	In response to a question from Andrea Young on any seasonal opportunities to plan in advance for potential increases in OAPs, the Executive Managing Director for Mental Health, Learning Disabilities and Autism replied that there was no clear seasonal pattern but there was a constant demand on bed capacity which required continuous planning. OAPs would fluctuate over the year and between counties. The work of the Patient Flow Teams was, however, beginning to have a positive impact on supporting clinical teams to ensure that patients were cared for in the right place. He reminded the Board that the Trust had a comparatively low bed base compared to other trusts and that it aimed to maintain a low level of bed occupancy.	
e	David Clark referred to the ongoing impact of the clinical systems outage and asked whether there were now secure back-up systems to ensure that the organisation could not be impacted similarly again. The Executive Managing Director for Mental Health, Learning Disabilities and Autism replied that a different provider had now been procured but the Trust, like other organisations, was still using an externally-provided system. The Chief Finance Officer added that the Trust also still required some access to the previous legacy systems but the former provider had increased their security. In relation to the new provider, they had been subject to detailed cyber security assessment to test their security before the Trust contracted with them. She would provide David Clark, out of session, with recent cyber security reporting to the Audit Committee and any other relevant assurance on the new Electronic Health Record system and on the Trust's access to the legacy system.	**HeS**
f	The Executive Managing Director for Primary, Community & Dental Care Services referred to the report and highlighted: • the successful tender for the 0-19 service in Oxfordshire and progress developing the operational plan and reconfiguring teams into locality teams to form an integrated team around a local community; • the Oxfordshire SEND inspection report and ongoing work with partners to support the action plans. He had also offered to chair the group that reviewed transitions for children and young people; and • the ongoing development of EMIS.	

g	He noted that pressure points remained in relation to Out of Hours services, Podiatry, District Nursing and to support managers to adapt to new arrangements with temporary/sessional staffing from NHS Professionals.	
h	In response to questions from Mohinder Sawhney on: • any specific learning for the Trust from the SEND inspection report, the Chief Executive replied that he and the Executive Managing Director for Primary, Community & Dental Care Services had commissioned an internal group to review what improvements could be made beyond the system-based focus of the report; and • NHS Professionals, the Chief Nurse replied that staffing fill rates had improved under NHS Professionals compared to the previous arrangements through the Trust's Staffing Solutions staff bank. However, the process for accessing temporary staff was different and had taken time to embed; this had been a significant cultural shift for individual workers (who now also had to comply with NHS Professionals' compliance requirements) and teams. The Director of Clinical Workforce Transformation was continuing to work closely with NHS Professionals on the implementation.	
i	Lucy Weston asked the Board to reflect on whether the issues brought to light by the SEND inspection report would have become apparent through the Trust's existing mechanisms, such as performance reporting and risk management. If not, it may be necessary to consider whether the Board was spotlighting the right areas or getting sidetracked by national priorities such as OAPs. The Executive Director of Strategy & Partnerships agreed that a more aggregated view of performance was required and noted that she had started to work with both the Executive Managing Directors on reporting on performance across the Trust and bringing more insights to the Board.	
j	Philip Rutman reflected upon reporting from earlier in the year, on staff shortages within the Speech and Language Therapy (**SaLT**) service and the impact upon provision of speech therapy for young children, and asked whether there had been any improvement in this area.	
k	The Executive Managing Director for Primary, Community & Dental Care Services responded that there was a close link between SEND and SaLT services which often provided services to the same young service users. The recruitment challenge in the SaLT service remained but would be addressed through the wider SEND plans.	
l	Philip Rutman also commented upon the pressure which District Nursing teams were under and the reported deferral of appointments. He asked if there was anything else to be done in support. The Executive Managing Director for Primary, Community & Dental Care Services explained that the District Nursing service daily received 1200 requests for visits whilst having capacity for approximately 750 visits each day, therefore 30% of visits had to be rescheduled. However, the District Nursing service was currently well staffed, especially further to successful international recruitment, and good quality care was being provided with a low level of pressure-related incidents. The capacity issue related to the service not having grown at the same rate as the population and the shift to providing more care at home rather than in an acute setting. Work was	

	taking place with other community trusts in the BOB region to seek more investment. Philip Rutman noted that the Board may need to assist in persuading the BOB ICB to identify this as one of its priorities for the new financial year. ***Strategic Objective 1: Quality – deliver the best possible care and outcomes***	
m	The Chief Nurse highlighted: • there had been significant reductions in use of prone restraints which was positive, although there was still further progress which could be made; • continuing focus was needed to support recording of clinical supervision therefore an external service had been commissioned through the National Scheme of Professional Nursing advocates to provide further support; • although the Lester Tool data reported was somewhat old, she was reassured that spot checks were taking place within directorates to check completion of the Lester Tool for people with enduring Serious Mental Illness (**SMI**). However, this may still be a challenge in Adult Mental Health teams, especially as life expectancy for people with SMI had not significantly shifted; and • the Oliver McGowan autism training had been rolled out, with completion at 65%. This would now become part of all staff training requirements. ***Strategic Objective 2: People – be a great place to work***	
n	The Chief People Officer highlighted: • progress with mandatory training (90% against a target of 95%) and PDRs, although recording of clinical supervision had flatlined at around 70%. Changes had been made to make it easier to record supervision including allowing administrators to record group and individual supervision on the clinician's behalf, in a single step. This would remain a focus for the year ahead; • overall agency spend was reducing. The financial forecast for agency spend at year end was £35.5 million against a target of £32.2 million and ongoing interventions (such as international recruitment) may reduce this spend closer to target. This was the biggest reduction in agency spend for 4-5 years; • overall staff sickness had reduced but may fluctuate during the winter months; and • reduction in turnover although this was also a national trend. Going forwards, there would be focus upon staff retention and the employee experience, with a potential bid for funding from NHS England to focus on staff retention.	
o	**The Board noted the report.** *The meeting took a break for 5 minutes and resumed at 11:13.*	
BOD 111/23 a	**Patient Story - Children's Integrated Therapies - Occupational Therapy Sensory Pilot (Oxfordshire)** The Chief Nurse introduced the team from the Children's Integrated Therapy service (Kathryn Stevenson, Karen Pinel, Nicole Robinson, Emma Croft and Emma Leaver) and the parent who was attending to present their story. The background and information on the Occupational Therapy Sensory pilot was set out in the report at paper BOD 78/2023. The Sensory pilot aimed to support children, families, teachers and carers to	

	understand and implement strategies to manage sensory processing and self-regulation difficulties and to enhance participation in learning, play and leisure.	
b	The parent described their experiences with their child and their challenges in dealing with various environments. The Sensory pilot had provided the parent with a better understanding of their child's struggles, together with regulation techniques to prepare the child better to cope with tasks and the world around them. The positive difference for the child had been significant; they were now like a different child and could talk, respond, ask for what they needed and attend school well-regulated and set up for the day. The parent had also been able to support and educate their child's teachers, using the skills that they had learned from the Sensory pilot.	
c	The Trust Chair asked whether external funding would be required in order to expand this service and the pilot. Emma Leaver confirmed that this was part of discussions already taking place on how to re-focus these services, further to the outcome of the SEND inspection in Oxfordshire.	
d	Lucy Weston commented upon how impressive the pilot had been and the positive feedback which the service had received. She emphasised the importance of such Early Intervention work for parents and teachers, noting how supporting children with regulation helped them to remain in school. However, given the co-morbidities and other neurodevelopmental conditions which such children could also have, it may be crucial for this kind of service to be linked into wider service provision and for the Trust to consider its resourcing.	
e	**The Board thanked the parent for their story and the wider team from Children's Integrated Therapies.** *The team from Children's Integrated Therapies left the meeting*.	
BOD 112/23	**Finance Report and Strategic Objective 3 - Sustainability**	
a	The Chief Finance Officer reflected upon the section on Strategic Objective 3, Sustainability, in the report at paper BOD 75(ii)/2023, and highlighted overall favourable performance against the financial plan and that work was continuing on the next phase of the Green Plan.	
b	The Chief Finance Officer presented the more detailed Finance report at BOD 75(iii)/2023 which set out that the Month 7 position was a surplus of £2.8 million, which was £1 million favourable to plan, and that the financial forecast was still for a surplus of £3.2 million (on plan). She singled out two areas which would impact overall performance: • agency spend which, at Month 7, was £22 million. As referred to at item BOD 110/23(n) above, agency spend after anticipated improvements from the ID Medical and NHS Professionals contracts was forecast at £35.5 million against an agency target from NHS England of £32.2 million; and • the Cost Improvement Programme (**CIP**) which had delivered £4.9 million to date against a year-end target of £7.2 million. The Trust also had a £11 million	

	Productivity Improvement Programme (**PIP**) target to be met through a reduction in temporary staffing spend. Reasonable progress was being made on CIPs and PIPs; CIPs in particular would be subject to renewed focus further to appointment to a new internal post to improve tracking and development of plans and making them recurrent.	
c	**The Board noted the report.**	
BOD 113/23	**Board Committees' update reports and recommendations**	
a	The Trust Chair thanked the Committee Chairs for their 3As reports on matters for Alert, Advice and Assurance, noting that these were available for the November meetings of the Audit Committee, the Charity Committee, the Finance & Investment Committee, the People, Leadership & Culture Committee and the Quality Committee at papers BOD 76(i)-(v)/2023, together with supporting Committee minutes and agendas at RR/App 57-62/2023. The reports and supporting minutes and agendas were taken as read.	
	Audit Committee recommendation - Emergency Planning annual report	
b	The Director of Corporate Affairs & Company Secretary presented the report at BOD 77/2023 and explained the NHS Emergency Planning, Resilience and Response (**EPRR**) self-assessment included in the annual report. This had been reviewed by External Audit and recommended by the Audit Committee.	
c	The Trust Chair noted that the emergency evacuation at the Fulbrook Centre, referred to at item BOD 105/23(a) above, had been a demonstration of effective Emergency Planning. The Director of Corporate Affairs & Company Secretary agreed but noted that there was still learning to be taken from the experience. Lucy Weston, in her capacity as Audit Committee Chair, added that there had been perhaps a few too many opportunities to test Emergency Planning over the years, including the COVID-19 pandemic and the Audit Committee had been assured that there were robust Business Continuity and Emergency Planning procedures in the Trust, with impressive staff engagement and proactive approaches demonstrated, even with limited central resource.	
d	**The Board noted the 3As reports and APPROVED the NHS Emergency Planning, Resilience and Response (EPRR) core standards self-assessment as described in the Emergency Planning annual report.**	
BOD 114/23	**Journey to Excellence update**	
a	The Chief Nurse introduced the Head of Clinical Standards & Excellence and the Associate Director of QI & Clinical Effectiveness who gave a presentation on the Journey to Excellence programme and progress since its launch in 2021 to support teams and services to learn, improve and deliver consistently good care. The programme provided a framework for learning from the key elements of outstanding trusts, with continual learning through QI methodology. The various projects within the programme had also been aligned with the Trust's 4 Strategic Objectives (Quality, People, Sustainability and	

	Research). The areas to focus on included: further engaging staff across the Trust to drive continuous improvement; mapping achievements; understanding and scoping gaps; supporting staff to understand what standards were expected and how to measure delivery; making the Journey to Excellence programme a collaborative effort which was everyone's business; preparing for inspection and supporting teams to demonstrated compliance; and embedding a culture of co-production.	
b	Chris Hurst commented upon the journey which the Trust was on through this programme and the positive impact upon patients as it progressed. However, it also caused him to reflect upon unmet needs and challenges such as the demands upon the District Nursing service discussed at item BOD 110/23(l) above. The Board needed to be confident about what was in the organisation's power to offer and to reflect upon how effectively this was communicated and how to manage expectations of the local population and provide advice on how they may be able to source other support or support themselves. The Trust Chair endorsed this and noted the link with commissioners to also be responsible for providing resources.	
c	**The Board noted the presentation.**	
BOD 115/23	**Patient Safety Incidents (PSI) report**	
a	The Chief Nurse presented the paper at BOD 80/2023 which summarised the 8 PSIs over September to October 2023, PSI reporting over the past 5 years and the approach to implementation of the national Patient Safety Incident Response Framework (**PSIRF**). The report also provided the final draft of the new incident response plan which would also be submitted to the BOB ICB. The incident response plan and approach to PSRIF had also been reviewed by the members of the Change Programme Board, the Quality Committee, the Executive and Provider Collaborative network leads.	
b	**The Board noted the report and was assured by the new PSI response plan and approach to PSIRF implementation.**	
BOD 116/23	**Freedom to Speak Up Guardians' annual report**	
a	The Freedom to Speak Up Guardians (Lianne Bowes and Rita Bundhoo-Swift) joined the meeting and introduced the report at BOD 81/2023. They highlighted the need for leadership support in raising the profile of the Guardians and securing resourcing; and they asked whether enough was being done to change the culture within the Trust.	
b	The Trust Chair noted that there would be a separate Board workshop on effectiveness of Speaking Up arrangements in early 2024, further to item BOD 103/23(b) above.	
c	**The Board noted the report and that there would be an opportunity to consider the effectiveness of Speaking Up in more detail in early 2024.**	
BOD 117/23	**Corporate Registers: (i) application of Trust seal; and (ii) receipt of gifts and hospitality**	

	The Director of Corporate Affairs & Company Secretary took the reports at paper BOD 82/2023 as read. **The Board noted the reports and confirmed its approval of the application of the Trust seal.**	
BOD 118/23 a	**Any Other Business** None.	
BOD 119/23 a	**Questions from the public and any governors or staff attending.** None.	
BOD 120/23 a	**Review of the meeting** No comments received.	
BOD 121/23 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.	
	The meeting was closed at: 12:04 **Date of next meeting: 31 January 2024**	

Summary of Actions from the Board meeting on 29 November 2023

Relevant Item	Action	Responsibility:
BOD 107/23(a)	**Draft Annual Plan 2024/25 and review of Annual Plan 2023/24** January 2024 Board meeting to include review of the draft Annual Plan 2024/25, whilst the March 2024 Board meeting to include sign-off of the Annual Plan 2024/25 and review of the Annual Plan 2023/24 final position. March reporting will also include reporting on the Corporate Directorate **Status: *complete/on the agenda*** *for the Board meeting in private on 31 January 2024 to review the draft Annual Plan 2024/25. March reporting scheduled – to cover 2023/24 final position and 2024/25.*	AB
BOD 107/23(e)	**Annual Plan 2023/24** Rob Bale to review progress and RAG-ratings against the 2023/24 Annual Plan for Forensic Services in particular, given the currently relatively high number of red-ratings. The current red-ratings may not reflect the work taking place and the activity being delivered. **Status: *in progress*** *for final position of the Annual Plan 2023/24, to be reported in March.*	RB
BOD 110/23(e)	**Clinical systems outage – security of new and legacy systems** To provide David Clark, out of session, with recent cyber security reporting to the Audit Committee and any other relevant assurance on the new Electronic Health Record system and on the Trust's access to the legacy system. **Status: *complete*** *– confirmed over email by the Chief Finance Officer on 30 November 2023.*	HeS

Actions held over from the meeting on 27 September 2023		
BOD 93/23 (l)	**Effectiveness of Speaking Up Arrangements** To organise a workshop/development day to allow further conversation on this. **Status: *in progress*** *– for Board private workshop on 28 February 2024.*	DW/KR
BOD 95/23 (j)	**Board Committees' update reports** Consider options for when to hold a risk workshop and topics on which to focus. **Status: *in progress*** *– for Board private workshop on 28 February 2024.*	DW
Action held over from the meeting on 19 July 2023		
BOD 77/23 (k)	**Experience & Involvement Strategy for Patients, Service Users and Carers – 2023-25** To review the proposed metrics/measurements on "how will we know we are making a difference" as the targets may be too ambitious e.g. on % of patients responding that overall care was very good, from a starting point of 82.5% in physical health services to Year 3 target of 100%, and from a starting point of 62% in mental health services to Year 3 target of 82%. Targets to be reviewed and benchmarked nationally. **Status: *complete*** *– targets re-evaluated and updated version of the Experience & Involvement Strategy presented to the Council of Governors' meeting on 07 December 2023.*	MC

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

BOD 03/2024
(Agenda item: 5)

Board of Directors

31 January 2024

Trust Chair's report and system update

For: Information/ Discussion

Executive Summary

There will be a whole lot of votes to be cast this year. It is highly likely there will be a general election, the timing of which lying within the discretion of the prime minister, so an intensely political decision. By statute elections will also take place for police and crime commissioners, for mayors (including the mayor of Greater London) and for a variety of local authorities including all the metropolitan districts. Near home, half of seats on Oxford Council and a third of seats in Cherwell and West Oxfordshire are being contested and, within the Buckinghamshire, Oxfordshire and Berkshire West (**BOB**) system, there are elections taking place in Reading and Wokingham and there are also seats being fought in Swindon. We must not forget, too, that there are elections for our Council of Governors.

You sometimes hear people bemoaning the part that collective decision-making plays in the National Health Service. Keep politics out of it, they say. But that is not possible. At this macro level, the allocation of public spending to health involves a huge commitment of resources, which inescapably involves values and priorities – as of course does the size of the spending pot, and concomitant decisions about taxation and borrowing. Those choices are the very essence of politics and ideology.

We too make 'political' decisions as, within the NHS totals, allocations are made to different services and, as a provider of mental health and community services, we fight our corner. When the chief executive of the NHS urges us to pay more

attention to inequalities she is expressing a political (value-based) judgement. If rates of illness are higher among certain groups, if certain kinds of people are found more frequently among our patients, the resulting concern stems from a philosophy that highly values fairness and rejects discrimination. Sometimes, in the NHS, we seem to assume deep agreement when in fact those values and judgements are contestable.

As you would expect, in this election year we are keeping open our connexions to incumbent political representative and, if things change, we will make sure new arrivals are invited to visit and get briefed about our services. During recent weeks, we welcomed Robert Court, the Conservative MP for Witney and West Oxfordshire on a visit to the Meadow Unit at the Warneford and, on a different occasion, Anneliese Dodds, the Labour MP for Oxford East to take part in a presentation about the development of the Warneford site, along with colleagues from the University of Oxford.

As the BOB integrated care system evolves, we are becoming more familiar with our councillors. A milestone was passed recently – as discussed in today's Board papers – when the Oxfordshire Health Oversight and Scrutiny Committee accepted plans for the future of the Wantage health hub. It is a badge of pride that town, district and county councillors care deeply about community facilities and perhaps inevitably take some persuading of the case for change. Perhaps it has also been inevitable that these overview committees, in existence for two decades now, find it easier to scrutinise the decisions made by the NHS and other public services than those made by their councillor colleagues. But we welcome their attention and interest.

Let us hope that the value citizens place on the franchise will outweigh any potential electoral fatigue during 2024.

Recommendation

The Board is asked to note the report.

Author and Title: David Walker, Trust Chair

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

2. ***Strategic Objectives/Priorities*** *– this report relates to the following Strategic Objective(s)/Priority(ies) of the Trust:*

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

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

2) People - Be a great place to work

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

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

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

Oxford Health
NHS Foundation Trust

Report to the Meeting of the

Oxford Health NHS Foundation Trust

Board of Directors

31 January 2024

BOD 04/2024
(Agenda item: 6)

Chief Executive's Report

Introduction

This is my first Chief Executive's report of 2024 and, as such, I thought I would devote some of it to looking ahead to the new year. Before I do, I'd like to start with a few lines on recent events over the previous month or so.

First, I'd like to express my thanks to colleagues who covered shifts or were involved in planning to keep patients safe and services responsive during junior doctors industrial action earlier in January. There was minimal impact on the Trust's services and this was largely due to the commitment and efforts of staff across the organisation. The Trust continues to work closely with the Local Negotiating Committee and with colleagues in the Integrated Care Board when planning for medical colleagues industrial action.

I'd also like to mention the Trust's recently signed Sexual Safety charter – this is an important document committing the Trust to a zero-tolerance approach to any inappropriate, unwanted and/or harmful sexual behaviours towards the Trust's patients, service users and staff. The charter is structured around a number of principles that set out commitments to providing support and training, setting standards and reporting processes, and capturing and using data relating to sexual safety. The Trust's Health & Wellbeing and Safeguarding teams have been working together to identify key actions that will enable the Trust to meet the obligations of the charter.

Lastly, I was pleased to hear that the Oxfordshire Joint Health Overview and Scrutiny Committee met earlier this month to review proposals developed for the future of Wantage Community Hospital and unanimously supported the recommendations for the site. With this support, the Trust will work with the community and other NHS partners to implement

plans to refurbish parts of the hospital and apply for funding to expand the offer of clinic-based services. There is a dedicated item on the January Board agenda on this so I will leave it there for a fuller update.

Looking ahead

Each new year is a busy time for NHS providers as the winter season puts pressure on local systems. However, the ongoing commitment and innovation of Trust staff is always inspiration and a reason to be positive. Looking ahead, there is much that the Trust will be focusing on over 2024 and I'd like to mention just a few below.

Firstly, work is currently underway to develop the Trust's Annual Plan for 2024/25. This is a comprehensive process and I'd like to thank all representatives from the Trust's directorates for their time generating the plans and the Trust's planning team for establishing a coordinated process. The Board of Directors and governors will be reviewing finalised draft plans over the coming months so I won't say much more at this stage but the following paragraphs note just some proposed areas of focus.

There are a number of key priorities for the Primary, Community & Dental Services directorate including: the development of sustainable children and young people service and community rehabilitation pathways; establishing a sustainable model for Adult Community Nursing (District and Specialist); and the continued development of the Thames Valley Community Dental Services Partnership.

For Buckinghamshire mental health services, there will be a focus on the development of three Mental Health Primary Care hubs to enable closer working between mental health services, primary care networks (PCNs) and social care and working in partnership with the voluntary sector. The hubs will include embedding talking therapy workers, developing the physical health outreach offer and improving provision for eating disorder patients. The directorate will also be working on an inpatient improvement programme and remodelling of the two main pathways in the county for child and adolescent mental health.

In mental health services for Oxfordshire and BaNES, Swindon and Wiltshire (BSW). In Oxfordshire and BaNES, Swindon and Wiltshire mental health services, the coming year will see a focus on reviewing models and pathways of care (including crisis resolution and home treatment, and continuing with the development of the Brain Health Centre); continuing to develop community-based health services including via partnership integration; and reviewing current use and allocation of the medical workforce across the directorate. In Oxford in March, the Trust's new Psychiatric Intensive Care Unit (PICU) will be formally opened by Oxford East Member of Parliament.

In Forensic services, the expansion of the Specialist Community Forensic Team (SCFT) will continue over 2024 as planned, including a particular focus on recruitment of social workers

working with the partners across the provider collaborative. The key aim of the SCFT will be to continue to support the safe transition of high risk patients from secure inpatient services into the community, and reduce unnecessary readmissions to secure inpatient care and reduce lengths of inpatient stays while continuing to ensure robust public protection.

2024 will be a significant year for the Trust's estate. Following the signing of the Conditional Option Agreement and Memorandum of Understanding with the University of Oxford late last year, the planning permission process for a new Warneford Park hospital will begin over of the year. If plans are approved, the Warneford Park site will provide a new mental health hospital alongside a major brain health research and innovation campus.

The Trust will also begin work this year on setting up further Community Health hubs in Oxfordshire following Board approval for capital funding in November 2023. Two of the hubs will be refurbishments of existing Trust sites in East Oxford and Blackbird Legs but a new north Oxford site will be established at Jordan Hill providing accessible and sustainable bases for healthcare delivery and for staff to work from.

Furthermore, the first half of 2024 will see the election of governors for the Trust's Council of Governors. Governors play a key role in representing the Trust's membership, who elect them, and the wider public and in working with and holding non-executive directors to account. The poll for voting will open in late April and close in late May with the intention of having results declared in time for the 12 June 2024 Council of Governor's meeting. As well as public, service user and carer governors, there are also staff governors and I'd encourage any colleagues interested in becoming a staff governor to look out for further internal communications on this.

Lastly, from a personal perspective, I'd like to say how much I've enjoyed getting to know a broad range of Trust colleagues and services in my first 7 months as Chief Executive. In this time I have sought to focus on communication and to understand what matters most to people across the Trust so that I can reflect this to Executive and Board colleagues. This is vitally important so that I and Trust leaders can focus attention and resources where it matters most to our colleagues and the people we serve.

My best wishes for 2024.

Grant Macdonald, Chief Executive

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

BOD 05/2024
(Agenda item: 7)

Board of Directors

31st January, 2024

Corporate Affairs Update Report

For: Awareness and Assurance

Executive Summary

The Reading Room contains the detail of this regular report to inform the Board of Directors on recent legislation, regulation and compliance/policy guidance issued by bodies such as NHS England, the Care Quality Commission, and other relevant bodies. It highlights where their action/publications have a consequential impact on the Trust or an awareness of the change/impending change is relevant to the Board of Directors and its committees' business. This report covers the period since the last report to Board and includes any noteworthy contributions covered by health think tanks and a section in the Addendum on learning / 'True for Us' considerations.

With regard to the concept of 'True for Us' and the section in the report; I continue to remind Board members, that the effects of corporate failure cast a long shadow forward. In consequence each failure of a business becomes magnified in terms of the analysis of its impact. The responsibility to avoid corporate failure lies with the directors who may or may not be able to take evasive action. Failures contribute significantly to the collapse of confidence in the Trust but importantly, understanding them supports us to improve and prevent recurrence, and also helps enhance the effectiveness of risk and controls management. The process of reviewing the failings of other organisations can achieve the same and supports identification of warning signals to drive the ongoing learning and development of successful mitigating actions.

Risk Management

The Code of Governance for the NHS replicates Provision 28, UK Corporate Governance Code (July 2018) 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 January 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 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. Board members should pay particular attention to the TRR also, in order to challenge constructively if it captures the realities of operational delivery and so that in aggregate the Board is able to consider wider impact and challenge any contradictions.

The FIC and PLC committee were alerted to recommended closures of risks on the TRR at their January meetings, and the February meeting of the Extended Leadership Committee will approve removal of risks accordingly as part of their oversight of the operational risks monitored through the TRR. As previously reported, a deeper review of the strategic objectives and associated risks will be conducted and this is scheduled for the February 2024 Board workshop.

The main changes from the last Board reporting at the end of November are as follows:

- BAF 2.6 (Adequacy of Staffing) formally replaces former BAF risks 2.1 (Workforce) and 2.2 (Recruitment) which have now been archived from the current version of the BAF; BAF 2.6 is an extreme/red-rated risk. BAF 2.6 is a new risk which has been developed through the People, Leadership & Culture (PLC) Committee since April 2023 and was approved for inclusion and publication on the BAF at the PLC Committee's most recent meeting on 17 January 2024; it is still work in progress and will be subject to further refinement through the Chief People Officer and the PLC Committee, as well as being subject to comments from the Audit Committee at its next meeting in February 2024. BAF 2.6 aims to achieve greater interconnectivity between the Workforce and Recruitment themes and mitigations and to tie in with the evolving work around Temporary Staffing;

- BAF 2.5 (Retention) currently retains its high/orange-rating. Whilst the PLC Committee discussed whether to increase the rating, it was decided to retain it at a high/orange level for the time being but for this to be kept under review and for Retention to be considered in more detail by the PLC Committee;

- BAF 2.3 (Succession planning, organisational development & leadership development) – most recent updates highlight that Personal Development Review (PDR) compliance is maintaining a steady improvement trajectory with a 91% compliance rate as at October 2023 but still below the overall target of >95%; and

- the PLC Committee and the Finance & Investment Committee have been able to review their risks at their recent meetings in January 2024 and other Board Committees are due to review theirs over February-March and by the next Board meeting at the end of March. The Executive will also be considering Trust Risk Register risks and potential inclusions and closures which Committees which have met have been alerted to.

As such, the Trust's extreme/red-rated risks continue to relate to workforce, recruitment, financial sustainability and major projects; which are themes previously identified to Board as being consistent with current and emerging health sector risks as benchmarked by the Trust's previous Internal Auditors, PwC, and as played out in various reports included in the body of this update.

Impact Reporting – Corporate Affairs

Ongoing iterations of the update report will include wider corporate affairs updates as considered pertinent/useful in the prevailing circumstances.

- **Communications, Involvement and Engagement**

A detailed report is available in the Reading Room at RR/App 02(iv)/2024, but again, a very busy period supporting the communications and engagement activities across the Trust.

- **Charity, Involvement & Volunteering**:

The Reading Room contains the detail of our project focus on Oxford Health Arts Partnership with the presentation of our Annual Report. Oxford Health Arts Partnership (OHAP) is an award-winning program that delivers *Creative Health* through Art and Nature for Oxford Health NHS FT, supported by Oxford Health Charity (OHC). This report highlights some of the work the team has delivered during 2023 - the second year of the OHAP 2022-2026 strategy. Special thanks to Julie Pink's leadership and the hard work of Tom Cox, Angela Conlan and Laura McCarthy. I hope Board will agree with me that this is another really positive report and a great showcase of the impact this part of my team is having on improving the experience of those receiving and giving care across the Trust.

Compliance matters and prospective analysis

The Legal Regulatory and Policy Update Report is designed to reflect changes in legislation, guidance, the structure of the NHS, and government policy and direction on health and social care. A summation of the change is provided for each item and where relevant, a sense of the Trust's position with regard to the change. **The Board of Directors is invited to consider and note the content of the report and where relevant, members should each be satisfied of their individual and collective assurances that the internal controls in place to deliver compliance or improvement against any Trust's obligations are effective.** The Appendix should, on a risk basis, prompt consideration of the need to commission any deep dive (or 'true for us' reviews) in order to enhance the level of assurance or to improve the control environment, and/or decisions about the focus of any relevant Board Committee.

The Executive team meeting' focus will where relevant ensure Executive Directors are aware of the changes related to their portfolios and will take forward any key actions arising from the Legal, Regulatory and Policy Updates. Progress updates on any relevant actions will be

reported to the Board of Directors, as pertinent and appropriate either through the report itself or via the relevant routine Board reports of individual Executives or Board committees.

The principal Committee meetings of the Board are aligned to the cadence of the Board calendar, with the Chair of each Committee providing the Board with their latest updates and recommendations for approval. Following the final report of the Good Governance Institute as part of the external review against the Well Led framework into quality governance, the Chair of each Committee has since November 2022 adopted a 'Three A's' approach to upward reporting to Board (Advice, Alert, Assure). In addition to the matters in this report, the Board will need to use the Committee Chair's updates to also influence its identification and assessment of new/emerging risk and its own assessment of gaps in control or assurance.

Early consideration of matters in this report supports a prospective understanding of risk and opportunity. Chairs and members of Board Committees should consider whether more detailed assurances relevant to their committees, are necessary, utilising this report as a constructive stimulant to inform the composition of meeting agendas and reporting/assurance focus as necessary or appropriate.

In this month's Legal and Regulatory Update, similar to my last report there has been a less significant number of legal and regulatory matters of import to the Board than in recent periods, but a rather worrying array of concern and no doubt far reaching impact for governance and management regulation continues, and the David Fuller inquiry (phase 1 governance and management) is a case in point and referenced later.

Health Service scrutiny - The 2022 Act established local authorities as mandated members of the ICB, giving local authorities a greater voice than ever before in NHS decision-making. Local authorities are also mandated members of the integrated care partnership (ICP), tasked with developing an integrated care strategy to address the health, social care and public health needs of their system.

The section in the reading room alerts Board that Health Overview and Scrutiny Committees' (HOSC) powers of referral have changed, and from 31st January, the Secretary of State has a general power to direct a call-in for any reconfiguration proposal. This power allows the Secretary of State to call in and take any decision on a reconfiguration proposal that could have been taken by the NHS commissioning body. The Secretary of State will be able to use this call-in power at any stage of the reconfiguration process and will enable the Secretary of State to determine a way forward for challenging reconfigurations.

On a related matter, the Department of Health and Social Care (DHSC) has published **Reconfiguring NHS services - ministerial intervention powers** ('the 2024 statutory guidance') to provide NHS commissioning bodies (ICBs and NHS England) and NHS providers (NHS trusts and NHS foundation trusts) with practical guidance on the new process for ministerial intervention in reconfiguration of NHS services. This includes setting out the considerations the Secretary of State will take into account when deciding whether to use the call-in power.

Local authorities' powers of referral to the Secretary of State have been removed. Instead of the referral power, health overview scrutiny committees and other interested parties can write to request (via a call-in request form) that the Secretary of State consider calling in a proposal. DHSC expects requests only to be used in exceptional situations where local resolution has not been reached. Such a request will then be considered as set out in the statutory guidance.

Where there are concerns about proposals for substantial developments or variation in health services (also referred to as 'reconfiguration' for the purposes of this guidance) local authorities and the NHS commissioning body should work together to attempt to resolve these locally if at all possible. If external support is needed, informal advice is available from the Independent Reconfiguration Panel (IRP). In considering substantial reconfiguration proposals local authorities are required to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on the sustainability of services, as well as on their quality and safety.

Additionally, the report in the Reading Room highlights that the **statutory duty of candour** is under review which by way of reminder, is about people's right to openness and transparency from their health or social care provider. It means that when something goes wrong during the provision of health and care services, patients and families have a right to receive explanations for what happened as soon as possible and a meaningful apology. The duty of candour applies to all health and social care providers that the Care Quality Commission (CQC) regulates and has applied since 2015.

It puts a legal duty on health and social care providers to be open and transparent with people using services and their families and sets out actions that providers must take when a 'notifiable safety incident' happens. Notifiable safety incidents:

- are unintended or unexpected;
- happen during the provision of an activity the CQC regulates;
- are incidents that - in the reasonable opinion of a healthcare professional - could, or already appear to have, resulted in death or severe or moderate harm to the person receiving care.

As soon as a notifiable safety incident has been identified, organisations must act promptly. The CQC regulates compliance with the duty. Failure to comply can result in enforcement activity ranging from warning or requirement notices to criminal prosecution.

Commissioner guidance for adult mental health rehabilitation inpatient services is another relevant addition to the Reading Room report, underpinned by the overarching commissioning framework for mental health inpatient services. It draws on the following learning, standards and guidance:

- GIRFT (2022) Mental health – rehabilitation national report
- NICE (2020) NICE guideline [NG181] Rehabilitation for adults with complex psychosis
- Royal College of Psychiatrists (2022) Standards for inpatient mental health rehabilitation services, 4th edition
- Royal College of Psychiatrists (2023) Standards for mental health inpatient rehabilitation services for adults with a learning disability
- NHS England (2019) Community mental health framework for adults and older adults

This guidance is for those who have commissioning responsibility for the mental health needs of their local population, recognising that commissioning can be carried out by different individuals and organisations, separately and collaboratively, and it can be delegated depending on local arrangements. The commissioner of mental health rehabilitation inpatient services could be:

- an integrated care board (ICB)
- a provider collaborative
- an NHS-led provider collaborative

The scope of this guidance is mental health rehabilitation inpatient services for all adults and older adults; that is people aged 18 years and over. This includes anyone who has additional diagnoses and/or needs; for example, people who also have a learning disability or who are autistic, and people who have been given a diagnosis of personality disorder. Also included are those who may transition from children and young people's (CYP) mental health inpatient services. It incorporates people detained under the MHA, including those detained under section 37/41 of the MHA.

Community mental health transformation is at the heart of the NHS Long Term Plan for Mental Health. All areas are expected to develop dedicated adult community mental health rehabilitation services as part of their transformation of community mental health provision, reducing the reliance on inpatient care and to support people in the least restrictive setting. Policy context relevant to all mental health inpatient services, including adult rehabilitation, is described in the overarching commissioning framework for mental health inpatient services.

In another item in the report, I highlight that NHS England has republished guidance on **Patient Safety Specialists** who have been asked to prioritise the local implementation of the following areas from the NHS patient safety strategy:

- Support transition from National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) to the new Learn from Patient Safety Events (LFPSE) service
- Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
- Improving safety culture
- Responding to National Patient Safety Alerts
- Implementation of the Framework for Involving Patients in Patient Safety
- Improving patient safety education and training
- Addressing patient safety improvement
- Implementing medical examiners

It will be important for the Quality Committee to have a sense of progress with this agenda.

The **True for us and learning/for interest** section of this Report references reviews that are of particular import to the Board. As is routine, the appendix includes a number of **CQC reviews** offering members of the Board opportunity to consider our own position against some of the areas of good governance highlighted to be suboptimal. These will in due course also be useful insight into how the new Well Led inspection regime will operate.

The Fuller inquiry phase 1 report highlights the inquiry has been established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed, for so long. A phase 2 report, looking at the broader national picture and the practices and procedures in place to protect the deceased in the NHS and other settings, is planned for publication at a later date.

The report is a very difficult read, and examines how those charged with oversight and regulation of mortuary services at that Trust had allowed the development of an environment in which David Fuller was able to offend with impunity. In identifying where governance, systems and processes have failed, it recommends the corrective action required and considers whether the governance arrangements in place for the mortuary at Maidstone and Tunbridge Wells NHS Trust were adequate and how they operated.

It considers whether the Trust Board received sufficient information to provide the necessary assurance on the key issues raised by the case of David Fuller, namely the management and oversight of the mortuary service, the Trust's compliance with the requirements of the Human Tissue Authority (HTA) and the adequacy of the Trust's arrangements for criminal record checks. It reviews how the Board was apprised of the requirements and reports of the wider system, including regulation, and the level of importance it attached to each organisation.

In addition to interviewing the previous and current Chief Executives and Chairs who were in post during the period David Fuller offended at the Trust, the inquiry reviewed Trust Board papers from 2000 to 2020; Quality Committee (and its predecessor) papers from 2008 to 2021; and executive team meeting papers from 2003 to 2010, and 2016 to 2021.

I recommend Board members read the section starting on page 207, which references an absence of focus by the Board and the Quality Committee, despite a voluntary relinquishment of a Human Tissues Act licence in part due to safety concerns. It highlights that governance structures in place at the Trust were overly complex. This complexity and ineffective delegation arrangements meant that serious issues regarding the mortuary and the Human Tissue Authority (HTA) requirements received little focus at the Quality Committee and did not reach the Trust Board. Executive Director responsibility for the mortuary was not clear. Despite the Trust's intention to introduce three-yearly criminal record checks in 2015, this did not happen for a period of more than five years. The Board was not kept apprised of this.

In making findings and recommendations, the Inquiry identifies gaps in regulation, in governance and in management that together allowed David Fuller to offend. The national regulatory framework and its effectiveness will be reviewed in Phase 2 of the Inquiry.

As in many of my previous True for Us examples, again those referenced in the Reading Room continue to amplify the importance of recognising the unique nature of each of our sites and understanding the value of sub-cultures within them, that serve many staff and the local population well. The enabling work initiated by the CEO will support considerations on how to unify the whole Trust without disrupting the distinctive pockets of good, supportive, and inclusive culture. The governance and operating framework streams in Enabler 1 will build on

the operating models by creating a common understanding of standards and values that are understood and lived by each site, whilst maintaining a degree of autonomy at local level.

The learnings from failings elsewhere should continue to remind us of the size and complexity of the Trust and how in many comparable Trusts I have reported on, it amplifies the difficulty of behaving as a single organisation with one distinct way of working and the often-demanding logistical issues that arise when delivering, and assuring the quality of, care across multiple sites. The PLC and Quality Committees will need to continue to consider the risks posed accordingly in determining their annual workplans.

Governance Route/Approval Process
This is a routine report with direct relevance to the Board and its committees and serves to provide early insight into the changing legal, regulatory and policy environment thereby allowing a risk based approach to stimulating further enquiry where relevant. The governance framework (Board, committees, legal duties and management functions) facilitate responsive and effective decision making, ensuring the Board and its Committees and the Executive Management Committee and senior management are able to collaborate, consider issues and respond.

Good governance is at the core of successful operation, ensuring considered and efficient decision making in furtherance of our overarching strategy and long-term sustainability. In discharging its duties the Board is supported by its various Board Committees. In addition to the matters in this report, and other Board reporting, the Board will need to use the Committee Chair's updates to also influence its identification and assessment of new/emerging risk to performance or objectives, so this is kept continuously under review.

Recommendation
The Board of Directors is invited to consider and be aware of the content of the report and where relevant, members should each be satisfied of their individual and collective assurances and reassurance that the internal plans and controls in place to deliver compliance against relevant Trust obligations are appropriate and effective.

Chairs and members of Board Committees should consider whether more detailed assurances relevant to their committees, are necessary, utilising this report as a constructive stimulant to inform the composition of meeting agendas and reporting focus as necessary in order to discharge the responsibilities delegated to them by the Board.

Author and Title: Kerry Rogers, Director of Corporate Affairs & Company Secretary
Lead Exec: Kerry Rogers, Director of Corporate Affairs & Company Secretary

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*

Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

BOD 06/2024
(Agenda item: 8)

Board of Directors

31st January 2024

Future of Wantage Community Hospital Services

Report for: Decision

Executive Summary
Over the past year, Oxford Health has worked with partners and the local Wantage & Grove Community to deliver a co-produced approach to agree the future shape of services at Wantage community hospital. On the basis of this work a report identifying recommendations has been completed which proposes developments that will maximise clinic-based services. In order to redevelop the site, this will result in the permanent closure of the inpatient beds which were temporarily closed in 2016. This proposal was considered by the Joint Health Overview & Scrutiny Committee (JHOSC) on January 16th, and they supported the locally co-produced plan for health partners to work with local community stakeholders to progress the next stage of work to deliver more hospital services at Wantage Community Hospital.

Recommendations

i) The board is invited to receive the co-produced stakeholder report on the outcome of the engagement work with the local Wantage & Grove community (see supporting paper) which includes the following recommendations:

- **The closure of the community inpatient beds is made permanent.**
- **NHS partners to work with local community to progress with an application in 2024 to The Vale District Council Community Infrastructure Levy (CIL) fund to provide necessary capital to support a sustainable range of outpatient**

and community clinics to be delivered from the ground floor of the community hospital building.

- **Continue to work with the countywide end of life project and with local care homes to strengthen the local palliative and end of life care offer.**
- **Agree to further develop and confirm a range of outpatient services and community clinics through a detailed proposal of which services, operating hours, estimated activity will be delivered from within the community hospital.**
- **Develop urgent care offer including consideration or diagnostics for those with long term conditions and work with GP practice to support local urgent care for the wider population.**

ii) Subject to all appropriate approvals, the Board of Oxford Health is invited to:

a. Approve the implementation of the recommended service model at the Community Hospital, to include permanent closure of the inpatient beds in order to develop clinic-based services.

b. Confirm its commitment to progress plans with the local stakeholders and health & care partners for the development of clinic-based services at the hospital.

c. Support the progression of an application for Community Infrastructure Levy (CIL) funding to enable the refurbishment of the ground floor of the Community Hospital.

Author and Title: Sue Butt. Transformation Director, Primary, Community and Dental Care (PCDC)

Lead Executive Director: Dr Ben Riley, Executive Managing Director Primary, Community and Dental Care (PCDC)

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

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

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

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

   2) People - Be a great place to work

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

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

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

Situation

Over the past year, Oxford Health has been working with NHS partners and the local community in a stakeholder group, to co-produce proposals to agree the future of services at Wantage Community Hospital. Community inpatient beds at the hospital were temporarily closed in 2016 following identification of Legionella bacteria in the old pipework of the hospital. In 2021, following work to replace the pipework, the outpatient services were reopened alongside a range of additional pilot outpatient services.

Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) met on 16th January and supported a locally co-produced plan for health partners to work with local community stakeholders to progress the next stage of work to deliver more hospital services at the Community Hospital. If agreement is received to make the closure of the inpatient unit permanent, Oxford Health will work with the community to enable plans to progress to refurbish the ground floor of the hospital to expand the range of clinic-based services. This will also secure the longer-term future of the outpatient services that have been running as pilots from the hospital and enable the development of a long-term plan for more clinics.

The full report contains a short Executive Summary which concisely summarises the findings of the public engagement work and the stakeholder group's future recommendations for the hospital and can be found in the supporting papers.

Background

Services currently available at the hospital include clinics and assessments for children and adults with speech, language, swallowing and communication delays and disorders, ophthalmology (eye care) clinics, perinatal care including mental health, adult eating disorders, Talking Space, psychological therapies, neuro development clinic, audiology clinic, podiatry clinic, Health Share Physiotherapy Clinic, and Musculoskeletal (MSK) physiotherapy services. There are no changes planned to the maternity services provided by OUHFT on the first floor of the hospital building.

Alongside the Community Hospital changes, the Trust is also progressing plans to establish a 'keystone' mental health and wellbeing hub in Wantage town centre, to provide local residents with easier access to mental health support, as well as continuing to develop its services based in Wantage Health Centre.

Assessment

Of particular importance to Oxford Health, the report recommendations include the permanent closure of the inpatient unit at the hospital (temporarily closed since 2016) and the progression of plans to apply for CIL capital funding to refurbish the ground floor of the hospital (the old inpatient wards and support areas) to enable the provision of more clinic-based outpatient services. The outpatient services to be provided will include the pilot services that have successfully been trialed over the past 2 years. Additional service development plans will be progressed through further co-production with stakeholders and health partners (particularly OUHFT) and are expected to include a mix of planned care and urgent care.

The Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) of the proposals have been completed and no substantial quality or equality impacts have been identified. The Trust is committed to continuing to work with its health and care partners and local community stakeholders to agree the range of clinic-based services to ensure an inclusive approach to implementation of this proposal.

Recommendation

i) The board is invited to receive the co-produced stakeholder report on the outcome of the engagement work with the local Wantage & Grove community which includes the following recommendations:

- **The closure of the community inpatient beds is made permanent.**
- **NHS partners to work with local community to progress with an application in 2024 to The Vale District Council Community Infrastructure Levy (CIL) fund to provide necessary capital to support a sustainable range of outpatient and community clinics to be delivered from the ground floor of the community hospital building.**
- **Continue to work with the countywide end of life project and with local care homes to strengthen the local palliative and end of life care offer.**
- **Agree to further develop and confirm a range of outpatient services and community clinics through a detailed proposal**

of which services, operating hours, estimated activity will be delivered from within the community hospital.

- **Develop urgent care offer including consideration or diagnostics for those with long term conditions and work with GP practice to support local urgent care for the wider population.**

ii) Subject to all appropriate approvals, the Board of Oxford Health is invited to:

a. Approve the implementation of the recommended service model at the Community Hospital, to include permanent closure of the inpatient beds in order to develop clinic-based services.

b. Confirm its commitment to progress plans with the local stakeholders and health & care partners for the development of clinic-based services at the hospital.

c. Support the progression of an application for Community Infrastructure Levy (CIL) funding to enable the refurbishment of the ground floor of the Community Hospital.

Supporting papers

- Future of Wantage community hospital Co-produced Report
- Future of Wantage community hospital Co-produced report appendices
    - List of outpatients provided at the hospital currently
    - History of engagement
    - Engagement report
    - Map of community hospitals
    - OUH letter of support for proposals
- BOB ICB letter of support for proposals
- OHFT Executive letter of support for proposals
- HOSC recommendations

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

BOD 07/2024
(Agenda item: 9)

Board of Directors

31 January 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, People, Finance and Research & Education.

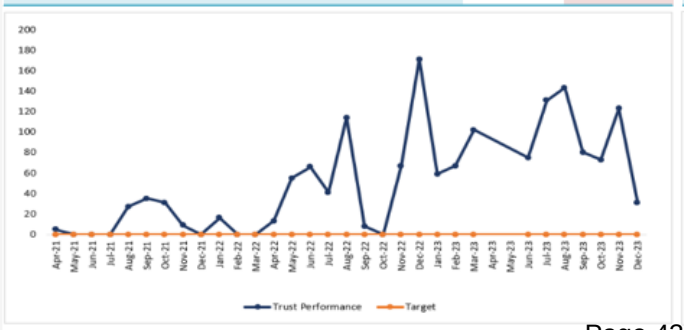
IPR - Performance Summary

(1) Delivery of the NHS National Oversight Framework

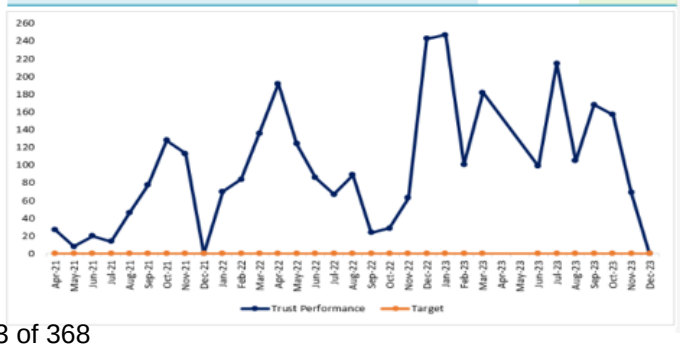
The Trust continues to perform well against the targeted metrics with the exception of Inappropriate OAPs bed days used and MIU 4 hour performance. The latter is being monitored by not action required at present.

In December 2023 locally reported total bed day usage was 31 days (31 inappropriate OAP bed days in Bucks, and 0 inappropriate OAP bed days in Oxon). This is an improvement against last month, especially in Oxon, following directorate focus on reducing the use of OAPs to improve the quality of patient care and improve cost control.

NHS Oversight Framework Metric	Target	Actual
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Bucks)	0	31



NHS Oversight Framework Metric	Target	Actual
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Oxon)	0	0



(2) Delivery of strategic objectives (Objective Key Results (OKRs)

The Trust has 32 OKRs. 22 of the OKRs have targets attached to them

- Quality – 18 OKRs (9 have targets)
- People - 9 OKRs (8 have targets)
- Sustainability - 5 (all have targets)
- Research & Education- 2 (none have targets)

The Trust is achieving 32% (7 out of 22) of its OKRs. The table below provides an overview of the 15 OKRs that are **currently not achieving target,** their performance compared to last month and the trend (I.e. whether performance is improving or worsening)

Strategic objective	OKR	Target	Last month's performance unless stated otherwise	This month's performance unless stated otherwise	Status/ Trend
Quality	Clinical supervision compliance	95%	70%	70.5%	→
Quality	Reduction in use of prone restraint	183 YE (137 YTD)	131 YTD against YTD target of 107	160 YTD against YTD target of 137	reducing
Quality	Improved completion of the Lester Tool for people with enduring SMI-AMHT	95%		64% (July 22*)	Current status not known
Quality	Improved completion of the Lester Tool for people with enduring SMI (EIP)	95%		80.5% (July 22*)	Current status not known
Quality	Evidence patients have been involved in their care plans	95%	82% (Sept-Oct)	89% n=624 (Nov & Dec)	↑
Quality	% staff have completed the national autism/LD training	95%	65%	70%	↑
People	Reduction in agency usage	<8.2%	10%	9.5%	↓
People	Staff sickness	<4.5%	5.7%	5.3%	↓
People	Reduction in early turnover	<14%	17.2%	16.5%	↓
People	Reduction in vacancies	<9%	15.5%	13.4%	↓

People	Personal Development Review (PDR) compliance	95%	91%	89.2%	↓
People	PPST compliance	95%	88.8%	89.6%	↑
Sustainability	Delivery of cost improvement plan	£-	£1.4m adverse	£1.7m adverse	→
Sustainability	Delivery of estates related NHS Carbon Footprint reduction target of 2879 tonnes by 2028 ,Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-2038. (25,550 C02t)	4508	4960	4960	→
Sustainability	Achievement of all 8 targeted NOF measures	8	2 not achieved (OAPs and MIU)	2 not achieved (Bucks OAPs and MIU)	While there is no change to the overall number of underperforming indicators, OAPs in Oxon has improved this month to 0

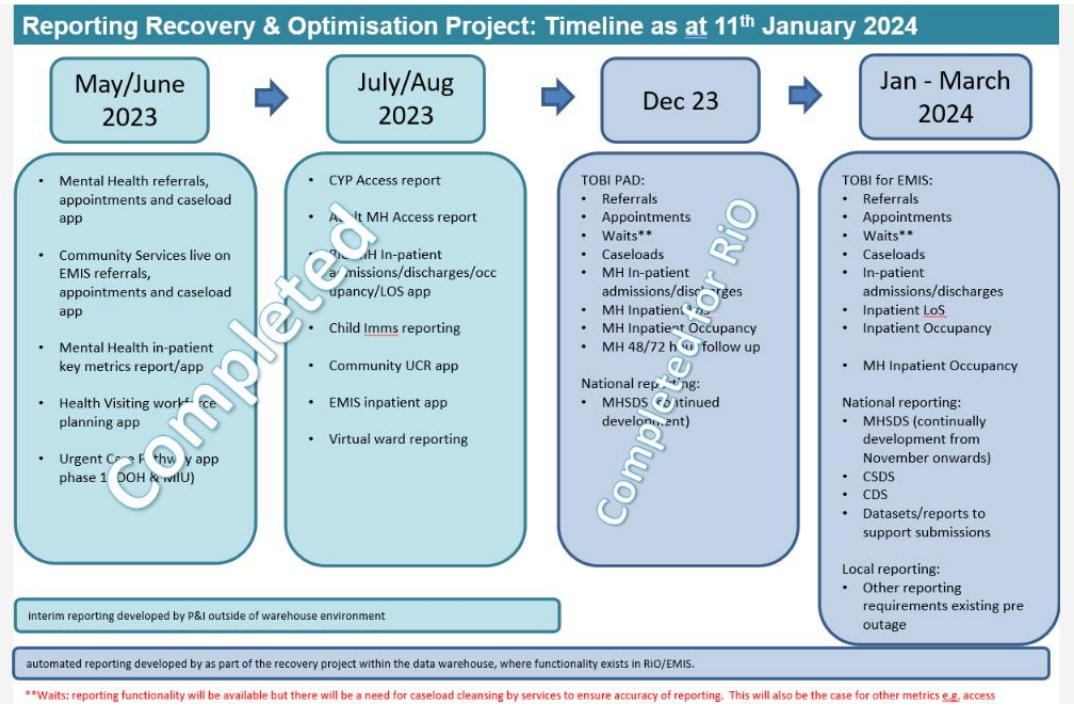
Please see the report for further information and plans to address.

* latest available due to clinical systems outage and need to recover reporting

Patient Activity and Demand and Recovery of Reporting:

The Trust initiated a project in May working with a third party (Concept Analytics) to support the recovery of reporting.

In Q3 the Trust started re-flowing its National datasets and on 28 December, the Performance and Information and BI teams re-launched the Trust's intelligence platform containing the first wave of recovered reporting for RiO. Work will continue over the next couple of months to include EMIS, further national reporting and other local reporting requirements that existed prior to the outage. Further detail is provided in the visual below.



The recovery work will report on the data available. However, the Trust has, and will continue to have, gaps in its data for two reasons:

- **Data gap 1:** The clinical systems outage due to the cyber attack resulted in data not being recorded in systems and that will therefore not be recovered. Between August – December 2022 for majority of services using Carenotes prior to outage and between August 2022 – July 2023 for Community Hospitals, Hospital @ Home, RACU and EMU services.

- **Data gap 2:** Reduced functionality of the new systems; RIO and EMIS, due to the pace at which they needed to be implemented. This means that some data cannot be entered and therefore will not be available for reporting and analysis purposes. This gap will be closed as the optimisation of systems progress and these return to pre outage status. At the time of writing, the estimated data gap due to system functionality is c13%.

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

Author and Title: Nic McDonald
Head of Business Intelligence

Lead Executive Director: Amélie Bages
Executive Director – Strategy & Partnerships

Integrated Performance Report (IPR) Report: January 2024

December 2023 data unless stated otherwise

Assuring the Board on the delivery of the Trust's 4 strategic objectives; quality, people, sustainability and research and education

Section 1:

Introduction to the Trust strategy 2021-2026

Introduction to the Trust Strategy 2021-2026

Introduction to the Trust Strategy 2021-26

Oxford Health NHS Foundation Trust (OHFT, the Trust) has developed an organisational strategy for the five year period 2021-26. The aim of the strategy is to set the Trust's long-term direction, guide decision-making and address strategic challenges – for example rising demand for and complexity of healthcare, recruiting and retaining a stable workforce, and ensuring sufficient resourcing. Following the publication of the 2021 NHS White Paper, the NHS is likely to change over the period of the strategy - shifting from a commissioner/provider model to one characterised more by system working and collaboration with healthcare partners (NHS, local authority, independent and third sector) focused on collectively improving overall population health and addressing health inequalities.

The Trust's vision is Outstanding care by an outstanding team, complemented by the values of being Caring, Safe & Excellent. Flowing from the vision and values are four strategic objectives:

1. Deliver the best possible care and outcomes (Quality)
2. Be a great place to work (People)
3. Make the best use of our resources and protect the environment (Sustainability)
4. Become a leader in healthcare research and education (Research & Education)

Key focus areas and Objective Key Results

To move the strategy into a focus on delivery, each strategic objective has been developed into a set of key focus areas (workstream descriptors). The aim of the key focus areas is to identify priority activities and workstreams for the Trust over the coming years and to provide a bridge between the high-level ambitions of the strategic objectives and a set measures and metrics to track progress. Existing and new measures and metrics have been gathered and/or created using an Objective Key Results (OKRs) approach. OKRs allow for measurement of activities that contribute to key areas of focus and workstreams and will be reported to relevant Board committees and Board via an Integrated Performance Reporting approach.

While the key focus areas are intended to be fixed for the lifespan of this strategy, the OKRs can be updated and added to as required. To enable this, the OKRs are an appendix to the main Trust strategy document. This approach allows for a consistency of approach for the strategy but the flexibility to adapt the metrics used to measure progress. For example, a specific OKR may be achieved and can then be replaced with a new target.

This report reports delivery of the strategy and performance against the OKRs. Supporting data and narrative is supplied where there is underperformance.

Section 2:

‘At a Glance’ Performance and Trust Headlines;

An overview of performance relating to;

- National Oversight Framework
- Delivery of the strategic objective key results (OKRs)

Key risks, issues and highlights are provided by the Executive Managing Directors (updated bi-monthly)

‘At a glance’ performance – delivery of strategic objectives and NHS oversight framework

This page provides a ‘at a glance’ view of performance against the **5 key sections of this report**. Further detail relating to performance of each section can be found on the report pages shown below.

Report Section	# of metrics	Targets not achieved	% OKRs achieved	Description	Report pages
NHS Oversight Framework (NOF)	8 (all have a target)	2	75%	Overall performance is good, with the exception of the number of **inappropriate out of area placements (Bucks indicators) and MIU 4 hour performance**	Pages 9-10
Strategic Objectives – **Quality; Deliver the best possible care and outcomes**	18 (9 have a target)	6	33%	We do not have up to date data for 2 of the 6 non-performing metrics due to the clinical information systems outage and these items still not ready for deployment. Their last known performance, however, was non-compliant (**improved use of the Lester Tool in EIP and AMHTs).** The other areas of non-compliance are; • **clinical supervision** • **evidence patients have been involved in their care** • **Reduction in the use of prone restraint and** • **% staff have completed the national autism/LD training**	Pages 12-18
Strategic Objectives - **People; be a great place to work**	9 (8 have a target)	6	25%	• **Agency usage, sickness rate, early turnover, vacancy rate and statutory and mandatory training in particular** are not yet achieving targets. The PDR indicator is also not meeting to target but has been removed from exception reporting due to the significant improvement observed during the past year.	Pages 19-24
Strategic Objectives - **Sustainability; make the best use of our resources and protect the environment**	4 excl. the NOF OKR (all have a target)	2	50%	The **CIP plan** at month 9 is £1.7m adverse and delivery of NHS Direct carbon footprint of 47% reduction by 2028 compared to 2019-20 baseline year is slightly off trajectory	Pages 25-27
Strategic Objectives – **Research & Education**	2 (no targets)	-	-	The Trust is ranked 4th Nationally for participants recruited to CRN Portfolio studies and 7th Nationally for CRN Portfolio studies that recruited this FY	Page 28

Directorate highlights and escalations: Mental Health, Learning Disabilities and Autism

Executive Director commentary: Rob Bale, Consultant Psychiatrist and Interim Executive Managing Director for Mental Health & Learning Disability
Narrative updated: 22 January 2024
For reporting period ending: 31 December 2023

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Workforce challenges	Issue and risk	The central recruitment team continue to support services in ensuring there is a rolling campaign to fill vacancies alongside exploring creative approaches to attraction. A range of initiatives are in process to support recruitment and retention across services. Temporary staff are used to maintain service levels and the agency management programme supports services to reduce reliance on, and cost of temporary workers sourced in this way.
Inappropriate Acute Out of Area Placements (OAPs)	Risk	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 has reduced from the demand peak in December 22 and January 23 however numbers continue to fluctuate based on clinical demand and acuity. A total of 31 inappropriate bed days are reported for December
Service pressures	Risk	Services remain under pressure due to acuity and demand. • The introduction of Primary Care mental health services in Oxfordshire and Gateway in Buckinghamshire are having a positive impact on capacity within adult mental health team • In Neurodevelopmental services (CAMHS and Adult) demand exceeds capacity. Work is underway across BOB to identify further mitigations. Adult ADHD services paused to new referrals for 3/12 to allow triage of current wait list and review of pathway • Pressures compounded by gaps in Consultant roles in 3 inpatient services (locums currently in place)
Finance	Risk	Medical agency spend remains a risk, directorates are developing plans to address this with support of workforce transformation team and medical recruitment

Directorate highlights and escalations: Primary, Community and Dental Care

Executive Director commentary: Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care
Narrative updated: 18th January 2024
For reporting period ending: 31 December 2023

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Operational Update	Issue and Risk	• 0-19 Healthy Child Consultation completed on time. Uptake of one to ones and staff feedback high. Review of feedback in process. • Partnership Local Area SEND Inspection implementation work continues to develop. Internal OHFT plan to develop internal response to PAP in progress. Good engagement across OHFT • EMIS functionality remains in development. Some concerns about capacity and expertise • Significant pressures remain in OOHs/ Podiatry and District Nursing • Significant challenges to access theatres at the OUH for Paediatric Dental Operations • Sessional staffing/operational issues with our external staffing partners remain problematic. Directorate capacity strengthened to manage the recovery plan for temp staffing and linked to agency reduction plan
Service Pressures	Risk	• OOHs and MIUs remain under pressure. Some success in recruitment for both clinical and leadership roles. • Podiatry Improvement Plan is beginning to take form. We are engaging some external clinical support to assist us. • District nursing continue to be under extreme pressure. National Safer staffing tool outcome due to report at Board demonstrates significant gap in capacity
System and financial pressures	Risk	• System urgent care Programme is developing led by our Transformation team • Workstreams include SPA/ H@H and Integrated neighbourhood Team developments • 24/25 CIP Planning in progress. System BCF planning has commenced requiring OHFT rigour in process • Ongoing challenges with recruitment of Special Care and Paediatric Dental Specialists impacting on performance and waiting list targets • Financial risk of £1.6m income still not received (£1.3m from ICB for H@H and UCR and £300k from OCC for CIT). The Trust's current reporting gap may impact H@H funding that is due.

Section 3:

NHS Oversight Framework performance

National objective: Compliance with the NHS Oversight Framework

This year, the NHS Oversight Framework indicators that have targets are;	Target	National position (England)	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	69% (Dec)	87.8% (Dec)	→
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	69.8% (Sep)	88.2% (June 22)	
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	76.70% (March)	96.0% (July 22)	
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	50% (Sep)	52.0% (Sep)	→
(N5) IAPT - Percentage of people waiting six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	75%	89.3% (Sep)	99% (Sep)	→
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.2% (Sep)	100% (Sep)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	31 (Dec)*	↓
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	0 (Dec)*	↓

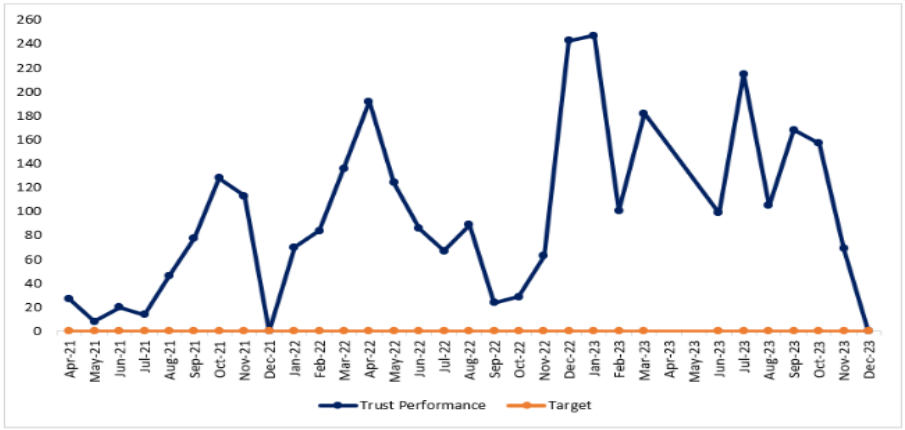
Executive Summary: Amélie Bages, Executive Director of Strategy and Partnerships
Narrative updated: 12 January 2024 for reporting period ending: **31 December 2023**

About: The NHS Oversight Framework replaced the provider Single Oversight Framework and the clinical commissioning group (CCG) Improvement and Assessment Framework (IAF) in 2019/20 and informs assessment of providers. It is intended as a focal point for joint work, support and dialogue between NHS England, Integrated Care Systems (ICS), and NHS providers. The table above shows the Trust's performance against the **targeted** indicators in the framework. Areas of non-compliance are explained overleaf.
Performance: The Trust is compliant with the targets in the Framework, with the exception of the number of inappropriate out of area placements (OAPs) and MIU performance. The latter is being monitored by not action required at present. Please see overleaf for more information re OAPs. Updated data for other reported items is not available due to publication timelines.
**the figure provided is a local Trust figure owing to technical issues with the national submission. Indicators greyed out have not refreshed due to unavailability of data nationally following the clinical information systems outage therefore, no commentary is provided based on historical positions.*

National Objective: exception report

NHS Oversight Framework Metric	Target	Actual
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Bucks)	0	31

NHS Oversight Framework Metric	Target	Actual
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP **bed days used** (Oxon)	0	0



Executive Director commentary: Rob Bale, Consultant Psychiatrist and Interim Executive Managing Director for Mental Health & Learning Disability
Narrative updated: 12 January 2024
For reporting period ending: **31 December 2023**

The issue and cause
The use of Out of Area Placements decreased in Q3.

The plan or mitigation
Following NHSE guidance the Trust has reviewed the use of OAPs and is assured that continuity of care principles are adhered to. Reporting from April 2021 reflects this change and please note this change when viewing performance against historical trends. **In December 2023 locally reported total bed day usage was 31 days (31 inappropriate OAP bed days in Bucks, and 0 inappropriate OAP bed days in Oxon).**

Section 5:

Delivery of our four strategic objectives

Objective 1: Quality - Deliver the best possible care and outcomes

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee
Reported period: December 2023 unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results (OKRs) are;	Target	Comm Services	Oxon &BSW	Bucks	LD	Forensics	Pharm	**Trust**	**Trust Trend**
(1a) Clinical supervision completion rate	95%	67%	72%	73%	78%	80%	-	70.5%	→
(1b) Staff trained in restorative just culture	20	-	-	-	-	-	-	28	→
(1c) BAME representation across all pay bands including board level	19%	16.4%	20.6%	30.2%	10.4%	47%	21.4%	22.1% (Q3) (all staff in Trust)***	↑
(1d) Cases of preventable hospital acquired infections	<3 YE	-	-	-	-	-	-	0* YTD	→
(1e) Reduction in use of prone restraint by 25% from 2022/23	183 YE (137 YTD)	-	95	38	-	27	-	160 uses	reducing
(1f) Patient/carer safety partners	2 YE	-	-	-	-	-	-	2	→
(1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP)	95%	-	88%	70%	-	-	-	81% (July 22**)	n/a**
(1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT	95%	-	66%	61%	-	-	-	64% (July 22**)	n/a**
(1g) Evidence patients have been involved in their care (clinical audit result) reported bi-monthly	95%	-	-	-	-	-	-	89% n=624 (Nov & Dec)	↑
(1h) % staff have completed the autism/learning disabilities training	95%	70%	68%	73%	82%	82%	-	70% (all staff in Trust)	↑

* 1 CDI case in Dec 2023 waiting to be reviewed by system meeting. Probably unavoidable.
** Latest available data due to Carenotes outage.
*** Although overall target being reached, representation is less in posts band 8s and above.

The arrows indicate the trend against the last reported position and the colour is the RAG status against the target

Objective 1: Quality - Deliver the best possible care and outcomes

Governance: Executive Director: Chief Nurse | **Responsible Committee**: Quality Committee

Executive Summary: Chief Nurse
Narrative updated: 15th January 2024.
For reporting period ending: 31st December 2023

Four OKRs are underperforming YTD; three OKRs continue to improve and the performance for one OKR has remained quite similar (clinical supervision). Please see overleaf for more information by measure on the cause of the underperformance and the plans to mitigate and improve performance.

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

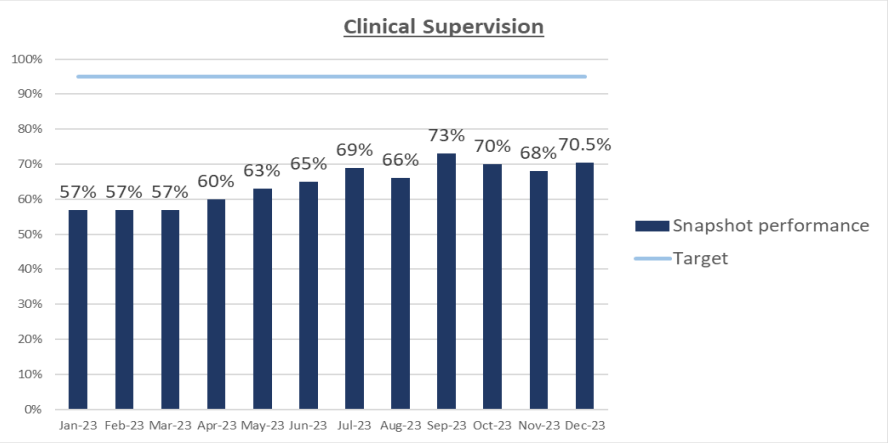
The Trust is carrying out Quality Improvement Projects in the following areas relevant to the Quality OKRs;

- Positive and Safe – reducing restrictive interventions including use of prone restraints
- Working with families and carers, alongside implementing the Carers, Friends and Family Strategy 2021-2024
- Improving co-production in care planning, which is a core part of the co-produced Patient Experience and Involvement Strategy being finalised
- Equality, Diversity and Inclusion programme

The indicators here have been reviewed by the CN and CNO and will be changing shortly in line with the Trusts strategic objectives.

Objective 1: Quality; exception report

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	95%	70.5%



Executive Director commentary: Chief Nurse
Data updated to 31st December 2023.

The risk or issue
The risk is staff may be struggling in their role and be unsupported to manage difficult situations which may then impact on their well-being.

The cause
Increased demand on clinical teams, poor central recording and issues with accuracy of reporting.

What is the plan or mitigation?
Rates of compliance are increasing more steadily now and there is a lot of focus from the teams on ensuring this is done.

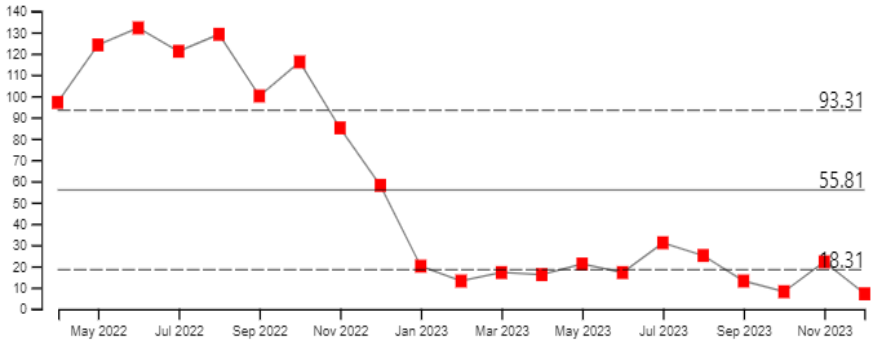
Supervision steering group is leading on the improvement plan. Some directorates are running local supervision forums to address the challenges locally and feedback to the steering group.

There is targeted work with the lowest performing teams including attendance at team meetings by the Trust Lead, Deputy Director of Quality and steering group members to understand where challenges lie and remedy accordingly. There is a particular focus on Bucks services as this is where some of the poorest rates of compliance are.

There is continuous review of the data to cleanse the numbers of staff being pulled into the report – particularly focusing on Corporate services where there are clinicians in non-clinical roles.

Objective 1: Quality; exception report

Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint	25% reduction from 2022/23 (183 YE)	160 uses against YTD target of 137



Executive Director commentary: Chief Nurse
Data updated to 31st December 2023.

The risk or issue
Use of prone restraint carries increased risks for patients and should be avoided and only used for the shortest possible time.

The cause
The most common cause for this type of restraint is violence, followed by self-harm. The position is used mostly to administer immediate IM.

What is the plan or mitigation?
Graph 1 shows the use of prone by month for all wards.

There has been a continued decline in use of prone restraint.

Compared to the same period last year (April-Dec 2022), excluding the uses for 1 patient in an exceptional situation, there were 197 uses of prone compared to 160 this year. Although the numbers are small this is a **19% reduction.**

Every use of prone is reviewed by the ward Matron and there is a detailed questionnaire completed to review practice for every use.

The use of the restraint positions standing, supine and safety pod have increased whilst prone has reduced.

The Positive and Safe Steering Group is overseeing and measuring the impact of an improvement plan.

Objective 1: Quality – exception report

Objective Key Result (OKR)	Target	Actual
(1fb) Improved completion of the Lester Tool for people with enduring serious mental illness (AMHTs for patients on CPA)	95%	64% (July 2022)

Objective Key Result (OKR)	Target	Actual
(1fa) Improved completion of the Lester Tool for people with enduring serious mental illness (EIP teams for patients on CPA)	95%	81% (July 2022)

Executive Director commentary: Chief Nurse
Data last updated July 2022.
Narrative updated: January 2024.

Please note performance is not RAG rated because the last data available is from July 2022. In 2022/23 the target was 90% for EIP and 75% for AMHTs. The revised target for 2023/24 is 95%. We hope to be able to start reporting again soon.

An exception slide is provided to describe the work that is happening.

Context
The indicator is based on the completion of the Lester physical health assessment tool for patients with a serious mental illness. The tool covers 8 elements including smoking status, lifestyle, BMI, blood pressure, glucose and cholesterol, and the associated interventions.

The risk or issue
People with severe mental illness (SMI) die on average 15-20 years sooner than the general population. They are dying from physical health causes, mostly commonly respiratory, circulatory diseases and cancers

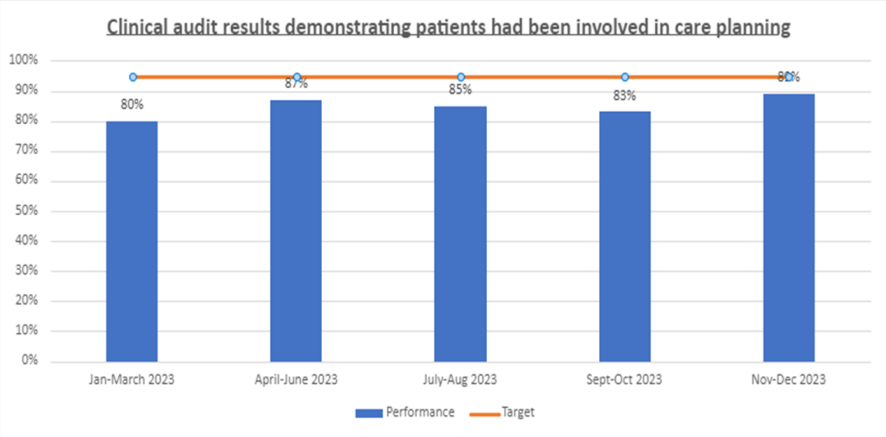
The plan or mitigation
Local intelligence from teams is there has been an increase in reviews and availability of physical health clinics. Clinical audits are supporting where to focus improvement work. We have some patient reported outcomes which show patients reporting feeling more supported with managing their physical healthcare.

The focus is on:
- Diabetes management on the wards
- Physical health skills training for community mental health teams/ ward staff
- Developing patient information to support conversations and promote improving health
- An inpatient referral pathway to embed a care treatment programme for tobacco dependency has been developed. 4 new tobacco dependency advisors employed.
- Improve flexibility and mobility of testing through mobile clinics and point of care testing kits
- Make changes to the physical health forms on the electronic patient record.

Objective 1: Quality; exception report

Objective Key Result (OKR)	Target	Actual
(1g) Evidence patients have been involved in their care (bi-monthly clinical audit)	95%	89% n=624

Clinical audit results



Patient/carer Surveys (IWGC);
Average score of 4.68 (out of maximum of 5.0) for patients/families reported as being involved in their care from April-December 2023 (review count n=15,852).

Executive Director commentary: Chief Nurse
Data updated to 31st December 2023.

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

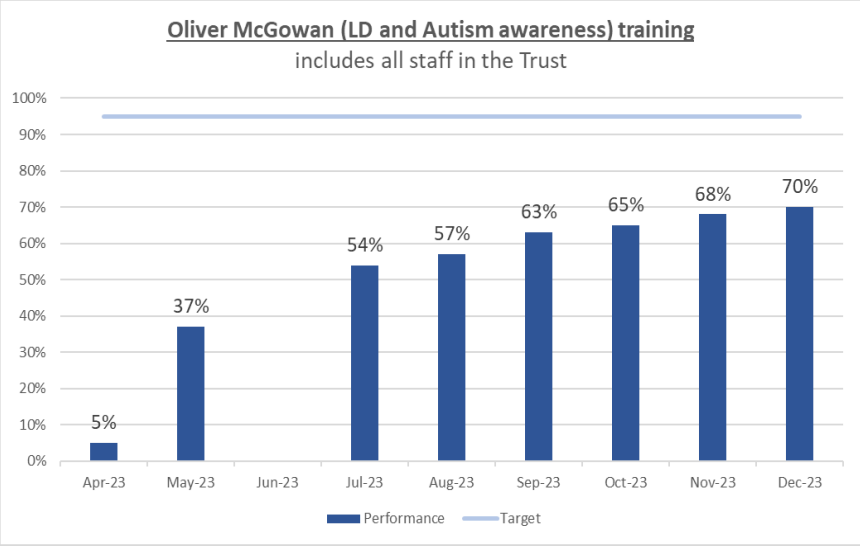
Our local patient survey data through IWGC shows an average score of 4.68 for the question 'were you involved as much as you wanted to be in your care' from April-Dec 2023.

The clinical audit results are updated bi-monthly. The Nov and Dec 2023 results include audits across every Directorate including the care plan audit in mental health community services, essential standards audit across inpatient mental health wards, matrons walkarounds in community hospitals, district nursing pressure ulcer and clinical documentation audits and end of life care audits.

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

Objective 1: Quality – exception report

Objective Key Result (OKR)	Target	Actual
(1h) % staff have completed the national autism/learning disabilities training	95%	70%



Executive Director commentary: Chief Nurse
Data updated to 31st December 2023.

The Context
The Trust participated in the 2022 pilot of the new national training on autism and learning disabilities (Oliver McGowan) to help shape the content, which 125 staff attended. The Trust also developed internal short training videos as an interim while waiting for the national training to be released.

The plan or mitigation
Tier 1 of the new national training has now been released and all staff are expected to complete the training. It is on the essential training matrix for all staff. The performance reported here is based on completion of part 1 of the national training provided on-line. Tier 2 of the training is being developed with partners in the BOB ICS as it requires the provision of face-to-face teaching – development has currently been paused by the ICB until 2024/25.

The L&D Team have also liaised with higher education leads to ensure they have plans for pre-registration programmes to complete the training.

Performance against the national training is improving across all areas, current position at 70%. Active promotion is happening. Our performance is monitored by NHS England at regional and national level.

The Trust has set up an Autism Strategy Steering Group to coordinate and prioritise broader improvement work including development of skills.

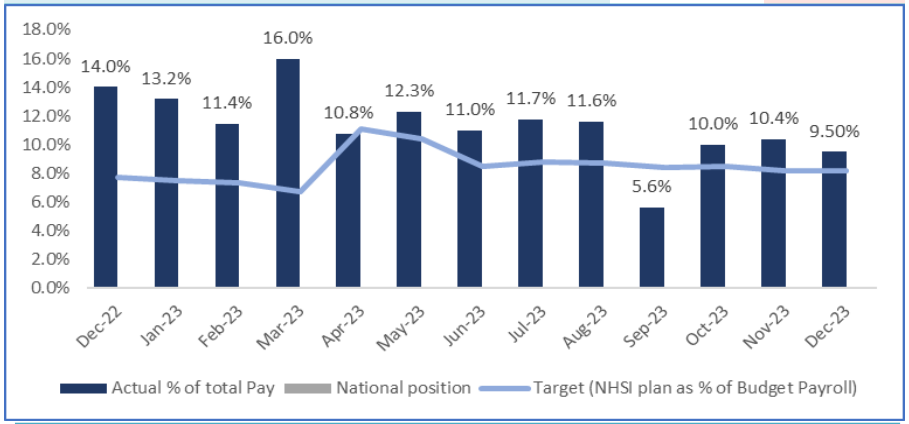
Objective 2: People – be a great place to work

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

This year, our Objective Key Results are;	Target	Buckinghamshire Mental Health	Community Services	Corporate	Forensic Services	Learning Disabilities	Oxford Pharmacy Store	Oxfordshire & BSW Mental Health	Provider Collaborative Commissioning	Research & Development	Trust	National comparator	Trust Trend
(2a) Staff Survey- Staff Engagement score July Pulse 23	>/=?	6.63↑	6.50↓	6.89↓	7.14			7.1↑			6.83↑	6.45	↑
(2b) Reduce agency usage to NHSE/ target	</ 8.2%	17.6%↓	6.7%↑	3.4%↑	8.7%↓	12.8%↓	0.0%→	12.7%↓	0.0%→	0.0%→	9.5%	ModHos Peer Avg 5.1% - National Value 5.4 %	↓
(2c) Reducing staff sickness to 4.5%	</=4.5%	5.4%↓	6.4%↓	3.9%↓	6.8%↑	5.4%↓	2.1%↑	5.0%↓	2.3%↑	4.6%↑	5.3%	ModHos Peer Avg 4.6% - National Value 5.3 %	↓
(2e) Reduction in % labour turnover	</=14%	13.8%↑	15.5%↓	10.6%↓	13.2%↓	21.4%↑	10.4%↓	12.8%↓	7.0%↓	19.5%→	13.47%	ModHos Peer Avg 19.7% - National Value 17.8 %	↓
(2f) Reduction in % **Early** labour turnover	</=14%	15.3%↑	21.6%↓	14.2%↓	21.4%↓	16.5%↓	0.0%	14.6%↓	6.4%↓	9.0%↑	16.5%		↓
(2g) Reduction in % vacancies	</=9%	17.7%↑	9.7%↑	-1.1%↓	22.8%↑	14.4%↓	43.0%↓	18.4%	-20.8%↓	50.9%↑	13.4%	ModHos Peer Avg 9.8% - National Value 9.7%	↑
(2h) PDR compliance	>=95%	86.4%↓	91.5%↓	87.8%↓	95.0%↓	92.1%	95.2%→	87.0%↓	90.0%	87.5%↓	89.2%	None	↓
(2i) S&MT (Stat and Mandatory training)	>=95%	89.8%↑	91.2%↑	88.0%↑	93.0%↑	91.0%↑	93.9%↓	87.8%↑	94.1%↓	84.3%↓	89.6%	None	↑
(2j) Number of Apprentices as % substantive employees	>=2.3%	7.6%→	6.1%↑	9.9%	7.2%→	22.4%↓	21.7%↓	0%→	0%→	2.9%→	5.7%	None	↑

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2b) Reduce Agency Usage to Target	</=8.2%	9.5%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Agency use in the Trust is extremely high which increases costs and impacts quality and safety of patient care and staff wellbeing.

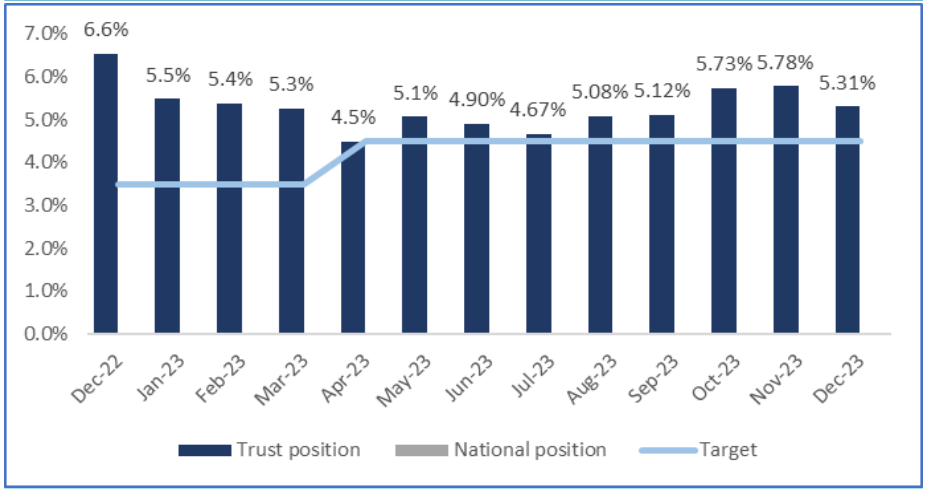
The cause
The causes are multifaceted and are being addressed by the Improving Quality Reducing Agency Programme which has several workstreams and aims to improve the quality of our services whilst reducing agency spend.

The plan or mitigation
Overall, total agency spend in December was £2,912K against an NHSE/I target of £2,500k. It has been identified that previous accruals made in FY 22/23 and FY 23/24 have been overstated, work is currently underway with the temporary staffing and finance teams to revise monthly spend to date. The impact of these accruals should result in the Trust being on plan with the NHSE/I ceiling target of £32.022K by Month 12 of FY23.

The Improving Quality and Reducing Agency Programme has a number of workstreams which aim to improve the quality of our services whilst reducing agency spend.
The **recruitment workstream** has launched new marketing and branding materials. They have moved to phase 2 for the internal talent mobility programme and are currently reviewing systems for talent management. The workstream is also in the process of finalising the process for internal secondments and acting up agreements.
The **international recruitment workstream** has seen 15 nurses commence employment with the Trust, 6 nurses are due to start in January, 9 nurses are awaiting their visas, 5 nurses are awaiting a Certificate of Sponsorship, 14 nurses are going through the pre-employment check process. The IR programme is on track to meet the target of 45 nurses arriving in the UK by the 30th March 2024.
The r**etention workstream** is in the process of working with Resourcing, HR, OD and EDI to facilitate a pathway to support internal candidates with the application and interview process. The PDR QI team has developed an Autism and Dyslexia friendly PDR form to meet the needs of these staff groups. The retention team is working with the Research and Development Team to promote internal opportunities for career development and dual roles
The medical workforce and finance teams have undertaken a full review of the **medical workforce establishment** (working with Clinical Directors and Associate Medical Directors) to ensure that there is one clear and shared understanding. This work will enable us to better implement the necessary controls to minimise our use of agency doctors as far as possible. An options appraisal is being developed to determine whether Patchwork or Allocate is the optimum system for managing the Medical and Dental temporary workface. Once determined, the workstream will explore moving the management of all the medical and dental temporary workforce to one platform.
Managed Service Provider Update - ID Medical are continuing the work of moving lines of work that are on bespoke charge rates to the phased rate card, this will be completed by the end of March. ID Medical have migrated 30 medics to the direct engagement model. NHSP are now attending Trust monthly corporate inductions to discuss the benefits of joining the bank with new starters. NHSP fill rates are 62.7% at M9 against a revised target of 63%. In Q4 a programme of work will be undertaken to scope out an Introduction of an auto enrolment to the bank for new starters. The Clinical Workforce Transformation team and NHSP are undertaking a programme of work to identify the agency lines of work that can be migrated to an Agenda for Change band and those that will require a Personalised Pay Rate (PPR). This work started at the beginning of Q4 with a cohort of 33 workers, this programme will continue into Q1 of FY24/25.

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=4.5%	5.31%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The sickness absence decreased from 5.78% to 5.31% and has remained above target. Excluding Covid absences the rate was 4.8% (5.3% last month). High sickness absence rates result in increased temporary staffing use and pressure on colleagues.

The Cause
Whilst sickness absence remains above target the proportion of long term versus short term cases remains broadly consistent with the previous month. The most common reasons for absence were Cough/Cold, Flu, CoronaVirus confirmed, Gastrointestinal and Anx/Stress Non work related.

The plan or mitigation

There is a small decrease in absence from the previous month, and a reduction in >1.3% from the same period (December) in 2022.

Work continues to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees. This is a key enabler to ensure that appropriate referrals are made, including signposting to the various support/assistance programmes that are available (e.g. our Employee Assistance Programme).

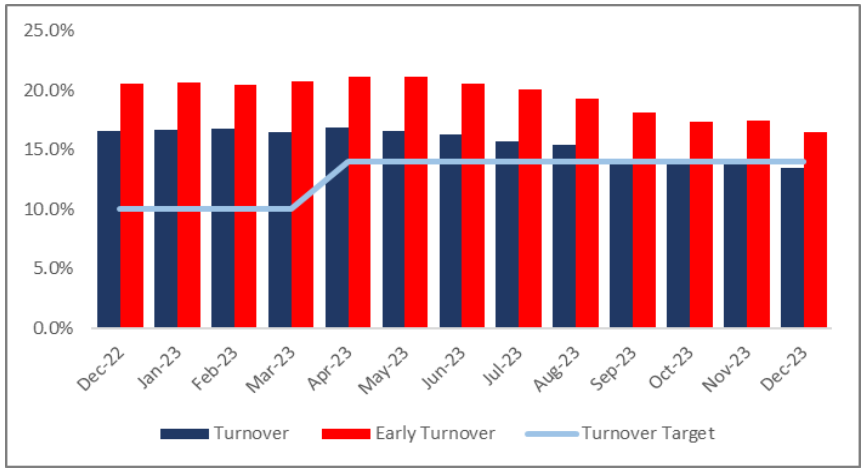
We have recently agreed a renewal of the Goodshape contract which included the onboarding of a new app which supports users in reporting absence efficiently. We are working through some final issues with the App relating to information governance. The App will go live shortly, as soon as these issues are resolved, and will lead to a more user-friendly experience for staff to record their absence. The option to call GoodShape rather than use the app remains in place.

The absence team continue to work with the operational HR teams to attend team meetings and support managers with using the GoodShape system and in managing absence. This works hand in hand with dedicated support from the HR Advisory team supports managers both with the management of individual sickness absence cases, and through proactive measures to upskill managers, including manager briefings and bespoke absence management training.

Increased investment was made into Occupational Health for this financial year: 2023/24 to support psychological wellbeing (which came on the back of the national NHSE funded offer ending for the You Matters service across BOB) and recruitment is underway to these posts with a view to launching an enhanced offer to OHFT staff later this year.

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<14%	13.5%
Early Turnover	<14%	16.5%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
Staff turnover decreased to 13.5% , below the 14% target. Early labour turnover has decreased to 16.5%. High levels of turnover will impact on vacancies, agency spend, quality of patient care and staff experience.

The cause
The cost-of-living crisis and the below inflation pay offer is impacting on staff retention (especially in the lower bands) with wage increases in other sectors increasing rapidly. Staff are still leaving based on promotion in different Trusts, work life balance and access to flexible working

The plan or mitigation

Since the Retention Team started in May 2023 there has been a month on month decrease in turnover, with the last 4 months being under the 14% target. First year turn over has also reduced month on month but remains above the target of 14%.

The Retention Team are running several projects including:
- PDR Season 2
- Onboarding
- Exploratory phase of Talent Management
- Exit Interviews
- Stay Conversations
- First year experience

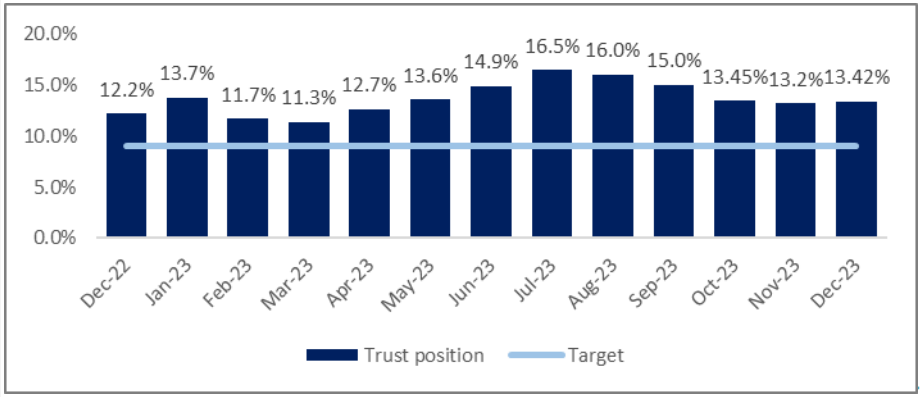
In addition, the Retention team are engaged in several supporting programmes such as the 3 Race Equality QI Programmes, 3 Disability QI Programmes, the Nursing Transformation Team and the Recruitment Team areas of work.

The Trust have been successfully accepted into national Cohort 2 of the 'Delivering the People Promise' programme and have received funding for 1 year for a 8a 'People Promise Manager'. The details of this project are currently being scoped.

Focus continues to be applied to areas with the highest turnover and professions with the biggest vacancy rates which remain HCA and B5 nurses.

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(**2g**) Reduction in % vacancies	</=9%	13.42%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue
The vacancy rate has increased from 13.2% to 13.42%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients. The lengthy time that it is taking to hire an employee results in candidates withdrawing from recruitment process or securing roles in other organisations.

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

The plan or mitigation
Overview:
The Trust budgeted establishment has continued to increase, from 6,579 FTE in December 2022 to 6,949 FTE in December 2023, an increase of 370 new posts in the last year.

The vacancy rate has increased slightly from 13.2 to 13.42 due to the addition of 36 new posts in the past month.

The General Recruitment team have now appointed 2 x new Band 5 Recruitment Advisors and area almost back to fully staffed.

Priority:
Recruitment for the PICU remains a priority, in particular Band 5 nurses. The campaigns team will continue to support the unit until it is fully staffed. The Highfield unit is now also high priority due to the impact of the opening of the Meadow unit which has led to staff shortages in difficult to recruit to skill areas.

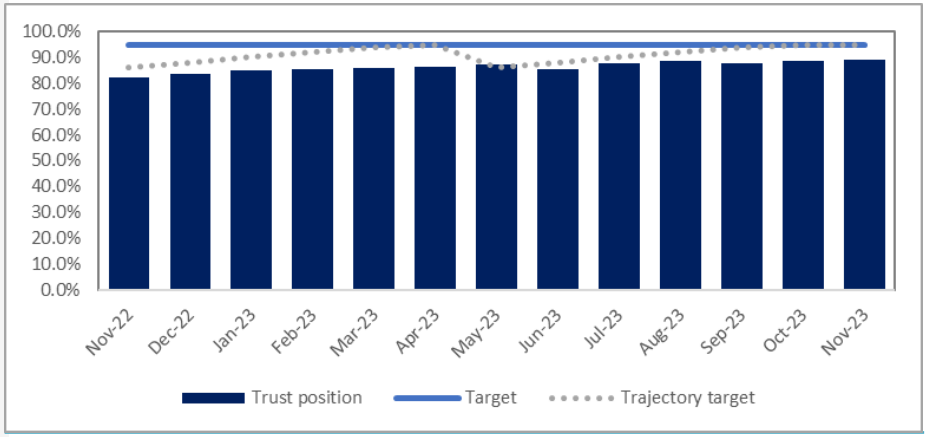
A QI project is underway focused on reducing time to hire, ensuring we lose less candidates in the recruitment process, attracting more suitable candidates, and ensuring a fairer, more inclusive recruitment process, allowing less bias creep is currently in the Discovery phase.

Due to the success of the Recruitment Roadshows that were held across 4 counties in November 2023, 2 further roadshows are being planned for 2024, in April and November which will take place across approx. 6 Trust locations, these events will be split into half days, targeted at both internal and external candidates.

Current Campaign Focus:
1. Proactive recruitment campaigns are taking place for priority areas including Littlemore Forensic units, Bucks Older Adult, Oxford City, Meadow PICU, Highfield CAMHS, Podiatry and Corporate Estates. Indeed Nursing Hiring Events and Jobs have been sponsored for Highfield and for Primary care and Adult City and North-East Adult Community teams.
2. Recruitment Branding has been approved and is currently in implementation.
3. University / student recruitment events are being prioritised with successful events held through October and November at UEA, Cardiff & Southampton, these type of events are being prioritised and planned for 2024. A Mental Health Student Recruitment Day is booked at Oxford Brookes on 24 March and Bedford University on 9 Feb.

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2i) Statutory and Mandatory training	>/=95%	89.8%



Executive Director commentary:
Charmaine De Souza - Chief People Officer

The risk or issue
The percentage of Statutory and Mandatory training modules reported as complete at the end of October has increased from 89.3% to 89.6%. Individuals who have not completed their training may not have the skills and knowledge to carry out their role safely.

The cause
There is an increase in the overall compliance rates, with reports that attendance to face to face skills-based training is improving. Staff continue to report that at times due to ongoing staffing pressures, they are not being released to attend. Work continues to correct anomalies in job roles to ensure accurate training is allocated to each staff member as this remains an issue.

The plan or mitigation

- All Directorates in the Trust are at et circa 86% completion with improvements across all training requirements. The Provider Collaborative directorate is above the 95% and 8 other Directorates are at circa 90%.
- There are 8 pieces of Mandatory training that have a compliance rate of circa 90% and for the other 3 there is a clear understanding of the existing risks and barriers and plans in place to address these.
- Development of Statutory and Mandatory training policy is underway A review of the Learning Advisory Group format and agenda is complete.
- Moving & Handling compliance rates have improved greatly to 89.4% following review of training and focused action plan.
- Focused work on Resus continues; The L&D team are booking staff onto courses targeting areas of poorer compliance and higher risk. An e-learning package review is to be completed year end. The L&D team are increasing the number of training places for ILS in response to service need. A new Band 7 has been appointed as team lead in the absence of a Band 8a.
- The Trust continues to roll out Level 1 of the Oliver McGowen training with continued improved compliance which currently sits at 70.4%. This will be added to statutory and mandatory training reporting once the Trust is above 85% compliance. The second part of the roll out of the Tier 2 training is on hold until the costings have been agreed.

Objective 3: Sustainability; make the best use of our resources and protect the environment

This year, our Objective Key Results (OKRs) are;	Trust	Trust Trend
(3a) **Favourable** performance against financial plan (YTD)	£0.9m Fav	↓
(3b) Cost Improvement Plan (CIP) delivery (YTD)	£1.7m Adv	→
(3c) **95%** of estate to achieve condition B rating by 2025 (75% in 2021)	98%	↑
3d) Delivery of estates related NHS Carbon Footprint reduction target of 2879 tonnes by 2028 ,Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-2038. (25,550 C02t)	4960 tonnes	→
(3e) **Achievement of all 8 targeted measures** in the NHS Oversight Framework (see section 2 of this report)	2 not achieved	→

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

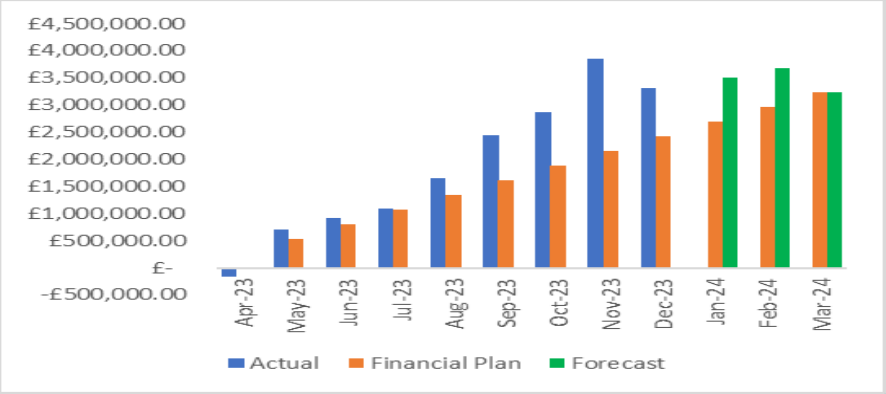
Executive Summary: Heather Smith, Chief Finance Officer
Narrative updated: January 2024
For reporting period ending: 31 December 2023

I&E £3.3m surplus, £0.9m favourable to plan. This includes some significant areas of year-to-date overspend which need to be addressed: Block income £1.7m (due to underperformance on the Eating Disorders & Secure contracts), Learning Disabilities £0.9m due to expensive out of area placements, Corporate £0.8m due to overspends in Estates & Facilities and £0.5m in Buckinghamshire Mental Health due to agency usage.

The CIP target allocated to directorates for FY24 is £7.2m, made up of £5.1m for FY24 and £2.1m unmet from FY23, So far £5.0m has been delivered: £1.0m from the temporary staffing team following the NHSP transfer and £3.9m from clinical directorates through the planning of new investment.

Objective 3: Sustainability – exception report

Objective Key Result (OKR)	Trust
(3a) Favourable performance against financial plan	£0.9m favourable



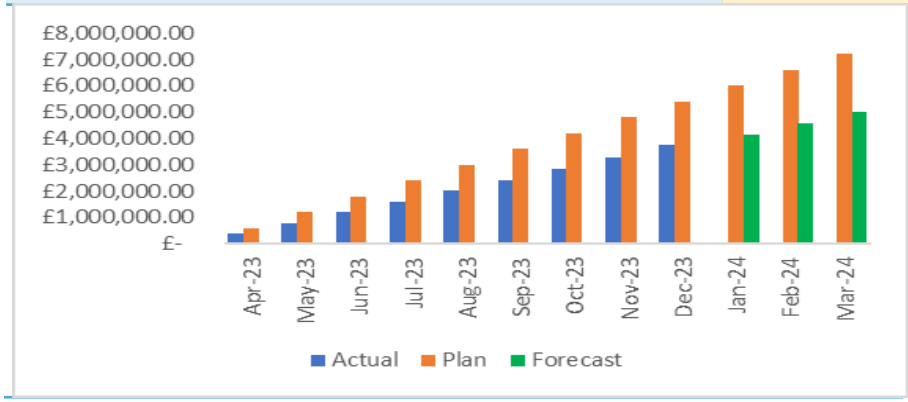
Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
Financial performance is £0.9m favourable to plan at month 9, but there are significant overspends in some directorates. The Trust is also spending more on agency staff than the target set by NHSE.

The cause
Directorates with year-to-date overspends: Block income £1.7m (due to underperformance on the Eating Disorders & Secure contracts), Learning Disabilities £0.9m due to expensive out of area placements, Corporate £0.8m due to overspends in Estates & Facilities and £0.5m in Buckinghamshire Mental Health.

The plan or mitigation
Agency control panels have been set up monthly
Finance Deep Dive meetings have taken place with Directorates and action plans produced.
The forecast in month 12 deteriorates due to expected year-end adjustments and non-recurrent spend which is not expected to be incurred until March.

Objective Key Result (OKR)	Trust
(3b) Cost Improvement Plan (CIP) Delivery	£1.7m adverse



Executive Director commentary:
Heather Smith, Chief Finance Officer

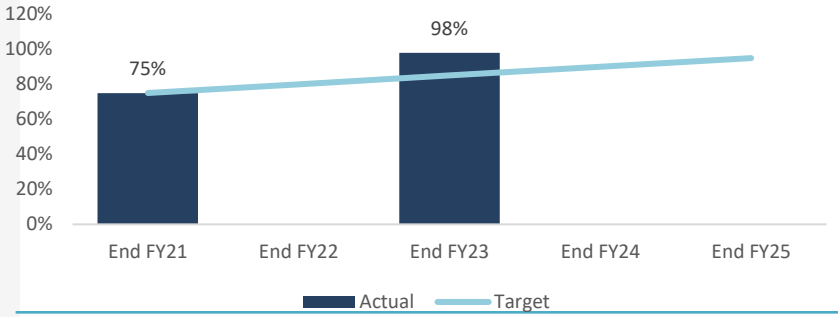
The risk or issue
CIP Performance against plan is £1.7m adverse at month 9.

The cause
CIP schemes have not been developed yet for the full CIP target.

The plan or mitigation
Finance will work with directorates over the next few months to identify schemes for the remaining CIP target and to develop CIP plans for the next financial year. As part of this Finance have recruited to a new post to co-ordinate the CIP programme and the postholder has recently started. The budget setting principles for FY25 include a requirement for directorates to meet 75% of their CIP requirement before they receive any investment.

Objective 3: Sustainability – exception report

Objective Key Result (OKR)	Target	Actual
(3c) 100% of estate to achieve condition B rating by 2025	85%	98%



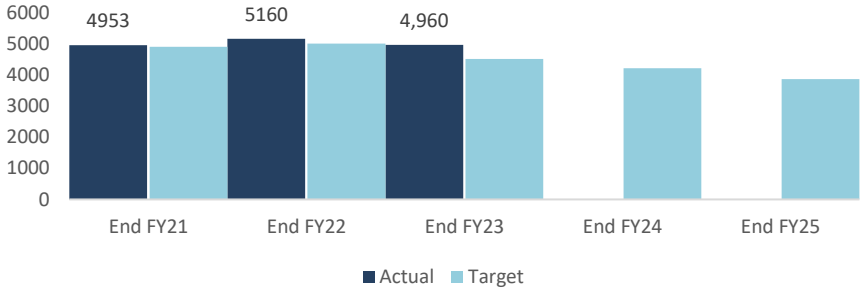
Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
The condition of the estate can have serious impact upon its safety and useability. Guidance sets out a requirement for the NHS Estate to be rated as Condition. An updated 6 facet survey has been undertaken by Gleeds. The survey identified that the estate mainly achieving condition B. There are some elements and sites within individual buildings that fall short of this and investment is required to rectify this and also to enable the maintenance of the estate at the appropriate level.

The cause
Lack of future investment will impact upon the condition of the estate.

What is the plan or mitigation?
Investment requirements are set out in the Trust Capital Investment Plan

Objective Key Result (OKR)	Target	Actual
(3d) Delivery of NHS Direct carbon footprint of 47% reduction by 2028 compared to 2019-20 baseline year	4508	4,960



Executive Director commentary:
Heather Smith, Chief Finance Officer

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

The cause
Q1 FY24 saw 12% reduction in overall carbon emissions (58tCo2)when compared to Q1- FY23.However Fossil fuel burning Gas consumption increased by 7 % (17tCo2).
Staff Business mileage increased by 533,996 miles, increasing the travel related carbon footprint by 17% (147 tCO2e)

What is the plan or mitigation?
The estates department has an action plan describing potential schemes and a 'Green Plan' has been produced for the Trust. A key objective for FY24 to review modal shift to more sustainable travel. Report with recommendations to support modal shift of travel into sustainable alternatives to be considered by Green Task Force

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

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

	FY24 - TD				FY23 for reference
Studies	Opened (currently active)	Closed	Studies that recruited		National comparator	
CRN Portfolio	14 (69 inc.7 students)	5	Community Services Oxon & BSW Bucks Corporate inc. R&D TOTAL	6 8 4 23 41	OHFT 4th nationally – 41 studies 1st Trust – 63 studies	OHFT 4th nationally – 46 studies 1st Trust – 72 studies
Non-Portfolio	12 (24 inc.12 students)	11	13		n/a	n/a

	FY24 - TD		FY23 for reference
	Recruited participants to the above studies		National comparator
CRN Portfolio	Community Services Oxon & BSW Bucks Corporate inc. R&D Oxford Monitoring System for attempted Suicide TOTAL	79 121 60 419 843 1522	OHFT 7th nationally – 1522 participants 1st Trust – 4259 participants	OHFT 5th nationally – 1789 participants 1st Trust – 6598 participants
Non-Portfolio	216		n/a	n/a

Executive Summary: Karl Marlowe, Chief Medical Officer \ Vanessa Raymont, R&D Director **Data cut:** 8th January 2024

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

Impact of limited Electronic Health Records access

Being unable to review patient records is delaying or prevent recruitment of patients to clinical studies. The impact of this will be, reputational, if we fail to meet national deadlines and financially, if will fail to recruit to funded studies and where the recover excess treatment costs are based on patient recruitment.

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

For Information

Finance Report
November 2023 (Month 8), FY24
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 - £1.7m better than plan
- Forecast – on plan

Risks £7.2m
Opportunities £8.2m
Net £1.0m upside

Capital Expenditure
- YTD - £5.1m behind plan
- Forecast – capex to exceed funding by £2.5m

Cash
- Actual £89.6m, £21.0m better than plan

Highlights:

- The month 7 YTD position is a surplus of **£3.8m, £1.7m** favourable to plan.
- The forecast is a surplus of **£3.2m**, on plan.
- There are **£7.2m** of risks and **£8.2m** of opportunities to the forecast. This gives a forecast range of between **£8.2m** better than plan and **£7.2m** worse than plan. This month there are no risks and opportunities assessed as high likelihood as items from previous months have now been included in the forecast.
- The Directorates forecasting adverse variances to budget are: Forensic Mental Health **£0.4m,** Learning Disabilities **£0.9m,** Provider Collaboratives **£0.2m,** Primary, Community and Dental Care **£0.4m,** Corporate **£1.9m,** Buckinghamshire Mental Health **£1.1m** and Block Income **£2.0m**. Agreed non-recurrent spend of **£2.6m** has been included in directorate positions this month which accounts for why some of the variances have increased from month7.
- At month 8 **£24.8m** has been spent on agency staff, which is **10.4%** of total staff costs. The Trust's agency ceiling set by NHS England for FY24 is **£32.2m**. The agency forecasts in directorate positions is **£36.7m**. This is mainly based on YTD trend and does not take into account any further improvements from the ID Medical and NHSP contracts. When these are taken into account the forecast is **£35.2m**. There is also a potential benefit from the agency accrual from FY23. Finance and the Clinical Workforce team are working with ID Medical to confirm whether all invoices for FY23 have been paid in order to determine whether an accrual is still needed.
- **£4.9m** of the **£7.2m** CIP target has been delivered so far. Further work is needed to identify schemes for the remaining **£2.3m**.
- The Trust has a **£11.0m** PIP target to be met through a reduction in temporary staffing spend. **£4.7m** of savings have been made so far.
- Capital expenditure is reporting a **£5.1m** underspend YTD. The forecast is for a **£2.5m** overspend against the funding available.
- Cash remains strong with a cash balance of **£89.6m**.

1. Income Statement

INCOME STATEMENT	Month 8			Year-to-date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Clinical Income	44.1	42.6	(1.5)	341.7	332.5	(9.2)	512.4	504.7	(7.7)
Other Operating Income	7.4	9.3	1.9	58.2	64.6	6.4	87.9	95.5	7.6
Operating Income, Total	**51.5**	**51.9**	**0.4**	**399.9**	**397.1**	**(2.8)**	**600.3**	**600.2**	**(0.1)**
Employee Benefit Expenses (Pay)	30.9	30.1	0.8	245.4	238.9	6.5	367.8	360.4	7.3
Other Operating Expenses	19.0	19.9	(0.9)	141.7	144.6	(2.8)	213.4	221.0	(7.5)
Operating Expenses, Total	**49.9**	**50.0**	**(0.1)**	**387.1**	**383.4**	**3.7**	**581.2**	**581.4**	**(0.2)**
EBITDA	**1.6**	**1.9**	**0.3**	**12.7**	**13.7**	**0.9**	**19.1**	**18.8**	**(0.3)**
Financing costs	1.3	0.9	0.4	10.6	9.8	0.8	15.9	15.6	0.3
Surplus/ (Deficit)	**0.3**	**1.0**	**0.7**	**2.2**	**3.9**	**1.7**	**3.2**	**3.2**	**(0.0)**
Adjustments	0.0	0.0	0.0	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Adjusted Forecast Surplus/ (Deficit)	**0.3**	**1.0**	**0.7**	**2.1**	**3.8**	**1.7**	**3.2**	**3.2**	**(0.0)**
Gap between internal and external forecasts									0.0
Forecast Surplus/ (Deficit)							**3.2**	**3.2**	**(0.0)**

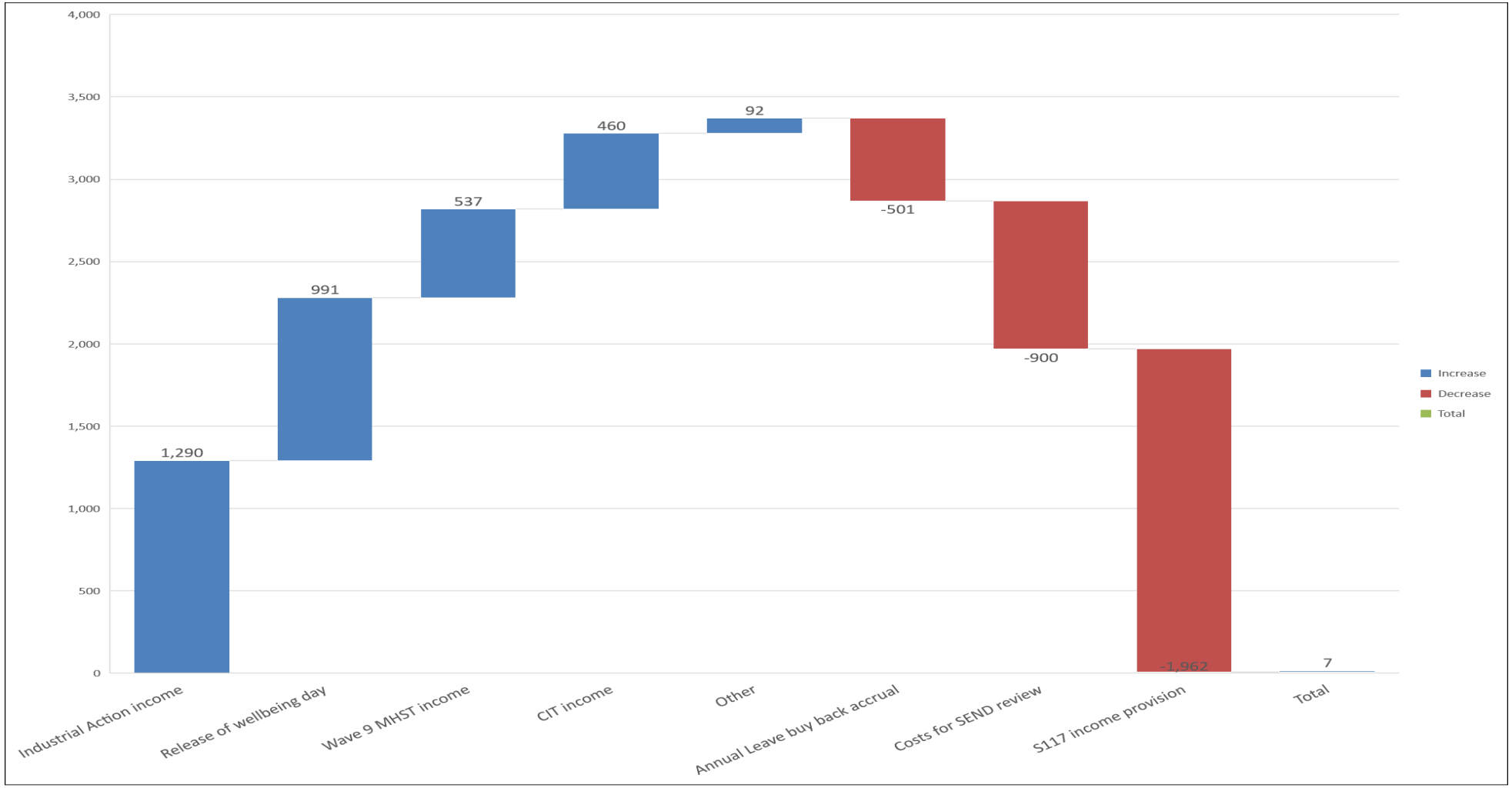
Year-to-Date Performance

The month 8 YTD position is a surplus of **£3.8m, £1.7m** favourable to plan. EBITDA is **£0.9m** favourable to plan and Financing costs are **£0.8m** favourable to plan.

The adverse variance on income (**£2.8m**) is made up of **£6.6m** on Provider Collaboratives where income has been deferred to match lower spend and **£1.5m** on block income due to performance adjustments for lower than planned bed occupancy in Forensics and Eating Disorders. These are offset with **£2.5m** higher sales in Oxford Pharmacy Store, **£2.2m** education and training income above budget, **£0.4m** additional income in Research & Development and **£0.2m** the net amount of smaller variances.

The favourable variance on expenditure (**£3.7m**) is made up of **£6.6m** in Provider Collaboratives (offset with income) and a **£6.6m** favourable variance on pay. These are offset with **£2.3m** higher cost of sales in Oxford Pharmacy Store, **£1.7m** overspend in Estates & Facilities, **£2.2m** overspend on Mental Health out of area placements and **£0.7m** overspend on Learning Disabilities out of area placements. The remaining **£2.5m** adverse variance is due to various non-pay costs including subcontracts funded through pay underspends due to vacancies.

2. Forecast movement from previous month



Increase = Favourable change

Decrease = Adverse change

The month 8 forecast remains on plan.

The Industrial Action income is central NHS England non-recurrent funding that has come through to ICSs and providers this month.

3. Forecast Risks & Opportunities

Risks	£'000	Likelihood
Prior year CHC income	1,100	Medium
Winter pressures	1,000	Medium
Capital to revenue transfer	1,000	Medium
Frontline Digitalisation income	400	Medium
Increase in OAPs	300	Medium
Income risks	250	Medium
Balance Sheet/Audit	3,000	Low
Additional LD OAPs	120	Low
	7,170	

Opportunities	£'000	Likelihood
Agency reduction	1,500	Medium
Modern Equivalent Assets valuation	1,000	Medium
Additional release of PC deferred income	900	Medium
Contracting issues with BOB ICS	761	Medium
Agreement on old NHS PS invoices	400	Medium
Discharge of LD OAPs patients	344	Medium
Reduction in OAPs	200	Medium
R&D CRF building work - release of income	58	Medium
Additional income	30	Medium
Balance Sheet/Audit	3,000	Low
	8,193	

The Trust's Forecast Outturn is for a **£3.2m** surplus, which is on plan.

There are **£7.2m** of risks and **£8.2m** of opportunities to the forecast. This gives a forecast range of between **£8.2m** better than plan and **£7.2m** worse than plan.

This month there are no risks and opportunities assessed as high likelihood as items from previous months have now been included in the forecast.

The Trust is still trying to agree additional income values from the BOB ICS for this year. However, the forecast now reflects the income that has been agreed so far and agreement on any disputed items will improve the Trust's forecast position.

The agency reduction opportunity may come from the release of the FY23 agency accrual or further reductions in agency spend in the last few months of the year.

£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. This year this may include any adjustments needed due to exit from the PFI agreement for the Oxford Clinic in September 2024. This is being worked through with the auditors.

Forecast range - all risks and opportunities			
£'000	Full Year Budget	Full Year Actual	Forecast Outturn to Plan
Upside Forecast	3,312	11,505	8,193
Downside Forecast	3,312	-3,858	-7,170

Forecast range - high likelihood risks and opportunities			
£'000	Full Year Budget	Full Year Actual	Forecast Outturn to Plan
Upside Forecast	3,312	3,312	-0
Downside Forecast	3,312	3,312	-0

4. Capital Investment Programme.

	FY24	FY24 Expenditure			FY24 Outturn			FY24	
Project Names	(B) Latest Budget £,0	(C) Profiled Budget £,0	(D) Actual Expenditure £,0	(C-D) Variance £,0	(E) System Commt's £,0	(F=D+E) Actual Plus £,0	(B-F) Variance £,0	(G) Estimated Forecast £,0	(B-G) Variance £,0
Estates - Projects c/f	193	186	70	115	292	363	(170)	138	55
Estates - Highfield PICU	1,810	1,810	2,616	(806)	14	2,630	(820)	2,636	(826)
Estates - Jordan Hill	500	318	(5)	324	4	(1)	501	200	300
Estates - PDC Projects	1,149	731	47	684	3	49	1,100	1,149	-
Estates - MH Projects	5,073	2,658	294	2,364	911	1,204	3,869	4,202	872
Estates - Community Projects	1,725	1,244	228	651	261	489	892	2,525	(800)
Estates - Life Cycle & Back Log Work	1,792	1,096	423	673	977	1,400	392	1,761	31
OPS- Oxord Pharmacy Store	800	509	478	31	472	949	(149)	1,457	(657)
Sub Total - Estate Improvements	9,744	6,611	3,079	3,533	1,433	4,512	5,233	10,071	(327)
Sub Total - Operational Capital	2,498	1,431	594	837	1,029	1,623	875	2,540	(42)
Sub Total - Oxford Pharmacy (MX	800	509	478	31	472	949	(149)	1,457	(657)
Grand Total - All Estates	13,042	8,552	4,150	4,401	2,934	7,084	5,958	14,068	(1,026)
IT Capital	1,140	725	402	324	80	482	658	1,213	(73)
IM&T Clinical Systems	3,445	2,192	1,911	281	292	2,203	1,242	3,488	(43)
IM&T - PDC Projects	435	277	202	75	-	202	332	492	42
Grand Total - IM&T	5,119	3,195	2,515	680	372	2,887	2,232	5,194	(75)
PFI	-	-	6	(6)	-	6	(6)	15	(15)
Grand Total	18,161	11,746	6,672	5,075	3,306	9,977	8,184	19,277	(1,116)

Funding Sources	Latest Funding
Total Funding Available	16,823
Net Funding Surplus /(Deficit) vs Budget	(1,339)
Net Funding Surplus /(Deficit) vs Est. Outturn	(2,454)

FY24 - Leases IFRS 16	£,000 Lease Liability	£,000 Lease Dilaps	£,000 Total Lease Liability
Windrush House Room G6 & G7 (Witney Business & Innovation Centre)	69	18	87
Oxford Pharmacy - Unit 7, MXL Centre, Lombard Way, Banbury, OX16 4TJ	1,301	326	1,627
New Leases Started FY24	***1,370***	***344***	***1,714***
Unipart House 4th Floor	1,066	250	1,316
Murray House, Jordan Hill (20 yrs)	7,112	1,500	8,612
Cowley Road CMHF Hub	357	90	447
Kidlington CMHF Hub	TBC	TBC	TBC
Wantage CMHF Hub	TBC	TBC	TBC
Potential New Leases FY24	***8,535***	***1,840***	***10,375***
Ambrosden (MOD) (Est 3yr)	8	TBC	8
Potential Renewal of Leases FY24	**8**	**-**	**8**
Total Leases FY24	**9,913**	**2,184**	**12,097**

The Trust spent **£6,672k** on its capital programme in the first 8 months of the year against a year-to date expenditure budget of **£11,746k**, an underspend of **£5,075k**.

The Trust has a forecast outturn of **£19,277k**, which represents an overspend against plan of **(£1,116k)** and a funding deficit of (**£2,454k)**. It is likely that this position will be mitigated by slippage, and the ICB also have additional capital available. However, plans are in place to mitigate this cost pressure by deferring projects if needed.

There are a couple of risks to the year-end position relating to Frontline Digitalisation income no longer being available and any consequences in this year's accounts of the exit from the Oxford Clinic PFI in September 2024.

5. Directorate Financial Performance Summary

	Month 8			Year-to-date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Directorate	£m	£m	£m	£m	£m	£m	£m	£m	£m
Oxfordshire & BSW Mental Health	(9.5)	(10.9)	(1.4)	(75.3)	(74.9)	0.4	(113.5)	(113.3)	0.3
Buckinghamshire Mental Health	(4.4)	(4.9)	(0.5)	(35.0)	(35.7)	(0.6)	(52.6)	(53.6)	(1.1)
Forensic Mental Health	(2.6)	(2.5)	0.0	(20.4)	(20.5)	(0.1)	(30.7)	(31.1)	(0.4)
Learning Disabilities	(0.5)	(0.5)	(0.0)	(3.9)	(4.6)	(0.8)	(5.8)	(6.7)	(0.9)
Provider Collaboratives	0.2	0.2	(0.0)	7.6	7.6	(0.0)	11.5	11.3	(0.2)
MH Directorates Total	**(16.8)**	**(18.7)**	**(1.9)**	**(127.0)**	**(128.1)**	**(1.1)**	**(191.1)**	**(193.4)**	**(2.3)**
Primary Community & Dental Care	(8.4)	(8.3)	0.1	(66.4)	(65.9)	0.5	(99.0)	(99.4)	(0.4)
Corporate	(6.4)	(6.5)	(0.4)	(49.3)	(49.3)	(0.0)	(74.1)	(76.0)	(1.9)
Oxford Pharmacy Store	0.0	0.1	0.0	0.2	0.3	0.2	0.4	0.8	0.5
Research & Development	(0.0)	0.0	0.1	(0.3)	(0.0)	0.3	(0.5)	(0.3)	0.2
Covid-19 Costs	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0
Reserves	(0.9)	1.7	2.6	(4.4)	(1.9)	2.5	(5.9)	(0.1)	5.7
Block Income	34.0	33.6	(0.5)	260.0	258.5	(1.5)	389.3	387.2	(2.0)
EBITDA	**1.6**	**1.9**	**0.1**	**12.7**	**13.7**	**0.9**	**19.1**	**18.8**	**(0.3)**
Financing Costs	1.3	0.9	0.4	10.6	9.8	0.8	15.9	15.6	0.3
Adjustments	0.0	(0.0)	0.0	0.0	0.0	(0.0)	(0.1)	(0.0)	(0.0)
Adjsuted Surplus/(Deficit)	**0.3**	**1.0**	**0.4**	**2.2**	**3.9**	**1.7**	**3.2**	**3.2**	**(0.0)**

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

The forecast overspend on Provider Collaboratives (PCs) relates to the Adult Eating Disorders PC. The Secure and CAMHS PCs are forecasting underspends but the forecast for the Trust position is on plan as it is assumed that the underspends will be carried forward into next year for re-investment.

6. Provider Collaboratives Financial Performance Summary

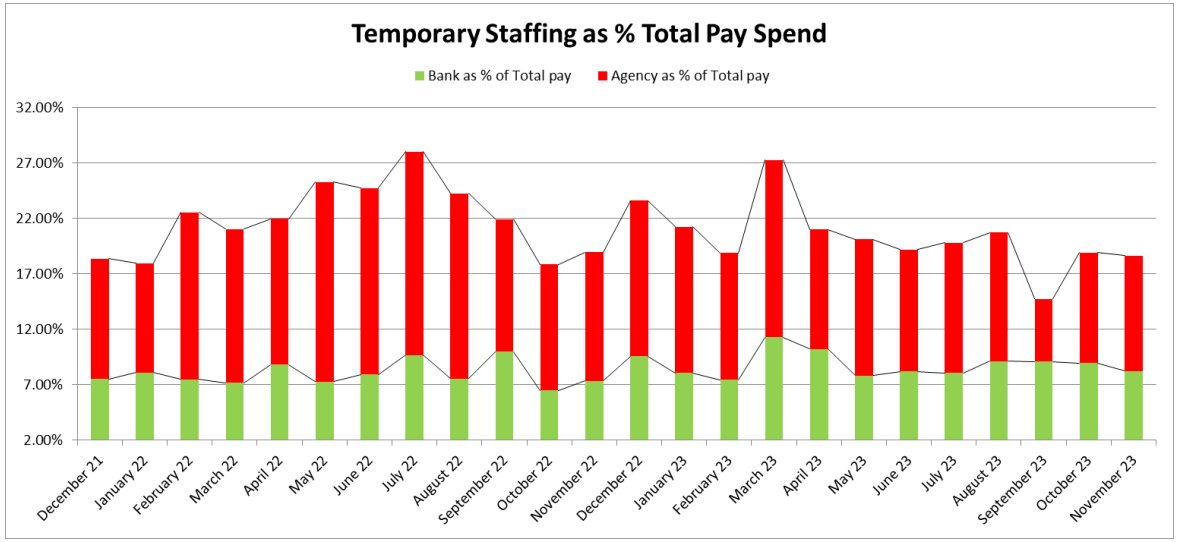
INCOME STATEMENT	Month 8			Year-to-date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Secure	7.7	7.6	0.1	61.6	60.6	1.0	92.5	90.9	1.6
CAMHS	2.3	2.0	0.3	18.7	17.3	1.4	28.1	25.8	2.3
Adult AED	0.8	0.9	(0.1)	5.9	5.7	0.2	9.4	9.6	(0.2)
Provider Collaboratives Total	**10.8**	**10.5**	**0.3**	**86.2**	**83.6**	**2.6**	**130.0**	**126.3**	**3.7**

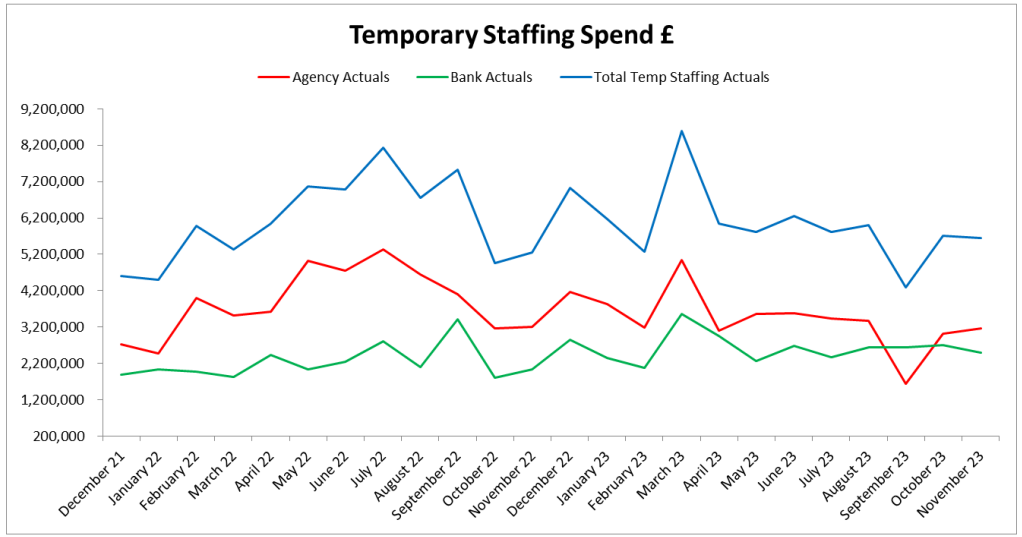
For the secure and CAMHS Provider Collaboratives income is deferred in the YTD and forecast position to match spend. The table above details the expenditure position.

The Provider Collaboratives (PC) YTD position is **£2.6m** favourable to plan.

The PC forecast position is **£3.7m** favourable. Secure and CAMHS (£3.5m favourable) are reported as breakeven in the Trust overall position in line with the principles of the PC to reinvest savings into services. Adult ED £0.2m adverse is reported as such in the Trust overall position.

7. Agency Analysis





At month 8 **£24.8m** has been spent on agency staff, which is **10.4%** of total staff costs. This includes **£0.4m** to support one patient on 10:1 observations, who was discharged on the 9th October. These figures and the graphs above now include agency spend related to Covid vaccinations from April, but the figures from previous years still exclude this spend.

The Trust's agency ceiling set by NHS England for FY24 is **£32.2m**. The agency forecasts in directorate positions is **£36.7m**. This is mainly based on YTD trend and does not take into account any further improvements from the ID Medical and NHSP contracts. When these are taken into account the forecast is **£35.2m**.

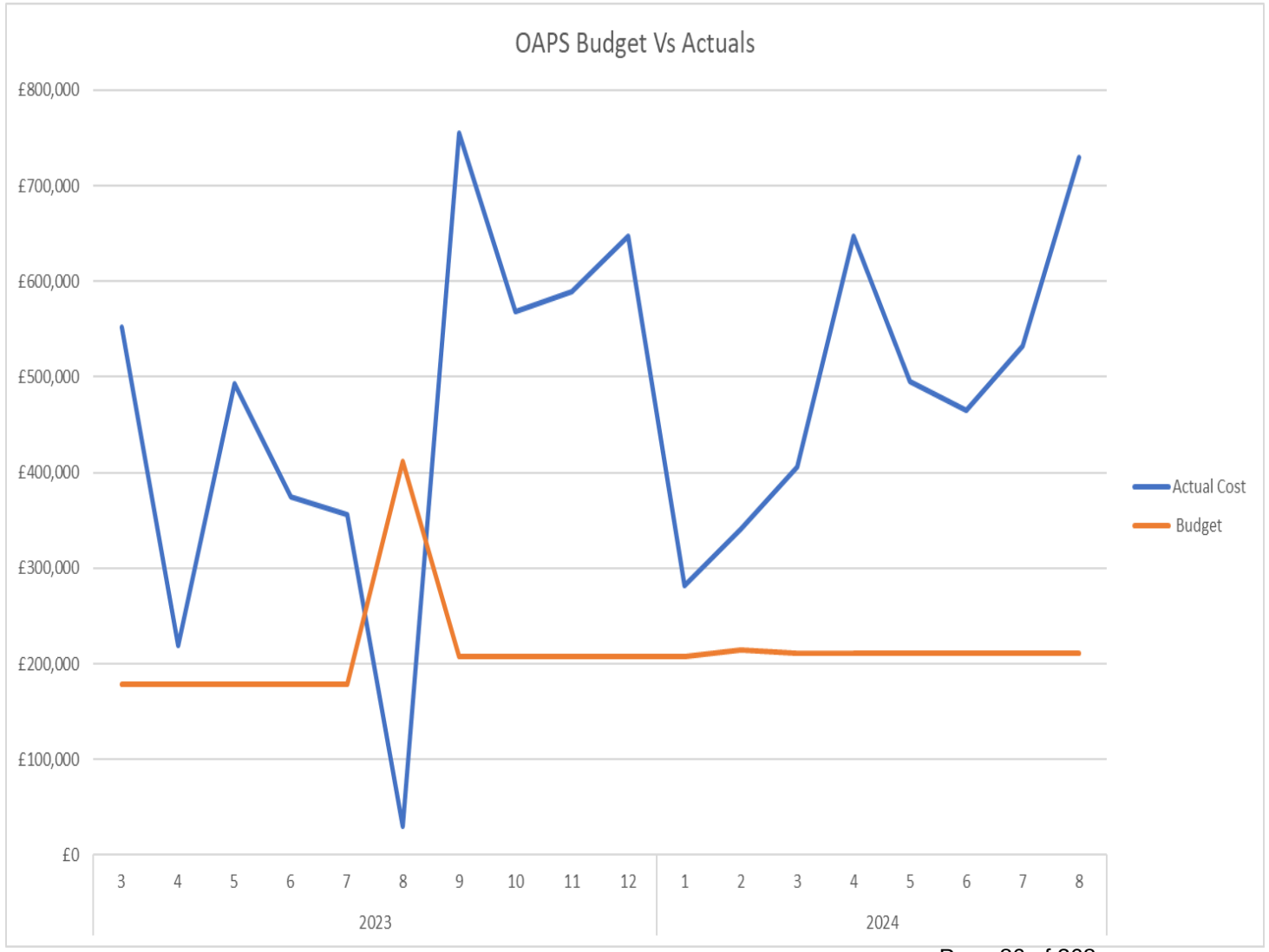
There is also a potential benefit from the agency accrual from FY23. Finance and the Clinical Workforce team are working with ID Medical to confirm whether all invoices for FY23 have been paid in order to determine whether an accrual is still needed.

8. Non-Pay Expenditure Analysis

£'000s	Month 8				Year-to-Date			
Category of Spend	Budget	Actual	Variance	% Variance	Budget	Actual	Variance	% Variance
Clinical Supplies & Services	1,546	2,467	-921	-60%	12,563	16,440	-3,878	-31%
Drugs	350	372	-22	-6%	2,799	3,301	-502	-18%
Establishment	1,291	1,126	164	13%	6,711	7,958	-1,247	-19%
General Supplies And Services	284	312	-27	-10%	2,317	2,416	-100	-4%
Other	1,270	2,582	-1,311	-103%	10,707	11,916	-1,209	-11%
Oxford Pharmacy Store Cost of Sales	3,338	4,644	-1,306	-39%	25,333	28,272	-2,939	-12%
Premises	1,047	1,588	-541	-52%	8,363	11,924	-3,561	-43%
Provider Collaborative Contracts	6,135	4,297	1,838	30%	46,078	39,612	6,466	14%
Purchase of Services	841	1,285	-443	-53%	6,732	8,618	-1,887	-28%
R&D non-staff costs	1,354	712	642	47%	10,715	10,219	496	5%
Reserves	1,083	0	1,083	100%	5,430	0	5,430	100%
Transport	499	533	-34	0%	3,987	3,889	98	0%
	19,040	**19,918**	**-878**	**-5%**	**141,734**	**144,566**	**-2,832**	**-2%**

- Clinical Supplies & Services are overspent by **£3.9m** YTD driven by **£0.7m** in Childrens Continuing Care (offset by additional income), **£0.7m** for out of area placements in Learning Disabilities, **£0.2m** for beds in Community Hospitals (agreed as spend in FY23 but they did not arrive until July), **£1.0m** for equipment and supplies spend in the Primary, Community and Dental Care directorate, **£1.3m** in the Oxfordshire & BSW and Buckinghamshire Mental Health directorates mainly on sub-contracts with providers to assist with waiting lists where services have vacancies.
- The overspend on Drugs costs is made up of overspends across all clinical areas.
- The overspend on Establishment costs is driven by IT related costs in services e.g. software licenses fees and purchase of IT hardware.
- The overspend on Other is driven by and overspend in Research & Development, offset with the favourable variance on R&D non-staff costs and additional income.
- The overspend on Oxford Pharmacy Store Cost of Sales is offset by additional sales income.
- The overspend on Premises costs is driven by a **£2.5m** overspend in Estates & Facilities costs due to pressures contracts and property costs, **£0.5m** spend on furniture, **£0.2m** new works costs in directorates, **£0.2m** due to prior year electricity costs for the Covid vaccinations centres and a **£0.4m** net overspends in other areas.
- The underspend on Provider Collaboratives contracts reflects lower than planned spend and this is offset by an adverse variance on income.
- Purchase of Services is overspent by **£1.9m** YTD driven by Mental Health Out of Area Placement costs - **£1.3m** overspent in Oxfordshire and **£1.0m** overspend in Buckinghamshire. These are offset by **£0.6m** of extra packages of care income in Forensics (reported in non-pay as it is a transfer from Provider Collaboratives). The balance of £0.2m overspend is due to smaller variances across several other areas.
- The Reserves budget is the contingency held by the Trust to offset pressures elsewhere.
- The Transport underspend is driven by an underspend on business mileage costs.

9. Out of Area Placements (OAPs)



Out of Area Placements are **£2.2m** adverse at month 8, **£1.2m** adverse in Oxfordshire and **£1.0m** adverse in Buckinghamshire.

This includes the cost of the 4 block beds contract with Elysium. Plus, a further 2 block beds which were added to the contract in month 6, originally for 3 months but has now been extended to 31st January 2024. This is due to the continuous high demand on the service's acute beds.

These costs exclude Secure Transport spend which is currently **£103k** across the two directorates.

10. Cost Improvement Programme (CIP)

The Trust's external CIP target as reported to NHSE is **£16.1m** made up of a **£5.1m** efficiency from contract uplifts (CIP) and **£11.0m** cost management (Productivity Improvement Programme (PIP). The Trust continues to report a forecast full delivery of the **£16.1m** to NHS England on the assumption that any shortfall in these programmes will be mitigated by other non-recurrent benefits in the Trust's position.

Internally the Trust has an additional **£2.1m** CIP for FY23 CIPs that were not delivered recurrently last year, making the total internal CIP target **£7.2m**.

£4.9m of the **£7.2m** CIP target has been delivered so far through CIPs made up front from investment funding and a **£1.0m** saving in HR from the Temporary Staffing team following the transfer to NHSP. A Finance Business Partner has just been appointed to lead on efficiency programmes to help develop plans for the remaining £2.3m recurrently and develop plans for FY25.

£'000s	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast	Forecast Variance
Community	1,291	667	-625	1,937	1,000	-937
Oxon & BSW MH	1,185	969	-216	1,778	1,454	-324
Bucks MH	535	535	0	803	803	0
Forensics	410	410	0	615	615	0
Learning Disabilities	71	0	-71	106	0	-106
Provider Collaboratives	19	19	0	29	29	0
Corporate	632	0	-632	948	0	-948
NHSP transfer (internal bank team costs)	667	667	0	1,000	1,000	0
Total CIP	**4,811**	**3,267**	**-1,543**	**7,216**	**4,901**	**-2,315**

11. Productivity Improvement Programme (PIP)

The **£11.0m** PIP target is to be met through a reduction in temporary staffing spend including the cost reduction from moving from agencyto bank staff as well as a reduction in demand for temporary staffing. This is being calculated as the YTD reduction in spend between FY23 and FY24 (excluding the Covid mass vaccination centre spend). At month 8 **£4.7m** of savings have been made, which is **£1.7m** lower than the YTD target. The forecast spend is **£7.0m** lower than FY23 spend which is **£4.1m** below the target. This shortfall is being offset by vacancies. The forecast may improve as the current forecast does not take into account further improvements in performance by ID Medical and NHSP.

The performance against the PIP target is different to the performance against the agency spend target. For the latter any reduction in agency spend counts towards this target. For the PIP target it is only reduction in agency spend which results in an overall cost saving to the Trust that can be regarded as a PIP saving. For example, if the same number of hours move from agency to bank there will be a saving against both targets. But, if spend moves to bank and demand increases then there won't be a reduction in costs so no PIP savings.

£'000s	M1	M2	M3	M4	M5	M6	M7	M8	YTD	Full Year Actual/Forecast
FY23 Bank	2,463	2,008	2,218	2,803	2,135	3,366	1,793	2,021	18,807	29,627
FY23 Agency	4,322	3,417	5,041	3,681	3,920	3,760	4,741	2,563	31,445	44,761
Total FY23	**6,785**	**5,425**	**7,259**	**6,484**	**6,055**	**7,126**	**6,534**	**4,584**	**50,252**	**74,388**
FY24 Bank	2,946	2,390	2,542	2,493	2,667	2,499	2,680	2,491	20,708	30,741
FY24 Agency	2,922	3,253	3,351	3,127	2,594	3,474	3,275	2,810	24,806	36,690
Total FY24	**5,868**	**5,643**	**5,893**	**5,620**	**5,261**	**5,973**	**5,954**	**5,301**	**45,514**	**67,431**
Savings	**917**	**-218**	**1,366**	**864**	**794**	**1,153**	**580**	**-717**	**4,739**	**6,957**
Target	**920**	**920**	**920**	**920**	**920**	**920**	**920**	**920**	**6,442**	**11,043**
Variance	**-3**	**-1,138**	**446**	**-56**	**-126**	**233**	**-341**	**-1,637**	**-1,703**	**-4,086**

12. Statement of Financial Position

Statement of Financial Position as at 30th November 2023

31 March 2023		Month 7 FY24	Month 8 FY24	Movement Year to date	Movement In month	
£'000		£'000	£'000	£'000	£'000	
	Non-current assets					
4,977	Intangible Assets	5,813	5,700	723	(113)	
215,796	Property, plant and equipment	216,201	216,039	243	(162)	
30,850	Finance Leases	28,469	28,025	(2,825)	(443)	
1,125	Investments	1,125	1,125	0	0	
512	Trade and other receivables	519	519	7	0	
485	Other Assets	486	486	1	0	
253,745	Total non-current assets	252,612	251,894	(1,851)	(718)	1
	Current Assets					
2,932	Inventories	2,777	2,902	(30)	125	
35,215	Trade and other receivables	21,637	23,500	(11,715)	1,863	2
840	Non-current assets held for sale	840	0	(840)	(840)	3
74,610	Cash and cash equivalents	89,760	89,616	15,006	(144)	4
113,597	Total current assets	115,014	116,018	2,421	1,004	
	Current Liabilities					
(83,398)	Trade and other payables	(73,089)	(72,274)	11,124	815	5
(2,019)	Borrowings	(2,070)	(2,079)	(60)	(9)	
(5,374)	Finance Leases	(5,371)	(5,371)	3	0	
(2,249)	Provisions	(2,252)	(2,253)	(4)	(1)	
(23,002)	Deferred income	(34,844)	(35,356)	(12,354)	(512)	6
(116,042)	Total Current Liabilities	(117,625)	(117,333)	(1,291)	292	
(14,640)	Borrowings	(13,588)	(13,568)	1,072	20	7
(19,983)	Finance Leases	(17,015)	(16,512)	3,471	503	8
(6,085)	Provisions	(5,934)	(5,928)	157	7	
(40,707)	Total non-current liabilities	(36,537)	(36,008)	4,699	529	
210,592	Total assets employed	213,463	214,571	3,979	1,107	
	Financed by (taxpayers' equity)					
109,631	Public Dividend Capital	109,631	109,750	120	119	
82,587	Revaluation reserve	82,589	82,148	(439)	(441)	
1,125	Other reserves	1,125	1,125	0	0	
17,250	Income & expenditure reserve	20,117	21,547	4,298	1,430	9
210,592	Total taxpayers' equity	213,463	214,571	3,979	1,108	

1. Non-current assets have decreased by (**£1.8m**) in-year and **(£0.7m)** in-month. The in-year decrease is due to the disposal of Harlow House of **(£0.8m)** and cumulative depreciation of **(£9.4m)** exceeding capital additions of **£8.4m** (including £1.7m of leased assets)**.**
2. Trade and other receivables decreased by **£11.7m** in year and increased by **£1.9m** in month. Most of the decrease in-year is due to a decrease in outstanding debt of **(£8.0m)** and accrued income of **(£4.7m)**. Other debtors (mainly prepayments) have increased by **£0.9m** in year.
3. Non-current assets held for sale have decreased by **(£0.8m)** in-year and in-month following the sale of Harlow House.
4. The cash balance has increased by **£15.0m** over the year and decreased by **£0.1m** in month. The in-year increase is mainly driven by an increase in cash generated from operations – see note 13. The cash flow statement.
5. Trade and other payables have decreased by **£11.1m** in year and **£0.8m** in month. The decrease in-year is largely due to a fall in trade payables and accrued expenditure of **£11.1m.**
6. Deferred income has increased by **£12.4m** in year and **£0.5m** in-month. Most of the in-year increase can be attributed to the Provider Collaborative (£7.7m) and advanced payments from Health Education England (£2.7m).
7. Non-current borrowings have decreased by **£1.1m** in year. This relates to capital repayments against the Trust's DHSC loan of £0.7m and £0.4m against the Trust's PFI liability.
8. Finance Leases liabilities (IFRS16) have decreased by **£3.5m** in year and **£0.5m** in month due to capital repayments.
9. The in-year and in-month movements in the I&E reserves reflects the Trust's reported surplus position for the same time periods.

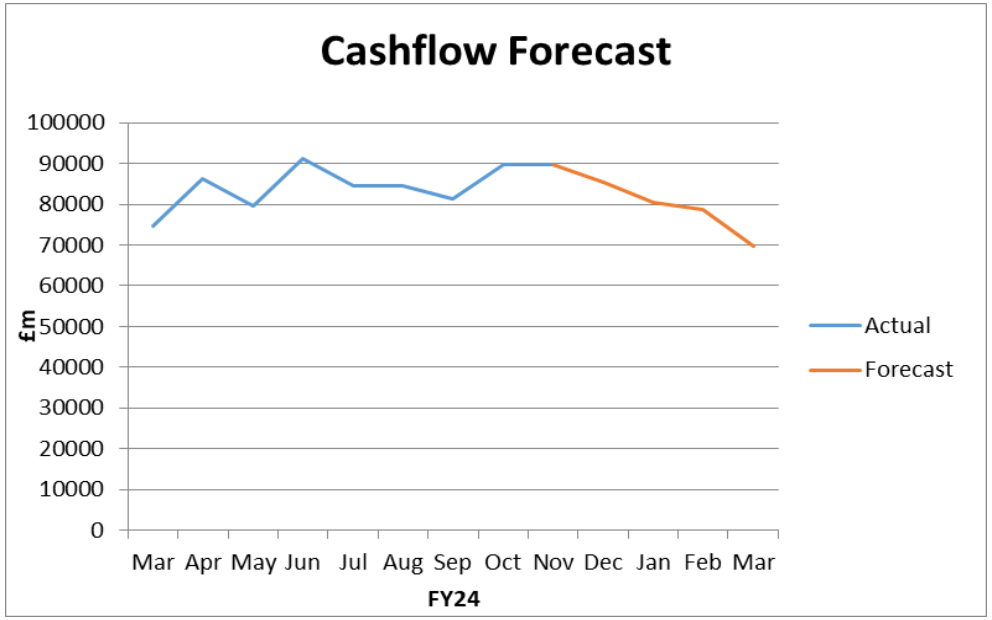
13. Cash Flow

STATEMENT OF YEAR TO DATE CASH FLOWS

	Month 8 FY24 Actual £'000	Plan £'000	Variance £'000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations	4,208	579	3,629
Operating surplus/(deficit)	**4,208**	**579**	**3,629**
Non-cash income and expense:			
Depreciation and amortisation	9,461	9,560	(99)
(Increase)/Decrease in Trade and Other Receivables	11,715	3,795	7,921
(Increase)/Decrease in Inventories	30	245	(215)
Increase/(Decrease) in Trade and Other Payables	(11,517)	(8,021)	(3,496)
Increase/(Decrease) in Deferred Income	12,354	39	12,316
Increase/(Decrease) in Provisions	(155)	156	(311)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**26,097**	**6,353**	**19,744**
Cash flows from investing activities			
Interest received	3,335	2,552	784
Purchase of Non Current Assets	(7,668)	(8,414)	746
Net cash generated from/(used in) investing activities	**(3,132)**	**(5,862)**	**2,730**
Cash flows from financing activities			
Loans repaid	(669)	(669)	0
Capital element of lease rental payments	(4,406)	(3,288)	(1,118)
Capital element of Private Finance Initiative Obligations	(328)	(300)	(28)
Interest paid	(291)	(317)	26
Interest element on leases	(135)	(168)	33
Interest element of Private Finance Initiative obligations	(829)	(482)	(347)
PDC Dividend paid	(1,420)	(1,310)	(110)
Net cash generated from/(used in) financing activities	**(7,959)**	**(6,534)**	**(1,425)**
Increase/(decrease) in cash and cash equivalents	15,006	(6,042)	21,049
Cash and Cash equivalents at 1st April	**74,610**	**74,610**	**0**
Cash and Cash equivalents at	**89,616**	**68,567**	**21,049**

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 November was **£89.6m**.



14. Working Capital Indicators

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	24	
Debtors % > 90 days	5.0%	7.1%	
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	93.3%	
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	93.5%	
Cash (£m)	69.6	89.6	

Summary Notes

- Debtor days are ahead of target.
- Debtors % over 90 days is marginally below target, due to unpaid invoices. These are mainly Provider Collaboratives £276k, various ICB's £119k, Salary overpayments £357k, NHS Property Services £154k, HEE (£829k), NHSE £31k and other £405k.
- NHS BPPC (Better Payments Practice Code) is marginally below target (76.2% in Nov)
- Non-NHS BPPC (Better Payments Practice Code) is marginally below target (91.8% in Nov)
- Cash is better than plan, as outlined in section 9.

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

BOD 08/2024
(Agenda item: 10)

31 January 2024

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

Executive Summary

The Committee continues to meet every quarter and last met 17 January 2024 and considered the agenda attached (minutes attached). There were no items raised for Alert in our last report to the Board.

Recommendation

1. The Committee considered our local Clinical Excellence Awards (LCEA) arrangements. The ongoing national negotiation between the BMA and the Government regarding Consultant pay includes a proposal to fold local awards into basic pay. This is being put to a membership vote. The vote closes 23 January 2024. The proposal is similar in sentiment to the balance of view expressed by colleagues locally which is to move to equal distribution. In light of these developments, we recommend to the Board that:
    a. We postpone any local changes pending the outcome of the BMA vote
    b. Should the national vote be positive, we implement the incorporation of LCEA into basic pay
    c. Should the vote not be positive, we move ahead with the approach of equal distribution of LCEAs for 2024/25 as previously proposed.

For Alert

1. NHSE/I Agency spend target

- ***Current forecast is 10% over NHSE/I Agency ceiling by year end:*** At M8 the Trust is £0.5M off target and without trend improvement will result in spend of £35M (vs £32M Agency spend ceiling) by year end. This is primarily driven by lower than planned performance in the recruitment of Registered Nurses, and higher use of Agency rather than Bank Nurses to fill shifts. While Retention is tracking above target, this masks an overperformance in retention of HCAs but lower than planned retention of Registered Nurses
- ***Significant underlying improvements:*** The headline figure masks some significant improvements, including the retention of HCAs, the continuing increase in fill rates, and the ongoing transfer of Medics and AHPs from Agency to direct engagement arrangements
- ***Potential to breach the Working Time Directive:*** Currently, the NHSP systems and Trust systems do not integrate to allow us to be assured that colleagues do not breach the Working Time policy. Work is being undertaken by the Trust to mitigate this risk
- ***Ongoing implementation challenges:*** Despite improved fill rates, colleagues continue to report difficulties operating the NHSP (bank) and ID Medical (agency) interface and in filling shifts and further work is planned to understand the actual and perceived barriers as reported by front line staff
- ***Consequences and mitigations:*** The Executive has amended internal budgeting assumptions regarding Bank vs Agency use whilst still holding NHSP to its contracted performance standard and the attendant penalties incurred. Colleagues advise that should we indeed breach our NHSE/I ceiling, this will carry over and increase the magnitude of the task to reduce Trust Agency costs in FY 24/25 – additional reductions will be announced in the forthcoming planning guidance. Agency use targets are set at ICB level and it is unlikely system partners will be willing to extend the same headroom to the Trust as was the case in budget setting this year. The Trust CEO has instituted bi-weekly meetings to monitor progress, whilst colleagues across the Trust are involved in Agency Control Panels. The Trust will engage more fully with the SE Region Temporary Staffing Programme Team. NHSP representatives are joining Directorate and Service meetings in order to understand better the challenges colleagues face in operating the system.

To Advise

1. **NHSE 6 high impact actions as set out in the NHS EDI Improvement Plan**
   - ***Not on track to complete 4/15 of the recommended sub-actions by March 2024:*** In June 2023, NHSE published 6 high impact actions (each with a number of sub-actions) to advance EDI across the NHS. 15 of these sub-actions should be completed in part or total by March 2024, and two sub-actions must be completed by the Board:
     - *By March 2024:* Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. The Trust intends to wrap this into the annual PDR season which runs April-July 2024 which was strengthened in the last reporting year. This sub-action is included within the total (4) actions not on track to complete by March 24 but we are assured this will be complete by end of Q1 in 24/25
     - *By March 2025:* Board members should demonstrate how organisational data and lived experience have been used to improve culture. The Culture change programme is launching 2024 and during the same period the Trust will move into the delivery phase of the 3 EDI QI projects begun last year which have drawn heavily from WRES and DES data sets, supplemented by qualitative focus group work.

     PLC will continue to monitor progress on the 6 high impact actions.

For Assurance

1. **BAF and TRR Updates**

- ***Development of new Workforce risk***: Following a risk workshop, the Committee has agreed to replace BAF risks 2.1 (Workforce Planning) and 2.2 (Recruitment) with a newly formulated risk 2.6 Adequacy of staffing. The Committee considered areas in which controls and mitigations should be further strengthened but agreed that overall, this was an improvement in the understanding and statement of Trust risk. The risk remains Red rated
- ***TRR1168 Payroll risk closed:*** Given a suitable provider has been secured, the Committee closed this risk
- ***TR1166 Statutory and Mandatory training risk to be further developed:*** The Committee agreed the current aggregation of compliance may mask

areas of concern. The Executive undertook to consider how this risk may be better monitored and propose a way forward for the next PLC meeting. PLC continues to receive assurance on compliance segmented by training module and organisational unit

- ***New TRR risk on Visa Sponsorship for international staffing:*** The Committee agreed an addition of a new risk regarding visas. The responsibility for ensuring the Trust is abreast of Visa sponsorship is not clearly assigned and monitored and may result in expired visas
- ***BAR and TRR ratings differ:*** The Committee considered the difference in rating of Retention and Recruitment risks on the registers and agreed in principle this may be appropriate given an item may have differing impacts strategically and operationally. The risk ratings themselves remain unchanged.

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2. Staff Wellbeing, Culture & People Systems

- ***Health, Safety & Security Annual Report:*** It has been agreed that PLC will be the recipient of this annual report covering a critically important area for the Trust. Going forward, the Committee will seek to be assured of the link between HSS findings and Trust activities, and that data have been assessed for any differential impact by protected characteristic
- ***Freedom to Speak Up Guardian Annual Report:*** the Committee was pleased to consider in more depth this Report that had previously been considered by the full Board. We note the step change in activity and the engagement of leaders across the Trust in promoting open dialogue. The Committee agreed ongoing focus on addressing the issues of real and perceived detriment and the resulting impact/changes from acts of speaking up
- **Pharmacy colleagues:** The Committee noted ongoing challenges in some of the People metrics and received reassurance about activity underway to help support colleagues
- ***Development of performance assurance:*** The Committee received an update on the development of a 'People dashboard' which will aid early identification of hotspots, and the ongoing efforts to shift the balance from presentation of raw data to analysis.

Author and Title:

Mindy Sawhney
Chair of People Leadership and Culture Committee

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

*Strategic Objective(s)/Priority(ies) of the Trust [OR N/A – no Strategic Objectives/Priorities apply] (**please delete as appropriate**):*

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

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

2) People - Be a great place to work

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

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

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

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

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

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

BOD 09/2024
(Agenda item: 11)

Board of Directors

31st January 2024

Oxford Health Allied Health Professionals Strategy 2023-2027

For: Information

Executive Summary

We are sharing the Oxford Health Allied Health Professionals (AHPs) Strategy 2023-2027 to update The Board of Directors on the work of AHPs within Oxford Health and show that our strategic objectives align with both the Trusts strategic direction and also the objectives demonstrated within the national AHPs Deliver strategy.

https://www.england.nhs.uk/publication/the-allied-health-professions-ahps-strategy-for-england/

Progress and achievements to date from the previous strategy:

Profile

• Appointment of Associate Director of Allied Health Professionals.
• Allied Health Professionals leadership represented within the extended executive team and embedded across all the directorates.
• Oxford Health's AHP strategy profile raised through social media and AHPs day.
• Celebrating Allied Health Professionals with the Introduction of the Trustwide BEE (Be Excellent Everyday) awards.

Capacity

• Rotational opportunities in Dietetics, Occupational Therapy, and Physiotherapy.
• Apprenticeship roles developed and recruited to across five professional groups.
• Development of Trainee Advanced Clinical Practitioner posts.

• Recruitment of an Allied Health Professionals Workforce Lead.
• Collaborative recruitment with system partners to improve patient outcomes.
• International recruitment campaigns.

Impact
• Expanded clinical responsibilities as part of the pandemic response.
• Optimising digital consultation opportunities.
• Appointment to Research & Development post.
• Involvement in research in Stroke and Community Therapy.
• Development of strategic working relationship with local universities.

Governance Route/Escalation Process
The Oxford Health Allied Health Professionals Strategy 2023-2027 was co-produced with Allied Health Professionals attending the 2022 AHPs Day celebration. The participants were asked to work through a series of questions, considering the national AHPs Deliver Strategy, health inequalities, their local knowledge of services and populations, and their areas of work.

The development of the strategy was supported by Mo Patel, Head of Inclusion, Joe Smart, Head of Organisational Development, Pete McGrane, Clinical Director Community, AHP Students, and the Health & Wellbeing team before being signed off by Marie Crofts, Chief Nurse at the time.

The Strategy was presented at the meeting of the Clinical & Governance Quality Sub-committee on 30th November 2023 where it was approved.

Recommendation
The Board is asked to discuss the report and confirm that it is assured that the AHP professions are working towards the strategic aims of the trust.

Author and Title: Sam Rigg, Associate Director of AHPs.
Lead Executive Director: Britta Klinck, Chief Nurse.

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 and Priorities of the Trust*

   1) Quality - Deliver the best possible care and health outcomes
   Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).

2) People - Be a great place to work

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

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

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

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

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

The Oxford Health Allied Health Professionals Strategy 2023-2027

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Quality

Deliver the best possible care and health outcomes

- Effective and diverse clinical leadership.
- AHPs work collaboratively across services.
- Demonstrating the impact of AHPs.

People

Be a great place to work

- Respect diversity and embrace inclusion within our workforce.
- Provide opportunities to be the AHP you want to be.
- Be the place AHPs want to train, work and stay.

Sustainability

Make the best use of our resources and protect the environment

- AHPs are environmentally aware and seek sustainable solutions.
- Adopt digital technology to improve effectiveness.
- Develop and deliver sustainable clinical services.

Research

Be a leader in healthcare research and education

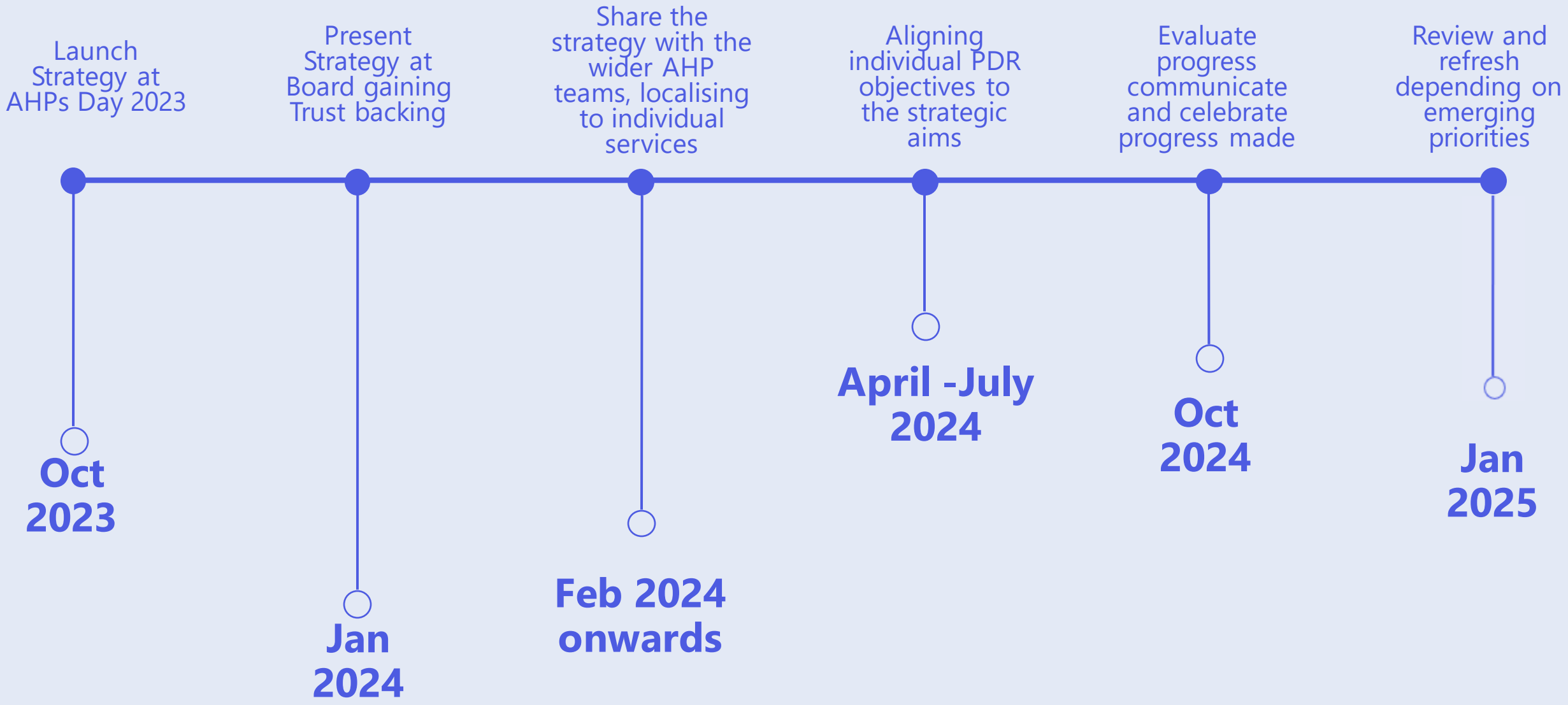
- Improve services to deliver the most effective and efficient practice.
- Make research part of everyday life and contribute to the evidence base for AHPs.
- Ensure that Quality Improvement is part of our culture and practice.

Anti-Racist/Health Inequalities

Co-production

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Implementation Timeline – 1 Year Plan



Anti-Racist/Health Inequalities

Oxford Health NHS Foundation Trust

What are we doing?

EDI/EDIB
Inclusive recruitment guide
Uncomfortable conversations
International recruitment
AHP careers fair

Challenges

Multi-factorial
Availability of training
Accessibility of resources
Accessibility of different communication channels

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Co-production

Oxford Health NHS Foundation Trust

What are we doing?

Supporting recruitment to the Head of Patient Experience
Expert by Experience involved with BEE awards
Patient & Community representatives involved with focus groups for recruitment
Sharing of patient experience stories
CHSS website developed with care homes, other teams and members of the public
CTS – asking on discharge if patients would like to be involved with service design/review
CTS patients supporting with leaflet review and update
Co-production via Arts Projects

Challenges

Patient & Community representatives are a limited resource

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Quality

What are we doing?

AHP leadership placements
Virtual seat
Reciprocal mentoring
Meeting agendas changed in line with strategic domains
TOR update – previous objectives achieved
Trustwide rollout of Therapy Outcome Measures (TOMs)
Staff training on TOMs
TOMs article for national publication
QI projects
AHPs Day

Challenges

Digital & Data – availability, accessibility, interpretation and support
Availability of profession specific supervision
Demand and Capacity
Communication Pathways

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

People

What are we doing?

One AHP Network
Apprenticeships
OT Celebration Day
BEE awards
Rotations
Trustwide bitesize training
Significantly increased the student placements offers
Job planning
Upskilling and development of OTs in Mental Health

Challenges

Ability to recruit
Recruitment process
Demand and capacity
Cost of living
Digital capability

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Sustainability

What are we doing?

Review of intranet and internet pages
Virtual checks and virtual smart card
Waiting list initiatives
Geographical caseload management
Increased digital offer
Providing case studies for the ICB Green AHP Showcase
April 22-26th will be Greener AHP week

Challenges

IT/digital solutions to support reduction of carbon footprint
IG/IT Approvals
Impact of incremental rather than big impact change

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Research

What are we doing?

Research capability and capacity project in conjunction with Brookes
Topics on interest
Research skills acquisition programme
Institute for Applied Health Research event 12th September.
Representation at NMAHP Research Forum
Developing collaboration and relations with the BRC to support AHP Research

Challenges

Capacity and capability
Accessibility of opportunity
Translation into Practise

AHP COMMUNITY: THE RIGHT PLACE, THE RIGHT TIME, THE RIGHT SKILLS

Oxford Health
NHS Foundation Trust

Allied Health Professions (AHPs) Strategy 2023-27

Part of the Oxford Health Trust Strategy

Building on the National AHP Strategy

Contents

Allied Health Professionals in Oxford Health

Allied Health Professionals are the third largest workforce in the NHS. They practise in most clinical pathways and work across organisational boundaries at all stages of the pathway, providing solution-focused, goal-centred care to support patients' aims, independence, and autonomy. In Oxford Health we have nine of the fourteen professional groups practising across physical health, mental health and learning disability services.

We have the following Allied Health Professions within Oxford Health:

Arts Therapists

Paramedics

Dietitians

Physiotherapists

Music Therapist

Podiatrists

Occupational Therapists

Orthoptists

Speech and Language Therapists

Our Ambition

Our ambition is to be *the place* to work for Allied Health Professionals. To attract, train, and retain people to deliver high quality, financially viable, effective, and respectful interventions enabling patients to achieve their best outcomes. We want to be an inclusive and diverse workforce, where individuals are valued and welcomed into the wider multi-disciplinary team. At Oxford Health we want to nurture our workforce providing opportunities to grow, develop, and be the Allied Health Professional you want to be. We are committed to the NHS People Promise; valuing a sense of team, striving to ensure that every voice is heard, and supporting our people. We want Allied Health Professionals to be at the forefront of developing, delivering, and transforming services to meet the population need. Research and evidence based practice underpins our delivery of prevention, crisis intervention, and rehabilitation services.

The Oxford Health Allied Health Professionals Strategy was co-produced with Allied Health Professionals attending the 2022 AHPs Day celebration. The participants were asked to work through a series of questions, considering the national AHPs Deliver Strategy, health inequalities, their local knowledge of services and populations, and their areas of work.

We acknowledge the complexity of meaning and terminology used when describing people who interact with our services and for the purpose of this strategy we refer to patients and communities.

The Oxford Health Allied Health Professionals Strategy is underpinned by the Trusts' mission, vision and values.

Our Vision

- Allied Health Professionals in Oxford Health are at the forefront of developing and delivering high quality, effective clinical services; demonstrating outcomes, impact, and sustainability.
- Allied Health Professionals have opportunities to develop themselves and their career pathway.
- Allied Health Professionals understand and actively contribute to reducing health inequalities and are committed to an anti-discriminatory, anti-racist culture, striving to create a fair and safe place to work.
- Allied Health Profesionals will ensure that co-production and social justice is at the centre of their work.

Background and Context

What have we achieved as a result of our previous strategy?

In 2017 the first national strategy for Allied Health Professions (AHPs into Action) was developed to implement the triple aim set out in the Five Year Forward View; driving improvements in health and wellbeing, restoring and maintaining financial balance, and delivering core quality standards. The Oxford Health Allied Health Professions Strategy 2017 – 2023, focussed on developing the capacity, impact, and profile of Allied Health Professionals in Oxford Health in line with the national strategy. Despite the unforeseen consequences of an international pandemic and shift of focus; significant progress has been made towards achieving the strategic aims giving a strong base from which to deliver our new strategy.

Progress and achievements to date include:

Profile

- Appointment of Associate Director of Allied Health Professionals.
- Allied Health Professionals leadership represented within the extended executive team and embedded across all the directorates.
- Raising the profile of Allied Health Professionals through social media and AHPs day.
- Celebrating Allied Health Professionals with the Introduction of the Trustwide BEE (Be Excellent Everyday) awards.

Capacity

- Rotational opportunities in Dietetics, Occupational Therapy, and Physiotherapy.
- Apprenticeship roles developed and recruited to across five professional groups.
- Development of Trainee Advanced Clinical Practitioner posts.
- Recruitment of an Allied Health Professionals Workforce Lead.
- Collaborative recruitment with system partners to improve patient outcomes.
- International recruitment campaigns.

Impact

- Expanded clinical responsibilities as part of the pandemic response.
- Optimising digital consultation opportunities.
- Appointment to Research & Development post.
- Involvement in research in Stroke and Community Therapy.
- Development of strategic working relationship with local universities.

National Allied Health Professions Strategy

Oxford Health's Allied Health Professions Strategy builds on the national Allied Health Professions Strategy 'AHPs deliver 2022-27' which sets out the national priorities for Allied Health Professionals. It has been developed to give strategic direction to the Allied Health Professions community across England, to enable the Allied Health Professionals and those they work with to maximise their contribution to improving health outcomes for all, providing improved quality of care, and sustainability of health and care services.

Strategy principles of anti-racism and co-production

This strategy makes an overarching commitment that the AHP community will be anti-discriminatory and anti-racist in its approaches, using co-production to ensure actions are inclusive.

Four enhanced foundations

The four priorities – described as 'enhanced foundations' – remain the same as in the first strategy but have been further refined and are supported by updated frameworks and policies.

Five areas of focus

Five 'areas of focus' have been identified for the next five years, each complemented by a set of ambitions.

Our Allied Health Professions Strategy at a Glance

We have based the strategic priorities within this Allied Health Professions Strategy on the Oxford Health Trust Strategy and objectives:

ANTI-RACIST

Quality

Deliver the best possible care and health outcomes

- Effective and diverse clinical leadership.
- AHPs work collaboratively across services.
- Demonstrating the impact of AHPs.

People

Be a great place to work

- Respect diversity and embrace inclusion within our workforce.
- Provide opportunities to be the AHP you want to be.
- Be the place AHPs want to train, work and stay.

Sustainability

Make the best use of our resources and protect the environment

- AHPs are environmentally aware and seek sustainable solutions.
- Adopt digital technology to improve effectiveness.
- Develop and deliver sustainable clinical services.

Research

Be a leader in healthcare research and education

- Improve services to deliver the most effective and efficient practice.
- Make research part of everyday life and contribute to the evidence base for AHPs.
- Ensure that Quality Improvement is part of our culture and practice.

COPRODUCTION

Delivering the Allied Health Professions Strategy Principles

Committing to being anti-racist

The Allied Health Professions community is committed to achieving real and lasting change for ethnic minority AHPs, patients, and communities through proactive challenge, advocacy, and collaboration.

- Educating people and actively championing anti-racism.
- Addressing racial inequality, improving equal opportunities to access services, and employment progression for underrepresented groups in the AHP community professions.
- Being an ally by recognising that privilege exists, being proactive in our own education, and taking action to amplify the voices of under-represented patients and communities.

Co-production is central to our work

Co-production of services is much more than consulting people; it is ensuring an equal voice in service conception, design, steering, and management. We are committed to working with our workforce, patients, and communities to ensure that wide ranging views are considered whenever designing and delivering services. This approach is set out within the patients and carer engagement strategy which will sit alongside this AHP Strategy and inform our approach to implementation.

- Ensure inclusive recruitment practises, engaging patients and communities as a fundamental part of the process.
- Use accessible language to improve communication and reduce barriers.
- Proactively seek to understand social justice and reduce health inequalities to improve experience and outcomes.

Quality

Deliver the best possible care and health outcomes

The Allied Health Professions community is committed to having the right Allied Health Professionals, with the right skills, in the right place, at the right time. This must be underpinned by enabling Allied Health Professionals to optimise their skills and deliver consistently great treatment and interventions across the Trust.

Effective diverse clinical leadership

- Ensuring effective AHP clinical leadership and representation within services.
- Promotion of inclusive, diverse, and authentic leadership throughout the organisation.
- Expansion and creation of opportunities within the workforce for AHPs to develop leadership capability.

Allied Health Professionals work collaboratively across services

- Cross-pathway integration and collaboration to reduce duplication and maximise effectiveness.
- Optimisation of peer support and professional supervision opportunities, actively sharing skills, knowledge, and experience between teams across the Trust.
- Develop relationships with partner organisations to enhance the AHP offer ensuring AHPs have a voice that is heard.

Demonstrating the impact of Allied Health Professionals

- Celebrate and share what we do well raising awareness of AHP roles and the value they add.
- Effective use of internal and external communication; including social media activity.
- Use of outcome measures and patient reported measures to demonstrate clinical effectiveness.
- Development and use of comprehensive AHP competency frameworks across all professional groups and specialities.

People

Be a great place to work

Our ambition is to have the right workforce, with the right skills, in the right place to deliver high-quality care. We will ensure we can meet the needs of our patients and communities by developing new and existing routes into the professions. We will make Oxford Health the employer of choice by celebrating our workforce, providing career frameworks, and recognising wellbeing as essential.

Respect diversity and embrace inclusion within our workforce

- Promote a culture of psychological safety, and develop confidence to engage in difficult conversations, ask questions, and recognise bias.
- Hold personal accountability for being inclusive in our practise.
- Develop an adaptable and flexible approach within the AHP workforce.

Provide opportunities to be the Allied Health Professionals you want to be

- Provide opportunities for continuing professional development and protected time to enable this.
- Commit to providing the best student offer across all AHP groups.
- Establish career pathways for all registered AHPs and support workers, from student to advanced clinical practice.

Be the place AHP's want to train, work and stay

- Ensure diverse and inclusive recruitment practices.
- Grow our workforce, providing alternative entry points to the AHP professions such as apprenticeships and return to practice.
- Listen to feedback and lived experiences within the workforce to improve our offer and ensure that Oxford Health is the best place to be an AHP.
- Actively promote a culture of kindness and respect; investing in a Restorative Just and Learning Culture.
- Promote and support the wellbeing of our colleagues to ensure we are able to provide effective care for our patients and communities.

Sustainability

Make the best use of our resources and protect the environment

Collective action from all Allied Health Professionals is crucial in helping to reduce the environmental impact of the things we procure and prescribe as part of our practise. The AHP community must advance the implementation of the AHP digital framework and harness digital technology and innovate with data. AHP communities need to be supported to successfully implement digital tools that optimise workforce capacity. Understanding population health will enable Allied Health Professionals to provide the most effective and sustainable services to improve health outcomes.

Allied Health Professionals are environmentally aware and seek sustainable solutions

- Consider small actions that have incremental impact, for example turn lights off, reduce printing, manage food waste.
- Optimise equipment life cycles; including timely return and recycling of equipment.
- Prevention of avoidable admissions to hospital, encouraging and supporting patients to manage their own health.

Adopt digital technology to improve effectiveness

- Optimise the use of digital consultations to support accessibility, flexibility, and minimise environmental impact.
- Provide access to digital tools and technology to enable us to better support our workforce, patients, and communities.
- Promote digital solutions to access data, evidence outcomes, and support service delivery and development.

Develop and deliver sustainable clinical services

- Transform our workforce and teams to ensure the right AHP in the right place at the right time.
- Actively engage in health promotion and education to prevent ill health.
- Provide services that recognise the impact of social, economic, and wider determinants of health in the population.

Research

Be a leader in healthcare research and education

Allied Health Professionals must strengthen the evidence base to inform service design, recognising innovation is critical to achieving the ambitions set out in the NHS Long Term Plan. We have seen that Allied Health Professionals are innovators throughout the pandemic and that research is key to ensuring safe evidence-based practice to support patients and clinical pathways.

Improve services to deliver the most effective and efficient practice

- AHPs will use research and the evidence base to support practice development and service improvement.
- Raise awareness of Quality Improvement projects across professions and directorates to ensure we are sharing learning.
- Develop a safe and open learning culture to promote problem solving.

Ensuring that research is part of everyday life and we contribute to the evidence base for Allied Health Professionals

- Actively use evidence-based practice, research, and national guidance to improve clinical expertise and effectiveness.
- Increase awareness and confidence in identifying and engaging in research opportunities to further build our research capacity.
- Enhance collaboration with universities, Biomedical Research Centre, and external organisations with support from the rehabilitation professorial role.

Ensure that Quality Improvement is part of our culture and practice

- Actively use Quality Improvement to improve clinical effectiveness across all AHP professions.
- Increase awareness and confidence in identifying and engaging in Quality Improvement methodology.
- Give time, permission, skills, and resources to use Quality Improvement to problem solve.

How will we know if we have succeeded?

We will assess progress through ongoing review of data, outcomes, and patient and workforce feedback. Further detail can be found in our annual objectives.

Get involved

We are committed to working collaboratively with colleagues who deliver our services, our partners, patients, and communities who use allied health services, ensuring that their experience informs the development of future service plans. This is an ongoing conversation, and we would value your input. If you would like to find out more about this strategy please email us at adminAHP@oxfordhealth.nhs.uk or visit us at Get involved - Oxford Health NHS Foundation Trust

References

The Allied Health Professions (AHPs) Strategy for England - AHPs deliver
NHS England » The Allied Health Professions (AHPs) strategy for England – AHPs Deliver

Buckinghamshire, Oxfordshire & Berkshire West (BOB) Allied Health Professions (AHP) Faculty
BOB AHP Faculty (padlet.com)

The NHS People Promise
NHS England » Our NHS People Promise

The NHS Long Term Plan
NHS Long Term Plan

The Oxford Health Strategy
Our strategy - Oxford Health NHS Foundation Trust

The Oxford Health Patient & Carer Engagement Strategy
Strategy & Policy (sharepoint.com)

Published by Oxford Health NHS Foundation Trust, October 2023.

Report to the Meeting of the
Oxford Health NHS Foundation Trust

Board of Directors

31st January 2024

BOD 10/2024
(Agenda item: 12)

Patient Safety Incidents reported November and December 2023
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.

The report focuses on the period November and December 2023 following on from the last report. Six Patient Safety Incidents (PSI) have been identified in the period, and reported externally to STEIS;

- 2 physical health unexpected deaths of patient known to community physical health teams (sepsis death and ischemic colitis)
- 2 suspected suicides
- 1 delay in treatment (self-neglect)
- 1 physical heath deterioration of a mental health inpatient and unexpected death

The report shares the reporting of PSIs over the past 5 years and summaries the recent improvement areas and safety actions being taken.

Recently the Trust's 'Approach to PSRIF' and our new 'Incident Response Plan' were signed off by the Integrated Care Board and Provider Collaboratives. We transitioned and started working under PSRIF from 4th December 2023. The documents describing our new way of responding and learning from incidents have been published and are available here Patient Safety Incident Response Framework (PSIRF) - Oxford Health NHS Foundation Trust. The paper details the changes we made in preparation in 2023 and our plans for 2024.

Governance Route/Escalation Process

Every Patient Safety Incident (PSI) is investigated which includes the involvement of patients/ families and those staff involved in the incident. A report is then scrutinised at an internal PSI panel by senior clinicians which is shared with clinical teams for learning and the patient/ family members involved. This process has Executive Director oversight via the Chief Medical Officer and the Chief Nurse.

There are a number of weekly and monthly forums and different methods used to share learning across the Trust to focus on our key areas for improvement.

The incident response plan and our approach to PSRIF was developed with and signed off by the programme board members, the Trust's Quality Committee, Board of Directors, Integrated Care Boards (BOB and BSW[1]) and Provider Collaborative network leads.

Recommendation
For the Board to be assured regarding the current management and learning from Patient Safety Incidents.

Author and Title: **Victoria Harte, Patient Safety Service Manager**
Jane Kershaw, Head of Patient Safety

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] Buckinghamshire, Oxfordshire and Berkshire West (BOB) and Bath and North East Somerset, Swindon and Wiltshire (BSW).

1. Patient Safety Incidents reported

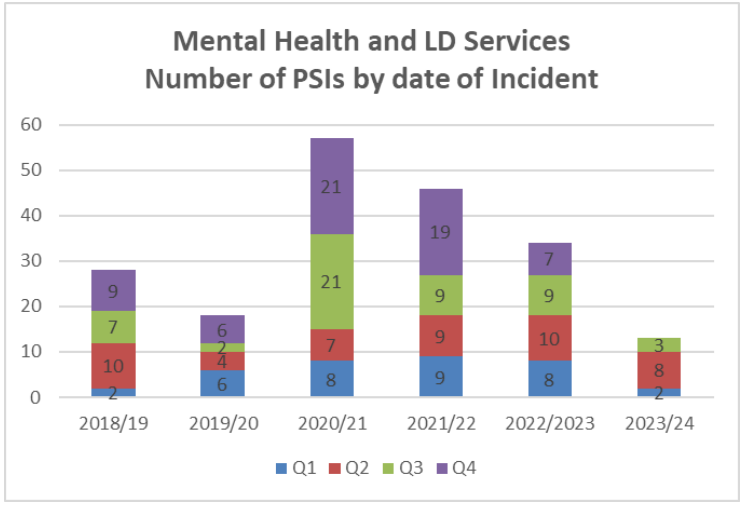
Following the last report there have been six PSI investigations reported to STEIS (national reporting system) in November and December 2023, described below;

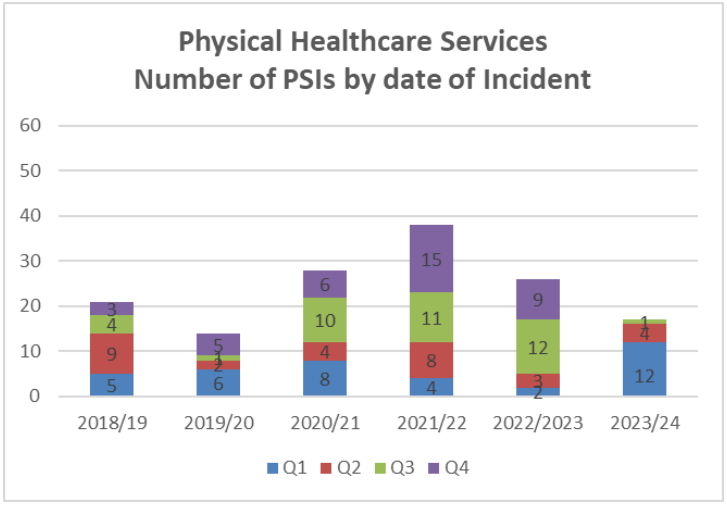
- 2 physical health unexpected deaths of patient known to community physical health teams (sepsis death and ischemic colitis)
- 2 suspected suicides
- 1 delay in treatment (self-neglect)
- 1 physical heath deterioration of a mental health inpatient and unexpected death

There was one review commenced meeting our new Incident Response Plan as an emergent theme. This is in relation to a cluster of medication incidents with no/minor harm but potential near misses in one of the community hospital wards. More details about the driver and context of the Incident Response Plan is detailed below in section 3.

The graphs below represent PSI reporting over the past 5 years up to December 2023. The higher than usual figures in 2020/21 and 2021/22 relate to COVID-19 inpatient infection outbreaks. The physical healthcare services saw an increase in the number of PSIs in April, June and July 2023 with the majority of incidents happening across the Minor Injury Units (misdiagnosis), Podiatry (delays in treatment) and Community Hospital wards (falls and pressure damage).

There are a number of weekly and monthly forums and different methods used to share learning across the Trust to focus on our key areas for improvement. We also continue to monitor regional and national trends in terms of suicide rates and work towards reducing suicides through implementation of our Suicide Prevention Strategy.





2. Completed Investigations and Learning

We use a systems-based methodologies to identify and act on learning. The key actions from the PSI investigations completed in November and December 2023 are shared below:

Improvement area	New safety action(s) following review
Awareness of the bruising policy and following it in practice every time	The senior safeguarding named nurse met with all health visiting team leaders in November to discuss learning regarding assessment of threshold of needs, contextual factors and unconscious bias and the use of the Bruising policy with an expectation that this will be shared by the team leads with local teams. Information regarding the two Bruising policies will be launched by the OSCB network, the Safeguarding Newsletter and as agenda items at Operational Governance meetings for community and mental health teams in Oxfordshire.
Consideration of mechanism of injury and decision of X-ray request (Minor Injury Unit)	The service will review the current in-house system for on-going competency assessment and refresher training. The management team will reassess the current supervision oversight. The management team will review its recruitment strategy and allocation of current staff across the two services of Minor Injury Units and GP Out of Hours.
Completeness of clinical documents. (District Nursing)	Clarity around documentation standards. The team allocating a longer first visit for new patients, to allow sufficient time to complete a meaningful assessment and plan of care.
The issue of unallocated patients in adult mental health team	The 'floating caseload' has reduced with progress continuing to be made. Work is continuing to ensure the substantial posts are recruited to. Ongoing progress with service developments monitored through the harm minimalization process.
Delayed diagnosis of fracture and identifying communication of pain with patient with leaning difficulty.	The community hospital wards are reviewing the format of the multi-disciplinary meetings held each week to ensure that progression against goals and expected presentations (for example pain levels) are clearly discussed. The directorate are completing a piece of work to improve the involvement of LD teams in the care of patients, and the handover of care when patients are transferred.
Interface between GP OOH and 111 service. Demand and staffing in OOH GP Service.	A comprehensive review of the communication between 999/111 pathways and the GP OOH service to ensure that relevant patient information is always relayed to help prioritise support. Ensure SCAS clinical teams know about and use the Health Care Professionals line to communicate clinical findings with the OOH service specifically when leaving a sick patient at home awaiting further information/follow up from the GP OOH service.

Improvement area	New safety action(s) following review
	Demand and capacity planning and monitoring for the GP OOH continues.
Coordination of care, diagnostic formulation, risk formulation, care plan, interventions	Team Managers are implementing new team-based training to support staff in best practice in safety formulation and management. Uptake is being monitored. Clinical Practice Educators are supporting training, including simulation training for staff undertaking mental health telephone triage assessments.
Communication with family, GP and private therapist	The ward has started on an inpatient Discharge of Patient QI project; this includes improving discharge planning and risk formation around leave.
Record keeping	Team developing a discharge and transfer plan document. A project is underway to ensure there is a dedicated place within the electronic record system to record confidentiality preferences. A project is currently underway to include PCMIS and eventually other mental health records to be available through the shared clinical record this will become a working feature in 2024. This will ensure that all Oxford Health services are aware of coexisting referrals and treatment.
Reliance on experienced support staff	Ensure support and supervision for staff completing advanced areas of their role.
Engagement in relation to protective characteristics	This case example is being shared throughout the Mental Health Directorates with discussion points to generate learning and greater consideration of culture and working with healthcare professionals.
Lost to follow up podiatry service	All members of the Podiatry team to always complete reason for any change to appointment in the patient notes, with increased oversight of caseload.
Missed opportunity for earlier identification of a hip fracture	Review scope/approach of weekly Multi-Disciplinary Team (MDT) meetings to improve scalations when a patient is not progressing as expected in treatment. Increase staff awareness of ability to access OUH patient records to understand tests completed prior to transfer. Develop step in admission to ensure contact details for next of kin are correct.

3. Patient Safety Incident Response Framework

As part of the national Patient Safety Strategy around developing a safer culture, safer systems, and safer patient care is the development of the Patient Safety Incident Response Framework (PSIRF). The PSIRF is an exciting and new way the NHS will be able to approach and respond to incidents/near misses involving patients, with an increased focus on identifying meaningful learning to inform improvements. The work we have been taking in the Trust has been steered and overseen by the Learning Together for a Safer Tomorrow programme board.

Recently the Trust's 'Approach to PSRIF' and our new 'Incident Response Plan' were signed off by the BOB System Quality meeting and Commissioners. The documents have been published and are available here Patient Safety Incident Response Framework (PSIRF) - Oxford

Health NHS Foundation Trust. We formally transferred from Monday 4th December 2023 so any new incidents from this date will be managed quite differently with greater flexibility and more attention and energy on the learning and changes we can make.

Some of the key changes we have made in 2023 include;

- More attention and time on engagement and support of those affected by an incident.
- Not all incidents with more significant patient harm will lead to an investigation or review. The national Serious Incident threshold no longer exits, instead we will be led by our local incident response plan and where we can make the greatest impact. This does not change all incidents still being reported regardless of harm and our responsibility under the legal duty of candour requirements.
- We are using a wider range of approaches to learn from incidents. Expect more incident learning huddles and less initial review reports and full in-depth investigations.
- We are leading and participating in many more cross- organisational reviews. We have new written principles of working across health organisations in the BOB Integrated Care System.
- The methodology used for learning responses is now SEIPs (System Engineering Initiative for Patient Safety) to better understand the system we work within to identify strengths and how we can improve. We will no longer use linear or cause and effect models.
- Greater sharing of learning and actions being taken
- The majority of learning responses are now led by a dedicated and specialist trained member of the Patient Safety Team
- Changes to the templates we use to summarise the outcomes from learning responses
- Changes in oversight internally and externally, as well as more system-wide learning forums

We have made lots of progress however this is a long-term programme of work, our next steps are on;

- Embedding the changes made in 2023
- Monitor we are always meeting our Duty of Candour requirements
- Strengthening the development and monitoring of safety actions
- Trialling new learning response techniques
- Looking at how to better more on what is working well and good practice

We are planning to deliver a workshop to board members in 2024 focusing on their role in supporting a just and learning culture, being proactive in problem-sensing, using systems thinking and ensuring we have robust governance for patient safety.

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust Board of Directors

RR/App 01/2024
(Agenda item: 4 & 18)

31 January 2024

Declarations of Interests and Register of Directors' Interests

For: Information

Executive Summary

The Trust is required to have a formal Register of Directors' Interests under the Constitution and the Health and Social Care Act. The accompanying table in the Reading Room/Appendix to the Board papers sets out the declared interests of the members of the Board. This has been updated since last substantive changes presented at the Board meeting on 29 November 2023.

The most recent changes (shown in tracked changes for transparency) relate to updating of interests for: Britta Klinck, Chief Nurse.

In accordance with the Standing Orders for the Practice and Procedure of the Board of Directors (Annex 9 of the Constitution) each member of the Board is required to disclose:

- any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust (see Standing Orders 8.2.1);
- any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other such matter concerning the Trust (see Standing Orders 8.2.2 and 8.2.3); and
- any actual or potential family interest, direct or indirect (see Standing Orders 8.2.5).

Members of the Board are reminded that, in accordance with the NHS Foundation Trust Annual Reporting Manual, the Trust's Annual Report should disclose details of company directorships and other significant or material interests held by directors or governors which may conflict with their management responsibilities e.g. where those companies or related parties are likely to do business (or are possibly seeking to do business) with the Trust or where they may conflict with

their management responsibilities. As NHS Foundation Trusts must have registers of directors' and governors' interests which are available to the public (also in accordance with guidance from NHS England on managing conflicts of interest), an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report (this alternative disclosure is typically used by the Trust).

The registers of governors' and directors' interests are publicly accessible as part of the Board papers published on the Trust's website and the most recent versions are also published in a section of the Trust's website for disclosures and declarations here:
https://www.oxfordhealth.nhs.uk/about-us/governance/disclosures-and-declarations/

Recommendation
The Board is asked to note the report or, if further updates are required, members of the Board are asked to provide details of their interests.

Author: Hannah Smith, Assistant Trust Secretary
Lead Executive Director: Kerry Rogers, Director of Corporate Affairs and Company Secretary

Oxford Health
NHS Foundation Trust

RR/App 01(ii)/2023
(Agenda item: 4 & 18)

REGISTER OF DIRECTORS' INTERESTS

PART A – CURRENT BOARD MEMBERS
PART B - FORMER BOARD MEMBERS DURING 2023/24

January 2024

DECLARATION OF INTERESTS

PART A – CURRENT BOARD MEMBERS

NAME	POSITION	INTERESTS DECLARED
Amélie Bages	Executive Director of Strategy and Partnerships	Husband is the Chief of Staff for the Chief Operating Officer of **NHS England & Improvement**

Date of last change: 19 July 2022

NAME	POSITION	INTERESTS DECLARED
Rob Bale	Executive Managing Director for Mental Health, Learning Disability and Autism services	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

Date of last change: 28 November 2023

NAME	POSITION	INTERESTS DECLARED
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 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.

Date of last change: 10 July 2023

NAME	POSITION	INTERESTS DECLARED
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/Improvement** as a Clinical Network Senior Clinical Programme Manager for the London Clinical Networks

Date of last change: 25 May 2022

NAME	POSITION	INTERESTS DECLARED
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.

Date of last change: 18 October 2021

NAME	POSITION	INTERESTS DECLARED
Chris Hurst	Non-Executive Director	Formerly Managing Director & Owner, **Dorian3d Ltd** – which provided strategic consultancy, board development support, independent expert advice to private sector; and executive coaching and mentoring services (past clients include government

		and NHS organisations). Dorian3d Ltd closed on 31 December 2022. Wife is Regional Delivery Director with the **Strategic Estates Planning team of NHS Improvement**

Date of last change: 23 January 2023

NAME	POSITION	INTERESTS DECLARED
Britta Klinck	Chief Nurse	None to declare.

Date of last change: 01 December 2023

NAME	POSITION	INTERESTS DECLARED
Grant Macdonald	Interim Chief Executive Officer (formerly Executive Managing Director for Mental Health, Learning Disability and Autism services)	No interests to declare.

Date of last change: 01 July 2023

NAME	POSITION	INTERESTS DECLARED
Karl Marlowe	Chief Medical Officer	Educational Supervisor, Clinical Studies, **Oxford University Medical School** (from Sept 2023) Chairman of **The Social Interest Group** Board (charity partnership working for marginalised populations). (unremunerated)

		Advisor to **UNTANGLE GRIEF**, digital peer support platform (unremunerated) Advisor to **Tasting Colours,** digital wellbeing service (unremunerated)

Date of last change: 20 September 2023

NAME	POSITION	INTERESTS DECLARED
Ben Riley	Executive Managing Director for Primary & Community Care Services	GP Partner (minority share owning) 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** Joint Clinical Director of the **'Healthier Oxford City' Primary Care Network (PCN)** which comprises three NHS GP practices and the Trust's Luther Street Medical Centre **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) • until 30 September 2020 - Clinical Partnership Officer (part-time employee and not a board or director position)

Date of last change: 24 November 2020

NAME	POSITION	INTERESTS DECLARED
Kerry Rogers	Director of Corporate Affairs & Company Secretary	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.

Date of last change: 06 September 2022

NAME	POSITION	INTERESTS DECLARED
Philip Rutnam	Non-Executive Director	Chair, **National Churches Trust**. This is the national charity for the UK's historic chapels and churches, seeking to keep them open for worship and community use (which may include uses related to health and wellbeing). Director and Secretary, **West Library Association**. This exists to promote community use of a historic library building in North London. It is dormant after a refurbishment was completed. One extended family member works for **Evergreen Life**, provider of wellness apps and software service for primary care. Non-Executive Director has no economic interest in this business and no visibility of it. Senior Advisor to **WA Communications** (a communications consultancy with specialist knowledge in: health; energy and the environment; financial services; transport and infrastructure; education and children's services; and private equity). Does not

		generally work in the NHS provider sector but does work more in pharmaceuticals and life sciences.

Date of last change: 22 March 2023

NAME	POSITION	INTERESTS DECLARED
Mohinder (Mindy) Sawhney	Non-Executive Director	Non-Executive Director at **Hampshire and Isle of Wight Integrated Care Board** (remunerated) from 01 December 2023. Managing Director of **root+branch ltd** (management consultancy). Has previously undertaken engagements with related bodies including the General Medical Council, health charities and suppliers to the NHS. Husband was Chief Customer Officer at **NHS Test and Trace** - secondment ended 01 June 2021. Husband commenced as Chief Operating Officer at the **Bank of England** in January 2022.

Date of last change: 28 November 2023

NAME	POSITION	INTERESTS DECLARED
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.

Date of last change: 27 September 2023

NAME	POSITION	INTERESTS DECLARED
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) 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.

Date of last change: 11 July 2022

NAME	POSITION	INTERESTS DECLARED
David Walker	Trust Chair	Miscellaneous journalism, lecturing and writing Partner is a member of the **NHS Assembly** - created 2019 to advise NHS England and NHS Improvement on delivery of improvements in health and care, potential to influence NHS policy affecting the Trust

Date of last change: 15 June 2020

NAME	POSITION	INTERESTS DECLARED
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**

Date of last change: 28 November 2023

NAME	POSITION	INTERESTS DECLARED
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. Associate with **Tricordant** an Organisation Development consultancy on NHS England's framework for Organisation Development support. Organisation Development work with Tricordant is limited to individual coaching. 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.

Date of last change: 28 November 2023

PART B – FORMER BOARD MEMBERS DURING 2023/24

NAME	POSITION	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.

Date of last change: 25 January 2023

NAME	POSITION	INTERESTS DECLARED
Marie Crofts	Chief Nurse	No current interests to declare (formerly, until September 2020 Trustee of PAPYRUS, prevention of young suicide charity).

Date of last change: 30 September 2020

NAME	POSITION	INTERESTS DECLARED
Anna Christina (Kia) Nobre	Non-Executive Director – nominee of the University of Oxford	**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**.

Date of last change: 29 July 2021

Oxford Health
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

RR/App_02(i)/2024

31st January, 2024
READING ROOM PAPER

LEGAL, REGULATORY AND POLICY UPDATE

SITUATION

This report provides an update to inform the Board of Directors on recent regulation and compliance guidance/policy issued by such as NHS England, the Care Quality Commission and other relevant bodies where their action/publications have a consequential impact on the Trust, or an awareness of the change/impending change is relevant to the Board of Directors. A section in the Addendum to pick up learning or consider a 'True for Us' position is also included to support development/improvement activity and focus of the Board and its committees.

Proposals regarding any matters arising out of the regular Legal, Regulatory & Policy Update report will where necessary be received by the Executive Team. This will ensure timely updates, to enable the Trust to respond as necessary or helpful to consultations and to ensure preparedness for the implications of, and compliance with changes in mandatory and best practice frameworks.

BACKGROUND

1. **CQC - New assessment approach for providers**

On 21 November, Care Quality Commission (CQC) **launched its new regulatory approach in the south of England**. The regulator has explained that the rollout across the country will be gradual, and that existing processes will remain in place until the new approach is implemented in each region. The rollout of the new provider portal will follow that of the **new single assessment framework.**

In the last few months CQC has also published a large amount of information and guidance relating to its new approach to regulation, including:

- findings from its five pilot local authority assessments,
- updated guidance on local authority assessments,
- updated enforcement policy,
- information on how CQC manages its relationships with services,
- guidance on:
    - how the new assessment process will work,
    - how CQC will gather evidence,
    - the different levels at which they will rate services,
    - how they will calculate the first scores for services,
    - on factual accuracy checks,
    - how they will publish findings, and
- updated information on displaying your ratings.

Trust position: We are anticipating given our last inspection was in 2019, that our next inspection will be in 2024. The Chief Nurse is leading organisational readiness to ensure the CQC are received well in the event of an inspection and Board and the Executive have received previous reports on activity as part of the Journey to Excellence. In addition, is work that has focused the activity of OHI and the Regulation oversight sub committee's efforts to support the Trust's understanding of key areas of ongoing improvement focus. The CEO has recently reminded the organisation's leadership that the care today is the care the CQC should see, but that it is within our gift to build on the things we are proud of and to be clear about those areas we need to keep improving.

2. **Guidance – Advice to local authorities scrutinising health services**

This guidance is intended to support local authorities, NHS bodies and health service providers in discharging their responsibilities under the relevant legislation to support effective scrutiny of local health services. It includes an up-to-date explanation and guide to the updated 2013 regulations (to be amended 31 January 2024) and reflects amendments to the local authority scrutiny.

https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services#full-publication-update-history

Trust position: Health scrutiny is part of the accountability of the whole system and OHFT supports its role in the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. The paper to the Board this month regarding the Wantage Community Hospital is an example of work that has supported improvement in relations with HOSC in terms of extensive co-production in order to make supported proposals to the Board and Council of Governors.

3. **Statutory guidance: Reconfiguring NHS services - ministerial intervention powers**

Guidance setting out the process for ministerial intervention in reconfiguration of NHS services, including when and how NHS commissioning bodies must notify the Secretary of State for Health and Social Care of NHS service changes. The guidance applies from 31 January 2024.

Paragraph 5 of schedule 10A to the NHS Act 2006 is a new power which gives the Secretary of State power to direct an NHS commissioning body to consider a reconfiguration of NHS services. This provision has not yet been commenced and timescales for commencement will be reviewed after the most recent changes have been embedded into the system.

https://www.gov.uk/government/publications/reconfiguring-nhs-services-ministerial-intervention-powers

NHS Providers briefing https://nhsproviders.org/resources/briefings/on-the-day-briefing-secretary-of-state-intervention-powers-in-the-reconfiguration-of-nhs-services

Trust position: This guidance will be relevant when the Trust's services change in a way that impacts on how services are delivered to patients, or the range of health services available. Reconfigurations should be clinically led local decisions following appropriate engagement with patients and stakeholders. NHS commissioning bodies lead decisions relating to substantial changes in the reconfiguration of NHS services. The Trust has recently engaged with HOSC concerning Wantage, Warneford Park developments and other community service configuration plans.

4. **Guidance: Duty of candour review: terms of reference**

The review will consider the design of the statutory (organisational) duty of candour and its operation (including compliance and enforcement) to assess its effectiveness and make advisory recommendations. The review will focus on solutions in response to concerns within independent reports that the duty is not always met as intended. The SoS for Health and Social Care will publish the review in spring 2024.

https://www.gov.uk/government/publications/duty-of-candour-review-terms-of-reference

Trust position: The Trust will await the outcome of the review and its published recommendations so they are considered against existing policies that ensure compliance with the spirit and the letter of current duties.

5. **Commissioner guidance for adult mental health rehabilitation inpatient services**

NHS England's guidance supports the planning and commissioning of local mental health rehabilitation inpatient services as part of a whole pathway, to meet the identified need of local populations. Standardising the approach to the commissioning

of these services is to support identification of and reduce inequalities and improve quality, ensuring services are safe, effective, evidence based and informed.

This is based on the premise that 'all means all'. Services will be commissioned so that everyone who presents with a mental health rehabilitation need requiring an inpatient service should be able to access this locally, when they need it and in a way that is flexible and responsive to their needs.

https://www.england.nhs.uk/publication/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/

Trust position: Community mental health transformation is at the heart of the NHS Long Term Plan for Mental Health. As part of planning, Trust services are expected to develop dedicated adult community mental health rehabilitation services as part of their transformation of community mental health provision, reducing the reliance on inpatient care and to support people in the least restrictive setting.

6. **Meeting the needs of autistic adults in mental health services**

This guidance provides advice on how to improve the quality, accessibility and acceptability of care and support for autistic adults to meet their mental health needs, both in the community and in inpatient settings. It outlines 10 principles for implementation and provides practical examples of how these principles may be applied.

https://www.england.nhs.uk/publication/meeting-the-needs-of-autistic-adults-in-mental-health-services/

7. **Requirements for Patient Safety Specialists**

These role requirements are designed to support NHS organisations in identifying individuals with the right skills and experience to take on the role as a Patient Safety Specialist. They outline the purpose of Patient Safety Specialists, the key requirements of the role, and how we expect them to work in their own organisation, as well as with local, regional and national partners.

https://www.england.nhs.uk/publication/requirements-for-patient-safety-specialists/

Trust position: Organisations yet to identify Patient Safety Specialists, are required to follow the process whereby the relevant executive director with responsibility for patient safety must confirm they have considered the Role requirements for Patient Safety Specialists document as part of the process for identifying specialists, and email patientsafetyspecialists.info@nhs.net providing the name, email and contact number for the person they are identifying, as well as, where appropriate, those of the person they are replacing. The role currently sits in the Quality and Safety directorate led by the Chief Nurse.

8. NHS equality, diversity and inclusion improvement plan actions

A reminder of next steps to support the delivery of the NHS equality, diversity and inclusion improvement plan, and actions due by March 2024 including items for board members.

https://www.england.nhs.uk/publication/nhs-equality-diversity-and-inclusion-improvement-plan-actions/

Trust position: Progress against the six High Impact Actions was last reviewed by the PLC Committee at its January meeting including those that are required to be implemented by March 2024.

RECOMMENDATION

The Board of Directors is invited to consider and note the content of the report and where relevant, members should each be satisfied through any additional enquiry, of their individual and collective assurances and reassurances that the internal plans and controls in place to deliver or prepare for compliance against any of the Trust's obligations are appropriate and effective.

Lead Executive and Author: **Kerry Rogers, Director of Corporate Affairs & Company Secretary**

Addendum A

AWARENESS/LEARNING/'TRUE FOR US'/THOUGHT PIECES

CQC Inspections and updates

CQC publishes report on South London and Maudsley NHS Foundation Trust's mental health services

CQC, 22 Dec 2023

The report follows an inspection of the child and adolescent mental health services' (CAMHS) psychiatric intensive care unit (PICU) at Bethlem Royal Hospital, run by South London and Maudsley NHS Foundation Trust in September. This inspection was carried out to see if improvements had been made following a serious incident which occurred on the ward in June 2023.

https://www.cqc.org.uk/press-release/cqc-publishes-report-south-london-and-maudsley-nhs-foundation-trusts-mental-health

CQC find improvement in mental health services at Birmingham Women and Children's NHS Foundation Trust

CQC, 15 Dec 2023

CQC has found some improvements following an inspection of specialist community mental health services for children and young people at Birmingham Women's and Children's NHS Foundation Trust. The rating for the service has changed from inadequate to requires improvement.

https://www.cqc.org.uk/press-release/cqc-find-improvement-mental-health-services-birmingham-women-and-childrens-nhs

CQC finds improvement at Cheshire and Wirral Partnership NHS Foundation Trust but more needs to be done

CQC, 14 Dec 2023

CQC has found improvements in acute wards for adults of working age and psychiatric intensive care units (PICU) at Cheshire and Wirral Partnership NHS Foundation Trust that sees its rating for this service change from inadequate to requires improvement.

https://www.cqc.org.uk/press-release/cqc-finds-improvement-cheshire-and-wirral-partnership-nhs-foundation-trust-more-needs

CQC upgrades the rating of Wirral Community NHS Foundation Trust to good following inspection

CQC, 13 Dec 2023

The inspection covered three core services and how well led the trust was overall. This inspection sees the overall rating of the trust move from requires improvement to good. The trust provides a range of primary, community and public health services to the people of the Wirral, parts of Cheshire, St Helens and Knowsley.

https://www.cqc.org.uk/press-release/cqc-upgrades-rating-wirral-community-nhs-foundation-trust-good-following-inspection

CQC finds improvement needed in Birmingham and Solihull Mental Health NHS Foundation Trust's community-based services

CQC, 29 Nov 2023

The rating for community-based mental health services for adults of working age has declined from good to requires improvement, following an inspection in August. CQC carried out a short notice announced focused inspection due to receiving information of concern about the safety and quality of care being provided. This related to serious incidents involving people who use the service, including three deaths.

https://www.cqc.org.uk/press-release/cqc-finds-improvement-needed-birmingham-and-solihull-mental-health-nhs-foundation

Of interest/relevance:

Independent report: David Fuller inquiry: phase 1 report
DHSC, 28th Nov 2023
The independent inquiry's phase 1 report on matters relating to David Fuller's actions at Maidstone and Tunbridge Wells NHS Trust. The inquiry has been established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed, for so long.
https://www.gov.uk/government/publications/david-fuller-inquiry-phase-1-report

Evaluation of CQC's local authority pilot assessments
CQC, 8 Dec 2023
CQC ran pilots of the new regulatory model assessing how local authorities meet their adult social care responsibilities under the Care Act with 5 local authorities. The report provides an evaluation of the new assessment approach.
https://www.cqc.org.uk/publications/evaluation-la-pilot-assessments
See also: Starting our local authority assessments – updated guidance published, *CQC 13 Dec 2023* https://www.cqc.org.uk/news/starting-our-local-authority-assessments-updated-guidance-published

Guidance: Reducing harm from ligatures in mental health wards and wards for people with a learning disability
CQC, 21 Nov 2023
https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance

Improving the physical health of people living with severe mental illness (SMI)
NHS England, Dec 2023
This guidance supports ICSs and service providers to improve the physical health care of adults living with severe mental illness (SMI), through improved physical health checks and supported follow-up interventions.
https://www.england.nhs.uk/publication/improving-physical-healthcare-for-people-living-with-severe-mental-illness-smi/

See also: Case studies https://www.england.nhs.uk/publication/case-studies-physical-health-support-services-for-people-living-with-severe-mental-illness-smi/

Guidance: Improving the mental health of babies, children and young people
DHSC, 8th Jan 2024
A framework of modifiable factors to guide promotion of good mental health in babies, children and young people. These 3 documents: highlight the wide range of modifiable factors that interact to influence the mental health of BCYP, summarising them in a framework; convey opportunities across the BCYP life course to both promote and minimise risks to the mental health of BCYP; provide information on activities being taken across government that positively impact upon the mental health of BCYP.

https://www.gov.uk/government/publications/improving-the-mental-health-of-babies-children-and-young-people

National guidance to support integrated care boards to commission acute mental health inpatient services for adults with a learning disability and autistic adults
NHS England, 29 Nov 2023
This is national guidance for ICBs to follow as they commission for their populations and sets out minimum standards and expectations to consider when commissioning high quality inpatient care. People with a learning disability and autistic people should not be admitted to a mental health hospital unless there is a suspected or identified mental health need requiring inpatient care and support.
https://www.england.nhs.uk/publication/national-guidance-to-support-integrated-care-boards-to-commission-acute-mental-health-inpatient-services-for-adults-with-a-learning-disability-and-autistic-adults/

LeDeR report into the avoidable deaths of people with learning disabilities
Jan 2024
Summary https://www.kcl.ac.uk/news/2022-leder-report-into-the-avoidable-deaths-of-people-with-learning-disabilities
NHS Providers briefing https://nhsproviders.org/resources/briefings/next-day-briefing-learning-disabilities-mortality-review-report-2022
Full report available https://www.kcl.ac.uk/research/leder
Action from learning report 2022/23, NHS England, https://leder.nhs.uk/images/resources/action-from-learning-report-22-23/20231019_LeDeR_action_from_learning_report_FINAL.pdf

Five key elements for discharge – supporting people with a learning disability and autistic people to leave hospital
NHS England, 11 Jan 2024
In collaboration with the Local Government Association and Association of Directors of Adult Social Services as Partners in Care and Health, they published this letter which identifies five key actions that will have the biggest impact on supporting people with a learning disability and autistic people to leave mental health hospital**.**
https://www.england.nhs.uk/publication/five-key-elements-for-discharge-supporting-people-with-a-learning-disability-and-autistic-people-to-leave-hospital/

Case study: The West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative
NHS Providers, 30 Nov 2023
This case study explores the evolution of the collaborative and partnership working, including the role of leadership.
https://nhsproviders.org/case-study-the-west-yorkshire-mental-health-learning-disabilities-and-autism-collaborative

Renewals and CTOs - are remote examinations permitted under the Mental Health Act?

Browne Jacobson LLP, 14 Dec 2023

The High Court has handed down its judgment in Derbyshire Health Care NHS Trust v Secretary of State for Health and Social Care and others [2023] EWHC 3182 (Admin) ("the Derbyshire judgment"). This case considered certain provisions of the Mental Health Act (MHA) and clarified whether a remote examination of a mental health patient is lawful under the Act in relation to renewals and Community Treatment Orders ("CTOs").

https://www.brownejacobson.com/insights/renewals-and-ctos-are-remote-examinations-permitted-under-the-mental-health-act

Rapid literature review: Health inequalities within a local area

CQC, 12 Dec 2023

The report looked at good examples of how those responsible at an ICS area level are thinking about, supporting and meeting the needs of people who might not have equal access, experience, or outcomes from healthcare. By understanding what best practice looks like CQC can use it to inform their assessments of ICSs and consider how local systems can reduce health inequalities.

https://www.cqc.org.uk/about-us/transparency/external-reports-research/rapid-literature-review-local-area-inequalities

Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

NHS England, 27 Nov 2023

Integrated care boards, trusts and foundation trusts should use this statement to identify key information on health inequalities and set out how they have responded to it in annual reports.

https://www.england.nhs.uk/publication/nhs-englands-statement-on-information-on-health-inequalities/

HIGH PROFILE FAILINGS – LEARNING/'TRUE FOR US'

A number of high profile corporate governance failures and/or weaknesses continually litter the headlines and the events that damage such organisations do not just happen. They are commonly linked to boards being blind to the underlying risks that threaten their organisations and to the effectiveness of governance systems. Whilst these are predominantly headline news items with some containing allegations to be investigated – they are routinely presented to the Board in this report to stimulate consideration of the importance of corporate governance (and of perceptions on reputation) and to give due regard to there being any risk of it being 'true for us'. We are developing a Framework to ensure that in a planned way we assess where any of these significant failings could happen

at the Trust in order to learn and improve control environments accordingly, but regardless, each member of the Board should consider their individual responsibilities to 'be assured' and as such consider requirements to support attaining that position.

Trust Directors guilty of 'significant failure'

The HSJ reports that leadership of Maidstone and Tunbridge Wells Trust has been told to 'reflect' on the 'weaknesses and failings' which contributed to a maintenance supervisor being able to sexually violate more than 100 bodies in hospital mortuaries over a period of at least 15 years.

The independent inquiry into the actions of convicted murderer David Fuller, which reported this month, is heavily critical of the trust in a number of areas. It notes, for example, that Mr Fuller accessed the mortuary 444 times during 2020, and yet his actions went "unnoticed and unchecked".

The inquiry concluded: "It is clear to the inquiry that members of the executive team knew about the problems with the mortuary service as early as 2008. However, we were unable to identify any evidence that these issues were discussed in any detail at trust board meetings. The inquiry considers the failure to keep the trust board fully informed of the problems in the mortuary to be a significant failure of corporate governance on the part of the successive executive teams."

The report also states that: "Successive chairs and chief executives [of MTW] failed to provide the level of board leadership required for effective governance of the mortuary."
The report identifies "systemic procedural failings," which meant the mortuary at the Tunbridge Wells Hospital was an "uncontrolled environment". There had been calls from the security management at the trust for CCTV cameras to be installed but this had not happened.

The report concludes "the trust did not place an overall strategic value on the security of its estate and this had an impact on how security of the mortuary was approached."
It adds: "The trust did not recognise the importance of ensuring the security of its estate, nor the potential safety impact that security lapses might have for those for whom it was responsible."

Inquiry chair Sir Jonathan Michael, former chief executive of Guy's and St Thomas' Foundation Trust, said the report's findings were a stark reminder that apparently well-performing NHS organisations may also have serious problems. Sir Jonathan's report makes 16 recommendations to the trust, stating that if they had been in place, Mr Fuller's offending could have been prevented. These include:

- The trust board should change its governance to ensure it had greater oversight and assurance of legally regulated mortuary activity.
- Non-mortuary staff and contractors being accompanied when they access the mortuary.

- CCTV cameras should be installed in the mortuary and post-mortem rooms with footage regularly reviewed.
- An end to the practice of leaving deceased bodies out of mortuary drawers overnight.
- The trust should ensure that it and its contractors comply with current policy on criminal record checks and rechecks. The trust had said it intended to introduce three-yearly checks in 2015 but this did not happen until 2020. The report described this as a “lax approach”.

BOARD ASSURANCE FRAMEWORK FULL VERSION JANUARY 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 Nurse / Quality Committee	**Triangulating data and learning to drive Quality Improvement** A failure to triangulate different sources of quality data and learning to inform and drive the quality improvement programme could result in patient harm, impaired outcomes, and/or poor patient experience.	9	8	↔	24/08/23 09/11/23
1.5	Exec MD for MH & LD / Quality Committee	**Unavailability of beds/demand and capacity (Mental Health inpatient and LD)** **Unavailability of beds** (across all mental health inpatient services, including Adult MH & LD, and CAMHS, PICU, ED & GAU) 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	↔	23/10/23 09/11/23
1.6	Exec MD 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	↔	19/10/23 09/11/23

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; the Trust becoming a clinically-led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain	12	4	↔	11/01/24 17/01/24
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	↔	11/01/24 17/01/24
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	↔	11/01/24 17/01/24
2.6	Chief People Officer People Leadership and Culture Committee	**Adequacy of Staffing** [*NEW RISK – work in progress, will be subject to further refinement. Replaces former BAF risks 2.1 (Workforce Planning) and 2.2 (Recruitment)*] 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	↔	11/01/24 17/01/24

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	↔	23/10/23 09/11/23
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, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding 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	↔	12/01/24 23/01/24
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.	12	4	↔	15/02/23 22/02/23
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	↔	09/01/24 23/01/24

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	↔	09/11/23 23/01/24
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	↓	05/09/23 22/02/23
3.13	Chief Finance Officer Finance & Investment	Risk Description: A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties (Health & Care Act 2022), national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028 – 2032. Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036 2038) could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.	9	3	↔	12/01/24 23/01/24
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; and unplanned expenses, delays and wasted resources.	16	6	↔	08/11/23 23/01/24
4. Research & Education - Become a leader in healthcare research and education						
4.1	Chief Medical Officer Quality Committee	**Failure to realise the Trust's Research and Development (R&D) potential.** Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.	6	3	↔	20/10/23 09/11/23

Risk rating matrix and scoring guidance appears at Appendix 1

Strategic Objective 1: Deliver the best possible care outcomes

1.1: Triangulating data and learning to drive Quality Improvement

Date added to BAF	10 February 2022
Monitoring Committee	Quality Committee
Executive Lead	Chief Nurse
Date of last review	24/08/23
Risk movement	↔
Date of next review	January 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**3**	**3**	**9**
Target risk rating	4	2	8
Target to be achieved by			

Risk Description:
A failure to triangulate different sources of quality data and learning to inform and drive the Quality Improvement (QI) programme could result in patient harm, impaired outcomes, and/or poor patient experience.

Key Controls	Assurance	Gaps	Actions
- Use of TOBI (Trust Online Business Intelligence) data from ward to Board level; - Quality & Safety Dashboard; - Integrated Performance Report to Board; - Oxford Healthcare Improvement (OHI) Centre; - Quality Improvement (QI) Hubs, supported by QI Hub Programme Board and QI & Learning Group; - QI strategy implementation plan as part of wider Trust QI Strategy; - Clinical Audit team transferred to management under the Head of QI (since Q1 FY23); - Weekly Review Meeting triangulating incidents, complaints,	**Level 1: reassurance** - QI Hubs meet monthly and report into QI & Learning Group to share progress and learning across Hubs; - Monthly Directorate Quality Groups; - Weekly Safety Forums; - Complex Review panels. **Level 2: internal** - Quality & Safety Dashboard regularly reported into Quality Committee; - Integrated Performance Report to Board; - Quality Committee; - Quality & Clinical Governance Sub-Committee; - Weekly Review Meeting (Clinical Standards); - Patient Safety Incident (PSI) updates and review reports at Quality	GAP: The clinical system outage from August 2022, which resulted from the failure with third party supplier-hosted patient record systems, has led to a decreased focus upon local QI programmes of work (including Clinical Audit) whilst the Trust has been focusing upon the response to the critical incident. Some progress has been delayed on QI workstreams and members of the OHI had needed to be redeployed from usual roles, as part of the response. OWNER(s): Associate Director of QI & Clinical Effectiveness and Chief Nurse GAP (controls): embedding QI as part of Trust culture still an ongoing process; and appropriate resourcing required to support and maintain the OHI Centre in	During Q2 FY23, QI activity continues to embed across the Trust and approx. 1,262 colleagues, service users and carers have received QI training since the launch of the training programme in 2021; all cohorts for QI training during the 2023 period are fully subscribed. QI work remains spread across trust services with trust priority QI focused work such as Reducing Restrictive Practice; Involving Families and Carers; and Risk Assessment documentation and formulation now led and embedded within directorates. There are currently 162 active projects in progress that reflect the trust strategic objectives. (1) Embed use of Quality Dashboard to identify areas

deaths/inquests, claims, CAS alerts etc; - Mechanisms for feedback, including 'I Want Great Care' surveys, PALS, complaints and patient stories, and Trust-wide Experience & Involvement Group; - Experience & Involvement Strategy; - New framework for incidents incl. safety huddles, after action learning reviews and thematic reviews; - central monitoring of progress of Patient Safety Incident (PSI), complaints and inquest actions; - Whistleblowing Policy & Freedom to Speak Up Guardian; - Journey to Outstanding internal review self-assessments.	Committee and private Board; - Patient Experience/ Experience & Involvement updates into Quality Committee; - OHI Centre/QI updates into Quality Committee; - Annual Quality Account. **Level 3: independent** -- CQC Inspections; - Patient/carer feedback, incl. 'I Want Great Care' results; - Quality Account signed off by Local Authorities; - Annual National Community Mental Health Survey results; - Multi-agency review processes e.g. Homicide Reviews, inquests, CDOP; - performance against national NHS Oversight Framework indicators.	order to support ambition to embed QI. ACTIONS: To sustain momentum and support continuous and sustainable improvements a review of OHI Centre resource and capacity was undertaken during Q4 FY22 with an options appraisal presented in Q1 FY23 to the Executive to consider support and direction for QI going forwards; options appraisal decision in progress. OWNER(s)~~:~~ Associate Director of QI & Clinical Effectiveness and Chief Nurse	for improvement and prioritise QI workstreams; (2) continued roll out of QI Hubs and QI & Learning Group as vehicles to pick up learning; (3) Engage & train frontline staff in use QI methodology to improve service concerns raised through PSIs. Q1 FY23 saw the launch of OHI Level 1 QI online training module for staff, service users and carers to increase the spread of awareness of QI; Currently approx. 500 people have completed the L1 training. Oxford University Hospitals NHS Trust approached the trust to adopt the OHI L1 training for their staff and this was agreed and is now part of the OUH training package. Discussions are in progress regarding adoption across the BOB region. (4) External review from peer QI team to benchmark our progress and plan for the future is under consideration for the 2024/25 period. (5) Complete targeted peer reviews following findings of Journey to Excellence internal review self-assessments; A Head of Clinical Standards & Excellence was recruited to earlier this year and aligned with the Oxford Healthcare Improvement Team. This post is now leading the Journey to Excellence with a programme of service self-assessment and Peer Review in progress with OHI

			supporting identified improvement opportunities. (6) Continue to improve quality of and access to TOBI data so areas for improvement can be identified more easily. Work is in progress to link TOBI data to the Audit Management and Tracking (AMaT) System to allow data pull through for trust audits to allow access to audit information in real time. OWNER: Chief Nurse.

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	Executive Managing Director for Mental Health & Learning Disabilities
Date of last review	23/11/23
Risk movement	↔
Date of next review	January 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:

Unavailability of beds (across all mental health inpatient services, including Adult MH & LD, and CAMHS, PICU, ED & GAU) 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
- Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors;	**Level 1: reassurance** - Directorate SMT monitoring; - Provider Collaborative Single	Restricted capacity and instances of long waits for young people requiring CAMHS & Psychiatric Intensive Care Unit (**PICU**) beds. PICU project is off plan on opening	Finance & Investment Committee (**FIC**) monitoring delivery of PICU project and due to open in September 2023

- Proactive management of flow and OAPs; - Single point of access for provider collaborative network beds; - 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; - SOPs/processes in place for any Young Person in seclusion or Long-Term Segregation, including Clinical Director reviews; - Improvements to flow and reduce length of stay. - Initiation optimisation programmes for Oxfordshire Adult wards. This looks at the process from patient admission to discharge with a view to improving the average length of patient stay which will in turn increase capacity.	Point of Access monitoring (weekly); - weekly regional calls for CAMHS **Level 2: internal** - Review of incidents, restraints, seclusions and inappropriate use of s.136 by Heads of Nursing and through Weekly Review Meeting; escalation to OMT and Exec; - OAPs trajectory monitoring internally through Directorate OMT and Executive; - Integrated Performance Report to Board **Level 3: independent** NHSE reporting and monitoring of progress against OAPs trajectories. Regional monitoring of CAMHs acute pathway metrics	due to staffing requirements and build issues. Shortage of substantive nursing and therapy staff across the Trust (and in some team's difficulties in recruiting medics e.g. CAMHS community, adult acute mental health and Adult Eating Disorder services) i.e. vacancies continue to result in capacity pressures and increased reliance on agency staffing at a time when demand is increasing. Ultimately can reduce capacity to see patients and families. Waiting lists and access to some services are rising as a result of increased demand, pressures in the wider system i.e., housing, shortage of staff and the aftermath of COVID-19. Some mental health community teams are also managing high numbers of patients unallocated to a care coordinator due to demand being higher than capacity. This impacts inpatient areas and creates the need to use Out of Area Placements (OAPs). Restricted capacity leading to long waits for admission to Adult ED units, resulting in patients with very low BMIs being managed in the community or acute hospitals. National reduction in Assessment & Treatment Unit (ATU) beds and estate does not enable support for individuals with LD or autism requiring reasonable adjustments or a single person placement.	Vacancies continue to be high. Details reported in the Quality and Safety Dashboard provided to the Quality Committee (and to the Board), as well as in highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. Mitigations via Retention and Recruitment workstreams and the Improving Quality Reducing Agency programme (monitored through the People, Leadership & Culture Committee). Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate Senior Management Team. Operational risks also monitored through the Trust Risk Register at 1068 (mental health waiting times), 1024 (reporting on waits) and 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. Adult Eating Disorder (ED) service to extend and develop Day Hospital

			and Hospital at Home offerings; The TVPC established the Hospital at Home ED (H@H ED) pilot with views to reducing the need for T4 admission for ED treatment. LD services to continue to provide specialist LD support to mainstream mental health wards to facilitate reasonable adjustments. OWNER: Executive MD for Mental Health & Learning Disabilities

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	Executive MD for Primary Care and Community
Date of last review	19/10/23
Risk movement	↔
Date of next review	January 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. Reporting on activity and waiting times (with revised metrics agreed with services) Monitoring of key mitigating actions	**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	• Limited capability and capacity in Community Services for innovation and quality improvement. • Senior Clinical Leadership gaps in some services. • Quality and Risk issues in some services linked to insufficient capacity to maintain urgent care and non-urgent planned care (e.g., pressure-related harms, podiatry, CTS/district nursing). • Limited workforce planning and high staff vacancy rates in specific services linked to local or national workforce shortages (e.g., podiatrists, dieticians). • Fragmentation of care pathways across siloed service management and support structures (e.g., H@H, OOH services, IT systems). • Change management capability gaps – limited mid-tier	*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. Partnership working 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.

through Directorate and Trust reporting processes (including monitoring of relevant Directorate Plan objectives) Delivery and monitoring of Frontline Digitisation Plan	Leadership Board (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).	experience in change management and QI. • Substantial need for re-design of costed service models and consequent contract and finance re-negotiation – many service contracts contain irrelevant KPIs, commissioning gaps or duplications, and some have seen no income uplift for over 10 years, despite significant expansions in provision due to legislative and population changes. Other core services, such as the Urgent Community Response, have continued to operate as extended national pilots since the pandemic, without a secured service contract, which limits long-term planning. • **Lack of suitable premises to collocate the staff and deliver sustainable service models.**	A second programme of work has started. This is focusing on improving the sustainability of the UEC pathway. *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 a new Transformation Director role within the Directorate Leadership who started in May 23. **Development of the Oxford City estates plan and business case to develop a North and South city hub.** An early task of the Transformation Team has been supporting the development of a more sustainable delivery model for the Oxfordshire 0-19 healthy child services which have been reprocured by Oxfordshire County Council. At Place level, regular meetings are held with the ICB Oxfordshire Place Director to progress work on local stakeholder engagement for transformation work (focusing on Wantage CH services initially) and at a county level with system Exec leads at the Oxfordshire Integrated Leadership Board. May 2022, the Trust and OUH signed a Memorandum of Understanding (MoU) to support closer working for Oxfordshire patients and communities. The MoU identifies

			urgent care and end of life care as early priorities for collaboration. MoU reviewed and supported by Trust Board in March 2022 and approved by OUH Board. MoU is not legally binding, and both organisations will continue to operate within current governance frameworks. 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	11/01/24
Risk movement	↔
Date of next review	April 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; the Trust becoming a clinically-led organisation; **staff being supported in their career development and to maintain competencies and training attendance**; staff retention; and the Trust being a "well-led" organisation under the CQC domain

Key Controls	Assurance	Gaps	Actions
- Service model review and modifications of pathways across	**Level 1: reassurance**	GAP The L&D team will continue to monitor the new system and revise the	The first PDR season (supported by a brand new codesigned form with staff

Operations (cross-reference to 1.2 and the risk against failure to deliver integrated care); - completed restructuring of Operations Directorates to provide for development of clinical leadership and for a social care lead in each directorate; - "planning the future" programme and ongoing Aston Team Working programme; - effective team-based working training in place with L&D; - 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; - individual professional review and development through development of individual professional leadership strategies e.g. Nursing Strategy (updates provided into the Quality	**Level 2: internal** - People, Leadership & Culture Committee; - Use of annual staff survey to measure progress and perception of leadership development; - staff appraisals; - PDR compliance rate was 91% in October 2023 compared to 89.3% in 92.3% in August 2023. - Clinical supervisions 70% in October 2023 compared to 66% in August 2023. - Mandatory training performance **88.8%** in October 2023. **Level 3: independent** - CQC reviews - a rating of "good" was achieved in the Well Led domain in 2015 CQC inspection.	training matrices for the small number of teams that are still outstanding and work with teams and areas where compliance is particularly low. The priority for 2023 is to ensure mandatory training figures achieved to date remain consistently strong, with an assessment of the barriers in relation to implementation so that these can be removed. GAP (controls - application of Strategy Framework): coherent Trust-wide learning from existing leadership development projects. Localised good performance and good practice may not be picked up across the Trust. Unwarranted variation without justification may be a gap rather than variation itself. GAP (controls): Equality and Diversity. The WRES and WDES are monitored against national benchmarks and areas variation are reviewed and action plans developed.	and brand-new bite size training) launched in April 2023 and ended in July. All PDRs were reset to 0% on the 1st of April. PDR had a 91% compliance rate in October 2023 and is maintaining a steady trajectory but is still below target (target >95%). A core component of the PDR was a focus on 1) Career Conversations 2) Wellbeing Conversation and 3) Flexible working Conversation (as these remain the top 3 reasons for leaving the organisation) The Trust can be assured that 91% of its staff has had these very important conversations. A direct result of PDR has been the increase of staff signing up to training courses with Learning & Development, which has been very welcomed. HR and L&D are fully integrated and working and the services are being rebranded as the People services. OD Club continues to grow and has 140+ members across the Trust and OD presents on corporate induction as well as ongoing engagement with front lines teams as part of the commitment to ensuring 'everyone having a voice that counts' for the 2023 Staff Survey. ACTION: Implementation of the NHS People Promise across the organisation has been completed.

Committee, most recently in July 2020); - Masters' framework offering clinically relevant development opportunities for registered professionals; - Inspire Network (replaced Linking Leaders conferences) event focused on Organisational Development on 10 March 2022 and considered Staff Survey results; and - Trainee Leadership Board -currently being reviewed as part of the wider look into Leadership		GAP (controls): Equality and Diversity. National picture of little progress having been made in the past 20 years to address the issue of discrimination (BAME and other groups including LGBT, people with disabilities and religious groups) in the NHS.	The Trust first People Plan was developed (October 2022) and has been delivered over the past 12 months and is being reviewed as part of the planning process for 2024/25. ACTION: 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 currently 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 programmes have completed the 'discovery' phase and will be starting the 'design' and 'delivery' phase October 2023 – April 2024. OWNER: Head of OD

Strategic Objective 2: Be a great place to work

2.4: Developing and maintaining a culture in line with Trust values

Date added to BAF	19/01/21
Monitoring Committee	People Leadership and Culture Committee
Executive Lead:	Chief People Officer
Date of last review	11/01/24

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	3	12
Current risk rating	**3**	**3**	**9**

Risk movement	↔
Date of next review	April 2024

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; - Equality, Diversity and Inclusion team, plans, training and groups, Staff Equality Networks; - Health & Safety Policies, and H&S Team; - Zero-Tolerance of Violence and Aggression to Staff Policy; - Training, supervision and Performance and Development Review (PDR) processes; - Communications bulletins & intranet resources and news.	**Level 1: reassurance** - Health and Wellbeing Group; - Stress Steering Group; - Learning Advisory Group (LAG) Group; - Equality & Diversity Steering Group, (all reporting to PLC Committee quarterly); - H&S group SEQOSH accredited **Level 2: internal** - People, Leadership & Culture Committee (quarterly); - Quarterly People Pulse checks (measures of staff engagement) **Level 3: external** - National Staff Survey results; - External endorsement of the Trust's wellbeing work via take-up of Trust's model through BOB ICS.	GAP Need to improve staff experience and respond to issues identified by Staff Survey results in order to improve retention.	Promotion and embedding of a "civility and respect including: Team and manager focus on Health & Wellbeing -support; wellbeing conversations (July 2021); Embedding Restorative Just Culture model; Embedding Civility & Respect model; Mental Health First Aid training for managers; Enabling safe spaces and confidential support to all staff. Kindness into Action (part of the Civility & Respect Culture) A new Restorative Just and Learning Culture clinical lead began in May 2023 and has started 3 work programmes to embed the RJLC approach across the organisation. The RJLC Lead is also teaching, training and presenting to teams across the Trust to build awareness, buy in and engagement with this new way of working.

			OWNER: Chief People Officer & Head of Health & Wellbeing Development of Quality Improvement (QI) Equality Diversity & Inclusion (EDI) programmes around Race Equality (based on feedback from the Workforce Race Equality Standard (WRES)). The key workstreams are: 1 – Increasing workforce diversity 2 – De-biasing the disciplinary process 3 – Improving equal opportunities in career development and progression These programmes have been developed and are due to end the 'discovery' phase at the end of September 2023. The 'design' and 'delivery' phase will take place Oct 23 – Mar 24

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	11/01/24
Risk movement	↔
Date of next review	April 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, aim to reduce agency costs and support recruitment and retention workstreams; - career development pathway for HCAs; - Learning from Exit Questionnaires / Interviews; - Health & Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives; - Freedom to Speak Up Guardians; - Training, supervision and Performance and Development Review (PDR) processes;	**Level 1: reassurance** - Quarterly review of leavers exit interview data by HR SMT. **Level 2: internal** - Reports to Extended Executive (monthly); - Reports to People Leadership and Culture Committee (quarterly); - Performance data reports to Board: - Turnover 13.83% in October 2023 (target <14%); - Vacancies 15.5% in October 2023 (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.	High vacancy numbers, challenges recruiting to vacancies, and demands of recruitment upon operational management of recruitment can have negative impact on experience of existing staff. Need to improve staff experience and respond to issues identified by Staff Survey results to improve retention. The OD Team is working to improve the Staff Survey engagement across the	The October 2023, the turnover rate has reduced and remains within the overall the Trust target. Analysis of leavers data shows significantly less Healthcare Assistances are leaving; however, Nursing turnover remains above target. The counter measure this is the Retention team is focusing activity in hot spot areas. Onboarding QI project; and Career Conversations QI project. As at October 2023 PDR was 91% PDR processes had been redesigned with a focus on Wellbeing, Flexible working and career development to ensure people have the best experience at work. The Career Conversations QI group is working on setting up the process for staff to have in depth career conversations and 'stay' conversations with people who may be looking to leave for career development or looking for better work life balance. This project is now completed and has been turned into business as usual for the new Retention Team New Starter Experience QI group is looking to ensure new starters have the best

		Trust for 2023 so more data will be available to drive improvements. Pressure from cost of living increases likely to be a theme for staff over 2023-24.	experience in the first 6 months to mitigate the risk posed by people leaving within their first 12 months. A questionnaire has been developed to check in with new starters so improvements can be made quickly to improve new starter experience. Staff Survey 2023 engagement plan included the Organisational Development team looking to visit as many teams as possible across the Trust to have direct conversations to drive engagement. As of September 2023, plans are in place to visit many sites and teams as possible, as well as 4 'road shows' at the major Trust sites alongside Wellbeing, EDI and Retention actions relating to recruitment.

Strategic Objective 2: Be a great place to work

2.6: Adequacy of Staffing [*NEW RISK* - work in progress, will be subject to further refinement. Replaces former BAF risks 2.1 (Workforce Planning) and 2.2 (Recruitment)]

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	12/01/2024
Risk movement	↔
Date of next review	February 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 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.

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.

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.

[Replaces former BAF risks 2.1 Workforce Planning and 2.2 Recruitment]:

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.	**Level 1: reassurance** -Consistent and regular updates to staff via whole staff communication; -Support to managers to deliver key message; - Easily accessible intranet resources. - Internal monthly programme board to track the progress of each of the workstreams , chaired by the Director of Clinical Transformation **Level 2: internal**	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	Development of non-clinical career pathways Establishment of other clinical apprenticeship offers including pathways in dental, pharmacy and social worker. Complete Training Needs Analysis based on information gathered from a variety of sources (PDRs, individual feedback, discussions with leaders and managers)

Train theme: Enhanced Education and Training initiatives, including Apprenticeship programmes, and career development pathways from HCA to Advanced Practice.	– 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 -Monthly updates to the Executive team -Engagement with the Southeast Temporary Staffing Programme who can provide advice and challenge. - Quarterly Updates to the People Leadership and Culture Committee. **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;	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. 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.	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. Development of Education career pathway for all staff including L3 – L7 qualification offer in response to the newly published Educator workforce strategy. 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. 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.

Retain Theme Ongoing and consistent work to ensure that our people recognise OHFT as a good place to work and choose to stay working with us. **Reform Theme** New approach to recruitment and onboarding to better attract and secure talent to the Trust.		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. 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.	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. Development of a just and restorative culture through which people feel supported and enabled to do their best work. Enhanced health and wellbeing offer including the promotion of the new resource that in Occ 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) Refreshed annual awards approach from 23/24 which will be continued for 24/25 to recognise exceptional individual and team achievements and contributions. Better local induction and candidate and new starter experience to ensure our

Improving Quality and Reducing Agency Programme This programme has been running for 2 years and provides oversight of the interventions to support the recruitment and retention of staff (including the workstream aimed at recruiting international nursing staff) and the commercial contracts and delivery of temporary staffing Managed Service Providers. Additional workstreams relate to better workforce planning and the efficiencies that can be maximised through the E-Rostering.			people have the best start. Delivery of new interventions related to our successful bid to become part of Cohort 2 of Delivering the People Promise Design and delivery of Successful bid accepted to become part of Cohort 2 of Delivering the People Promise 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. Talent Attraction and Hiring - Create a proactive, Talent Acquisition and Compliance team by redesigning resourcing. In relation to Recruitment and Retention – actions are detailed above. Managed Service Providers – further work needed to overcome operational issues in relation to the use of bank staff sourced via NHSP and nursing and AHP agency staff sourced via ID Medical SE temporary staff programme to support how we work with ID Medical on medical agency use to maximise opportunities for cost saving. Activity required to understand how we retain the international nursing staff that we have recruited in years 1 and 2 of the programme and whether we continue to run an internal nursing recruitment workstream going forward which will require Trust investment. Analysis of our Workforce Planning requirements is currently being undertaken by Director of Strategy and Partnerships prior to Executive

			consideration and decisions on what is required in the short / medium and long term to complement the work already done in relation to nursing workforce plans. (Further actions to be added once objectives for 2024/25 for the IQRA programme are agreed)

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	23/10/23
Risk movement	↔
Date of next review	April 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.

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	**Level 1: reassurance** - Reporting through Directorate SMTs and OMT. **Level 2: internal** - Reporting through: Executive Management Committee; and	**Performance and planning:** Absence of system-wide data sets and aligned reporting. **ICS and Place-level governance**	Work ongoing to agree performance reporting at System, Place and Trust levels, aligned with Internal Planning process. Owner: Executive Director of Strategy and Partnerships

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 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. **Resourcing:** - Role of Associate Director to lead work on the BOB Mental Health Provider Collaborative on behalf of the Trust being appointed to; - Service development lead for each Mental Health directorate now in post. Director of Transformation for Community Services now in post and launching Partnership workstream as part of Community Transformation Programme; - new Executive Director role of Executive Director of Strategy & Partnerships from April 2022.	Trust Board. **Level 3: independent** - ICS-level and Place-level emerging governance for Mental Health, Learning Disability and Autism (MH, LD&A) and Community - Partnership and Alliance arrangements with other organisations, including the voluntary sector; - Provider Collaborative Governance	New BOB Mental Health Partnership Governance nascent and 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. Learning Disability governance being developed by ICS. Lack of oversight and governance for Community services at ICS and Place-level. Unclear decision-making impeding collaborative working with partners. Collaborative arrangements for community services in Oxfordshire and ICS to be developed. Financial pressure on ICSs, County Councils and Social Care impacting adversely on required MH & LD investment. No systematic approach to support partnership working in Place.	Working with Place-based and local partners to ensure place and system governance. Resourcing requests for BOB Mental Health Provider Collaborative sent to ICB. Partnership approach for Community Services being developed as part of new Community Services Transformation Programme. OWNER: Executive Managing Directors, Executive Director of Strategy & Partnerships and Chief Executive Ensuring engagement in funding dialogue with ICSs for system clinical and financial planning. For Mental Health, enable this via Provider Collaborative arrangements. OWNER: Chief Finance Officer, Executive Director of Strategy & Partnerships and Executive Managing Directors Embedded resources now in place within operational Directorates, and role of Associate Director of Mental Health leading on the BOB Mental Health Provider Collaborative being recruited. Ways of working and internal governance for this work to be established.

			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. OWNER: Executive Director of Strategy & Partnership.

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	12/01/24
Risk movement	↔
Date of next review	May 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	2025		

Risk Description:

Failure to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding 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 means skills and ownership to manage budgets over the medium term are widespread; - Annual Financial Plan and Budget produced, and approved by FIC and the Board; - Standing Financial Instructions and Financial Policies; - regular reporting on Financial position and impact of wider financial system risks to FIC and Board; - active management of Capital Programme; and - monthly reporting to, and monitoring by, NHSE.	**Level 1: reassurance** - Monthly CFO led finance review Monthly finance review meetings within Finance team and with directorates; - Capital Programme Sub-Committee (monthly); and - monthly cash-flow reports. **Level 2: internal** - Exec team and Strategic Delivery Group discussions; - Finance and Investment Committee (every 2 months); - Monthly Finance, including CIP, reporting to the Board to provide assurance on progress and recovery actions. Nov 23 (M8) – I&E forecast is to plan of £3.2m surplus.	Funding pressures - underfunding of Oxfordshire community services contract is endemic. Additional funding has been received for community services and mental health services in year allowing additional resources to deal with demand pressures, mitigating risks of overspending due to unfunded demand. Although prior year funding shortfalls have been resolved, moving the Trust to a surplus budgeted position. £7.5m, of this funding is technically non-recurrent. Using non-recurrent funding into the system which continues next year. There is uncertainty on the level of new funding for	Financial challenges to be escalated to the ICS and NHSE through annual planning process. FY24 Budget Setting and Annual Plan update to be delivered by end of March 2024 and linked to operational and workforce plans owned by directorates. Planning process to produce more evidence based and quantified business cases for additional funding to put the Trust in a stronger position for negotiating. Refresh of the Long-Term Financial Plan to be scheduled. Discussions with NHSE have confirmed MHIS will continue in at least a reduced form. **Medium term financial planning to be taken regularly to FIC for**

	Capital expenditure forecast above plan with plans to mitigate. -Quarterly Finance Deep Dives with the Exec Team -Monthly Directorate agency review panels **Level 3: independent** - Internal Audit reviews; - External Audit review pf financial statements; - Monthly reporting to, and monitoring by, NHSE and the Integrated Care System (ICS).	mental health going forward due to the end of the 5-year LTP plan for mental health funding. Pressure on the ICS position, currently in a system deficit, may translate to restricted funding for the Trust. Agency spend – the Trust's workforce challenges are leading to excess agency usage and spend which puts pressure on ability to remain within budget	**consideration and planning.** (a) Community Services Strategy to be completed, followed by (b) costs analysis, and (c) structured discussions about funding gaps with Commissioners. Improving Quality Reducing Agency (IQRA) work programme aimed at addressing underlying drivers of agency use. **Actions taken so far have reduced spend to meet the FY24 agency target, but more work is needed to reduce agency spend further in FY25.** Owner: Chief People 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	15/02/23
Risk movement	↔
Date of next review	May 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**3**	**12**
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	**Level 1: reassurance** The Nominations, Remuneration and Terms of Service Committee	GAP (assurances and review/oversight): delays to Psychiatric Intensive Care Unit (**PICU**) project	Current risk rating increased in November 2021 to overall rating of 12, pending assurance that gaps resolved.

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. 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); - Standing Financial Instructions and Scheme of Delegation; - Integrated Governance Framework (IGF); - Engagement Policy (significant transactions); - Procurement Policy (CORP04) and Procurement Procedure Manual; Investment Policy (CORP10), Treasury Management Policy (CORP09);	(NEDs) and Nominations and Remuneration Committee (Governors) review the composition, balance, skills and experience annually as per minutes of meetings and Board refresh. Board self-assesses (and CoG) against various statements and declarations with evidence of compliance to include – AGS, Corporate Governance Statement, Annual Report declarations, Code of Governance comply or explain, EPRR statement and various Annual Reports – H&S, Infection Control, Safeguarding, Quality Accounts etc **Level 2: internal** - Annual Governance Statement reviewed by Audit Committee and Auditors; - 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 review management of significant risks and key governance issues; - Escalation reports from the Sub Committees to	may suggest issues with oversight mechanisms or lack of understanding of complexities of project. Risk that there might be a lack of specialist knowledge and/or expertise amongst decision makers in relation to a significant decision or transaction. PICU project was paused in June 2021; subject to external review December 2021; actions monitored through Finance & Investment Committee (FIC), Audit Committee and Board) during 2022. Missed original target of May 2022; new target of completion after March 2023. GAP (controls): systemic tendency towards short-termism and not looking ahead/peering around corners to see what could be coming. 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	Internal Audit (PwC) report on PICU received and reviewed by Audit Committee, December 2021; actions monitored through Finance & Investment Committee (FIC), Audit Committee and Board) during 2022 and assurance received that programme and project governance strengthened. Monthly Programme Board now in place. Major Capital Projects risk also included on the BAF at 3.14 to monitor PICU and Warneford redevelopment (see 3.14 for more detail). OWNERS: Director of Corporate Affairs & Co Sec, and Executive Director for Digital & Transformation 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. Draft Trust Annual Plan 2023/24 provided to the Board in private in January 2023, bringing together draft Directorate service priorities and financial position. Once finalised by the end of March 2023, 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

- Trust Strategic Objectives and setting of key focus areas for achieving objectives (New Strategy approved April 2021); - Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts); - 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; - Membership Involvement Group, Membership Development Strategy, and membership development responsibilities through the Communications function; - Speak up systems embedded – whistleblowing, F2SUG, Wellbeing Guardian (NED), PALS & Complaints, compliments, surveys, IWGC, governors.	Board Committees and on to Board; - Annual Report and reports for Council of Governors to demonstrate engagement with 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; - Annual External Audit (including review of governance); - Well Led inspection (CQC) March 2018; and - 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)	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: Control – Risk Appetite Statement agreed by Board to support sound decision making and avoid inopportune risk taking or overly cautious approaches stifling growth/development. COG working groups paused for COVID-19 pandemic	IPR including the focus of the Board on variance/exception. OWNERS: Director of Corporate Affairs & Co Sec, and Executive Director of Strategy & Partnerships. TARGET DATE: APRIL 23 Operational Plans; JUNE 23 Strategic Plan; BAF review against agreed strategic plan JUNE/JULY 23 Risk Appetite considered with Board and Audit Committee (last in March 21) and to be revisited in Q1 22/23 beginning with AC in Feb23. OWNER: Director of Corporate Affairs & Co Sec/Board of Directors TARGET DATE: April 2023 COG working groups being reinstated during 2022 and being re-formulated for 2023. Invitations to Board Committees will continue with the potential to make old subgroup structures redundant. OWNER: Director of Corporate Affairs & Co Sec. TARGET: March 2023

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	23/10/23
Risk movement	↔
Date of next review	January 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 being finalised for use by Trust Leadership Team to guide delivery of current strategy and as basis for engagement process with staff, patients, carers and partners to develop next Trust's strategy. Strategy team mostly resourced as of October 23 and able to put in place 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 being finalised. **Level 2: internal** Integrated Performance Report to the Board in public – on delivery against the strategic objectives, key focus areas and Objective Key Results. Integrated Annual Planning Process co-lead by Finance and Strategy and reporting to	Service Change and Delivery (SCAD) Team disestablished (Oct 2023) following consultation process and resources now embedded in directorates. Data outage means that planning work for 2024/25 will not include robust and systematic trajectory-setting process for all directorates and that objectives will not be as SMART as required. Although process to make plan more quantitative will start as part of 2024/25 planning process, it will require further trajectory	Track delivery of 2023/24 Annual Plan and report to the Board, aim to iterate this reporting process so it becomes more quantitative in 2024/25 and 2025/26. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. Develop Annual Plan for 2024/25, iterate process for 25/26 aiming to embed trajectory setting and more quantitative approach. OWNER: Exec Director of Strategy &

Second round of Annual Planning process started in September 2023, jointly led by Finance and Strategy and involving: Performance & Intelligence, HR, Capital and Business Services team.	Executive Management Committee **Level 3: independent**	and metrics development work as part of 2025/26 planning process. ICS Planning process not established, also limiting ability to progress this work in the Trust. Workforce Planning function and leadership is a gap. Need to clarify performance processes, resources and leadership. Trust could benefit from medium term (3 year) plan to tie together finance and service improvement/sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an implementation for the Trust strategy.	Partnerships and Chief Finance Officer. Support development of ICS Planning process (link with BAF risk 3.1). OWNER: Exec Director of Strategy & Partnerships. Put in place Strategic Delivery approach to identify and align strategic programmes of work to current Strategy Delivery Plan and report to Trust's Leadership and Board. Put in Place new Board Strategy development cycle and governance. OWNER: Exec Director of Strategy & Partnerships. Following disestablishment of SCAD team, develop new reduced central approach for Change and Programme Management oversight and implement it. OWNER: Exec Director of Strategy & Partnerships and relevant Executive Leads for each delivery area. Workforce Planning approach and leadership to be identified. OWNER: Executive Team Proposal for Performance processes, resourcing and leadership to be developed. OWNER: Executive Director of Strategy & Partnerships. IPR to be iterated to reflect Strategy development and performance work. OWNER: Executive

			Director of Strategy & Partnerships.

Strategic 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	09/11/23
Risk movement	↔
Date of next review	February 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; - Membership of Oxfordshire Cyber Security Working Group; - '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	**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 - 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.	In August 2022, IT failure with patient record systems provided and externally hosted by a third-party supplier led to staff being unable to access patient record systems and clinical information, thereby leading to risks to staff and patient harm. Trust internal operational and cyber security not compromised. The clinical system outage, which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting mandatory data-set information and contractual information to commissioners, which	Major incident response set up to manage contingency plans, resolve the technical issue and provide alternative access to clinical information. Patient safety risk and more detailed incident-related risks maintained at Trust Risk Register level. Cyber assessments for alternative solutions fast tracked. The Trust has initiated a project working with a third party to support the recovery of reporting (project runs May 2023 - January 2024); the priority is to enable prompt recovery of reporting whilst 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:

DSPT Cyber Security standards; - Systems access control and audit managed by way of a programme of penetration testing (annually from 2020); cyber security assessed and tested prior to 3rd party contracts being awarded; Implementation of new Security information and event management system (SIEM) has taken place. Event logs are now being automatically monitored for suspicious activity; Microsoft Defender for mobile has been applied to mobile devices managed by InTune. Those devices now have malware and web filtering applied.; Privileged Access Management (PAM) has been implemented which controls and constrains access to elevated administrative accounts on the network; USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender Advanced Threat Protection); - Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit the flow of phishing	- 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 NSCN WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated; -Independent, annual penetration test planned for July 2023; Independent DSPT annual audit for external assurance; -Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. - Secure messaging accreditation achieved (NHS Digital DCB1596);	could lead to contractual and reputational consequences. R&D Trials are also facing delays due to gaps in data. Penetration testing undertaken in May 2022 (with OUH), July 2022 (NHS Digital) identified a few low to medium risk information system and user account weaknesses; the issues were addressed by the IT team. With the rise of AI, there is an increasing reliance on staff proficiently handling suspicious Web, Teams, and Email content, Staff awareness of such threats is only partially mitigated via existing guidance. The Trust needs a dedicated mandatory customisable targeted Cyber Security Awareness Training solution, providing audited participation, knowledge validation and success metrics and reporting, to significantly mitigate the risks from poor cyber security behaviours.	(i) whilst mitigations have been put in place to ensure that the data that was captured during the outage is accessible to clinicians, it will not be possible to use this data for external reporting; and (ii) reduced functionality of the new systems RIO and EMIS, due to the pace at which these needed to be implemented, means that some data will not be available for reporting and analysis purposes until the full functionality is implemented. Funding and approval to recruit to enhance the cyber security team has been secured and recruitment has started. 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. 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

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.		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.	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 committee (sub-group to Executive Management Committee) and Audit Committee
Executive Lead	Director of Corporate Affairs & Co Sec
Date of last review	05/09/23
Risk movement	↔
Date of next review	April 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 & Co Sec), supported by a clinical director; - Designated Emergency Planning Lead, supporting the executive in the discharge of their duties; - Emergency Planning Group 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates & facilities. - Psychosocial Response Group (subgroup reporting to Emergency preparedness resilience and response committee. - Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic; - EPRR Response Manual incident response plan - (updated September 2023) provides emergency response framework; - On call system; - Directorate/service specific Business Continuity Plans (BCPs)	**Level 1: reassurance** - Emergency Preparedness Resilience and Response (EPRR) Committee 3 x per year; - Psychosocial response group (sub-group of Emergency Planning group); - Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee. **Level 2: internal** - Annual Emergency Planning, Resilience and Response report (most recently to the Audit Committee and the Board in Nov 2022); - 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 NHSE/I EPRR Core Standards. 2022 Full compliance - Self-assessment against NHSE/I EPRR Core Standards 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	On 2020 Self-assessment against NHSE / I EPRR Core Standards, Trust had been only partially compliant with 4 of 54 standards (fully compliant with other 50). The Trust Sept 2023 is fully compliant against NHSE / I EPRR Core Standards. - No Further GAPs identified.	Further to improvement plan for actions against the 4 core standards against which the Trust had not been compliant (actioned over 2020-21), by October 2022 reporting, Trust had achieved full compliance with NHSE core standards for EPRR (as set out in annual report to the Audit Committee and the Board in November 2022). Self-assessment 2023 (for submission to BOB integrated care board) currently being undertaken and will be completed by November 2023 OWNER: Director of Corporate Affairs & Co Sec, & Emergency Planning Lead

in place for services, in respect of: Reduced staffing levels (for any reason e.g., pandemic); evacuation; technology failure; interruption to power supplies (gas & electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown; infection control; food supply; pharmacy supply; - Completion and updating of BCPs supported and monitored by Emergency Planning Lead, with register of BCPs held centrally; - BCPs are reviewed annually or following an incident; - Training for directors on call (strategic and tactical), heads of service (tactical), key staff with operational 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, 2015)). Lessons incorporated into -incident response plans, business continuity plans and	clinical systems outage; from Strike Action; from COVID response, from OOH business continuity incident, from locality floods etc **Level 3: independent** - Self-assessment examined and accepted by CCG on behalf of NHSE/I; - Improvement plan for actions against the 4 core standards with which Trust was not compliant was presented to CCG. Trust had achieved full compliance by October 2022 with NHSE core standards for EPRR (as set out in annual report to the Audit Committee and the Board in November 2022). - There is no formal mechanism in place to obtain assurance from any independent third parties that take place in EPRR exercises. If the Trust participates in a multi-agency exercise, then other participants can make comment during any verbal or written debrief process. In June 2023, KPMG governance risk and compliance services inspected a total of 13 assertions from a total of 33 mandatory assertions in the data security and protection toolkit. All four assertions relating to EPRR were rated as substantial.		

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.		When the Trust participates in a multi-agency exercise, then other participants can make comment during any verbal or written debrief process. No formal independent third-party mechanism is available to obtain assurance on multi-agency EPRR Exercises.	

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	12/01/2024
Risk movement	↔
Date of next review	April 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	2023		

Risk Description:

A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties (Health & Care Act 2022), national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028 – 2032. Reach net zero NHS Carbon Footprint Plus by 2045,reducing emissions by at least 73% by 2036 2038), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.

Key Controls	Assurance	Gaps	Actions
- Trust Green Plan/Strategy 2022-25; (Green Plan 2 2025-28 to be developed for sign off. Jan 25) - Executive Lead for Sustainability Chief Finance Officer; - Commitment by Board to Zero Carbon Oxford Charter (Jan 2021); - Full time Sustainability Manager post within Estates & Facilities Team; - Green Task Force - Benchmarking and annual emissions reporting; - Procurement Policy – sets out sustainability commitments required by suppliers; - Green Energy Supplier for electricity via CCS, - New Developments in accordance with NHS Net Zero Buildings Guidance	**Level 1: reassurance** - 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; - Annual C02 emissions against previous year; FY23 has seen 19% reduction in carbon emissions when compared to the 2019 baseline year. Annual target of 5% reduction when compared to FY22 not met due to increase in Business mileage. - The modal shift of staff travel into more sustainable alternatives will be focus of the next iteration of Green Plan in 2025. **Level 3: external** - BOB ICS Net Zero Program Board - Total Carbon Footprint Plus now reported by NHS England (54,000Tco2) Trust is leading on the BOB ICS Sustainable Travel Group . - The Trust is also part of ZCOP sprint group with Oxford University to review how to adapt our building estate to climate	Trust is not meeting annual carbon budget FY 23 (Actuals 4960 Tco2- Target 4508 Tc02) GAP: current resource may be insufficient to implement Green Plan.	Sustainable travel Trial (EV for Community Nursing Team) commenced in May 2023, data from trial will be used to inform Trust long term sustainable travel plan Executive team have approved Target temperature for non-inpatient areas of 20-degree C° Developing Green Plan 2 which will set out aims and objectives to reduce carbon impact 2025-28 . OWNER: Director of Estates and Facilities/Sustainability Manager. Additional resources to be considered (Sustainable Travel Officer / Sustainability Coordinator)

	change risk e.g., extreme heat, floods.		

Strategic Objective 3: Make the best use of our resources and protect the environment

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	23/01/24
Risk movement	↔
Date of next review	March 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
Current risk rating	**4**	**4**	**16**
Target risk rating	3	2	6
Target to be achieved by	December 2024		

Risk Description (revised June 2023)**:**
Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; and unplanned expenses, delays and wasted resources.

Key Controls	Assurance	Gaps	Actions
- Programme Boards for key projects. - Standing Financial Instructions and Scheme of Delegation. - Senior teams' leadership of change and focus on ensuring delivery. - In-house and contracted in expertise in managing projects where deployed.	**Level 1: Reassurance** Capital Programme sub-committee (reviews project progress and capital spend, can escalate issues to the Finance & Investment Committee); and - Warneford Park Programme Board with partners chaired by Non-Executive Director of Trust **Level 2: Internal** - FIC receives updates on level of risk exposure associated with Major Projects. **Level 3: Independent** - Internal audit reviews of PICU project and of SCAD methodologies completed in 2022/23 plan.	There have been gaps in the capacity and capability of the Trust to deliver major projects with our most significant projects dependent on external resource. The current risk rating reflects the gap against the Trust's objectives to have strong change leadership capabilities rather than a series of known gaps in delivery against specific projects. Methodology for major capital programmes investment appraisal and project management not yet clearly laid out although direction of travel agreed by FIC. Lack of PMO oversight of major programmes and key	- Renewed focus at Board, Committee and Exec level on developing our capacity and capability to plan for, prioritise and deliver change. - Deliver SCAD team restructure ensuring change expertise sits with the accountable directorates (Exec Dir Strategy & Partnerships – Q3 2023/24). - Consider and implement resourcing strategy for ongoing capital projects as their progress is confirmed (CFO - timing as appropriate) - Develop and roll out methodology, guidance and templates for investment appraisal and project management for major capital and for significant service change programmes.

		change projects to feed into Exec and Board scrutiny and no resource yet in place to deliver (Some oversight is in place via CPSC where projects are capital funded and an Estates PMO approach has been recently updated)	(CFO – Q4 23/24) - Develop oversight reporting mechanisms for major capital programmes to the Board. (CFO and Exec Dir Strategy & Partnerships – Q1 2024/25)

Strategic Objective 4: Become a leading organisation in healthcare research and education

4.1: Failure to realise the Trust's Research and Development (R&D) potential

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Chief Medical Officer
Date of last review	20/10/23
Risk movement	↔
Date of next review	March 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:
Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.

Controls	Assurance	Gaps	Actions
- Director of R&D; - NIHR Infrastructure Managers meetings provides an opportunity for managers of the OH hosted NIHR awards and the R&D Director to meet regularly to ensure alignment and discussion future opportunities. On a quarterly basis these meeting will be augmented by the OUH BRC and CRF Managers. - Clinical Research Facility (CRF) steering committee - Biomedical Research Centre (BRC) Steering Committee and Partnership Board; - Oxford Applied Research Collaboration Oxford and	**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); - Annual Statement of Expenditure Reports are	GAP: The clinical system outage from August 2022, which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting data-set information and contractual information which could lead to contractual and reputational consequences. R&D Trials will also face some delays due to gaps in data. GAP: Owing to the clinical system outage and issues with migration and recording of diagnosis within RIO the ability to produce accurate	The loss of CareNotes and the move to RiO has the potential to impact all areas of research from set-up and participant recruitment through to study delivery. The Head of Research Informatics is part of the RiO programme board.

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 development of the research element of NMAPS.	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;	recruitment lists has caused severe delays in meeting recruitment targets for national trials. Diagnosis migration issues should be resolved by end of September 2023. GAP: The Trust 'Count me in (CMI)' programme paused following the CareNotes outage. Recruitment reverted to a consent model and direct clinician referrals. This remains on hold as a Trust research recruitment strategy, awaiting new research forms in RIO and the ability for appointment letters with CMI leaflet attached, to be sent direct from RIO. If CMI service resumes, it will require a relaunch to staff and patients. We have no date for this to be resolved GAP (Controls): Warneford redevelopment – to progress. Complicated capital project and is being carefully monitored by the Finance & Investment Committee and with regular updates to the Board in private session. GAP (Controls): R&D Strategy in development. Includes Monitor and Improve study set-up times, Sustain and expand existing Research Clinics, Develop Clinical Academic posts, support early adoption of innovation to reduce waiting lists and increase productivity, Review / re-launch "Count me in"	Monitoring through reporting into the Finance & Investment Committee (FIC) and the Board. FIC also monitoring BAF risk 3.14 on delivery of Major Projects, such as the Warneford. The R&D operational plan will be developed as part of the OH Planning process.

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Table 1a: Risk Matrix

		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Impact/severity	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Table 1b: Likelihood scores (broad descriptors of frequency and probability)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might/does it occur	This will probably never happen/recur	Do not expect it to happen/recur but it is possible	Might happen or recur occasionally	Will probably happen/recur, but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	<0.1%	0.1-1%	1-10%	10-50%	>50%

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Table 1c - Assessment of the impact/severity of the consequence of an identified risk: domains, consequence scores and examples

	Consequence score (severity) and examples				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness requiring minor intervention Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Incident resulting serious injury or permanent disability/incapacity Requiring time off for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident resulting in fatality Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ Complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major safety implications if findings are not acted upon	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Major patient safety implications	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

			Low staff morale Poor staff attendance for mandatory/key training	competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Informal recommendation from regulator. Reduced performance rating if unresolved.	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage– long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage of a week	5–10 per cent over project budget Schedule slippage of two to four weeks	10–25 per cent over project budget Schedule slippage of more than a month Key objectives not met	>25 per cent over project budget Schedule slippage of more than six months Key objectives not met
Finance including claims	Negligible loss	Claim of <£10,000 Loss of 0.1-0.25% of budget	Claim of between £10,000 and £100,000 Failure to meet CIPs or CQUINs targets of between £10,000 and £50,000 Loss of 0.25-0.5% of budget	Claim of between £100,000 and £1million Purchasers fail to pay promptly Uncertain delivery of key objective / Loss of 0.5-1.0% of budget	Loss of major contract / payment by results Claim of >£1million Non-delivery of key objective/loss of >1% of budget

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Additional examples	Incorrect medication dispensed but not taken Incident resulting in bruise/graze Delay in routine transport for patient.	Wrong drug or dosage administered with no adverse effects Physical attack such as pushing, shoving or pinching causing minor injury Self harm resulting in minor injury Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare acquired infection (HCAI)	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure sore Long term HCAI Loss of a limb Post-traumatic stress disorder	Unexpected death Suicide of patient 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 ARTS PARTNERSHIP

ANNUAL REPORT 2023

"I really want you to know how much you encouraging me to paint has helped my hand. Through painting it started my exercising of it which has transformed my movement in my hand from a week ago"

Patient Comment

Overview

Oxford Health Arts Partnership (OHAP) is an award-winning programme that delivers *Creative Health* using Art and Nature. This report highlights some of the work the team has delivered during 2023 – the second year of the [OHAP 2022-2026 strategy.]

2023 has been a year of growth for OHAP; we have increased our team with the addition of a Green Spaces Coordinator, and we look forward to all the work Laura will do in 2024.

56 Trees Planted

Warneford Hospital 10 x Betula pendula (Silver Birch) & Lucy's Room 6 x Prunus trees (Edible Cherry)

Littlemore Hospital 10 x Sorbus aucuparia (Rowan) & 10 x Betula pendula (Silver Birch)

Whiteleaf Centre 20 x Prunus avium (Wild Cherry)

All our systems and governance have been improved by the work Angela has been doing as part of her MBA. She has been able to study and to increase the number of sessions we have delivered across the Trust by 22%.

Tom co-produced artwork with artists, staff and young people for the opening of a new building at the Warneford Hospital. The Meadow Unit will increase the work the Trust can do for the most vulnerable young people in Oxfordshire. The Unit is the most up-to-date facility in the Trust and includes artwork specially designed to create a calm and positive healing environment.

These are just a few of the highlights from 2023. This report details how we have fulfilled our key strategic aims: to deliver **Arts** across the Trust; to **Grow**; to **Inspire** people; to help people **Produce** great work; and to increase **Understanding** about the benefits of creative health through **Research**.

NB: We no longer refer to Artscape or Creating with Care – it is now all under the banner of Oxford Health Arts Partnership (OHAP).

Meet the Team

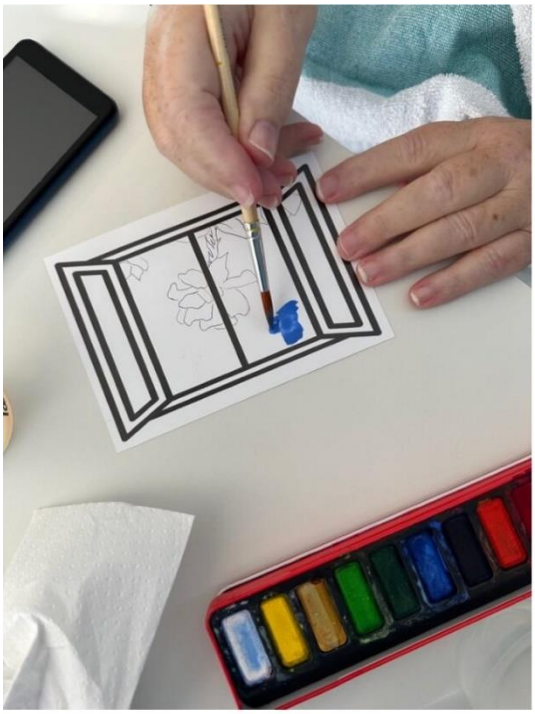
The programme is delivered by a team of creative individuals:

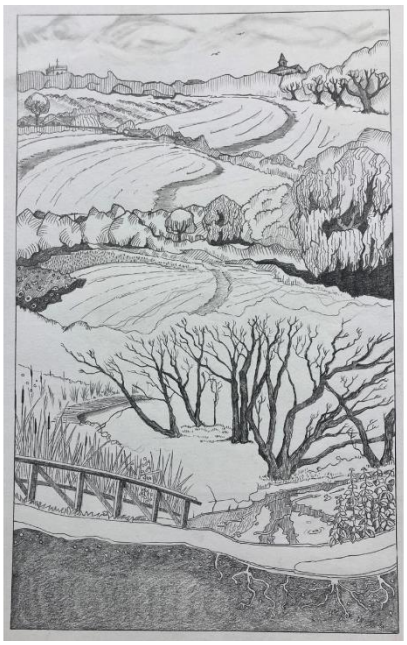
Tom Cox is now the full-time OHAP Project Manager. He covers art across the mental health divisions and manages the Green Spaces Coordinator. With over 20 years' experience in the NHS, he is a visual artist by background but has experience working with all artforms, from music to social sculpture.

Angela Conlan, Arts Project Lead, manages a programme of creative sessions across the Trust in all art forms. Angela has over 20 years' experience as an arts manager and a background in performing arts. She is currently working on a Senior Leader Apprenticeship (Arts and Culture) with an MBA at the University of Wolverhampton.

Laura McCarthy is the new Green Spaces Coordinator for the Trust. She started in November 2023 and has already made a big impact at Warneford Hospital, planting trees and helping to create the garden area for Lucy's Room. Laura has an MA in Landscape Architecture and over 12 years' experience of maintaining and developing gardens, as well as active experience of green space engagement.

GROW | RESEARCH | UNDERSTAND

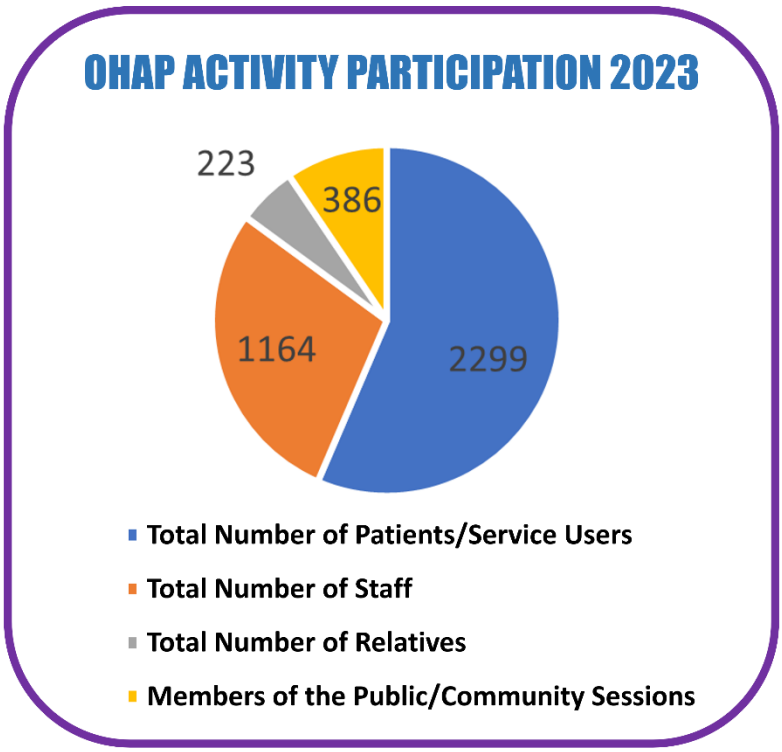


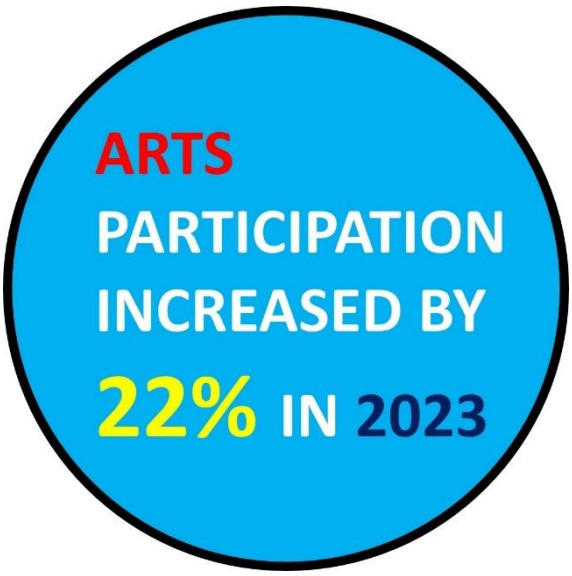


PRODUCTION | INSPIRE

Key Statistics

In 2023, OHAP worked with 29 artists and 38 partner organisations to deliver a full programme of creative health across the Trust. There was an increase in participation numbers of 22%. External Evaluation of OHAP Arts Interventions found that, in taking part, participants had a positive mood increase of 224%. Total number of sessions delivered: 386.





OHAP Participation in Numbers

Total Number of Patients/Service Users	2299
Total Number of Staff	1164
Total Number of Relatives	223
Members of the Public/Community Sessions	386
Total Participants/Attendances	4072

Grow - To develop OHAP through collaboration, co-production and partnerships.

Green Spaces

The role of Green Spaces Coordinator was created to help us deliver a trustwide programme of activities and engagement opportunities based around nature and wellbeing. The coordinator will also work with patients, service users and staff to improve ward gardens across the Trust and create restorative spaces using naturalistic planting to boost biodiversity, as well as incorporating spaces to grow herbs, fruit, and vegetables.

Since Laura started in November, OHAP has already:

- delivered green space workshops for staff and service users, including wreath-making sessions at Witney Community Hospital and on Wintle Ward at Warneford Hospital.
- supported 13 service users and staff with a range of green space engagement activities, preparing the Warneford allotment and polytunnel for the new growing season.
- supported 4 service users staying on Wintle Ward to do a winter tidy of borders in the ward garden.
- arranged engagement opportunities for staff and service users to get involved with planting trees for National Tree Week at Littlemore, Whiteleaf and Warneford Hospital.
- assisted Chiltern Rangers creating the garden area for Lucy's Room.

We continue to work in partnership with Chiltern Rangers, who look after the green spaces at Saffron House in High Wycombe and support volunteers to look after the Tranquillity Garden at Abingdon Community Hospital as well as the garden at the Sue Nichols Centre in Aylesbury.

The Gardens, Libraries and Museums of the University of Oxford

Oxford University Gardens, Libraries and Museums service (GLAM) delivered 25 museum object-handling sessions in Community Hospital and Adult Mental Health wards in 2023. GLAM also offer free education space at their venues as well as staff support and refreshments for hospital groups.

Early Intervention Service

OHAP have been working with the EIS team for several years and since the pandemic this had all been online. In 2023, in partnership with GLAM, we started working in person again and grew the number of courses we can deliver. OHAP run two-hour creative sessions based on a theme or exhibition. The aim is to allow people to explore their creative side and offer guidance and materials for them to try. The groups have been very well received and we plan to continue in 2024. So far, we have taken groups to The Natural History Museum, The Pitt Rivers Museum, The Ashmolean, Oxford Botanic Garden and The Weston Library. Highlights have included sessions in the Ashmolean print room, workshops in the Bodleian Library print room, and books made of cheese!

Music at Oxford Health

Orchestra of St. John's (OSJ) have delivered over fifty concerts led by a team of eight experienced musicians and singers who have brought classical and contemporary music to the wards, including: viola, voice, saxophone, violin, clarinet, and, on occasion, a native American flute. Each musician has a wide repertoire, which enables them to play the right music for each group of patients.

Orchestra of St. John's delivered:

53 mini-concerts & bedside serenading sessions, in

16 community and mental health wards, entertaining

614 patients, service users, staff and families.

All concerts have been funded by Orchestra of St. John's.

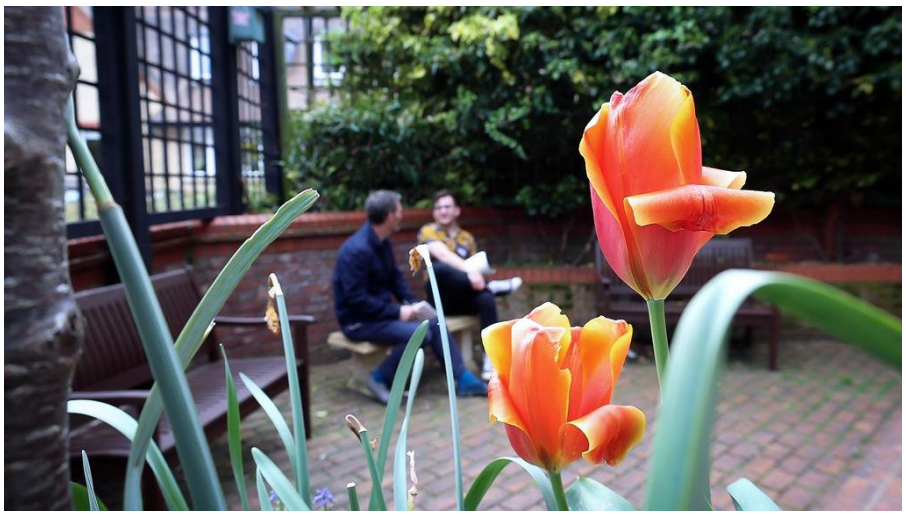
Our partnership work with Oxford Philharmonic Orchestra (OPO) re-grew in 2023, after sessions stopped in 2020 due to the pandemic. This year, the Orchestra delivered and funded 20 group music workshops at three wards at the Fulbrook Centre.

Funding

Over the year, the team wrote several external funding applications resulting in £12,700 of successful bids:

- £500 – Goring Arts Society – Wallingford Community Hospital Artist-in-Residence
- £1100 – Berkshire Nurses – Wallingford Community Hospital Artist-in-Residence
- £1100 – Vale of White Horse District Council – Wantage Community Hospital Artist-in-Residence
- £900 – South Oxfordshire District Council – Creative Health Discharge Packs
- £3600 – Didcot League of Friends – Didcot Community Hospital Artist-in-Residence
- £4000 – Vale of White Horse District Council – Abingdon Community Hospital Artist-in-Residence
- £1500 – Wallingford League of Friends – Co-design and installation of Murals at Community Hospital

Additionally, partnership work resulted in over £17,000 in kind support.

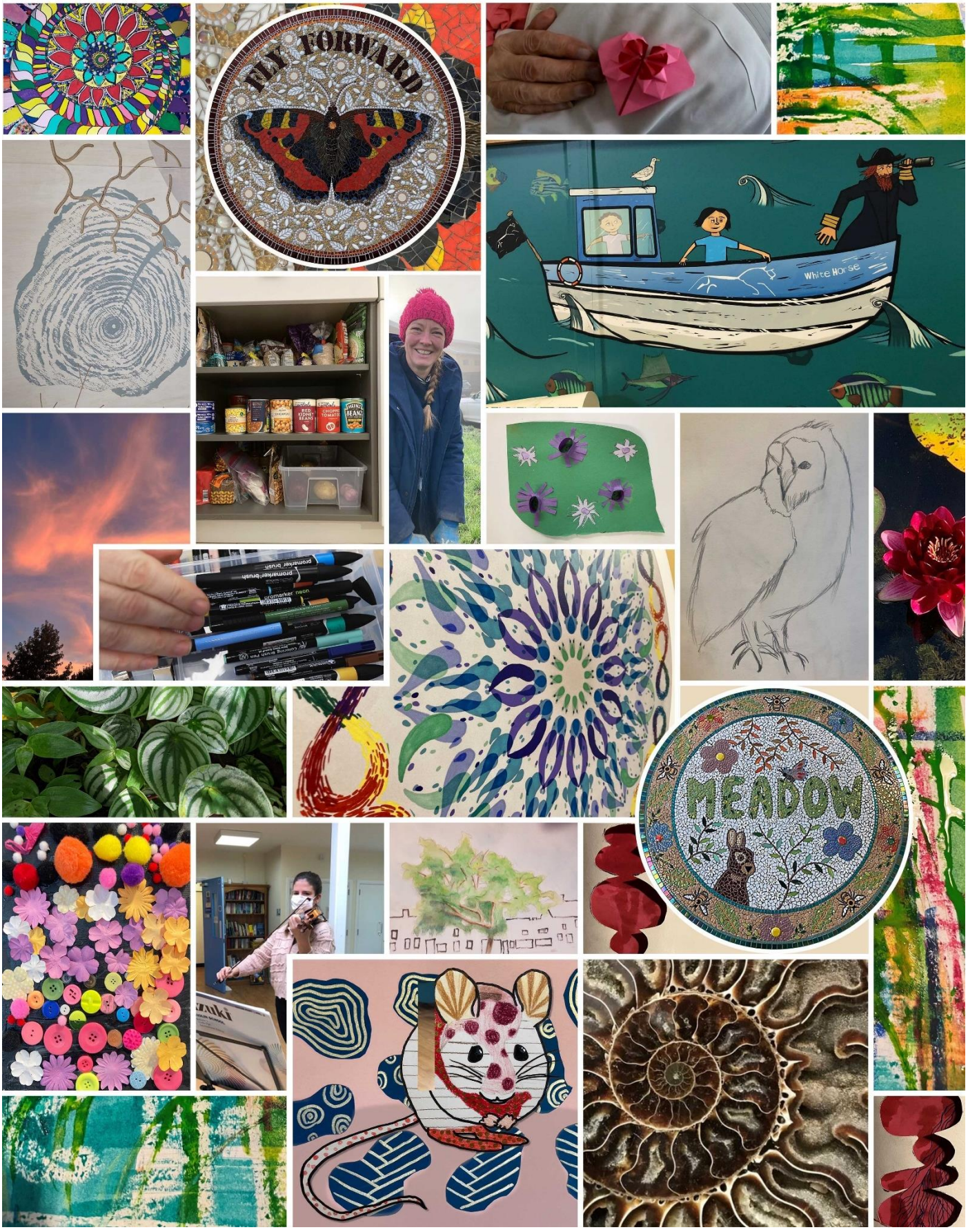


Creative Health 2023

Oxford Health Arts Partnership

OHC OXFORD • HEALTH • CHARITY

NHS Oxford Health NHS Foundation Trust



Inspire - To innovate and inspire creativity within healthcare.

Oxford Health Charity Art Auction

OHAP helped Oxford Health Charity with the preparations for their first charity art auction in aid of the Meadow Unit. The team collectively approached artists for donations and worked on the brochure design for the event, which is scheduled to take place in 2024.

Oxford Health Arts Partnership on Film

In June, the team launched their new video that showcases the work we do across Oxford Health NHS Foundation Trust services to bring the Arts into patient wellbeing and recovery.

The new film demonstrates the breadth of the programme being delivered through the OHAP team, Artists-in-Residence, and volunteers.

Art Making a Difference | Oxford Health Charity

Place-based Working and Community Workshops

The OHAP team have developed a place-based project approach as a direct result of the Artist-in-Residence projects that took place in 2021-2022. This work includes Didcot's Brilliant and wider community workshops around Wantage Community Hospital.

As a result, the team delivered 34 community-based workshops for 386 members of the community.

Have a Go Learning Disability Day

OHAP were delighted to lead a full day of dance at the annual Have a Go Festival at Horspath Driftway Athletics Club in July. The event was attended by over 120 participants who engaged with movement, sensory props, and music.

Marketing Strategy

OHAP officially launched with a new logo and branding in 2023. Over the year, the team also worked on developing a marketing strategy which will be published in 2024.

NHS 75 Celebrations and Exhibition

Our Stories: Celebrating 75 Years of the NHS is a celebratory art exhibition showcasing artwork created by patients, their families and the people who care for them, curated by Artist-in-Residence, Tom Cross. The exhibition, which includes artwork created with staff reflecting on their own superpowers, aims to raise awareness of art in healthcare and is currently touring Oxfordshire.

Jun – Aug'23: The Mill Arts Centre, Banbury
Sept – Dec'23: Makespace Oxford, The Community Works
Jan – Mar'24: Makespace Didcot, The Junction
Mar – Jul'24: Makespace Wantage, The Old Stables
Aug'24: Witney Community Hospital

As part of the celebrations, the OHAP team also coordinated concerts and tea parties at all community hospitals as well as music for the staff celebration at Warneford Hospital.

Work Experience Placements

OHAP continues to offer work experience placements throughout the year and, during 2023, worked with students in Didcot and Witney Community Hospitals. The team also worked with five volunteers, with regular volunteer-led sessions in Abingdon and Didcot Community Hospitals.

Meadow Unit 2023

Production - To contribute to the recovery and experience of service users, patients, clients and the health and wellbeing of those in contact with Trust services.

Meadow Unit

In 2023 the new Meadow Unit opened. This eight-bed, psychiatric intensive care unit (PICU) at the Warneford Hospital, will enable young people who are experiencing the most acutely disturbed phase of a serious mental disorder to receive specialist help closer to home.

The Unit has been carefully designed to create the most welcoming and nurturing environment for young people. A team of artists co-produced artwork with patients and staff that integrates seamlessly into the building. Using robust materials, such as plywood and window vinyls that bond with the windows, the artwork was created to be safe for those using the environment.

The works of art were developed during several workshops with young people and staff and followed with consultation at each stage of the design. Many of the young people's original designs can been seen in the finished artwork.

Peach Tree House and Prospect House

Peach Tree House (Aylesbury) and Prospect House (High Wycombe) have had new artwork installed following creative workshops by OHAP. Colourful mandalas were designed by staff that use the spaces and the final artwork was chosen in consultation with staff.

Lucy's Room

The new building for Lucy's Room was installed at Warneford Hospital in 2023 and OHAP, in partnership with Oxford Health Charity, got to work straight away to transform it into a dedicated music space and garden area. The outside of the building has been painted with music-themed murals, while raised beds and careful planting have been installed to provide privacy for people when using the building. We look forward to continuing with the development of this exciting new resource in 2024.

Abingdon Minor Injuries Unit

At the beginning of the year, OHAP worked with local freelance artist and illustrator, Tom Cross, to co-design bespoke artwork for the children's waiting area and treatment room at Abingdon's Minor Injuries Unit. The seaside scene, which features a beach with changing huts, fish and starfish swimming in the sea, is now used by staff during consultations to assess cognitive ability and has also created a calming and inviting environment for children.

Didcot's Brilliant

OHAP's yearlong placed-based project, "Didcot's Brilliant", was made possible with a £10,000 grant from the National Lottery Community Fund in 2022.

The project funded freelance Artist-in-Residence, Dionne Freeman, to work creatively with patients and staff at Didcot Community Hospital as well as participants of all ages and abilities in the town.

The project co-produced 18 separate, large artworks for Didcot train station and will be celebrated in January 2024 with a community event for all who took part at The Junction in Didcot.

Didcot's Brilliant Key Outcomes

- 57 Workshops
- 541 Participants
- 9 venues
- 1 Hospital
- 16 Community Groups

I just wanted to let you know what an impact these sessions have on patients. One patient, who has just been discharged, said that her weekly art sessions with you were the one thing that kept her going. She suffers from anxiety and depression and the art sessions with you gave her purpose and focus.

Staff Comment

Understand - To raise awareness of the benefits of arts interventions in healthcare settings.

OHAP continued to raise awareness of the benefits of art interventions in healthcare settings by delivering staff workshops, hosting a national creative health conference, and delivering creative workshops for patients and service users across the Trust.

Staff Workshops

OHAP has delivered 14 creative workshops to 366 members of staff who wanted to explore their creative side:

OHAP delivered 14 creative workshops to 366 members of staff

- Online art sessions in origami and Zentangle.
- Creative movement for clinical staff at the Physical Health Week Conference – in partnership with Ajos Dance.
- Dance workshops for the School Immunisation Team away day.
- A two-day, creative workshop for staff at the new PICU – focusing on team building and pushing the teams out of their comfort zones; experimenting with art materials; and working collaboratively to create new artwork for the Unit, including 25 individual canvases that are displayed in the staff area. Some of the staff artworks were also used as inspiration for designs to go onto the windows in the Unit.
- Mindful drawing workshops.
- Mandala workshops for staff areas.

Staff Awards

As part of the wider team, we contributed to the visual display at this year's staff awards with images of patient and staff artwork on the theme of kindness.

NPAG Conference

OHAP co-hosted the National Performance Advisory Group (NPAG) Arts, Heritage & Design in Healthcare Network meeting on 15 June 2023, with OUH, which was held at the new Oxford Hospitals Education Centre and over 50 colleagues from across the country attended the conference.

The day focussed on working in partnership, research to demonstrate the impact of arts in a healthcare setting on patients and staff, arts in support of wellbeing through co-production, and art installations in hospital environments. OHAP commissioned a new film to show the variety of work we do across Oxford Health NHS Foundation Trust.

Click here to view the film: Art Making a Difference | Oxford Health Charity

MSc Module - Advancing Practice in Dementia Care

OHAP has been involved in both the design and delivery of a teaching session on Non-Pharmacological Interventions on the Oxford Health NHS FT/Oxford Brookes Dementia Care module, which runs 2-3 times per year.

Music Strategy

During 2023, OHAP consulted with a wide range of staff and members of the community to develop a trustwide Music Strategy document. The document outlines the role of music in enhancing patient care, improving staff wellbeing, and fostering a healing environment. It recommends working towards a set of goals which will see the team increase provision for music trustwide; to be published in 2024. The recommendations included:

- increasing access for patients, service users, staff and visitors through increased music-making workshops and projects.
- collaborating with Lucy's Room, the Highfield Unit, and Littlemore where possible.
- expanding the geographical reach for music projects into Bucks and Wiltshire.
- a wider reach for concerts (currently only in Oxfordshire).
- co-ordination and training for volunteer musicians.
- research into social prescribing on the ward and on discharge – including music in patient care plans to aid in pain management, reduce anxiety, and promote relaxation.
- enhancing the wellbeing of staff members by offering music-based stress relief activities as well as basic training for staff to develop music delivery skills.
- collaborating with local musicians and music therapists to provide engaging musical experiences for patients and staff.
- increasing access to, and the number of, available resources (musical equipment).
- increased intergenerational work.

Research - To actively engage and lead on research to demonstrate the impact of the Arts on health.

Senior Leader Apprenticeship

In 2023, Angela completed her first year of the Senior Leader Apprenticeship (Arts and Culture) with an MBA at the University of Wolverhampton Faculty of Arts, Business and Social Science.

Arts Impact Measured

During 2023, OHAP continued to work with The University of Oxford's Nuffield Department of Primary Care Health Sciences, to conduct a comprehensive evaluation of the impact of arts interventions on patients' wellbeing.

The key findings included:

- **Positive Mood Enhancement** Arts interventions led to improved feelings of happiness in patients, with 29% experiencing positive emotions before the intervention and 94% after; **this was a 224% increase**.
- **Memory and Individuality** Patients who engaged in arts interventions, shared memories and stories; fostering a sense of community and individuality.
- **Engagement** Patients reported feeling more **engaged and connected** with their peers and care providers during the arts sessions.
- **Impact on Patient Experience** "I want great care" scores, a measure of patient experience across NHS facilities, demonstrated a notable increase in the "involvement" variable. Although not directly linked to arts interventions, this increase suggests an overall positive impact on patients' satisfaction and engagement.

Read the full report here.

UCL MASc Creative Health Dissertation Student

Over the summer, OHAP mentored a final year student on the MASc Creative Health course at UCL. The student based her dissertation on the emotional effects of live music performances on patients staying in Oxfordshire's Community Hospitals. The study concluded that there were substantial benefits for music provision including:

- enhanced communication/fostering richer relationships.
- a rejuvenated environment, where patients can find solace and happiness.
- enhanced mental and emotional wellbeing.
- a substantial reduction in anxiety levels.
- an increase in overall happiness and physical activity.

Hospital at Home

OHAP worked together with the Oxford Health Community Research team, the University of Southampton, and the University of Oxford's Nuffield Primary Care Health Sciences Department on a funding proposal for an arts-based pilot research project. The project will be run with patients who are at the end of, or just finishing treatment with, the Hospital at Home and the Urgent Response Teams, and/or community patients (identified by neighbourhood teams) with chronic conditions.

The aims of this project are to:

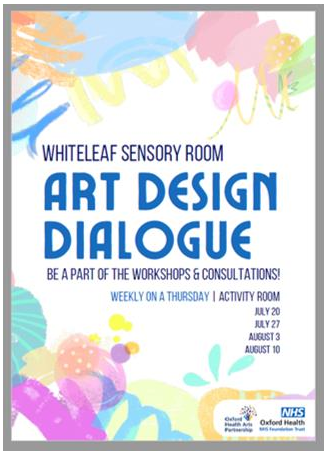
- understand the effects of arts activities for patients after treatment at home.
- to test the potential of a pilot creative arts intervention to improve patient wellbeing (including perception of pain and impact on isolation).
- understand the impact on staff wellbeing when delivering a project like this.

Now funding has been agreed with Oxford Health Charity, work is currently underway to develop a project protocol and ethics. We hope this project will start in September 2024.

OT Placement Student

During 2023, Tom had his first Occupational Therapy Student. This placement was shared between Oxford Health Arts Partnership and the Buckinghamshire Autism Team. During her 12-week placement, the student:

- carried out independent research around the benefits of arts and health.
- focused on the environment of the wards at Whiteleaf from a sensory perspective.
- ran a series of visual art workshops on the male and female wards at Whiteleaf.
- wrote a report about her findings here.
- helped deliver staff and service user workshops with Tom.



Oxford Health Arts Partnership would like to thank our artists and partners

ARTISTS

Dionne Freeman

Tom Cross

Dave Noble

Tabitha Grove

Dr Roosa Leimu Brown

Dan Wilson

Anne Griffiths

The Mary-Lou Revue

Benedict Heaney

Kate Wilkinson

Kate Holland

Rachel Byrt

Lizzie Burns

Anne Marie Cadman

Sandra Diesel

Jake Rae

Miranda Bence Jones

Rachel Barbaresi

Jacqui Miles

Rachel Maby

Julia Castellanos

Becky Paton

Damien Clarke

Trina Banerjee

Elisabeth Spight

Karin Norlen

Vickie Kearney

Alice Barron

PARTNERS

GLAM

Sustainable Didcot

Style Acre Adult

Adult Mental Health Team - Didcot

Didcot WI

Didcot Community Partnership

Didcot Library

Makespace Oxford

Didcot Silver Pride

Didcot Bereavement Group

Age UK

Didcot Garden Town

Didcot Health & Wellbeing

Chiltern Rangers

Cornerstone Arts Centre

Aureus School

Didcot Concert Orchestra

Oxford Wood Recycling

Didcot Community Hospital - League of Friends

RAW

UCL Creative Health

University of Oxford

Orchestra of St. John's

Oxford Philharmonic Orchestra

Museum of Oxford

Didcot Dukes

Didcot Girls' School

Ajos Dance

Akademi Dance

Sound Resource

King Alfred's Academy

Vale and Downland Museum

Vale of White Horse District Council

South Oxfordshire District Council

Sanctuary Care, Wantage

Wallingford Community Hospital - League of Friends

Witney Community Hospital - League of Friends

Goring Arts Society

The Berkshire Nurses & Relief in Sickness Trust

VOLUNTEERS/STUDENTS

Andy Simpson

Chris Sivewright

Christine Bland

Lin Dewsnap

Hemashu Kotecha

Jackie Owen

Xue Bai

Madeline Tatum

Shir Grunebaum

Oxford Health NHS Foundation Trust

☑ **Communications & Engagement**

Board Report November and December 2023

Contents

Board Report November and December 2023

Staff engagement

On November 13th our latest **Exceptional People Awards** event was held, where the winners were:

- Margaret Louch, a peer support worker
- Timothy Farr, the ward clerk on Linwood Ward at Witney
- the Community Rehabilitation patient Flow Lead team, who work across all the community hospital sites in Oxfordshire
- the Oxford City Crisis Resolution and Home Treatment team.

All the winners celebrated with refreshments with the Executive team.

During November, the Psychological Professions teams and the Occupational Therapists teams marked their annual awareness days with staff events, and social media coverage of their work, achievements, career opportunities, and what their roles entail. We also marked Disability Awareness Month through November and December, and highlighted our work to support veterans and their families in the week leading up to Remembrance Day. That included an Armed Forces Network event at the Warneford for those impacted by military service to come together and learn about the support on offer. We also marked Learning Disability Nurses Day with news of our new Hospital at Home service for those with learning disabilityes.

In December our Peer Support Graduation Event was held in Thame, with 21 students graduating – these peer support workers will bring their own lived experience of mental health challenges to support those receiving care and treatment in their recovery. We also marked the contribution of our 600 Healthcare Support Workers with a networking event in mid-December.

Media

The Oxford Mail covered the future of services at Wantage hospital in late December, acknowledging the public involvement in the development of discussions, and the ongoing work to address urgent action required to improve the support for children and young people with special educational needs and disabilities (SEND) in Oxfordshire.

HealthTechWorld covered the "gameChange" VR automated therapy programme which has been recommended for use in the NHS for the treatment of severe agoraphobia in patients with psychosis. The recommendation follows the largest ever clinical trial of VR for mental health led by the University of Oxford chair of psychology, Daniel Freeman. This coverage

strengthens the reputation of Oxford Health in connection with brain health research and development.

The Banbury Guardian have been reporting on district nursing provision in the north of the county, which has been followed up by the district nursing team speaking to the family concerned.

Stakeholder engagement

We continue to engage with MPs, Councillors, Health Overview and Scrutiny, residents' and staff on the large projects which will ensure we are providing care in fit for purpose, therapeutic and modern settings, including the Warneford redevelopment, and the transformation of our community healthcare hubs.

In late December the Conditional Option Agreement was signed by Prof Irene Tracey, Vice Chancellor of the University of Oxford, and Grant Macdonald, confirming the partnership between the two organisations to progress our plans for the Warneford site.

MP meetings have been diaried for early January with both Anneliese Dodds and Robert Court visiting the Warneford. Mr Courts will also visit the Meadow Unit, our new PICU. Ms Dodds has agreed to formally open the Meadow Unit in March 2024.

Oxford Health NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

31st January 2024

RR-App 03/2024
(Agenda item: 21)

Quality and Safety Dashboard
For Information

Executive Summary
The information in the Quality and Safety Dashboard is up to 31st December 2023. The purpose of the dashboard is to bring together data and 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 position in December 2023 and a review of any trends from the last 3 months (October-December 2023).

Over the last few months we have been reviewing the dashboard and as a result have introduced some new indicators in this month's report. We are also planning to make some changes to expand how the report is used within Directorates with agreed escalation points.

The following wards/teams have been highlighted, split into 2 groups; to keep a watching eye and alert status.

Highlighted wards/teams by exception:

	Alert Status	**Keep a Watching eye**
Community Teams	• District Nursing • Oxon City and NE AMHT • Bucks and Oxon CAMHS Neuro Diversity • Bucks and Oxon Adult Neuro	• Minor Injury Units • GP OOH • Bucks Crisis Teams (Aylesbury and Chiltern) • Podiatry • Complex Needs Service
Inpatient Wards		• Wintle ward • Ashurst ward (PICU) • CAMHS Highfield ward • CAMHS Marlborough House, Swindon • Ruby ward • Sapphire ward • City Community Hospital • Kestrel ward

The report includes further detail about each of the wards/teams at 'alert status' and the mitigations and actions being taken.

In addition, to the teams/wards highlighted above 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. The teams with high vacancies are listed in the Dashboard. The Trust has an improvement programme of work called 'Improving Quality, Reducing Agency use' which has eight workstreams, each implementing a number of Trust-wide recruitment initiatives. In addition each month the wards and teams with the highest vacancies are discussed with the HR recruitment campaign consultants.

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

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 Committee 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 December 2023.

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 December 2023 and a review of any trends from the last 3 months (October-December 2023).

Waiting time and access information has been reintroduced into the Dashboard this month however some caution should be used with the information as there is likely to be some data quality work required.

See accompanying excel sheet for the full detailed dashboard for the inpatient wards. The new CAMHS PICU Meadow Unit is not included in the Dashboard yet.

Over the last few months we have been reviewing the dashboard and as a result have introduced some new indicators in this month's report. We are also planning to make some changes to expand how the report is used within Directorates with agreed escalation points.

2. Highlighted wards/teams

The following wards/teams have been highlighted, split into 2 groups; to keep a watching eye and alert status. A watching eye means the area has workforce challenges such as vacancies and 1 quality indicator flagging, whereas alert status means the areas has workforce challenges and at least 2 quality indicators flagging.

Highlighted wards/teams by exception:

	Alert Status	**Keep a Watching eye**
Community Teams	• District Nursing • Oxon City and NE AMHT • Bucks and Oxon CAMHS Neuro Diversity • Bucks and Oxon Adult Neuro	• Minor Injury Units • GP OOH • Bucks Crisis Teams (Aylesbury and Chiltern) • Podiatry • Complex Needs Service
Inpatient Wards		• Wintle ward • Ashurst ward (PICU) • CAMHS Highfield ward • CAMHS Marlborough House, Swindon • Ruby ward • Sapphire ward • City Community Hospital • Kestrel ward

The rest of the report provides the detail for the each of the wards/teams at 'alert status' and the mitigations and actions being taken.

3. Teams with High Vacancies

In addition, to the teams/wards highlighted above 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. Vacancies are based on data provided by finance. The teams with high vacancies 30% or above are listed below to show a complete picture.

The Trust has an improvement programme of work called 'Improving Quality, Reducing Agency use' which has eight workstreams, each implementing a number of Trust-wide recruitment initiatives. In addition each month the wards and teams with the highest vacancies are discussed with the HR recruitment campaign consultants.

Areas with High Vacancies - 30% or above (data source Finance)	
Inpatient Wards	Community Teams
• Wintle 33% (no change) • Ashurst 33% (improvement) • CAMHS Highfield 38% (no change) • Cherwell 32% (decline) • Woodlands 35% (no change) • Glyme 32% (no change) • Kestrel 33% (decline) • Kingfisher 32% (no change) • Lambourne House 38% (decline) • Ruby 37% (Nov 2023 data, improving picture)	• LD Intensive support team 36% (improvement) • LD Reasonable adjustment team 34% (no change) • LD North Community Team 58% (decline) • LD City Community Team 79% (decline) • Oxon CAMHS Crisis 35% (improvement) • Oxon CAMHS Neuro 41% (improvement) • CAMHS Marlborough community team 38% (decline) • Oxon City and NE AMHT 39% (same) • Oxon North and West AMHT 33% (decline) • Wiltshire Eating Disorder services 31% (improvement) • Bucks Aylesbury AMHT 42% (decline) • Bucks Aylesbury CRHT 31% (decline) • Bucks Chiltern AMHT 49% (decline) • Bucks PIRLS 35% (no change) • Bucks SCAS & Street Triage 33% (improvement) • Bucks OA South CMHT 47% (decline) • Bucks CAMHS Neuro 40% (decline) • Podiatry 38% (same) • Chronic Fatigue and ME Service 38% (decline) • Childrens Community Nursing West 31% (decline) In addition there are a number of separate medical/doctor professional cost centres across the community mental health teams with very high vacancies.

4. Wards Highlighted at Alert Status

No wards have been highlighted at alert status however 8 wards are at a 'keeping a watching eye'. Recruitment and retention remain the main challenges for the wards with 10 wards having more than 30% of their establishment vacant. The central recruitment team continue to support services in ensuring there are rolling campaigns to fill vacancies alongside exploring creative approaches to attraction. A range of initiatives are in process to support recruitment and retention across services. Temporary staff are used to maintain safe staffing levels. There remain some ongoing issues with the contract with NHS Professions who provide our temporary and agency staff. Recruitment and retention is a high risk on the Trust's Risk Register.

Priority areas:
Recruitment for the new CAMHS PICU called Meadow Unit remains a priority, in particular Band 5 nurses. The campaigns team will continue to support the unit until it is fully staffed. The CAMHS Highfield unit is now also high priority due to the impact of the opening of the Meadow Unit which has led to staff shortages in difficult to recruit to skill areas.

Proactive recruitment campaigns are taking place for the following areas: Littlemore Forensic wards, Meadow PICU, Highfield CAMHS, Bucks older adult community mental health teams, Oxon City and NE AMHT[1] and podiatry.

A QI project is underway focused on reducing time to hire, ensuring we hold onto candidates in the recruitment process, attracting more suitable candidates, and ensuring a fairer, more inclusive recruitment process.

Due to the success of the Recruitment Roadshows that were held across 4 counties in November 2023 and the University recruitment events held in October and November 2023, we will run more events like these in 2024. Two Roadshows are planned for 2024, in April and November which will take place across approx. 6 Trust locations, these events will be split into half days, targeted at both internal and external candidates. Two University events are planned for Bedford in Feb and Oxford Brookes in March, with more being set up.

[1] AMHT = adult mental health team

5. Community Teams Highlighted at Alert Status

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

Four teams/services have been highlighted which are particularly struggling; District Nursing Service, Oxon City and NE AMHT, Bucks and Oxon CAMHS Neuro Diversity (ASD/ADHD), and Bucks and Oxon Adult Neuro. They are listed below with the mitigations and actions being taken.

Teams/Service	In last Dashboard under ALERT status?	Reason for Highlighting	Mitigations & Actions
District Nursing	Yes	• District nursing service continues to be under extreme pressure. The outcome of the NHSE Safer Staffing Tool Census evidences significant gap in capacity compared to demand. • 1,886 referrals received in Dec 2023. 17,302 referrals received April-Dec 2023. Average caseload 5,235 patients. • Vacancies vary by team, the highest being in City 26% and SE 22%. • Non-urgent patients being 'rolled' and experiencing extended delays to be seen. • 11 complaints, 29 concerns and 1 MP concern over 3 months from Oct-Dec 2023. Increase in Dec 2023. Themes; service provision, insufficient care, discharged too soon, communication and staff attitude. • 64 patient incidents with moderate harm or above over 3 months from Oct-Dec 2023. Majority of which are pressure ulcers; 16x category 4, 20x category 3, 11x unstageable and 4x deep tissue injury. 0 PSIs identified as no significant lapses in care.	• Clinical prioritisation document in place, agreed with ICB and GP leads to guide the service in the prioritisation of patient care. Very high-risk patient care is protected daily, which includes end of life care, daily medication administration (e.g., insulin, heparin, IV antibiotics) and urgent interventions such as blocked urinary catheter care. • Monthly meetings with BOB ICB to monitor situation. • Clinical harm reviews carried out for 'rolled over' patients. • All pressure ulcers developed in service are reviewed and reported into the Pressure Ulcer Steering Group to identify learning. • There is a comprehensive District Nursing Improvement Programme in place. This includes a number of QI projects to maximise capacity, staff retention and improve clinical outcomes i.e. wound care recovery and anticipatory care model pilot in Bicester.
Oxon City and NE AMHT	Yes	• 39% vacancies, with similar high agency staff use. • 4 complaints, 14 concerns and 2 MP concerns over 3 months from Oct-Dec 2023. Increase in Nov 2023. Themes; diagnosis, insufficient care and staff behaviour. • 415 patients waiting for assessment or care coordinator to be identified for treatment (data quality needs to be checked).	• Agency workers being used on long lines. • Active recruitment campaign is continuing. • Sessional staff helping to work through assessment waiting list. Number of patients waiting to be assessed has declined.

Teams/Service	In last Dashboard under ALERT status?	Reason for Highlighting	Mitigations & Actions
		• 2 suspected suicides in 3 months Oct-Dec 2023. • 1 PSII relating to self-neglect in 3 months Oct-Dec 2023. • To put in context team received 1,438 referrals April-Dec 2023.	• Transformation work continues to address capacity and demand gap, including development of the health and wellbeing hubs and primary care mental health teams. • Regular leadership support to team to help prioritise work.
Bucks and Oxon CAMHS Neuro Diversity (ASD/ADHD)	No (waiting list information wasn't available)	<u>Bucks</u> • 40% vacancies • 2 complaints, 6 concerns and 1 MP concerns over 3 months from Oct-Dec 2023. Relating to access/waiting times and communication. • 3,000 patients waiting of which 1,968 have waited more than a year. • To put in context team received 1,077 referrals April-Dec 2023. <u>Oxon</u> • 41% vacancies • 2 complaints, 5 concerns and 5 MP concerns over 3 months from Oct-Dec 2023. Relating to access and waiting times. • 1 moderate harm incident not related to a waiting time. • 3,228 patients waiting of which 2,000 have waited more than a year. • To put in context team received 1,329 referrals April-Dec 2023.	• Ongoing recruitment to fill vacancies. • Regular review of data and waiting list monitoring. • Risk management of waiting lists and implementation of harm minimisation plans. • Work is underway across BOB ICS to identify further mitigations.
Bucks and Oxon Adult Neuro	No (waiting list information wasn't available)	<u>Bucks</u> • 0% vacancies. • 1,215 patients waiting of which 620 have waited more than a year. • To put in context team received 1,250 referrals April-Dec 2023. <u>Oxon</u> • 13% vacancies, improvement from 47% in Nov 2023. • 2,522 patients waiting of which 1,411 have waited more than a year. • To put in context team received 1,303 referrals April-Dec 2023.	• Regular review of data and waiting list monitoring. • Risk management of waiting lists and implementation of harm minimisation plans. • Work is underway across BOB ICS to identify further mitigations.

FIC 01/2024
(Agenda item: 02)

Meeting of the Oxford Health NHS Foundation Trust
Finance and Investment Committee

DRAFT Minutes of the meeting held on
Tuesday 16 November 2023 at 09:00
Via Microsoft Teams Virtual Meeting

Present:
Core members and attending Board members included in quorum

Chris Hurst	Non-Executive Director (**CMH**) (the Chair)
Rob Bale	Executive Managing Director for Mental Health & Learning Disability Services (**RB**)
Amélie Bages	Executive Director of Strategy and Partnerships (**AB**)
Grant Macdonald	Chief Executive (**GM**)
Philip Rutnam	Non-Executive Director (**PR**) – from 9.10am
Heather Smith	Chief Finance Officer (**HeS**)

In attendance:

Brian Aveyard	Risk, Assurance and Compliance Manager (**BA**)
Susannah Butt	Transformation Director – Primary, Community & Dental (**SB**) – part meeting
Ben Cahill	Deputy Director of Corporate Affairs (**BC**)
Simon Cook	Warneford Park Programme Director (**SC**) - *part meeting*
Matt Edwards	Director of Clinical Workforce Transformation (**ME**) - *part meeting*
Wayne Heal	Head of Property Services (**WH**) – *part meeting*
Jane Little	Head of Procurement (JL) – *part meeting*
Neil McLaughlin	Trust Solicitor and Risk Manager (**NMc**) – *part meeting*
Peter Milliken	Director of Finance (**PM**)
Paul Pattinson	Finance Business Partner (**PP**) – *part meeting*
Dr Ben Riley	Executive Managing Director for Primary, Community & Dental Care (**BR**)
Andrea Shand	Associate Director CAMHS & Eating Disorders Provider Collaborative (**AS**) – *part meeting*

1.	**Apologies for Absence**	
a	Apologies were received from Kerry Rogers – Director of Corporate Affairs & Company Secretary.	
b	The Chair welcomed all to the meeting and confirmed it was quorate.	
2.	**Minutes of the Meeting held on 19 September 2023 and Matters Arising**	
a	The minutes of the Finance and Investment Committee meeting held on 19 September were approved as a true and accurate record. The chair summarised the log of actions, noting that the majority of action areas were being addressed via the meeting agenda. The chair noted the good work done on capital authorisation processes and business case processes but asked about the current staff capacity to progress this work? HeS confirmed that the Deputy Director of Finance was currently supporting the implementation of this work. AB added that the action may not be dependent on project management capacity and recommended that the action be re-worded to clarify the position and agreed to provide an update on progress at the next committee meeting. **ACTION** AB/HeS/PM: update on capital authorisation processes and business case processes for next FIC meeting	
b	The chair commented that receiving the meeting papers on the Friday prior to the meeting reduced time available to read papers and opportunities to ask any queries of colleagues in advance of the meeting. The natural timing of receiving paper may make this necessary on occasion but, wherever possible, he reminded executive colleagues that meeting papers should be sent at least 5 working days prior to the meeting.	
c	**Matters Arising** The chair noted a paper received outside of circulation timescales providing the committee with an updated on capital investment approvals for Community Mental Health Framework hubs. He agreed that this item be covered under Any Other Business.	
3.	**Review of current financial performance** <u>Financial report</u>	
a	HeS introduced the paper on the Month 6 (M6) financial position, noting that at M6 Trust was £1m ahead of plan reflecting improvements in the agency expenditure forecast. The position has also been improved by actions such as setting aside money for non-recurrent spend. HeS noted that she included a 'health warning' in the paper that there is continuing movement against some agency forecasts - relating to where staffing data flows may alter forecasts – but confirmed that this risk is being addressed and monitored. HeS noted that capital expenditure is forecasted to overspend however the current assessment is that it is unlikely that the Trust will be overspent by the end of the financial year due to normal scheme slippage, adding that – if an overspend did	

	occur - the Trust would work with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) to consider brokerage options within the ICB.	
b	HeS summarised the system financial context at present noting the significant deficit of the BOB ICB. Nationally, systems in deficit are being supported to break even or return to original plan (which for BOB ICB is a £20m deficit). Additional funding for ICBs will flow according to a methodology around numbers of clinical whole time equivalents (WTEs) however there is an assumption that this benefit would flow back to the BOB ICB. The Trust needs to agree a position its case for retaining some of this funding to address prioritised areas for investment (such as SEND).	
c	On financial culture, HeS described the reflective approach being taken and noted the progress beginning to be made. HeS's assessment is that that the right areas are now being focused on and that there is significant effort across directorates to manage pressures within budgets, but noted that this work is in the early stage for corporate services. HeS gave an example of Estates not having a history of a corporate budget which prevented more active work by Estates budget holders.	
d	PM outlined the Trust's financial position as at Month 7 (M7) where the Trust is a little ahead of plan (by £180k). Across commissioned services in clinical directorates, the Trust is ahead of plan (surplus approx. £2m M7). This is offset by Learning Disabilities - which has a deficit of £700k (due a small number of high cost patients) which may improve, Forensic services - which has an income deficit (being addressed via Provider Collaboratives longer-term but will persist this year), and contract negotiations and agreements with the BOB ICB (including funding to address any reported losses from industrial action). PM summarised that the position is relatively positive and stable but flagged current uncertainty caused by agency forecasting challenges.	
e	Following the summary of the report, PR had some specific comments: 1. Total pay costs and headcount (slide 8). PR noted that the Trust's total headcount is running steadily below budget and asked if this was because of real operational shortfalls or if the original estimate on headcount required was an overestimate? Additionally, how would this position inform forecasting for the next financial year? HeS responded that pay is the key driver for the Trust's financial position and noted that a part of the underspend resulted from increasing budgets, including establishment positions that weren't previously budgeted but are now in place. HeS flagged that current pressures would impact on staff rather than budget positions. RB concurred, stressing that the impact is felt on staff working under pressure; 2. Non-pay spend (slide 13) - PR reflected that if the provider collaborative £10.7m is removed there is an adverse variant on non-pay costs of approximately £7m which, as a significant proportion of £105m, should be taken into consideration; 3. Confidence in data accuracy - PR asked HeS and PM for their level of confidence in the accuracy of workforce and financial data (noting the change of position relating to agency forecasts) and if there would be anything material that would affect future confidence in data accuracy. HeS responded that she did not have a wide ranging set of concerns about data quality but flagged that there were areas	

	where there were lags in data including capital position which is under review and is reported to the Audit Committee as part of financial controls.	
f	Specific to the variability in the Trust's agency forecasting, CMH commented on two significant issues. Firstly, the need to exercise caution about setting an expectation that will be close to the NHSE target/ ceiling for agency expenditure at the year-end – this has yet to be confirmed given the forecasting challenges. Secondly, agency expenditure is noted in the report as an opportunity for improved performance by the year end. However, given the current forecasting challenges, there is also a case for including it in the list of downside risk. HeS agreed that this risk should be explored more fully to set out the balance of risks.	
g	From a system relationship perspective, DW commented on the uncertainty around the Trust's fiscal relationship with the BOB ICB - referencing proposals to 'give back' funding, practical arrangements to address any disagreements that arose between the Trust and BOB ICB, and how the Trust should best communicate its financial position in a way that set system expectations but also reflected the realities for the Trust's staff. PR concurred with DW's view and adding that, from reading the report (and noting details such as positive positions against plan, and positive cash performance), it would be difficult to conclude that the Trust is a provider under financial pressure which, if a fair assessment, would require thought about how the Trust positioned itself strategically. CMH agreed with DW and PR noting the importance of language used to communicate the Trust's financial position to the system and approach for investment of any underspends. CMH suggested that the Board have a discussion to shape this narrative.	
h	In response HeS noted that the financial report to the Board later in November could include an outline narrative on the Trust's financial position for Board to review. HeS recommended that the Trust's stated position should be an ongoing willingness to collaborate with the system (and be willing, towards the end of the financial year, to support providers in need if possible) while being alert to the need to continue to reset the balance of resources towards community-based services that remain underfunded. HeS stated that the ICB has accepted a proposal from the Trust to invest in Special Educational Needs and Disability Services (SEND) in Oxfordshire.	
i	GM supported HeS's summary, adding that a narrative should convey the volatility from year to year of very high cost placements and the Trust's limited controls around these, and to note the unlikelihood of filling all vacancies meaning that investment in alternatives to staffing should be explored. RB agreed, adding that work planned to invest in service redesign, innovation and use of technology should be made clear. HeS noted that the Trust is already doing a lot of innovative work compared to other providers in recruitment and apprenticeships and recruiting roles such as nurse cadets.	
j	CMH asked that any system narrative reflect that the Trust is experiencing, like many other Trusts, the impact of the inevitable 'drag' (the extended time taken to fill vacant posts) due to the wider inelasticity of NHS labour supply market. While recognising its responsibilities and willingness to financially support the ICB's financial challenges, it is important to note that it is managing its own financial pressures using short-term	

	flexibilities like this. With this in mind, CMH asked Executive colleagues to consider the scope for the Trust has to accelerate essential spend and investment which may not be so constrained by labour supply issues – that is, what essential investments planned for next year could be brought forward into this year? <u>Working capital including cashflow</u>	
k	Noted with no points to draw for attention – taken as read by committee.	
4.	**Improving Quality Reducing Agency (IQRA) benefits realisation update**	
a	CMH summarised the discussion in the previous item to ME around the financial position noting that the greatest sensitivity on financial position relates to agency position and availability of data to date.	
b	ME thanked CMH and set out some key information from the report: i. Position at M6, including a lower month-on-month spend compared to last year, is positive, and there is now growing confidence in data accuracy. The Trust is assessed to be on track to be within the NHS England (NHSE) target/ ceiling for agency expenditure. The position at M5 had previously been reported to be £0.9million above NHSE trajectory but, correcting for position to include retrospective shifts, the variance increases to £1.3million. This reflects two 'moveable pieces' – firstly, around systems and data accuracy (and a lag in these) and, secondly, historic practice in services on how staff choose to use systems, for example creating 'workarounds' – the workforce planning team is doing some focused work with services on how best to use systems; ii. Trajectory against spend showing a downward curve. ME expects this to flatten out and begin to follow NHSE target. ME is confident that the Trust will meet the NHSE target at year end; iii. Impact of external interventions on agency position including ID Medical and Nursing & Midwifery. The Trust is further away in some areas – there remain challenges to operationalise in some areas e.g. GP out of hours service where there is historical high cost agency spend; iv. Net improvement compared to previous years recorded via NHS Professionals – this is following a dip June-August 2023 but from September 2023 there has been visible improvement e.g. in fill rates; v. Internal interventions including challenges remaining around recruitment which is being reported to Executive and worsening position compared to last year on recruited nurses that the Trust has retained. There will be a focused piece of work to understand and address this. Some positive aspects including retention key performance indicators where good progress had been made against recruitment. International nursing recruitment is on plan and the Trust has declared to NHSE it will meet its target for international nurses recruitment (55); vi. Appendices 1-3 set out that the Trust is improving its unit rates for nurses and doctors - for example, following focused work, the unit cost for a Band 5 nurse is now more cost effective than it was a year ago.	

c	CMH thanked ME for the update and reflected that as the IQRA programme progresses it has exposed further issues to address which, in the main, was to be expected with a project like this. However, CMH sought clarity on: 1) what were the material factors to variances in agency rates - for example systems used, historic practice of services, NHS Professionals performance, etc - and 2) what the Trust was doing to address these factors. ME replied that there were two broad areas. Firstly, cultural approach to use of systems and supporting and training to staff to make the most of system options to best record information rather than adopt local workarounds which can impair data recording. Secondly, that sections of the workforce weren't listed as contractually compliant on NHS Professionals systems, meaning that NHS Professionals couldn't allocate these staff to shifts. The adoption of the NHS Professionals system has enabled a clear focus on and improvement around this practice and non-compliance, including reducing the use of local workarounds.	
d	GM supported ME's assessment commenting that it was a good news story but stressed the importance of continuing to simplify systems and requirements on staff as much as possible recognising the demands of day-to-day healthcare delivery. GM asked that the areas of work that need continuing focus are driving down need and to understand why it can take 6 months for historic practice to become clear to enable better forecasting, reflect real world work environments and to inform decision-making. CMH agreed commenting that this time last year meeting the achievement of the NHSE target looked unlikely which now demonstrates the good progress made over the year.	
5.	**Capital Programme** <u>FY24 capital report</u>	
a	HeS summarised the report highlighting that capital expenditure is behind plan year to date but that this wasn't of particular concern at this stage in the year. HeS noted that the Psychiatric Intensive Care Uni (PICU) project is forecasting an overspend but that results from the VAT position which, as this becomes clearer, should place the project back on plan. Other capital projects are listed as delivering as forecast. There has been a request from NHSE to defer some of the planned Frontline Digitisation funding due to the Trust which may have implications and present risks to be assessed.	
b	CMH thanked HeS for the summary, commenting that the position is broadly consistent with previous month updates excepting areas noted. <u>Estates project update inc. Integrated Care Board infrastructure</u>	
c	HeS noted that this item arose from a request from the Trust Chair about approaches across the BOB ICB on sharing of estates and premises. HeS and WH have meet with Estates leads from the BOB ICB to set out Trust priorities (including the Warneford proposal, Oxford City estates project, long-term planning around Community Hospitals, and staff accommodation) and initial ideas to work together.	
6.	**Primary, Community & Dental Care Transformation – Oxford Estates Project**	

a	CMH welcomed Dr Ben Riley, Wayne Heal and Sue Butt to the meeting for the item. CMH introduced the item stating that, since the last update to the committee, the project has focused on a narrower set of practical options and that the underlying rationale for the need for the project hasn't changed. The papers outline that the longlist of six options has been narrowed to four options – with a preferred option - all of which feature the Jordan Hill site. CMH has been in dialogue with WH about creating a benchmark for cost comparisons.	
b	HeS stated that, as Senior Responsible Officer (SRO), she considers that the project has come a long way in refining options that meet a range of criteria. HeS noted that if the preferred option receives Board approval, that Sue Butt will become the SRO.	
c	BR provided strategic context for the preferred option (Option 4) as set out in the paper to create a new 'north hub' at the Jordan Hill site in the north of Oxford, aligning with proposals for developing existing sites in the city – East Oxford Health Centre and Blackbird Leys site. BR summarised that the proposals would involve moving 300 staff from across 40 service teams currently working in 9 sites into 3 hubs. Benefits of the preferred option include enhanced joining up of clinical patient care, a more beneficial and convenient base for staff, greater alignment with population health needs and deprivation, contribution to net zero ambitions by reducing the number of unnecessary visits and reducing staff travel time, and offering good connections to local public transport (e.g. park and ride, station and ring road). Key stakeholders have been informed and engaged including the county council and the BOB ICB Place Director with universal support for the proposal and preferred option.	
d	HeS noted the capital cost of £5.9m gross capital required to undertake the investment in the preferred option noting that the net capital position will be improved, offset by capital receipts (estimated to be closer to £4m). Although there are short term revenue cost pressures for the preferred option, HeS noted that it is forecast to yield £3m of savings over the medium to long term. GM asked if he could be provided with an assessment of the impact of the proposal on the next financial year's capital plan and the extent that it would mean reducing capital spend on other projects.	
e	CMH noted that the comparative cost estimate of a new build on a site – if a site were available – would be approximately £12m and that compared with this figure the capital request of the preferred option represented reasonable value for money. CMH highlighted that current working arrangements, numerous sites, and barriers to joined-up working need to be addressed.	
f	GM also asked for consideration to be given for any future under-utilisation of space. BR responded that the potential for under-utilisation is being considered with proposals, if required, including housing other Trust teams as a priority but also sub-letting to healthcare partners. WH added that a utilisation system used at Saffron House in High Wycombe would be applied to the Jordan Hill site proposal enabling real time information on usage of space.	

g	PR commended the amount of effort and consideration that had gone into the proposals. PR noted that he couldn't find a consolidated risk assessment within the paperwork despite reference to such an assessment and asked that a consolidated risk overview be added to the proposal to be recommended to the Board.	
h	**ACTION** - a consolidated risk overview added to the proposal to be recommended to the Board.	
i	CMH proposed that the committee support the option and recommend the business case to the Board of Directors to the capital expenditure required, and to enter the lease with Jordan Hill (recognising the Board's explicit request to approve the lease).	
j	The committee approved the recommendation as set out in the covering report to recommend the business case, and associated investments and delegations, to the Board of Directors.	
7.	**Warneford Park programme**	
a	CMH welcomed Simon Cook to the meeting for the item. SC summarised that, since the Board of Directors decision in September 2023, good progress had been made including work on valuation of land disposals and legal documentation review. SC noted that the CZ parcel of land must now be specifically considered and that the joint venture (JV) is obliged to develop the design for the research facility at the same pace as the hospital. Specific requirements have been put into place for the development of the link building including a recognition that whichever party is to build the link building will have a responsibility to build this on time with financial compensation arrangements in place for late delivery of the link building (to a maximum of £5m payable if the building was 50 weeks late). Referencing land parcel CZ, SC highlighted considerations around 'marriage values' (where the whole of the land value is worth more than the separate parcels) and that these should be reflected in the purchase price of land parcel CZ.	
b	SC noted other outstanding matters including: national policy change rewording (e.g. implications of policy change on Outline and Final Business Cases); valuation points and principles for A2 (where the new POWIC building is proposed to be located); indexation of plot B if the event that the JV purchases plot A; valuation principles of plot B leases and of rents and market rents; and planned sequencing of plot disposals in the unlikely scenario that funding doesn't follow despite an Outline Business Case being approved to give the Trust degrees of flexibility over plot disposals. In terms of timelines, the COA is scheduled to be signed in December 2023 with a signing ceremony scheduled for the week commencing 11th December 2023.	
c	CMH thanks SC for his update. GM enquired if it were possible to consider the perspective of an independent third party on the proposals, specifically to consider if the Trust was approaching the project in the right way, to avoid any risks of 'group think', and whether the Trust's interests were at the core of proposals. In response to SC's reply that lawyers and valuers are both providing regular and robust challenge, GM asked whether a face-to-face briefing with the project lawyers would be beneficial ahead	

	of the signing. CMH noted that the lawyers would be looking at individual areas of risk in isolation but perhaps not collectively and it would be the Trust's responsibility to come to an overall judgement on the balance of these considerations. HeS supported a conversation with lawyers. CMH added that the Strategic Property Team at NHS England would also have a view on the project from an outside perspective at a later stage.	
d	The progress update was noted.	
8.	**Provider collaborative update**	
a	CMH welcomed Andrea Shand and Paul Pattison to the meeting for the item.	
b	AS summarised the update paper on the Trust's provider collaboratives (for Child and Adolescent Mental Health Tier 4 services, Adult Eating Disorders services, and Forensic services) noting the geographic complexity of provider collaboratives and the number of Integrated Care Boards and healthcare partners involved.	
c	The Trust is in a consultation phase with the provider collaboratives to strengthen staffing infrastructure and to create a commissioning hub that will serve the 'operating pillars' of each provider collaborative. To date there have been no material changes to the model that was issued to staff side. AS summarised the risk and gain share for each provider collaborative noting the different balance for each and liability of the Trust.	
d	Specific to governance, each provider collaborative currently has a monthly partnership board which include all provider partners and Integrated Care Board representatives. AS noted that the level of governance over the provider collaboratives when taken on by the Trust was light-touch and has been significantly developed. As of 17th November 2023, governance will be further strengthened with the establishment of a Provider Collaborative Assurance Board, to be chaired by OHFT's Chief Finance Officer. Decisions and matters from this Board will be escalated to the Finance & Investment Committee (e.g. an investment decision) and, if required, to Executive.	
e	AS noted that there are a number of planned investment intentions for the coming years including a new NHSE two-year contract due to start in April 2024 for all three provider collaboratives. As such the services have been developing business and financial plans on a 2 year timescale. From 2026 it is proposed that provider collaboratives would sit within an Integrated Care Board – OHFT have asked whether the Integrated Care Board chosen will be the ICB associated with the lead provider (in this instance BOB ICB).	
f	PP noted that the financial position of each provider collaborative is set out each month in the Board report and highlighted to the committee the profile of spend and investment for each provider collaborative in appendix 1 of the report, noting cashflow over the next three years, investments made and planned.	
g	CMH thanks AS and PP for the summary update.	

h	In response to a question from CMH about the two year contract from April 2024, AS confirmed that there are no material changes to the contract adding that NHSE are currently undertaking due diligence of all provider collaboratives with no concerns arising for those led by OHFT.	
i	GM highlighted the excellent work done by AS and Karen Drabble in managing and overseeing the Trust's provider collaboratives. GM noted that there remain some questions over the proposed placement of provider collaboratives within Integrated Care Boards given the wider potential uncertainties of NHS funding over the coming years. CMH supported these concerns, noting that the collective turnover of the provider collaboratives led by the Trust is approximately a third of OHFT's whole turnover.	
j	PR asked whether sufficient strategic attention is given to the future of provider collaboratives over the short-term given their scale of financial activity (albeit currently positive positions), the variety of governance approaches, and their status as almost 'subsidiaries' of the Trust. As such, PR asked if the governance is adequate to effectively identify and mitigate risks and to ensure effective use of resources if the scenario occurred were finances performed poorly. GM responded that the Trust's senior management have been focused on governance of the provider collaboratives leading to a review of governance arrangements and the proposed new structure. GM shares the concerns raised by PR and suggested that the governance of provider collaboratives be a future topic for internal audit. DW agreed and suggested that the Trust's Audit Committee also dedicate attention to provider collaborative governance.	
k	**ACTION** – note provider collaborative governance as a possible future internal audit topic for 2025.	
l	CMH thanks all for their contributions to the item and noted that the committee and Board should keep a focus on the overview and governance of provider collaboratives.	
9.	**Inquest & Claims (Legal) annual report**	
a	CMH welcome Neil McLaughlin to the meeting. NMc summarised the paper highlighting a number of areas: ▪ The Trust's annual contribution to NHS Resolution's indemnity scheme. The NHS Resolution scheme comprises three elements: a property expenses scheme, a liability to third parties scheme, and a clinical negligence scheme, the latter being of the most significant value. The Trust's contribution has increased over the last 12 months by over 20%. The Trust has historically had low contributions due to a good claims record however, over the last four to five years, claims values (paid) have increased resulting in the higher contribution this year. NMc highlighted to the committee that contribution rises are likely to rise over the coming years as the Trust has had some larger settlements. NMc reassured the committee that the rise from one year to the next is capped at 40% which is a clear benefit of the NHS Resolution model compared to the commercial market; ▪ Overview of the Trust's legal spend – NMc noted that the spend comparative to recent years has not increased but flagged that the real estate category spend has	

	decreased due to the removal from the legal budget spend of expenditure on the Warneford project; ▪ Comparative spend to other NHS Trusts – NMc noted that the Trust does not appear to be an outlier compared to other Trusts on numbers of claims received or contributions to NHS Resolution; ▪ Looking ahead into 2024 NMc stated that an area of focus would be disproportionate solicitor costs compared to the value of claims paid. these have increased over the last 12-24 months and present a financial risk to the Trust.	
b	CMH thanked NMc for the report adding support for future focus on influenceable spend on legal fees.	
10.	**Information Management Group - highlight and escalation report**	
a	The paper was noted.	
11.	**Information Management & Technology (IM&T) update**	
a	CMH welcomed Ali Corfield to the meeting. AC summarised the paper for the committee noting the proposed capital and revenue spends for IM&T through the next five financial years and revenue overspends this year largely stemming from impacts of the clinical systems data outage and recovery work. AC highlighted some project updates including: good progress of optimisation of RiO and EMIS; integrating data between clinical systems; moving to a new redeveloped platform for True Colours; and issues being addressed with the provider of a test result ordering system.	
b	The Electronic Prescribing and Medicines Administration (EPMA) system is now being implemented in the final few mental health inpatient wards, scheduled for completion over December 2023. Virtual smart cards are now going live to provide support in specific service areas including Urgent Care with a larger early use case being developed in early 2024. IM&T are working with the Mental Health Office to enhance functionality of the Mental Health Act on RiO and move away from the reliance on spreadsheets. A rolling programme to refresh devices is now in place to ensure that no devices are older than five years and that the right systems are being used on devices for example e-observations on wards.	
c	CMH thanked AC for the summary and thanked her team for their work. CMH noted the potential changes to expectations to receive Frontline Digitisation funding from NHS England and the potential uncertainties and risks to the Trust.	
12.	**Procurement & Supply chain resilience update**	
a	CMH welcomed Jane Little to them meeting and thanked her for her work since joining the Trust in summarising and presenting procurement information to the committee. JL highlighted some areas of the report including the new procurement bill due for full implementation by October 2024 and the implementation of the Provider Selection Regime coming into effect from January 2024. JL noted that both pieces of legislation	

	will enable greater flexibility for provider selection but with a corresponding requirement for greater transparency, reporting and record-keeping. JL noted that the procurement team are looking at areas of internal non-compliance with good progress being made in addressing these.	
b	CMH thanked JL for the report. DW commented that the Provider Selection Regime also applies to organisations that contract with Oxford Health which may have benefits to improve ways of working between third parties and the Trust. AB stated that the Provider Selection Regime will be an area of focus as the Trust builds its approach to non-specialised provider collaboratives.	
13.	**Single Action Tender Waiver**	
a	The paper was noted. JL added that the process has been revised which has enabled greater engagement.	
14.	**Operational & Strategic risks – Board Assurance Framework & Trust Risk Register**	
a	CMH noted the updated risks since the September committee meeting. There were no proposals to change the risk scoring following the revisions made to the risk narratives. Given the discussion on provider collaborative risks, CMH suggested that these could feature more substantively in the Trust Risk Register and perhaps the Board Assurance Framework. Noting the change of chair for the committee from January 2024, CMH requested a pause on requests for risk 'deep dives' to allow the new chair to come to a view on risk areas to review.	
15.	**Any Other Business (AOB)** <u>Community Mental Health Framework hub business justification</u>	
a	RB described the hubs to the committee noting the key features of offering walk-in mental health support at high street locations (e.g. former retail sites) to improve access to – and reducing stigmas and barriers around - mental health advice and care. RB added that recruitment of staff for the new roles at the hubs has been successful as the roles are of interest and are perceived as good sites to work from. The introduction of the hubs is beginning to have positive effects for example reductions in referral rates. HeS described that the development of the hubs progressed fully through the revenue planning process last financial year but only partially through the capital planning process. As a result the business justification document sets out capital requirements retrospectively for the hubs undertaken in the Capital Programme Sub-Committee and to seek approval from the committee for capital expenditure of £1.2m. HeS noted that the capital expenditure for the hubs would add to capital overspend but that this is being managed.	
b	DW thanked RB and HeS for their overview of the hubs noting his hope in the potential of the positive benefits of the high street mental health hubs in particular improving early access to services. PR supported this view but requested that future reporting on	

	the progress of the hubs had clear measures of success and indicators. RB replied that this is being addressed as how outcomes are measured in the community mental health framework e.g. around referrals and activity.	
c	GM noted the importance of process measures, adding that the overall evaluation process around the hubs is to inform continual improvement rather to assess the continued merits of the model which will be refined.	
d	The committee approved the capital expenditure, noting the revenue implications. HeS informed the committee that she is seeking to appoint an interim director for Estates and Facilities to cover Claire Dalley who is off sick.	
16.	**Brief reflections on today's meeting**	
a	DW on behalf of the committee thanked CMH for his expertise, experience and commitment in chairing the committee over the last 6 years adding his personal thanks.	

Meeting close: 12:15pm
Date of next meeting: 23 January 2024 9:00-12:00 via Microsoft Teams

Meeting of the
Finance and Investment Committee

Tuesday, 23 January 2024
09:00 – 12:00
Microsoft Teams virtual meeting
Apologies to nicola.gill@oxfordhealth.nhs.uk

AGENDA

			Start time	Allocated time (mins)
1.	Apologies for Absence,[1] and quoracy check	LW	09:00	
2.	Minutes of Meeting held on 16 November 2023 FIC and Matters Arising (paper – FIC 01/2024) – *to note*	LW		5
	Financial Management			
3.	Review of current financial performance:			
	a) Financial Report (paper – FIC 02/2024) – *to note*	PM/HeS	09:05	20
	b) Working capital, including cash flow (paper – FIC 03/2024) – *to note*	PM/HeS		
	• *Oxford Pharmacy Store (OPS) performance report – see **Reading Room/Appendix (paper – RR/App 01/2024)***			
4.	Annual Planning & Budget setting (paper – FIC 04/2024) – *to note*	PM/HeS/ AB	09:25	25
	Productivity and Innovation			
5.	Improving Quality Reducing Agency benefits realisation update (paper – FIC 05/2024) – *to note*	ME/PM/ BK/CDS	09:50	15
	Capital Investment			
6.	Capital Programme			
	a) FY24 Capital Report – spend against budget and forecast (paper – FIC 06/2024) – *to note*	HeS	10:05	10
	• *Supporting information: Capital Programme Sub-Committee minutes (to note) - see **Reading Room/Appendix (papers – RR/App 02/2024)***			
	b) Estates Projects update – (oral update) – *to note*	MW/HeS	10:15	10

[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: No apologies received.

7.	Warneford Park Programme: update on the Conditional Options Agreement (COA) (paper – FIC 07/2024) – *to note* • *Information to note: Warneford Park Internal Programme Board minutes - see* ***Reading Room/Appendix (papers – RR/App 03/2024)***	SC/HeS	10:25	15
8.	Capital Plan update (oral update) – *to note*	WH/PM/ HeS	10:40	10

Break 10:50 – 11:00 (10 minutes)

Information Governance, Financial Governance & Other Matters

9.	Information Management Group (IMG) highlight and escalation report (oral update from 11 January IMG Meeting) – *to note* • *Supporting information: IMG report & Minutes – see* ***Reading Room/Appendix (papers – RR/App 04/2024)***	KR/BC	11:00	10
10.	IM&T update including update on Frontline Digitisation programme (paper - FIC 08/2024) – *to note*	AC/HeS	11:10	10
11.	Procurement & Supply Chain Resilience update (paper - FIC 09/2024) – *to note*	JL/HeS	11:20	5
12.	Single Action Tender Waiver (SATW) (paper - FIC 10/2024) – *to note*	JL/AC/ PM/HeS	11:25	5
13.	Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) - (paper - FIC 11/2024) – *to note*	KR/HeS/ HaS	11:30	15
14.	Any Other Business: *to include matters referred to FIC from Audit Committee*	LW	11:45	
15.	Brief reflections on today's meeting	LW		
Meeting Close			12:00	

Date of next meeting: 12 March 2024 09:00 - 12:00 via Microsoft Teams virtual meeting

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted -

16. Oxford Pharmacy Store (OPS) performance report (to note) (paper – RR/App 01/2024)

17. Capital Programme Sub-Committee minutes: 11 October and 14 November 2023 (to note) (paper – RR/App 02/2024)

18. Warneford Park Internal Programme Board minutes: October-December 2023 (to note) (paper – RR/App 03/2024)

19. Information Management Group report & minutes: 18 October 2023 (to note) (papers – RR/App 04(i)-04(ii)/2024)

FIC Attendance 2023/24

FIC - Core members (Quorum)	May-23	Jun-23 *(Extraordinary)*	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24
Chris Hurst	✓	✓	✓	✓	✓	*N/A*	*N/A*
Rob Bale	*N/A*	*N/A*	*N/A*	✓	✓		
Amélie Bages*	✓	✓	✓	✓	✓		
Nick Broughton	☒	✓	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Grant Macdonald	✓	✓	✓	*Apols*	✓		
Philip Rutnam	✓	✓	✓	✓	✓		
Heather Smith	✓	✓	✓	✓	✓		
Lucy Weston	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*		
Attending Board members (voting & non-voting included in quorum)							
Kerry Rogers*	✓	✓	✓	✓	*Apols*		
David Walker	✓	✓	✓	✓	☒		
Regular Attendees (non-voting)							
Peter Milliken	✓	✓	✓	✓	✓		
Hannah Smith	✓	☒	✓	✓	☒		

* = non-voting

FIC – overview plan for 2023 – 2024

Key: ✓ on agenda
x item planned
x deferred

Item	Owner(s) or function	Q1 May 2023	June 2023 Extraordinary meeting	Q2 July 2023	Q2 Sept 2023	Q3 Nov 2023	Q4 Jan 2024	Q4 March 2024
FINANCIAL MANAGEMENT – Review of the current financial performance								
Financial Report *(to include most recent FY Month reporting)* *(see below areas included)*	Heather Smith	✓		✓	✓	x	✓	x
Financial Report RR:								
• Working capital, including cash flow *(update on latest position and outlook)*	Michael Williams/Peter Milliken/Heather Smith	✓		✓	✓	x	✓	x
• OPS performance report	Mark Byrne/Heather Smith	✓		✓	✓	x	✓	x
Annual Planning & Budget setting *(rolling update to plan each meeting in Financial Report)*	Peter Milliken/Heather Smith/Amelie Bages	✓					✓	x
PRODUCTIVITY & INNOVATION								
Improving Quality Reducing Agency benefits realisation *(Management update)*	Matt Edwards/Marie Crofts Peter Milliken/Heather Smith	✓		✓	✓	x	✓	x
Cost Improvement Programmes/ Product Improvement Programmes (CIPs/PIPs)	Laura Carter/Debbie Cakmak/Amelie Bages	x		*(to be included in Financial Report)*	x	x	✓	x
CAPITAL INVESTMENT (Including IM&T)								
FY Capital Programme (Plan) and YTD spend against budget *(financial*	Michael Williams/Heather Smith	✓		✓	✓	x	✓	x

Item	Owner(s) or function	Q1 May 2023	June 2023 Extraordinary meeting	Q2 July 2023	Q2 Sept 2023	Q3 Nov 2023	Q4 Jan 2024	Q4 March 2024
update - Estates, IT & transformational projects)								
Capital Programme RR:								
• Estates Projects update	Mark Waring/Heather Smith	*(included in Finance Report & FY24 Plan)*		✓	✓	x	✓	x
• Capital Programme Sub-Committee minutes	Maureen Collins/Heather Smith	✓		✓	✓	x	✓	x
Psychiatric Intensive Care Unit (PICU) *(to be included in Estates Project update)*	Heather Smith	x		*(to be included in estates update)*	x	x	x	x
Development of Warneford Park Business Case	Claire Dalley/Heather Smith	✓	✓	~~x~~	✓	x	✓	x
Warneford Park Internal Board minutes		✓		✓	✓			
Capital Plan (Estates)	Heather Smith	x				x	✓	x
Capital Programme Board annual report	Claire Dalley/Heather Smith			✓				
INFORMATION GOVERNANCE & FINANCIAL GOVERNANCE								
IMG – Information Management Group RR IMG minutes	Maureen Collins/Mark Underwood/Kerry Rogers	✓		✓ ✓	✓ ✓	x	✓	x
IM&T update *(to include Digital Strategy)*	Alison Corfield/Will Harper/Heather Smith	✓ *(included in Capital plan)*		✓	✓	x	✓	x
Strategic Procurement Update	Peter Milliken/Heather Smith	x		✓		x	✓	

Item	Owner(s) or function	Q1 May 2023	June 2023 Extraordinary meeting	Q2 July 2023	Q2 Sept 2023	Q3 Nov 2023	Q4 Jan 2024	Q4 March 2024
Single Action Tender Waiver (SATW) (*end of quarter and included in procurement)*	Jane Little/Amanda Crawford/Peter Milliken/Heather Smith	x		✓		x	✓	
Treasury Management annual report	Michael Williams/Heather Smith				✓			
Review of National Reference Costs	Paul Vincent/Heather Smith			✓ *(update in Financial Report)*	✓		✓	x
Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF)	Brian Aveyard/Hannah Smith/Neil McLaughlin/Kerry Rogers	✓		✓	✓	x	✓	x
GOVERNANCE								
Minutes of the FIC	Corporate Governance Office/ Kerry Rogers	✓		✓	✓	x	✓	x
FIC annual report	Corporate Governance Officer / Kerry Rogers	x		✓				
Inquests and Claims (Legal) annual report	Neil McLaughlin/Kerry Rogers				x	✓		
POLICIES								
Treasury Management Policy *(Renewal 30.09.23)*	Peter Milliken				✓			
Procurement Policy *(Renewal 30.09.25)*	Peter Milliken				x			
Investment Policy *(last reviewed Feb 23)*	Heather Smith			x				
Budgetary Control Policy *(Renewal 30.07.25)*	Alison Gordon/Paul Pattison			x				
Acquisition & Disposal Policy for Land & Property *(Renewal 30.09.25)*	Wayne Heal				x			

Item	Owner(s) or function	Q1 May 2023	June 2023 Extraordinary meeting	Q2 July 2023	Q2 Sept 2023	Q3 Nov 2023	Q4 Jan 2024	Q4 March 2024
Data Protection Act 2018 Appropriate Policy Document *(Renewal 31.07.25)*	Mark Underwood			x				
Integrated Information Governance Policy *(Renewal 31.07.24)*	Mark Underwood			x				
Standing Financial Instructions *(Nov'22 approved, and recommended to AC)*	Peter Milliken				[x]	x		
OTHER ITEMS								
TV Prisons Integrated Mental Health Service Partnership contract	Jude Deacon/Grant Macdonald	✓						
Capital Projects planning improvement document *(05.07.23 - CFO confirmed being tracked through BAF risk on major projects and CPSC reports)*	Claire Dalley/Heather Smith	x			~~x~~			
Capital Plan FY24	Claire Dalley/Heather Smith	✓ *(including IMT plan)*						
Jordan Hill	Wayne Heal/Claire Dalley/Heather Smith	✓	✓		x	[x]		
Frontline Digitisation Business Case	Alison Corfield/ Heather Smith	✓	✓				✓	
Major Capital Projects (BAF 3.14 deep dive)				✓				
Information Governance & Cyber Security (BAF 3.10 deep dive)				✓				
Medium Term Financial Plan				~~x~~	✓			
Provider Collaborative					x	✓		
Procurement Review/ supply chain BAF update (action)					✓			

People, Leadership and Culture Committee
17th January 2024 13:30 – 17:00 (MS Teams)
Agenda

	Item	Lead	Purpose	Purpose detail	Relating risk(s)	Time
1	Introductions: Apologies: Ben Riley (Emma Leaver attending) Heather Smith (Christina Foster /Peter Milliken attending) Britta Klinck Observers: Vicki Bull – Head of Business Services Emma Short – Governor Chair of Staff Experience Governor sub group	**MS**				**13:30**
2	Declaration of Interests	**MS**				
3	Minutes and action tracker from PLC meeting 12th October 2023 (papers PLC01(i) & PLC01(ii)/2024)	**CDS**		To approve minutes To provide update on Action log		

4	Voice of someone who is bringing significant change in the trust – AHP tbc			To ensure the Committee receives qualitative data regarding colleague experience in the Trust		**13:50** 30m
5	People Plan highlight Report + For Reading room: • Operational priorities for Mental Health and Specialised, • Community and Dental Referencing: Trust Annual Plan HR People Plan, Directorate People priorities (papers PLC02(i) – PLC02(iii)/2024) *Zoe Moorhouse/Jill Castle in attendance*	**ZM/JC**	**Assurance**	To ensure the Committee can be assured: a) Priorities have been identified b) Target performance by end of year formulated c) Duplications/omissions/ interdependencies identified d) Ongoing, that progress is on track to achieve target performance by quarter and to allow for exception reporting		**14:20** 15m
6	CPO Briefing incorporating: Summary Dashboard + For Reading room: • Workforce Reports - HR - Whole Trust - Mental Health - Community (papers PLC03(i) – PLC03(vi)/2024) *Sigrid Barnes in attendance*	**SB**	**Assurance**	To be assured that the Trust has identified implications for its People Plan, Annual Plan and Strategy To ensure the Committee is appraised of key national ICS and Trust developments as they impact upon the Trust's ability to realise its strategic and operational aims To provide assurance on key people performance activities, and to be assured the Trust is able to identify and respond to emerging and current issues	Succession planning, organisational development & leadership development (BAF 2.3) Workforce planning (BAF2.1 / TRR1020)	**14:35** 15m

7	IQRA update (paper PLC04(i)+(ii)/2024) *Matt Edwards in attendance*	**ME**	**Assurance**	To ensure the Committee is assured that: a. underlying dynamics of Agency use increasingly understood and improving strategies to address b. Performance against plan being managed and course corrected c. Interdependence with other Trust initiatives identified d. Focus: recruitment of longline Agency	Retention of Staff (BAF 2.5 / TRR 1146) Recruitment (BAF 2.2/TRR 1019)	**14:50** 10m .
8	Strategic and Operational Risks (papers PLC05(i) – PLC05(iii)/2024) *Hannah Smith/Brian Aveyard in attendance*	**HS/BA**	**Approval**	to include - revised risks and mitigations and discrepancy in ratings in the BAF and TRR for Recruitment - Updated Workforce BAF risk and associated information and risk / drivers – which are outside our control and which are inside out control and their mitigations		**15:00** 25m
	BREAK					15:25 10m
9	Clinical Excellence Awards (paper PLC06/2024) *Alison Cubbins in attendance*	**AC**	**Approval**	To approve new CEA policy and make recommendations to the Board ahead of the policy going live in April 2024		15:35 5m
10	Health & Safety Annual Report with Action plan (paper PLC07(i)+(ii)/2024)	**CF**	**Assurance**	To assure that the Trust is discharging its H&S responsibilities to Staff		15:40 10m

	Christina Foster in attendance					
11	People Dashboard (paper PLC08/2024) *Sigrid Barnes in attendance*	**SB**	**Assurance**	To propose how People data can be aggregated and analysed to provide a dashboard style approach as to where there may be 'hotspots' and align this with the format used in the Quality Dashboard		15:50 10m
12	Strategy and Planning annual plan 2023/24 and 2024/25 (paper PLC09/2024 – coversheet only) *Priya Thompson in attendance*	**AB/PT**	**Assurance**	To provide a first look at the plan for 24/35 to see how it's shaping, specifically the more strategic areas within the plan. A verbal update will be provided in the meeting as the info will not be shared with Executive team until 15th January		16:00 10m
13	People Systems Development Program (papers PLC10(i)+(ii)/2024) *Sigrid Barnes in attendance*	**SB**	**Assurance**	To assure the Committee of arrangements that are in place in relation to the transformation work of our People systems		16:10 5m
14	Race Equality (incl. Intersectionality) deep dive into experience of BAME colleagues 6 high impact actions to be included EDI QI projects (papers PLC11(i)-(v)/2024) *Joe Smart & Mo Patel in attendance*	**JS/MP**	**Assurance**	To assure the Committee in relation to how the Trust is delivering the objectives set out in the NHSE/I EDI Improvement plan and the 6 High Impact Actions. To update on the Race Equality QI programmes		16:15 15m
15	Freedom to Speak up Guardian Annual Report (paper PLC12/2024) *Rita Bundhoo-Swift and* *Lianne Bowes in attendance*	**RBS/LB**	**Assurance**	To discuss the FTSUG Annual Report and its recommendations		16:25 10m

16	**Highlight / Escalation Reports** Discussion/Questions a. People Steering Group (ZM) (paper PLC13/2024) b. Learning Advisory Group (BE) (paper PLC14/2024) c. EDI Steering Group (JS) (paper PLC15/2024) d. HR Systems Program Board (SB) (paper PLC16/2024) e. Health & Safety Committee (CF) (paper PLC17/2024)		**Assurance**	To provide assurance to the Committee		16:35 15m
	Any other business	**MS**				16:50
	For information only – **Papers in Reading room**					
	ER Casework review Report (paper PLC18/2024)	**JC/ZM**		To ensure that PLC has sight of numbers of staff currently suspended; and that their wellbeing is being supported	Staff Wellbeing (TRR 1018)	
	PLC Workplan (paper PLC19/2024)	**CDS/SI**				

Meeting of the Oxford Health NHS Foundation Trust Quality Committee

[DRAFT] Minutes of a meeting held on Thursday, 09 November 2023 at 09:00

virtual Microsoft Teams meeting

Present[1]:

Core members and attending Board members included in quorum

Andrea Young	Non-Executive Director (Committee Chair) (**AY**)
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (**RB**)
Marie Crofts	Chief Nurse (**MC**)
Grant Macdonald	Chief Executive (**GM**)
Karl Marlowe	Chief Medical Officer (**KM**)
Ben Riley	Executive Managing Director Primary, Community & Dental Care (**BR**)
Kerry Rogers	Director of Corporate Affairs and Company Secretary (**KR**)
Heather Smith	Chief Finance Officer (**HeS**)
David Walker	Trust Chair (**DW**)

In attendance[2]:

Brian Aveyard	Risk Assurance and Compliance Manager (**BA**)
Rachel Caira	Clinical Lead, Abingdon Minor Injuries Unit (**RC**) – *part meeting*
Lynda Dix	Associate Director of Nursing, Forensic Services (**LD**) (deputising for Rami El-Shirbiny, Clinical Director, Forensic Services)
Michelle Barclay	Safety Partner (**MB**)
Helen Bosley	Nurse Consultant, Infection Prevention and Control and Deputy DIPC (**HB**)
Benjamin Cahill	Deputy Director of Corporate Affairs (**BC**)
Nicola Gill	Executive Project Officer (**NG**) (minutes)
Mike Hobbs	Public Governor (**MH**)
Rose Hombo	Deputy Director of Quality (**RH**)
Jane Kershaw	Head of Quality Governance (**JK**)
Britta Klinck	Deputy Chief Nurse (**BK**)

[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.

Janice Leaffe	Patient Safety Partner (**JL**)
Tina Malhotra	Clinical Director, Buckinghamshire Mental Health Directorate (**TM**)
Michael Marven	Chief Pharmacist and Clinical Director for Medicines Management (**MM**)
Pete McGrane	Clinical Director, Community Services (**PMcG**)
Ros Mitchell	Deputy Chief Medical Officer & Clinical Director (**RM**)
Bill Tiplady	Director of Psychological Professions (**BT**)

1.	**Apologies for Absence**	**Action**
a	Apologies for absence were received from the following Committee members/Board members: Geraldine Cumberbatch, Non-Executive Director.	
b	Apologies for absence were noted from the following regular attendees: Angie Fletcher, Associate Director of Quality Improvement & Clinical Effectiveness; Rami El-Shirbiny, Clinical Director Forensic Services (Lynda Dix, Associate Director of Nursing Forensic Services deputising); Neil McLaughlin, Trust Solicitor and Risk Manager; and Matt Edwards, Director of Clinical Workforce Transformation.	
c	The Chair confirmed the meeting was quorate.	
2.	**Minutes of the Quality Committee on 07 September 2023 and Matters Arising**	
a	The Chair welcomed all to the meeting.	
b	The minutes at QC 58/2023 Minutes of the Quality Committee (**QC**) on 07 September 2023 were confirmed as a true and accurate record.	
c	***Matters Arising*** The Committee noted that the following actions had been completed: • 6(e) – Buckinghamshire Community Mental Health Framework and Crisis Resolution and Home Treatment Team slides had been circulated over email to the Committee and regular attendees on 07 September 2023, shortly after the meeting; • 9(a) – Clinical Audit and The National Institute for Health and Care Guidance (**NICE**) Q3 activity, the slides had been circulated over email to the Committee and regular attendees on 07 September 2023, shortly after the meeting; • 10(c) – Governor query and recommendation on the use of the Triangle of Care, email sent to Nyarai Humba cc'ing the then Lead Governor (Mike Hobbs) and the Director of Corporate Affairs & Company Secretary on 07 September 2023, shortly after the meeting; and • 14(c) – Data gap risk following on from the clinical systems outage, Board Assurance Framework (BAF) clinical discussions took place on 18 October 2023 involving the Chief Finance Officer, and Chief Medical Officer and members of the IT Performance and Risk teams. With regards to BAF 1.1, the	

	Chief Finance Officer noted that, following conversations about the data outage and the consequence of reporting, it had been agreed to update the risk.	
d	The following action (from July 2023) was on hold: 14(c)&(e) for Board Assurance Framework (**BAF**) risk 3.1 (shared planning and collaborative work with partners) to consider governance of Provider Collaboratives, pending evidence of how well processes were working further to recently included controls and actions.	
SAFETY		
3.	**Quality and Clinical Governance Sub-Committee (QCG-SC) escalation report**	
a	The Chief Nurse presented the report, at paper QC 59/2023 which provided a QCG-SC highlight report and the Quality & Safety Dashboard. She highlighted 4 areas for escalation from the QCG-SC: • shortage of substantive nursing, medical and therapy staff across the Trust - vacancies and retention remain the greatest challenge and risk with temporary and agency staff being used to mitigate vacancies; • timely access to services and waiting lists were a problem as a result of increased demand, staff vacancies, higher patient acuity, and pressures in the wider system. This potentially increases risk to patients, delays treatment and may mean not meeting national targets. Services highlighted were Child and Adolescent Mental Health Services (**CAMHS**), Complex Needs Service, Attention deficit hyperactivity disorder (**ADHD**) services, GP out of hours, Children's Integrated Therapies, District Nursing, Podiatry, Community Therapy Services, and dental treatment for children requiring are the use of anaesthetic/access to OUH theatres; • booking temporary/agency staff from NHS Professionals and ID Medical - significant issues remained with both of these since transition which has impacted on maintaining safe staffing levels. Regular escalation meetings with NHS Professionals are in place and a process established to work through individual staff issues; and • several estate issues affecting dental services, the services at East Oxford Health Centre have long standing issues with the air conditioning, the patient lift, and a collapsed ceiling due to water leaks. The property is not owned by the Trust. Services are also having issues at Bicester related to water quality and a collapsed ceiling due to water leaks and at Luther Street GP. The issues have been escalated to the Estates Team.	
b	The Chief Nurse reported positively on the segregation garden at Evenlode being completed in September; and new Meadow Unit opening on 31 October.	
c	The Chief Nurse reported the following matters for committee awareness: • An electrocardiogram (**ECG**) machine replacement programme was needed/would be put in place; • Risk around numbers of staff affected by incomplete records on staff immunisations';	

	• Increasing referrals to ADHD Service in Oxfordshire and Buckinghamshire which has been escalated to the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (**BOB ICS**) for discussion and resolution; and • The medical device waste management system is not well defined across the Trust. Interim arrangements and mitigations are fragile, and the issue is being addressed by the Executive Team. **Quality and Safety Dashboard**	
d	The Chief Nurse referred to the Quality & Safety Dashboard noting that there were continued high levels of vacancies which were covered by temporary staffing both through Bank and Agency. Fill rates had been met. The following key actions were being taken: • Recruitment initiatives are continuing and there is a strategy in place to combine recruitment and efforts for all the wards at the Whiteleaf Centre; • A number of Band 5 roles had been offered at Ruby Ward and were currently going through the recruitment process. A new Ward Manager was in post. There were still vacancies for 3 out of the 5 deputy Ward Managers; • Plans to reduce barriers to students being employed, attending nursing and AHP recruitment fairs across the UK and holding Trust-wide roadshows over November.	
e	The Chief Nurse highlighted that through the change to Talking Therapies services, and the subsequent review undertaken, five inboxes had identified that had been closed down but contained high numbers of emails. The Director of Psychological Professions noted that it was the first inbox where the issues were found as there was only one clinical email in the other four. 305 clinical related emails were found and staff from Talking Therapies had reviewed them and followed up. In the end 300 of these had gone on to receive the correct response In 5 cases this was not the case, 3 of the people had been sent a Duty of Candour letter letting them know if they still needed the service they could contact a senior member of staff in Talking Therapies, there were 2 who were subsequently deceased, one of whom was followed up with a GP in area who confirmed they had died sometime later of natural unrelated causes and the other was now out of area. The services were confident that all inboxes had now been thoroughly checked and necessary action taken. The Chief Finance Officer noted there were a substantial number of shared inboxes and because of this IT would be checking and validating all inboxes with a regular review process moving forwards.	
f	The Executive Managing Director Primary, Community & Dental Care highlighted the work being undertaken by District Nurses, led by Gabbie Parham, on the development of the BOB ICB Community Opel Framework which had been agreed locally to recognise the pressures in those services especially with the reliance on out of hospital care.to understand what needs to be prioritised versus what can safely be postponed.	
g	The Chair summarised the committee discussion noting:	

	• That the committee noted there were continuing staffing issues being experienced and the work being done to mitigate risk and manage safety; and • The committee's interest in ADHD and other neuro divergent conditions and that she would frame a set of questions about how the Trust could better utilise resources and expertise to support the individuals and their families. The chair suggested that the February 2024 committee agenda include a further discussion.	**AY**
	Safe staffing report	
h	The Chief Nurse presented the report at paper QC 60/2023. The Chief Nurse has reviewed fill rates which formed part of the Quality and Safety dashboard outputs and has begun a piece of work to continue to improve the accuracy of data regarding shift duties.	
i	Following a review of the Trust's current position by the Chief Nurse against the expectations of 'Right Staff, Right Skills, and Right Place and Time' a number of areas for improvement were identified with next steps including: • using validated tools and data collection during November to ascertain acuity and dependency levels in all ward areas; • confirming with ward managers the unavailable hours across the working week to ensure that the establishment is accurate (e.g., deputy ward managers having time to supervise junior staff); • taking forward in Q4 the e-rostering improvement programme; and • further driving down the use of temporary staffing.	
j	The Chair asked the Deputy Chief Nurse when it might be possible to review progress on these actions. The Deputy Chief Nurse expected to be able to report back at the February meeting.	**BK**
	Patient Safety Incident report	
k	The Head of Patient Safety presented the report at paper QC 61/2023 noting that between July – September there had been 13 significant Patient Safety Incidents (**PSIs**) identified, of which 5 were suspected suicides (across 4 teams), 1 unexpected death (related to physical health deterioration), 1 fall on a community hospital ward resulting in a fracture, 1 medication incident and 5 treatment delays/diagnostic incidents. She highlighted the Trust was seeing an increase in the number of system reviews across organisations, in line with the national direction.	
l	The Trust was currently participating in 16 Domestic Homicide Reviews or Mental Health Homicides and there had been no new homicides in the last 3 months. Key areas of learning were also included in the report. The report concluded with an update on how the Trust was progressing against the objectives in the national patient safety strategy including the Patient Safety Incident Response Framework (PSIRF), Patient Safety Partner roles, roll out of Patient Safety Level 1 training and implementation of the national Learn from Patient Safety Events Service (LFPSE).	
m	The Chair made the following observations:	

	1. Safeguarding processes had been raised as one of the issues in the summary of themes over the last 3-6 months and, acknowledging that the Trust's safeguarding training compliance was low, she requested that a focus be kept on this to look at how the Trust addresses and improves training. 2. The Chair questioned whether the report was saying that Oxford University Hospitals (**OUH**) and Buckinghamshire Healthcare Trust (**BHT**) had failed to provide us with a medical examiner role for some time and asked whether this needed escalating. Ros Mitchell responded that there was a process in place but there were issues in securing national documentation for primary care and GPs but chase further. The Chair suggested flagging this at Board and including it in the committee's 3As report to the Board of Directors, if RM felt useful.	
n	The Deputy Chief Nurse assured the committee that the Safeguarding Committee were overseeing the training numbers and there was a specific piece of work being undertaken on different ways of delivering the training.	
o	**The Committee noted the reports.**	
4.	**Quality Compliance & Regulation Update** **a. CQC Compliance & Regulation**	
a	The Chief Nurse presented the report at paper QC 62/2023 providing the committee with a brief update on any inspections conducted to monitor the use of Mental Health Act (MHA) and compliance with the Code of Practice for the year to date with recommendations and outstanding actions from previous inspections. Since the last report in September 2023 there had been 2 MHA inspections and, year to date across the Trust, there had been a total of 6 CQC MHA monitoring visits. All actions were followed up at the MHA Committee and at the Regulatory Action Monitoring Group. The Chief Nurse noted that all 'should' actions from the previous comprehensive inspection had now been closed.	
b	The Chief Nurse noted that the new Regulatory Single Assessment Framework was due to come into effect on 21 November 2023.	
c	**The Committee noted the report.**	
CARING, RESPONSIVE & EFFECTIVENESS		
5.	**Service deep dive including:** **a. Quality Improvement project/spotlight – implementation of a Minor Injuries Unit (MIU) escalation tool**	
a	Rachel Caira - Clinical Lead, Abingdon Minor Injuries Unit - shared her presentation with the Committee on the implementation of an MIU escalation tool and Clinician Appointment List noting the following aims and rationale behind this quality improvement (QI) project: *Aims* • To create a tool that enabled an accurate and non-subjective snapshot of the waiting time and patient flow within that base;	

	• Provide clear information to patients to inform them of wait times thus improving the patient journey and experience; • To highlight any areas of concern or issues which may need escalating ; and • To calculate a waiting time for each base using a pre-existing proforma. *Rationale* • Feedback from staff that, due to an open list structure, patients would often wait a long time to be seen when they could have been seen sooner by a more appropriate clinician if seen out of turn; • Feedback from staff that the significant rise in patient numbers (average increase by 30% per month in Abingdon) had felt very overwhelming; • Consultation and performance amongst practitioners varied widely and the toil enabled this to be reviewed and standardised; and • Low compliance with supervision and 1:1s due to high demand in the unit and staff reporting that they often had to cancel 1-1 meetings to retain sufficient time on clinical work.	
b	RC commented that feedback had been gained from her team via Microsoft forms and that this was being reviewed. Overall, staff felt very positive about the changes as it enabled standardised workload, which also felt more manageable. The Chair thanked Rachel for her presentation.	
c	The Executive Managing Director Primary, Community & Dental Care asked RC how she had found the experience and was there anything more the directorate or Trust could have done to help? RC commented that the QI Team had been helpful and supportive, and the training had been helpful. Within her service she worked closely with her Matron and other clinical lead colleagues. RC felt it went smoothly but noted the importance of listening to feedback. RC concluded by noting that they would now be looking to roll out to other sites. *Rachel Caira left the meeting at 10.28 am*	
	b. Mental Health, Learning Disability & Autism Inpatient Quality Transformation Programme progress report	
d	The Deputy Chief Nurse presented the paper at QC 63/2023 noting that in response to guidance issued by NHS England outlining its vision for inpatient mental health care for adults and older adults, the Trust had launched a transformation programme, led by herself and the Associate Director of Psychological Professions endorsed by the Chief Nurse, Chief Medical Officer, General Manager for Mental Health, and Chief Executive. To date they had been collating data to understand where the Trust was in relation to the specific elements of the guidance and had focussed on establishing the structure needed for this comprehensive programme. The workplan identified 3 phases of the programme and the Committee was asked to decide how often it wanted to be updated on progress of this programme.	
e	The Chair asked if there was a national reporting expectation? The Chief Executive commented that the approach being taken was to look at the national direction but	

	also use it as an opportunity to look at what the Trust was doing across inpatient and mental health services and identify learning and reduce duplication.	
f	The Chair requested that it be reviewed by the Committee in 3-4 months, once baseline data had been collected and an initial set of priorities became clear.	**BK/BT**
g	**The Committee noted the presentation and report.**	
6.	**Patient and Carer Race Equality Framework (PCREF)**	
a	The Deputy Director of Quality & Clinical Standards presented the paper at QC 64/2023 noting the report gave the committee an overview of the patient and carer race equality framework (PCREF). PCREF is a national organisational competency framework to help services provide culturally appropriate care and enable Trusts to understand what practical steps they need to take to meet the needs of diverse communities. PCREF is a participatory approach envisaged to be a 'social contract' which enables service transformation that is co-created in a collective effort to improve the access, experience, and outcomes for different races within communities. PCREF is split into three core components: Leadership & Governance, Organisational Competencies, and 3 Patient & Carers Feedback.	
b	The Deputy Director of Quality & Clinical Standards noted that the next steps were: • A mapping exercise using NHSE standards – Self Assessment; • Creation of an implementation Board and identification of an Executive Lead (proposed as the Chief Nurse); • Co-creation of implementation plan with key stakeholders (patients, carers, community groups, OHFT staff); and • Setting out data monitoring and assurance arrangements/monitoring/ assurance.	
c	RH asked the committee how they wanted PCREF to be reported and at what frequency? The Chair suggested a report on PCREF be brought to the May committee to allow time for further development and data gathering.	**RH**
d	DW noted the need to recognise the geographical variations across Trust's services and to be aware that other organisations are trying to deal with similar issues suggesting that there might be the opportunity for mutual learning.	
e	**The Committee noted the report.**	
7.	**Clinical Effectiveness update:** **a) Clinical Effectiveness Decision Group**	
a	The Chief Medical Officer referenced the minutes available in the Reading Room and confirmed an update would be brought to the next meeting.	
	b) Clinical Audit update	

b	The Chief Medical Officer presented the report at paper QC 65/2023 written by Angela Ward, Clinical Audit & NICE Manager and Angie Fletcher, Associate Director of Quality. The Clinical Audit and National Institute for Health and Care Excellence (NICE) Guidance Annual Report 2023-24 Quarter 1 provides a summary of: Clinical Audit and NICE activity across the Trust, the latest changes made following the Clinical Audit and NICE activity moving to Oxford Healthcare Improvement to align to the Quality Management System. The report includes: • An introduction to Clinical Audit; • An update on the Clinical Audit Plan; • An update on compliance with NICE guidance; • An update on the audit due to commence in Q3 2023-24 of the management of patients prescribed Valproate in response to the alerts issued by NICE and the Medicines and Healthcare products Regulatory Agency (MHRA); • A summary of key successes; and • An update on next steps.	
	c) Medicines Management report	
c	The Chief Pharmacist & Clinical Director for Medicines Management presented the report at paper QC 66/2023 and noted that new regulations came into force around the supply of valproate medicines. Although mainly affecting primary care and community pharmacy, the principles are entirely applicable to secondary care. Pharmacy Standard Operating Procedures (**SOPs**) and Trust guidance had been updated to reflect these changes so that patients received the necessary safety information with every supply.	
d	The Chief Pharmacist provided the following key updates: • for awareness, nitrous oxide gas was now classed as a Schedule 5 controlled drug and that there may be unintended consequences for which mitigations would be put in place; • shortage of some medicines for ADHD which is having an impact on community and pharmacy teams although a collaborative piece of work across the Integrated Care System (**ICS**) is co-ordinating an approach and support for patients and GPs in managing queries; • ePMA programme is a key digital transformation enabler and is already delivering significant clinical, safety and operational benefits to the 14 wards using the system. Feedback from staff had been very positive, and the benefits of ePMA had been immediately evident to ward teams; • A proposal to remove the medicines management risk from the Trust Risk Register (TRR).	
e	The committee accepted that the recommendation that the medicines management risk be removed from the TRR and noted the narrative in the report.	
	Questions	
f	In response to a question from DW about the learning available from clinical audit data, the Chief Medical Officer and Chief Nurse stated that significant progress had been made and the information gathered was being used to drive improvements.	

g	The Chair acknowledged the great work undertaken on the ePMA.	
h	**The Committee noted the update and reports.** *The Committee took a 10-minute break*	
8.	**Oxford Pharmacy Store update**	
a	The Chief Pharmacist & Clinical Director for Medicines Management presented the report at paper QC 67/2023 noting the purpose of the report was to update the committee on the status and developments regarding Oxford Pharmacy Store (**OPS**) Quality agenda, in line with Good Distribution Practice (**GDP**) under the terms of its Wholesale Dealer Authorisation (**WDA**).	
b	He explained that internal compliance re GDP reporting and assurance for governance, including: • Monthly Quality Report; • Monthly Responsible Person (**RP**) Report; • Monthly Operations & Procurement Report; • Other departmental reports (Sales & Marketing, Projects, Finance); and • Rolling Quarterly Review of GDP Trends and KPIs for FY23.	
c	He noted that the proportion of incidents were low compared to the activity that OPS was undertaking but it was important to not become complacent. He explained that the MHRA were changing their focus from historically looking at individual premises, processes, and people to looking at the wider organisation and the licence holder i.e., Oxford Health as an organisation. He felt the Trust had good governance processes in place but were working with an external company made up of ex-MHRA inspectors to help strengthen these. Following a decision made by the committee to appoint a new Responsible Person, Natasha Arif, Head of Quality had been appointed.	
d	The Chief Finance Officer commented that currently OPS was focussed on maintaining quality during the move to a new warehouse. She spoke about the need to look at governance, strategy, and level of ambition along with the purpose, scope, and risk appetite in respect of OPS.	
e	The Chair asked if there was a group that sat beneath Quality Group that looked at assurance and regulatory aspects for OPS. The Chief Pharmacist & Clinical Director for Medicines Management responded that this was an area that was being explored and arrangements would be confirmed with the Committee.	
f	**The Committee noted the report.**	
Policies and Governance		
9.	**Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF)**	

a	The Risk, Assurance & Compliance Manager presented the report at paper QC 68/2023 alerting the committee to two emergent risks for inclusion to the TRR: 1. An Infection, Prevention & Control (**IPC**) risk was raised at the Quality & Clinical Governance Sub Committee in October. The risk had several causal factors: i) accuracy and quality of staff vaccination data which was inhibiting timely follow up of revaccination; ii) ongoing loss of IT systems functionality and data transfer with requirement to transfer to a differing IT system model; and iii) capacity and capability to manage and mitigate the spread of infection between staff and from staff to patients due to i) and ii) above. There was the potential for the Trust to breach legal obligations and non-compliance with governing CQC standards. The risk had the potential to undermine future CQC assessments.	
b	2. The committee was asked to consider/approve the inclusion of the emergent Urgent Care provision (**UCP**) risk on to the TRR. Urgent community and primary care services no longer meet the population/system needs for enhanced care delivery in the urgent care and out of hospital pathways due to a notable mismatch between capacity, skill mix and demand. This was driven by increased acuity and complexity in cases referred by 111 and other partner organisations. The adverse effects on duration of clinical consultations further impacting on resource available to manage demand.	
c	The Chair commented that whilst it was reasonable to add the risks to the TRR, the committee needed to be satisfied that there were controls in place to mitigate the risks and sought reassurance that these were in place. Furthermore, the Chair asked if adding the risk to the TRR would be a duplication given the BAF risk on demand for primary and community services.	
d	On vaccinations, the Deputy Chief Nurse stated that there were no immediate clinical risks around this but added that issues arising from out of date systems and reporting of rates was being addressed.	
e	The Chief Executive suggested that the BAF and TRR be separate papers. The Chair thanked him for his helpful suggestion and noted the proposal for the two additions to the TRR and the two removals.	
f	The Executive Managing Director Primary, Community & Dental Care provided an update on BAF 1.6 and noted this had been reviewed and, as a result, it was proposed the risk rating be dropped from 12 to 9.	
g	The Director of Corporate Affairs & Company Secretary noted the suggestions for the separation of BAF and TRR reporting that her team would look into options for this but noted the importance of both papers coming to the same meeting for collective discussion.	**KR**

h	**The Committee APPROVED the change to the risk rating of BAF 1.6 from 12 to 9 noted the report.**	
10.	**Health & Social Care gap analysis and IPC Board Assurance Framework (BAF)**	
a	Dr Helen Bosley, Nurse Consultant, Infection Prevention and Control and Deputy Director of Infection Prevent and Control (**DIPC**) presented the report at paper QC 69/2023 noting the Health & Social Care Act had been updated in December 2022 as a result of which gaps had been identified which led to the development of an action plan. Both the gap analysis action plan for the Health & Social Care Act and the IPC BAF were reviewed, updated, and monitored at the quarterly Infection Prevention, Control and Decontamination Committee (**IPCDC**) and were a standing agenda item.	
b	She highlighted that there were some policies out of date which mostly sat within the Estates and Facilities teams and updates were awaited. Other key gaps around the Health & Social Care Act were around antimicrobial stewardship (**AMS**) work and the fact a risk register around staff immunisations was needed.	
c	The Chair asked what the different layers of assurance and risk reporting were and felt this probably needed to sit in the TRR rather than just stand alone. The Chief Nurse felt his was a good observation and agreed with the suggestion.	
d	The Director of Corporate Affairs & Company Secretary agreed with this and that her team would pick this up.	**KR/BA**
e	**The Committee noted the report.**	
11.	**Annual Reports** **a) Health & Safety annual report**	
a	*The Chair confirmed that, in consultation with the Chief Finance Officer, the Health & Safety annual report had been removed from the agenda and would come to a future meeting.*	
	b) Inquests & Claims annual report	
b	The Director of Corporate Affairs & Company Secretary presented the report at paper QC 71/2023 noting it provided a potted history of what the Legal team did, the volume of work undertaken by a small team and acknowledged Neil McLaughlin for his hard work and the invaluable support he offered teams during inquests.	
c	She noted the pertinent section for the committee was 1.16 which identified lessons noted from inquests in 2022/2023, whether through questions from the coroner or from the family of the deceased, or by letter from the coroner after the conclusion and highlighted themes/trends arising from the inquests. She felt the coroner's had been reasonably assured by the information presented to the numerous inquests we had been involved in. There had been one Prevention of Future Death (**PFD**) report and four letters from the Buckinghamshire Coroner and three from the Oxfordshire Coroner regarding areas where the organisation needed to evidence improvement.	

d	The Deputy Chief Nurse highlighted that the Trust's transition to PSIRF would make the submissions to coroners very different and there were currently ongoing conversations at ICB level and within the Trust with coroners over implications and responses to different approaches to investigations. The Chief Executive asked if there had been a national communication around this. The Deputy Chief Nurse responded it had been acknowledged nationally but had been left to ICBs to communicate this to coroners. RM noted the Chief Coroner had been involved and had been at the training.	
e	The Chair noted that best practice was to meet with the family before a coroner's investigation and asked whether this was the Trust's practice. The Chief Nurse responded that families were involved from the beginning if they wished, and that the Trust had Family Liaison Officers who supported families.	
f	The Chair asked if future reporting of issues identified from inquests could be reported in a more thematic way for the information and overview of the committee.	**KR**
g	**The committee noted the report.**	
16.	**AOB**	
a	The Chair noted she would summarise matters to escalate to the Board following the meeting and share with Executive Leads. Items to add for future meetings: • Waiting times information; and • Standard set of items for the committee's workplan.	
b	The Chair thanked the Chief Nurse for her superb commitment to the Trust over the last four years noting that this would be the last Quality Committee for the Chief Nurse prior to her leaving the Trust at the end of December 2023.	
17.	**Review of the meeting**	
a	NA	
	Meeting closed at 12:07 **Date of next meeting:** 08 February 2024 at 09:00 via Microsoft Teams virtual meeting	

Wantage Community hospital next steps and recommendations
January 2024

A report co-produced with the Wantage Community Hospital Stakeholder Reference Sub-group

Submitted on behalf of the Stakeholder group by:

Name	Organisation
Dr Ben Riley (Executive director primary community and dental care)	Oxford Health NHS Foundation Trust
Daniel Leveson (Place director Oxfordshire)	Buckinghamshire Oxfordshire & Berkshire West ICB
Cllr Jenny Hannaby (Chair)	Wantage Town Council Health Sub-Committee

See appendix E for statements of support from partner organisations

Executive summary

Since June 2023, local stakeholders from the Wantage and Grove area and NHS partners have worked collaboratively with weekly meetings and three wider workshops to co-produce a proposal for the future role of Wantage community hospital. We are committed to keeping the hospital open and developing its services to improve the health and wellbeing of local residents.

The project has reviewed local priorities, supported by activity data and public engagement to agree 'How can we use space in Wantage Community Hospital to benefit the health and wellbeing of the local community'. This report brings together the work done to date and makes recommendations on next steps.

Following confirmation by Oxford University NHS Foundation Trust that the maternity services will continue to be provided on the first floor of the hospital, it was agreed that these services need not form part of the wider public engagement work.

A key principle throughout this work has been that whatever is decided must be sustainable so that it can be maintained for the community moving forward. Two of the most important principles of sustainability are the extent to which services match the local need, and their affordability in the context of the overall NHS budget. Consideration has also been given to both the workforce (ability to recruit staff) and estates (space in buildings and capital costs of any adaptations). All of these factors have been considered in recommending the role of the hospital moving forward.

Three types of care have been considered within this project based on the co-produced priorities agreed with stakeholders:

- Inpatient beds and the alternatives
- Planned care
- Urgent care

Since the Wantage community hospital inpatient beds were temporarily closed in 2016 there have been a number of changes to the role of community hospitals. More preventative care reduces hospital admissions. More complex care can be provided at home. When people are admitted to hospital, we work to enable them to return home more quickly after their stay. This improves outcomes for patients and their families and reduces the need for inpatient beds. Although there was some feedback around difficulties with coordination and support, it was acknowledged there has been a significant increase in the services to enable people to return and remain at home since 2016 and further plans are in place to continue to strengthen these services.

Reinstatement of inpatient beds has been considered carefully. The minimum sustainable size of an inpatient unit has been identified as 18-20 beds. This is a result of changes to modern safety standards and sustainability of staffing. This is more than were provided in 2016 (12 beds) and significantly more than the current local need of c. 5 beds/month. Additionally, the space needed would require closure of the current outpatient services pilot. Alongside consideration of the inpatient beds at the hospital, the need to include Wantage in the countywide review of end of life care has also been identified as a recommendation to support stronger palliative care.

If inpatient beds are not re-opened within the hospital, there would be an opportunity to maintain the pilot clinic services and significantly increase the number of these clinics. Two types of clinic services have been considered in this work, planned care and urgent care. Both types of clinics would require the ground floor to be redeveloped to maximise clinic space and remove remaining inpatient infrastructure. Community Infrastructure Levy (CIL) funding has been identified and if this path is agreed, the NHS partners are

committed to working with the local community to develop an application for this funding to expand the offer in the Wantage area. NHS partners are also committed to dedicating appropriate additional resource to co-produce the business case to deliver this.

Since 2021, a pilot of outpatient clinics including Ophthalmology (eyes), ENT (hearing) and mental health services have been offered at the hospital. These services have been largely well received by the local community and were positively reported on as part of the engagement work. Data shows that these planned care services are the ones needed most frequently by the majority of patients. This also aligns with the local population trends towards an older population and those with complex care needs who will require continuity of care via planned outpatient services.

There are a range of urgent care services currently available to residents of Wantage including a Minor Injuries Unit (MIU) in Abingdon and Accident & Emergency departments in Oxford and Swindon. The type of service required for this type of care and the frequency with which it is needed is much more varied then planned care. The most popular services identified by the engagement were those with an x-ray service, either an MIU or an Urgent Treatment Centre (UTC). However the cost and challenges associated with staffing this are significant.

Looking to the future, it is important that services are able to address this challenge of the growing number of people living with long-term health conditions. An option has been identified to bring together a team of expert clinicians to provide urgent care for those with identified health conditions who are experiencing a deterioration in their health. This would enable patients living with long-term health conditions or frailty to access a local, holistic care offer, reducing the need for admission to hospital. This care could be provided within the same type of clinical facility as outpatient clinics. It is therefore recommended that specialist urgent care is included within the development of a business case for clinic-based services in Wantage.

In summary, based on the co-production work and considering the evidence and findings from the engagement completed with local residents, it is therefore recommended that the community inpatient beds are confirmed to be permanently closed in order to develop the ground floor to provide an expansion of clinic-based services which will provide a mixture of both planned care and targeted urgent care services.

In order to deliver this, NHS partners intend to work with the local community to progress with an application to the Vale of White Horse District Council for Community Infrastructure Levy (CIL) funding for the adaptations against the allocated £600k of funding available for healthcare related capital development. If this approach is agreed, our ambition would be to complete the business case and adaptations to the building during 2024 with services transferring from the start of 2025. It is understood from our liaison with the District Council that a CIL funding application could be supported subject to its demonstration of meeting the changing healthcare needs of the community as a result of local housing related growth and developments which through the co-production process all partners are confident can be readily demonstrated.

Summary of report recommendations

In relation to inpatient beds and the alternatives:

- Based on co-production and considering evidence and findings from engagement we recommend the community inpatient beds at Wantage Community Hospital are permanently closed.
- In line with wider work the BOB ICB is taking forward work to improve the local end of life care pathway, to see how we can strengthen the local offer for patients requiring palliative care.

In relation to planned care services:

- ICB, OHFT and OUHFT work to confirm the outpatient services currently being delivered in Wantage Community Hospital.
- ICB to work with providers (including OHFT, OUHFT and other service providers) to identify sustainable community clinic-based services from Wantage Community Hospital. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.

In relation to urgent care:

- Due to the high capital cost of providing a large x-ray within the hospital against the significant demands and constraints of the limited available capital funding in the system alongside the concerns over the workforce implications, it is not recommended to take forward a walk-in service at the community hospital at this time. However, consideration should be given to what diagnostic services could be included as part of the same day services and this should be kept under consideration in the future.
- Based on the noted increased complexity of needs within the local population, it is recommended to focus on developing a specialist local response service for those with long term conditions. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.

Contents

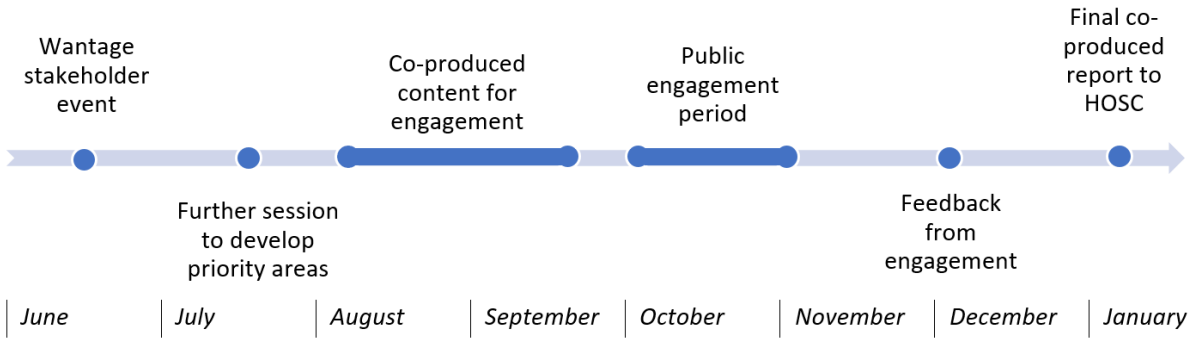
Introduction & context

1 The objective of this project is to work with the local community and stakeholders to agree 'How can we use the space in Wantage Community Hospital to benefit the health and wellbeing of the local community'. This co-production project commenced in June 2023.

2 The Oxfordshire Place Director of Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board (BOB ICB) and Oxford Health NHS Foundation Trust confirmed at the outset that they have no plans to close Wantage Community Hospital and this commitment to keeping it open remains. Oxford University Hospitals NHS Foundation Trust also confirmed its commitment to continuing to provide maternity services at the hospital.

3 Initial work was facilitated by the consultation institute to agree the priority areas for consideration. During the development of the public engagement materials and approach it became evident that some additional time was required to refine the material and maximise the reach during the public engagement phase, such that a revised timeline was needed and agreed with HOSC in September 2023. As part of this it was agreed to bring in an independent organisation to facilitate and analyse the public engagement, to ensure there was sufficient resource to deliver the engagement.

4 The project has followed the below timeline (2023-24):



5 We have now completed the engagement process and the purpose of this report is to set out the co-production process that has taken place and detail the resulting recommendations to the Wantage Health Sub-committee and HOSC. This is to facilitate a decision as to whether the project has done enough to enable agreement of the long-term future service configuration to be provided from the community hospital.

Historical context

6 Wantage Community Hospital (WCH) is home to a range of health and care services. The Hospital is managed by Oxford Health NHS Foundation Trust (OHFT) and provides a range of NHS services from several healthcare providers. These include maternity services, community therapy services and specialist outpatient services, providing clinical assessment, tests, treatment and therapy for the local community. These include a mixture of one-off and repeat visits depending on the service.

7 Oxford Health NHS Foundation Trust is the main NHS provider of community healthcare services for the population of Wantage and Grove and manages the services provided by several providers (including the Trust) in Wantage Community Hospital.

8 Until 2016, Wantage Community Hospital provided inpatient beds, maternity care and a range of other NHS services from a single site over two floors. Following the detection of legionella in the hot water system in 2016 the inpatient facilities were temporarily closed and in 2020-21 all the old pipework was replaced, and this enabled all the clinical areas of the hospital building to reopen, although the inpatient beds have remained temporarily closed.

9 A trial of a number of different specialist outpatient clinics (clinic-based tests, treatment and therapy) have been running downstairs for the last 18 months, alongside the community therapies, with maternity services operating upstairs.

10 As of December 2023, the hospital premises are used to provide:

- On the ground floor - a range of services (clinical assessment, tests, treatment, therapy, follow ups) for the local community. A trial of a number of different specialist outpatient clinics have been running downstairs for the last 18 months, alongside these services. The hospital also serves as the local base for some outreach community services (e.g. school nurses and vaccination teams). See appendix A for a full list of the services.
- On the first floor – maternity services including a community delivery suite

11 The local community were previously asked for views about Wantage Community Hospital in what was called the "OX12 Project" between 2017 and 2019, which concluded without a decision. Over the past 6 months, a co-design process has been developed by the NHS with the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) and the Town Council Health Sub-committee with a commitment shared across the partnership to work together, which was agreed at an extraordinary JHOSC meeting on 11 May 2023.

See appendix C for the full HOSC history of Wantage community hospital

Governance and decision-making arrangements

12 Oxfordshire's Health Overview and Scrutiny Committee (HOSC) agreed a process of co-production at an extraordinary meeting on 11th May 2023 with Wantage Town Council Health sub-committee and key local stakeholders, in recognition of the need for the health and care system to work with the previously engaged community, with an aim to achieve a recommended way forward for the future type of services to be delivered from Wantage Community Hospital.

13 The NHS commissioning body responsible for the population, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), was formally established as a new statutory body on 1 July 2022, replacing the three former clinical commissioning groups. BOB ICB is the commissioner of community healthcare and NHS services provided at Wantage Community Hospital.

14 The stakeholder reference group for this project has the following representation who are committed to working in a co-productive way:

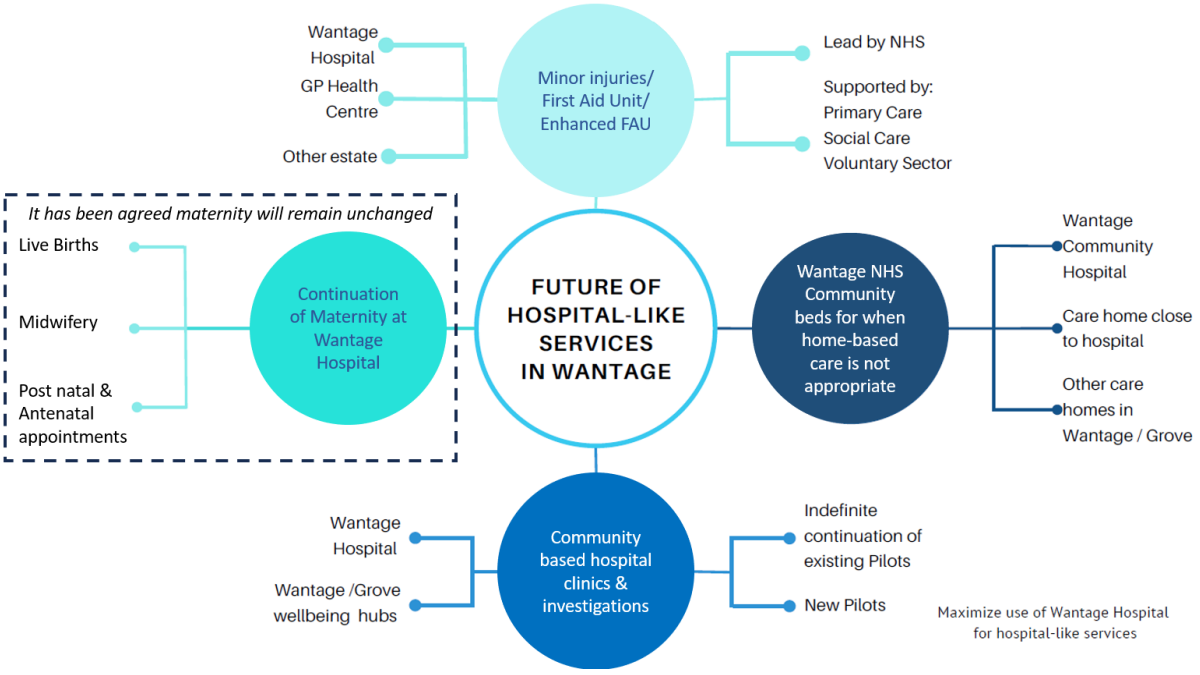
- Wantage Town Council
- Grove Parish Council
- Vale of White Horse District Council
- Wantage Hospital League of friends
- Wantage Patient Participation Groups
- OX12 Project representatives
- GrOW Families
- SUDEP Action
- Wantage Rural and OX12 Village

- Sanctuary Care
- Oxfordshire County Council
- BOB Integrated Care System & Board (ICS & ICB)
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Wantage Primary Care Network (PCN)
- Vale Community Impact
- Community First Oxfordshire
- Healthwatch Oxfordshire

15 From this wider stakeholder reference group a smaller working 'sub-group' was agreed to lead on the public engagement process. The sub-group consisted of local councillors, NHS representatives, Vale community impact and Wantage PCN.

16 Through our co-design process we also identified there may be a need for other types of health and care provision in other buildings and/or parts of the community to contribute to people's experiences and outcomes.

17 The below summary sets out, the co-produced summary of community needs for hospital-like services for the Wantage and Grove area:



Public Engagement process

18 A phase of public engagement was completed between October and November 2023. This was co-ordinated through the sub-group and built on input from residents, clinicians and NHS managers as well as learning from previous completed engagement. The engagement sought to understand the broader views of local people to help shape final proposals.

19 The engagement process used a blend of face-to-face and online approaches to gather suggestions and feedback from a wide range of participants representative of the local communities. By providing a range of opportunities through an array of channels the aim was to make it as easy as possible for people to have their say and shape the future of health and care services based in the Wantage and Grove area.

20 Focus groups and deliberative events were selected because they are a particularly good approach where plans are at an early stage and the user perspective can influence thinking significantly; there are

co-dependencies or trade-offs to consider; complex choices that require rich, well-informed discussion. In addition, a survey was used to understand the viewpoints of the wider population which received 285 responses (see appendix B).

21 The objectives for this engagement were to:

- provide scope and focus which will support the stakeholder reference group in the next stage of co-design.
- explore views on the three scenarios developed through the previously engaged community and stakeholder reference group and gather over-arching comments through a structured process.
- identify themes to inform decisions moving forward, avoiding repeating earlier research and engagement
- enlist the help of an independent organisation to facilitate the process and provide analysis of findings

Local population needs

22 This project has focused on developing the future role of WCH to ensure its long-term sustainability. In order to do this, consideration has been given to both existing and future needs of the local community alongside current and emerging models of health and care.

23 Wantage is located within Oxfordshire a county of around 725,300 residents, with a fast-growing population. Between the 2011 and 2021 census the population grew by 10.9% compared to 6.6% in England, and the number of people aged over 65 grew by 25%. Oxfordshire is the most rural county in the Southeast region but 60% of the population live in the city of Oxford or other main towns. Life expectancy and healthy life expectancy in Oxfordshire are each significantly higher than national and regional averages for both males and females. Oxfordshire is ranked the 10th least deprived of 151 upper-tier local authorities in England.

24 Wantage is a market town in Oxfordshire with just over 33,000 residents registered with local general practices. The area is within the local authority areas of Wantage Town Council, Vale of White Horse District Council and Oxfordshire County Council, and health services are within the purview of both the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) and the local Wantage Health Sub-committee of the Town Council.

25 For the purpose of this project, the Wantage and Grove local area has been identified through two measures, firstly the postcode area of OX12 and secondly the GP practices registration.

Wantage & Grove - OX12 postcode area

Newbury street practice boundary

Church street practice boundary

26 Within this geography which we have described as the Wantage & Grove area, there are a number of key trends which need to be considered.

27 **The population is growing, particularly within the Grove area**
In 2022, there were 33,179 patients registered with Wantage GP practices, this is an increase of nearly 10,000 since 2014 when it was 24,296. Based on housing growth trajectory, this is due to increase further to around 41,000 by 2030.

28 **The population is ageing, and more people are forecast to live longer**
As well as increasing in number, the population of the Wantage area is also getting older. Census data shows that between 2011 and 2021, the proportion of the population aged over 65 increased in both the Wantage and Grove areas.

	Grove (% over 65)	Wantage (% over 65)
2011 census data	17.0	19.6
2021 census data	18.0	22.0

Oxfordshire insights, Wantage & Grove profile 2018

29 ONS population estimates show that the number of people aged 75+ in Oxfordshire increased by 22,600 over the 20 years from 2001 to 2021. In the 20-year period between 2021 and 2041, this age group is expected to increase by 40,200 residents, almost double the number added in the previous 20 years (2001 to 2021). Both the ONS and Council's Housing-led forecasts predict a significant increase in people over the age of 65.

30 **More people both young and old are living with more complex needs**

According to Age UK, as we get older there are some conditions and illnesses that we are more likely to develop (*https://www.ageuk.org.uk/information-advice/health-wellbeing/conditions-illnesses/)*. Applying the prevalence of long-term health conditions in 2011 to the actual and predicted growth in the older population, suggests that there could be 80,200 people aged 65+ living with a life limiting long term health condition or disability in Oxfordshire by 2031, an increase of 32,600 (+68%) (*Oxfordshire Older people's strategy 2019-24*). As a result, this population require an increase in planned care services often with regular appointments and more integrated care as identified in the ambitions of the NHS Long Term Plan[1] and recently published guidance on Proactive Care[2].

Case for Change

31 The co-design project is now seeking to agree the long-term future of the hospital and confirm whether the inpatient beds should re-open or be permanently closed. There are a number of changes to the community and NHS best practice which have occurred since 2016, which impact on the way in which the hospital might be best used, and potential opportunities to fund new primary care developments in the Wantage area:

Temporary closure of the inpatient beds

32 Inpatient beds on the ground floor of the community hospital have been temporarily closed in 2016, following the detection of legionella in the hot water system. In 2020-21 all the old pipework was replaced, and this enabled all the clinical areas of the hospital building to reopen, although the inpatient beds have remained temporarily closed. A trial of a number of different specialist outpatient clinics (clinic-based tests, treatment and therapy) have been running downstairs for the last 18 months, alongside the community therapies, with maternity services operating upstairs.

Home First

33 Home First is the national NHS policy ambition to help older people receive care in their own homes wherever possible. NHS Reducing length of stay guidance describes taking a 'Home First' approach, providing patients with support at home or intermediate care. Home First requirements are that we should always seek to support people at home; assessing and intervening without a hospital admission wherever possible and getting people back to their own home before we assess their needs and plan their care [3].

34 A study carried out by the Better care support programme (available at reducingdtoc.com) found that on average, 27% (a range of between 19% and 35% across the areas) of the 10,400 individuals studied were declared to be medically fit for discharge yet remained in hospital. This study and other evidence support that an extended stay in a hospital bed is not good for vulnerable frail patient who is ready to go home, it can lead to disorientation, loss of physical conditioning and risk the person's future independence.

Discharge to assess model

35 It is widely accepted that the vast majority of people admitted to hospital want to leave as quickly as possible and that almost everyone wants to return to the living arrangements they enjoyed prior to their admission with the highest level of independence, wellbeing and quality of life possible, given their

[1] NHS Long Term Plan » Ageing well
[2] NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty
[3] NHS England » Principle 5: Encourage a supported 'Home First' approach

circumstances. Staff caring for people also want them to be discharged to the right place, in the right way, at the right time[4].

36 Oxfordshire health and care system is committed to the discharge to assess model which sets out principles around the number of patients who should be supported to return home following an acute hospital admission[5]. The Oxfordshire Way is the vision for Adult Social care to support people to live happy, healthy lives here in Oxfordshire. It brings together the council, health and care organisations and voluntary sector groups and is focused on 'what's strong rather than what's wrong'. You can see a video about the Oxfordshire Way in practice here: https://player.vimeo.com/video/842913641?h=9bcf384398&app_id=122963

37 Oxfordshire has been piloting a discharge to assess home first model since July 2023. In the pilot, we took people home with support and assessed them at 72 hours after their discharge. All of the patients in the pilot had been assessed in hospital as needing *long-term care*. In the pilot we found that

A. 24% were fully independent at 72h
B. 32% were able to engage in reablement at 72h
C. 33% were for long-term care support at home

38 Although many patients benefit from an admission to hospital, this can also bring its own risks. For the more vulnerable, being in a hospital bed can mean:

- losing confidence in the ability to live independently
- losing the continuity of whatever care packages are in place
- losing mobility
- a risk of secondary health complications (e.g. higher risk of picking up an infection)

39 In addition, older patients can often experience confusion and disorientation in an unfamiliar environment and daily routine. As a result, the home first approach proposes that where an individual is able to return home safely, they should be supported to do this rather than remaining in a hospital bed. In the discharge to assess pilot above 56% of patients supported to go home would have otherwise been waiting in hospital for the Council to arrange long-term care at home with all these risks to their health, wellbeing and independence.

40 Aligned to The Oxfordshire Way, the NHS Hospital Discharge Policy requires all health and care systems to discharge 95% of people from acute beds directly home or to their normal place of residence, whether independently or with support. Currently in Oxfordshire and prior to the Discharge to Assess pilot we have been achieving about 91%. That amounts to approximately 20 people a week who will have been placed in a step-down bed rather than their own bed and who will probably have been unnecessarily delayed in hospital. When a person does not need bed-based care, admitting them to hospital unnecessarily may compromise their reablement, reduce independence and can cause harm. As learning from the discharge to assess pilot embeds, the number of people who return home directly and earlier is anticipated to increase. The Oxfordshire health and care system is committed to discharge to assess and has been rolling out a County-wide 7-day service from November 2023. This has involved a reorganisation of social work teams working into and out from hospital sites which will be completed in January 2024.

Specialist bed provision

41 In recent years within the NHS, there has been a shift in approach to rehabilitation, to develop specialist centres of expertise which bring together staff with a specific skill set on one site, to better meet the needs of a particular cohort of patients. Although the majority of community hospital inpatient beds

[4] People-first-manage-what-matters.pdf (reducingdtoc.com)
[5] https://www.local.gov.uk/publications/developing-capacity-and-demand-model-out-hospital-care

continue to offer general rehabilitation, there has been a shift towards the development of specialist wards. Within Oxfordshire, as well as rehabilitation beds, there are also the following specialist beds:

- Oxfordshire Stroke Rehabilitation Unit (Abingdon)
- End of Life beds (Wallingford)
- Bariatric beds (Witney)
- Short-stay medical step-up beds for people with acute health problems (Abingdon & Witney)

42 Three community hospitals also provide an ambulatory care model, where the patient attends for treatment during the day and returns to their own home overnight (Henley, Abingdon & Witney).

43 This move towards more specialist provision means that where a patient has additional needs requiring inpatient care, they may be admitted to a specialist bed rather than to a general rehabilitation ward.

Urgent community response (UCR)

44 With increases in the older population, more people in the community are living with one or more long-term health conditions. Many services were commissioned to manage specific illnesses rather than the whole person. This means that people with multiple conditions can experience disjointed care which can result in an individual having to have contact with multiple different services. People with one or more long-term condition need high quality, consistent and integrated health and social care. People with more than one condition, or who have a long-term condition when something else happens to impact on their health (such as having a fall), often require more complex support. Health and social care services need to be designed differently to respond to these needs.

45 In response to this and in accordance with the national standard for community health services to deliver two-hour urgent community response, we have developed Oxfordshire's Urgent Community Response service which is focused on reducing avoidable admissions (Further details are available on the NHS England website https://www.england.nhs.uk/community-health-services/community-crisis-response-services/).

Preventative care to support sustainability

46 Preventing admissions and providing care at home is critical to managing hospital capacity. Many people with frailty currently admitted to hospital through A&E don't need inpatient care – estimates range up to 30%. Care Quality Commission (CQC) research (2018) has shown that investment in preventative services can lead to a reduced need for care and support and cost saving equivalent to £880 per person. Therapy-led reablement is proven to reduce need[6]. In order to increase the financial sustainability of community services it is therefore necessary to review the way in which we deliver services to ensure we are achieving the best patient outcomes within the financial resources available to the NHS. In general this would move from bed-based crisis care towards a more preventative approach based within the community. There is an opportunity to support this approach directly for local residents through the development of planned and preventative outpatient care in local community hospitals.

Workforce sustainability

47 Like many other parts of the NHS, community services are facing significant challenges in recruiting and retaining sufficient staff to meet the needs of the population. Central to addressing this challenge is ensuring that staff teams are supported to have an appropriate workload and mix of skills to be able to meet patient needs. Over the past 2 years Oxford Health NHS Foundation Trust has invested in both community urgent community response and community hospital staffing teams to increase their capacity and resilience. As part of this, a project to reduce use of agency staff has developed an

[6] Evidence review for adult social care reform (publishing.service.gov.uk)

international nursing recruitment campaign which has enabled the Trust to reduce vacancy rates within staff teams. In order to maintain staff retention however it is necessary to ensure services are both financially sustainable and there is sufficient capacity to meet the demand for services. This means that whichever services are agreed to be provided within Wantage community hospital there will need to be a sustainable approach to staffing them, including consideration of how these plans will impact on teams across other sites. Once the future of the community hospital is confirmed we would be looking to work with the local community to explore options to support recruitment within the local community.

48 Nationally the NHS has committed to the ambition of delivering seven-day services to ensure that patients receive consistent high quality safe care every day of the week. This has been shown to have significant patient benefits and reduce variation in patient care. However, in order to move to this model, services need to either change how they provide services or increase staffing by nearly 30%. In order to deliver this model sustainably it is necessary therefore to review how services are provided and identify opportunities to align services better to meet patient needs every day of the week.

Estates considerations

49 The buildings in which community inpatient services are provided are no longer cost effective or best suited to the needs of patients. A report produced in 2021 by NHS Benchmarking showed that Oxfordshire community hospitals are relatively inefficient to run compared to the hospitals in Buckinghamshire and Berkshire. This is due to the limited number of beds operating at each site and the old design of the buildings, requiring proportionately higher staffing numbers to deliver the same safety and quality of care as in larger bedded units. Within BOB ICS, Oxfordshire operates nine community hospitals of which six have inpatient wards; in contrast, Berkshire West has consolidated its provision to three, larger inpatient units; Buckinghamshire has closed its community hospital wards at Thame and Marlow and co-located its inpatient rehabilitation with its acute hospital care.

50 In addition, Wantage Community hospital site has particular limitations relating to the physical estate including parking, building size, design and age, and requirements to share space with other services.

51 Having reviewed the site, the Oxford Health estate team are of the view there is no opportunity to expand the ground-level footprint of the hospital. There is potential to look at what development could be done on the upper floor, but careful consideration would need to be given to the business case as it is anticipated this would have a significant cost. It is also important to assess the staffing implications and restrictions on parking space associated with expanding the space within the hospital.

NHS capital constraints

52 OHFT have already invested capital funds into Wantage Community Hospital since 2020/21 to rectify the old pipework and provide the clinical accommodation for the pilot outpatient/clinic/therapy services on the ground floor. Any funding for further estate refurbishment works to create space for additional clinical space (i.e. to enable expansion of services beyond the current pilot services) must be classed as NHS capital spend under the NHS finance regime (annual revenue funds cannot be used). There are nationally set constraints on how this is funded. Unless funded via NHS England under a national capital framework, such as the new hospitals programme, this must be funded via provider capital funds. This amount must be affordable for providers, in having available cash in the bank, and fit within their capital department resource limit (CDEL), which is a fixed amount and has not increased in line with population changes. For OHFT the majority of its capital funding for next year is pre-committed against existing multi-year programmes. Additionally, there are a number of urgent maintenance programmes requiring funding meaning there are pre-commitments against new CDEL allocation where the Trust has a continuing ageing estate. This means that any hospital site requiring new refurbishment

will require an external funding source and use of Local Authority community infrastructure level (CIL) funds would support this.

CIL funding

53 Following the May 2023 JHOSC meeting, a meeting was held with the District Council Infrastructure and Development Team Lead who is responsible for CIL funding, which identified that there is £2,503,892 of funding for CIL allocated for Health within the Vale area. It is understood that of this, approximately £2m has been identified as required for primary care developments which are currently at the early phases of development. An update on this funding opportunity was brought to the July Reference group session and a discussion took place to explore how this funding might be used in reference to this project.

54 It is understood from our liaison with the District Council that a CIL funding application would be supported through its demonstration of meeting the changing healthcare needs of the community as a result of local housing related growth and developments. The co-production process has generated significant enthusiasm and confidence of being able to describe a long-term future plan for Wantage Community Hospital that meets these requirements to enable a strong application.

Community hospital inpatient beds and the alternatives

55 In the period prior to their closure in 2016, 12 general inpatient rehabilitation beds were being provided within Wantage Community Hospital. Following their temporary closure due to the replacement of the plumbing system in the community hospital, this inpatient care has been provided at other community hospitals in Oxfordshire. Any long-term decision on the services to be provided at Wantage Community Hospital needs to address whether or not these beds should be reopened at that site, not least as this determines the facilities and space available at the hospital for other services.

56 As described within the case for change above (paragraphs 33-54), there are a number of changes in policy and approach which have taken place since 2016, in particular the focus on reducing length of stay within a hospital[7] and providing more care at home, both to reduce admissions to hospital and to support individuals to return home sooner. As such the consideration of the role of these beds and the option to reinstate them also considers the alternatives to bed-based provision, what services are available to individuals as well as the impact of reopening a ward within the community hospital on the currently available services.

The current service offer

Inpatient beds

57 The following types of inpatient beds are currently provided within Oxfordshire:

A. Community hospital inpatient beds

58 Community hospital inpatient beds provide rehabilitation following an admission to an acute hospital for those who are not able to return home. Within Oxfordshire, there are currently 8 community hospital inpatient wards open across 6 sites (see appendix D). These provide a mixture of general rehabilitation and specialist care (including Stroke, end of life, medical and bariatric care).

[7] NHS England » Reducing length of stay

59 Each month around 5 people from the Wantage and Grove area are admitted to a community inpatient bed. Despite the ageing population it is not anticipated that this will change because of the growing number of alternative health and care pathways to avoid hospital admissions.

60 Most people from the Wantage and Grove area (55%) currently go to either Abingdon (10 miles from Wantage) or Didcot (8 miles from Wantage) community hospitals. Of those that don't go to these hospitals (45%) the median distance travel from Wantage is 20 miles to other community hospitals. The average (median) length of stay in a community hospital bed is around 34 days.

B. Short Stay Hub Beds

61 In addition to community hospital beds, bedded care is also provided within care homes as part of the short stay hub bed model. This model was developed by Oxford University Hospital NHSFT in the winter of 2015-16 as what was planned to be a short-term provision to create the capacity to maintain hospital flow where there was not sufficient home-care capacity for the patient to go home. At that time, Oxfordshire had one of the worst performances in terms of delayed transfer of care ("bed-blocking") in the country. The model was retained over succeeding winters and then was integrated with the Council's intermediate care model in 2019. The current "short-stay hub beds" were recommissioned and contracted by the Council from November 2019 and the model is currently under review.

62 The short-stay hub beds are supported by a dedicated team of nurses, social workers, and therapists (the "Hub team") that is hosted by OUH. Medical cover is provided by local GP practices under an additional contract which reflects the fact that patients are not registered permanently with the practice. The average length of stay is intended to be relatively short at 14 to 21 days at which point the individual is then discharged home (in 70-80% of cases).

63 Each month, approximately 2 people from the Wantage and Grove area require either bed-based reablement or a period of bed-based assessment and are admitted to short stay hub beds in care homes (mainly to The Close in Burcot, 15 miles from Wantage) where they are supported by the Hub team and local GP practice as set out above.

C. Winter/ surge beds

64 As part of the approach to managing capacity over the winter or in times of increased demand, additional beds may be purchased within care homes normally to support further assessment outside of hospital for people who are likely to need Council or NHS Continuing Healthcare funded residential care in the longer term. The Oxfordshire health and care system currently has no plans to purchase any additional capacity for 2023/24 but if required would go to the care market to ascertain what could be made available for short periods of stay, typically 1 – 2 weeks per stay for a few months of the year. When this capacity is purchased, we also need to fund additional therapy in-reach and dedicated GP cover from the GP practice local to the home. This is in line with the system's ability to flex beds up or down as required.

D. Palliative and end of life care (EOLC) (outside of the individual's home)

65 Most people wish to receive a package of care to pass away in their own home, but sometimes alternatives are needed, particularly at times of crisis. Specialist end of life beds are currently provided at Wallingford Community Hospital (16 miles from Wantage) and within the Sobell House hospice in Oxford (20 miles from Wantage).

Home-based services

66 In addition to inpatient beds, as described within the case for change, there has been a significant increase in recent years in the number of services provided in an individual's home. Within Oxfordshire this includes:

A. Admission avoidance services (Hospital@Home & Urgent community response)

67 Provide healthcare in your own home and facilitate earlier discharges from hospital. Oxfordshire has both children & young people and adults Hospital@Home services. Around 45 people from the Wantage and Grove area currently access the service per month with the service continuing to expand over the coming 6 months to provide 40 places per 100,000 population by April 24. In addition, around 150 people from the Wantage and Grove area access the urgent community response service per month. In the past, many of these patients would have been admitted to a hospital bed as there was not the ability to diagnose the cause of the health crisis or offer the care to enable them to remain at home.

B. Discharge to Assess

68 The Oxfordshire health and care system is committed to discharge to assess and has been piloting a discharge to assess "home first" model since July 2023. The County-wide 7-day service has been operational from November 2023 including covering the Wantage and Grove area. This has involved a reorganisation of social work teams working into and out from hospital sites which will be fully completed in January 2024.

69 Discharge to assess is also a new service for people who are clinically optimised for discharge (i.e. considered medically well enough to return to their home or usual place of residence) and do not require an acute hospital bed, but may still require care services. They are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting where a package of care is provided whilst an assessment for longer-term care and support needs is then undertaken.

C. Reablement services

70 Reablement is a type of care that helps someone to relearn how to do daily activities. Most people who receive this type of care do so for 1 or 2 weeks after they have been discharged from an acute hospital. This service is commissioned by the Council and is in place across Oxfordshire including to Wantage and Grove residents. This has been a priority area for increased capacity and in November 2023, 91% of patients from this service (137 people) were discharged independent or with reduced dependency. Going forwards we understand this service may be wrapped into the Discharge to Assess model as this works by taking people directly home and then determining whether the person needs reablement.

Engagement feedback on inpatients and the alternatives (see appendix B for further details)

71 Within the inpatient services considered, rehabilitation beds were the clear priority over the other kinds of inpatient services with the view that other beds might be better provided less locally.

72 The rationale behind support for these services, as with other services, related to the ease of travel. If visiting a loved one recovering in hospital involves a long, difficult and expensive journey, that is good for neither patient nor visitor. Having patients return closer to home to recover enables them to receive greater social support, which has been shown to speed up recovery, something from which all parties gain, including the NHS as it frees up a bed earlier.

73 There was significant support for having more local beds within Wantage; when looking at the bigger picture, more people felt that if the price of providing rehabilitation beds is the loss of outpatient clinics, then the latter should be the priority - especially when looking at the relative demand for each service (based on the presentation handout made available during the focus groups).

74 Other inpatient possibilities – palliative care and specialist stroke rehabilitation beds – were felt to be best offered regionally rather than necessarily locally and, though it is difficult to find places, palliative care can be offered though care homes.

75 Home based services were seen as a high priority and provide a really good alternative to admission as an inpatient at a regional hospital, with consequent travel issues for visitors. However, the importance of having sufficient capacity and a joined-up approach were highlighted and feedback reflected a mixed experience of these services currently.

Options identified

76 Were inpatient beds to be reinstated within Wantage community hospital, the following options have been identified:

A. Re-open an inpatient ward of around 20 inpatient beds within the community hospital

- General rehabilitation
- Mixture of specialist (e.g. EOLC beds) and general rehabilitation

As part of this work, the sustainable staffing models for community hospital inpatient units have been reviewed. The Lord Carter review (2018) noted that *"…one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure"*[8]. In order to provide a safe and sustainable service, it is recommended that a minimum staffing level (equivalent to 15-20 general beds) should be maintained on each site. It is neither clinically safe nor sustainable from a workforce perspective to operate a smaller number of beds at Wantage nor to shift resources to Wantage from other community hospital inpatient units to reduce their bed numbers further.

77 Based on an assessment of the building layout of Wantage Community Hospital, and on the advice of local hospital clinicians, it is recommended that any inpatient unit operated at the hospital should consist of a minimum of 18-20[9] beds; this would ensure that there is sufficient staffing and expertise available on the ward to cover the 24-hour rotas and manage sickness and other absences sustainably, to ensure safe care can be reliably maintained.

78 If a higher number of specialist beds are provided, with a higher workforce to patient ratio than the 1:6 nursing ratio used for generic rehabilitation beds, the total number of beds on the inpatient unit could be slightly lower than 18-20 due to the proportionately larger staffing team required for each of the more complex patients, although this would not reduce the size of the overall workforce requirement of the unit.

79 Throughout this work the focus agreed by the stakeholder group has been on ensuring that all options identified for the hospital must be safe and sustainable; an option to operate fewer than 18 generic inpatient beds within the hospital is not recommended on this basis.

Enabler considerations

Estates implications

80 To deliver this option it would be necessary to modernise and refurbish the whole ground floor of the community hospital to an inpatient ward with 18-20 beds in line with current infection prevention and control standards. It would be necessary to upgrade the kitchen facilities**.**

81 If Community hospital beds were provided in Wantage there would be no space for any outpatient (tests, treatment and therapy) services or potential urgent care type service. Wantage and Grove residents would need to access these at other hospital and health and care locations (e.g. Oxford).

[8] Lord Carter review (2018)https://www.england.nhs.uk/wp-content/uploads/2019/09/20180524_NHS_operational_productivity_-_Unwarranted_variations_-_Mental_....pdf p3

[9] Productivity in NHS hospitals - GOV.UK (www.gov.uk)

82 Were this option to be taken forward it would be necessary to review the location and configuration of community hospital beds across the County as a whole, in order to redistribute the available NHS staffing expertise and resources. Additional investment in staff recruitment, staff consultation and training programmes would be required to develop the required ward workforce.

Workforce implications

83 The cost would be dependent on number of beds and type of care interventions provided. A ward would be typically staffed for an equivalent size ward with nursing ratio 1:6 (24 hours per day), Therapy ratio 1:8 (7.5 hours per day) Occupational Therapy, Physiotherapy, Dietetics and Rehab Assistants, ward medical input and on-call cover (GP and Advanced Care Practitioners), and ward discharge support by a patient flow team.

84 Where a ward and overall hospital site has only a small number of beds, and a correspondingly smaller expenditure budget, it is much harder to maintain a core team with the headcount, skill mix and expertise to provide sustainable staffing, which can impact on the ability of that environment to provide optimal care. To ensure wards can be staffed appropriately to meet patient needs, consideration needs to be given to a viable ward size and smaller units have higher running costs on average where they have limited opportunities to share resource across multiple wards including the more specialist workforce.

Wider dependencies within the Wantage & Grove area

85 The following were identified as dependencies relating to the provision of inpatient beds within the community hospital:

Local short stay hub beds for reablement care

86 Most reablement care is provided in the person's own home. Some people, however, require a short period of reablement in a bedded care facility, such as a care home. We understand the profile of this demand may change with the adoption of the discharge to assess model set out above and the need to divert more people home to meet the NHS policy requirement of 95% of people going home from hospital. Using the *current* model, the need to provide short stay bedded reablement care to Wantage and Grove area residents has been considered during this work, including the option to provide this care in local care homes. However, the demand data suggests, only 2-3 Wantage and Grove residents require this type of bed at any one time in the current model.

87 As noted within the case for change, there is a national focus on moving to provide as much care as possible at home, as part of the 'discharge to assess' and 'home first' approach. Oxfordshire has only ever achieved c 90-91% of people going directly home. This amounts to 20-25 people per week who go into a bed who should not need one and could instead be diverted to Home First. To address this, an extended reablement service is currently being developed to offer additional assessment, reablement and long-term care in people's homes together with any equipment and/or assistive technology. As part of this work it was agreed in May by Oxfordshire County Council and the ICB that the number of short stay hub beds should be reduced from the current 94 to 40-45 over time. The impact of discharge to assess and the implications for the step-down bed provision in the County will be considered at the January 2024 extraordinary JHOSC meeting.

Local end of life care home beds

88 A second area identified for review was the need for local specialist beds to support people receiving care at the end of life.

89 Members of the stakeholder group expressed the view that more resilient and responsive EOLC should be provided in the person's home or usual place of residence, if this is their choice, and this should be priority area of focus for the future development of the end-of-life care pathway in Oxfordshire.

90 End-of-life care is not ideally provided in a busy acute hospital or inpatient rehabilitation ward optimised for the delivery of strengths-based therapy, due to the different nature of the care environment, therapy facilities, clinical expertise and skill-mix required for this cohort of patients.

91 Two areas of end-of-life care identified for possible development in Wantage are:

- Enhancing end-of-life care support for local residents at the end-of-life whose usual place of residence is a local care home, enabling more people to die in the place of their own choice
- Developing end-of-life care 'crisis beds' (24-48 hours stay) in local care homes - this was seen to be particularly relevant where the families and carers of people at the End of Life may need a brief period of additional end-of-life nursing support in a community setting, if the dying person is temporarily not able to remain at home but does not require admission to an acute hospital.

92 It is agreed this is an important area to get right for people and is therefore recommended that these proposals are taken forward as part of the End-of-Life care pathway development work being progressed by the Oxfordshire system.

Summary & recommendations

93 There have been a number of changes to the role of community hospital beds since the Wantage community hospital inpatient beds were temporarily closed in 2016. Recently, there has been an increase in the amount and complexity of care which can be provided at home. This means that more people are able to return home quickly after a stay in hospital and fewer people are admitted in the first place.

94 It has been widely recognised that preventative care, and providing more care in the patient's home, leads to better outcomes for them, their families and carers, and reduces pressures on the health and care system. This also means that, despite a growing and ageing population, there is less need for inpatient beds than there was in the past. In addition, there have been changes to the needs of the local population which mean that it is important to focus more on the older population and those with complex care needs. All of these factors have impacted on the way in which we have approached determining the role of the hospital moving forward.

95 In order to be sustainable from a staffing perspective a ward needs to have between 18-20 beds. To open a ward of this size in Wantage would require an equivalent number of beds to be closed within other community hospitals within the county, and these beds would not be efficiently scaled to the needs of the local community. Moreover, due to the space required, difficult choices would then need to be taken on which of the current planned care pilot services currently provided in WCH would need to be downgraded or removed to make room.

96 When considered against all the options within the engagement process, although there was a significant level of support for the future role of the hospital being to provide inpatient beds within the survey, this view was expressed by significantly fewer people than the number who supported both outpatient and same day services. Taking the evidence, the costing and service implications, in conjunction with the stakeholder views, into consideration, it is therefore recommended that the inpatient beds are not reopened.

97 However, this is not the only way to provide beds in the local community. The role of local care home beds and end of life specialist beds were identified as areas for consideration by the local community. It is recommended that the work to review the local offer for these alternative beds options should be taken forward alongside discussions with local care homes, in line with the countywide approach to strengthening reablement and end of life care.

98 If inpatient beds are not re-opened within the hospital, a strong alternative identified as part of this project is to use the hospital to provide clinic space. Two types of clinic services have been considered, planned care and urgent care. Both types of clinics would require the ground floor to be redeveloped to maximise clinic space and remove remaining inpatient infrastructure.

99 **In relation to inpatient beds and the alternatives it is therefore recommended that:**

- **Based on co-production and considering evidence and findings from engagement we recommend the community inpatient beds at Wantage community hospital are permanently closed.**
- **In line with wider work the BOB ICB is taking forward work to improve the local end of life care pathway, to see how we can strengthen the local offer for patients requiring palliative care.**

Clinic-based services

100 If the ground floor of the community hospital were not to be used to provide an inpatient ward, then it could be redeveloped to provide an expanded range of clinic-based services. There are two types of clinic-based service which we have considered as part of this work:

- Planned care (tests, treatment and therapy for planned care appointments) – booked in advance
- Urgent care (minor injury, common illness and mental health issues) – accessed on the same day

A: Planned care (tests, treatment and therapy for planned care appointments)

101 Planned care refers to care or treatment that is scheduled in advance, most commonly for a long-term health condition or a problem which is not deemed to be urgent. This may be accessed directly by a patient or may follow a referral to a specialist service by a GP or other primary care practitioner or by another specialist team. Planned care tends to be preventative in nature and is focused on maintaining health and wellbeing as well as treating chronic injury or illness.

102 A range of these types of services is currently being piloted within the hospital (see appendix A). These services have been operating at the hospital since the inpatient space was refurbished in 2020-21 and have received positive feedback from patients overall.

Securing and extending the current service offer

103 The types of services required by the local population vary significantly based on age, socioeconomic factors and demographic characteristics. This could include therapy, specialist appointments or diagnostic services for example. Currently, the specialist outpatient service most needed by residents from the Wantage and Grove area is Ophthalmology (specialist eye appointments). This is the outpatient clinic that people attend most often. Between April 22 and April 23 an average of 299 patients per month used ophthalmology outpatient services from the Wantage and Grove area.

104 The mental health service within the Wantage & Grove area with the highest number of referrals between April 2021 and August 2022 was the Children and Adolescent Mental Health Services (CAMHS) Team followed by Adult Mental Health team. Outpatient appointments for both these services have been provided as part of the outpatient pilot within the community hospital.

105 Clinic-based planned care services are currently available at the below locations:

A. Wantage community hospital pilots

106 An initial review of these pilot services identified that, 1,445 patients came to an outpatient clinic as part of the pilot services being provided on the ground floor of Wantage Community Hospital between

November 2021-22. Most of these patients were seen by Ophthalmology and they mainly (57%) came from an OX12 postcode. On average 120 people per month come to Wantage Community Hospital to access the range of clinic-services currently provided.

B. Outpatients within John Radcliffe/Great Western hospitals

107 A wide range of clinic-services are available within acute hospitals, for most people in Wantage this would either be the John Radcliffe hospital in Oxford (23 miles from Wantage) or Great Western in Swindon (34 miles from Wantage).

C. Oxford city clinic bases

108 Clinics can also be accessed at the Churchill hospital site in Oxford (20 miles from Wantage) or at one of the other clinic bases within Oxford.

D. Other community hospitals

109 Most other community hospitals also have some clinic-based appointments providing community clinics with outreach from Oxford University Hospital specialists, community teams and mental health teams.

Engagement feedback on planned care (see appendix B for further details)

110 Residents are aware of many of these services currently offered at the Wantage Community Hospital, many of which are well used, such as podiatry and ophthalmology. People want these existing services to remain now that they have become accustomed to having them and are loath to lose them.

111 Ease of access that comes with a locally-based service is seen as the key benefit, especially when considering the alternative of having to travel to regional hospitals. The inconvenience involved in having to travel to the John Radcliffe in Oxford (especially) clearly weighs heavily on residents, and having appointments in Wantage is welcomed even by those able to travel further. Those who reported driving to the John Radcliffe cited frequent holdups on the A34, heavy traffic and the difficulty and high price of parking once there, and travel issues are significantly worse for people reliant on public transport. Outpatient clinics, especially those which might require frequent visits, mean that the inconvenience and cost pile up to an extent that would cause real stress to patients and carers alike.

112 It is worth noting that in workshop introductions, the frame was “hospital-like” services. Services like podiatry and physiotherapy may have felt to participants very much like hospital outpatient services and hence seen to provide a coherent and consistent service offer. The feeling is that what is offered at Wantage Community Hospital Community Hospital needs to be well defined, with clear demand and avoid replicating services covered elsewhere. Views were also more mixed on children’s and mental health services.

Options identified

113 If the decision were taken to focus on clinic-based services within the community hospital rather than inpatient beds, then there would be an opportunity to both confirm the current pilot services and look to increase the number of clinics available.

A vision for outpatient care at Wantage Community Hospital

114 There is considerable support in the stakeholder group to develop additional clinics within the community hospital to deliver more planned and preventative care locally and reduce the number of people who need to travel to acute hospital sites, such as the John Radcliffe.

115 There is potential to secure the existing outpatient and therapy clinics at the hospital and also to expand the space available for additional clinics and outpatient services. This potential has been confirmed by the ICB Place Team, the Community Hospital Estates Team and by the clinical and

operational leads at Oxford Health NHS Foundation Trust (OHFT) and Oxford University Hospitals NHS Foundation Trust (OUH). This approach of providing more clinics and outpatient services (planned care) out into local community sites and through greater service integration is a key objective of both OHFTs Community Strategy[10] and OUH Clinical Strategy[11].

116 This development of the hospital would enable additional clinic-based services to be provided to local residents. A number of new services have been proposed, based on three main sources:

A. The health needs data for the local population
B. Service data and operational information from the NHS providers
C. Experience from local residents and other local stakeholders through the engagement work

117 If this option were taken forward, examples of the types of services could include:

- Community gynaecology and menopause services
- Community Urology and men's health services
- Specialist planned and outpatient services
- Services supporting people with epilepsy and other neurological conditions
- Children's mental health services
- Art therapy services at the hospital, particular for people with long-term health issues and mental health conditions
- Facilities for digital health and multi-disciplinary team working

If this option were taken forward the lead partners (Wantage Town Council health subcommittee, BOB ICB and Oxford Health NHS Foundation Trust are committed to continue to work within the local community and with its provider NHS partners to identify which clinics can be provided.

Enabler considerations

Estates implications

118 As mentioned above, if the option to develop additional clinical space were to be taken forward, then NHS partners would be looking to access local CIL monies to fund the development of the new rooms. Consideration would also need to be given to improving transport and accessibility to the hospital for those using the additional outpatient services.

119 OHFT Estates have undertaken an indicative assessment of refurbishment of the ground floor space of Wantage Community Hospital not currently used for clinical activity, in order to convert it to general/flexible clinical space. This could realise up to approximately 12 additional clinical rooms, which could be used to support an expanded range of services available at the hospital (the exact number of additional clinical rooms would depend on service and clinical design requirements).

120 Redevelopment of the whole ground floor would involve removing the currently unused kitchen space to maximise clinic room provision and to improve waiting areas. There would also be an opportunity to consider the relocation of non-clinic-based services currently hosted within the hospital to maximise clinic space. Due to space restrictions, it is not possible to provide both the inpatient and outpatient options on the ground floor of the hospital.

Workforce implications

121 If this option is preferred, further work would be required to determine the workforce requirements for the type of clinic-based service to ensure viability.

[10] Community Services strategy - Oxford Health NHS Foundation Trust

[11] Our Clinical Strategy 2023-2028 (ouh.nhs.uk)

122 As existing NHS providers of clinic-based services at Wantage Community Hospital Oxford University Hospitals NHS Foundation Trust (OUH) and OHFT have committed to identify the services which could be sustainably staffed to provide expanded outpatient services should this be the preferred option. Consideration would need to be given to both the size, specialities and skill mixed needs of a service offer to ensure that these services remain sustainable. Other local NHS providers of clinic-based services would also be approached.

123 This option could be delivered through the reallocation of existing resources to focus on the provision of more community-based specialist services. This means that substantial additional funding would not be required to support these services; instead this could be delivered from within existing system resources.

Wider dependencies within the Wantage & Grove area

124 The following were identified as dependencies relating to the provision of clinic-based planned care services within the community hospital:

Role of the GP health centre

125 Some planned care services are currently provided at the health centre alongside GP services. Currently this includes District Nursing, Health visiting and community dentistry. As part of any considerations around services to be located within the community hospital, there is an opportunity to review the services within the health centre and also whether some of the services currently provided within the community hospital would better be provided from the health centre.

126 As part of this work it was also considered whether there is any opportunity to expand the number of services provided at the health centre, however, it has been advised that there is no additional capacity within the building to increase the number of clinics provided there. Consideration could be given to deliver services at alternative times outside of current health centre operating hours, subject to resource requirements and appropriate measures being able to be put in place.

Kingsgrove & Grove community hubs

127 Other local sites have also been considered as dependencies within this type of service provision. In particular, the development of additional community sites within the local area including community hubs at:

- Kingsgrove (due to be completed in Summer 2025)
- Grove (timeline still under development)

128 As part of any future discussions these options should be considered to identify any services which would better be located at sites other than the community hospital.

Summary & Recommendations

129 Since 2021, a pilot of outpatient clinics made up of a range of service types has been offered at the hospital. These services have been largely well received by the local community and were positively reported on as part of the engagement work. In particular, respondents highlighted the benefits of not having to travel to access regular appointments. The data shows that these types of services are the ones needed most frequently by the majority of patients. Should the decision be made to not reopen the inpatient beds there would be an opportunity to significantly increase the number of these clinics available within the hospital

130 In this eventuality, the NHS partners are committed to dedicate appropriate additional resource to co-produce the business case for expansion of the services offered from the hospital, complete the work to redevelop the hospital and to work with OUH specialty departments, NHS partners and other planned care providers to deliver these.

131 **In relation to planned care clinic-based services it is therefore recommended that:**

- **ICB, OHFT and OUHFT work to confirm the existing outpatient services currently being delivered in Wantage Community Hospital.**
- **ICB to work with providers (including OHFT, OUHFT and other service providers) to identify sustainable community clinic-based services from Wantage Community Hospital. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

B: Urgent care (minor injury, illness and mental health issues)

132 Alongside planned care services within a clinic, consideration has also been given to services which people need urgently. A range of these services have been reviewed as part of this project which include unplanned services including minor illnesses, injuries and mental health crisis.

The current service offer

133 There are many reasons why someone might need an appointment on the same day. As noted within the case for change, the local population is ageing, and there is an increased complexity of care needs. This means that it is important to consider the different types of urgent care needs that are required currently and in the future.

A. 111 service

134 The 111 service provides an initial assessment, and signposting to same-day healthcare services; this includes 'option 2' to seek mental health support on the same day.

B. Minor Injuries Units (MIUs)

135 MIUs are for injuries, such as deep cuts, eye injuries, broken bones, severe sprains, minor head injury, minor burns and scalds. There are currently two MIUs in Oxfordshire, one in Abingdon and one in Witney.

136 On average a resident of Oxfordshire visits an MIU once every 7 years. The most recent data available tell us that the Wantage & Grove population made 1361 visits to an MIU over one year, which equates to an average of 3.7 total visits from this area to an MIU a day. (164 visits a month to Abingdon MIU).

137 When considering forecast population growth and assuming similar demand patterns, the average number of visits from Wantage and Grove area could increase to 4.8 visits a day to an MIU (1745 visits per year).

C. Emergency Department (A&E)

138 If you have had an accident and contacted the 111 service, you would usually be recommended to go to a Minor Injuries Unit (MIU) or the Emergency Department (ED). From Wantage the majority of patients go to the John Radcliffe (23 miles from Wantage) or the Great Western in Swindon (34 miles from Wantage). Between 2017 and June 2023, 53% of patients attended an OUH site, 36% an Oxford Health MIU and nearly 5% the Great Western hospital site.

D. Ambulatory Assessment Unit or Emergency Multidisciplinary Unit (EMU)

139 Where an older person needs additional assessment which cannot be provided at home then they may be referred to an ambulatory care service. Within the community this would usually be to either Abingdon or Witney Emergency Multidisciplinary Unit (EMU) or the John Radcliffe Ambulatory Assessment Unit (AAU).

140 Between April 2021 and August 2022, the vast majority of patients from the Wantage area who required these services, were usually referred to Abingdon EMU (387 patients) or the John Radcliffe AAU (847 patients) rather than Witney EMU (only 18 patients).

E. GP same day appointment

141 In addition, people can also contact their GP to access a same day appointment. This is a key part of the same day care offer for minor illnesses. Across the two Wantage and Grove GP practices an average of around 800 same day appointments are offered each week.

F. GP Out of hours

142 Outside of GP practice hours, patient support is provided by the out-of-hours GP service. Where a patient needs to be seen they can either attend an out-of-hours base or can be seen at home. Where a patient from the Wantage and Grove area requires a base visit they nearly always go to Abingdon. On average over the period of April 2019 – March 22, this equated to 83 patients per month. In addition, when a patient needed to be seen at home there were, on average a further 35 home visits per month by the out of hours GP team over the same period.

G. Mental health crisis support hubs

143 Mental health access on the same day is through the 24/7 Mental Health Helpline (via 111) or through referral to a crisis support hub.

Engagement feedback on urgent care (see appendix B for further details)

144 Suddenly being presented with the need to seek urgent treatment can be stressful and people reported sometimes being at a loss around the most appropriate first port of call. This was reflected both in responses in the focus groups and the multiple options quoted in the wider survey when people are asked where they would turn in such circumstances.

145 With the A&E department at the John Radcliffe hospital seeming so far away and feeling quite inaccessible, people feel that only the most serious injuries merit seeking help there. Although some cited Abingdon as an alternative, getting there can also pose a challenge.

146 When asked specifically how urgent care can be made more accessible, the clear response is the provision of a minor injuries unit (MIU) as well as clearer information around the options available to deal with these cases. Many residents were keen to see such a unit provided locally and see Wantage Community Hospital Community Hospital an ideal site. Some remember fondly a similar service provided locally and would like to see it return.

147 Jargon is an issue here. It is important to note that due to the large number of clinical terms used to refer to urgent care services, there may be some confusion among members of the public about which services would meet a specific need. An MIU for example, has a specific meaning within healthcare management, but may be used by a non-specialist to cover a broader range of services.

Options identified

148 There are a range of types of same day care which could be provided within the community hospital which have been considered within this project:

Whole population services

149 There are a range of similar urgent care services open to the whole population, of these three have been identified which could be provided at Wantage community hospital:

A. Nurse/AHP led first aid service

Like a MIU but with narrower criteria, run by a team of highly qualified nurse practitioners with a lot of experience and expertise in the treatment of minor injuries. Does not have access to x-ray facilities https://www.oxfordhealth.nhs.uk/service_description/minor-injuries-units/

B. Nurse/AHP led minor injuries unit with x-ray on site
See above, an urgent service for those who have had an accident but do not need to go to an emergency department (A&E).

C. GP led urgent treatment centre with x-ray on site
Urgent treatment centres provide medical help when it's not a life-threatening emergency. They can diagnose and deal with many of the common problems people go to A&E for. Unlike MIUs they are overseen by GPs.

Specialist urgent care response for those with long term conditions

150 Based on public feedback and stakeholder discussions, one urgent care service that has been proposed for development at the hospital is an urgent care service for people experiencing a worsening of their long-term health condition(s) that requires a prompt review by a multi-professional expert team, avoiding the need for an acute hospital attendance or outpatient referral.

151 This service would focus on providing a rapid response to local residents with complex health needs, including people who live with multiple long-term health conditions (LTCs) and older people with frailty. It would provide rapid access to nurse- and therapist-led assessments, therapies and treatment interventions at the hospital for people identified by a suitable healthcare professional as needing same-day/next-day care to manage a flare up of a known long-term health condition, in order to prevent this from further deteriorating.

152 The service would integrate closely with the planned care Integrated Neighbourhood Team being developed in Wantage between the GP practices (Primary Care Network) and the community services (District and Community Specialist Nursing teams). It would also link closely with the relevant consultant-led specialist services, such as the diabetes, cardiology/heart failure, respiratory, geriatric medicine and neurology teams in secondary care.

Enabler considerations

Estates implications

153 If it were decided to develop a same day offer at the hospital this would align with the redevelopment of the ground floor as clinic spaces. This could be offered alongside planned care clinic spaces. The capital considerations to do this are therefore as above to develop clinic space.

154 If the decision were taken to install x-ray services at the hospital, this would have significant additional costs made up of a one-off capital investment for the estates works as well as equipment and ongoing maintenance costs. However, consideration will be given moving forward to the diagnostic options that could be included within any future provision.

Workforce implications

155 There are significant workforce pressures associated with the specialists needed to run urgent-care services so consideration would need to be given to the impact this would have on other local services and challenges associated with recruitment. In particular, were a GP led unit to be developed this **c**ould impact on the local GP services recruitment. Radiographers are also very hard to recruit so if an x-ray service were to be developed consideration would need to be given to the impact this might have on other local services and the sustainability of the service offer.

156 In contrast, the multi-disciplinary team needed to provide specialist urgent care could be brought together through improved co-location and collaboration between existing teams. This would therefore be a more sustainable offer.

Wider dependencies within the Wantage & Grove area

157 The following were identified as dependencies relating to the provision of same day care services with the community hospital:

Walk in minor injuries at the health centre

158 Alignment with services at the health centre is important as highlighted within the enablers around managing workforce pressures. Consideration has been given to whether urgent care could be provided within the health centre in line with the expanded GP offer, however as highlighted earlier there is very limited space at the health centre and concerns have been expressed around how this would be staffed so any proposal would need to address these issues.

Alignment with the Primary Care Network (PCN) frailty service

159 Work is currently in progress to develop same day services to patients with long-term conditions and frailty, who may have more complex health needs. The integrated neighbourhood teams within the GP practices to support patients with identified long-term conditions. Clinicians from the PCN have been involved throughout the discussions to date and are supportive of working alongside this project to support development of preventative care within the local area.

Summary & Recommendations

160 There are a range of urgent care services currently available to residents of Wantage including an MIU in Abingdon and A&E departments in Oxford and Swindon. The type of service required for this type of care and the frequency with which it is needed is much more varied. Within the engagement work, local access to these services was identified as a priority by many respondents, although not all felt this needed to be within Wantage, particularly if it conflicted with the planned care services that could be provided from the WCH site. The most popular services identified were those with an x-ray service, either an MIU or a UTC. However the cost and challenges associated with staffing this are significant. Therefore, although this option was preferred by many, it is not considered to be affordable or sustainable within the current service model.

161 The other area within urgent care which was identified relates to the complexity of patient needs which is increasing alongside the ageing population. Looking to the future, it is important that services address this challenge. In this regard, we will develop clinics to bring together a range of specialist clinicians to provide urgent care for those with identified conditions who are experiencing a health crisis. These clinics would help avoid unnecessary hospital attendances and admissions and ensure that they are given a holistic care offer. These clinics could be provided within the same space as outpatient clinics. It is therefore recommended that we include specialist same day care within the development of a business case for clinic-based services in Wantage.

162 **In relation to clinic based urgent care services it is therefore recommended that:**

- **Due to the high capital cost of providing a large x-ray within the hospital against the significant demands and constraints of the limited available capital funding in the system alongside the concerns over the workforce implications, it is not recommended to take forward a walk-in service at the community hospital at this time. However, consideration should be given to what diagnostic services could be included as part of the same day services and this should be kept under consideration in the future.**

- **Based on the noted increased complexity of needs within the local population, it is recommended to focus on developing a specialist local response service for those with long term conditions. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

Summary of project outcomes and next steps

163 To summarise the above, the following recommendations are made on the basis of this report:

164 **In relation to inpatient beds and the alternatives:**

- **Based on co-production and considering evidence and findings from engagement we recommend the community inpatient beds at Wantage Community Hospital are permanently closed.**
- **In line with wider work the BOB ICB is taking forward work to improve the local end of life care pathway, to see how we can strengthen the local offer for patients requiring palliative care.**

165 **In relation to planned care services:**

- **ICB, OHFT and OUHFT work to confirm the outpatient services currently being delivered in Wantage Community Hospital.**
- **ICB to work with providers (including OHFT, OUHFT and other service providers) to identify sustainable community clinic-based services from Wantage Community Hospital. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

166 **In relation to urgent care:**

- **Due to the high capital cost of providing a large x-ray within the hospital against the significant demands and constraints of the limited available capital funding in the system alongside the concerns over the workforce implications, it is not recommended to take forward a walk-in service at the community hospital at this time. However, consideration should be given to what diagnostic services could be included as part of the same day services and this should be kept under consideration in the future.**
- **Based on the noted increased complexity of needs within the local population, it is recommended to focus on developing a specialist local response service for those with long term conditions. There is a commitment if this option is chosen to work in a co-productive way to develop the services to be provided at the hospital.**

167 Therefore on the basis of the work done to date through the co-production with local stakeholders and the feedback from the local community as reflected above, it is recommended that the closure of the community inpatient beds is made permanent.

168 If the above is confirmed, then our preferred option for the ground floor is to continue to work collaboratively with local stakeholders to:

- NHS partners to work with local community to progress with an application in 2024 to The Vale District Council Community Infrastructure Levy (CIL) fund to provide necessary capital to support a sustainable range of outpatient and community clinics to be delivered from the ground floor of the community hospital building.
- Continue to work with the countywide end of life project and with local care homes to strengthen the local palliative and end of life care offer.

- Agree to further develop and confirm a range of outpatient services and community clinics through a detailed proposal of which services, operating hours, estimated activity will be delivered from within the community hospital.
- Develop urgent care offer including consideration or diagnostics for those with long term conditions and work with GP practice to support local urgent care for the wider population.

Proposed Future Project Delivery Plan

169 If the recommendations described in this co-produced report are endorsed and accepted following consideration through the governance framework of BOB ICB, OHFT, Wantage Town Council Health Sub-committee and Oxfordshire's HOSC, then the following proposed project delivery plan would realise the ambitions described in the report and secure a sustainable future for Wantage Community Hospital.

170 OHFT Estates and Facilities are a dedicated specialist team that manage and operate the estates infrastructure for the Trust across its entire operating footprint that encompasses Oxfordshire as well as Buckinghamshire, Bath, Swindon and Wiltshire. The specialist team have been engaged throughout the co-production process and have provided advice and guidance to help inform the final options and recommendations in this report. The team have a track record of delivering significant estate refurbishment and reconfiguration works working closely with services, community partners and other key stakeholders. If the report recommendations are agreed, the Estates Team would directly support delivery of the refurbishment works at Wantage Community Hospital by assisting with architectural design through to required NHS building design specification to meet such things as infection prevention and control through to informing procurement of contractors and fit out stage to works completion. Alongside, OHFTs Transformation Team would provide the required project support and co-ordination with the sub-group formed from the stakeholder reference group (the sub-group) and the other NHS provider partners.

Date	Action
Jan 24	Wantage Community Hospital report recommendations agreed.
Jan-Feb 24	Notification to Vale District Council by NHS partners to apply for £600k CIL funding for Wantage Community Hospital and provisional allocation confirmed.
Feb 24	Small proportion of provisional CIL funding allocation confirmed to enable appointment of Project Team to work alongside OHFT Estates and Sub-Group
Feb 24	Long Term Condition (LTC) and frailty Wantage pilot commences through Integrated Neighbourhood Teams (INTs) Oxfordshire Improvement Programme and Oxfordshire's Primary Care Strategy
March 24	Project Team commence
March-May 24	Project Team alongside sub-group work with NHS providers including OH, OUH, local PCN, MSK and GP feds to confirm which clinics/therapy/assessment type services for the ground floor. Estates design and costings finalised. Art therapy plan confirmed. Re-establish activities through Wantage Community Hospital League of Friends
Jun 24	Business Case and full CIL application submitted to Vale District Council.
Jul/Aug 24	CIL decision confirmed (estimated awaiting Vale confirmation of likely decision timeline)
Sept-Oct 24	Procurement of contractors for refurbishment and fit out.
Nov 24	Estates improvement works commence and any temporary relocation of services whilst works takes place put in place
Jan/Feb 25	Works complete. CIL project work concludes.

Feb -June 25	Service configurations confirmed and transfers take place.
Summer 25	Wantage Community Hospital service portfolio is managed through usual NHS system mechanisms.

Appendices

Appendix A: List of outpatient services

The following outpatient services are currently being piloted within the community hospital:

- Ophthalmology, including intravitreal (eye) injections
- Audiology & Ear, Nose & Throat (ENT)
- Mental health services (Adult mental health, psychological therapies Oxfordshire Talking Therapies, neuro-developmental)
- Learning disabilities care
- Diabetes screening
- Health visiting clinics including group sessions
- GP clinics
- Expansion of MSK/physiotherapy by Connect Health
- Health Share providing ultrasound clinics

In addition, the following services have been established at the hospital for a longer period of time (with a temporary suspension during the early part of the COVID-19 pandemic):

- Podiatry
- Adult & children's speech and language therapy
- Children's Integrated Therapy Services (e.g. speech and language, occupational therapy, SEND)
- MSK/Physiotherapy
- Maternity Unit (upstairs)
- School Nursing Team (not clinic-based)

Appendix B: Full engagement report

See attached document

Appendix C: HOSC history of wantage community hospital

https://mycouncil.oxfordshire.gov.uk/documents/s66454/Annex%201%20-%20Wantage%20Community%20Hospital%20Timeline.pdf

Appendix D: Map of community hospital inpatient locations

Appendix E: Statements of support from Partner organisations

Oxford University Hospitals NHS Foundation Trust statement of support:

See attached document

Oxfordshire County Council statement of support:

This approach aligns with and is supported by Oxfordshire County Council whose strategic vision is to support people to live happy, healthy lives here in Oxfordshire achieving this by supporting people to live well and independently within their communities, remaining fit and healthy for as long as possible which they refer to as the Oxfordshire Way. It is important that we work together as system partners to achieve better outcomes for the residents of Oxfordshire.

Karen Fuller (Corporate Director Adult social care)

Partner statements of support:

Further statements of support to follow week commencing 8th January

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REPORT

Wantage Community Hospital Public and Stakeholder Engagement

Author: Clive Caseley and Sue Clegg
Date: 01 December 2023

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MyOfficeClub
67-71 Lewisham
High Street
London SE13 5JX

REG VAT GB 858230025
Registered in England Company
Number 05358457
Registered office:
24 Old Bond Street, London W1S 4AP

+44 207 017 2011

hello@vervecommunications.co.uk
www.vervecommunications.co.uk

1. EXECUTIVE SUMMARY

1.1 OVERVIEW

This report collates and presents an analysis of residents' views heard during public engagement on community healthcare services in the Wantage and Grove area. It has been independently written by Verve Communications, and our team facilitated a series of events during the engagement period to complement a survey conducted by the NHS team which was open from 11 October to 06 November 2023.

Our brief for the project was to explore the types of services residents would like to be provided locally, including those services which might be provide from Wantage Community Hospital. In analysing both the survey, meeting notes and other feedback, we were asked to focus on three specific alternatives (referred to throughout this report as "scenarios"):

1. Clinic based services (tests, treatment and therapy) for planned care appointments
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.

1.2 FACTORS DRIVING PREFERENCES

- Travel and convenience. The major benefit of outpatient services provided locally is accessibility and convenience, and this is the same for local provision of a Minor Injuries Unit (MIU) for Wantage residents. Having to travel to and find parking at the John Radcliffe in Oxford or to the MIU at Abingdon is seen as a major inconvenience, especially when these journeys need to be made frequently or when already in some distress. This is compounded for those without cars.

- Filling a genuine gap. Residents took a generally pragmatic approach in prioritising the services they wanted to see. While it would be nice to have everything locally, people do realise that this is not possible and only want to see services made local that fill a genuine need or at least optimise added value (as with eliminating travel time above).

- Familiarity and stability. Those who are aware of and have used some of the existing piloted outpatient clinics at the hospital are reluctant to see them removed. In the focus groups every individual cited these outpatient services as something they felt it was important to be offered locally with many also feeling that the Wantage Community Hospital was the best site from which to provide these services.

- Services that people need regularly. The feeling was that clinic service provision should prioritise the kinds of tests and clinics that require people to go on a regular basis, rather than focus on services that someone might need on, say an annual basis. This makes sense on an individual level - however not everyone will need the same services at the same frequency.

- Whatever is provided, it must be done well. Not unreasonably, residents seek reassurance that any services that are provided will be adequately resourced and fully functional. Thus, they qualify preferences with questions such as whether a Minor Injuries Unit (MIU) would be equipped with an X-ray machine and whether it will be open outside 'office hours', or whether the capacity for nursing support will be available at any inpatient facility.

1.3 WHAT IS IMPORTANT TO PEOPLE?

Within Scenario 1 (Clinic Based Services and Planned Care Appointments), the retention and expansion of outpatient services currently being piloted at the Wantage Community Hospital are strongly supported. Those who are aware that these services are currently being provided are loath to see them disappear, especially if they or someone they know has used them.

If not provided at Wantage Community Hospital, then the clear feeling is that these services should be retained locally. Thus, there will be a cohort of the local population who will feel that they have lost something if this is not part of what is offered either at best at the hospital or at worst elsewhere locally.

Within Scenario 2 (Community In-patient Beds and Alternatives), calls for some form of rehabilitation bed provision strongest. Here too, if this is not provided at the hospital it is acceptable that it is at least provided locally. Although not a statistically valid exercise, the data suggests that overall inpatient beds are seen as less of a priority than other services.

Servies within Scenario 2 delivered at home seem to be less of a priority, although they are clearly seen as eliminating the inconvenience of travelling to visit patients at regional hospitals and supporting carers. Views from those with experience of these services were mixed – some had a positive experience, while others were less positive, citing the level of support available and examples of poor communication, and rushed provision.

Within Scenario 3 (Urgent care), the strongest call was for a minor injuries unit (MIU) which people feel would be a valuable addition to the healthcare services provided locally, and for which Wantage Community Hospital would be an ideal location. This is the only service within Scenario 3 that gets much traction, with others felt to be well covered already elsewhere.

It was felt important by some that, if provided, this must provide a comprehensive urgent care offer e.g. X-ray with capacity for reasonable opening hours.

1.4 NEXT STEPS

We understand that this engagement was undertaken at one point in time in a longer-term process. From everything we heard during the project, some strategic next steps suggest themselves, and we set out some high-level questions for next steps relating to these:

- How to focus dialogue about needs and services from the 'place' perspective
  Wantage Community Hospital – and its history – represents more than a 'bricks and mortar' health facility. The pride, sense of ownership, and local identity are palpable, and could play a hugely valuable role in making community healthcare services in Wantage and Grove successful - and a real asset for this growing community in future.

- How to manage expectations around choices and trade-offs
  Whatever decisions are reached, it will be important for both the Stakeholder Reference Group (SRG) and the NHS to avoid giving the impression there are "winners and losers".

- What might future co-design look like?
  The involvement and commitment across agencies and institutions within (and beyond) the public sector stands out. Under the auspices of the SRG, a robust, inclusive process has been developed - arguably ahead of the curve in the design and commissioning of healthcare in partnership with communities.

2. BACKGROUND AND INTRODUCTION

2.1 CONTEXT

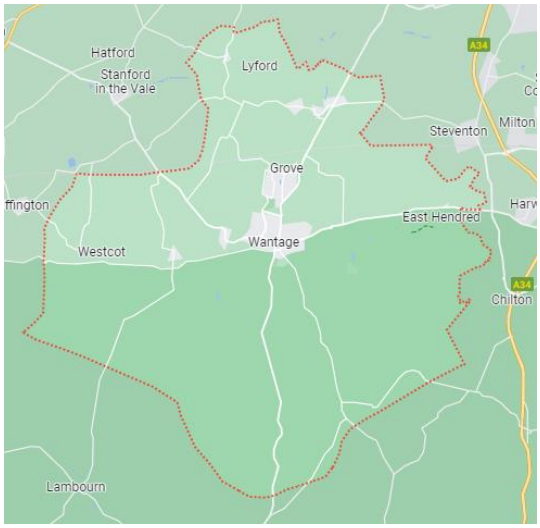
2.1.1 ABOUT WANTAGE AND GROVE

Wantage is a market town in Oxfordshire with just over 33,000 residents registered with local general practices. It has a population which is ageing and growing, largely within the Grove area. The total local population is forecast to grow to around 41,000 by 2030, and the proportion over 65 years increased in both the Wantage and Grove areas between 2011 and 2021.

As a result, the health needs of the local population are also changing, with both younger and older people living with more complex needs.

The area is within the local authority areas of Wantage Town Council, Vale of White Horse District Council and Oxfordshire County Council, and health services are within the purview of both the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) and the local Wantage Health Sub-committee of the Town Council.

The NHS commissioning body responsible for the population, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), was formally established as a new statutory body on 1 July 2022, replacing the three former clinical commissioning groups. BOB ICB is the commissioner of community healthcare and NHS services provided at Wantage Community Hospital.



OX12 boundary *Source: Fact*

2.1.2 ABOUT WANTAGE COMMUNITY HOSPITAL

Oxford Health NHS Foundation Trust provides physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset.

The Trust is the NHS provider of community healthcare services for the population of Wantage and Grove and manages the services provided by several providers (including the Trust) in Wantage Community Hospital.

Until 2016, Wantage Community Hospital provided inpatient beds, maternity care and a range of other NHS services from a single site over two floors. Due to Legionella risk, inpatient services were closed temporarily and, although remedial works to address this were completed in 2020, inpatient beds have remained temporarily closed.

Since 2020-21, the hospital could be re-opened fully, and is currently used to provide:

- On the ground floor - a range of services (clinical assessment, tests, treatment, therapy, follow ups) for the local community. A trial of a number of different specialist outpatient clinics have been running downstairs for the last 18 months, alongside these services.
- On the first floor – maternity services.

2.1.3 ENGAGEMENT ABOUT COMMUNITY HEALTHCARE SERVICES FOR WANTAGE AND GROVE

The community hospital inpatient ward has now been temporarily closed for almost eight years, and a partnership project has been established to consider the right mix of services for the future - with a focus on "hospital-like" services at Wantage Community Hospital in the context of local needs and other community health services available.

A co-design process has been developed by the NHS with the Oxfordshire JHOSC and the Town Council Health Sub-committee with a commitment shared across the partnership to work together, which was agreed at an extraordinary JHOSC meeting on 11 May 2023.

A Stakeholder Reference Group (SRG) has been appointed to shape this work (see Appendix 2 for membership of the SRG) and, from among its members, a smaller Sub-Group leads on engagement and has commissioned this exercise which reports to the SRG in the first instance.

The local community were previously asked for views about Wantage Community Hospital in what was called the "OX12 Project" between 2017 and 2019. However, this concluded without a decision and we heard prompted widespread community dissatisfaction. In addition, there have been stakeholder workshops over the course of 2023.

2.1.4 ABOUT THIS ENGAGEMENT EXERCISE

The starting points for this engagement exercise were:

- A shared commitment among NHS organisations and partners to retaining services in Wantage Community Hospital that are sustainable and best meet the needs of the local community (confirmed by the BOB ICB Place Director for Oxfordshire on 11 May 2023)
- No changes proposed to the current maternity services which are located upstairs in the hospital – and consideration of these is out of scope for this engagement.
- For use of the ground floor, a recognition that there is an opportunity to consider the service mix at an early stage and before proposals are finalised.

The SRG Sub-Group has developed three scenarios for services for consideration developed through a process of co-design informed by previous engagement and with input from residents, clinicians and NHS managers, and the SRG now seeks broader views from local people to help shape final proposals.

The central frame of reference for the project was therefore these three scenarios to explore the types of services to be provided from the hospital:

1. Clinic based services (tests, treatment and therapy) for planned care appointments
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.

Through the co-design process, it was also identified that there may be needs for other types of healthcare provision locally to complement effective healthcare pathways, and the SRG also seek to understand residents' views on these links and co-dependencies.

2.2 OBJECTIVES

2.2.1 THE OBJECTIVE OF THE SRG

The stated objective pursued by the SRG is to provide sustainable "hospital-like" services from Wantage Community Hospital for the longer term to meet the needs of the local population now and in the future that maximises use of the available space. This is articulated in discussion by the Oxfordshire JHOSC (11 May) in the question:

> *How can we use space in Wantage Community Hospital to benefit the health and wellbeing of the local community?*

Within this, the objectives for community involvement set out in the specification for this project are to ensure that public, patients, and stakeholders have an opportunity to:

A. Receive clear and accessible information about the options for future delivery of services at Wantage Community Hospital (and potentially other local health sites in Wantage)
B. Provide input to the development of local plans for the hospital, through a process of meaningful community co-production.
C. Demonstrate their support for these plans, once developed.

This engagement exercise therefore helps to meet objectives A and B.

2.2.2 THE BRIEF FOR THIS ENGAGEMENT

The brief for this work was therefore set out:
The Wantage Community hospital engagement programme will use a blend of face-to-face and online approaches to gather as representative as possible suggestions and feedback from a wide range of participants. This will inform current and future decision making.

By providing a range of opportunities through an array of channels we will seek to make it as easy as possible for people to have their say and shape the future of health services based in the Wantage and Grove area.

Focus groups and deliberative events were selected because they are a particularly good approach where:

- Plans are at an early stage and the user perspective can influence thinking significantly.
- There are co-dependencies or trade-offs to consider.
- Complex choices require rich, well-informed discussion.

The objectives for this engagement are therefore:

- To provide scope and focus which will support the SRG and partners in the next stage of co-design.
- To explore views on the three scenarios and over-arching comments through a structured process.
- Identify themes which inform decisions moving forward, avoiding repeating earlier research and engagement.

2.3 ABOUT VERVE COMMUNICATIONS

Verve Communications was commissioned to conduct the engagement exercise and produce this independent report to inform the co-design process. We use social research methodologies to support transformation and change in health services, including with patients at the early stage of developing a vision for clinical pathways and new models of care.

We bring experience supporting NHS clinical programmes, service reconfigurations, mergers/acquisitions and spinouts, and workforce engagement, as part of which we specialise in independently conducting engagement and evaluation of consultation.

We are a values-led company, and our focus is involving patients, service users and communities in developing vision and plans for their care.

Our role in this project was to work with the SRG Sub-Group to develop and conduct the engagement exercise using a range of methods and to produce this independent report summarising the views of participants and making relevant recommendations.

We would like to put on record our grateful thanks to the Sub-Group and NHS staff for their patience and all their support during the project.

3. METHODOLOGY

3.1 OVERVIEW OF ENGAGEMENT ACTIVITIES

The engagement ran from 11 October to 06 November 2023. In conducting this engagement, a range of opportunities was provided for people to participate:

- Public workshops
  Two workshops were held in person at The Beacon Centre in Wantage. These were open to all - however participants were invited to register using the Eventbrite platform.

  The events were independently facilitated by Verve with a structured agenda which is described in this section.

- Focus groups
  An invitation event was held for patients or carers of people with long-term health conditions, held in person at The Beacon Centre, independently facilitated by Verve.

  Two online focus groups were also scheduled, with the aim of engaging people with an interest in community health services for families, and to provide an additional opportunity for those who are not confident with technology or were unable to attend one of the in-person events.

  Although a significant number of people signed up for the online events, across both events only a small minority turned on their camera and actively participated. This was obviously disappointing – however, facilitators noted all comments made by those who contributed, and their views are incorporated into this report.

- Community engagement
  Members of the SRG Sub-Group and NHS staff engaged actively with local people to provide information about the engagement, encourage completion of the questionnaire and to collect information.

  For example, the team went out and about in the Market Square, Wantage on Saturday 28 October and held a drop-in session at the Beacon Centre to answer questions and promote the questionnaire. The notes of comments and questions raised during this activity, as well as any relevant correspondence received, were also included in this analysis.

- Online and printed copy questionnaires
  The questionnaire was hosted on the ICB's Your Voice engagement portal and open throughout the engagement period.

  Printed copies returned during the engagement period were added to the online response to enable analysis of a single quantitative data set.

  The client team undertook quantitative analysis, producing tables and coding free text comments. As described in the approach to analysis section, the code frame was designed in collaboration with the Verve team, to enable comments from workshops, focus groups and questionnaire to be considered in this single integrated report.

3.2 GATHERING DATA

3.2.1 ABOUT THE QUALITATIVE APPROACH

This engagement used qualitative methods to ensure that people's views and experiences could be explored in detail.

As feedback was received through a variety of channels, we have aimed in this report to ensure that comments gathered are analysed to provide insight which will inform commissioning decisions as fully as possible:

- Feedback from all channels integrated into a single set of conclusions.
- Analysis of comments reported thematically, with the aim of understanding the reasons behind participants' views and priorities.
- Although this is a qualitative exercise, we will aim to comment on commonly emerging themes and/or where high levels of agreement are suggested by the data.

The aim of qualitative research is to define and describe the range of comments and emerging issues and to explore linkages, rather than to measure their extent. The use of qualitative methods means that this report is not based on collecting, or reporting, on the numbers of people holding particular views or experiences.

Please note that caution should be exercised in considering majority opinions suggested by the data:

- The research received views from a relatively small number of respondents in comparison with the population of Wantage and Grove; they were not selected randomly to participate; nor do they comprise a representative sample of residents.
- For these reasons we cannot assume that the proportion of people holding any particular views reflect those of the population at large.
- While we asked questions to explore preferences, it was made clear to participants that primarily the aim was to understand their priorities and inform complex decisions about future services – and it was emphasised that this did not represent a referendum or "voting" for any specific service.

3.2.2 RESEARCH CO-DESIGN

The public workshops and focus groups were designed to enable a single integrated report, and the discussion guide was developed using the same themes as the questionnaire with prompts designed to explore these questions in more depth. While we would expect the response to differ between cohorts of patients or different groups within the community, we are aiming to collect views around a consistent set of topics.

The central principle of co-design was incorporated into the methodology. The purpose of this engagement is to support the SRG and NHS clinicians and managers to make decisions about services for the future. It was designed to:

- Enable the SRG to take stock, having developed some over-arching service models.
- Hear the views of patients and public at this key stage in the process.
- Ensure that views are independently analysed to inform next steps.
- Produce a report to support and build on the co-design process.

The engagement was therefore shaped to explore views about the models ("scenarios") developed on behalf of the SRG, and this was the key focus for the process. We were seeking insights which, over the coming months and years, will inform:

- Thinking about current services and needs and local priorities for future services
- Understanding about how services are, or should be, integrated and joined up into a single local system.
- Focus on local health and care.
- Commissioning decisions about the future of Wantage Community Hospital and (potentially) other community health services.

While qualitative research allows deeper exploration of people's experiences and allows them to tell their stories in their own way, the addition of a questionnaire also enables the measurement of variables and comparison of data from different types of respondents – where justified in the data.

As ever, our aim is to create a clear, positive report focused on supporting effective decisions and implementation. This means:

- Seeking to understand not only the views people hold, but also the rationale and drivers behind views.
- Exploring priorities and indicating the most common theme and indicating likely majority views where these are suggested in the data.
- Picking up all substantive points made across the engagement, to enable a comprehensive and inclusive report.
- Covering the key elements of the scenarios, while also leaving open the opportunity for people to add relevant information, for example suggested alternatives.

3.2.3 FACILITATION

The workshop and focus group sessions were structured and facilitated by the Verve team of experienced engagement and research professionals, who used their notes and recordings to synthesise the material thematically under a set of headers relating to the scenarios under consideration; anything which was discussed which fell outside of the main themes was noted.

We created discussion guides (see Appendix 4) for facilitators to shape, stimulate and facilitate workshop and focus group discussions, as well as a simplified version for use during community outreach. We are grateful for the opportunity to attend meetings of the SRG Sub-Group as the three engagement scenarios were fleshed out which were especially helpful in preparing prompts for the discussions.

At the outset of each face-to-face session, facilitators sought permission to record the discussion to support accurate notetaking, and all sessions were conducted under Chatham House Rules (i.e. verbatim comments were not attributed to any individual).

At the end of the fieldwork debriefing discussions took place where all those involved in the fieldwork explored the main themes arising. The findings were then analysed, looking for major themes and identifying similarities and differences, where these exist.

3.2.4 PRIORITY-SETTING EXERCISE

To focus attention on people's priorities within the qualitative consultations, participants were asked to select the eight services across all three scenarios that they would like to see provided locally, though not necessarily at Wantage Community Hospital.

Respondents were given eight coloured stickers to distribute between the 20 service options set out in the questionnaire. These could be allocated singly to services, or multiple stickers could be allocated to higher priorities.

This was conducted as an individual exercise rather than a collective discussion, which was different from the rest of the workshop discussions and intended to provide a clearer steer on preferences with equal influence for each participant's opinions.

It is important to be clear, and it was explained to participants, that the exercise was neither in any sense a 'vote' or conducted on a large or representative enough scale to be statistically reliable. Nevertheless, with this proviso, a picture emerges of participants' priorities when responses are aggregated.

Once this first exercise was complete, respondents were given three further (differently coloured) stickers and asked to prioritise – again across all three scenarios – the three services they felt it was most desirable to be provided at Wantage Community Hospital.

3.2.5 RECRUITMENT

The engagement was publicised by the NHS team and a leaflet was distributed with QR code and URL link to the questionnaire as well as promoting participation at the events (see Appendix 3). Participants were invited to register in advance using Eventbrite. The promotional activity has been summarised and reported separately to the SRG Sub-Group (07 November 2023).

We are also grateful to the SRG Sub-Group for distributing material through their networks and via community locations.

4. SUMMARY OF PARTICIPATION

4.1 EVENTS AND SURVEY

	Participation
Public Workshop 1 11 October – 12.00 – 2.00pm	8
Public Workshop 2 17 October – 12.00 – 2.00pm	9
Focus Group 1 - People living with long term/chronic health conditions (in person) 11 October - 2.30 - 4.30pm	7
Focus Group 2 – Services for families and people aged 18-40 years (online) 19 October – 7.00-8.00pm	1
Outreach – Drop-in at the Beacon Centre and Market Square, Wantage 28 October	Approximately 30 people attended the drop-in session 5 comments gathered in 1:1 conversations
Questionnaire survey	285

4.1.1 ATTENDANCE AT EVENTS

Overall, the events relied on individuals coming forward voluntarily and they participants were heavily skewed to an older demographic, with well over half of respondents over 60. Women also make up a clear majority, representing around three quarters of the total sample. The same pattern was also evident in the survey response.

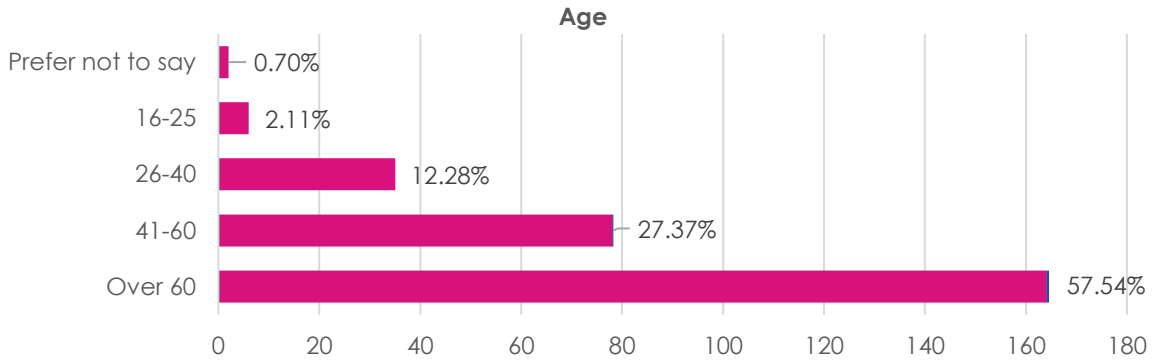
People serving as representatives or advocates for patient groups were well represented in the face-to-face focus group discussions. Nonetheless, residents' stated preferences and priorities in the focus groups are largely consistent with those that emerge from the wider survey exercise, suggesting a robust perspective has been gathered from the overall research study.

During the online sessions (in particular) it was clear that most of those on the calls were not from the Wantage area, but working with the client team we are confident that the contributions of the small number of local participants were recorded and kept separate and that views of non-participants were not taken into account.

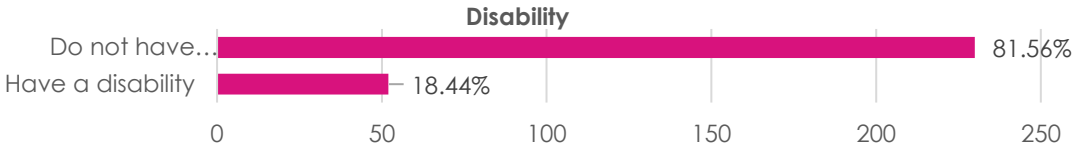
4.2 QUESTIONNAIRE

The questionnaire included demographic monitoring questions, and the profile of those responding was as follows.

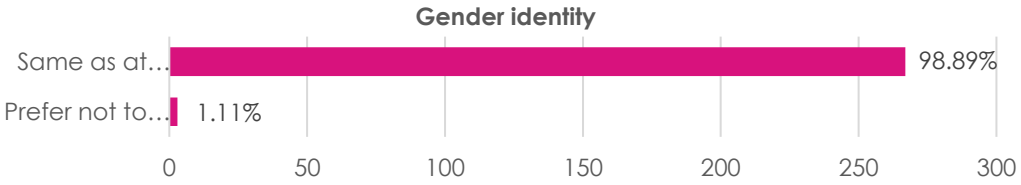
As accessibility and hence reach to individuals and groups experiencing health and other inequalities is an important element of this work, the background of those completing the survey is helpful to understand the perspectives and views we heard:



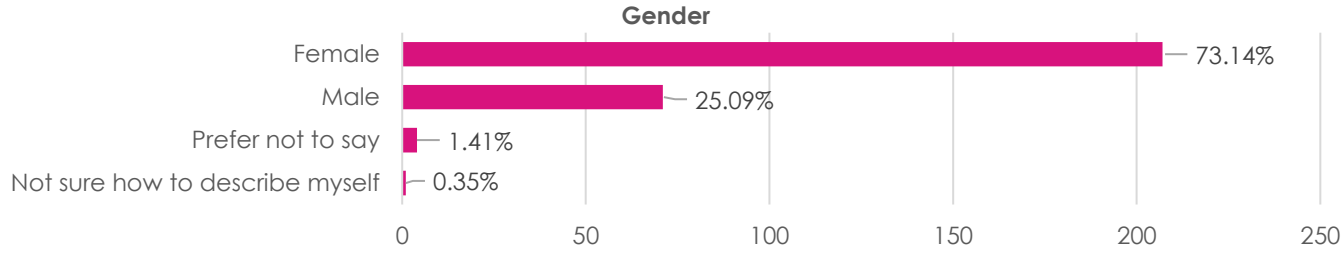
Base: All who responded = 283



Base: All who expressed a view = 282



Base: All who completed question



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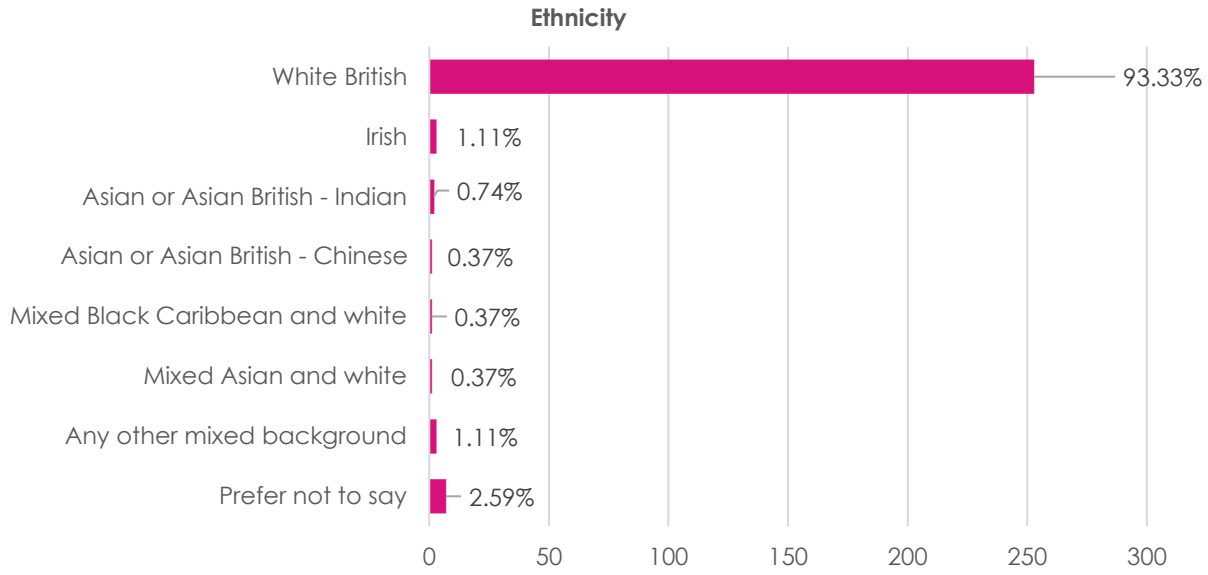
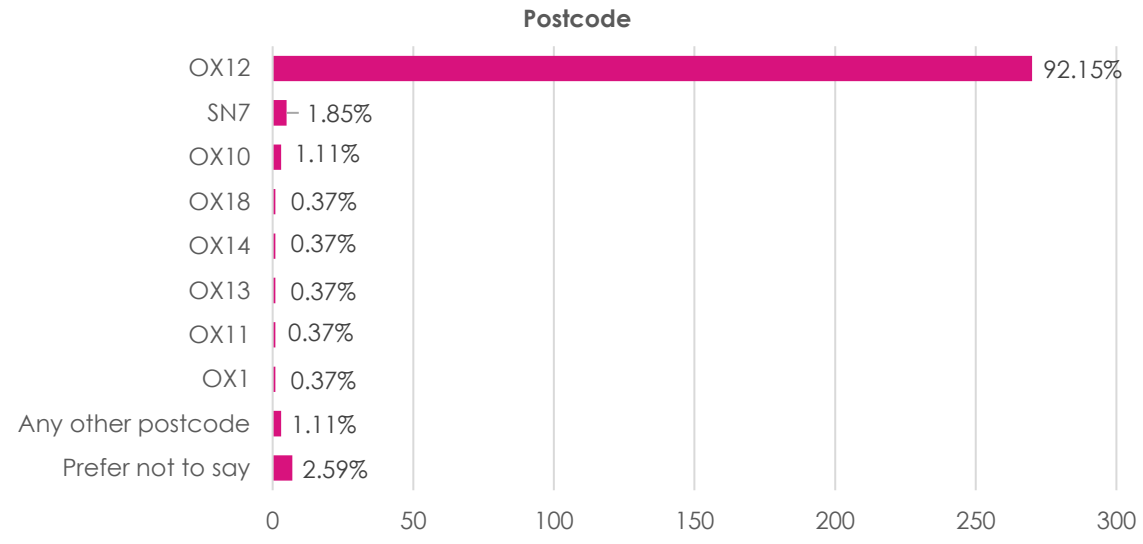


Base: All who completed question = 270



Base: All who completed question = 283

5. APPROACH TO ANALYSIS AND REPORTING

5.1 SUMMARY

The data collection approach for this project includes:

- Notes and recordings from public engagement workshops.
- Notes and recordings from face-to-face and online focus groups.
- Attendance at a local community festival (28 October) and other ad hoc comments received.
- An externally hosted survey, with questions developed by the SRG Sub-Group.

Analysis and reporting therefore incorporates a mix of qualitative comments and quantitative data, the latter derived from demographic monitoring survey questions.

Open questions with free text response in the survey and facilitated discussions at events were used to explore people's use of services, as well as their views on the scenarios and wider perceptions about local health and care.

Survey questions and prompts used at events were designed around the same topics in order to enable a single, consistent process for analysis. The discussion guide used at the workshops is attached for reference, along with the survey questionnaire.

5.2 IDENTIFYING THEMES

The central frame of reference for the whole project is the three scenarios developed through co-design by the SRG Sub-Group in light of previous engagement and with input from residents, clinicians and NHS managers:

1. Clinic based services (tests, treatment and therapy) for planned care appointments.
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate.
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day).

We therefore used these to structure discussion guides and the analysis. We should be clear that both development of the service model and NHS guidance around public engagement makes it inappropriate to regard this exercise too simplistically as a referendum between competing services.

Rather we are seeking to understand in more depth people's views and priorities to provide insight which will usefully complement clinical, financial and other data to inform commissioning decisions about future services.

5.3 INTEGRATING QUALITATIVE AND QUANTITATIVE DATA

5.3.1 QUALITATIVE ANALYSIS

In analysing qualitative comments, we aim to produce a comprehensive report which reflects all substantive points made and to explore the reasons behind people's priorities, especially where they may share the same or hold different views. These are reflected in the narrative report.

This report is set out thematic sections, and we aim to be clear where we are reporting:

- Individual comments (verbatims included to encapsulate key points)
- Inferences based on thematic analysis
- Our views and conclusions informed by comments received. These are based on Verve's experience and our understanding of the wider objectives of the engagement, and are set out in section 7.

The narrative report is complemented by an approach to "quantifying qualitative data". This is achieved by developing a coding frame in which similar answers are clustered together to develop categories.

This approach was used in the analysis of questionnaire free text comments by the NHS team. Each theme is given a numeric code (e.g. "I am concerned about xxxx" might be code 1, and "I am concerned about yyyy" might be code 2). The coding frame is constantly checked against new answers and modified if new categories were needed.

The advantage of this approach is that it provides an overview of the degree to which certain themes are raised more or less commonly, and also enables the analysis to "funnel" into more detailed comments on similar themes.

5.3.2 QUANTITATIVE ANALYSIS

Monitoring questions in the survey included five of the nine 'protected characteristics' identified in the Equality Act. Where survey respondents answered these, it is possible to produce a summary profile showing participation broken down by:

- Age
- Disability
- Gender
- Transgender
- Ethnicity.

6. REVIEW AND ANALYSIS

6.1 OVERVIEW

Residents' priorities around services that they want to see offered both locally and from the Wantage Community Hospital seem often to be strongly driven by prior experience, either personal or heard through word of mouth.

As for the priorities themselves, there are services participants valued across all three scenarios presented, though generally they understand that when opting for one type of provision, it means that other priorities may necessarily be excluded; that difficult choices need to be made.

6.2 SCENARIO 1 - CLINIC BASED SERVICES

Residents are aware of many of these services currently offered at the Wantage Community Hospital, many of which are "so well used", such as podiatry and ophthalmology. We understand that these are currently the most well-used services, and some of the participants had used these themselves.

People want existing services to remain now that they have become accustomed to having them and are loath to lose them. Because many of these services are located in Wantage Community Hospital, it seemed a reasonable proposition to participants to keep them there.

Ease of access that comes with a locally-based service is seen as the key benefit, especially when considering the alternative of having to travel to regional hospitals. The inconvenience involved in having to travel to the John Radcliffe in Oxford (especially) clearly weighs heavily on residents, and having appointments in Wantage is welcomed even by those able to travel further.

> *"Excellent, very well organised. When this appointment was made for me by my GP, I was expecting it to be at the JR, so was very surprised when I was told it was at Wantage. For such an appointment, I would have been quite happy to travel to the JR."*

For many people, however, travel and distance is a real issue. Those who drive cite frequent holdups on the main A34, heavy traffic and the difficulty and high price of parking once there, and we heard that travel issues are significantly worse for people reliant on public transport. Outpatient clinics, especially those which might require frequent visits, mean that the inconvenience and cost pile up to an extent that would cause real stress to patients and carers alike.

> *"It's so much easier than having to go to the John Radcliffe Hospital in Oxford which takes 90 minutes on the bus. It works very well. We used to go up to the JR and as you can imagine she's blind and very frail and for me it's an everyday trip but for her it's a trek and she's frightened of people bumping into her and you have the parking etc, so it's a godsend having it here".*

> *"Do not do away with the clinics now that they're there".*

The provision of local community healthcare clinics and therapies are relatively high on residents' priorities for what should be offered locally and, if possible, through the hospital. It is worth noting that in workshop introductions, the frame was "hospital-like" services. Services like podiatry and physiotherapy may have felt to participants very much like hospital outpatient services and hence seen to provide a coherent and consistent service offer.

Though 'nice to have', many question the need for a GP clinic at Wantage Community Hospital specifically. It was pointed out that there are several practices elsewhere in the area, though there were the complaints around the current availability of GP appointments and ease of communication with practices.

The feeling is that what is offered at Wantage Community Hospital Community Hospital needs to be well defined, with clear demand and avoid replicating services covered elsewhere.

> *"Most (if not all) of these outpatient clinics could be held upstairs at the Mably Way Health Centre"*

Two of the services considered drew a more polarised response. While many clearly value the provision of local children's services, others question provision through the Wantage Community Hospital. It seemed to some to be a specialism which would necessarily crowd out the more 'volume' outpatient and community services. This view was not shared by everyone, however, and – while the survey data suggests a relatively low priority for paediatric services – perhaps the older demographic profile of respondents explains this.

Similarly, while some stress the importance of mental health provision locally, others questioned why support for mental health should be offered at the hospital; they feel it is more of a specialised service and one that can be offered elsewhere – perhaps through specialist mental health facilities or primary care.

So we heard concerns to avoid spreading Wantage Community Hospital Community Hospital facilities too thinly and we heard the view that it is better to do a small number of things well.

Several questioned why online services were included in the list of potential services to consider as these can be located anywhere.

> *"You can do that out of an office block."*

Regarding digital services generally, participants have mixed views. Services such as eConsult and phone appointments were felt to be acceptable for relatively minor conditions, but if feeling really ill, filling out an eConsult can feel like too much.

Further, some elderly residents are either not online or find using digital services challenging without help: participants felt that those most in need of care often lack the digital skills necessary to negotiate the process.

There were criticisms of digital appointments in some instances. Some had themselves called on younger relatives to help them. If required, for instance, to post a photograph then a family member needs to be on hand, which is not always possible.

> *"There are areas on your body you can't photograph yourself". And "A lot relies of people's ability to negotiate the digital age, my husband is hopeless".*
>
> *"When you're my age it's not a good deal. When you're old you get very upset when things are not happening. You can't just phone up anymore and you get frustrated and bothered."*
>
> *"No amount of digital is going to substitute for face-to-face in any (minor injury) scenario."*
>
> *"If you're under stress it's very difficult to use the system even if you're a trained computer professional. I know from experience."*

Scenario 1 clinic-based services were the subject of most discussion during the focus group with people living with long-term and chronic health conditions, perhaps because these patients require frequent outpatient appointments and there were a mix of patients and carers in the group.

Their views were consistent with the wider groups and survey respondents, but the experiences we heard and the problems were more pressing, so views were strongly held.

Transport to appointments/services outside of Wantage is the main issue, and parking is often a problem – one person, caring for an elderly, visually impaired relative, said that it was difficult taking the person they care for to the John Radcliffe Hospital in Oxford:

> *"It isn't just that it's a long drive, but there are parking problems there too as there aren't enough Blue Badge spaces. So it's very traumatic."*

Travelling for appointments can also be difficult for people on the autistic spectrum, meaning that being able to be seen locally serves them better.

Many people are not eligible to use NHS transport services, and even when they are they sometimes have to wait hours for transport to take them home after appointments.

It was felt that some people simply do not attend appointments they find difficult to get to, for example those requiring eye treatments and people with mental health issues might find public transport daunting.

> *"So people just don't go"*

From an equalities perspective, given the local population demographics these patients probably face the greatest access challenges of any group.

6.3 SCENARIO 2 - COMMUNITY INPATIENT BEDS AND ALTERNATIVES

Across the range of inpatient beds, feelings were less strong and the consensus seemed to be that many of these services can be provided regionally rather than locally.

That said, thinking just about inpatient services, rehabilitation beds would be the clear priority over the other kinds of inpatient services discussed from the showcard - both locally and as something that could be provided through Wantage Community Hospital.

The rationale behind support for these services mirrors that behind support for local provision of outpatient clinics; the ease of travel. If visiting a loved one recovering in hospital involves a long, difficult and expensive journey, that is good for neither patient nor visitor.

We heard that having patients return closer to home to recover enables them to receive greater social support, which many believe helps to speed up their recovery, something from which all parties gain, including the NHS as it frees up a bed earlier.

Further, with care homes at full capacity, Wantage Community Hospital feels like a good place to provide these beds.

> *"My belief is that it's a very good step out from a major hospital to a community hospital."*

> *"Most of the care homes, to my knowledge are pretty well full up most of the time. There's no nursing home in Wantage that has any capacity at all."*

Some though, looking at the bigger picture, felt that if the price of providing rehabilitation beds is the loss of outpatient clinics, then the latter must be the priority - especially when looking at the relative demand for each service (based on the presentation handout made available during the focus groups).

Forcing a choice, participants tended to opt for retaining the outpatient clinics.

> *"I'd hate to have in-patient beds to the detriment of a lot of people losing out on all these outpatient clinics".*

Other inpatient possibilities – palliative care and specialist stroke rehabilitation beds – were felt to be best offered regionally rather than necessarily locally and, though it is difficult to find places, palliative care can be offered though care homes. These remain 'nice to have' options which are relegated down the order of priorities when residents are considering a range of alternatives and considering the trade-offs.

> *"I mean there's always give and take isn't there, and you've got to choose which beds you're going to provide."*

As an alternative to inpatient care, residents were asked to consider in-home care options: Hospital at Home, Urgent Community Response and Social Care Community Support for Reablement.

These services were seen as a high priority and provide a really good alternative to admission as an inpatient at a regional hospital, with consequent travel issues for visitors.

> *"Recently I needed Hospital at Home services which were excellent and saved me and my carer 3 weeks of daily visits to the John Radcliffe and got me well again without the need to be a hospital inpatient."*

Perhaps not surprisingly given its name, Urgent Community Response is seen as a priority for local provision, though not necessarily as something that should be offered through Wantage Community Hospital as it is, by definition, provided through home visits.

Collectively, these services are popular. Those with caring responsibilities reported feeling unsupported and would value being able to call on services like these to provide support and temporary respite from their caring duties.

> *"I'm unable to go on holiday".*

That said, knowledge of what help is available is patchy. Some reported that social services can be very helpful in providing funding for support, including home adaptations to help the carer and the patient cope better with their recovery.

Conversations around help at home highlight the importance of seamless communication between various healthcare strands.

Access to patient information is felt to be vital to be able to offer optimal care.

> *"With all medical records computerised there should be no reason for a paramedic arriving at your house without having a total history of the patient. There needs to be a one stop shop."*

The idea of Hospital at Home care was felt to sound good in that intuitively patients would be likely to recover better at home tended to by family in their own familiar environment.

> *"(My) mother in law had really excellent post hip op and stroke in-home care from specialist home teams for 6 weeks after. Without this she could not have come home."*

Contact with the Hospital at Home service by participants was limited, however some with experience of it reported being unsatisfied with the quality of delivery, with one describing it as "*absolutely appalling*".

We heard that poor communication was an issue, with carers unaware of the patient's circumstances and visits rushed, leaving carers, family and friends to fill in the gaps.

Reinforcing one of the key themes driving residents' views, this suggests that if a service is to be delivered, it has to be delivered well or not at all.

Just as both the focus groups and the wider survey highlight concerns around insufficient support for those undergoing rehabilitation at home, so we also heard a consistent list of what services residents feel might improve the situation.

GP support is key here as are sufficient availability of nurses, being able to access help and advice by phone and better interdisciplinary communications, so that any visiting healthcare professional will have a good knowledge of the patient's background.

6.4 SCENARIO 3 - URGENT CARE

Suddenly being presented with the need to seek urgent treatment can be stressful and people reported sometimes being at a loss around the most appropriate first port of call. Is it: 111; 999; visiting A&E (assuming there is one within reach and people have access to transport); MIU; calling their GP?

This is reflected both in responses in the focus groups and the multiple options quoted in the wider survey when people are asked where they would turn in such circumstances.

Clearly, the severity of the injury or condition can help drive people to a specific option, but we heard that this 'self-triage' can still be a challenge.

> *"Trying to negotiate which service you need and even getting a reply when you phone and when you're panicking".*

With the A&E department at the John Radcliffe hospital seeming so far away and feeling quite inaccessible, people feel that only the most serious injuries merit seeking help there.

Residents feel, though, that there is a range of relatively minor injuries which need medical attention, but which fall short of the threshold for A&E attendance.

Self-triaging these can be difficult. Some respondents gave example of experiences of this type of injury with relatives as evidence for the value of a local MIU. As well as the long journey to A&E – even by car – patients must often face many hours' wait to be seen.

However, though some cited Abingdon as an alternative, getting there can also pose a challenge.

> *"We want it brought back locally"*

> *"My husband drove to Abingdon with a very badly cut hand and didn't know if he'd get there."*

> *"Abingdon A&E is excellent, but it is difficult to get there so it would be good to have it available locally."*

> *"That 'urgent' bit, to have that more local is a huge reassuring factor, because you don't plan for it, do you?"*

When asked specifically how urgent care can be made more accessible, the clear response is the provision of a minor injuries unit (MIU) as well as clearer information around the options available to deal with these cases.

Many residents are keen to see such a unit provided locally and see Wantage Community Hospital Community Hospital an ideal site. Some remember fondly a similar service provided locally and would like to see it return.

While there is a MIU in Abingdon, this is ten miles away and for many, felt to be too far to travel Further. These views were justified by reference to the rising population in the area of both older

people and children – exactly the age groups expected to need such a service most and, for older people especially, the patients who might find mobility most challenging.

> *"They used to have the option of the nurse calling a GP if required. We've used that. Years back really. And it was very successful. We used it a number of times with our children . . . and it was very efficient and effective. I think it operated from about six in the morning until ten in the evening. That's quite good, isn't it? I thought it was excellent."*
>
> *"So as the population increases, you presume employment's going to increase. You could have quite a few people going into a minor injuries unit due to injuries at work, which wouldn't be picked up in this sort of survey."*
>
> *"if you could fit an X-ray service in as well, I mean that seems like a logical extension of a minor injury unit".*

Other services within Scenario 3 were seen neither as priorities for local provision or for siting at Wantage Community Hospital. A full A&E service is available at the John Radcliffe if the case is serious, and the First Aid service sounds too much like a 'nice to have' – so the MIU is a more popular priority. Further, any MIU ought to be able to dispense First Aid, so the distinction seemed a little academic to many.

Jargon is an issue here. Throughout discussions and the comments on unplanned care, we note a lack of public understanding and "incorrect" use of clinical terms which have a specific meaning within healthcare management, but sound interchangeable to the non-specialist.

Local Specialist Services sound like they could be offered within a MIU and while we heard many complaints about the difficulty of seeing a GP, Urgent GP Appointments sound like replication of a service which should be available anyway.

6.5 PRIORITIES

6.5.1 PRIORITY-SETTING

Participants at the workshops were asked to indicate two sets of preferences:

- Which services they would like to see locally. They were given eight 'tokens'
- Which services they felt should be offered from the Wantage Community Hospital. Here they offered only three options (so the numbers against the hospital will always be lower than against local provision).

Clearly numbers are very small and no statistical robustness is claimed for these figures. However, they do give offer an idea of the direction of residents' priorities.

The first exercise gives a sense of local priorities across community healthcare options more broadly, while the second is probably most usefully seen as indicating expression of preferences – especially of preferences between the alternative services presented within each Scenario.

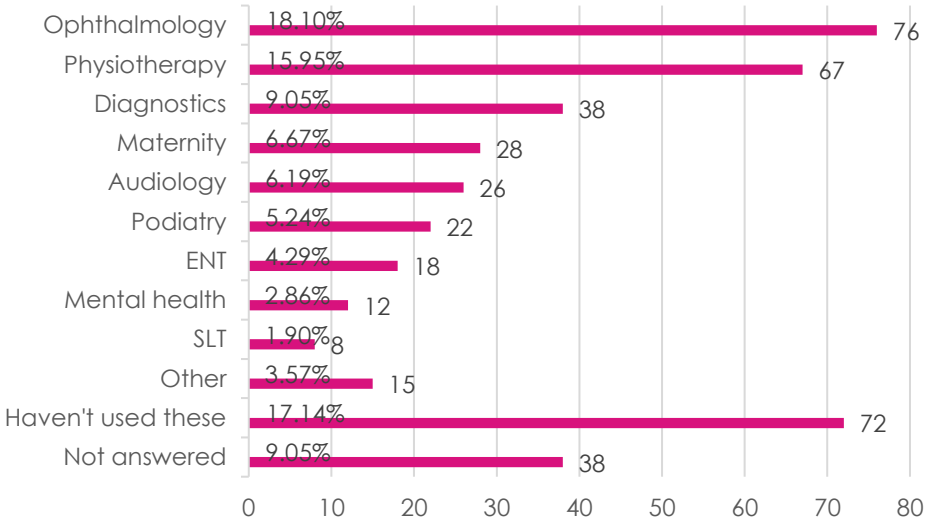
The summary of this exercise is shown in the table at Appendix 1, which indicates the levels of response for each of the 20 services described across all three scenarios.

6.5.2 SURVEY CODED QUESTIONS

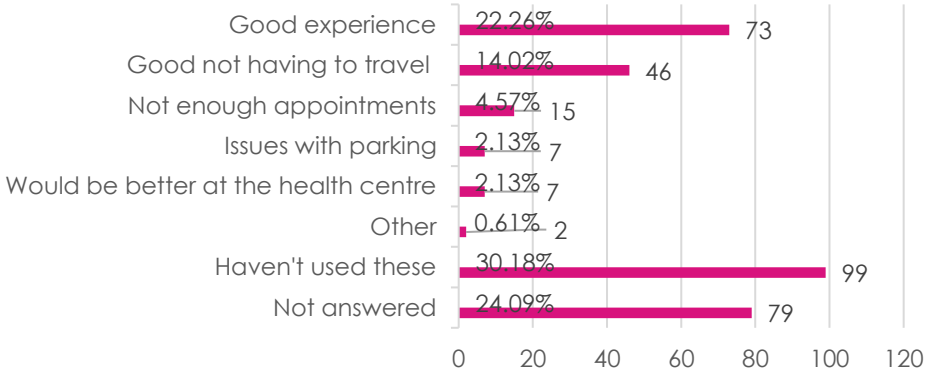
As described earlier (see 5. Approach to analysis and reporting) each free text comment received through the questionnaire was given a code to enable us to visualise the relative frequency with which each theme or comment was made.

These are shown in the following tables – there is one table for each questionnaire question.

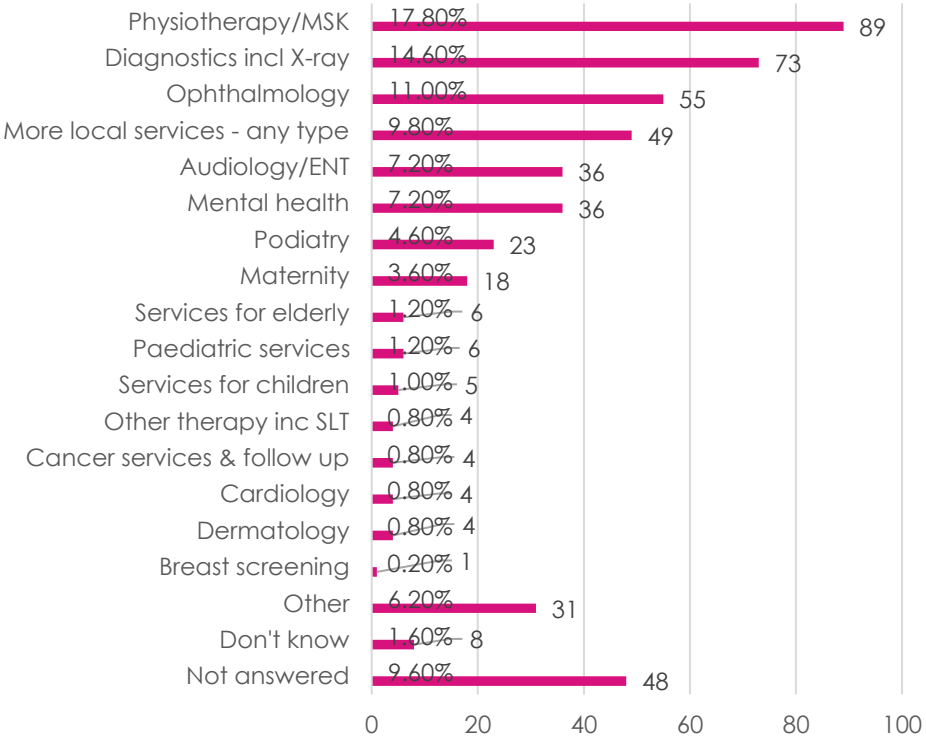
Q1. What type of planned care services have you or your family used or know about locally?



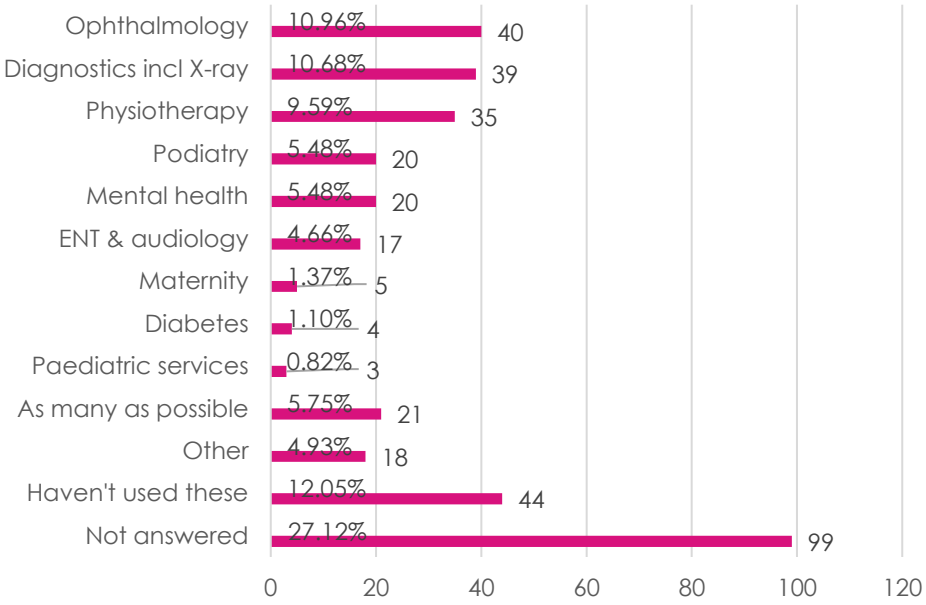
Q2. If you have accessed any of the outpatient clinics made available at Wantage Community Hospital (some of which have been running as pilots for the past 18 months), what has been your experience using them?



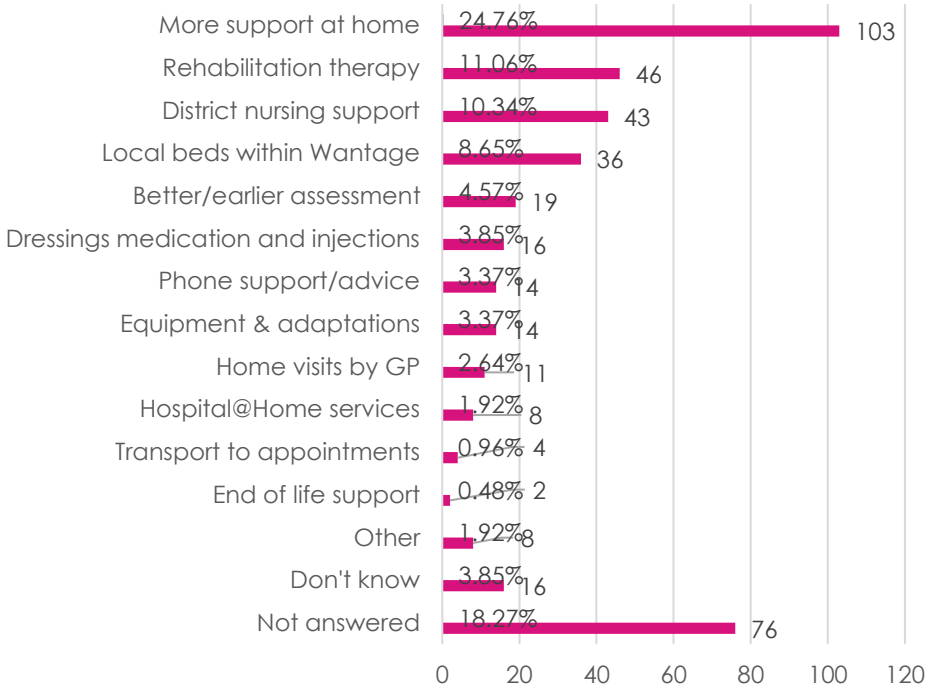
Q3. What types of planned care services would you value locally? These could be existing services (so a continuation) or services not currently available



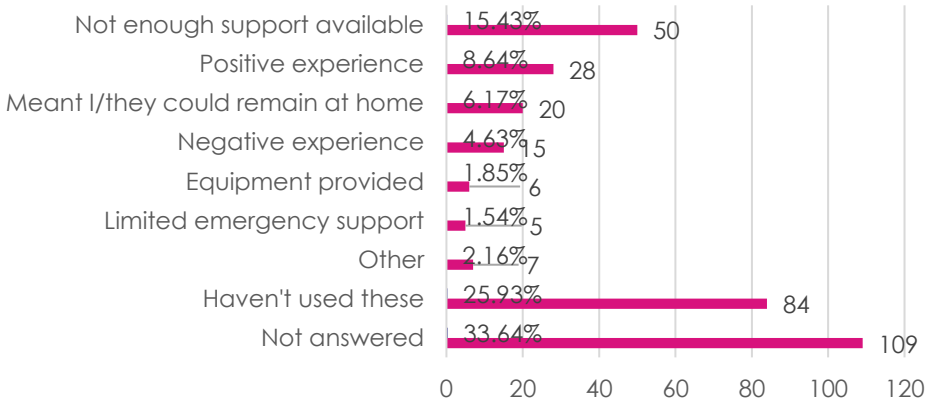
Q4. Thinking about the planned care services you or your family use most frequently (i.e., weekly or six-weekly), which services should be made available locally?



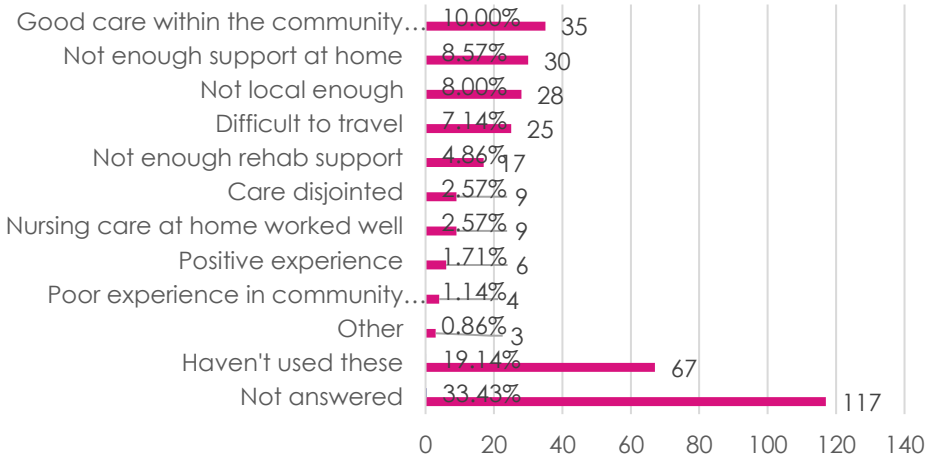
Q5. Most people return home directly from hospital. What type of help would get you or your family back to living independently and supported as quickly as possible?



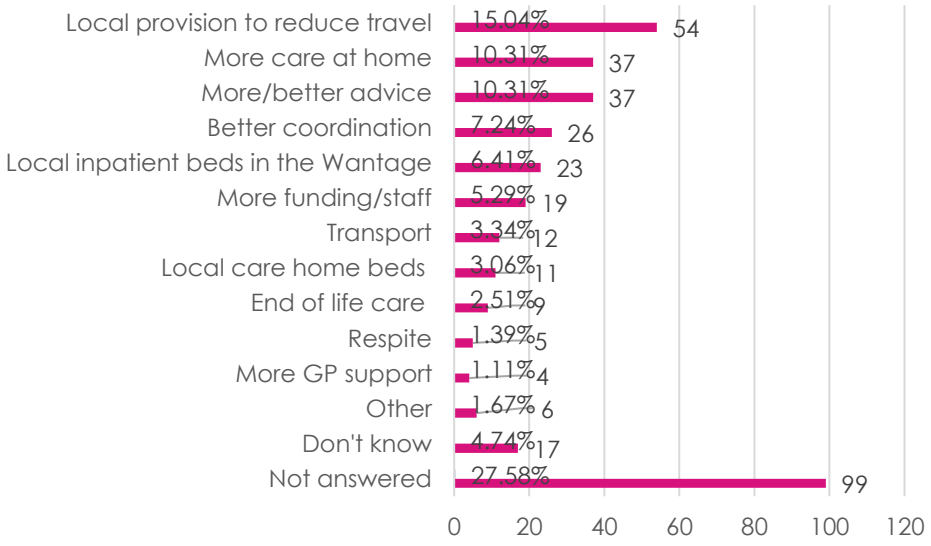
Q6. Can you describe your experience with services which support you and your family to remain at home during illness?



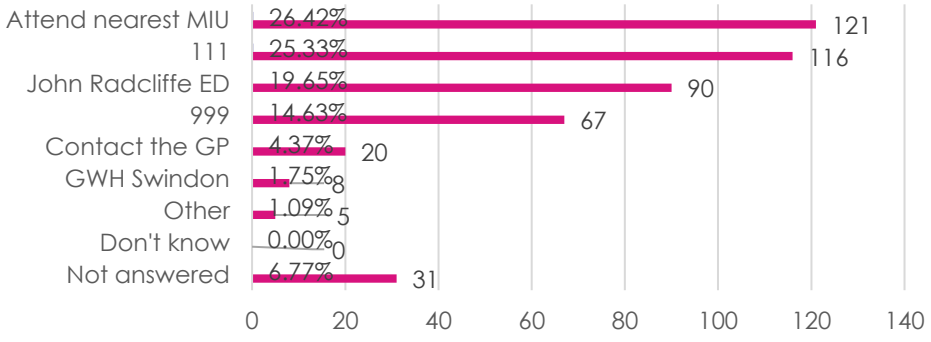
Q7. If you, or somebody you know, has accessed these services, can you describe your experience of care or rehabilitation in the following: other community hospitals; short term nursing and care home stays; palliative and end of life care outside of someo



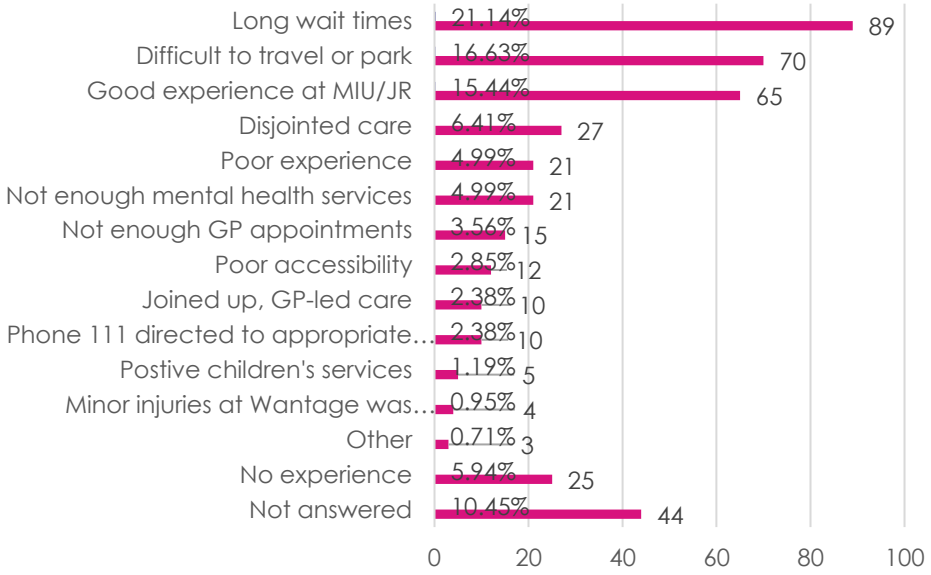
Q8. What would help to support you and your family in circumstances when you would need to access these types of services?



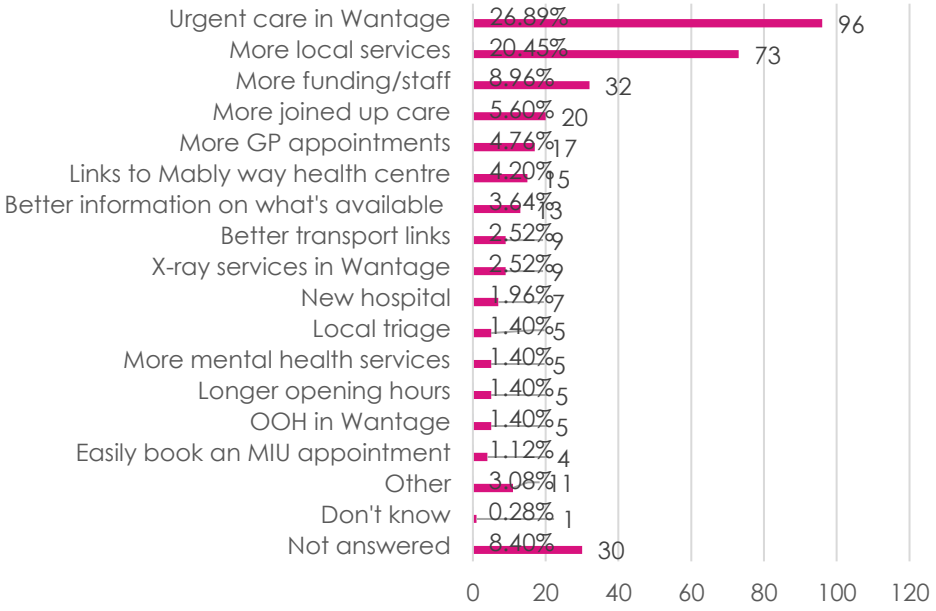
Q9. If you needed to access urgent care, what would you do?

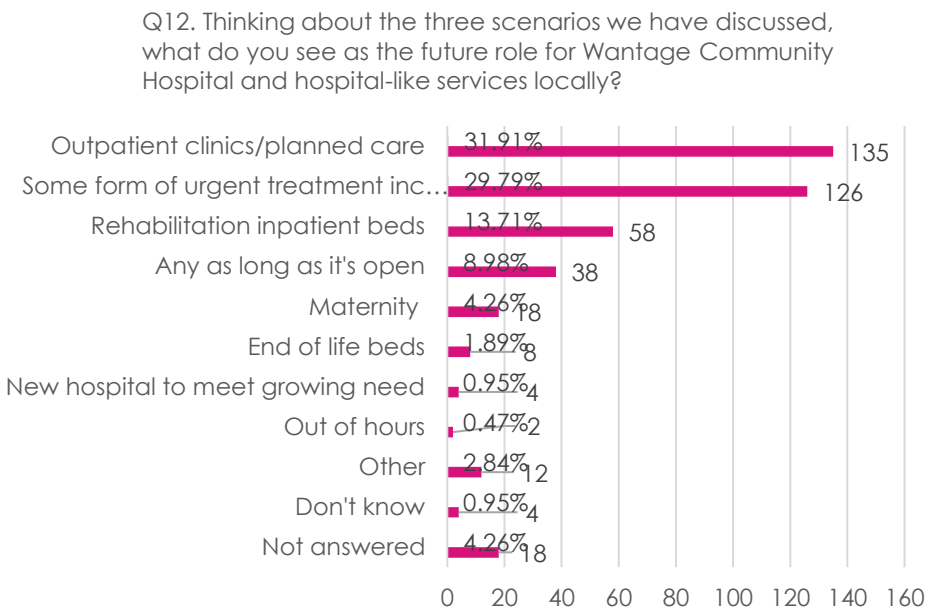


Q10. What has been your experience with accessing urgent care services for physical health and / or mental health issues?



Q11. How can we make it easier to access urgent care services for you and your family?





6.6 SCENARIO SUMMARIES

Within Scenario 1 (Clinic Based Services and Planned Care Appointments), the retention and expansion of outpatient services currently being piloted at the Wantage Community Hospital are strongly supported. Those who are aware that these services are currently being provided are loath to see them disappear, especially if they or someone they know has used them.

If not provided at Wantage Community Hospital, then the clear feeling is that these services should be retained locally. Thus, there will be a cohort of the local population who will feel that they have lost something if this is not part of what is offered either at best at the hospital or at worst elsewhere locally.

Within Scenario 2 (Community In-patient Beds and Alternatives), calls for some form of rehabilitation bed provision were strongest. Here too, if this is not provided at the hospital it is acceptable that it is at least provided locally. Although not a statistically valid exercise, the data suggests that overall inpatient beds are seen as less of a priority than other services.

Servies within Scenario 2 delivered at home seem to be less of a priority, although they are clearly popular and seen as eliminating the inconvenience of travelling to visit patients at regional hospitals and supporting carers. Views from those with experience of these services were mixed – some had a positive experience, while others were less positive, citing the level of support available and examples of poor communication, and rushed provision.

Within Scenario 3 (Urgent care), the strongest call was for a minor injuries unit (MIU) which people feel would be a valuable addition to the healthcare services provided locally, and for which Wantage Community Hospital would be an ideal location. This is the only service within Scenario 3 that gets much traction, with others felt to be well covered already elsewhere.

It was felt important by some that, if provided, this must provide a comprehensive urgent care offer e.g. X-ray with capacity for reasonable opening hours.

7. CONCLUSIONS

7.1 FACTORS DRIVING PREFERENCES

Factors driving preferences are:

- Travel and convenience. The major benefit of outpatient services provided locally is accessibility and convenience, and this is the same for local provision of a MIU for Wantage residents. Having to travel to and find parking at the John Radcliffe in Oxford or to the MIU at Abingdon is seen as a major inconvenience, especially when these journeys need to be made frequently or when already in some distress. This is compounded for those without cars.

- Filling a genuine gap. Residents took a generally pragmatic approach in prioritising the services they wanted to see. While it would be nice to have everything locally, people do realise that this is not possible and only want to see services made local that fill a genuine need or at least optimise added value (as with eliminating travel time above).

- Familiarity and stability. Those who are aware of and have used some of the existing piloted outpatient clinics at the hospital are reluctant to see them removed. In the focus groups every individual cited these outpatient services as something they felt it was important to be offered locally with many also feeling that the Wantage Community Hospital was the best site from which to provide these services.

- Services that people need regularly. The feeling was that clinic service provision should prioritise the kinds of tests and clinics that require people to go on a regular basis, rather than focus on services that someone might need on, say, an annual basis. This makes sense on an individual level - however not everyone will need the same services at the same frequency.

- Whatever is provided, it must be done well. Not unreasonably, residents seek reassurance that any services that are provided will be adequately resourced and fully functional. Thus, they qualify preferences with questions such as whether a Minor Injuries Unit (MIU) would be equipped with an X-ray machine and whether it will be open outside 'office hours', or whether the capacity for nursing support will be available at any inpatient facility.

7.2 QUESTIONS TO THINK ABOUT

The engagement brought comments about services which might be provided locally and, within this, from Wantage Community Hospital. The response suggests areas for consideration, both about needs and services, but also the future steps for involvement and co-design as the SRG and the NHS progress to the next stage.

7.2.1 HOW TO FOCUS DIALOGUE ABOUT NEEDS AND SERVICES FROM THE 'PLACE' PERSPECTIVE

Wantage Community Hospital – and its history – represents more than a 'bricks and mortar' health facility. The pride, sense of ownership, and local identity are palpable, and could play a hugely valuable role in making community healthcare services in Wantage and Grove successful - and a real asset for this growing community in future.

This suggests thinking about:

- Taking people on the journey: How to describe and involve people in the process? Where are people now, and what do they need to hear?

- Being clear and transparent: How to show the bigger picture of which community healthcare is a part? How to be clear on benefits and honest about constraints?

7.2.2 HOW TO MANAGE EXPECTATIONS AROUND CHOICES AND TRADE-OFFS

Whatever decisions are reached, it will be important for both the SRG and the NHS to avoid giving the impression there are "winners and losers".

This suggests thinking about:

- Making and communicating decisions: Which communication channels to reach people with consistency? How can all parties be represented? Who should be spokespeople?
- What to say and when: How to avoid news coming as a surprise? Who, how and at what stage to make announcements?

7.2.3 WHAT MIGHT FUTURE CO-DESIGN LOOK LIKE?

The involvement and commitment across agencies and institutions within (and beyond) the public sector stands out. Under the auspices of the SRG, a robust, inclusive process has been developed - arguably ahead of the curve in the design and commissioning of healthcare in partnership with communities.

This suggests thinking about:

- The engagement heard much more from some groups of patients than others: How to engage (particularly) younger people and families from the growing parts of the geography?
- Co-design means patients and residents playing a meaningful role in the design of complex clinical services: What are the right structures and processes to empower non-experts? How to draw insight from the expertise by experience that patients bring? How to strike the right balance between recognising community need while involving people in making (sometimes tough) choices?

Service	Priority local	Priority WCH
Scenario 1		
Hospital Outpatient Appointments: several are currently being piloted at the Wantage Community Hospital, e.g. Audiology; Ear nose and throat; trauma / orthopaedics and ophthalmology	17	7
Support for mental health - a range of services are being piloted at Wantage Community Hospital Community Hospital, including talking therapies and neuro-developmental services	10	5
GP clinics – being piloted at Wantage Community Hospital	1	0
Diagnostics (screening, tests and results) – e.g. haematology (blood tests). Diabetes screening is being piloted at Wantage Community Hospital	8	1
Local community healthcare clinics and therapies – already provide at Wantage Community Hospital Community Hospital are Podiatry (foot health), Speech and Language therapies, Physiotherapy / MSK (bones and joints problems)	11	5
Children's health services – a range of services for children and young people (some already provided at Wantage Community Hospital)	10	4
Online or virtual clinics - to enable you to communicate with a clinician remotely (e.g. video appointment)	3	0
Scenario 2		
Rehabilitation beds in a community hospital – short-stay for people recovering from treatment with medical needs or continued treatment before they are able to go home	8	6
Rehabilitation in a short-stay hub beds in the community – similar to a care home with support and some therapies. People from Wantage most commonly go to Abingdon Care Home for this service	7	2
Palliative Care (end-of life care) inpatient beds	2	1
Specialist stroke rehabilitation beds – e.g. linked to Abingdon Stroke Unit	3	0
Hospital at Home service – provide healthcare in your own home and facilitate earlier discharges from hospital	6	1
Urgent Community Response – Service to help adults, mostly older people, having a health crisis or difficulties being at home because their main unpaid carer is not able to cope with caring for them	11	3
Social care and community support for reablement (which may be provide by the Council or local charities and community organisations) e.g. Age UK	7	3
Scenario 3		
Hospital Emergency Department (A&E) and emergency Ambulance Service	3	2
GP-led Urgent Treatment Centre	2	3
Nurse-led Minor Injuries Unit (may also have other health professionals, e.g. Radiographer if X-Rays are available)	9	6
Nurse-led 'First Aid' urgent care service	4	1
Local specialist services – for older people to avoid having to go to A&E or be admitted to hospital (often located in a MIU)	9	1
Urgent GP appointments	1	1

APPENDIX 2 – STAKEHOLDER REFERENCE GROUP

As set out in JHOSC update report, the stakeholder reference group for this project has the following members:

- Wantage Town Council
- Vale of White Horse District Council
- Grove Parish Council
- Wantage Hospital League of friends
- Wantage Patient Participation Groups
- OX12 Project representatives
- GrOW Families
- SUDEP Action
- Wantage Rural and OX12 Village
- Sanctuary Care
- Oxfordshire County Council
- BOB Integrated Care System (ICS)
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Wantage PCN
- Vale Community Impact
- Community First Oxfordshire
- Healthwatch Oxfordshire.

APPENDIX 3 - LEAFLET

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

NHS Oxford Health NHS Foundation Trust

With input from wider partners and stakeholders

We want your views!

We are looking for residents of the Wantage and Grove areas, users of local NHS services and representatives of local voluntary groups to help shape potential future services at Wantage Community Hospital.

You can either take part in one of the sessions listed below, or fill in our online survey. Visit https://bit.ly/3tcr866 for more information or scan the QR code below.

Wednesday 11th October 12:30-14:00 - Public engagement session
The Beacon, Portway, Wantage, Oxfordshire

Wednesday 11th October 15:00-16:30 - Focus group
People living with long term/chronic health conditions. The Beacon, Portway, Wantage, Oxfordshire

Tuesday 17th October 12.30pm - 2.30pm - Public engagement session
The Beacon, Portway, Wantage, Oxfordshire

Wednesday 18th October 2pm - 3pm - Public engagement session
Via Zoom for those unable to attend a face to face session

Thursday 19th October 7pm - 8pm - Focus group online- via Zoom
Families with children and young people OR adults 18- 40 years living in or around Wantage and Grove.

Saturday 28th October - 10am - 4pm - Drop in information session
The Beacon, Portway, Wantage, Oxfordshire

If you have any questions please contact:
communityservicesfeedback@oxfordhealth.nhs.uk

APPENDIX 4 - DISCUSSION GUIDE

Explanation

Interviewer to introduce themselves
 	
As you have heard, we are keen to hear your views on **THREE SCENARIOS** for local services. (NB. Not necessarily mutually exclusive!)
 	
These are:
1. Clinic based services (tests, treatment and therapy) for planned care appointments
2. Community inpatient beds and the alternatives when care in your own home isn't appropriate
3. Urgent care (minor injury, illness and mental health issues) access needs on the same day.
 	
We particularly want to hear from you:
• What local services you currently (or have recently) used
  o Your experience of accessing them
  o How things fit together
• Your thoughts on the range of services which might make up each SCENARIO
• Your ideas on how the Community Hospital can support health and wellbeing for the people of Wantage and the Grove.
 	
• Recognise you might have more general questions or suggestions: We will also ask you <u>as a group</u> to prioritise 3x points, ideas or questions for the final session.

• This session will take about an hour. • We would like to record the session, with your permission. • The recording will only be used to make notes for analysis and will be destroyed at the end of the project.
We would be grateful if you would be as open and honest as you can be in what you tell us. What you tell us will not be shared directly with clinical teams and everything you say will be kept anonymous when we write our report. We do not use people's names in our reports, and we do not give any information which means they can be identified.
Do you have any questions? May I record our conversation?

1. **Scenario – Clinic based services (tests, treatment and therapy) for planned care appointments**

   Prompts:
   - SHOWCARD LIST (APPENDIX)

a. Which had you heard of before today?: Show of hands

b. Which planned care services (outpatients, tests, treatment, follow ups, therapy type services) have you or your family used or know about locally?

c. Have you accessed any of the outpatient clinics at Wantage Community Hospital - some have been running as pilots for the last 18 months and others more long term?

   - What did you think about these? (Like or dislike?)
   - Were they easy to access?

d. If not provided at Wantage Community Hospital, where else could this type of service be accessed?

   - John Radcliffe or Churchill Hospital in Oxford?
   - Great Western in Swindon?
   - Oxford City Clinic bases (e.g. East Oxford Health Centre or The Slade)
   - Abingdon Community Hospital (some mental health and children's therapy services)

e. What types of planned care services would you value locally? These could be existing (so a continuation) or not currently available.

   Prompts:
   - One-off/short-term vs. Long-term/ongoing condition
   - Frequency
   - Physically accessible buildings?
   - Planned vs Urgent
   - Conditions for which travel might be problematic
   - Kinds of patients
     - Deprivation
     - LTC
     - Life-stage (families / working age / older etc.)
   - Connectivity / integration / co-dependencies

2. Scenario – Community inpatient beds and the alternatives

Prompts:

- SHOWCARD LIST (APPENDIX)

a. Which had you heard of before today?: Show of hands

b. Most people return home direct from hospital. What would help get you back to living independently as quickly as possible?

Prompts:

- Local authority social care (domiciliary / home care)
- Additional support (e.g. live-in or overnight check-in service for people with delirium)
- Specialist support for carers (e.g. dementia) – may be from the voluntary sector
- (Re)assurance (e.g. alarms)
- Reablement / support (e.g. therapies)
- Knowing your carer has someone they can call
- A local multi-disciplinary team able to help you access all services

c. What has been your experience of people accessing medical ("hospital-like") support at home so you don't need to stay in hospital?

Prompts:

- Discharge to Assess
- Local Hospital at Home service
- Urgent community response

What has been your experience of:

d. Care as an inpatient in other community hospitals?

e. Short term nursing home stays?

f. Care for when you know someone has needed to access palliative and end of life care outside of their own home?

g. What types of inpatient care do you think it is important to provide locally? (Do some of these need to be more local than others?)

Prompts:

- Rehabilitation e.g. for people who have had an operation or a stroke
- End-of-life care
- Short-term care e.g. during winter pressures
- Short-term nursing home stays e.g. during times of crisis or for respite
- Specialist inpatient care (e.g. for stroke)

3. **Scenario - Urgent care (minor injury, illness and mental health issues) access needs on the same day**

Prompts:

- SHOWCARD LIST (APPENDIX)

a. Which had you heard of before today?: Show of hands

b. Which 'same day' services have you used or know about?

Prompts:

- GP; out-of-hours GP; Minor Injuries Unit; NHS111; John Radcliffe hospital A&E
  - How did /(do) you / family travel to these?
- Have you used Apps, video appointment, or other "digital" services
  - (**NB. be sure to prompt with this one!!!!**)
- Urgent Community Response (rapidly-growing new service – same-day home visiting service, e.g. nurse, therapist)
- Do you feel any additional services would be helpful?

c. What has been your experience with accessing these types of services for both physical health and/or mental health needs?

d. What would make access to these types of services work well for you and your family?

Prompts:

- Effective triage to the right service
- An easy first point of access
- Streamlined referral between services
- Travel / transport
- Accessibility / easy access / experience
- Which services? Frequency

e. Which services is it most important to have locally?

Prompts:

- What do we mean by local?
- Frequency of need / conditions needing regular appointments?
  - NB. weekly follow-ups / less commonly
- Mental health services
  - NB CAMHS – large local school (NB2 – minimal CAMHS currently in Wantage Community Hospital)
- Urgent care?
- What specialties would it be better to have more locally?
  - Wantage Community Hospital – current list: Eyes; Hearing; Mental Health; Diabetes screening; Foot care; Speech and language therapy; Physiotherapy; Maternity appointments; School nursing
  - What kinds of appointments are the most common? e.g. Diagnostics/scans etc.; follow-up/regular check-ups; Test results; clinics (e.g. vaccinations)

4. **Thinking about the different scenarios we've discussed, what do you see as the future role for Wantage Community Hospital and hospital-like services locally?**

   Prompts:
   - What makes a high-quality service?
   - How could it be joined-up better with other health services you use? (e.g. outpatient clinics? navigation?)
   - Choice – currently available / in the future
   - What mix of services should be offered on site?
   - Adults and children's services in the same place?
   - How does it work with your GP – pathway / referral / records?
   - Is there anything which would make things easier for you?
   - Buildings and environment

Prioritisation exercises

a. Based on what you have heard – which of these would you like most to be most local?

   Prompts:
   - STICKERS / FLIPCHARTS

b. If you had to choose TOP 3 PRIORITIES for services at Wantage Community Hospital, what would they be?

   Prompts:
   - STICKERS / FLIPCHARTS

5. **Feedback questions or comments**

   Prompts:
   - What do we mean by "local"?
   - What services are under consideration
   - What is the process?

SHOWCARD LIST OF SERVICES

Scenario 1.

Clinic based services (tests, treatment and therapy) for planned care appointments

- **Hospital outpatient appointments** – several are currently being piloted at Wantage Community Hospital to avoid patients needing to visit to hospital departments e.g. audiology/ear, nose and throat; trauma/orthopaedics (bones and joints) and ophthalmology (eye health - currently the most popular pilot at WCH).

- **Support for mental health** – a range of services are being piloted at Wantage Community Hospital, including talking therapies and neuro-developmental services.

- **GP clinics** – being piloted at Wantage Community Hospital

- **Diagnostics (screening, tests and results)** – e.g. haematology (blood tests). Diabetes screening is being piloted at Wantage Community Hospital

- **Local community healthcare clinics and therapies** – already provide at Wantage Community Hospital are Podiatry (foot health), Speech and Language therapies, Physiotherpy / MSK (bones and joints problems)

- **Children's health services** – a range of services for children and young people (some already provided at Wantage Community Hospital)

- **Online or virtual clinics** - to enable you to communicate with a clinician remotely (e.g. video appointment)

Scenario 2.

Community inpatient beds and the alternatives

Inpatient services

- **Rehabilitation beds in a community hospital** – short-stay for people recovering from treatment with medical needs or continued treatment before they are able to go home

- **Rehabilitation in a short-stay hub beds in the community** – similar to a care home with support and some therapies. People from Wantage most commonly go to Abingdon Care Home for this service

- **Palliative Care** (end-of life care) inpatient beds

- **Specialist stroke rehabilitation beds** – e.g. linked to the Stroke Unit in Abingdon

Increasingly, people go home from hospital quickly following treatment because the evidence is that it brings better health outcomes. Hospital-like care services are provided at home:

- **Hospital at Home service** – provide healthcare in your own home and facilitate earlier discharges from hospital

- **Urgent Community Response** – Service to help adults, mostly older people, who are having a health crisis or having difficulties being at home because their main unpaid carer is not able to cope with caring for them

- **Social care and community support for reablement** (which may be provide by the Council or local charities and community organisations) e.g. Age UK

Scenario 3.

Urgent care (minor injury, illness and mental health) access needs on the same day

- **Hospital Emergency Department (A&E)** and emergency Ambulance Service
- GP-led **Urgent Treatment Centre**
- Nurse-led **Minor Injuries Unit** (may also have other health professionals, e.g. Radiographer if X-Rays are available)
- Nurse-led **'First Aid' urgent care** service
- **Local specialist services** – for older people to avoid having to go to A&E or be admitted to hospital (often located in a MIU)
- **Urgent GP appointments**

APPENDIX 5 – QUESTIONNAIRE

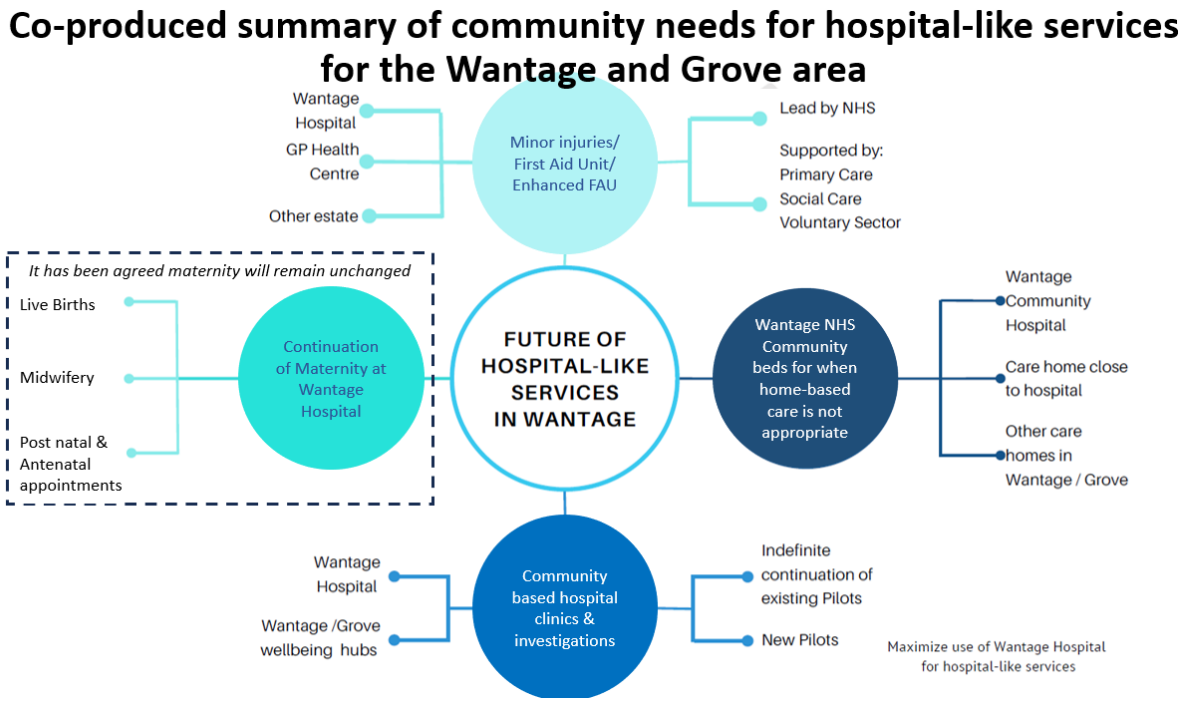
BACKGROUND INFORMATION

Wantage community hospital inpatient beds have now been temporarily closed for 8 years. The hospital is currently used to provide a range of outpatient services (tests, treatment, therapy, follow ups) for the local community, some have been running for some time and others as a pilot for the last 18 months after the space previously used as an inpatient ward was re-opened. We have been starting to co-design what future type of services could be provided from the hospital and now want to seek broader views upon to help shape final proposals.

Oxford Health and its NHS partners, have no plans to close Wantage Community Hospital. We are committed to keeping it open, but we need your input to help inform the types of services to be provided from the building that are sustainable and best meet the needs of the local community. Our objective is to provide sustainable hospital-like services from Wantage Community Hospital for the longer term to meet the needs of the local population now and in the future that maximises use of the available space.

We are not proposing any changes to the maternity services and support their continuation – located upstairs in Wantage Community Hospital. We have focused on three areas to explore further:

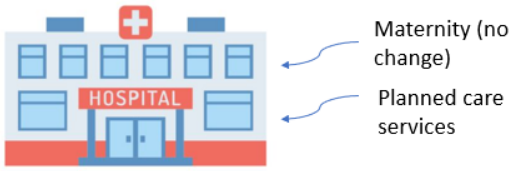
- Clinic based services (tests, treatment and therapy) for planned care appointments
- Community inpatient beds and the alternatives when care in your own home isn't possible
- Urgent care (minor injury, illness and mental health) access needs on the same day



SCENARIO 1: CLINIC BASED SERVICES (TESTS, TREATMENT AND THERAPY) FOR PLANNED CARE APPOINTMENTS

- Currently the most needed clinic service is **Ophthalmology** (specialist eye appointments)
- **1,445 patient**s came to an outpatient clinic as part of the pilot mostly from the OX12 postcode area
- On average **120 people per month** come to Wantage Community Hospital to access the range of clinic-services currently provided

Planned care services would take up the whole of the ground floor with scope for some more services to come in to maximise the available space



What this would mean:

- More planned care services could be provided within Wantage
- Hospital beds and urgent care services would need to continue to be accessed at other hospital and local care home sites

If Wantage Community Hospital didn't provide these planned care services, where else could this type of service be accessed?

John Radcliffe or Churchill hospital in Oxford

Great Western in Swindon

Oxford City clinic bases e.g. East Oxford Health Centre or The Slade

Abingdon Community Hospital for some mental health and children's therapy services

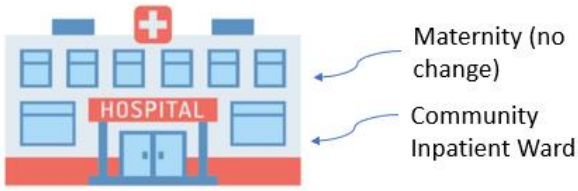
QUESTIONS

- Which planned care services (outpatients, tests, treatment, follow ups, therapy type services) have you or your family used or know about locally?
- What has been your experience of accessing any of the outpatient clinics made available at Wantage Community Hospital, some have been running as pilots for the last 18 months and others more long term?
- What types of planned care services would you value locally? These could be existing (so a continuation) or not currently available.
- Thinking about how frequently you or your family need to access these types of planned care services (e.g. weekly or 6 weekly for follow ups), what types of services should be available locally to those further away?

SCENARIO 2: COMMUNITY INPATIENT BEDS AND THE ALTERNATIVES WHEN CARE IN YOUR OWN HOME ISN'T APPROPRIATE

- Each month around **5 people from the Wantage and Grove area are admitted** to a community inpatient bed currently mostly in Abingdon or Dicot
- Each month, around 2 people from the Wantage and Grove area require less intensive rehabilitation and are **admitted to care homes (mainly to The Close in Burcot, 15 miles from Wantage)**
- Home-based care is also provided by a range of teams to help people get home after a hospital stay

The inpatient ward is likely to need the whole of the ground floor (around 20 beds).



What this would mean:

- If Community hospital beds would be provided in Wantage there would be no space for any outpatient (tests, treatment and therapy) services or potential urgent care type service. Wantage and Grove residents would need to access these at other hospital and community sites
- Community inpatient provision across the rest of the county would require a review to accommodate this new ward.

QUESTIONS

If Wantage Community Hospital didn't have any beds how would this type of healthcare be provided to the local population?

Living independently at home / in the community

- Most people **return home** direct from hospital. What would help get you or your family back to living independently and supported as quickly as possible?
- What has been your experience of accessing services to support you and your family to remain **at home** during illness?

Other care pathways out of acute hospital (if no inpatient beds at Wantage Community Hospital)

- What has been your experience of care in other community hospitals, short term nursing home and care home-based packages of care or for when you know someone has needed to access palliative and end of life care outside of their own home?
- What would help you and your family in circumstances when you would need to access these types of services?

SCENARIO 3: URGENT CARE (MINOR INJURY, ILLNESS AND MENTAL HEALTH) ACCESS NEEDS ON THE SAME DAY

- Wantage & Grove population made 1361 visits to an MIU over one year, which equates to an average of 3.7 total visits from this area this is forecast to increase by 2030 to around 4.8 visits a day to an MIU (1745 visits per year).
- Patients who need emergency treatment from Wantage & Grove largely go to the John Radcliffe Emergency department.

What this would mean:

- More urgent care could be supported in Wantage
- The range of planned care services (tests, treatment and therapy) currently provided would need to be reduced by around a half
- Hospital beds would need to continue to be accessed at other hospital and community sites

If Wantage Community Hospital didn't have an urgent care type service where else would this type of service be accessed?

Potential to explore an integrated model with local NHS and care partners at the Health Centre

Abingdon MIU

24/7 Mental Health line (via 111)

Mental health, social care and community health services and crisis support

QUESTIONS

- If you were to need to access urgent care, what would be the process you would follow?
- What has been your experience with accessing these types of services for both physical health and/or mental health needs?
- What would make access to these types of services work well for you and your family?

OVERARCHING QUESTION

- Thinking about the different scenarios we've discussed, what do you see as the future role for Wantage Community Hospital and hospital-like services locally?

ABOUT YOU – DEMOGRAPHICS

Please let us know what area you come from by entering the first 4 digits of your postcode

Age Group

- 16-25
- 26-40
- 41-60
- 60+
- Prefer not to say

Do you consider yourself to have a disability

- Yes
- No

What best describes your gender

- Female
- Male
- Non-binary
- A gender not listed here
- Unsure how to describe myself
- Prefer not to say

Is your gender the same as the sex you were given at birth

- Yes
- No
- Prefer not to say

Ethnicity

- See list

NHS
Oxford University Hospitals
NHS Foundation Trust

Trust Headquarters
Academic Block, Level 3
John Radcliffe Hospital
Headley Way
Headington
Oxford
OX3 9DU

04 January 2024

Mr Grant Macdonald
Chief Executive Officer
Oxford Health NHS Foundation Trust
Trust Headquarters
Littlemore Mental Health Centre
Sandford Road
Littlemore, Oxford
OX4 4XN

Dear Mr Macdonald,

I am writing to clarify Oxford University Hospitals (OUH) Foundation Trust position in relation to work undertaken on the future of Wantage Community Hospital.

OUH has been engaged throughout the co-productive process, facilitated by Oxford Health Foundation Trust (OHFT) and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) to determine the future of Wantage Community Hospital. OUH acknowledges the resulting recommendations regarding in-patient beds, planned care services and urgent care.

In the event recommendations on the future of Wantage Community Hospital be agreed, OUH will work with the ICB and OHFT to confirm the outpatient services currently being delivered in Wantage Community Hospital.

The OUH Clinical Strategy 2023-2028[1] contains a principle to transform where we deliver services; this approach includes delivering care which is closer to patients. We are therefore committed to working with system partners to explore the opportunities to provide sustainable community clinic-based services from Wantage Community Hospital.

Yours sincerely

pp Sara Randall.

Professor Meghana Pandit
Chief Executive Officer

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Cllr Jane Hanna
Chair, Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1 ND

Second Floor
Sandford Gate
East Point Business Park
Oxford
OX4 6LB
Email: bobicb.bobchiefexecutiveoffice@nhs.net

Sent via email to: Jane.Hanna@oxfordshire.gov.uk

10 January 2024

Dear Cllr Hanna

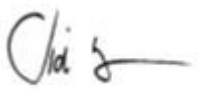
I am writing on behalf of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) with regard to the co-produced report on the future of Wantage Community Hospital.

I can confirm that the BOB ICB Executive Management Committee considered the draft co-produced report at its meeting on Monday 8 January and fully supported the recommendations, which are being presented to Wantage Town Council Health Sub-committee on 11 January and to Oxfordshire JHOSC at its extraordinary meeting scheduled for 16 January. I was especially pleased to read the extent of the co-production with stakeholders alongside the public involvement and engagement over recent months.

The future model described in the case for change aligns with our integrated care strategy and five year forward plan, supporting more people in their homes and offering expanded clinic-based services in communities. The report clearly demonstrates the ongoing commitment from local stakeholders and partners from the NHS, Local Authorities and voluntary community sector to co-production, capitalising on the success of this process, to implement the recommendations in the report.

I hope the report satisfies scrutiny at JHOSC this month and Oxford Health NHS FT can apply for Community Infrastructure Levy (CIL) funds to enable the adaptation of the building in the next phase of this project.

Yours sincerely



Dr Nick Broughton FRCPsych
Chief Executive Officer

Copied to

Cllr Jenny Hannaby, Chair, Wantage Town Council Health Sub-committee
Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care, OHFT
Grant Macdonald, Interim Chief Executive of OHFT

Oxford Health
NHS Foundation Trust

Chair, Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Chief Executive's Office
Trust Headquarters
Littlemore Mental Health Centre
Sandford Road
Littlemore
Oxford
OX4 4XN

Sent via email only to: Jane.Hanna@Oxfordshire.gov.uk

9th January 2024

Dear Cllr Hanna,

Oxford Health Foundation NHS Trust (OHFT) is pleased to have engaged with the Wantage and Grove community to co-produce a plan for the future of Wantage Community Hospital, built on a successful, co-produced stakeholder and public engagement programme.

The OHFT Executive has duly considered the co-produced work summarised in the report and confirms its support for the report's recommendations, which are being presented to Wantage Town Council Health Subcommittee and to Oxfordshire JHOSC in January 2024. The Trust Executive fully supports the future service model for the hospital recommended in the report, as a joint recommendation with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Commissioning Board (BOB ICB) and other local stakeholders. This will result in more clinic-based services being provided out of the hospital, rather than the re-opening of community inpatient beds. Plans to progress an application for Community Infrastructure Levy (CIL) funding to support future capital investment into the hospital were also endorsed by our Executive, to enable the provision of more clinics at the hospital that will benefit local residents.

As highlighted in the report, the Trust remains committed to continuing to work closely with the local stakeholders and our health partners to successfully implement these recommendations, including the ongoing co-production of the future plans for the hospital and its services.

Best wishes,

G. Macdonald

Grant Macdonald
Interim Chief Executive

Copied to:-

Cllr Jenny Hannaby, Chair, Wantage Town Council Health Subcommittee
Dr Ben Riley, Executive Managing Director for Primary, Community & Dental Care, OHFT
Dr Nick Broughton, Interim Chief Executive, BOB ICB
Daniel Leveson, Place Director for Oxfordshire, BOB ICB

Wantage Town Council Motion on Wantage Community Hospital:

The Council notes that the co-production exercise has determined that:-

1. On average 1361 OX12 residents per year currently access the Minor Injuries Units elsewhere in the County – predominantly in Abingdon. It's estimated that this will grow to 1745 visits per year with the forecast population growth.
2. Approximately 60 OX12 residents through the year are placed in In-patient Community Hospital beds elsewhere in the County (5 per month with a 34 day average stay). This number is not expected to grow due to the changes in alternative health and care pathways.
3. Currently, 1445 OX12 residents per year have used the ophthalmology outpatient appointments pilot at Wantage Community Hospital. The ICB have indicated that approximately 21,168 OX12 residents per year would benefit from expanded outpatient services if additional clinic space was made available (30,240 visits in total).
4. Within the hospital building there is insufficient space to provide more than one of the options of inpatient beds or expanded outpatient clinic offering.
5. The capital cost of providing a MIU in Wantage would be in excess of £3 million given the need for it to include comprehensive X Ray facilities to be fully viable.

Given the above the Council is minded to support the recommendations of the co-produced report. Namely the permanent retention of existing outpatient pilot clinics and additional outpatient services which would be facilitated by accessing approximately £600,000 of CIL funding to carry out necessary refurbishments and other capital expenditure.

In agreeing to the above the Council also:

1. Welcomes the commitment by the ICB to bring forward plans to source palliative care beds in the local community but also will continue, through discussions with Health partners including OCC Social Services, to seek ways by which early discharge and inpatient rehabilitation can be provided locally – for example within local nursing home settings.
2. Appreciates the engagement with health partners so far and wishes to continue this to identify means by which services provided by a Minor Injuries Unit or First Aid Unit could be sourced locally. For example, we note that GP led Urgent Treatment Centres are provided in some communities and would, inter alia, wish to explore if this is a facility that could be provided at Mably Way.

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC): Wantage Community Hospital Update Item

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 16 January 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the future of Wantage Community Hospital.

2. The Committee felt it was crucial to receive an update on the outcome of the Public Engagement Exercise undertaken by Oxford Health NHS Foundation Trust and key local stakeholders, with a view to receive an understanding of which specific hospital-like services would be delivered on the ground floor of Wantage Community Hospital. Lucy Fenton (Transformation Lead – Primary, Community & Dental Care, Oxford Health NHS Foundation Trust); Susannah Butt (Transformation Director-Primary, Community and Dental Care, Oxford Health NHS Foundation Trust); Dr Ben Riley (Executive Managing Director-Primary, Community and Dental Care, Oxford Health NHS Foundation Trust) were invited to discuss the final co-produced report providing details on both the outcomes of the Public Engagement Exercise around Wantage Community Hospital, as well as on the final offer from the NHS as to the future of services that will be provided at the Hospital following the closure of the in-patient beds in 2016.

3. The previous OX12 project involved working with the community as well as a HOSC Working Group between 2018 and 2020. The final report recommended the likelihood of the closure of the beds being permanent. Nonetheless, there was no explicit outcome for planned alternative provision. There was a refurbishment and bringing back of maternity services with live births during 2022 by Oxford University Hospitals NHS Foundation Trust. This followed scrutiny from HOSC as well as funding contributions by the Wantage Hospital League of Friends. Several temporary pilot hospital services were also launched and reported to HOSC by Oxford Health.

4. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects health as a whole; and this includes scrutiny over decisions as to the future of hospital services being provided to local residents throughout the county. There is also a recognition by the Committee that the future of Wantage Community Hospital has been a matter of discussion for several years since the closure of the inpatient beds in 2016, and that it was necessary to reach a resolution that would be suitable and acceptable to the local community in Wantage.

5. The Committee had set up the HOSC Substantial Change Working Group in February 2023, and its members have held a total of five meetings. This

Working Group, supported by the Health Scrutiny Officer, has been issuing ongoing recommendations to the HOSC (which have been agreed with the NHS), and has also provided advice and scrutiny to help support the process of coproduction around the future of Wantage Community Hospital. In line with what was agreed on the 30 June HOSC meeting, the Working Group has held two online check-ins with representatives of the ICB and Oxford Health on 30 August and on 24 October; these were to discuss the engagement with the local stakeholder reference group as well as the planned wider public engagement. As part of these check-ins, the Working Group requested and discussed information around the following areas: details and timelines for the stakeholder engagement events; the options around what the hospital's future services could potentially look like; the nature of the survey that was utilised to gather the public's views; and the barriers and enablers around the options being presented to the community as to how the hospital's ground floor services should be configured moving forward.

6. During the Engagement Exercise, the Community and stakeholders were presented with three scenarios as to how future services could be delivered on the ground floor of the hospital. These included:

    1. **Clinic based services** (tests, treatment and therapy) for planned care appointments.

    2. **Community inpatient beds** and the alternatives when care in people's own homes was not possible.

    3. **Urgent care** (minor injury, illness and mental health issues) access needs on the same day.

7. In the final coproduced report submitted by the NHS to the Committee for the 16 January meeting, recommendations were made for a sustainable future for Wantage Community Hospital and integrated working across the NHS and to be in ongoing co-production working with the local community.

8. The purpose of this item on 16 January was to receive absolute clarity on the outcomes of the Public Engagement Exercise (to include details of how residents who participated in the stakeholder sessions as well as the survey felt about how the hospital's future services should be configured), as well as into the final decision as to what was being offered by the NHS as to which specific hospital-like services would be delivered and how this would be the case.

9. During its meeting on 23 November 2023, the Committee received an update on the Public Engagement Exercise, which had not yet concluded at the time. The Committee agreed to the following recommendations which were issued by the Substantial Change Working Group:

    1. Defer the decision as to whether the closure of beds at Wantage Community Hospital constitutes a Substantial Change.

2. Defer the decision on whether to refer to the Secretary of State for Health and Social Care the matter of the closure of beds at Wantage Community Hospital.

3. Agree an extra HOSC meeting to be scheduled in mid-January to make a final determination as to whether to make a referral to the Secretary of State is necessary in relation to the removal of beds at Wantage Community Hospital, and as to whether declare the removal of the beds as a Substantial Change.

10. There were two key reasons as to why the Committee agreed to the recommendations outlined above. Firstly, the Committee needed to await the successful completion of the Public Engagement Exercise conducted by the NHS around the hospital's future, and this included the need to await the publication of the final co-produced report. Secondly, it was pivotal for the Committee to receive further clarity on the barriers and enablers around the potential future services to be offered at the hospital, and whether there were sufficient resources to support what will be offered.

SUMMARY

11. The Committee had received a written report from the Health Scrutiny Officer, which provided some context as well as clarity over the process around the decision that the Committee would have to make during this item.

12. The Committee Chair explained that the members of the Substantial Change Working Group (Cllr Hanna, Cllr Barrow, Cllr Champken-Woods, and Cllr Hayward) had considerations as well as provisional recommendations which were to be shared verbally with the Committee by herself.

13. The Chair reminded the Committee that 31 January 2024 was the date that formal powers of referral to the Secretary of State by HOSCs were to be removed by the government, and that this had influenced the necessary timing of this extra meeting and the intensity of work (including the public meetings that had been held in the lead up to the HOSC meeting).

14. The Oxford Health (OH) Executive Director of Primary Care and Community Services explained that the Public Engagement Exercise had represented an intense piece of work over the last 6 months, and it presented a fantastic opportunity to engage with local representatives and members of the stakeholder group to determine a secure future of Wantage Community Hospital. It was explained to the committee that the coproduction with the local stakeholder reference group had shared various different sources of information and types of data available on the health needs of the population (including the Joint Strategic Needs Assessment as well as service data) that supported the findings in the report.

15. The Committee were informed of the importance of the local community's engagement in the exercise and its stakeholder engagement events, and how

the NHS had taken the views of the local community seriously and that these had influenced the recommendations.

16. The OH Executive Director of Primary Care and Community Services also reiterated the three scenarios as to how the hospital's future ground floor services (outlined above) that were presented to the community during the engagement exercise, and explained that there were some key principles that would be used to guide the decision as to the future services. Such principles included a consideration that the Community wanted clarity about a secure future for the Community Hospital and that it was imperative for there to be sustainability around the future services that will be agreed and delivered.

17. It was explained to the Committee that the recommendation that was ultimately proposed in the co-produced report was that the closure of the inpatient beds would become permanent, and for the redevelopment of the ground floor of the hospital into a clinic-based facility.

18. The OH Executive Director of Primary Care and Community Services stated that the Trust would progress an application for Community Infrastructure Levy (CIL) funding to support the refurbishment of the hospital's ground floor, but that the application would only proceed depending on the decisions of HOSC on the report.

19. The Committee were informed that letters of support had also been obtained from key stakeholders, who were supportive of the recommendations outlined in the co-produced report. These included letters of support from Oxford University Hospitals NHS Foundation Trust as well as Oxfordshire County Council.

20. The BOB Integrated Care Board Place Director for Oxfordshire also expressed thanks to Wantage Town Council and the stakeholders who participated in the Public Engagement Exercise; and explained that upon assuming his post as ICB Director of Place he had heard two things. Firstly, that the community wished to reengage with the NHS; and secondly, that they wished to resolve a secure future for Wantage Community Hospital. The Place Director thanked the Town Council and Stakeholder reference group for engaging in the process which has planned outcomes.

21. The Chair invited Cllr Hannaby, Chair of the Wantage Town Council Health Committee, to read out a motion that was passed unanimously (the full text of the motion can be found below as appendix 1. Cllr Hannaby added her own observation that she hoped that in the future there could be local availability of national capital funds for much needed local health resource. However, Cllr Hannaby emphasised that Wantage Community Hospital needed to have a permanent future as local councillors had been active in pressing for this as far back as 2006 when plans for closure were made public. The plan funded by CIL capital and existing revenue would give the hospital this security and additional much needed hospital services. Working on the plan would mean continued trust in the NHS and a leap of faith, but she welcomed co-production and

thanked the NHS Director of Place for his offer to meet with the public again in June to share progress.

22. The NHS were asked for their response to the Wantage Town Council motion, and the NHS Director of Place welcomed the motion and thanked the Town Council and the stakeholder reference group. The Place Director explained that the NHS would clarify that the 3 million costing for a walk-in Xray is for capital and revenue costs and that the palliative care commitment is to continue to work with stakeholders so that Wantage would be included as a local area for additional services.

23. The HOSC Substantial Change Working Group welcomed the good understanding that had been achieved and that once delivered, the plan would give Wantage Community Hospital a sustainable future and would provide a growing population with a foundation of increased hospital services for the community for the next few years, and that this could be built on as and when the context of financial, estate, and workforce constraints improved.

24. The Committee were informed that 2022 marked the reopening of live births following OUH and HOSC liaison and the Wantage Stakeholder reference group; and the NHS had decided it would not be of interest to reopen this discussion as this service was confirmed. Options for the use of the ground floor were tested in respect of an inpatient hospital unit or repurposing the clinical space for a mix of specialist outpatient clinics with a mixture of preventative and urgent care. A data pack as well as the outcome of public engagement had been shared with the stakeholder reference group at a workshop on the 4 December 2023. OH would prioritise confirming the temporary clinics with OUH and would close the beds permanently so that the exact mix of additional specialist clinics could be worked up.

25. In terms of how and when CIL funding would be secured, the Director of Place reported that there had been communication with the CEO of the Vale District Council already. It was also the Substantial Change Working Group's understanding that provisional holdings of CIL funding with an estimate of the finance required could be made easily pending any formal application for funds. It was clarified that it would be Oxford Health NHS Foundation Trust that would make formal decisions concerning the hospital and make the application with system support for the funding. The committee was strongly of the view that a provisional holding of £600,000 be made by the NHS as soon as possible after the meeting.

26. In response to a query from the Committee regarding the assurances that Oxford University Hospitals could provide, the Trust's Director of Strategy and Partnerships gave assurance that she had attended the Wantage Community

Hospital workshops. OUH had a proven track-record of bringing out specialist clinics to Wantage Community Hospital. Hospital specialists liked coming to Wantage Community Hospital and the provision of additional clinics in community settings was very much part of OUH's strategy. The Director confirmed the commitment of existing clinical leads for their existing clinics as well as for working with partners to match the needs of the community with what additional hospital services OUH can deliver.

27. Moreover, the Committee also sought reassurances as to the liaison with Wantage Primary Care Network (PCN) for the proposed recommendations in the co-produced report. Oxford Health reported that liaison with the Primary Care Network with Dr Brammell had been effective. Dr Brammell had attended workshops also. There was a timings issue regarding receiving a communication from the PCN as the lead for the project was on maternity leave. Oxford Health had liaised with Dr Elaine Barber, the new clinical lead to ensure that the clinical lead received the report. Oxford Health were confident the PCN would be supportive of the plans and that Dr Barber specified that she would have expected that if there were any concerns at all, that these would have been communicated.

28. It was agreed by the Committee that ongoing scrutiny was essential going forward on both the process as well as the outcomes around the key stages outlined in the proposed project delivery plan. The assurance of coproduction was important as the exact outcomes would depend on each additional service and could include research as well as performance outcomes for the population.

HOSC WORKING GROUP CONSIDERATIONS:

29. The Substantial Change Working Group and the wider Committee had considered the co-produced report, and through scrutiny of the NHS engagement with the community and in agreeing to the recommendation NOT to refer this matter to the Secretary of State for Health and Social Care, had taken the following key points into consideration:

- ***Evidence of an intensive and good engagement process over six months***: The Working Group considered that this had been a much improved experience for the stakeholder reference group and Wantage Town Council Health Committee. The HOSC Working Group and officer worked intensively since the February HOSC meeting through to now with direct scrutiny and weekly engagement. The Working Group expresses thanks to the NHS partners, the Wantage Town Council Health Committee, and the stakeholder reference group which included the previously worked with community on the OX12 who have been involved throughout. The wider Committee would also like to thank the public who participated in public meetings as well as the survey.

- ***Time-tabled plan:*** The Working Group noted that the report presented includes a time-tabled plan to modernise the hospital, confirm temporary specialist clinics, and to open new hospital services. This differs from the

experience of the community and HOSC of the OX12 project which, after a lengthy process, resulted in a report in January 2020 that recommended the hospital inpatient beds, subject to further work to confirm, should permanently close without any proposed plan for improved hospital services or a timetable.

- ***Wantage Population Size:*** The NHS had also agreed to both the size of the population currently at 33,179 rising to 41,000 by 2030, as well as the history of the community hospital with the stakeholder reference group with the assistance of HOSC research https://mycouncil.oxfordshire.gov.uk/documents/s66454/Annex%201%20-%20Wantage%20Community%20Hospital%20Timeline.pdf . The NHS offer contained in the report, once delivered, would provide expanded community-based specialist clinic provision at a time of growing need and integration across the NHS to better join up as well as increase provision.

- ***Likelihood of losing benefit of CIL funding:*** The likely loss of the benefit to Wantage Community Hospital and the area's residents of CIL (Community Infrastructure Levy held for NHS health improvements in the Vale of White Horse) funding for the refurbishment of the hospital and the likely loss of benefit of securing the future of the hospital for hospital specialist services. The committee had heard from clinicians who had led the existing temporary hospital clinics that they wanted their clinic to be confirmed rather than being temporary in nature. The Working Group (and wider Committee) also heard from the public, who did not wish to lose the ophthalmology and other temporary clinics at the hospital.

- ***Sustainability of the proposed plan***: The stakeholder group had agreed that the plan proposed had to be sustainable to avoid loss of services. Working up a plan had to take account of the enablers and constraints, as this would be crucial for sustainability of the plan as well as hospital-like services more broadly. The key enablers and constraints were shared with a Stakeholder reference group workshop and meetings, and was also subsequently shared with the public. These included:

    (i) There were constraints of the estate available for hospital services in the community. Additional space had been a matter of liaison by the NHS with regard to whether estate was available at Mably Way Primary Care Network, although there was no available space at this time.

    (ii) The national context regarding capital available for local infrastructure improvements meant that the only funding available were CIL funds held for health at the Vale of the White Horse. This was the funding available if made a

priority by the NHS. This would happen if the HOSC supported the proposed recommendations in the co-produced report, with ongoing local scrutiny. A referral to the Secretary of State would have resulted in a delay to this funding.

(iii) There are also constraints related to workforce. Dr Ben Riley had explained to the public that there were serious shortages of workforce in some areas such as radiography for X-ray services. However, other areas of the workforce were well provided for such as community nursing.

- ***Letters of assurance***: The Working Group were pleased to see the letters of support and assurances that were provided with the co-produced report. It was reassuring to see the expressions of support for the proposed recommendations in the co-produced report from both Oxford University Hospitals NHS Foundation Trust as well as Oxfordshire County Council.

- ***Commitment to ongoing co-production:*** The Working Group are pleased to see that there is a commitment to ongoing co-production with the community as part of the project delivery plan for reconfiguring the services to be provided on the ground floor of the hospital and wider integration. It was also positive to see that the offer was being made to meet with the public to report progress against the project in June.

RECOMMENDATIONS

30. There were two sets of recommendations that were made during the item on Wantage Community Hospital on 16 January. The first was a recommendation made by the Working Group to the wider HOSC, which was:

*"That the matter of the closure of inpatient beds at Wantage Community Hospital is **NOT** referred to the Secretary of State for Health and Social Care."*

This recommendation was agreed by the wider Committee, in light of the points above, the report before the committee which includes the NHS offer, and the assurances given by organisations and letters of support. Additionally, apart from the Wantage Town Council Motion and a member of the public who had requested that the Committee did not refer to the Secretary of State, no member of the public or previously worked with community had petitioned HOSC to make a referral. At the public meeting a member of the public had expressed serious concern about the consequences of delay, and no member of the public had spoken in support of referral to the Secretary of State.

31. The second set of recommendations were those that were aimed at the NHS. Below is an outline of the specific wording of each of these recommendations,

as well as a brief description as to why each recommendation was being made:

No delay in securing CIL funding: The Committee understands that CIL funding will be utilised for the purposes of renovating the ground floor of the hospital in order to begin to deliver the clinical services outlined in the recommendations of the final co-produced report. Given the lack of available sources of funding for the purposes of this project, as well as the fact that the NHS has informed stakeholders that CIL funding from the Vale of the White Horse is the one capital source of funding that has been identified over the last six months, the Committee strongly recommends that the £600,000 available is formally applied for and utilised without delay. It is important that given that the inpatient beds have been removed since 2016, that there is some form of acceptable replacement of this within the hospital's services that also takes into account relevant local demand for clinical services.

The Committee is also recommending that the ground floor of the hospital and the space therein is maximised as much as possible for the purposes of expanding the specialist services that will be provided as well as confirming the clinics that have been supporting thousands of residents but that have been temporary in nature. This could allow for more space for a variety of services as well as the prospect of holding as many appointments as possible within as short a timeframe as possible (subject to staffing availability).

Recommendation 1: *That there is no undue delay in securing the CIL funding available in full for the purposes of providing the additional proposed clinical services on the ground floor of Wantage Community Hospital given the removal of the in-patient beds since 2016. It is recommended that there is a maximisation of the ground floor of the hospital for the purposes of expanding these specialist services.*

Clear Timescales and ongoing scrutiny: The Committee is pleased to see that a project delivery plan has been produced and proposed, and that this plan involves an outline of steps and actions that will be taken as to configuring hospital-like services as well as a timescale for each of the steps involved. This marks an improvement over the outcome of the OX12 exercise. Therefore, the Committee considers this delivery plan as a good starting point for understanding and anticipating how the specialist services will be expanded on the ground floor. However, the Committee also strongly recommends that there is ongoing oversight and scrutiny over this project delivery. It is important for this plan to remain on schedule for two reasons:

1. It has been several years that the community had been awaiting absolute clarity on what the future of the hospital will be. Adhering to the proposed timescales would therefore be crucial to maintain momentum as well as confidence and support in the process by key stakeholders and the wider community. As was highlighted during the HOSC meeting

on 16 January, the Committee (as well as Wantage Town Council) were engaging in a leap of faith by placing Trust in the process and proposals being put forth by the NHS.

2. Adhering to the timescales would allow for the proposed specialist services to begin to be delivered as soon as possible. The Committee is aware that there are many steps and stages that would be involved in this project, and therefore any undue delay should be avoided as much as possible.

Furthermore, the Committee also recommends for there to be ongoing scrutiny over the delivery of the proposed plan. Again, the final decision of the Committee represented a leap of faith, and the Committee has invested trust into the process. A healthy amount of ongoing scrutiny and engagement can help to ensure good momentum in the delivery of the project, and can help to provide reassurances not only to HOSC but also to key stakeholders and the wider Community/public.

Recommendation 2: *That the Project Delivery Plan for the future of the hospital's ground floor services is delivered on schedule as much as possible, and that there is ongoing scrutiny over the process of delivering the plan and its outcomes for the local population.*

Meeting with key organisations/stakeholders: The Committee is again supportive of the proposals being made by the NHS in the co-produced report, and feels that ongoing engagement with HOSC and the local community in Wantage are crucial for the success and sustainability of what has been proposed and agreed. Therefore, it is being recommended that an ideal stepping stone to all of this would be the convening of a meeting, as early as possible, between the key organisations and stakeholders involved. This meeting could help with the formulation and agreement of a plan for continued momentum on coproduction and for the purposes of agreeing a process of engagement and scrutiny moving forward. This would mark the beginning of a process of clear transparency around the delivery of this plan, and would also enable the spirit of coproduction to continue to exist on this journey.

Recommendation 3: *For a meeting to be convened as early as possible between identified leads within BOB ICB, Wantage PCN, Oxford University Hospitals, Oxford Health, Oxfordshire County Council, Wantage Town Council, and HOSC; with a view to plan for continued momentum on co-production and agreed scrutiny moving forward.*

Legal Implications

32. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

33. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

34. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Members Present during the meeting who **AGREED** to the aforementioned recommendations:

Councillor Jane Hanna
Councillor Elizabeth Poskitt
Councillor Nigel Champken-Woods
Councillor Jenny Hannaby
Councillor Nick Leverton
Councillor Mark Lygo
District Councillor Paul Barrow
District Councillor Katharine Keats-Rohan
Councillor Lesley McLean
Barbara Shaw

Annex 1 – Wantage Town Council Motion on Wantage Community Hospital

Annex 2 - Scrutiny Response Pro Forma

Contact Officer: Dr Omid Nouri
Scrutiny Officer (Health)
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

January 2024

Equality Impact Assessment - Wantage Community Hospital future service provision

The Equality Impact Assessment tool below should be undertaken in order to complete the Equality and Diversity section of the QIA.

		Yes/No	Comments
1	Does the project /service change affect one group less or more favourably than another on the basis of the 9 protected characteristics (Equality Act 2010):	No	It has been identified that the proposals for the future of services at Wantage community hospital will not impact significantly on any of the groups more or less favourably based on the 9 protected characteristics.
i	Age	No	The Community Hospital inpatient unit has not operated since 2016 and, as identified in the 2024 stakeholder group's report, multiple alternative services are now meeting the needs of older residents. The adverse impact of making this closure permanent in order to develop new clinic-based services will be minimal. Although the proposed new service model to provide a range of clinic-based services from the ground floor of the hospital is expected to predominantly provide services to adults, it also provides the opportunity to provide more local services to all age ranges, identified through the stakeholder co-production process.
ii	Disability - a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities	No	The proposal for more clinic-based services to be offered locally from the ground floor of the hospital will significantly increase the range of local services offered and thereby overall improve local access for those with disabilities and reduce the need to travel to other sites. Those with a disability were specifically considered throughout the engagement process, with participants being asked to self-declare if they had a disability to enable more detailed analysis of their views, alongside a dedicated focus group session to assess any additional considerations in regard to this group.
iii	Gender Reassignment	No	It is recommended that, to better understand any specific needs, the Trust should continue to take steps to reach this minority group as part of identifying the appropriate configuration of clinic-based services to be increased on the ground floor of the building and their access requirements.

iv	Pregnancy and Maternity	No	Maternity services will continue to be provided from the first floor of the hospital and are not impacted by this proposal.
v	Race - including Nationality and Ethnic Origin	No	No specific impacts have been identified, although it is recommended that, to better understand any specific needs, the Trust should continue to take steps to reach this minority group as part of identifying the appropriate configuration of clinic-based services to be increased on the ground floor of the building and their access requirements.
vi	Sex (Male, Female)	No	
vii	Religion or Belief (or lack thereof)	No	
viii	Sexual Orientation (Lesbian, Gay, Bisexual, Transgender)	No	It is recommended that, to better understand any specific needs, the Trust should continue to take steps to reach this minority group as part of identifying the appropriate configuration of clinic-based services to be increased on the ground floor of the building and their access requirements.
ix	Marriage and Civil Partnership	No	
2	Is there any evidence that some groups are affected differently?	No	The engagement process completed to date has sought to understand any disparities relating to the protected characteristics. It is recommended that this work is continued as part of the process to identify the final range of clinic-based services that will be available.
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	n/a	
4	Is the impact of the policy/ guidance likely to be negative?	n/a	
	If yes, can the impact be avoided?	n/a	
5	What alternatives are there to achieving the policy/guidance without the impact?	n/a	
6	Can we reduce the impact by taking different action?	n/a	

For advice in respect of answering the above questions, please contact: Equality and Diversity Lead.

Quality Impact Assessment – Wantage Community Hospital future service provision

This tool provides a template for carrying out a Quality Impact Assessment on a new or existing project, programme, or savings scheme. It is intended to support quality governance by assessing the impact of savings schemes and service change on quality. It is also intended to support the Trust in meeting its obligations under the Equality Act (2010), to undertake race, disability and gender impact assessments.

Scheme/Project/Programme Title	Wantage community hospital future service provision	
Project Director/Sponsor	Dr Ben Riley (Executive Managing Director - Primary Community & Dental Care)	
Author	Sue Butt (Transformation director) & Lucy Fenton (Transformation Lead)	
Date Completed	22/01/2024	
Medical Director Approval (Name and Date)	Karl Marlowe	29/01/2024
Director of Nursing Approval (Name and Date)	Britta Klinck	29/01/2024
Clinical Director Approval (Name and Date)	Pete McGrane	25/01/2024
Service Director Approval (Name and Date)	Emma Leaver	24/01/2024
Summary of Scheme/Project/ Programme	Wantage Community Hospital (WCH) is home to a range of community-based services. The Hospital is managed by Oxford Health NHS Foundation Trust (OHFT) and provides a range of NHS services from several healthcare providers. These include maternity services, community therapy services and specialist outpatient services (a number through a current pilot), providing clinical assessment, tests, treatment and therapy for the local community. Over the past year, Oxford Health has been working with NHS partners and the local community in a stakeholder group, to develop proposals to agree the future services to be provided at Wantage Community Hospital. This work has not included consideration of any changes to the first floor of the hospital, and it has been confirmed that these maternity services will remain. This Quality Impact Assessment considers the implication of implementing the recommendations to refurbish the ground floor of the community hospital to both confirm the existing permanent and pilot outpatient services and increasing the number of clinic-based services available.	

Impact Area	Summary of Impact	Current Risk			Risk Mitigation & Monitoring Arrangements	Residual Risk			Quality Metrics
		Impact	Likelihood	Risk Score		Impact	Likelihood	Risk Score	
Patient Safety	There are no material patient safety issues identified as a result of this proposal. Any urgent and emergency care will continue to be provided through normal procedures. If sufficient staff cannot be recruited to provide the relevant services, then this could result in a negative patient impact, however this is an enhancement of existing services, and usual process will be taken to managing any staffing pressures.	2	2	4	Consideration will be given to any staffing implications when determining which clinic services will be provided on the ground floor of the hospital. These will be dealt with through regular monitoring of staffing pressures.	2	1	2	
Clinical Effectiveness	Bringing together of increased specialist clinical expertise within the community provides the opportunity to better understand interdependencies and so there are no negative implications identified as a result of clinical effectiveness.	-	-	-		-	-	-	
Patient Experience	Patients who access clinic-based services will be able to access them in Wantage where previously they would have had to travel to another site. Clinic-based services have been identified as benefiting a much larger number of patients than would be served by an inpatient ward (estimated approx. 20,000 rather than 250).	2	5	10	Patients who require inpatient type services benefit from a significant increase in care provided at home through new services such as the urgent community response and an expansion of hospital @ home provision. This means that fewer patients are now admitted to an inpatient bed and so this will have less impact than it would have done previously.	2	3	6	

	Relatives of patients requiring community rehabilitation inpatient beds (older adults) may need to travel further than when an inpatient ward was provided at the hospital.								
Equality and Diversity	See Equality impact assessment for more details, no impacts identified based on protected characteristics.	-	-	-		-	-	-	
Non-Clinical/ Operational Impact	n/a	-	-	-		-	-	-	
Summary Rating	Highest Rating = Summary Score	2	5	10		2	3	6	

If Current Summary rating is 12 or higher Part B must be complete