

PUBLIC

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



BOARD OF DIRECTORS' MEETING

Wednesday, 22 May 2024
09:00 – 12:30

Microsoft Teams virtual meeting

Agenda

<u>INTRODUCTORY ITEMS</u>	Paper/ Reading Room	Purpose	Lead	Indicative Time
1. #Hellomynameis and apologies for absence ¹	-	Welcome	Chair	09:00
2. Patient Story – Buckinghamshire Adult Mental Health Services	BOD 26/2024	Discussion	Chief Nurse	09:05
3. Staff Story – Apprenticeship Programme, Abingdon Community Hospital	BOD 27/2024	Discussion	Chief People Officer	09:20
4. Declarations and Register of Directors' Interests	BOD 28/2024	Update	Chair	09:35
5. Minutes and Matters Arising of the meeting held on 27 March 2024	BOD 29/2024	Approval	Chair	
<u>STRATEGIC, REGULATORY & SYSTEM</u>				
6. Trust Chair's report	BOD 30/2024	Discussion	Chair	09:45
7. 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 31/2024	Discussion	CEO	09:55
8. 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 32/2024 RR/App 17/2024	Information & Assurance	AD of Corp Affairs	10:10

¹ Apologies: Amélie Bages, Executive Director of Strategy & Partnerships

PERFORMANCE, PEOPLE & SUSTAINABILITY

9. Annual Plan 2024/25 (including financial planning update)	BOD 33/2024	Approval	Chief Finance Officer	10:20
10. Integrated performance and sustainability reporting: a. Integrated Performance Report (IPR) ² ; b. Safety & Quality Dashboard; and c. Finance report	BOD 34/2024	Information & Assurance	Exec Team	10:35
<i>10 minutes' break (if required)</i>				11:15
11. Board Committees' update reports and recommendations from recent meetings:				11:25
a. 3As reports (matters for Alert, Advice and Assurance) from Committees (see Reading Room for supporting Committee minutes and agendas)	BOD 35/2024 RR/App 18-23/2024	Discussion	C'ttee Chairs	
b. Committee recommendations: i. Quality Committee recommendations: • Director of Infection Prevention & Control annual report; • Complaints annual report; and • Research & Development policy	RR/App 24/2024	Approval	Chief Nurse and QC Chair	
ii. People, Leadership & Culture Committee: Guardian of Safe Working Hours and Medical Education reports	RR/App 25/2024	Assurance	Chief Medical Officer and PLC Chair	

QUALITY & PEOPLE

12. Freedom To Speak Up Guardians' annual report	BOD 36/2024	Assurance	LB/RBS/ Chief People Officer	11:40
13. Patient Safety Incidents (PSI) report	BOD 37/2024	Assurance	Chief Nurse	11:55

GOVERNANCE & REGULATORY

14. Corporate Registers: receipt of gifts and hospitality	BOD 38/2024	Assurance	AD of Corp Affairs	12:10

CONCLUSION & RESOLUTION TO CONDUCT PRIVATE BUSINESS

² The IPR is being redesigned and the new format is scheduled for June/July 2024, in the interim the current format is provided using March 2024 data.

15. Any Other Business	-	-	Chair	12:20
16. Questions from the public and any governors or staff attending	-	-	Chair	
17. Review of the Meeting	-	-	Chair	
18. Resolution by the Board to exclude the public and conduct its business in private for confidential matters which may be prejudicial to the public interest if conducted in public or for other reasons	-	Approval	Chair	

Meeting Close

12:30

Next meetings in public:

- 26 June 2024 (Annual Report & Accounts)
- 24 July 2024

READING ROOM/APPENDIX

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

19. Appendix to the Chief Executive's report:

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

20. Appendices to the Corporate Affairs update report (paper - RR/App 17/2024):

- Legal, Regulatory & Policy update;
- Board Assurance Framework (strategic risks)
- Charity and Involvement impact and updates; and
- Communications and Engagement

21. Meetings, minutes, agendas and supporting information from Committees:

- Audit Committee on 22 February 2024 and agenda for 23 April 2024 (paper - RR/App 18/2024)
- Charity Committee on 07 February 2024 and agenda for 07 May 2024 (paper - RR/App 19/2024)
- Finance & Investment Committee on 12 March 2024 and agenda for 09 May 2024 (paper - RR/App 20/2024)
- Mental Health & Law Committee on 29 February 2024 and agenda for 13 May 2024 (paper - RR/App 21/2024)
- People, Leadership & Culture Committee on 30 April 2024 (paper - RR/App 22/2024)
- Quality Committee on 08 February 2024 and agenda for 02 May 2024 (paper - RR/App 23/2024)

22. Quality Committee recommendations (paper - RR/App 24/2024):

- Director of Infection Prevention & Control annual report;
- Complaints annual report; and
- Research & Development policy

23. People, Leadership & Culture Committee: Guardian of Safe Working Hours & Medical Education reports (paper - RR/App 25/2024)

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

Board of Directors

BOD 26/2024
(Agenda item: 2)

22 May 2024

**Triangle of care within Buckinghamshire Adult Mental Health Services (as
experience by a family in an adult Inpatient ward & a Crisis Team)**

For: Information

Executive Summary

Oxford Health NHS FT has adopted the Triangle of Care, a therapeutic alliance between carers, service users and health professionals. It aims to promote safety and recovery and to sustain wellbeing by including and supporting carers.

A carer can be anyone of any age who provides unpaid support to someone who could not manage without their help, due to their illness, disability, frailty, mental ill health, or substance misuse. Anyone can become a carer. Carers come from all walks of life, all cultures and can be any age. They may be a wife, husband, parent, partner, son, friend or have any other relationship with someone who cannot manage without your support.

Summary of the story

The carer's journey focuses on the need for services to work together with the families and carers of our patients and the impact it can have on both the family and the patient when this doesn't happen.

It raises the questions; are we realising the benefits of working with families and carers to support our patient's recovery? Are we making enough progress to embed the Triangle of Care and adopt a culture where effective communication,

active listening, involvement and sharing of information with carers is a consistent part of our working practice.

It also demonstrates the challenges faced by services and raises many questions for example:

- What can be done differently from a leadership perspective to support and enable services (front line services) to adapt and change practices that promotes value and add value to people's experiences of our services?
- How can involvement be made involvement at all levels in someone's journey in the Trust?

Nine years since their son's first admission, the carer had hoped that their son's relapse and subsequent second admission would bring a better experience than the first. Since they had spent the past couple of years getting involved in the Trust's work through the Triangle of Care.

The carer explains "that we were always happy, at any time, to help you with the incredible work you do. We know it's not an easy job but equally it's not easy being an untrained carer either". The carer will be in attendance to tell their story.

About the services involved

Buckinghamshire Inpatient Unit

The inpatient unit provides services to adults of working age across Buckinghamshire. For some patients this may be a brief stay for intensive treatment and support, others who suffer from severe and enduring mental illness may require more frequent admissions.

The wards offer a multi-disciplinary team approach to the provision of patient care. The interventions include talking therapies, medical input, socialisation, and social skills as well as assessment of needs and medication.

This service forms part of the patient pathway and works in conjunction with our community mental health teams, crisis response and home treatment team, as well as assertive outreach and early intervention service.

Crisis response and home treatment team

The crisis team is a seven day a week specialist team of staff who support people who are in acute mental crisis to prevent admission to hospital where possible and facilitate early discharge from the inpatient wards with intensive home treatments. The team is run by staff who are psychiatrists, psychologists, nurses, social workers, occupational therapists, peer support workers and administrators.

Recommendation

The Board is asked to note the story, discuss, and agree on steps/actions to be taken to enable and support directorates/services to embed all the triangle of care standards working alongside our families and carers. There is no risk to escalate.

Authors and Title: Dianne (Di) Hilson- Carers Lead Trust wide
Rose Hombo - Deputy Director of Quality

Lead Executive Director: Britta Klinck Chief Nurse - CNO

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

BOD 27/2024
(Agenda item: 3)

Board of Directors

22 May 2024

Staff Story

For: Discussion

Executive Summary

This staff story comes from Susan Halliwell, who has developed within the Trust through our apprenticeship programmes.

Susan was an HCA on the Abingdon Stroke unit, with a goal of becoming a Registered Nurse. Following completion of the Care Certificate, Susan started her Apprenticeship journey in 2019 with the Senior Health Care Support Worker level three.

She excelled and completed her Apprenticeship in time to move smoothly on Trainee Nursing Associate Apprenticeship two years later, in 2021. Susan continued to work hard, including when faced with the challenges that COVID brought to Health staff during this time. Her determination and hard work paid off, and she transitioned well into a Nursing Associate role. She qualified two years later and became a Registered Nursing Associate (RNA), completing the required 6 months preceptorship before going onto the Degree Nurse Apprenticeship.

Susan is a shining example of how our apprenticeships can support the development of our existing staff towards and into registered nursing roles. The lead for the programmes Susan has undertaken said:

"It has been a pleasure seeing her grow in confidence to become a dedicated, enthusiastic, registered member of staff who has supported others on this journey and shared her experiences at Apprenticeship events."

Recommendation

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

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

Lead Executive Director: Charmaine de Souza, Chief People Officer

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

BOD 28/2024

(Agenda item: 4)

REGISTER OF DIRECTORS' INTERESTS

May 2024

PART A – CURRENT BOARD MEMBERS

PART B - FORMER BOARD MEMBERS DURING 2023/24

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

DECLARATION OF INTERESTS
PART A – CURRENT BOARD MEMBERS

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

¹ On maternity leave March 2024 – September 2024)

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.
Charmaine De Souza	Chief People Officer	Board member for Hightown Housing , a charitable housing association covering Hemel Hempstead and the surrounding area and counties of Hertfordshire, Buckinghamshire, Bedfordshire and Berkshire.
Chris Hurst	Non-Executive Director	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.
Britta Klinck	Chief Nurse	No interests to declare.
Grant Macdonald	Interim Chief Executive Officer ²	No interests to declare.
Karl Marlowe	Chief Medical Officer	Educational Supervisor, Clinical Studies, Oxford University Medical School (from Sept 2023). Chairman of The Social Interest Group Board (charity partnership working for marginalised populations). Includes directorships of: Penrose Options; Equinox Care; Pathways to Independence; Safe Ground; and SIG Investments (all unremunerated). Advisor to UNTANGLE GRIEF, digital peer support platform, and Tasting Colours, digital wellbeing service (both unremunerated). Wife is founder of 'Jump in puddles' a social purpose consultancy working with various innovation health companies and charities.
Ben Riley	Executive Managing Director for Primary, Community & Dental Care	Former GP Partner (left the practice in September 2021) at Dr C Kenyon & Partners, Beaumont Street Surgery, Oxford. The practice partnership holds shares in two of the four GP federations in Oxfordshire: OxFed Health & Care Ltd and Principal Medical Ltd. Formerly linked to OxFed Health & Care Ltd (non-profit trading company of OxFed, one of the four GP federations in Oxfordshire): until 01 May 2020 - Chair and Director; until 31 May 2020 - Director (retired); and until 30 September 2020 - Clinical Partnership Officer (part-time employee and not a board or director position)

² Interim since 01 July 2023. Formerly Executive Managing Director for Mental Health, Learning Disability & Autism Services

Philip Rutnam	Non-Executive Director	Chair, National Churches Trust. This is the national charity for churches, chapels and meeting houses. It provides grants, advice and support and advocacy, including supporting the use of the buildings for community benefit which may be relevant to health care. Council Member, University of Surrey, and Lay Member of Governing Body of the University of Surrey. The University is a partner in the Oxford Health Biomedical Research Centre and has active research and teaching programmes in health care. Non-Executive Director, Innovate Surrey Limited (ISL). ISL is the innovation and enterprise arm of the University, supporting business development, spin outs and growth. Chair, Advisory Board, WA Communications. WA is a strategy and communications consultancy active in a number of sectors including energy, transport, financial services, education and health care. Senior Adviser, Civil Service College. CSC is a not-for-profit entity separate from Government which provides training, consultancy and development services for mainly public sector entities in the UK and abroad. Assistant Churchwarden and Parish Council Member, Parish of Barnsbury, Diocese of London.
Mohinder (Mindy) Sawhney	Non-Executive Director	Non-Executive Director at Hampshire and Isle of Wight Integrated Care Board (remunerated) from 01 December 2023. Managing Director of root+branch ltd (management consultancy). Has previously undertaken engagements with related bodies including the General Medical Council, health charities and suppliers to the NHS. Husband was Chief Customer Officer at NHS Test and Trace - secondment ended 01 June 2021. Husband commenced as Chief Operating Officer at the Bank of England in January 2022.
Heather Smith	Chief Finance Officer	Non-Executive and unremunerated Member of the Board and Trustee of Arts at the Old Fire Station (AOFS), a charity. AOFS shares the Old Fire Station building in Oxford with the homelessness charity Crisis and encourages people from all backgrounds to understand and shape the world in which we live through stories, creativity and the arts, and by connecting with others. Family member is General Manager at Latis Scientific Limited, who deliver water testing services to various NHS organisations both directly and via 3rd parties. Latis provide laboratory testing and technical consultancy services including advice on water systems such as management of microbiological risk. Latis Scientific is a subsidiary of SUEZ which is a consortium owned multinational company based in France specialising in water and waste services.
Richard (Rick) Trainor	Non-Executive Director	Exeter College, University of Oxford: Professor Sir Richard Trainor - Rector (Head) of Exeter College; Chair of the Governing Body and various college committees; Trustee of the affiliated Michael Cohen Trust; and Director of companies related to the College including Checker Hall Company Limited, Collexoncotoo Limited and Exeter College Trading Limited. University of Oxford (central functions): Pro Vice Chancellor without portfolio (presiding at ceremonies and chairing/serving on appointment boards for professors and other senior posts); member of the Audit & Scrutiny Committee; member of the Divisional Board, Social Sciences Division; and member of the History Faculty.

		Vice President & Trustee of the Economic History Society, Chair of the Scholarship Committee of the Jardine Foundation, Fellow and Emeritus Professor of Social History at King's College London, Chair of the Academic Panel of the Museum of London, Governor and Member of the Gift Acceptance Committee of the Royal Academy of Music (ending summer 2022) and member of the Council of Reference, Westminster Abbey Institute, Westminster Abbey. Various honorary affiliations including to: City of London; Institute of Historical Research, University of London; Merton College, Oxford; Rosalind Franklin University of Medicine and Science; Royal Academy of Music; Royal Society of Arts; Trinity Laban (Trinity College of Music); US/UK Fulbright Commission; University of Glasgow; University of Greenwich; University of Kent; and the Worshipful Company of Educators. Spouse has honorary affiliations to the University of Glasgow and to Wolfson College, Cambridge.
David Walker	Trust Chair	Miscellaneous journalism, lecturing and writing. Partner is a member of the NHS Assembly - created 2019 to advise NHS England and NHS Improvement on delivery of improvements in health and care, potential to influence NHS policy affecting the Trust.
Lucy Weston	Non-Executive Director	Chair of Red Kite Community Housing (charitable housing association in Buckinghamshire). Formerly Chair of Soha Housing (stepped down in September 2023) and Director of SIB Property Ltd (subsidiary of Soha). Self-employed - Lucy Weston Consulting.
Andrea Young	Non-Executive Director	Board Governor at University of West of England (second term running July 2023 – July 2026) and member of its Audit Committee. The University is the trainer and supplier of Allied Health Professionals and Nurses in the West of England, which may be relevant to contracts/services in the Bath, Swindon and Wiltshire area. Member of the Independent Reconfiguration Panel, providing independent advice to Ministers on changes to health services (4-year appointment starting 18 March 2024). Self-employed independent coach/mentor and member of the Critical Coaching Group, a professional body for independent coaches and mentors. Partner owns/runs Wantage Natural Therapy Centre and is a practicing chiropractor with referrals from Oxfordshire GPs.

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

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

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

Meeting of the Oxford Health NHS Foundation Trust Board of Directors

BOD 29/2024

(Agenda item: 5)

Minutes of a meeting held on 27 March 2024 at 09:00 Microsoft Teams virtual meeting

Present:¹

David Walker	Trust Chair (the Chair) (DW)
Grant Macdonald	Chief Executive Officer (GM) – <i>part meeting</i>
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (RB)
David Clark	Non-Executive Director appointee of the University of Oxford (DC)
Geraldine Cumberbatch	Non-Executive Director (GC)
Charmaine De Souza	Chief People Officer (CDS)
Britta Klinck	Chief Nurse (BK)
Karl Marlowe	Chief Medical Officer (KM)
Kerry Rogers	Director of Corporate Affairs & Company Secretary (KR)* ²
Philip Rutnam	Non-Executive Director (PR)
Mohinder Sawhney	Non-Executive Director (MS)
Heather Smith	Chief Finance Officer (HeS) – <i>part meeting</i>
Rick Trainor	Non-Executive Director (RT)
Lucy Weston	Non-Executive Director (LW)
Andrea Young	Non-Executive Director (AY)

In attendance³:

Attendees/observers from Oxford Health NHS FT

Ben Cahill	Deputy Director of Corporate Affairs
Claire Forrest	Head of Clinical Standards – <i>part meeting</i>
Bernadette Kapungu	Quality & Governance Lead and joint Chair of the Race Equality Network – <i>part meeting</i>
Pete McGrane	Clinical Director, Oxfordshire Community Services
Andrew Mutandwa	Race Equality Programme Support Officer and joint Chair of the Race Equality Network – <i>part meeting</i>
Vanessa Raymont	Director of Research & Development (VR) – <i>part meeting</i>
Joe Smart	Head of Organisational Development – <i>part meeting</i>
Hannah Smith	Assistant Trust Secretary (HaS) (Minutes)
Amber Sparrowhawk	Experience & Involvement Lead – <i>part meeting</i>
Priya Thompson	Head of Strategy (PT)

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

² * = non-voting

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

Governor Observers

Ekenna Hutchinson

Staff Governor representing Oxfordshire Mental Health Services

Vicki Power

Staff Governor representing Community Health Services Oxfordshire

BOD 17/24	Apologies for Absence	
a	Apologies for absence were received from Amélie Bages, Executive Director of Strategy & Partnerships, Chris Hurst, Non-Executive Director; and Ben Riley, Executive Managing Director for Primary, Community & Dental Care.	
BOD 18/24	Patient Story - Oxfordshire Adult and Older Adult Mental Health Services	
a	The Experience & Involvement Lead explained that the patient's story and involvement was not unusual and had helped to inform improvements including: • increased focus upon prevention especially for patients with complex needs; • introducing mental health practitioners into primary care. This could bridge the gap for patients who were more complex but not enough for referral to secondary care; and • implementing a 'whole person' approach, supporting patients' mental health needs alongside their socio-economic needs. The Experience & Involvement Lead also acknowledged the Oxfordshire Mental Health Partnership (OMHP) which offered access to a wider range of services which supported people back into employment, education and stable accommodation, as set out in more detail in the report. Through the OMHP, the Trust worked with: Restore; Oxfordshire Mind; Response; Connection Support; and the Elmore Community Service.	
b	Non-Executive Director discussion raised whether the Trust could offer intervention and support at an early stage in life in order to make a positive difference which could have a lasting effect later in their life. The Experience & Involvement Lead noted that the Trust's involvement with this patient had been when they were an adult and accessing adult services; however, for younger people, more multi-agency work was taking place to work with schools and provide support for families.	
c	The Executive Managing Director for Mental Health, Learning Disabilities and Autism explained that he had personally worked alongside the Elmore Community Service for many years and they were a core part of the OMHP, providing third sector support in substance abuse and criminality; Elmore had also recently partnered with the Trust to work on the personality disorder pathway and to support patients with structured interventions Oxfordshire Mind also ran support groups that linked into the Trust's community healthcare hubs. He noted that more needed to be done as a system to support the prevention agenda.	
d	The Board noted the Patient Story. <i>The Experience & Involvement Lead and the patient left the meeting.</i>	

BOD 19/24	Staff Story from the Race Equality Network	
a	The joint Chairs of the Race Equality Network (REN), Andrew Mutandwa and Bernadette Kapungu, Andrew Mutandwa and Bernadette Kapungu highlighted: • challenges with chairing the staff network when this was not their full-time role and managing the expectations of members; • increasing workforce diversity, debiasing processes, implementing restorative just and learning culture principles, improving equality opportunities and career development and progression. Real or perceived lack of career development and progression, especially in achieving Band 8d roles or being selected for acting-up opportunities, had been raised along with the importance of receiving feedback if unsuccessful in job applications; • the need to help managers when making decisions on acting-up opportunities, and to address unconscious bias as part of recruitment training; and • the role of inclusion representatives on interview panels who were helping to check and challenge unconscious bias during the interview process (both joint Chairs had participated in this role). The Primary Care, Community and Dental Services Directorate now had a different approach to appointments and recruitment as a result of work with Andrew Mutandwa and Bernadette Kapungu.	
b	They noted that overall the Trust was a good place to work and it was gratifying to see former colleagues return to the Trust as a result. They also thanked: (i) the Chief Executive for having given fresh impetus to the REN and being open to challenging conversations; and (ii) Recruitment and Retention Teams in HR for working collaboratively with them, especially on supporting internationally recruited staff.	
c	In discussion, these points were made: • consistency across the organisation was still work in progress and not the main focus for the REN compared to retention initiatives to keep good staff; • it was difficult for staff to address sensitive areas openly and have ‘ask me anything’ conversations; however, this was where progress could be made to change perceptions; and • resourcing officers to support the work of the joint Chairs of this and other staff networks. The Chief People Officer noted that all staff network chairs held dual roles in the organisation and needed to be supported appropriately so that they were not subject to unreasonable demands.	
d	The Board noted the Staff Story. <i>Andrew Mutandwa and Bernadette Kapungu left the meeting.</i>	
BOD 20/24	Register of Directors’ Interests No interests were declared pertinent to matters on the agenda.	
a		
BOD 21/24	Minutes of the Meeting held on 31 January 2024	
a	The Minutes of the meeting were amended to refer to “reduction in prone restraint had not quite achieved its ambitious target but had still reduced by 40% <i>over the past three years</i>” (addition in italics).	HaS

b	Matters Arising Andrea Young referred to item BOD 07/24(a) on page 6 of the Minutes and asked for a response to her suggestion that it may be helpful if Executive accountability for oversight of particular regulatory activities was clearer. She suggested that a log of every regulatory body which the Trust responded to would be helpful. The Chief Executive replied that the Executive was reviewing a draft operating framework which would clarify this.	
BOD 22/24 a b c	Trust Chair's Report and system update The Trust Chair highlighted: - the open question of whether the Trust had a moral responsibility for the behaviour of arm's length organisations or suppliers which it paid or contracted with and the potential impact upon Executive time of monitoring their behaviour; - the revised Standing Orders of the Board at BOD 21/2024 and in a tracked changes version in the Reading Room at RR/App 16/2024; and - the approval of the Council of Governors for the appointment of Chris Hurst to the role of Vice Chair and of Philip Rutnam to the role of Senior Independent Director (with more detail on those roles contained within the revised Standing Orders and the updated Senior Independent Director job description included at paper BOD 14(ii)-(iii)/2024). Lucy Weston said meeting and training between Trust staff and staff from other organisations providing children's services were still happening for many education and social care teams but some medical staff may be missing out due to work pressures. There were still opportunities for more strategic conversations to be taking place between those involved in children's care, including the NHS, local authorities and the voluntary sector. The Board noted the report.	
BOD 23/24 a b c	Chief Executive's Report The Chief Executive noted improved scores in the Staff Survey but that the Trust was on a journey of continuous improvement and would need to demonstrate improvement year on year. In future he would comment upon the recent joint targeted inspection in Buckinghamshire from the CQC, Ofsted (Office for Standards in Education, Children's Services and Skills) but at this stage he summarised that it had been a positive inspection. He also thanked the Director of Corporate Affairs & Company Secretary for her work on the Board, noting that this was her final Board meeting in public and wishing her well in her new role. The Board noted the report.	
BOD 24/24	Corporate Affairs update report	

a	The Director of Corporate Affairs & Company Secretary highlighted: - the role of the Extended Executive, through the Extended Leadership Team meetings, would evolve in relation to risk management with increased oversight of operational risks; - the pre-election (purdah) period for the 2024 local authority elections on 02 May 2024 would require the Trust to maintain political impartiality; and - Charity, Involvement & Volunteering supporting material in the Reading Room.	KR
b	Learning from the independent review of Greater Manchester Mental Health NHS FT (Edenfield), included: - their board papers had aggregated data to such a high level that there was no obvious way of identifying hotspots at ward level or visibility of understaffed services; - their governance framework had not escalated serious quality concerns in a timely way; - a lack of helpful, relevant data for frontline clinicians to help them to understand the quality of care they were delivering; and - the risk of unhealthy sub-cultures being created across an organisation.	
c	She would circulate: the Government's response to the rapid review into data on mental health inpatient settings; the Government's response to the Joint Committee on the draft Mental Health Bill; the CQC's report on Monitoring the Mental Health Act in 2022/23; and a Guide for NHS trust board members on reducing health inequalities.	
d	Philip Rutnam referred to Board Assurance Framework (BAF) risk 1.1 (utilising digital, data and technology to drive quality, efficiency, economy, research and innovation) and emphasised that this was a critical risk to be monitored as it underpinned core areas for the organisation. Although its future monitoring may be shared by both the Finance & Investment Committee and the Quality Committee, a decision on this would need to be made and documented.	
e	The Board noted the report and that a decision on monitoring and ownership of BAF 1.1 would need to be made and documented. <i>The Head of Organisational Development joined the meeting.</i>	
BOD 25/24	Staff Survey results	
a	The Chief People Officer and the Head of Organisational Development (OD) explained that although the 51% response rate was the highest number ever received to date by the Trust, the scores on the 'We are Safe and Healthy' People Promise element had been hidden to comply with a directive from the National Staff Survey Coordination Centre which had instructed all trusts to not yet report on this element. Overall, all 6 of the reported People Promise elements, and the themes of Staff Engagement and Morale, had increased their scores since 2022. Specific initiatives had contributed to the improved scores, such as the PDR season initiative, the introduction of the new Retention Team (turnover rates for the organisation had been decreasing for over 6 months) and the Staff Survey 'one action' approach supported by coaching and team events from OD Team.	

b	The Board discussed: - the risk of aggregating data to such a high level that there was no obvious way of identifying hotspots or probing the data; - Board attention would be required to areas or teams with the lowest scores as there may be some correlation between those areas or teams and high stress levels or quality issues; - assurance that such low-scoring areas had been identified, investigated and appropriate action was being taken or support provided; - the OD Team would be working with these services where scores had fallen; and - the Quality Committee had recently reviewed Learning Disability performance indicators and these had indicated some high vacancy levels and other changes further to local organisational restructuring which may be worth taking into consideration.	
c	The Board APPROVED the report and noted that the Staff Survey results would be acted upon and used as a source of data to drive improvements across the Trust. <i>The Head of OD left the meeting.</i>	
BOD 26/24 a b c d	Annual Plan 2024/25 (including financial planning update) and review of 2023/24 position The Chief Finance Officer and the Head of Strategy explained that NHS Financial Planning had been delayed due to ongoing funding discussions between NHS England and the Government. Therefore, a FY25 Financial Plan was not yet available for approval but the FY25 Capital Plan had been included amongst the Board's private papers for consideration. The Board acknowledged and supported the stronger strategic focus of the draft FY25 Annual Plan, noting that the identification of the Strategic Enablers would help to unlock organisational progress, together with alignment of planning with financial resources. The Board discussed: - Quality Indicators could better capture measures of effectiveness, in particular in relation to patients being able to access care. There were concerns that: (i) without access-to-care metrics or measures then the Board may not be able to exercise oversight of how the Trust was helping to address health inequalities; and (ii) the Trust may not be learning from outcome measures or being as ambitious about this as other Mental Health trusts; - there were already 16 Quality Indicators and it may not be practical to keep on adding to the list of indicators, especially after the Board had already spent time looking at these measures; and - caution around change control and noted that if the Trust were to adopt a new set of metrics then there would need to be an audit trail to advise the Board on why changes were being made. The Chief Finance Officer explained that outcome measures would be key in order to measure effectiveness. However, from a system perspective, some of the ways of capturing that outcome information were only just being rolled out and it would not be possible to report on these this financial year, therefore progress measures were	

e	provided instead. She was also not aware of other trusts successfully aggregating outcome measures yet.	PT/ HeS
f	During the year progress would be reviewed against a strategic dashboard and the Finance & Investment Committee would also undertake oversight of delivery against the Annual Plan, so as to provide the Board with additional assurance. A new Integrated Performance Report would also report on the metrics. An audit trail to track changes to metrics would be included in the strategic dashboard and available as an Annex with the updated FY25 Annual Plan for the May Board meeting.	
g	The Board APPROVED: • in principle the draft FY24/25 Annual Plan, acknowledging that final approval was likely in May 2024 to allow for most of the Integrated Care System priority work to be completed; and • the FY25 Capital Plan in order to progress capital projects, acknowledging that baseline budgets would be issued but still subject to further revisions over April-June 2024 depending upon Integrated Care Board and national timelines. The Board also noted: the year-end update for the FY23/24 Annual Plan; and the Financial Plan and Budget update. <i>The Director of Research & Development (R&D) joined the meeting</i>	
BOD 27/24	Research & Innovation report	VR/KM
a	The Chief Medical Officer commented upon changes to the team with the retirement of the Head of R&D and the Chair of the Oxford Academic Health Partnership and noted his thanks to both. The Director of R&D explained that the report was now more focused upon new developments in research clinics and trials; she also confirmed that many research clinics were involved in delivering care and innovative treatments to patients.	
b	The Dementia Mission would be critical for the strategic case which would be put forward for the Warneford redevelopment project and welcomed giving this a higher profile in discussions. The Director of R&D agreed that more emphasis could be put upon the Dementia Mission but noted that its infrastructure was currently less developed than that of the Mental Health Mission.	
c	The Trust Chair commented that the appointment of Professor Rachel Upthegrove as Director Designate and Senior Clinical Researcher of the Oxford Health Biomedical Research Centre, due to officially start in August 2024, may also present new opportunities for wider national collaboration.	
d	The Director of R&D took an action to include research clinic work on Virtual Reality could be in future reporting. The Board noted the report. <i>The Director of R&D left the meeting.</i>	
BOD 28/24	Integrated Performance and Sustainability Reporting	
a		

b c d e f	The Chief Executive introduced the report and explained that the Trust continued to perform well against the NHS National Oversight Framework metrics with the ongoing exception of inappropriate Out of Area Placements (OAPs) and Minor Injuries Unit 4-hour performance targets. The use of inappropriate OAPs remained lower than the previous year however numbers continued to fluctuate based on clinical demand and acuity. The report also included an update on the project to support the recovery of reporting in response to the clinical systems outage. Since the last update, work had continued on re-flowing national datasets and the re-launch of the Trust's intelligence platform for staff. Recovery work would continue into FY25. However, the Trust would continue to have gaps in its data as: i. the clinical systems outage had resulted in data not being recorded in systems; and ii. the new systems had reduced functionality due to the pace at which they had needed to be implemented, although this gap would be closed as the new systems were optimised. Currently, the estimated data gap due to system functionality was approximately 10%. Directorate highlights and escalations from the Executive Managing Directors The Executive Managing Director for Mental Health and Learning Disabilities noted that issues remained around ongoing pressures across services. Strategic Objective 1: Quality – deliver the best possible care and outcomes The Chief Nurse noted that the Quality Objective Key Results had been reviewed and would change from April 2024 in line with the Trust's strategic and quality objectives. She highlighted: • there were still data availability issues hampering reporting on completion of the Lester Tool for people with enduring Serious Mental Illness (SMI); • spot checks were taking place to provide assurance that people with SMI were receiving appropriate physical healthcare and that physical health clinics were taking place. Local intelligence from teams was that there had been an increase in reviews and availability of physical health clinics; and • 74% of staff overall had completed their Oliver McGowan autism training (level 1). Level 2 of the training was being developed with system partners as it required face-to-face provision but development had been paused by the Integrated Care Board until 2024-25. Although vacancies had reduced, demand for District Nursing services in particular had increased nationally. Work had taken place to help District Nursing teams to prioritise their caseload and focus upon those patients with the greatest need; District Nurses had been doing excellent work to keep their patients safe. Strategic Objective 2: People – be a great place to work The Chief People Officer highlighted that: • the Trust was on track against the NHS England target on reduced agency usage and having taken over as interim Executive lead for temporary staffing, she had ideas for opportunities for further savings; and	

g h i	on statutory and mandatory training, the Trust was at 90.5% against a target of 95%. Finance report and Strategic Objective 3: Sustainability The Chief Finance Officer summarised that all key indicators were currently green-rated. Income and Expenditure and Cash were all performing better than plan; and £1.3 million had been set aside in the forecast for any unknown year-end pressures and for Private Finance Initiative exit costs being higher than estimated (the accounting implications were being worked through). Since the report had been written, forecast Capital overspends had reduced and the Capital forecast was now for a balanced position. In relation to Sustainability, she reported that: (i) a deep dive had been undertaken into the Estates budget and this would be worked on with the new Interim Director for Estates & Facilities; and (ii) the Trust's Green Plan had been discussed at the Extended Leadership Team and there was positive engagement in the Green Agenda. The Board noted the report.	
BOD 29/24 a b	Board Committees' update reports The Board took as read the 3As reports on matters for Alert, Advice and Assurance from the Audit Committee, Quality Committee, Finance & Investment Committee and Charity Committee. The Director of Corporate Affairs & Company Secretary presented the revised Standing Orders of the Board, as recommended by the Audit Committee at paper BOD 21/2024 (tracked changes version in the Reading Room at RR/App 16/2024) and confirmed that housekeeping updates had been made. The Board APPROVED its revised Standing Orders, as recommended by the Audit Committee, and noted the 3As updates from the Audit Committee, Quality Committee, Finance & Investment Committee and Charity Committee, with supporting minutes and agendas in the Reading Room.	
BOD 30/24 a b c	Mortality and Suicide Prevention reporting The Chief Medical Officer reported that learning from deaths was informed by a range of sources from Coroners' inquests, local learning from deaths of people with a learning disability and the Integrated Care System Learning from Deaths Network. The key areas of focus for learning identified from mortality reviews were: (i) end of life care in relation to timeliness of care; (ii) suicide prevention involving communication with families; and (iii) early identification of physical deterioration, including early identification of sepsis. cases of deaths in mental health services were analysed separately from deaths of older patients in community hospitals or community care. All Learning Disability deaths were reported into the national Learning Disability and Mortality Review (LeDeR) process and national findings were then fed back to, and considered by, the Mortality Review Group. The Board noted the report.	

BOD 31/24	Patient Safety Incidents (PSI) report	
a	The Chief Nurse reported on learning identified from 18 PSI reviews completed in January and February 2025 and 5 reviews within the new local incident response plan under the national Patient Safety Incident Response Framework (PSIRF) which the Trust had transitioned to in December 2023. Further to the report, there had also been one domestic homicide case which would be subject to domestic homicide and mental health homicide review.	
b	The Board discussed how to receive reporting on themes from learning and get a sense of trends under the new national PSIRF. The Board agreed that it could be helpful to have a more in-depth workshop on PSIRF in approximately a year's time when PSIRF had had a year to operate.	
c	The Board noted the report and that in Q4 FY25 or Q1 FY26 the Board should hold a workshop on the national Patient Safety Incident Response Framework once it had had a year to operate. <i>The Chief Executive and the Chief Finance Officer left the meeting.</i>	HaS/ BK
BOD 32/24	Journey to Excellence update	
a	The Head of Clinical Standards joined the meeting and, together with the Chief Nurse, presented slides on the Trust's Journey to Excellence. Resources to support services and staff to improve their readiness for inspection and maximise learning opportunities had been developed including a staff guidance pocketbook, team leaders' evidence toolkit and regular Communications updates to demystify the inspection process.	
b	The Board noted the update.	
BOD 33/24	Corporate Registers: (i) application of Trust's seal; and (ii) receipt of gifts and hospitality	
a	The Director of Corporate Affairs & Company Secretary presented the reports and, from the report on the application of the Trust's seal she highlighted the execution of: (i) the Conditional Options Agreement and supporting leases and other documents for the Warneford redevelopment project; and (ii) the lease at Jordan Hill Business Park.	
b	From the report on Gifts, Hospitality and Sponsorship, she noted that some cases of potential acceptance of vouchers were under investigation. If vouchers were found to have been accepted from patients or their families then there would have been a breach of policy and this would be discussed with staff who would be reminded of the guidance to follow from NHS England. However, if it were to be possible to decline or redirect the vouchers to the Trust's Charity then this would be done as an alternative.	
c		KR

Public

d	Further to a suggestion from the Chief People Officer, the Director of Corporate Affairs & Company Secretary took an action to include the name of the organisation which had provided sponsorship for a medical away day. The Board noted the reports.	
BOD 35/24 a	None.	
BOD 36/24 a	Review of the meeting No comments received.	
BOD 37/24 a	Board resolution to conduct further business in private The Board resolved to exclude the public and conduct its business in private for confidential matters which may be prejudicial to the public interest if conducted in public or for other commercial or financial reasons. The Trust Chair explained that any such private decisions taken would become public knowledge in due course and when appropriate and he would as usual provide an update to the Lead Governor afterwards.	
	The meeting was closed at: 12:24	

Summary of Actions from the Board meeting on 27 March 2024

Relevant Item	Action	Responsibility:
BOD 21/24 (a)	Amendments to Minutes from 31 January 2024 Item BOD 09/24(g) on page 9 to be amended to refer to "reduction in prone restraint had not quite achieved its ambitious target but had still reduced by 40% <i>over the past three years</i>" (addition in italics). Status: complete	HaS
BOD 24/24 (c)	Links/reports to circulate Following the Board meeting to circulate: the Government's response to the rapid review into data on mental health inpatient settings; the Government's response to the Joint Committee on the draft Mental Health Bill; the CQC's report on Monitoring the Mental Health Act in 2022/23; and a Guide for NHS trust board members on reducing health inequalities. Status: complete – circulated over email by the Director of Corporate Affairs & Company Secretary on 27 March 2024 after the Board meeting in public	KR
BOD 26/24 (e)	Annual Plan 2024/25 An audit trail to track changes to metrics would be included in the strategic dashboard and available as an Annex with the updated FY25 Annual Plan for the May Board meeting. Status: completed/on the agenda for the private meeting	PT/HeS

BOD 27/24 (d)	Research & Innovation reporting To include research clinic work on Virtual Reality in future reporting. <i>Status: not yet due/on hold – for next regular Research & Innovation reporting in July or September 2024.</i>	VR/KM
BOD 31/24 (c)	Patient Safety Incident Response Framework (PSIRF) In Q4 FY25 or Q1 FY26 the Board should hold a workshop on the national Patient Safety Incident Response Framework once it had had a year to operate. <i>Status: not yet due/scheduled – for private Board Workshop in February or April 2025 or Board Seminar in May 2025.</i>	HaS/BK
BOD 33/24 (c)	Report/register of Gifts, Hospitality & Sponsorship Further to a suggestion from the Chief People Officer, the Director of Corporate Affairs & Company Secretary took an action to include the name of the organisation which had provided sponsorship for a medical away day. <i>Status: complete – report updated after the meeting to clarify that the sponsorship had been received from Lundbeck.</i>	KR

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

Board of Directors

22 May 2024

Trust Chair's report and system update

For: Information/ Discussion

BOD 30/2024
(Agenda item: 6)

Executive Summary

Recent weeks have had an internal focus, perhaps because it is the season for end of year assessments and looking back at the past twelve months. It is also because the quality and safety of our services depend on our people and so on how they are treated, developed, managed and appraised. We need to attract them, keep them and help them grow, which is why our people function – human resources in old speak – is so important and within it learning and development. The recent gathering of HR staff at Unipart was vibrant and enthusiastic, even accepting that some of the biggest determinants of staff wellbeing are outside the direct control of the Trust, pay and pensions especially.

What was impressive at that event was the widespread sense that the people (HR) function, while important, can only support (while hoping to influence) day to day management on wards and in teams. It is there on the proverbial front line that so much of the 'culture' of the organisation is knitted. We use that richly ambiguous word a lot in the NHS. It usefully covers everyday behaviour and the attitudes and assumptions staff bring to their dealings with patients and colleagues, especially reflexes and taken-for-granted habits. We aspire to a culture – a pattern of behaviour – based on mutuality, respect and, in a wider as well as clinical sense, caring.

By chance the same day HR staff met, psychiatric consultants from across the Trust came together for the kind of session that happens too rarely – to deliberate and

think in company with professional colleagues. Dr Kezia Lange had organised an intriguing contribution from a specialist in medical law and ethics on 'kindness': he posed the question whether doctors should be required as part of their practice to be kind to their patients. Amid thoughtful contributions, colleagues discussed various dimensions of their interaction with patients, their families and carers and the special issues that arise when the former may be acutely unwell and lack capacity. Is it 'kind' to detain a patient for their own good? One theme that emerged was reciprocity: how far patients and carers must also treat their doctors and other clinicians with respect. Data is sketchy but there are indications that the volume of abuse of clinicians by patients and families has been rising.

Staying with the theme of people, I am responsible for the development of the Board, both collective and individual, for the Non-Executive Directors. I know some colleagues worry about navel gazing and inwards focus at the expense of keeping a close eye on performance, especially helping patients. The two should not conflict. On the knowledge and effectiveness of the Board depend the services the Trust provides. In that spirit, the Board recently held a session looking at its obligations under law and regulation – on health and safety and under mental health legislation. Trust staff are responsible for ensuring the Trust carries its responsibilities on a daily basis but it is salutary for the Non-Executive Directors to be reminded of their corporate obligations, which range from fire safety to water tanks to the way detained patients are treated. Directors are not going around holding fire drills or checking the temperature in our fridges but we have to be assured these things are happening. We have to trust our staff – not that they are mindlessly ticking boxes but that they are imbued with a sense of the necessity of checking, and insisting colleagues do what is necessary when the (practice) fire bell sounds. It is back to that word 'culture', meaning we are an organisation where it is second nature to be alert to risks and deal with them as a matter of course, regardless of whether inspectors or directors are looking over people's shoulders.

Recommendation

The Board is asked to note the report.

Author and Title: David Walker, Trust Chair

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **Strategic Objectives/Priorities** – *this report relates to the following Strategic Objective(s)/Priority(ies) of the Trust:*

- 1) *Quality - Deliver the best possible care and health outcomes*
Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).
- 2) *People - Be a great place to work*
Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.
- 3) *Sustainability – Make best use of our resources and protect the environment*
Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects

**Report to the Meeting of the
Oxford Health NHS Foundation Trust
Board of Directors
22 May 2024**

BOD 31/2024
(Agenda item: 7)

Chief Executive's Report

International Nurses Day

I'd like to open my report by noting the celebrations for International Nurses Day which took place this year on the 12 May. The Trust organised a number of events in the run up to and following the 12 May and has used the occasion to launch a new nursing newsletter. The first edition of the newsletter includes a welcome from our Chief Nurse, Britta Klinck, and a focus on learning and development opportunities and quality improvement. I'd like to express my personal thanks to all our fantastic nurses who make such a remarkable difference to so many lives day in and day out.

Mental Health awareness week

The 13-19 May marked Mental Health awareness week. The week has been running since 2001 and aims to give a national focus each year and raise awareness of the importance of good mental health. Public awareness and understanding of mental health has improved over the last 20 years and this has significantly improved the lives and life chances of many people, however there is always more to do.

As a leading NHS mental health provider Oxford Health is at the forefront of this work ranging from working with a variety of partners to help prevent mental health conditions before they become more acute - for example the Trust's Keystone mental health and wellbeing hubs set up to support, treat and help to rehabilitate those with a range of mental health conditions. A new Keystone mental health and wellbeing hub opened on

the 14 May in Cowley, the site also being home to the Oxford Community Action (OCA) Café.

Mental health first aiders – fifth anniversary

April marked the fifth anniversary of Mental Health First Aiders at the Trust. Mental Health First Aiders are Trust colleagues trained to identify, listen, reassure and help colleagues who may be experiencing challenges with their mental health – this can make a real difference by giving someone the help they need when they need it most.

Over the five years, the Trust has trained over 500 Mental Health First Aiders working to the target of one in ten staff being training in the role. The training has been led by a team within Learning & Development since April 2019 and the five-year anniversary sees the team meeting the national training targets. My thanks to the team and all those who have done the training and put it to good use supporting the wellbeing of colleagues and those around us.

Luther Street Medical Centre

I was very pleased to visit the newly refurbished Luther Street Medical Centre earlier this month and to meet with some of the staff there. The centre is an award-winning GP surgery and has been providing important healthcare and support for people who are homeless or vulnerably housed in Oxford city for nearly forty years.

I really valued speaking with staff there and was very impressed by the relationships built up with population they serve. It is an important facility and although the refurbishment may be seen as a small change it makes a big difference to the experience of those using and working there.

Royal College of Psychiatry awards

Trust colleagues had significant success at the recent awards of the Royal College of Psychiatry with twelve colleagues winning or securing a finalist positions across a range of categories. My congratulations to all the winners and shortlisted finalists:

Dr Monty Lyman (Trainee innovator of the year); Dr Shah F Tarfarosh (Trainee peer of the year); Dr Bethany Elder (finalist – Foundation doctor of the year); Dr Isabel Leach & Dr Anneka Tomlinson (finalists – Core trainee of the year); Dr Heidi Cooper, Dr Douglas Kohler & Dr Anna Mead-Robson (finalists – Higher trainee of the year); Dr Douglas Kohler (finalist – Trainee peer of the year); Dr Jacek Lindner (finalised – Trainee innovator of the year); Dr Hasanen Al-Taïar & Dr Daniel Maughan (finalists – Psychiatric trainer of the year); and Prof Rupert McShane and Dr Jacek Lindner (finalist - Psychiatric Trainer and Trainee Project of the Year 2024).

Oxfordshire Healthy Children and Young People's Public Health Service

Following the Trust's successful tendering to continue provision of the Oxfordshire Healthy Children and Young People's Public Health Service; the service is now being rolled-out across the county from April. The new service - which brings together health visiting, school health nursing and the family nurse partnership into an integrated service has given the Trust an opportunity to improve the way services for families and young people access and are provided with services.

The new 0-19 model retains the wealth of experience and commitment of the Trust's existing teams and brings in effective ways of working including access to the service through a single point of access team. Key aspects of the new service include health visitors, community public health nurses and community public health associates who will working with children up to eight years old where there are known concerns or vulnerabilities, and the introduction of a new universal four-year health and development review.

Research work on blood biomarkers in dementia

In early April, it was great to see the colleagues gaining national media attention for research work on blood biomarkers in dementia. The BBC coverage featured Oxford Health's Research & Development Director, Dr Vanessa Raymont. Dr Raymont is Senior Clinical Researcher and Honorary Consultant Psychiatrist for Oxford University. It was great to see this important work being recognised: [Alzheimer's: Thousands to trial blood tests for dementia - BBC News](#).

Administrative & Clerical conference

On the 16th April a series of sessions were held focused on the Trust's administrative and clerical staff. These colleagues are critical to the smooth running of clinical services and the management and support of the corporate services. It's a large cohort of staff but can sometimes be overlooked as a profession. I attended the opening session of the day and greatly valued the conversations, questions and feedback from colleagues.

Governor elections

From the beginning of June, the Trust will have a number of new governors following the close of the governor election period in late May. Governors have a key role in representing the membership of the Trust and the public we serve, and in holding directors to account for the performance of the board. I look forward to meeting the new governors and to continue working with returning and existing governors at the 12th June Council of Governors meetings.

Lastly, I'd like to welcome Georgia Denegri to the Trust as the Associate Director of Corporate Affairs replacing Kerry Rogers on an interim basis following her departure the Trust at the end of April 2024.

Grant Macdonald, Chief Executive

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

22 May 2024

BOD 32/2024

(Agenda item: 8)

Corporate Affairs Update Report

For: Awareness and Assurance

Summary overview

This is the regular report to the Board, albeit in part in different format, providing updates on:

- a. legal and regulatory guidance relating to the work of the Trust;
- b. Board Assurance Framework (strategic risks);
- c. communications and engagement activity (see Reading Room); and
- c. Charity and involvement impact and updates (see Reading Room).

The key legal and regulatory guidance, relevant to the work of the Trust, issued from 1 April to 15 May 2024, is presented in Appendix 1.

A new format has been used which could be developed further according to the Board's feedback. Its purpose is to inform the Board of the guidance issued and agree at high level how it will be progressed through the committees and the Board.

The regular update on Board Assurance Framework (**BAF**) recent developments is presented in Appendix 2 whilst the full BAF is available in the Reading Room. The Board has already agreed that the BAF will be refreshed in the coming months.

Also available in the Reading Room are the regular communications and engagement activity update for March and April and the regular Charity and involvement impact update.

Governance Route/Approval Process

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

Recommendation

The Board of Directors is asked to note the report.

Authors and Titles:

Georgia Denegri, Interim Associate Director of Corporate Affairs (regulatory guidance)

Hannah Smith, Assistant Trust Secretary (BAF)

Jane Appleton, Associate Director of Communications and Engagement (communications and engagement update)

Julie Pink, Head of Charity and Involvement (Charity and involvement update)

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

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

Appendix 1

Legal and regulatory guidance published 1 April to 15 May 2024

	Publication and link	Trust's initial response and actions
1.	NHS Priorities and operational planning guidance 2024/25 NHS England published the priorities and national NHS objectives 2024/25. The guidance focuses on the recovery of core services through continuous improvement in access, quality, and productivity, whilst transforming the way the NHS delivers care and creates stronger foundations for delivery in the future. Link to website/document: Priorities and operational planning guidance 2024/25	These are being incorporated in the Trust's Integrated Performance Report and will be monitored by the Board and relevant committees. Board development or seminar sessions will be scheduled in areas where the Board will benefit from more detailed briefings, e.g. at the recent Board seminar, the Board received a presentation on patient safety and how we are implementing the Patient Safety Incident Response framework (PSIRF) which is the quality and patient safety national objective for 2024/25.
2.	Reducing health inequalities: a guide for trust board members, NHS Providers It includes a vision for what good looks like, a self-assessment tool and a list of suggested objectives for board members. Link to website/document: guide for trust board members outlining their role in reducing health inequalities.	Consider session at board workshop
3.	NHS Volunteers data collection NHS England introduced a new mandatory NHS Volunteers data collection for all NHS trusts and foundation trusts on Monday 1 April, with the first return due July 2024 for the previous quarter's data.	This is a new quarterly return, and arrangements are currently being developed for the collection of data and submission.

	The data will help to understand the number of volunteers, the hours contributed and to gather equalities information, aligning with workforce data. Data will provide a baseline to drive improvements in equality of access and opportunity. Link to website/document: Find out more about submitting your volunteer data	
4.	The reasonable adjustments digital flag: achieving compliance The Reasonable Adjustment Digital Flag is a national record which indicates that reasonable adjustments are required for an individual and optionally includes details of their significant impairments, key adjustments that should be considered, and underlying conditions. NHS England is preparing for full implementation of the digital flag; and they are asking organisations to prepare to conform to requirements by phase 1 from no later than April 2024. To support this, they shared a checklist, so organisations can ensure that processes are in place to identify, record, flag, share, meet and review and update reasonable adjustment needs on their own systems and records. The Reasonable Adjustment Digital Flag Information Standard mandate applies to NHS and independent providers, social care (as providers) as well as independent contractors such as GPs and dentists. It also impacts all health and care IT system suppliers. Links to websites/documents:	This work will be progressed through the Digital & Transformation Group with assurances escalated to the Information Management Group, the Executive Team and the Audit committee.

	digital flag action checklist Alongside, there is a good practice resource package on FutureNHS .	
5.	Guidance on visiting and accompanying in care homes, hospitals and hospices (Regulation 9A) The Care Quality Commission has published final guidance to help providers understand and meet the new fundamental standard on visiting and accompanying in care homes, hospitals, and hospices. It also sets out what people using health and social care services and their families, friends or advocates can expect. Link to website/document: CQC has published final guidance	This regulation aims to make sure: • people staying in a care home, hospital or hospice can receive visits from people they want to see • people living in a care home are not discouraged from taking visits outside the home • people attending appointments in a hospital or hospice, that do not require an overnight stay, can be accompanied by a family member, friend or advocate if they want someone with them. Compliance will be monitored by the Quality Committee.
6.	Improving fairness in practitioner performance management NHS Resolution has published research and resources aimed at understanding ethnic minority and international medical graduate practitioners' (IMG) experience of performance management. The resources cover themes including discrimination and bullying. Ethnic minority and IMG practitioners are disproportionately impacted by formal disciplinary processes as published by the GMC, and the NHS. NHS Resolution have also found that these groups are overrepresented in concerns reported to them by employers and contracting bodies and that Black and Black British practitioners are statistically more likely to face exclusion. Following on from these findings, NHS Resolution commissioned qualitative research from the company Opinion Research Services	For information. This research may be of interest particularly to the People, Leadership and Culture committee. The findings of the research show a mixed range of experiences with the Practitioner Performance Advice service and of the handling of cases by employers and contracting organisations, as well as experience of racism in the wider NHS.

	(ORS) into the lived experiences of ethnic minority and IMG practitioners for whom it received a request for advice from their Practitioner Performance Advice service. Link to website/document: practitioner performance research and resources	
7.	Sexual safety in the NHS NHS England published an update on the sexual safety charter implementation and results from the NHS Staff Survey and the National Education and Training Survey which highlights the important work the NHS is doing to address domestic abuse and sexual violence. Link to website/documents: update on the sexual safety charter implementation and results from the NHS Staff Survey and the National Education and Training Survey NHS priorities and operational planning guidance 2024/25	In the NHS priorities and operational planning guidance 2024/25, NHSE are asking every organisation to implement the actions in the sexual safety in healthcare charter to improve safety at work. They are also asking organisations who have not already done so, to sign up to the charter and to appoint a domestic abuse and sexual violence (DASV) lead. The DASV lead works with the organisation to understand its survey results and to support a review of the organisation's policies in relation to sexual misconduct and domestic abuse. To support implementation of the charter, NHS England will be providing for local adoption or adaptation: • policies on both sexual misconduct and domestic abuse developed by an expert advisory group including trade union representation • training materials, including on how to respond appropriately to disclosures of sexual misconduct or abuse • improved support offers for staff • a toolkit signposting to sources of further support following a disclosure. Implementation to be overseen by the People, Culture and Leadership committee.

8.	Independent Review of Gender Identity Services for Children and Young People NHS England issued its response to Dr Hilary Cass who led a four-year review into gender identity services for children and young people. The review has been invaluable in helping the NHS introduce a fundamentally different model of care and improve and expand service provision for this vulnerable group of children and young people. Link to website/document: response to Dr Hilary Cass	For information.
9.	Managing research finance in the NHS Managing Research Finance in the NHS sets out good practice and other information to support NHS organisations to maintain or develop their research finance management policies and processes. Link to website/document: Managing Research Finance in the NHS sets	For information.
10.	NHS Premises Assurance Model (PAM) The latest version of the NHS Premises Assurance Model has been updated to reflect feedback from users and the working group, the NHS Constitution and changes in policy, strategy, technology and regulation. These updates ensure the model is as useful and	For information. Regular annual update of PAM.

	effective as possible for trusts. The model provides the assurance that actions needed to keep the NHS estate and facilities safe, effective, efficient and of high quality are in place. It includes self-assessment questions grouped into five areas: Safety, Patient Experience, Efficiency, Effectiveness, and Organisational Governance. PAM supports NHS trusts to prioritise investment decisions effectively, measure compliance with legislation and guidance, and ensure robust systems are in place. Link to website/document: NHS Premises Assurance Model	
11.	NHS Community Health Services (CHS) Data plan The Community Health Services Data Plan for 2024/25 to 2026/27 sets out how the NHS will improve the quality, relevance and timeliness of data to improve patient care and patient experience in community health services. It also outlines recommended actions for ICBs and CHS providers to improve the quality and timeliness of data. Link to website/document: Community Health Services Data Plan for 2024/25 to 2026/27	NHSE's plan for improving reliability of data at national, system or local level, to optimise and improve services, patient care and outcomes across care pathways. The actions NHSE has committed to delivering in this plan: • Produce a roadmap that recommends what and how national CHS data will be collected in future, and an overarching data model that reflects user requirements and priority models of care – by April 2024 • Work with the Department of Health and Social Care (DHSC) to ensure CHS representation in any plans to review the National Workforce Data Set, to ensure it provides reliable information about the CHS workforce – from April 2024 • Start a phased approach to onboarding all CHS providers onto Community FDE, based on learning from an early adopter

		phase and formal evaluation, and alongside a national support offer – from May 2024 • Establish transparent change processes for all national CHS specifications, with appropriate governance – by September 2024 • Work with NHS England regions to develop and implement an effective approach to harnessing and spreading good practice across the sector – by September 2024 • Develop a method of measuring waiting times in community health services at record level – by November 2024 • Develop guidance for CHS providers on what good data quality looks like – by November 2024 • Develop data visualisation tools for Community FDF, including feedback on data quality to enable providers to identify and make improvements quickly – by April 2025 • Review guidance for national CHS data specifications to ensure it is clearly defined which providers and services are in scope – by March 2025 • Engage with less digitally mature providers to understand their needs and design any appropriate national support for them to subsequently flow data – by March 2025 • Develop data visualisation tools for Community FDF, including feedback on data quality to enable providers to identify and make improvements quickly – by April 2025 • Review the NHS approach to CHS information standards – by April 2025 • Review existing CHS datasets, with appropriate consultation with data users, to inform decisions and plans regarding transition to automated, daily data flows – by May 2025 • Assess the carbon emissions associated with Community FDF – by March 2026

		• Develop an aligned, strategic approach to primary and CHS data development that supports integrated care – by March 2026 • Review possible financial incentives, and financial and regulatory levers, that could support and incentivise CHS data quality improvement – by April 2026 • Develop plans to improve data on the ethnicity, deprivation, gender, age, and specific clinical conditions identified in Core20PLUS5, of people who need community health services – ongoing • Develop plans to support the consistent use of clinical coding such as diagnosis (condition) in community data – ongoing • Work with the sector to develop definitions for specific community services, based on CHS priorities – ongoing • Work with the sector to develop clinical outcome, and patient outcome and experience, measures for specific priority pathways or patient cohorts based on CHS priorities – ongoing • Engage with clinical IT system suppliers and providers to support ICSs to address the challenges providers face with EPR system functionality, procurement, and interoperability – ongoing
12.	CQC well-led guidance for trusts CQC has published well-led guidance for trusts, developed jointly with NHS England, to provide a consistent understanding of what it means to be a well-led trust and reflect shared expectations across regulators. The guidance is part of CQC's broader new Single Assessment Framework, which applies to all regulated providers across the health and care sector.	The guidance describes how CQC will be assessing the well-led key question. It aims to help NHS trusts and foundation trusts understand what good leadership looks like. In new much simpler approach, Key Lines of Enquiry (KLOEs) have been replaced by quality statements (pitched at the level of 'Good') which are the obligations that providers, commissioners, and system leaders need to live up to. For each quality statement, there is guidance on 'what does good look like', further detail and context, and best practice/guidance. The quality statements for the well-led are:

This will be the basis for CQC's well-led assessments of NHS trusts and foundation trusts. CQC's well-led assessment will continue to be a key consideration as part of the NHS oversight framework, and the content of the well-led guidance for trusts is closely aligned to NHS England's leadership competency framework for board members to ensure a consistent approach to the development of trusts and their leaders. Link to website/document: well-led guidance for trusts	• Shared direction and culture We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these. • Capable, compassionate, and inclusive leaders We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively and do so with integrity, openness and honesty. • Freedom to speak up We foster a positive culture where people feel that they can speak up and that their voice will be heard. • Workforce equality, diversity and inclusion We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us. • Governance, management and sustainability We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate. • Partnerships and communities

		We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement. • Learning, improvement and innovation We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research. • Environmental sustainability We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same. We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same. A Board workshop on the well led and Trust's self-assessment to be scheduled.
13.	Death certification reforms The Department of Health and Social Care has confirmed that from Monday 9 September, all deaths in any health setting that are not investigated by a coroner will be reviewed by a medical examiner. The changes form part of the death certification reforms. Providers will be required to share records of deceased patients with medical examiner offices.	For information. Operational procedure to be implemented.
14.	Improving the working lives of doctors in training	Implementation to be overseen by the People, Leadership and Culture committee.

	NHSE's letter highlights ways to improve the working and learning experience of doctors and sets out actions for trust boards covering 3 areas: • increasing choice and flexibility • reducing time spent on mandatory training and improving payroll accuracy • creating a sense of value and belonging Link to website/document: Read our letter about improving the working lives of doctors in training.	
15.	Culture of care standards - Including those for people with a learning disability and autistic people The 12 standards apply to all mental health inpatient services. Topics include lived experience, safety, patient choice and therapeutic support. Link to website/document: Read our standards for mental health inpatient services.	In 2022, the Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme was established to support cultural change and a new bold, reimagined model of care for the future across all NHS-funded mental health, learning disability and autism inpatient settings. The culture of care standards for mental health inpatient care set out in this guidance supports all providers to realise the culture of care within inpatient settings everyone wants to experience – people who need this care and their families, and the staff who provide this care. They apply across the life course to all NHS-funded mental health inpatient service types, including those for people with a learning disability and autistic people, as well as specialised mental health inpatient services such as mother and baby units, secure services, and children and young people's mental health inpatient services. The standards represent the collective vision we all hold for our inpatient services. They were co-produced with people with lived experience of inpatient services and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff

		who work in inpatient settings at various levels of the organisation; voluntary sector organisations; royal colleges; and academic experts. Further consultation was undertaken with key stakeholders across the system, at national, regional, system and provider level, and with additional focus groups of people with lived experience, particularly those with experience of secure inpatient settings and people from Black and minority ethnic communities. Overseen by the Quality Committee.
16.	Psychological therapies for people with severe mental illness The guidance supports increasing access to services for people with severe mental illness, through upskilling and expanding the workforce. It includes the principles and competency requirements and outlines our national training offer. It is for mental health providers and ICBs. Psychological therapies for people with severe mental illness. Link to website/document: Read our psychological therapies guidance	Guidance aims to support mental health providers to deliver the Long Term Plan objective to increase access to psychological therapies for people with severe mental health problems, as part of a wider transformation of adult and older adult community mental health services. Implementation to be overseen by the People, Leadership and Culture committee.
17.	Dental workforce collection guidance – for NHS primary care dental contract holders NHSE's letter about the national dental workforce collection informs that the next data collection opens on 7 May 2024 and closes at midnight on Tuesday 28 May. Read our dental workforce collection guidance which provides advice on completing the collection and information on data relating to your dental practice and staff.	There have been longstanding concerns about the lack of data available at a national level to understand the dental primary care workforce. Therefore, a new biannual dental workforce collection was introduced in October 2023 to be completed by all General Dental Services (GDS) Personal Dental Services (PDS) contractors on a six-monthly basis.

	Link to website/documents: letter about the national dental workforce collection Read our dental workforce collection guidance	
18.	DHSC consultation on the NHS Constitution DHSC has published its consultation on the NHS Constitution. The NHS Constitution, last updated in 2015, has to be updated at least every 10 years by the Secretary of State for Health and Social Care. The consultation will run for 8 weeks. This is a DHSC consultation, patients, public and staff, stakeholders and partners can respond via the formal DHSC consultation process Link to website/document: consultation on the NHS Constitution.	For information. The NHS Constitution sets out the principles, values, rights and pledges underpinning the NHS as a comprehensive health service, free at the point of use for all who need it. It empowers patients, staff and the public to know and exercise their rights in order to help drive improvements in quality, efficiency and responsiveness throughout the NHS. It brings together, in one place, existing rights as set out in various legislation. It does not, in itself, create new rights or replace existing ones. DHSC is seeking views on how best to change the NHS Constitution. This consultation is part of the process to complete the 10 year review of the Constitution, as legislated for in the Health Act 2009.
19.	Duty of candour review - call for evidence The Department of Health and Social Care is reviewing the statutory duty of candour and has launched a call for evidence. The review is being conducted to understand to what extent the duty of candour is honoured, monitored and enforced. The call for evidence closes on Wednesday 29 May at 11.59pm. Link to website:	For information. This call for evidence forms part of a review by the Department of Health and Social Care (DHSC) to consider the operation (including compliance and enforcement) of the statutory duty of candour ('the duty') for health and social care providers in England. The review was announced in the government's response to the Hillsborough disaster report on 6 December 2023. The terms of reference for the review were published on the same day.

	DHSC is reviewing the statutory duty of candour and has launched a call for evidence	
20.	Dental recovery plan and recruitment incentive scheme NHSE's guidance includes information on the new patient premium; implementation of the minimum unit of dental activity value; recruitment; dental vans and contract reform. The Dental Recruitment Incentive Scheme (DRIS) aims to attract dentists to work in parts of the country that are struggling to attract workforce. Supporting resources include a repayment calculations template. Link to website: update on the dental recovery plan Read our DRIS guidance for dental practices and dentists	To be considered by directorate
21.	Mental health service specifications NHSE issued updated mental health service specifications for children and young people. They include a service overview; service aims and outcomes; and care pathways. Community forensic mental health services - This service specification describes a community-based Forensic Child and Young People's Mental Health Service (FCAMHS) model. The service will be delivered for a geographical area as defined by local commissioners but will generally cover one or more Integrated Care Systems, as determined by local arrangements.	Needs assessment by the executive team is relevant to the Trust and implications.

	Specialist mental health medium secure in-patient services - This service specification covers the provision of specialist Children and Young People's Mental Health Medium Secure Services (MSUs) for children and young people with forensic mental health presentations, who are detained under The Mental Health Act 1983. MSUs are delivered on a national footprint and children and young people are admitted via a central referral network. Links to website: community forensic mental health services specialist mental health medium secure in-patient services	
22.	Oliver McGowan training communications pack NHSE's Oliver McGowan mandatory training communications pack helps organisations raise awareness of Oliver's Training to staff and includes an update for members of the public. Assets include social media cards, email signatures and guidance on language. Links to website: Oliver McGowan mandatory training communications pack For further information about Oliver's Training visit The Oliver McGowan Mandatory Training webpage.	The Oliver McGowan Mandatory Training on Learning Disability and Autism aims to provide the health and social care workforce with the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. This statutory requirement is set out in the Health and Care Act 2022. NHS England wants to work with partners to raise awareness and ensure the health and social care staff complete Oliver's Training. This employer champion pack is to help health and care employers and integrated care systems who wish to become Champion Employers. The employer champion initiative supports Trusts to: • demonstrate your commitment to improve and save lives for people with a learning disability and autistic people • raise awareness of Oliver's Training and help your staff to understand why they need to complete it

		• celebrate your involvement in and progress with Oliver's Training • attract and recruit potential trainers • provide reassurance to people using your services, stakeholders and members of the public that progress is being made to meet the requirements of the Health and Care Act 2022 Overseen by People, Leadership and Culture committee.
23.	New HFMA NHS Audit Committee Handbook published in March 2024 The HFMA <i>NHS audit committee handbook</i> (the handbook), developed by the HFMA Governance and Audit Committee, is designed to help NHS governing bodies and audit committees as they review and continually re-assess their system of governance, risk management and control to ensure that it remains effective and 'fit for purpose', while also ensuring that there is a robust system of assurance to evidence it. The handbook has had a complete rewrite and replaces previous editions, including the last full hard copy version printed in 2018 and the online supplement published in 2022. The HFMA is grateful for the support provided by NHS England in providing this handbook. The handbook is freely available online and will be updated on a regular basis to ensure it remains relevant. In terms of its content, the handbook starts by explaining why governing bodies need audit committees and how they provide	Being considered as part of the review of the Audit committee's terms of reference.

	support in fulfilling statutory duties and organisational objectives. It then looks at how audit committees should be set up, before moving on to focus in detail on what they do and how they work with others. Practical examples are included throughout to bring the theory to life and cross references to further sources of guidance are included. The appendices also include example tools such as self-assessment checklists, agendas and terms of reference, as well as a comprehensive glossary of terms. The NHS Providers' briefing on the new NHS Audit Committee Handbook and the actual handbook can be viewed in below links. Link to website/document: nhs-providers hfma auc handbook- mar24.pdf (nhsproviders.org) NHS audit committee handbook HFMA	

Appendix 2

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 May 2024 edition of the BAF.

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

Since last reporting to the Board, the Executive Team meeting on 29 April 2024 reviewed an overview of the BAF and BAF movement over the past year, whilst the Extended Leadership Team meeting on 07 May 2024 reviewed an update on the TRR and Directorate Risk Registers including progress on migrating Directorate Risk Registers onto the same platform as the TRR. The Extended Leadership Team meeting, which is also attended by senior managers from Directorates, will approve changes to TRR risks and the removal of TRR risks, as part of their oversight of operational risks.

Board Committees also received their regular updates on BAF and TRR risks and undertook deep dives into selected risks through meetings of the Audit Committee on 23 April 2024, the PLC Committee on 30 April 2024, the QC on 02 May 2024 and the FIC on 09 May 2024. The Audit Committee meeting also reviewed the Internal Audit report into Operational Risk Management, which had received a rating of significant assurance with minor improvement opportunities.

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

- BAF 1.1 on *Utilising digital, data and technology to drive quality, efficiency, economy, research and innovation*, having been significantly revised to amalgamate risks around digital, data and triangulation of information, has been reviewed by both the FIC and the QC and is subject to further development and discussion on how oversight may be shared or allotted;

- BAF 1.5 on *Lack of local admission beds due to demand outstripping capacity*, has been updated in particular to highlight: (i) that the recently opened Psychiatric Intensive Care Unit is not yet working to capacity due to lack of staff; and (ii) the overall impact of vacancies and demand upon teams with finite capacity. Monitoring arrangements and mitigations are in place at a team level and overseen by each Directorate Senior Management Team;
- BAF 1.6 on *Sustainability of the Trust's primary, community & dental care services* has been updated to acknowledge the impact upon capacity in the Urgent and Emergency Care Pathway due to delays to the FY24 Estates work programme; and
- BAF 3.4 on *Delivery of the financial plan and maintaining financial sustainability* and BAF 3.14 on *Major Projects* have been discussed and reviewed at the FIC meeting on 09 May 2024. Although the Current Risk Ratings remain unchanged, the content of the risks has been updated and is available in the latest iteration of the BAF in the Reading Room. BAF 3.4 highlights gaps in controls and assurances in relation to: funding pressures and system shortfalls; agency spend; and the Cost Improvement Plans process.

Trust Risk Register

The Board is also informed of the escalation of the following risk from the Primary, Community & Dental Care Directorate risk register to the TRR: TRR 1194 on Planned Care Provision in relation to increasing demand on planned services within funded establishments. Controls are in place and mitigating actions are being advanced.

The full BAF is included in the Reading Room and an overview of the Trust Risk Register in the Private Reading Room.

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

Board of Directors

BOD 33/2024

(Agenda item: 9)

22 May 2024

**Annual Planning and Budget setting
For Approval**

Executive Summary

This cover note provides an update to the Board of Directors on Oxford Health's Annual Planning for FY24/25 and is accompanied by:

- OHFT (Oxford Health Foundation Trust) FY24/25 Annual Plan
- Financial Plan and Budget Update for FY24/25.

OHFT FY24/25 Annual Plan

Our staff at Oxford Health have worked together to develop our Plan for FY24/FY25 to bring to life our vision of ***Outstanding care delivered by an outstanding team.***

Challenges of demand, acuity and workforce continue against a backdrop of an increasingly constrained financial landscape. Despite these challenges, we continue to provide care and treatment to those who need it across a wide geography spanning Buckinghamshire, Oxfordshire, Bath, Swindon, and North Somerset.

The priorities teams have identified this year will help us to achieve our four strategic objectives:

- 1. Quality** – Deliver the best possible care and health outcomes
- 2. People** - Be a great place to work

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

4. Research & Education - Become a leader in healthcare research and education

Since the Board of Directors meeting on 27th March 2024, the key changes made to the Annual Plan include:

- further strengthened the focus on Outcome Measures, which is now included as a Strategic Programme (slide 15).
- expanded Mental Health Inpatient Improvement Programme to also include the Community Mental Health Framework and will now be known as the Mental Health Inpatient and Community Programme (slide 14)
- strengthened the focus on health inequalities both within the Patient and Carer Race Equality Framework programme via data analysis (slide 11) and within the Mental Health Inpatient and Community Programme via the focus on physical health checks to people with severe mental illness (slide 14)
- included workforce planning within the People Plan: Train Retain Reform & Temporary Staffing Programme (slide 12)
- further work on the Strategic Dashboard to identify data sources that can be used for the strategic metrics as well as relevant targets, and alignment to Quality Priorities where relevant.

Tracking/Monitoring of FY24/25 Plan

The Annual Plan will be tracked and monitored to ensure issues are escalated and priorities can be adjusted if required. It is proposed that a review against progress of the overall Annual Plan will be shared with the Board of Directors twice a year: a mid-year update in November 2024 and an end of year update in March 2025. These updates will be shared with Finance & Investment Committee prior to being shared with the Board of Directors.

The Executive Team will maintain a regular review of progress against the overall Annual Plan.

- Clinical directorates will review progress against their plans systematically and report these to the Executive Team on a quarterly basis to highlight achievements to date, outline next steps and to escalate any key issues for risks/ awareness.
- The Executive Team will maintain oversight of the delivery of the portfolio of Strategic Programmes and Enablers within the Annual Plan via the Strategy Delivery Group which reports through to the Executive Team.

Many of the Strategic Programmes have established Programme Boards which report to Committees which will continue. As part of the corporate strategy governance, we will work with Programme Senior Responsible Owners to ensure that the appropriate governance is established for each of the Strategic Programmes.

Financial Plan and Budget Update for FY24/25.

The final financial plan submission was made to NHSE (NHS England) on 2nd May with a planned deficit of £4.3m. The report includes the key details of this plan and changes from the draft plan submitted at the end of March. Due to the timescales the CEO and CFO were given delegated authority by the Board to approve the 2nd May submission. The Board is asked to formally approve the plan.

The report also includes further details about elements of the plan including agency and CIPs and an update on budget setting. The Board is asked to note these and raise any queries or concerns.

Governance Route/Escalation Process

The Plan was presented to Finance and Investment Committee on 9th May 2024 prior to being shared with the Board of Directors. An earlier version of the Plan was presented to the Board of Director's meeting on 27th March 2024 for approval in principle though the finance envelope was not confirmed at that stage and so the Plan could not be finalised.

The Board of Directors and Council of Governors have been fully sighted on the development of the Plan and details of the various meetings were included in the update to the Board of Directors meeting on 27th March 2024.

Statutory or Regulatory responsibilities

The Board of Directors is required to approve the Trust's strategic and operational business plans and associated financial plans.

Recommendation

The Board is asked to approve the Trust's Annual Plan and Financial plan, noting that change control will be applied by the Executive team if further changes are

required as part of the Integrated Care System's planning settlement and escalated to the Board if needed.

Author and Title: Priya Thompson, Laura Carter, Heads of Strategy, Alison Gordon, Head of Financial Management, Peter Milliken, Director of Finance
Lead Executive Director: Heather Smith, Chief Finance Officer

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** – *this report relates to or provides assurance and evidence against the following Strategic Objectives/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.

Oxford Health Foundation Trust (OHFT)

FY24/25 plan

Board of Directors

May 2024

Our staff at Oxford Health have worked together to develop our plan for FY2024/FY2025 to bring to life our vision of ***Outstanding care delivered by an outstanding team.***

Challenges of demand, acuity and workforce continue against a backdrop of an increasingly constrained financial landscape. Despite these challenges, we continue to provide care and treatment to those who need it across a wide geography spanning Buckinghamshire, Oxfordshire, Bath and North East Somerset, Swindon and Wiltshire.

The priorities which teams have identified this year will help us to achieve our four strategic objectives:

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

Our service delivery plans for the coming year are predominantly focused on improvement and include reviewing our models of care and improving access. We will also seek to continue to work in partnership with others within the Integrated Care Systems which we offer services.

We have asked each clinical directorate to identify their top priorities based on the needs of the local population, known service pressures and engaging with staff, patients and carers. In addition to this Oxford Health will also be working to deliver Integrated Care Board (ICB) and National guidance.

The outstanding care which we aim to deliver to patients not only improves their mental or physical health but also has wider benefits, particularly if we can target our help early and in community settings. For example, some of our community services allow patients to receive the care they need at home, safely and conveniently, rather than in hospital; our Talking Therapies services can support people's mental health and even help people achieve their goals including getting people back to work and to sustain them in work.

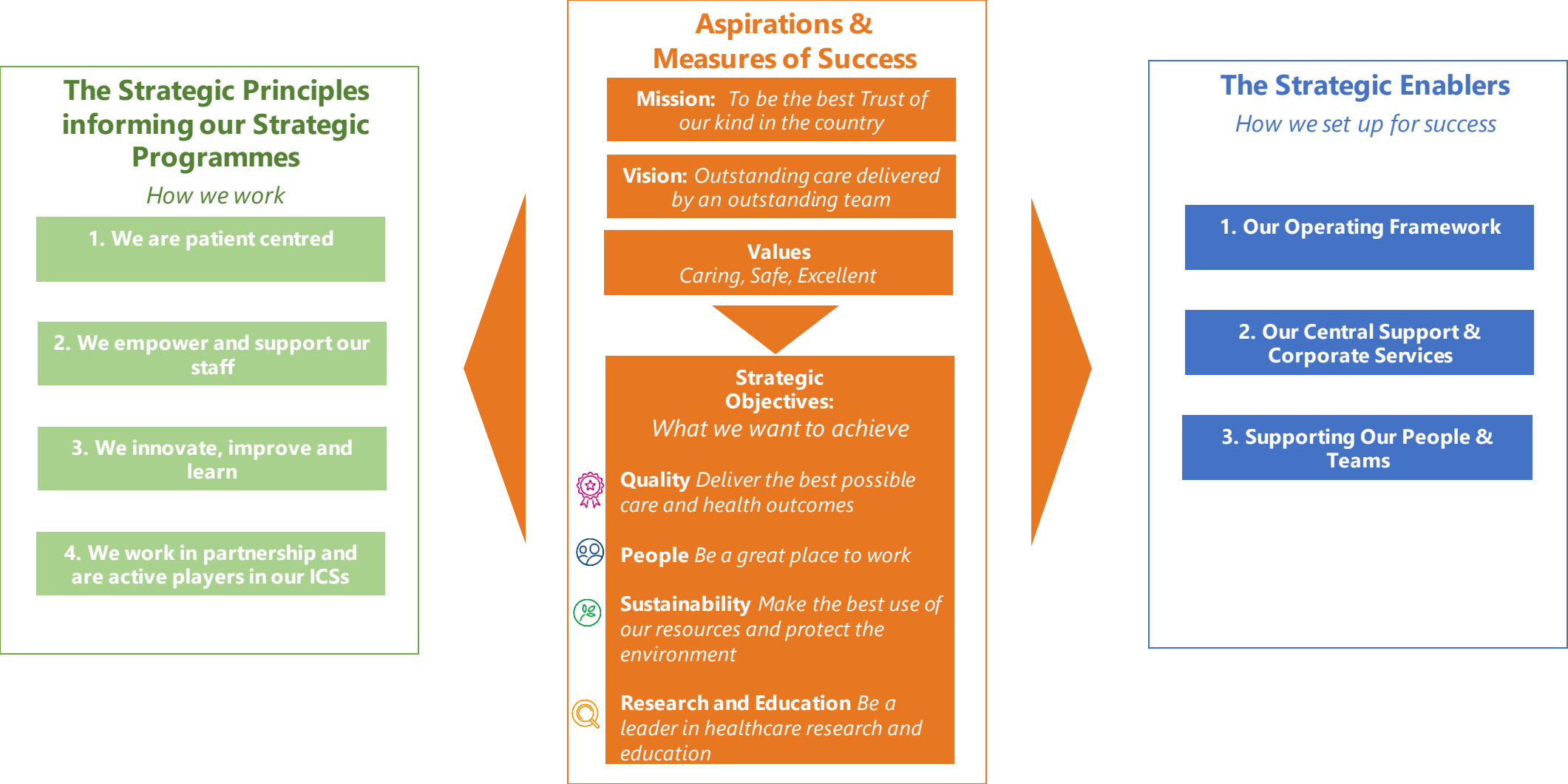
We'll ensure that we work with patients and carers as we develop our services, using insight and feedback to improve the experience of care. We are also working hard to create the right conditions within the Trust for our staff, to enable us to continue to deliver great care leading to improved patient outcomes.

Grant Macdonald, Chief Executive

- **Oxford Health Foundation Trust (OHFT) Strategy delivery - FY24/25**
 - Strategic Objectives and the Strategic Dashboard
 - Strategic Principles and Strategic Programmes
 - Strategic Enablers
- **Oxford Health Foundation Trust (OHFT) System planning - FY24/25**
- **Oxford Health Foundation Trust (OHFT) Clinical Directorates' high-level priorities - FY24/25**
- **Glossary**

OHFT Strategy delivery FY24/25

To support the delivery of Oxford Health's Strategy and objectives, a set of strategic principles and enablers have been identified to inform how we work and how we set up for success.





Oxford Health's four strategic objectives have been translated into a set of ambitions and related outcome measures. These outline what we want to achieve and how we will measure success by 2026.

This Strategic Dashboard will give the Board oversight of the progress Oxford Health is making in achieving its strategy.

It will form part of the Integrated Performance Report (IPR) and is shown on the following two slides. We will review and monitor progress against these measures and seek to review and refine the measures if required.

It should be noted that the measures within the Strategic Dashboard are a subset of indicators which the Board will review on a periodic basis which can help assess whether the Trust is meeting its strategic objectives. There are many other indicators which are measured through the IPR, by Committees and at Directorate level to focus on and understand our performance.

Strategic Dashboard (1 of 2)



Oxford Health
NHS Foundation Trust

The Strategic Dashboard contains a subset of indicators which will be reviewed on a periodic basis to help assess whether the Trust is meeting its strategic objectives and will be included within the Integrated Performance Report (IPR). There are many other indicators which are measured through the IPR, by Committees and at Directorate level to focus on and understand our performance. Work is ongoing to develop these targets.

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

Strategic Dashboard (2 of 2)



Oxford Health
NHS Foundation Trust

The Strategic Dashboard contains a subset of indicators which will be reviewed on a periodic basis to help assess whether the Trust is meeting its strategic objectives and will be included within the Integrated Performance Report (IPR). There are many other indicators which are measured through the IPR, by Committees and at Directorate level to focus on and understand our performance. Work is ongoing to develop these targets.

Strategic Objective	Strategic ambition	Strategic metric	Target FY24/25	Target FY25/26
People	We have a sustainable workforce	Reduce agency usage to meet target	tbc	tbc
		Reduction in % labour turnover	< = 14%	tbc
		Develop approach to workforce planning (Process Measure)	Narrative	tbc
	We have an engaged, well led workforce	Staff survey staff engagement score	> = 6.45	tbc
		Confirm Trust's approach to leadership development (Process Measure)	Narrative	tbc
	We have a skilled, learning workforce	% of staff completing Quality Improvement Training Level 1	95%	tbc
	We foster a just work environment	Black, Asian and Minority Ethnic representation across all bands including Board level	> = 19% tbc	tbc
		Black, Asian and Minority Ethnic representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Manager)	> = 19% tbc	tbc
		Develop our approach to mitigating the intersectional impacts of disadvantage, discrimination & bias (Process Measure)	Narrative	tbc
Sustainability	We are spending and investing as efficiently as possible and sustaining our financial position over the medium term	Set and meet plans to deliver a balanced or surplus budget each year in revenue	Within Budget	Within Budget
		Set and meet plans to deliver a balanced or surplus budget each year in capital	Within Budget	Within Budget
		Achieve National Cost Collection of 100 or below	< = 100	< = 100
	We are on track for net zero carbon emissions by 2045 as defined with the NHS Carbon Footprint plus	By 2026, achieve 29% reduction in direct carbon emissions compared to 2019 baseline	22%	29%
		Confirm the baseline for supply chain carbon emissions and update the Trust Green Plan to show how carbon reductions will be delivered.	Baseline/ Narrative	tbc
	Our digital systems work for us, providing and asking for the right information to enable clinical care and population health management	Achieve an average score of 4 out of 5 in the sections 'ensuring smart foundations and improved care' within the Digital Maturity Assessment	> = 4	tbc
Research	We will have moved towards a modern, efficient estate that enables access and wellbeing for staff and patients	Develop a strategy for our estates (Process Measure)	Narrative	tbc
	We will sustain our leadership in research, strengthen our academic partnerships and embed research capability in the organisation	Participants recruited to Clinical Research Network (CRN) portfolio studies by directorate	Narrative	tbc
		Number of active or aspirational principal investigators by directorate	Narrative	tbc
	We will build our capacity to translate our research into services	Number of dual academic/clinical role	Narrative	tbc
		Develop infrastructure to translate research into services and demonstrate impact (Process Measure)	Narrative	tbc
	Education ambition TBC	TBC - Education ambition	tbc	tbc

The four Strategic Principles identified should increasingly guide how we work.

Over the next two years, we will engage with staff, patients, carers and partners to test and refine these to ensure the way in which we work is co-designed.

They will inform the design of our key priority initiatives across the Trust which will be known as our Strategic Programmes.

A Strategic Programme will deliver substantial and important changes across the organisation to improve patient care and outcomes.



There are 14 Strategic Programmes across Oxford Health that are well established. Collectively, they will constitute key areas of focus across the Trust for FY24/25 and we will keep developing these.

Our 14 Strategic Programmes FY24/25

Patient Experience and Involvement Strategy
Learning Together for a Safer Tomorrow
Patient and Carer Race Equality Framework
Journey To Excellence
Equality, Diversity and Inclusion Programme
People Plan: Train, Retain, Reform & Temporary Staffing Programme
Green Plan
Frontline Digitisation
Warneford Park
Community Services Transformation Programme
Estates Strategy
Mental Health Inpatient and Community Improvement Programme
Outcome Measures
Provider Collaboratives and Strategic Partnerships

	Leads	Overview	Focus for FY24/25
 Patient Experience and Involvement Strategy	Executive Lead: Chief Nurse	The Trust's Experience and Involvement Strategy will support us to hear and act on the voices of our patients and carers to enable the development and delivery of co-produced outstanding services for excellent patient experience and outcomes.	- Continue to develop 'Our Voice' forum across the Trust to improve involvement and experience of patients. - Strengthen pastoral support for experts by experience and carers. - Development of standard processes for involvement of patients and use of feedback. - Grow peer support embedded in mental health clinical teams.
	Leads	Overview	Focus for FY24/25
 Learning Together for a Safer Tomorrow	Executive Lead: Chief Nurse	We are changing how we respond and learn from patient safety incidents at Oxford Health – we will be more supportive, compassionate and engaging for patients, families and staff (this programme includes implementation of the Patient Safety Incident Response Framework).	- Embed changes from 2023 that improve our response to incidents. - Focus on meeting Duty of Candour requirements. - Strengthen the development and monitoring of safety actions. - Grow capability to apply a wide range of learning response techniques.
	Leads	Overview	Focus for FY24/25
 Patient and Carer Race Equality Framework	Executive Lead: Chief Nurse	We will implement the national Patient and Carer Race Equality Framework, which is the NHS first anti-racism framework for all NHS mental health trusts. We will co-produce and implement concrete actions to reduce racial inequalities within our services.	Develop and roll out of the implementation plan for Patient and Carer Race Equality Framework within the Trust, focusing on the three main domains below: - Leadership and governance of actions to reduce health inequalities. - Creation and publication of new data sets on improvements in reducing health inequalities including strengthening the ability to gather data and establishing some criteria to inform analysis on areas of deprivation - Establishing visible and effective ways for feedback to be received and acted on.

	Leads	Overview	Focus for FY24/25
 Journey to Excellence	Executive Lead: Chief Nurse	This programme will focus on giving the Trust the ability to drive and maintain quality standards and have a consistent overview of how we are performing against these.	• Scope programme objectives and develop implementation plan. • Peer learning from how other Trusts have approached accreditation programmes. • Continue to deliver Care Quality Commission (CQC) readiness work to prepare Trust for future CQC inspections.
	Leads	Overview	Focus for FY24/25
 Equality, Diversity and Inclusion Programme	Executive Lead: Chief People Officer	The Trust Equalities programme has a number of components and we will review and develop our work in the context of the NHS Equality, Diversity and Inclusion (EDI) improvement plan.	• Deliver Race Equality and Disability Equality work programmes, focusing on increasing workforce diversity, de-biasing disciplinary processes and equalising opportunities for career progression. • Deliver the six high impact actions with the NHS EDI improvement plan. • Further development of staff networks and events.
	Leads	Overview	Focus for FY24/25
 People Plan: Train Retain Reform & Temporary Staffing Programme	Executive Lead: Chief People Officer	This programme will implement the three main component parts of the NHS Long Term Workforce Plan and the People Promise, together with a focus on temporary staffing. Reduction in temporary staffing is one of the key strategic metrics for the Trust, in line with our ambition to have a sustainable workforce, and will form a key workstream of our People Plan Strategic Programme being embedded throughout Oxford Health. In addition, we will also strengthen our approach to Workforce Planning.	• Train: career pathways and modernised roles, education and training capacity, our leadership and management framework. • Retain: NHS People Promise, flexible working and staff wellbeing. • Reform: recruitment processes, data quality and systems and underpinning culture. • Temporary Staffing: continued focus to reduce agency expenditure and increase bank fill rates. • Development of Workforce Planning approach in the second half of the year.

	Leads	Overview	Focus for FY24/25
 Green Plan	Executive Lead: Chief Finance Officer	The Green Plan ensures that the Trust is supporting the NHS ambition to reach Net Zero for emissions we control by 2040 and Net Zero for emissions we influence by 2045, prioritising interventions that tackle climate change and wider sustainability issues.	- Build on the existing Trust Green Plan to develop the Green Plan 2. This will set out our three-year carbon reduction plan (2025/6 - 2028/9) and approach to achieve Net Zero for emissions we control by 2040. - Focus will be on the chapters within the NHS Green Plan, including procurement, medicines, travel, models of care and food. - Assessment of Scope 3 emissions to establish NHS 'carbon footprint plus'.
	Leads	Overview	Focus for FY24/25
 Frontline Digitisation	Executive Lead: Chief Finance Officer	This programme will introduce and improve systems that support the digital empowerment of people who use our service; embed a digital organisational culture and approach within the Trust; create a resilient digital foundation for the Trust and enable further development of our research and innovation capabilities.	- Optimisation of Electronic Patient Records. - Further development and implementation of the Trust's outcome measure and mood monitoring tool. - Removal of paper records. - Complete roll out of electronic prescribing. - System interoperability. - Single Sign On, Multi Factor Authentication, Cyber Security. - Device and network improvements.
	Leads	Overview	Focus for FY24/25
 Warneford Park	Executive Lead: Chief Finance Officer	We are creating a £500m world-class centre for mental health and brain sciences at Warneford Park in Oxford. Warneford Park will provide a new, fit for purpose mental health hospital surrounded by a research and innovation hub.	- Engage with HM Treasury, NHS England (NHSE) and other key stakeholders to highlight the importance and significant value of this programme with a view to prioritising it in the next spending review. - Prepare for submission of planning documents in Spring 2025. - Engage with clinical teams, staff and experts by experience to develop the hospital design.

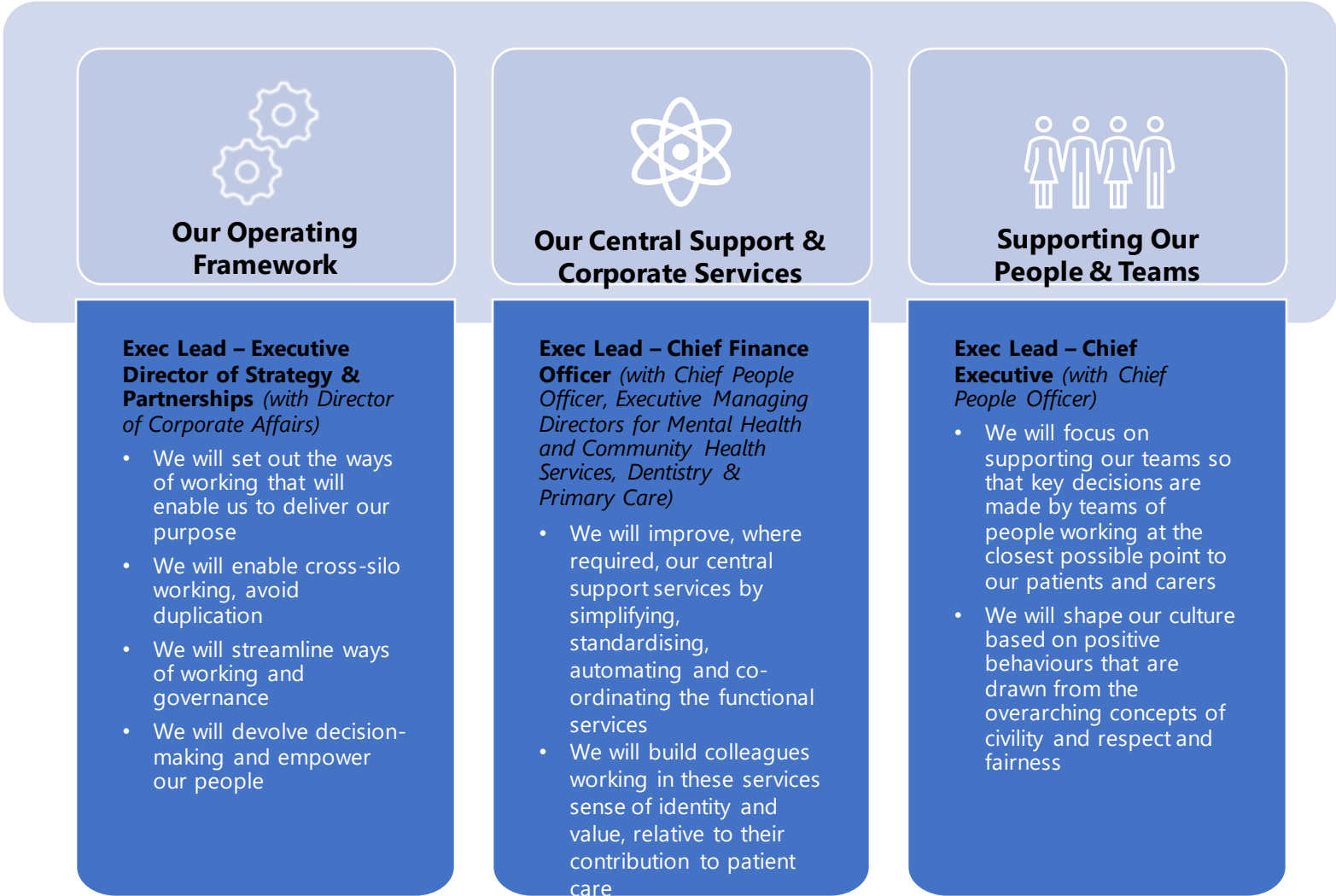
	Leads	Overview	Focus for FY24/25
 Community Services Transformation Programme	Executive Lead: Executive Managing Director for Community Health Services, Dentistry & Primary Care	The programme is structured through three key workstreams: Start Well; Live Well and Age Well. It will deliver more sustainable models of care that meet the changing needs of our population through a joined-up approach to care, providing the right care, in the right place and the right time, supported by the right resources.	• Safe and sustainable service development for children and young people's services and adult community nursing. • Improvements to same day urgent and emergency care services, including development of single point of access and 24/7 home visiting. • Community rehabilitation pathway development (including community inpatients). • Development of Oxford City healthcare hubs.
	Leads	Overview	Focus for FY24/25
 Estates Strategy	Executive Lead: Chief Finance Officer	This programme will support patient and staff wellbeing by developing our Estates Strategy and delivering hubs for Community Health Services, Dentistry & Primary Care in Jordan Hill, East Oxford Health Centre and Blackbird Leys to free up old estate and decrease cost and travel times while improving access and environment.	• Relocation of services to Jordan Hill hub. • Develop plans for Blackbird Leys hub. • Plan for the next phase of consolidation and improvement, focussing on Mental Health services in Oxford city (excepting inpatient services which are the focus of the Warneford programme). • Begin overarching Estates strategy for longer term challenges such as Community Hospital renewal and staff accommodation.
	Leads	Overview	Focus for FY24/25
 Mental Health Inpatient and Community Improvement Programme	Executive Lead: Executive Managing Director for Mental Health & Learning Disabilities	This programme comprises two parts: - One area will reflect the key components of the national mental health, learning disability and autism inpatient transformation programme by delivering an improved model of care for the future for our inpatient mental health services. - The other area will focus on the Community Mental Health Framework which was in place originally to deliver key ambitions of the NHS Long Term Plan (over a 3-year period) and focusses on developing and transforming community mental health services to improve the support offer available to people with a severe mental illness including physical health checks. Key focus has been on reducing health inequalities and integration with primary care to increase access and improve experience and outcomes for people with a personality disorder, eating disorder and rehab needs.	For the Inpatient Transformation Programme: • Set up the programme structure and governance. • Develop a clear oversight and support structure for services that is sustainable and transparent, where issues are identified early. • Explore and accelerate different therapeutic offers, including community-based alternatives to admission and a culture within inpatient care that is safe, personalised and enables patients and staff to flourish. For the Community Mental Health Framework: • Continued development of primary care mental health hubs in Buckinghamshire and Keystone hubs in Oxfordshire. • Dedicate resource to further develop the eating disorder offer and interface with primary care. • Continued development of voluntary sector infrastructure.

	Leads	Overview	Focus for FY24/25
 Outcome Measures	Executive Lead: - Executive Managing Director for Mental Health & Learning Disabilities	This programme will build on existing work to review mechanisms for direct monitoring of clinical outcomes and set out actions needed to improve our ability to consistently report on and use outcome measures to deliver effective care.	- Set up the programme structure and governance. - Set the context and review the different types of outcome measures (Patient Reported Experience Measures, Patient Reported Outcome Measures, Clinician Reported Outcome Measures etc). - Review and summarise national best practice and any relevant guidance or policy in relation to outcomes measurement across the service areas operated by the Trust. - Undertake a stocktake of what we are doing now against the above, and set out a roadmap for outcome measures we intend to capture and why.

	Leads	Overview	Focus for FY24/25
 Provider Collaboratives and Strategic Partnerships	Executive Lead: - Executive Managing Director for Mental Health & Learning Disabilities/ Executive Managing Director for Community Health Services, Dentistry & Primary Care/ Executive Director of Strategy and Partnerships	Provider Collaboratives are partnerships of trusts and independent providers which work together, at scale, to benefit their population. The following form part of this overarching programme: - Buckinghamshire, Oxfordshire and Berkshire West (BOB) Mental Health Provider Collaborative – working with partners to develop a collaborative for non-specialised mental health services. - Thames Valley Community Dental Partnership – working with partners to improve patient care, reduce inequalities and provide quality care within efficient use of resources. - Oxford Health and Oxford University Hospital Partnership - working jointly to support integrated work in some strategic areas.	BOB MH Provider Collaborative - Strengthen the infrastructure for the delivery of the BOB Mental Health Provider Collaborative and improve ways of working across all partners. - Enhance and embed co-production. - Make progress against key transformational priorities. Thames Valley Community Dental Partnership - Continue to recruit Special Care and Paediatric Consultants. - Continue the reduction of general anaesthetic waiting lists. Oxford Health and Oxford University Hospital Partnership - work is in train to identify areas of focus and joint working opportunities.

Over the next two years we will implement key changes in the way we work so that our internal capabilities align and enable us to deliver our strategy and objectives. These will be coordinated via three Strategic Enablers.

The Strategic Enablers	
1. Our Operating Framework	
2. Our Central Support & Corporate Services	
3. Supporting Our People & Teams	



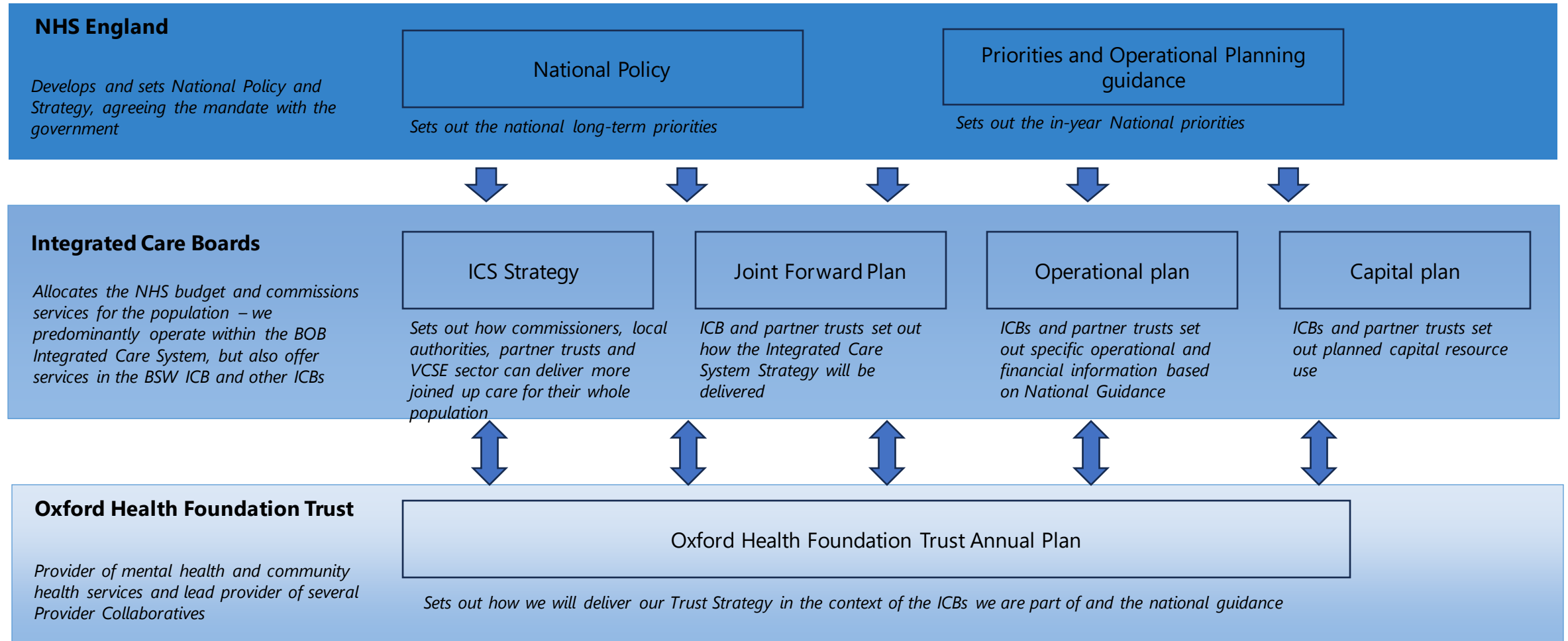
	Leads	Brief Description and rationale:	Outcomes	Key deliverables for FY24/25
 Our Operating Framework	Executive Lead: Executive Director of Strategy & Partnerships <i>(with Director of Corporate Affairs)</i>	- An operating framework is a high-level model of how an organisation can best be organised to more effectively and efficiently deliver and execute on its strategy. It aims to provide a common, and easily communicable, understanding of the organisation by allowing people to visualise the organisation from a variety of perspectives, in this case via: an organisational structure, governance and assurance framework, performance management framework and leadership framework. - Our staff can use this 'Operating Framework' as a manual; it can be used to set parameters for staff to work against. - Whilst several elements of the proposed operating framework currently exist, these do not exist together. Through codifying 'how things work' in a single place, and providing a common understanding and reference guide, we aim to empower staff and improve effectiveness.	- Improved awareness amongst colleagues of how the Trust works via a key explainer document. - Robust performance management process. - Improved decision-making processes and assurance. - Greater visibility from ward to board of intelligence, insights and performance - Improved data quality and completeness driven by improved visibility of data and performance.	- Operating Framework document. - Development of interactive dashboards via Trust Online Business Intelligence (TOBI) including an interactive tool (populated organogram) with key agreed metrics.

	Leads	Brief Description and rationale:	Outcomes	Key deliverables for FY24/25
 Our Central Support & Corporate Services	Executive Leads: Chief Finance Officer <i>(with Chief People Officer, Executive Managing Directors for Mental Health and Community Health Services, Dentistry & Primary Care)</i>	- We aim to improve central support services by simplifying, standardising, automating and co-ordinating processes and teams that have a direct impact on the delivery of clinical services. - Central support services can often be unaware of the importance of their role in the delivery of patient care. The programme will seek to build colleagues' sense of identity and value relative to their role in the primary task of improving patient care. - We aim for Central teams to know each other, align their models, join up communications and guidance, streamline and then continuously improve end-to-end processes and be accountable to (and appreciated by!) users for their performance. - Early focus on re-designing three processes: - Recruitment & onboarding of staff - Temporary Staffing - Procurement processes	- Corporate Staff motivation increases measured by staff survey engagement scores of corporate teams. Particular focus on Motivation and Involvement sub-scores. - Reduce recruitment & onboarding time, and remove inefficiencies in the process of temporary staffing and in the process of buying things freeing up clinical and corporate teams' time. - Build culture of continuous improvement in Central teams.	- Analysis of data on quality and value for money of existing processes. - Review of end-to-end processes for recruitment, procurement and temporary staffing taking into account quality and value for money. - Events and ways of working that increase sense of shared responsibility between Central teams and responsiveness to users.

	Leads	Brief Description and rationale:	Outcomes	Key deliverables for FY24/25
 Supporting our People & Teams	Executive Lead: Chief Executive <i>(with Chief People Officer)</i>	The culture of Oxford Health is crucial to ensuring the delivery of high-quality, safe and effective patient care. From a people perspective, we see the impact in levels of bullying and harassment, discrimination, sickness absence and presenteeism, staff turnover, and attraction of new staff. A culture that values our people as individuals is the way we will hold onto our people and recruit the next generation. It also recognises that "inclusive cultures depend on inclusive leaders". We will focus on supporting our teams so that key decisions are made by teams of people working at the closest possible point to our patients. We will shape our culture based on positive behaviours that are drawn from the overarching concepts of civility, respect and kindness in action. Alongside treating people fairly when things go wrong and building an improvement mindset.	To create a truly compassionate and inclusive working environments where all colleagues can thrive.	Establish a reference group and change team from the workforce to understand how colleagues working at Oxford Health perceive the current culture and existing activities. To test the established key components of the current approach and how they are being implemented or not. Build an objective understanding of our current position and use evidence-based tools to provide differing perspectives on our culture. To design an enhanced programme and begin delivery measure by clear outcome indicators.

OHFT System Planning FY24/25

This diagram seeks to set out how the OHFT Annual Plan relates to NHS planning.



Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) have developed a set of shared system goals which closely align to the ambitions within the Integrated Care Strategy and Joint Forward Plan (both developed in 2023).

There are six BOB system goals, and these are areas that the system will prioritise delivery of over FY24/25. The goals are focussed on Prevention and System Transformation as well as System Recovery and Improvement. In doing so, it will enable the alignment of a limited number of strategic priorities and deliver shared improvements for residents, people and the wider system.

Oxford Health is committed to supporting the six BOB system goals. There are several areas of work that the Trust will implement over FY24/25 that will contribute to successful delivery of these goals over FY24/25.

Whilst Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB have not developed system goals, Oxford Health continues to be an active partner in supporting BSW ICB with their priorities for FY24/25 via our Children and Adolescent Mental Health and Adult Eating Disorder Services.

	BOB ICB System GOAL	How we are contributing
1	Transform Primary and Community Care by delivering Same Day Access and bringing together teams and resources across organisations into Integrated Neighbourhood Teams	Continue to implement the Community Mental Health Framework programmes across both Oxfordshire and Buckinghamshire and develop our Community Services Transformation Programme, moving to a focus on supporting population outcomes.
2	Improve the mental wellbeing of children and young people by working together to pilot and scale preventative approaches and improvements, including within the neurodiversity pathway	We are developing and improving our Child and Adolescent Mental Health Services (CAMHS) model and pathways to better meet the range of needs of young people.
3	Extend healthy life expectancy by preventing strokes and heart attacks, through working together to improve CVD pathways and prevention and targeting action to where it will have most impact	Continue to focus on improving the physical health monitoring of people with a severe mental illness (SMI) to ensure that they receive early intervention support for preventable conditions.
4	Accelerate our Provider Collaboratives (Acute & Mental Health) to increase productivity and tackle variation to drive increased equity of access, outcome and experience	Continue to support the development of the Mental Health BOB Provider Collaborative.
5	Deliver system wide savings and value for money through more joined up efficiency programmes including medicine optimisation, procurement and estates across our places and providers	Continue to support the development of this through our Estates strategic programme to: • Cluster services together in local hubs • Provide modern, flexible estates that can support clinical transformation
6	Develop a more unified approach to supporting and retaining our people, reducing temporary staffing, supporting local employment and health and wellbeing	Continue to support the development of this through our People Plan to TRAIN, RETAIN, REFORM, and temporary staffing programme.

OHFT Clinical Directorates

High level FY24/25 priorities

- [Oxford Health Foundation Trust \(OHFT\) Quality Priorities for FY24/25](#)
- [Buckinghamshire Mental Health directorate](#)
- [Oxfordshire and BaNES \(Bath and North East Somerset\), Swindon & Wiltshire directorate](#)
- [Forensic Mental Health directorate](#)
- [Learning Disabilities directorate](#)
- [Community Health Services, Dentistry & Primary directorate](#)

The table below brings together our DRAFT Quality Priorities for FY24/25. These are being delivered via our strategic programmes and overall quality governance approach and embedded in the plans of our Clinical Directorates.

	Objectives	Outcome measures
Safe Care	Consistently deliver safe care, with a reduction in avoidable in-service harm	
	To improve in-patients' safety	➤ 95% Completion of NEWS2 and escalation across all In-patients wards ➤ Use internal audit to monitor NEWS2 escalation across all inpatient wards ➤ Reduction in numbers of prone episodes and duration by 30% over three (3) years (Reduction will be display via/using Statistical Process Control to show improvement)
	To provide timely access to care and effectively monitor patients and minimise harm when waits occur.	➤ Reduction in waiting list/ time to access service (focus on specific e.g. Child and Adolescent Mental Health Services or Out of Hours) ➤ [TBC]% of all referrals will be seen within the following ▪ Emergency within four (4) hours ▪ Urgent within seven (7) days ▪ Routine within four (4) weeks
	To address health inequalities	➤ Roll out and embed a structure for the implementation of PCREF (Patient and Carers Race Equality Framework)
	To have a safe and learning culture	➤ Use of staff feedback (staff experience from incidents) staff feedback after every Incident Learning Huddles (ILH) and strengthening the feedback mechanism for patients/families involved in reviews ➤ Use of families' feedback (families experience from incidents) as above
	To support staff wellbeing and build resilience	➤ To continue to develop effective mechanisms for supporting staff who experience trauma in the workplace through: ▪ Continuing rollout and evaluation of TRiM (Trauma Risk Management) as a model of peer to peer support and signposting for staff ▪ Mapping other areas of staff wellbeing provision including Post Incident Psychological Support (PIPS) and the Staff Psychology Service (SPS) to develop a robust and accessible model. ▪ Ensuring structured processes of monitoring and evaluation of the above.
Effectiveness	Delivering effective services to ensure care is planned and delivered around the needs of the patient	
	To build our capability to measure and capture outcomes in our Teams across the Trust.	➤ Pilot and implement new IT tools for capturing and recording patient reported outcomes (PROMS) ➤ Clarify structures for recording PROMS (Dialogue and True Colours) in our mental health and other services. ➤ Develop performance and analytic reports to enable outcome data to be fed back to clinicians and others and used to improve service quality.
	To improve the physical healthcare to people with a serious mental illness	➤ Cardiovascular assessment, improving completion of the Lester Tool for people with enduring SMI (Early Intervention in Psychosis (EIP) / Adult Mental Health Team (AMHT)) monitoring and supporting healthy behaviour lifestyles ▪ 95% completion of Lester tool (early intervention teams) ▪ 80% completion of Lester tool (community mental health teams) ➤ 100% screening of all admissions in MH and Forensic inpatient services for smoking status ▪ Measure % of quitters per quarter across all MH and Forensic wards
Experience	Consistently improve on the experience of those using our services	
	End of life care	➤ Review the current end of life audit tool to ensure it captures early recognition that the patient is at the end of life and that there is an advanced care plan put in place at the first opportunity. ➤ Use audit tool to measure improvement in early recognition and advanced care planning. ➤ To develop audit question in relation to accessing a face-to-face visit where it is indicated within one hour of request for clinician to attend. ➤ Pilot End of Life (EOL) audit in urgent care, review and agree implementation and monitor incremental rollout of EOL audit across other services
	Working with families	➤ Embedding Triangle of Care (ToC) across the Trust (80% completion of self-assessment of ToC all Mental Health and Forensic wards) ▪ 85% of patients responding that overall the care was good/very good - mental health ▪ 85% of patients responding that overall the care was good/very good - Primary, Community and Dental ▪ 80% of patients report being involved in their care - mental health ▪ 85% of patients report being involved in their care - Primary, community and dental

Buckinghamshire Mental Health: Summary plan

We are working to deliver National guidance, including supporting the delivery of the NHS Long Term Plan mental health commitments. This includes expanding Individual Placement and Support (IPS) services and supporting the digitisation and expansion of NHS Talking Therapies.

Top Directorate priorities and efficiencies

Developing and improving

- Urgent Care Pathway: Crisis Resolution and Home Treatment
- In-patient services (NHSE improvement programme)

Continuing community mental health transformation & integration with primary care

- Gateway (secondary care single point of access)
- Primary Care mental health Hubs

Advancing and embedding a directorate approach to tackling health inequalities and ensuring we achieve local and national ambitions

- Development of a strategic approach to the delivery of outcomes for people at risk of health inequality

Improving the timeliness of access to assessment, diagnosis and treatment across the age range

- Moving towards the NHS Long Term Plan (LTP) ambition for Talking Therapies and Memory Assessment Services

Delivering sustainability through reduction in agency staff & evolving service & workforce models;

- Children and Adolescent Mental Health Services (CAMHs) including neurodevelopmental
- Partnership with Voluntary, Community and Social Enterprise (VCSE)

Top risks

- Timeframes for delivery – the projects in this priority are complex and require a broad and diverse set of stakeholders. There is risk therefore of slippage to initial agreed timeframes

- In line with the national position, recruitment to mental health posts can be challenging which may impact service delivery

- Short term resource in place to support implementation of health inequalities task and finish group for 3 months only, therefore potential risk of inability to sustain long term impact

- Risk that increasing access without additional staffing will lead to longer waiting lists and impact on recovery rates

- Ability to recruit at pace to align with timeframes agreed with OFSTED and ensure delivery of demonstrable outcomes

We are working to deliver National guidance, including supporting the delivery of the NHS Long Term Plan mental health commitments. This includes expanding Individual Placement and Support (IPS) services and supporting the digitisation and expansion of NHS Talking Therapies.

Top Directorate priorities and efficiencies

Reviewing models of care

- Crisis resolution and Home Treatment expansion to cover the county
- Implementation of the Mental Health (MH) Inpatient Improvement Programme
- Oxon CAMHS Pathway Development
- Perinatal Expansion
- Consider a sustainable way to provide inpatients Psychological Therapy
- The Brain Health Centre continuation

Partnership Integration

- Continuing to develop community health services across the system
- Working closely with VCSE and Thames Valley Police to improve the current offer to those who access MH services
- Implement the BSW CAMHS VCSE Alliance
- Mental Health outcomes based contract review

Medical Workforce Review

- Reviewing the use of medics across the directorate
- Working with finance and medical workforce leads to reduce the use of locums and ensure medics are used in the most effective way

Recruitment and Retention / Health Inequalities

- Improving the recruitment & retention across the directorate and wellbeing of staff.
- Continue to develop the directorate People Plan with HR support
- Continue with the listening events
- Working to develop leadership skills
- Development of a consistent directorate approach to health inequalities and to run as a thread through the work and the services that we deliver

Top risks

Workforce: Inadequate resource to meet demand

- There has been an increase in the demand for services.
- Staff are stretched as there has not been a respondent increase in the resources available.
- This could lead to the quality of care being compromised.

Waits for both assessment and Treatment

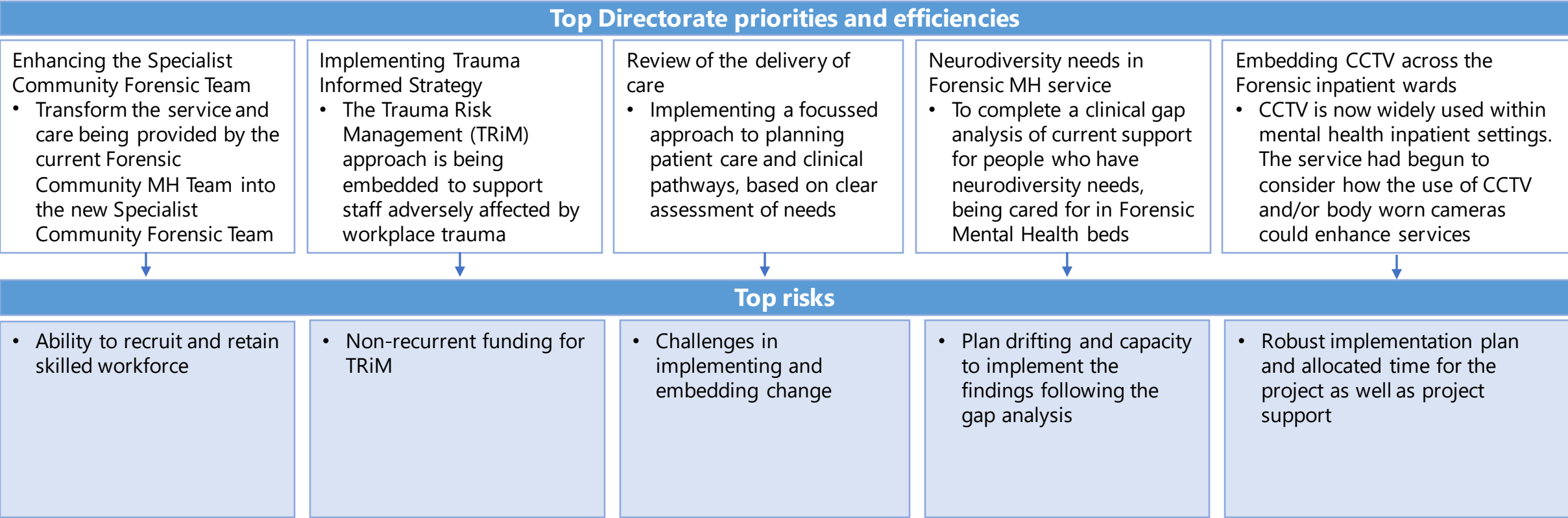
- Demand and capacity gap exacerbated by Covid. There is limited visibility of waiting lists due to Carenotes outage.
- This has resulted in lengthening waiting times.
- The effect could be possible harm to patients; poorer outcomes; longer treatment required.

Recruitment and Retention/ Quality of care provision

- There is a risk that the directorate may not be able to recruit high quality staff with the right skills into the services.
- This may lead to reduced capacity and service quality, reduction of the ability of services to see patients and families and provide them with a consistently high standard of care resulting in patients and families having poorer experiences and outcomes.

Ligature risk assessments

- Identified ligature risks assessed and mitigation managed locally within each individual ward risk register (regular review of risk registers taking place)



Top Directorate priorities and efficiencies

Good Lives, Good Deaths

- Improving discharge planning
- Health and care passports, links with Primary Care
- Proactive care planning, health and education training for families and carers
- Annual Health Checks
- Work on developing of Mental Capacity Act bespoke training

All Age Pathways

- In recent years, heightened autism awareness has increased and there is now a spotlight on healthcare provision which is tailored to meet the needs of persons with Autism Spectrum Disorder (ASD)
- A scoping exercise has commenced to assess Learning Disability (LD) and ASD provision across the entire Trust pathway.

Contract Negotiations

- To ensure we have validated data that demonstrates the work undertaken within the service to support patients and prevent any deterioration of their health/LD/ASD needs.
- Ensure sustainable funding of services.

Top risks

Financial risks centred around inpatient admissions

- Risk linked to cost of Learning Disability admissions as OHFT hold the commissioning budget

Learning Disability & Autism (LD&A) requirements

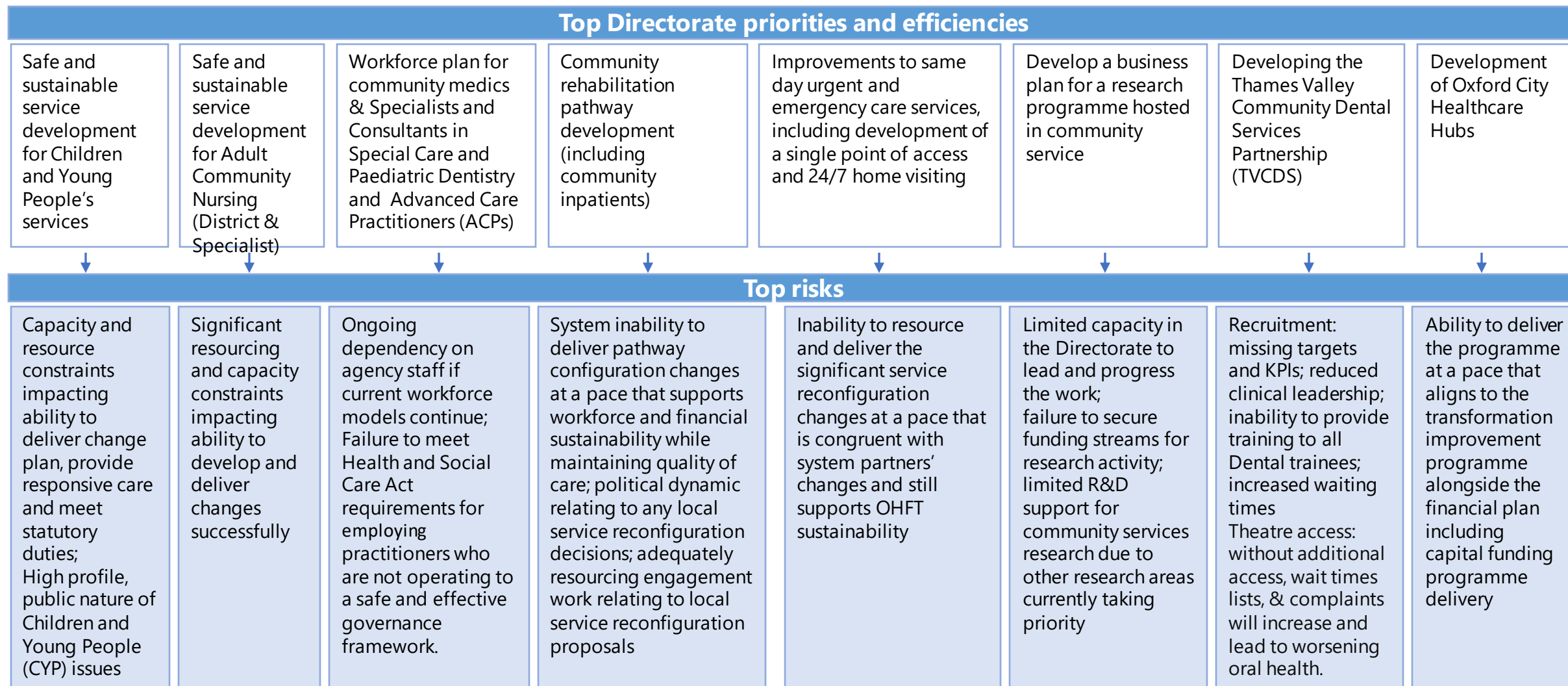
- Our national reporting combines LD&A however there is no current structure of a LD&A operational service. This poses risks of not being resourced to meet the expectations for Autism response

ICB development

- The Integrated Care Board (ICB) for Buckinghamshire, Oxfordshire and Berkshire West (BOB) is still developing and we are working in a system that continues to evolve

Contract negotiations

- Negotiations have commenced for contract renewal in July 2024. The challenge will be to ensure we have the correct data to evidence and demonstrate our outputs and prevention of patient deterioration.



Acronym	Full Name	Acronym	Full Name	Acronym	Full Name
ACPs	Advanced Care Practitioners	EHR	Electronic Health Records	PCERF	Patient and Carer, Race, Equality Framework
AED	Accident and Emergency Department	eMHA	Electronic Mental Health Act	PCN	Primary Care Network
AHP	Allied Health Professional	EPC	Enhanced Package of Care	PEI	Patient, Experience & Involvement
ASD	Autism Spectrum Disorder	EPMA	Electronic Prescribing and Medicines Administration	PICU	Pediatric Intensive Care Unit
BAF	Board Assurance Framework	EPS	Electronic Prescription Service	POCT	Point of Care Testing
BAU	Business as Usual	FY	Financial Year	PREOM	Patient Reported Experience and Outcome measures
BSW	Bath and North East Somerset, Swindon and Wiltshire	GH &GMH	Getting Help and Getting More Help	PROMs	Patient Reported Outcome Measures
CAMHS	Children and adolescent mental health services	ICB	Integrated Care Boards	QI	Quality Improvement
CAST	Clinical Applications Support Team	ICP	Infection Control & Prevention	R&D	Research and Development
CIP	Cost Improvement Programmes	IQRA	Improving Quality Reducing Agency	SAS	Specialty and Specialist
CMHF	Community Mental Health Framework	KPI	Key Performance Indicators	SCAS	South Central Ambulance Service
CPD	Continuous Professional Development	LA	Local Authorities	SEND	Special Educational Needs and Disabilities
CQC	Care Quality Commission	LD	Learning Disabilities	SMI	Severe Mental Illness
CQUIN	Commissioning for Quality and Innovation	LD&A	Learning Disability & Autism	SNA	Strategic Needs Assessment
CRF	Clinical Research Facility	LTfST	Learning Together for a Safer Tomorrow	SPA	Single Point of Access
CRHTT	Crisis Resolution and Home Treatment Team function	LTP	Long Term Plan	SPC	Statistical Process Control
CYP	Children and Young People	MAS	Memory Assessment Service	SSO	Single Sign-On
DDR	Dementia diagnostic rate	MFA	Multi-Factor Authentication	SUN	Service User Network
E&I	Experience & Involvement	OHFT	Oxford Health Foundation Trust	ToC	Triangle of Care
ED	Eating Disorder	OUH	Oxford University Hospital	TVCDS	Thames Valley Community Dental Services Partnership
EDI	Equality, Diversity & Inclusion	PC	Provider Collaborative	VCSE	Voluntary, Community and Social Enterprise

FY25 Financial Plan & Budget Update

Trust Board

May 2024

FY25 Financial Plan

March 18th Submission - £16.5m deficit

s117 Cost agreement (£2m)

10th April Stocktake- £14.5m deficit

Community Growth – (£3,405k)

CNST Funding – (£204k)

SR21 Efficiency Added - £859k

Additional Non-Recurrent CIP - £2,750k

18th April Flash Submission - £9,033k deficit

Additional Non-Recurrent CIP - £3,500k

Depreciation Funding - £1,212k

2nd May Plan Submission - £4.321k deficit

Due to the timing of the plan submission, the CEO and CFO were given delegated authority to agree the plan which was submitted on the 2nd May. This report includes details of the key elements of the plan. Detailed above is the Trust initial financial plan, as previously brought to FIC, with corresponding adjustments agreed with the ICB to give our plan as submitted.

The Committee is asked to formally approve the Financial Plan as submitted on behalf of the Board.

Bridge from FY24 Outturn

	FY24 Forecast Outturn	Adjustments to baseline	BOB ICB Covid Funding	Other NR income from BOB ICB	NR PC deferred income in FY24	Frontline Digitisation & Jordan Hill	FY24 NR CIP	CIP	Inflation	SDF increase	MHS	Community Growth	Other Funding from BOB ICS	CNST Funding	SR21 Savings	NHSE Growth	BSW Growth	Cost pressures	CIP to cover cost pressures	Additional CIP	Change in financing costs	Increase in depreciation costs	FY25 Plan
	£m	£m	£m	£m	£m	£m		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Clinical Income	503.4	-2.7	-7.4	-6.9					2.8	4.7	7.5	3.4	2.8	0.2	-0.9	2.8	1.1					2.6	513.4
Other Income	92.0							0.7															92.7
Pay	-358.3	1.9		0.9			-4.8	5.4	-4.7	-4.7	-7.5		-2.8				-1.1	-14.1	14.1	3.5			-372.3
Non-Pay	-219.1	0.8			-2.0	-1.5		1.8	-3.2							-2.8		-10.4	10.4	2.8	0.6	1.0	-221.6
Financing costs	-13.6																				-0.6	-2.4	-16.5
Surplus/ (Deficit)	4.4	0.0	-7.4	-6.0	-2.0	-1.5	-4.8	7.9	-5.2	0.0	0.0	3.4	0.0	0.2	-0.9	0.0	0.0	-24.5	24.5	6.3	0.0	1.2	-4.3

- Covid and other non-recurrent funding was given to providers in FY24 instead of other investment funding. This has been reduced in FY25 by the ICB on the basis that it was non-recurrent.
- The Other non-recurrent income reduction consists of £1.3m pay award funding for SDF, R&D and local authorities, £1.3m funding to cover Industrial Action costs, £3.4m funding to support the Trust's position including discharge, recovery and surge funding and £0.9m DWP income which last item we are likely to receive again
- In FY24 the Trust planned for a one-off benefit of £2.0m from releasing Secure Provider Collaborative income to offset capital expenditure.

Bridge from FY24 Outturn (continued)

- This plan includes cost pressures from Frontline Digitisation matched funding costs and Jordan Hill.
- £4.8m of non-recurrent CIPs have been taken out of the plan. The CIP for FY25 is £38.6m made up of:
 - £7.9m to reduce directorate budgets
 - £24.5m non-recurrent underspends (e.g. through vacancies) to cover cost pressures
 - £6.3m additional CIP to be delivered non-recurrently agreed a part of discussions with the ICB around improving our position
- SDF has been included based on our understanding of fair share allocations and MHIS has been included as per the agreement at the MH partnership board. These still need to be confirmed with the ICB but final amounts will be available for investment in mental health services
- Community growth of £3.4m is included in the plan but was given to the Trust on the agreement we would improve our bottom line so is not available for the services to invest. Additional CNST funding and the SR21 savings were also agreed at the same time.
- The other funding from BOB ICB includes funding for Long Covid £0.5m, Bucks CAMHS Neurodevelopment investment £0.9m, Childrens Integrated Therapies £0.5m, Better Care Fund £0.7m, Luther Street £0.1m and Speech and Language Therapy £0.1m. All of these are for investment in services.
- NHSE and BSW contracts have growth funding included which needs to be confirmed with commissioners. Once confirmed this will be available for investment in services. The NHSE value relates to the Provider Collaboratives.
- Depreciation costs have increased by £2.4m due to investment in Digital. These have been funded by national funding through the ICB. This was originally £1.4m and due to late notification of the final amount the Trust agreed to improve its plan by the difference.

FY25 Capital Plan

The FY25 capital programme is comprised of the following:

	£000
• Primary, Community & Dental Care	4,575
• Bucks Mental Health	798
• OBSW	775
• Forensic & Specialist Services	118
• Operational Estates	2,031
• FY24 Estates Carry Over Schemes	1,078
• IM&T Schemes	2,000
Total Capital Programme	11,375
ICB Capital Funding available	9,459
Funding deficit	-1,916

Jordan Hill Fit Out £4,502k, Other Schemes £73k

CAMHS SNC £766k

Tribunal room relocation £300k, Rowan House Refurbishment £300k, Other Schemes £300k

(Digital Pharmacy system £118k)

52 Projects between £5k and £300k

Frontline Digitalisation

This plan has been reviewed by Estates, IM&T, Finance and Services and is recommended by CPSC and FIC.

The proposed funding deficit is a higher than that taken into FY24 (£694k). This is partly because BOB capital allocations have now been reduced (as flagged to FIC), however this plan also takes account of the potential to identify other funding sources, dispose of capital assets, and the balance of VAT risks and opportunities.

It should be noted that PFI exit accounting is not yet fully worked through and may create pressures not taken account of in this plan.

There is a potential need to rework the plan if anticipated Frontline Digitisation funding continues to be withheld and funding from other sources is not available to cover that gap.

Agency

National planning guidance includes a provider agency cap of 3.2% of total pay bill, this would give the Trust a **£11.8m** target.

Finance, HR and directorate leads have worked up a challenging but achievable agency target for FY25 based on current plans and controls, which is in line with the overall financial plans submitted by the Trust to BOB ICB.

A target of **£25.5m** has been provisionally set which will represent a reduction against FY24 spend of **£12m**. This target has been allocated to Directorates in the form of two targets. One for Agenda for Change (AfC) staffing and one for Medical staffing. The Agency ceiling has not yet been agreed with the BOB ICB and provisional plans are very stretching compared to baseline.

Directorate	Agenda For Change	Medical	Total Target
Buckinghamshire Mental Health	£5,084,812	£3,132,383	£8,217,195
Digital & Transformation	£544,315		£544,315
Estates & Facilities	£200,095		£200,095
Forensic Services	£1,692,549	£153,568	£1,846,117
Learning Disabilities	£46,406	£312,954	£359,361
Oxfordshire & Bsw Mental Health	£4,532,453	£4,967,765	£9,500,218
Primary, Community And Dental Care	£3,016,393	£1,787,306	£4,803,699
Total Target	£15,117,024	£10,353,976	£25,471,000

Agency

Baseline projections for agency spend based on trends in FY24 with adjustments indicate that without interventions, the Trust would spend **£36m** in FY25. This is **£1.5m** less than the total agency spend in FY24.

Finance, HR and Directorate leads have worked together to produce plans which will bring this spend down a further **£10.5m** to **£25.5m**. This is made up of:

- Trust-wide bank fill rate improvement of **£0.6m**
- Trust-wide agency rate reduction through ID medical of **£5.9m**
- Oxfordshire & BSW MH have plans to reduce agency WTE which are expected to save **£2.8m** against AfC and a further **£0.2m** against medical staff
- Forensic Services have submitted plans to reduce agency WTE usage which is expected to save **£0.4m** against AfC staff
- Directorate plans still need to be finalised for Bucks and Community services

Category	Buckinghamshire Mental Health	Digital & Transformation	Estates & Facilities	Forensic Services	Learning Disabilities	Oxfordshire & Bsw Mental Health	Primary, Community And Dental Care	Grand Total
Baseline Forecast - A4C	£6,272,332	£544,315	£200,095	£2,782,571	£52,424	£8,439,069	£4,463,233	£22,754,040
Baseline Forecast - Medical	£3,968,534			£159,187	£523,936	£6,388,536	£2,145,983	£13,186,176
Baseline Forecast - Total	£10,240,866	£544,315	£200,095	£2,941,758	£576,360	£14,827,605	£6,609,216	£35,940,215
Directorate Recruitment & Initiatives - A4C				-£395,950		-£2,763,610		-£3,159,560
ID Medical Rate Saving - A4C	-£1,042,377			-£615,055	-£6,017	-£921,059	-£1,336,961	-£3,921,470
NHSP Fill Rate Increase	-£145,143			-£79,017		-£221,947	-£109,879	-£555,986
Directorate Recruitment & Initiatives - Medical	-£66,000					-£257,155		-£323,155
ID Medical Rate Saving -Medical	-£688,151			-£5,619	-£87,982	-£880,616	-£358,677	-£2,021,045
Removal of Jr Dr Grades	-£82,000				-£123,000	-£283,000		-£488,000
Total of Reduction Schemes	-£2,023,671	£0	£0	-£1,095,641	-£216,999	-£5,327,387	-£1,805,517	-£10,469,215
Grand Total	£8,217,195	£544,315	£200,095	£1,846,117	£359,361	£9,500,218	£4,803,699	£25,471,000

CIP Plans

The Trust's external CIP target as reported to NHSE is **£38.6m** made up of:

- **£24.5m** non-recurrent underspends to manage cost pressures
- **£7.9m** Directorate CIP targets including £1.8m unmet CIPs from FY24
- **£6.3m** additional non-recurrent CIP which will be managed centrally

Against the £7.9m Directorate target, provisional plans are in place to deliver **£7.6m** leaving a balance remaining to be identified of **£0.3m**.

	£'000						
Directorate	CIP Target	Fully Developed	Plans In Progress	High Risk	No Plans	Expected Slippage	Total
Community	2,548	915	1,649	762	0	-778	2,548
Oxon & BSW MH	2,038	2,038	0	0	0	0	2,038
Bucks MH	983	0	983	0	0	0	983
Forensic MH	526	0	526	0	0	0	526
Learning Disabilities	199	199	0	0	0	0	199
Corporate	1,636	126	1,217	0	293	0	1,636
	7,930	3,278	4,375	762	293	-778	7,929
		41%	55%	10%	4%	-10%	

Schemes identified will require quality impact assessments to be completed with final sign off at Executive Committee.

CIP Plans – Corporate Breakdown

Corporate services have identified a total CIP contribution of **£1.3m** leaving a further **£0.3m** to be identified. Savings of **£0.4m** will be made through pay establishment reviews, **£0.5m** will be delivered through energy savings following a reduction in the national price cap and the remaining **£0.4m** will be made through various other contracting and non-pay efficiencies.

Corporate	£'000						
Directorate	CIP Target	Fully Developed	Plans In Progress	High Risk	No Plans	Expected Slippage	Total
HR	255	0	255	0	0	0	255
D&T	187	0	187	0	0	0	187
Medical	248	0	0	0	248	0	248
Corporate Affairs	65	65	0	0	0	0	65
Nursing	217	0	217	0	0	0	217
Finance	154	34	120	0	0	0	154
Strategy & Partnerships	72	27	0	0	45	0	72
Estates & Facilities	438	0	438	0	0	0	438
	1,636	126	1,217	0	293	0	1,636

Mental Health Investment Standard (MHIS)

The MHIS uplift for FY25 is 4.2%. The Mental Health Partnership Board has agreed a figure of £7,533k for Oxford Health. The FY24 schemes have a full year effect cost which will come out of this allocation and directorates are developing plans for the additional investment. OHFT have worked with Berkshire Healthcare NHS FT and the ICB as a part of the system Mental Health Provider Collaborative to agree plans and use of funding.

Mental Health System Development Funding (SDF)

The Trust is expecting SDF funding of £20.5m, of which the majority is a continuation of previous year's funding. It includes new funding for:

- Mental Health Schools Teams £1.6m
- Individual Placement Support £0.3m
- Mental Health, Learning Disability and Autism Inpatient Quality Transformation £0.7m
- NHS Talking Therapies £0.3m
- Crisis Text Support £0.1m

Budget Setting Update

A budget setting process paper was presented at the January FIC meeting. This outlined 3 steps in the budget setting process. A progress update on each of these steps is included below.

1. Approval of baseline budgets (required as final budgets will not be ready before the start of the new financial year). This is the FY24 budget adjusted for the full year effect of changes and the removal of non-recurrent items. This represents the expected recurrent budgets prior to any FY25 contracting changes.
 - Baseline budgets were shared and discussed with Service Directors and Corporate Directorates in February and March
 - A summary of the baseline budgets was shared with the Executive Team in March and agreed by the CEO on behalf of the Executive Team on 2nd April
2. Adjustments made for inflation, contract changes (including growth, MHIS etc.) and agreed investments from the annual planning process
 - Deadline end May
 - Now that the final plan has been submitted budgets can be adjusted to reflect this
 - This is in progress and is on track to be delivered ready for month 2 reporting as in previous years.
3. Approval of final budgets with the inclusion of the adjustments for inflation, contract changes and agreed investments.
 - Deadline end of June
 - Time booked at the Executive meeting on the 24th June
 - On track to complete this

Oxford Health Financial Controls

23/24 Controls supported achievement of plan

24/25 Enhanced controls aligned to system requirements.

Area	Control	Oxford Health Oversight	System Oversight
Discretionary Non-Pay	- All discretionary spend above £25k reviewed. - Enhanced controls to limit spend beneath £25k	CFO organisational oversight lead for exceptions, reviewed by weekly executive review panel (CEO, CFO, CPO)	Oxford Health reports exceptions to System Recovery Board
Substantive Workforce Controls Temporary Workforce Controls	- Non-clinical recruitment reviewed subject to the following – - linked to a specific statutory or regulatory requirement. - funded by external sources of income. - directly linked to a financial saving e.g. insourcing, agency to substantive shift, income related etc. - All 8c+ clinical vacancy reviewed. - Locum medical appointments and pay levels require MD approval. - No non-clinical agency unless panel approve. - System rate card adherence for Nursing and AHP - Limitation on non-clinical bank cover by exception - Bank first approach and a range of other agency controls.	CPO organisational oversight lead for exceptions, reviewed by weekly executive review panel (CEO, CFO, CPO)	
Investment & Business Cases	SDF/new investment above that already committed must be in line with 2024/25 priorities and operational planning guidance	CFO organisational oversight lead for exceptions, reviewed by weekly executive review panel (CEO, CFO, CPO)	

Self-Assessment against 21/3 letter from ICB to NHSE

Oxford Health increased workforce control requirements (As outlined by ICB to NHSE on 21 st March)					
No.	Requirement: Establish robust workforce and departmental controls	Trust	Fully met	Partially met	Not met/not known
1.	Clinical – locum medical appts and pay levels required MD approval				
		Oxford Health			
2.	Bank first approach and improved NHSP performance				
		Oxford Health			
3.	System rate card adherence for Nursing and AHP <i>Plan for Compliance e/o May</i>				
		Oxford Health			
4.	8c+ clinical vacancy freeze for three months (need to be confirmed with Trusts that this is to include band 8c posts)				
	<i>No vacancies approved outside of set budget and executive review of all proposed recruitment 8c & above</i>	Oxford Health			
5.	Non-clinical -Robust vacancy control processes including Executive level oversight				
		Oxford Health			
6.	Complete non-clinical vacancy freeze <i>No vacancies approved outside of set budget and executive review of all proposed non-clinical recruitment.</i>				
		Oxford Health			
7.	No non-clinical agency appointments <i>Executive review of any exceptional requests if unable to fill via other route for statutory/regulatory requirements.</i>				
		Oxford Health			
8.	Limitation on non-clinical bank cover by exception				
		Oxford Health			
9.	Departmental – Prioritisation and enhanced controls across corporate areas <i>No vacancies approved outside of set budget</i>				
		Oxford Health			
10.	Prioritisation and enhanced controls across all non-patient facing Divisional/Directorate roles <i>No vacancies approved outside of set budget</i>				
		Oxford Health			
11.	Operational divisions/directorates corporate service assigned control totals <i>No vacancies approved outside of set budget</i>				
		Oxford Health			
12.	Monthly exec reporting of performance against control totals				
		Oxford Health			
13.	All clinical teams on e-roster/moving to 100% across whole organisation <i>98% of clinical teams (excluding medics) will be live by end of April</i>				
		Oxford Health			
14.	Prioritisation of vacancies by divisional leads				
		Oxford Health			
15.	Workforce pay/bill plan and performance for 24/25, FTE, Agency/Temp staffing reported monthly to Exec/Board				
		Oxford Health			

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

Board of Directors

22 May 2024

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

BOD 34/2024
(Agenda item: 10(a))

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.

The Integrated Performance Report (IPR) has been re-designed for an improved alignment with Trust strategic ambitions, national and local reporting performance requirements. The Board will receive the new IPR to its meeting in June 2024. Due to the changes, it is necessary to reset the reporting timelines and for this reason the Board will receive April's IPR containing March 2024 data for the Board of Directors meeting in May.

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; no action is required at present.

In March 2024 locally reported total bed day usage was 222 days (24 inappropriate OAP bed days in Bucks, and 198 inappropriate OAP bed days in Oxon). The directorates continue their focus on reducing the use of OAPs to improve the quality of patient care and improve cost control. The use of inappropriate OAPs remains lower than the previous year, however numbers continue to fluctuate based on clinical demand and acuity.

(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)
- Page 104 of 465

- Sustainability - 5 (all have targets)
- Research & Education - 2 (none have targets)

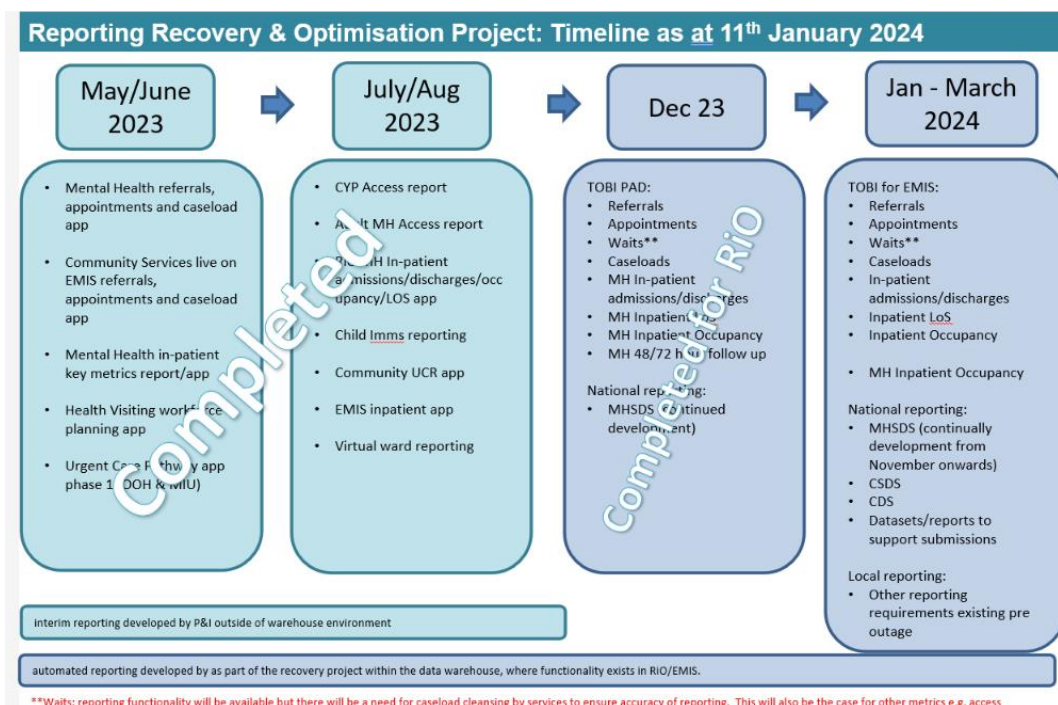
The Trust is achieving 36% (8 out of 22) of its OKRs.

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 (TOBI) containing the first wave of recovered reporting for RiO. Work has continued over Q4 to include EMIS, further national reporting and other local reporting requirements that existed prior to the outage. Further detail is provided in the visual overleaf.

Recovery work will continue in 2024/5 in order to deliver the full scope of the project as well as respond to essential revisions and additions in line with national changes.



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 c10%.

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: Grant MacDonald
Chief Executive

Integrated Performance Report (IPR) Report: April 2024

March 2024 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 2021-26

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)	3	62.5%	Overall performance is good, with the exception of the number of inappropriate out of area placements 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)	5	37.5%	• Sickness absence decreased from 5.26% to 4.18% and it is now below target. Agency usage, early turnover and vacancy rate are still not yet achieving targets. PDR is also not meeting target, however, this has been removed from exception reporting due to the significant improvement observed during the past year. Statutory and Mandatory training is also not meeting target but has significantly improved.	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 12 is £1.8m 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: 16 April 2024

For reporting period ending: 31 March

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. Over the last year there has been a reduction in turnover and improvement in recruitment
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 continue to fluctuate based on clinical demand and acuity. OAPs have shown a small increase again this month compared to last month. Understanding and managing OAPs is focus for the BOB Mental Health Provider collaborative. The directorates are engaged in the Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme
Service pressures	Risk	Services remain under pressure due to acuity, demand and workforce challenges • Data quality improvement plan is underway this has focused initially on CAMHS with significant improvement. Work has begun with adult services focussing on data quality and wait times in line with current standards • Implementation of outcome measures and a new care plan format are underway but are delayed due to IT challenges and need to embed in routine practice • Adult ADHD services remain paused to referrals but triage of referrals for risk is now complete and a revised operating model is being developed.
Finance	Risk	Agency spend remains a risk, there are clear processes within directorates to oversee the reduction in agency spend and support bank and substantive recruitment. Medical agency spend remains a challenge but following workshop with regional team there are plans to reduce agency spend. CIP planning in place across directorates

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: 15 April 2024

For reporting period 31 March 2024

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Workforce	Issue and Risk	Directorate Agency Panel launch April 22nd. This will focus on reducing agency, increasing bank, and will also sign off any planned agency spend. We will also monitor Rostering progress and the weekly Community Hospital Ward Staffing returns through the panel. Challenges with recruitment of specialist dentists resulting in increased waiting times for patients.
Service Pressures	Risk	• OOHs and MIUs remain under pressure, with increased activity. Some success in recruitment for both clinical and leadership roles. • Childrens Community Nursing service morale is low- leadership structure being stabilized and a focus on staff experience. • District nursing continue to be under extreme pressure. National Safer staffing tool outcome due to report at Board demonstrates significant gap in capacity. We are working hard to reduce agency spend in this service. • System working regarding flow is challenging due to pressures in partners, something we are working on. • SEND progress is limited, and requiring significant resource to support • Significant challenges with accessing theatres at the OUH for paediatric dental operations (general anaesthetic).
System and financial pressures	Risk	CIP planning has continued, and we are working to operationalise the plans.

Section 3:

NHS Oversight Framework performance

National objective: Compliance with the NHS Oversight Framework

This year, the NHS Oversight Framework indicators that have targets are;

	Target	National position (England)	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	74.2% (Mar)	86.6% (Mar)	↓
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	71.11% (Jan)	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%	50.3% (Feb)	52.1% (Feb)	→
(N5) IAPT - Percentage of people waiting six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT)	75%	90.2% (Feb)	99% (Feb)	→
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	97.2% (Feb)	100% (Feb)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	24 (Mar)*	→
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	198 (Mar)*	↑

Narrative updated: 15 April 2024 for reporting period ending: **31 March 2024**

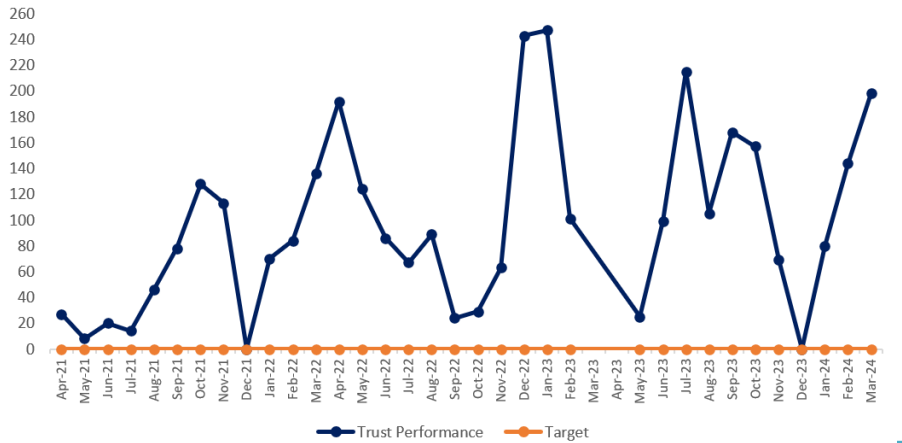
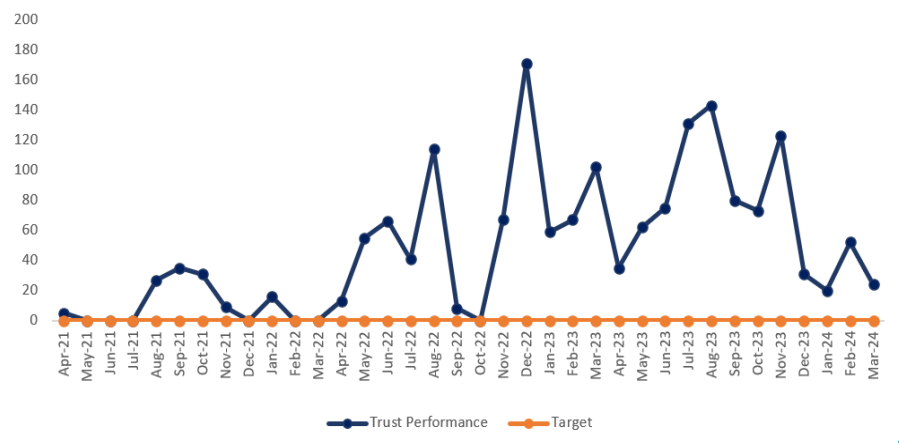
About: The NHS Oversight Framework replaced the provider [Single Oversight Framework](#) and the clinical commissioning group (CCG) [Improvement and Assessment Framework \(IAF\)](#) in 2019/20 and informs assessment of providers. It is intended as a focal point for joint work, support and dialogue between 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 and no action is 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	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	24	(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP bed days used (Oxon)	0	198



Executive Director commentary: Rob Bale, Consultant Psychiatrist and Interim Executive Managing Director for Mental Health & Learning Disability
Narrative updated: 15 April 2024
For reporting period ending: 31 March 2024

The issue and cause
 Ongoing use of OAPs due to lack of local provision

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 March 2024 locally reported total bed day usage was 222 days (24 inappropriate OAP bed days in Bucks, and 198 inappropriate OAP bed days in Oxon).** The directorates continue their focus on reducing the use of OAPs to improve the quality of patient care and improve cost control. The use of inappropriate OAPs remains lower than the previous year however numbers continue to fluctuate based on clinical demand and acuity. Pressures compounded by gaps in Consultant roles in 3 inpatient services (locums currently in place). There has also been a rise in clinically ready for discharge days.

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: March 2024 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%	69%	72%	75%	77%	74%	-	72%	➔
(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%	47.6%	21.1%	22.1% (Q4) (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	-	117	43	-	49	-	209 uses	reducing
(1f) Patient/carers safety partners	2 YE	-	-	-	-	-	-	2	➔
(1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP)	95%	-	Data not available		-	-	-	Data not available	n/a**
(1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT	95%	-			-	-	-	Data not available	n/a**
(1g) Evidence patients have been involved in their care (clinical audit results)	95%	-	-	-	-	-	-	84% n=365 (March 2024)	➔
(1h) % staff have completed the autism/learning disabilities training	95%	76%	73%	80%	91%	89%	59%	76% (all staff in Trust)	⬆

* Although overall target is being reached, representation by grade varies; bands 2-4 = 28%, bands 5-7 = 22%, band 8a to 8d = 12%, medics = 22%, dentists = 42% and board members = 11%,

** No data available since July 2022 due to Carenotes outage.

The arrow direction and colour is based on the trend.

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: 15 April 2024.

For reporting period ending: 31 March 2024

OKRs 1a, 1e, 1g and 1h are underperforming YTD; two OKRs, 1e and 1h continue to improve and two OKRs, 1a and 1g are performing similar to last month. Please see overleaf for more information by measure on the plans to mitigate and improve performance.

OKRs 1fa and 1fb 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/Carenotes 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.

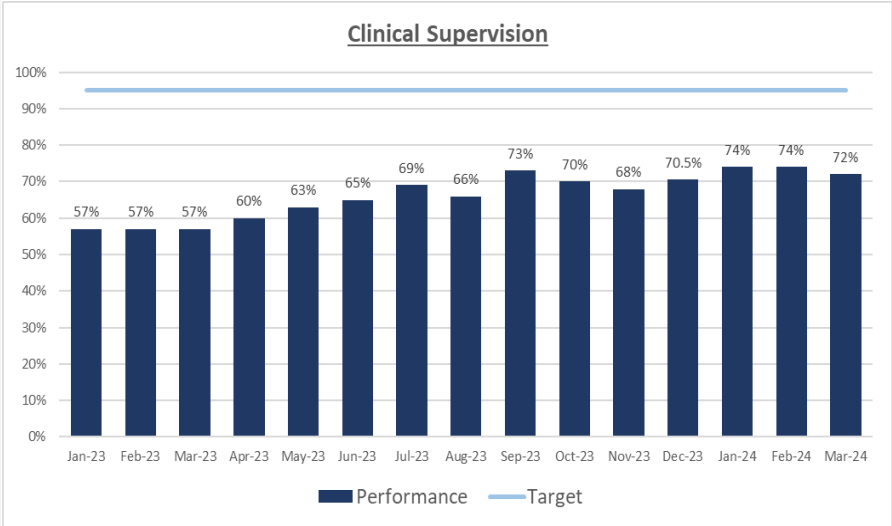
The Trust is carrying out Quality Improvement in the following areas relevant to the Quality OKRs;

- Positive and Safe – reducing restrictive interventions including use of prone restraints
- Implementing the Carers, Friends and Family Strategy 2021-2024
- Implementing the Patient Experience and Involvement Strategy 2023-2025
- Equality, Diversity and Inclusion programme

The quality indicators in the report have been reviewed and are planned to be changed from the next report to be in line with the Trusts strategic objectives and quality objectives.

Objective 1: Quality; exception report

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	95%	72%



Executive Director commentary: Chief Nurse
Data updated to 31st March 2024

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, annual leave, poor central recording and issues with accuracy of reporting.

What is the plan or mitigation?
Rates of compliance did increase and have remained around 72-74% in recent months.

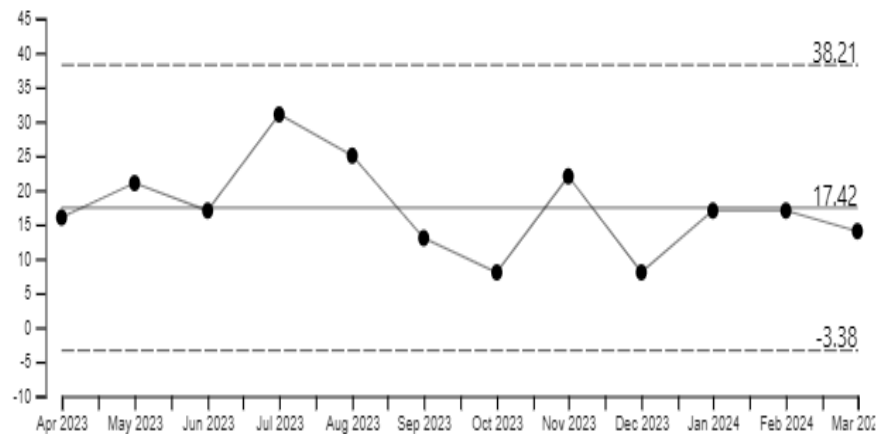
Supervision steering group is leading on the improvement plan. Some directorates are running local supervision forums to address the challenges locally and feedback to the steering group.

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 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	Target	Actual
(1e) Reduction in use of prone restraint	25% reduction from 2022/23 (183 YE)	209 uses



Executive Director commentary: Chief Nurse
Data updated to 31st March 2024

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?

In March 2024 there were 14 uses of prone compared to 17 uses in Feb 2024.

The graph shows the use of prone by month for all wards over the last 2 years. There has been a **significant and sustained reduction** in the use of prone restraint in 2023/24 across every directorate. The most common reason for the use of prone restraint is violence, with more than half having immediate IM administered.

Demonstrating sustained reduction in use of prone restraint;

2020/21 – 286
2021/22 – 257
2022/23 – 275*
2023/24 – 209

*excludes use of prone for 1 patient with an exceptional high use related to her care plan between April-Dec 2022.

The improvement work has seen a reduction in use of prone restraint in the last 12 months, however we have not been able to reach the internal ambitious target we set of a 25% reduction.

Objective 1: Quality – exception report

Objective Key Result (OKR)

(1fb) Improved completion of the Lester Tool for people with enduring serious mental illness (AMHTs for patients on CPA)

Target

Actual

95%

64%
(July 2022)



Executive Director commentary: Chief Nurse

Data last updated July 2022.

Narrative updated: March 2024

Please note performance is not RAG rated because the last data available is from July 2022.

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

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.
- Re-establishing regular reporting to teams.

Objective Key Result (OKR)

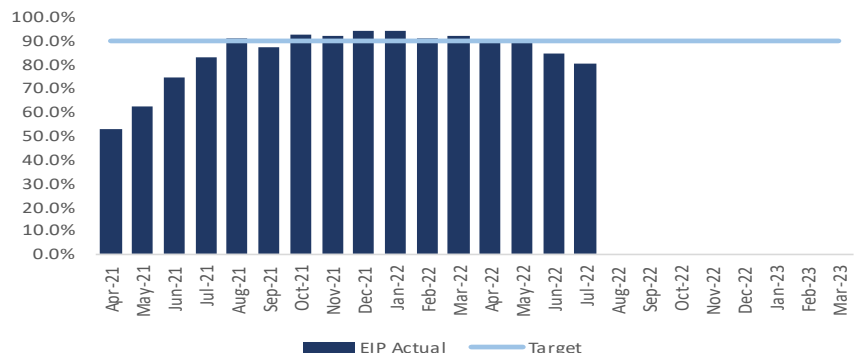
(1fa) Improved completion of the Lester Tool for people with enduring serious mental illness (EIP teams for patients on CPA)

Target

Actual

95%

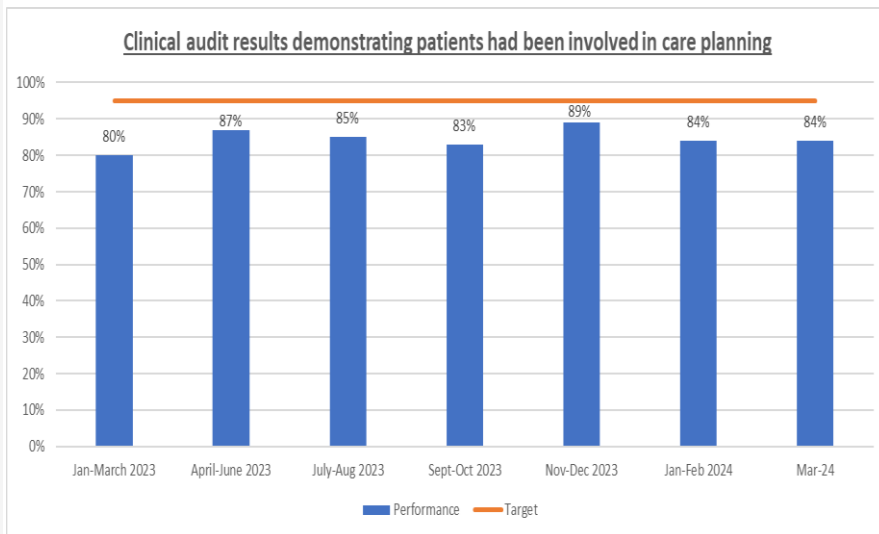
81%
(July 2022)



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%	84% n=365

Clinical audit results



Patient/carer Surveys (IWGC):

Average score of 4.69 (out of maximum of 5.0) by patients/families who reported feeling involved in their care in 2023/24 (n=14,601 patients/families have answered this question)

Executive Director commentary: Chief Nurse
Data updated to 31st March 2024

The context

Our local patient survey data through IWGC shows an average score of 4.69 for the question 'were you involved as much as you wanted to be in your care' in the last 12 months (n=14,601).

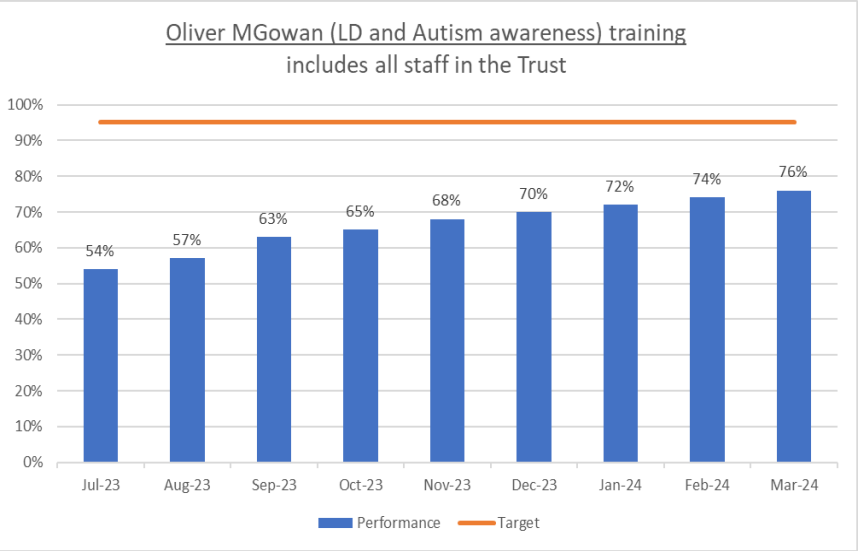
The clinical audit results are shared, 84% of records demonstrating the patient/family were involved in care planning. The results are usually reported on bi-monthly but audits completed in March 2024 have also been added as it is the year-end report. The results include audits across every Directorate 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 Experience and Involvement Strategy 2023-2025 which has a detailed workplan being led in each Directorate.

Objective 1: Quality – exception report

Objective Key Result (OKR)	Target	Actual
(1h) % staff have completed the national autism/learning disabilities training	95%	76%



Executive Director commentary: Chief Nurse
Data updated to 31st March 2024

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 in spring of 2023.

The plan or mitigation
Tier 1 of the new national training was released in 2023 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.

Trust engaged with local university providers to ensure all healthcare students have access to the Level 1 Oliver McGowan training as part of their training needs prior to clinical placement provision.

Performance against the national training is improving slowly across all areas, current position at 76%. 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

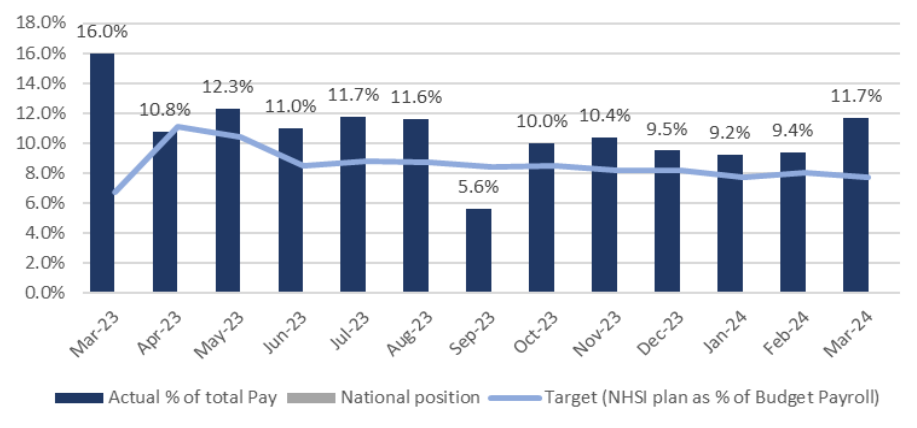
Governance: Executive Director: Chief People Officer | **Responsible Committee:** People, Leadership and Culture Committee

Reported period: **March 2024** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results are;	Target	Buckinghamshire Mental Health	Primary, Community And Dental Care	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 2023	>/?	7.0↑	7.2↑	7.1↑	7.4↓	7.6	7.6	7.2↑	↓	↓	7.19	Best 7.45 Average 7.11 Worst 6.46	↑
(2b) Reduce agency usage to NHSE/ target	</ 7.7%	17.5%↓	7.9%↑	2.2%↑	20.3%↑	11.9%↓	0.0%→	16.1%↑	0.0%→	0.0%→	11.7%	Not available	↑
(2c) Reducing staff sickness to 4.5%	</=4.5%	4.2%↓	5%↓	3.9%↓	3.9%↓	4.6%↓	0.7%↑	3.9%↓	0.3%↓	1.8%↓	4.2%	Model Hospital Peer Avg 5.1% National Value 5.6 %	↓
(2e) Reduction in % labour turnover	</=14%	13.1%↑	15.3%↑	9.3%↓	12.1%↓	19.1%↓	10.8%↑	12.4%↓	4.7%↓	19.5%↑	12.82%↓	Model Hospital Peer Avg 19.3% - National Value 19.8%	↓
(2f) Reduction in % Early labour turnover	</=14%	11.7%↓	19.7%↑	11.5%↓	17.8%↑	6.1%↓	0.0%→	14.8%↓	5.5%↓	9.6%↑	14.89%	None	↓
(2g) Reduction in % vacancies	</=9%	16.8%	11.1%↑	2.7%↓	16.1%↓	7.9%↓	43.0%→	16.7%↓	21.5%↓	42.8%↓	12.3%	Model Hospital Peer Avg 8.7% National Value 8.8%	↑
(2h) PDR compliance	>=95%	83.5%↓	89.5%↓	86.8%↓	91.4%↓	89.7%↓	100%↑	81.1%↓	85.2%↑	82.3%↓	86.8%	None	↓
(2i) S&MT (Stat and Mandatory training)	>=95%	90.7%↓	91.8%↓	86.4%↓	92.7%↓	94.3%↓	93.4%↓	88.9%→	95.8%↓	86.3%↑	90.1%	None	↓
(2j) Number of Apprentices as % substantive employees	>=2.3%	7.3%↑	6.4%→	9.7%↓	6.5%↓	25.7%↓	31.8%↓	0%→	0%→	2.5%↓	5.6%	None	↓

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2b) Reduce Agency Usage to Target	<=7.7%	11.7%



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 February was £3,730K against an NHSE/I target of £2,428k.

International Nurse Recruitment Update

The international nurse recruitment workstream has seen 40 nurses commence employment with the Trust. 3 nurses are due to start in April, 5 nurses are awaiting Certificate of Sponsorships/visas and 3 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 June 2024.

Managed Service Provider Update

ID Medical (AfC):

The programme of work to move lines of work that are on bespoke charge rates to the BOB phased rate card is continuing. This work is due to be completed by the end of April, once this has been completed the Trust will see further reductions in agency spend. In addition, ID Medical and the temporary staffing team are undertaking a programme of work to move AfC lines of work through the phased rate card which will bring out savings through reductions in hourly rates. The temporary staffing team and ID Medical, in partnership with Directorates, are undertaking a programme of work to identify high-cost line of work roles that can be advertised to replace the workforce with more cost-effective options. Agency Control panels are being run on a directorate basis by the Service Directors.

ID Medical (Medical):

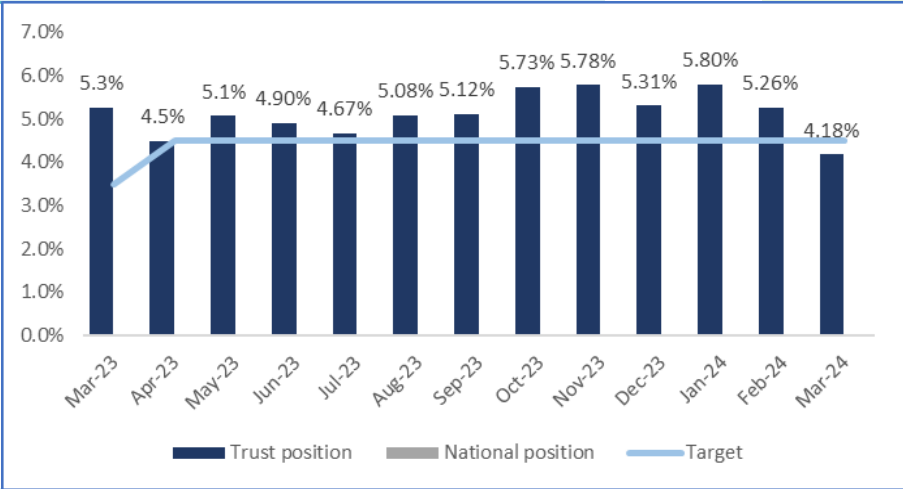
The temporary staffing team and ID Medical, in partnership with the medical staffing team, are undertaking a project to identify high-cost medic roles that can be replaced with more cost-effective options. A reduced rate card is being implemented in the OOH service for GPs which will see further reductions in agency spend. There is a programme of work being undertaken with ID Medical and the temporary staffing and medical staffing teams to migrate level 2 or below lines of work to substantive roles.

NHS Professionals:

The programme of work to migrate line of work and regular ad-hoc agency workers to the bank is continuing. The temporary staffing team are undertaking a review of shift demand compared to budgeted establishment/vacancies for all inpatient teams. Deep dives will then be held with the teams whose temporary staffing demand is significantly higher than their budgeted establishment / vacancies. The programme of work to improve utilisation and productivity of bank workers is continuing. A scoping exercise is being undertaken to explore how the Trust and NHSP could introduce auto-enrolment for new substantive staff

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	<=4.5%	4.18%



Executive Director commentary:
Charmaine De Souza, Chief People Officer

The risk or issue

The sickness absence decreased from 5.26% to 4.18% and it is now below target. Excluding Covid absences the rate was 4.04% (4.9% last month). High sickness absence rates result in increased temporary staffing use and pressure on colleagues.

The Cause

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

The plan or mitigation

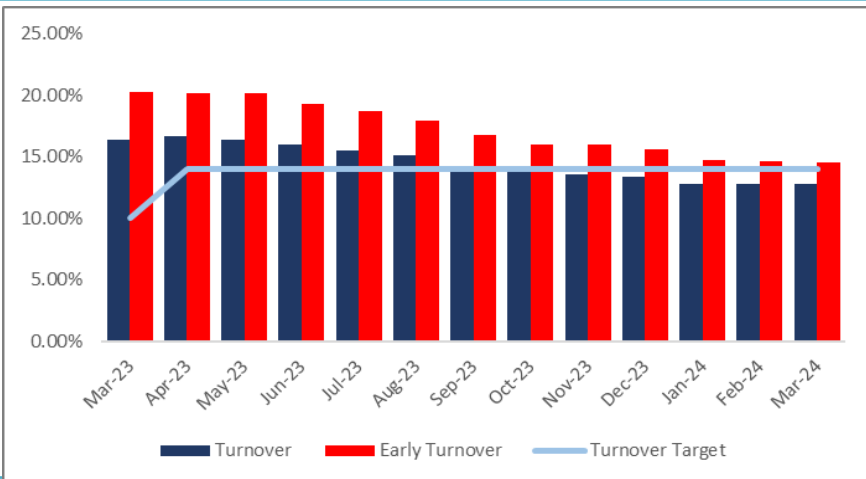
There has been a significant decrease in sickness absence this month which is below target for the first time this year and is less than that of March 2023. There is a three month decrease in rate.

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

The 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. We are also working on virtual e-learning sessions to make accessing training modules and materials easier for managers.

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<14%	12.82%
Early Turnover	<14%	14.89%



Executive Director commentary:

Charmaine De Souza, Chief People Officer

The risk or issue

Staff turnover slightly decreased to 12.82%, below the 14% target. Early labour turnover has decreased to 14.89%. 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

There has been a month on month decrease in turnover, since May 2023. First year turnover has also reduced month on month but remains just above the target of 14%.

The Retention Team are running several projects including:

- PDR Season 2 (launched 1st April 2024)
- Onboarding
- Exploratory phase of Talent Management
- Exit Interviews
- Stay Conversations
- First year experience

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 Band 8a 'People Promise Manager'. The role has been appointed too with the successful candidate being internal with a clinical background. The name and start date of the successful candidate will be published shortly.

The Retention team have completed another round of self assessment based on the NHS England tool and are preparing the first 30 days actions for when the person arrives in post, with the analysis pointing towards a focus on Flexible working

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

Staff Leaving the NHS

Staff leaving the NHS has slightly increased from 7.35% at the end of Feb to 7.38% in March 24.

* Turnover and Leaver % figures across the year have been adjusted to exclude some Honorary staff who had been recorded in ESR with FTE.

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual	The plan or mitigation
(2g) Reduction in % vacancies	<=9%	12.3%	Overview: The Trust budgeted establishment has continued to increase, from 6,604 FTE in March 2023 to 6,991 FTE in March 2024, an increase of 387 new posts in the last year and 36 new posts created in one month, since February 2024. The recruitment transformation QI project is ongoing, based on survey feedback gathered in the discovery phase, the project team are now reviewing application requirements with a view to adding a range of application forms to TRAC, these will be based on staff group. The project group are also exploring options to unsure TRAC applications are more inclusive and remove options for bias. The one-stage offer process is being trialled with the District nursing team after a recent successful recruitment campaign. Recruitment events continue throughout April, including University careers days and OHFT recruitment open day for the Meadow Unit.. Recruitment Roadshow are in the final booking stages and will run across May and into early June, these events will be hosted in multiple locations across the Trusts including High Wycombe, Littlemore, Banbury, Swindon and Aylesbury. Priority: The recruitment team are working on ensuring that the new immigration legislation that came into force in April 2024 does not unnecessarily impact our workforce, all employees that were eligible for visa renewal before the April deadline have been completed, all Home Office reporting and monitoring is currently up to date. A process is being developed for ongoing monitoring and reporting. We are also looking at the longer-term impact of the new visa changes to the future workforce. The new centralised phone line is in final testing stages however some teething problems are still being worked through, full role out including promotion of the new central phone number is now end of April 2024. * Vacancy figures across the year have been adjusted to exclude some Honorary staff who had been recorded in ESR with FTE.

Executive Director commentary:

Charmaine De Souza, Chief People Officer

The risk or issue

The vacancy rate has increased from 12. 2% to 12.3%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients. The length of time that it is taking to hire an employee results in candidates withdrawing from recruitment process or securing roles in other organisations.

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.

Month	Trust position (%)
Mar-23	12.1%
Apr-23	13.4%
May-23	14.2%
Jun-23	15.4%
Jul-23	16.8%
Aug-23	16.3%
Sep-23	15.3%
Oct-23	13.8%
Nov-23	13.5%
Dec-23	13.7%
Jan-24	12.8%
Feb-24	12.2%
Mar-24	12.3%

Objective 2: People; exception report

Objective Key Result (OKR)	Target	Actual
(2i) Statutory and Mandatory training	>=95%	90.1%



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 February has decreased from 90.5% to 90.1%. 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

- The position for Statutory and Mandatory training remains much the same with all directorates in the Trust are at circa 90% completion. Three directorates have dropped below 90%, Research & Development (86%), Corporate (88%) and Oxfordshire and BSW Mental Health (89%). For R&D and Corporate there are specific services with outlying numbers and work continues with the HR systems team to correct the training matrices which affects compliance rates.
- There are Statutory and Mandatory training subjects with a compliance rate above 95% and 5 at approximately 90%. There is a clear understanding of the risks and barriers which are resulting in the remaining 3 subjects being below this. Plans are in place to address these. Compliance is monitored quarterly at Quality and Clinical governance sub-committee.
- Focused work on Resus continues; new equipment has been ordered to enable delivery in more parts of the Trust, a contract with a new provider for the ILS course director role is being drawn up which will provide scope for more training sessions. The resus training team has moved from the Warneford to Unipart since the start of April to create better opportunity for training planning between admin and trainers.
- The Trust continues to roll out Level 1 of the Oliver McGowan training with continued improved compliance which currently sits at 75%. This will be moved to the Statutory and Mandatory training category in April. Focused comms are being rolled out to encourage staff completion.

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)	£1.3m Fav	↓
(3b) Cost Improvement Plan (CIP) delivery (YTD)	£1.8m 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)	5083 tonnes	↑
(3e) Achievement of all 8 targeted measures in the NHS Oversight Framework (see section 2 of this report)	3 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

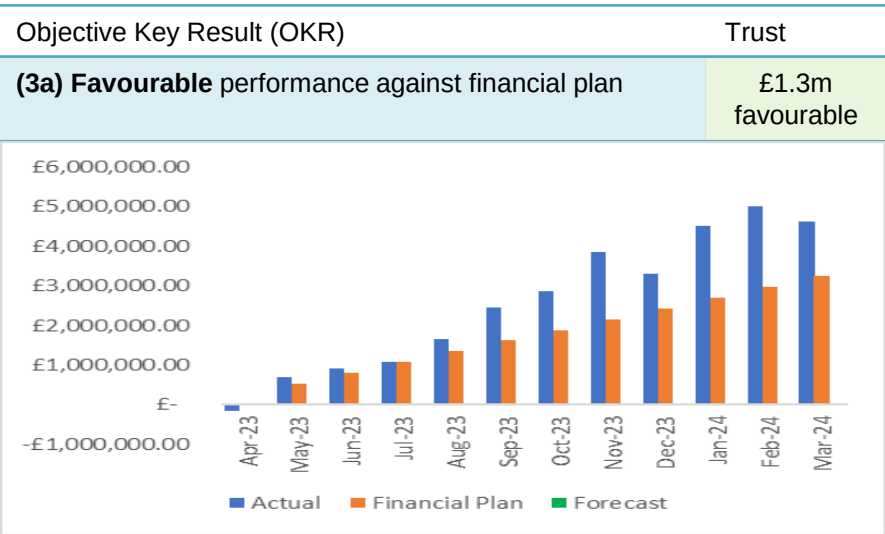
Narrative updated: April 2024

For reporting period ending: 31 March 2024

The adjusted year-end position was a surplus of £4.6m which is £1.3m better than plan and £124k better than the re-forecast position agreed with the ICS. The Directorates which were overspend at year-end were: Corporate £3.1m, Block income £2.3m (due to underperformance on the Eating Disorders & Secure contracts), Learning Disabilities £0.9m Forensic Mental Health £0.1m and Buckinghamshire Mental Health £0.1m.

The CIP target allocated to directorates for FY24 was £7.2m, made up of £5.1m for FY24 and £2.1m unmet from FY23. £5.4m was delivered: £1.0m from the temporary staffing team following the NHSP transfer and £4.4m from clinical directorates. The remaining £1.8m has been added onto Directorate CIP targets for FY25.

Objective 3: Sustainability – exception report

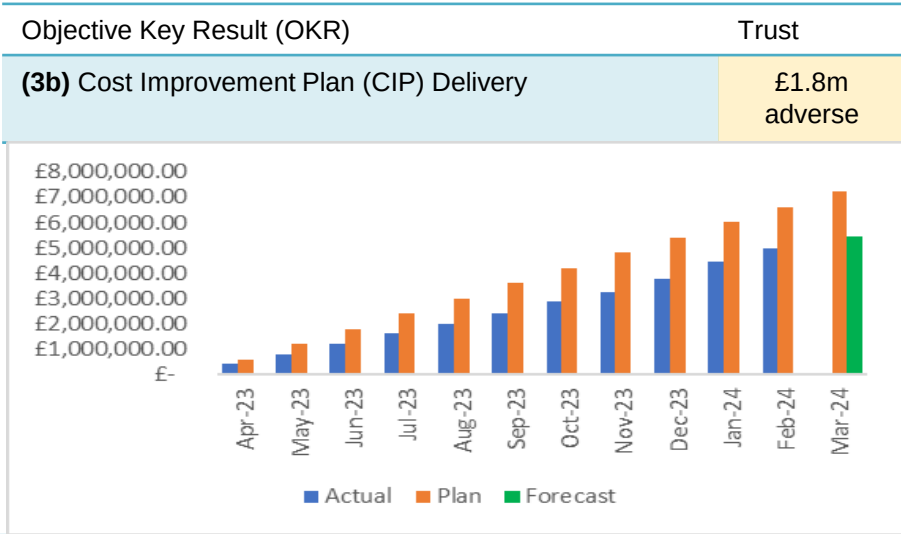


Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue
Although the Trust was better than plan at year-end, there are significant overspends in some directorates.

The cause and plan or mitigation

- Corporate £3.1m – £1.4m agreed non-recurrent spend in IT. Estates overspent by £3.9m – a review of budgets has taken place and more robust financial monitoring processes will be put in place next year. £0.5m overspend in L&D due to high spend in March. Finance will discuss this with L&D to ensure this doesn't happen again next year.
- Block income £2.3m due to underperformance in Secure and Eating Disorders. This will be reported in directorate positions next year to ensure it is more visible.
- Learning Disabilities £0.9m due to expensive out of area placements. The contract is due to be renewed in FY25 and discussions about this funding will take place with the ICB.



Executive Director commentary:
Heather Smith, Chief Finance Officer

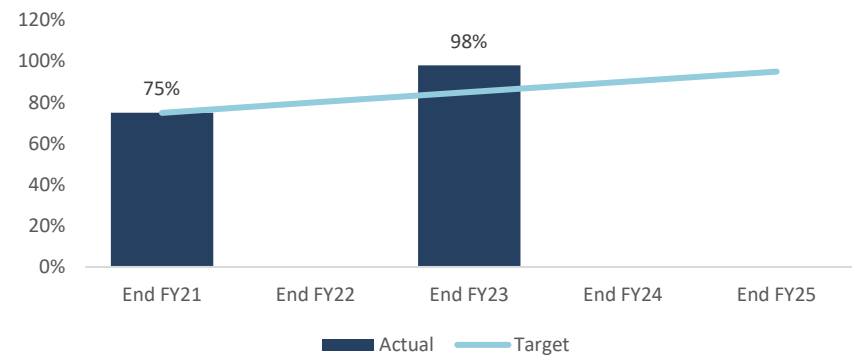
The risk or issue
CIP Performance against plan is £1.8m adverse at year-end.

The cause
CIP schemes were not developed for the full CIP target, especially in Corporate.

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.

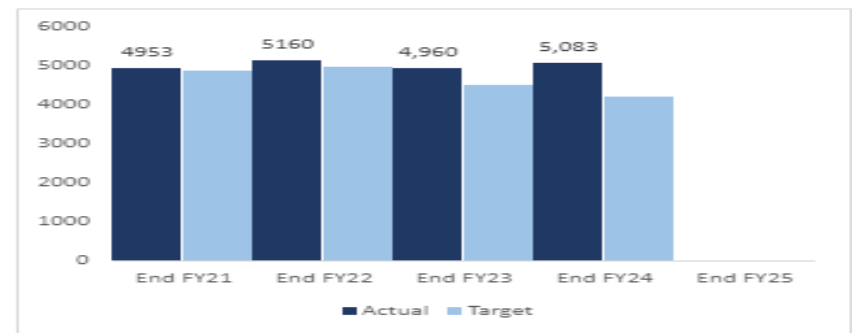
The cause

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	4210	5083



Executive Director commentary:
Heather Smith, Chief Finance Officer

The risk or issue

The Trust carbon footprint increased in FY24 by 2% when compared to FY23 . The overall position is positive in that the Trust have reduced its carbon footprint by 16% when compared to FY20 baseline .

The cause

Fossil fuel burning Gas consumption reduced by 1% ,this due to reduction in building target temperatures and mild winter conditions .Staff Business mileage increased by 9% (310,000 miles)

What is the plan or mitigation?

The estates department has an action plan describing potential schemes and Green Plan 2 is being developed for the Trust.

Key objectives to reduce carbon footprint for FY25

- review modal shift to more sustainable travel
- develop Building Heat Decarbonisation plan
- Complete replacement program for low energy LED Lighting .

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

Governance: Executive Director: Chief Medical Officer

	FY24 - TD				FY23 for reference	
Studies	Opened (currently active)	Closed	Studies that recruited		National comparator	
CRN Portfolio	24 (75 inc.8 students)	9	Community Services Oxon & BSW Bucks Corporate inc. R&D TOTAL	6 9 5 27 47	OHFT 4 th nationally – 47 studies 1 st Trust – 71 studies	OHFT 4 th nationally – 46 studies 1 st Trust – 72 studies
Non-Portfolio	18 (30 inc.16 students)	11	16		n/a	n/a

	FY24 - TD			FY23 for reference	
	Recruited participants to the above studies		National comparator		
CRN Portfolio	Community Services	104	OHFT 7 th nationally – 2109 participants 1 st Trust – 5654 participants	OHFT 5 th nationally – 1789 participants 1 st Trust – 6598 participants	
	Oxon & BSW	153			
	Bucks	110			
	Corporate inc. R&D	570			
	Oxford Monitoring System for attempted	1172			
	Suicide TOTAL	2109			
Non-Portfolio	733		n/a		n/a

Executive Summary: Karl Marlowe, Chief Medical Officer \ Vanessa Raymont, R&D Director

Data cut: 2nd April 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.

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)

Report to the Meeting of the Oxford Health NHS Foundation Trust

Board of Directors

22nd May 2024

BOD 34(iii)-(iv)/2024
(Agenda item: 10(b))

Quality and Safety Dashboard For Information

Executive Summary

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

From reviewing a range of activity, quality and workforce indicators the below wards and community teams are highlighted by exception as flagging with an area of concern based on the position in March 2024 and a review of any trends from the last 3 months (January-March 2024). Note data on activity and waits is not available for the Primary, Community and Dental services Directorate at the moment. This month the Dashboard includes waits information for mental health services and dental services, as well as performance against the 48 hour follow up target for inpatient mental health discharges.

See accompanying excel sheet for the full detailed dashboard for the inpatient wards. The new CAMHS PICU Meadow Unit is included in the Dashboard. For the community teams a range of indicators are also reviewed with any teams identified by exception below.

The following wards/teams have been highlighted, split into 2 groups; to keep a watching eye and alert status. Those highlighted in **BLUE** were identified in last month's Dashboard. No wards have been highlighted at alert status however 8 wards are at a 'keeping a watching eye'.

Highlighted wards/teams by exception:

	Alert Status	Keep a Watching eye
Community Teams	• District Nursing • Oxon City and NE AMHT	• Minor Injury Units • GP OOH • Podiatry • Bucks Adult Crisis Teams (Aylesbury and Chiltern) • Bucks Chiltern AMHT • Bucks and Oxon CAMHS Neuro Diversity • Bucks and Oxon Adult Neuro Services • Bucks and Oxon Complex needs service • Oxon CAMHS getting help and getting more help teams
Inpatient Wards		• Ashurst PCIU • CAMHS Highfield • Cotswold House Oxford

	Alert Status	Keep a Watching eye
		• Sapphire • Woodlands • Kestrel • Kingfisher • Evenlode

The report includes further detail about each of the 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 detailed in the Dashboard. The Trust has an improvement programme of work called 'Improving Quality, Reducing Agency use' to reduce vacancies and agency use.

Governance Route/Approval Process

The Dashboard is a regular paper, developed with input from the Clinical Directorates and discussion at the Quality and Clinical Governance Sub-Committee in April 2024 and also the Quality Committee in May 2024.

Statutory or Regulatory responsibilities

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

Recommendation

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

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

Main report

1. Introduction

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

From reviewing a range of activity, quality and workforce indicators the below wards and community teams are highlighted by exception as flagging with an area of concern based on the position in March 2024 and a review of any trends from the last 3 months (January-March 2024). Note data on activity and waits is not available for the Primary, Community and Dental services Directorate at the moment. This month the Dashboard includes waits information for mental health services and dental services, as well as performance against the 48 hour follow up target for inpatient mental health discharges.

See accompanying excel sheet for the full detailed dashboard for the inpatient wards. The new CAMHS PICU Meadow Unit is included in the Dashboard. There is some ongoing work to improve the accuracy of the staff fill rate data, the latest specification change will be applied to the data in the next dashboard and relates to how planned hours are calculated. For the community teams a range of indicators are also reviewed with any teams identified by exception below.

2. Highlighted wards/teams

The following wards/teams have been highlighted, split into 2 groups; to keep a watching eye and alert status. Those highlighted in **BLUE** were identified in last month's Dashboard.

Highlighted wards/teams by exception:

	Alert Status	Keep a Watching eye
Community Teams	• District Nursing • Oxon City and NE AMHT	• Minor Injury Units • GP OOH • Podiatry • Bucks Adult Crisis Teams (Aylesbury and Chiltern) • Bucks Chiltern AMHT • Bucks and Oxon CAMHS Neuro Diversity • Bucks and Oxon Adult Neuro Services • Bucks and Oxon Complex needs service • Oxon CAMHS getting help and getting more help teams
Inpatient Wards		• Ashurst PCIU • CAMHS Highfield • Cotswold House Oxford • Sapphire • Woodlands • Kestrel • Kingfisher • Evenlode

The rest of the report provides detail on teams/wards with very high vacancies, waiting times for community mental health teams and details for each of the wards/teams at 'alert status' with the mitigations and actions being taken.

3. Teams with High Vacancies

In addition, to the teams/wards highlighted there are a number of areas with a significant number of vacancies, although for the majority the quality indicators reviewed are not showing any concerns. 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' to reduce vacancies and agency use. In addition to the programme each month the wards and teams with the highest vacancies are discussed with the HR recruitment campaign consultants to help steer/inform their work.

Areas with High Vacancies - 30% or above (data source Finance)	
Inpatient Wards	Community Teams
• CAMHS Highfield 41.2% (decline) • CAMHS Meadow PICU (new unit) • Cotswold House Oxford 34.5% (similar) • Kingfisher 29.7% (similar) • Ruby ward 27.4% (similar) See accompanying excel sheet for the full detailed dashboard for the inpatient wards which includes fill rates.	• Oxon City and NE AMHT 38.3% (similar) • Oxon City East CMHF Hub 41.1% (similar) • Oxon North and West AMHT 30.4% (similar) • Oxon CRHT 44% (decline from last month) • Oxon maternal mental health 67.8% (similar) • Oxon CAMHS getting help South 39% (similar) • Oxon CAMHS Mhst North, City and South, 31-35% (similar) • BSW CAMHS Inreach 41% (similar) • Oxon CAMHS Crisis 31.5% (similar) • Bucks Aylesbury AMHT 36.3% (improvement) • Bucks Aylesbury CRHT 35.5% (decline) • Bucks Chiltern AMHT 45% (improvement) • Bucks PIRLS 44.8% (similar) • Bucks SCAS & Street Triage 33% (similar) • Bucks OA South CMHT 47.8% (similar) • Bucks Memory clinic service 37.7% (decline) • Bucks CAMHS LD 36.5% (decline) • Bucks CAMHS Neuro 50.6% (decline) • Podiatry 33% (similar) – [there is a national shortage of podiatrists and a small numbers of places being offered to training students which is worrying] • Chronic Fatigue and ME Service 37.5% (similar) • Childrens Community Nursing West 30.6% (improvement) • Community Nutrition and Dietetics 33.9% (decline) • OOH service – not GPs 69.3% (similar) • Luther Street GP 30.1% (decline)
In addition there are a number of separate medical/doctor professional cost centres across the mental health teams and wards with very high vacancies and locums in place for example Oxon CAMHS Neuro, BSW CAMHS, Oxon Adult Eating Disorders, Bucks adult and older adult community teams, Bucks Complex Needs. These vacancies compound the pressure on services and in some cases ward admissions are temporarily paused.	

4. Inpatient discharges followed in line with the national requirements¹

The data is now available again. The performance for follow up within 48 hours (Trust target) and 72 hours (national target) is shown below by ward the patient was discharged from. There are daily mechanisms in place to monitor performance. In 75% of eligible discharges the patient was followed up within 48 hours/2 days.

Eligible discharges followed up within 48hrs & 72hrs by ward					
Ward	Eligible Discharges	Follow up 48 Hour Compliant	Follow up 48 Hour Compliant %	Follow up 72 Hour Compliant	Follow up 72 Hour Compliant %
AMHB Ruby Ward	9	6	66.67%	7	77.78%
AMHB Sapphire Ward	10	8	80.00%	8	80.00%
AMHO Allen Ward	12	12	100.00%	12	100.00%
AMHO Phoenix	5	3	60.00%	3	60.00%
AMHO Vaughan Thomas	13	7	53.85%	8	61.54%
AMHO Wintle	9	5	55.56%	5	55.56%
B Older Adult Amber Ward	6	6	100.00%	6	100.00%
O Older Adult Cherwell	6	6	100.00%	6	100.00%
O Older Adult Sandford	5	3	60.00%	3	60.00%
Total	75	56	74.67%	58	77.33%

5. Wards Highlighted at Alert Status

No wards have been highlighted at alert status however 8 wards are at a 'keeping a watching eye', with the detail why below.

The two CAMHS wards are highlighted as having high use of physical restraint in the accompanying excel sheet, work is being led by the Associate Director of Nursing on reducing the use of restrictive practice in CAMHS.

Recruitment and retention remains the main challenge and presents the highest risk, with 4 wards having very high vacancies – CAMHS Highfield, Cotswold House Oxford, Kingfisher and Ruby. There has been a reduction of wards with very high vacancies over the last 2 months. 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 progress to support recruitment and retention across services, some examples are listed below. Temporary staff are used to maintain service levels. There are clear processes within directorates to oversee a reduction in agency spend and support bank and substantive recruitment. There remain some ongoing issues with the contract with NHS Professionals who provide temporary and agency staff which are being addressed. Recruitment and retention is a high risk on the Trust's Risk Register.

Examples of recruitment and retention initiatives

Recruitment for the new CAMHS PICU called Meadow Unit remains a priority, in particular Band 5 nurses. 10 newly qualified nurses and international nurses are in the recruitment pipeline. At CAMHS Highfield an OT development post has been appointed to which has been difficult to recruit. A further hiring event is being held in April 2024 to find new staff.

There is a recruitment focus on the forensic wards (including Glyme, Kingfisher and Kestrel) and a recruitment video has been developed, the wards are seeing associate nurses coming through.

Recruitment roadshow events continue to be held across the Trust with events in Buckinghamshire, Oxfordshire and Swindon in May 2024.

A new 12-month recruitment and retention bonus has been agreed for all mental health and learning disability services (inpatient and community teams for B5 and above) up until Feb 2025 to incentivise people joining to work in the Trust.

¹ The national criteria is 72 hours (3 days) and the Trusts internal expectation is within 48 hours (2 days) after the day of discharge. The follow up can be F2F, digital or by telephone with the patient. Contact with the family instead of the patient is not included.

Wards identified as 'keeping a watching eye':

- Ashurst PICU – high vacancies/high agency use – fill rate registered at night challenging - high use of seclusion– low supervision compliance
- CAMHS Highfield – High vacancies/high agency use/ high turnover (linked to opening new Meadow unit)– fill rate registered at night challenging – high rates of patient self-harm and use of restraint – supervision and mandatory training compliance low
- Cotswold House Oxford – high vacancies/high agency use/high turnover – fill rate registered in day challenging - supervision compliance low
- Sapphire – High vacancies/high agency use/sickness– fill rates fine – use of seclusion
- Woodlands – high vacancies/high sickness – fill rate registered in day challenging - low supervision compliance
- Kestrel – high vacancies/high agency use/high sickness - fill rate registered in day challenging – 1 patient with very high needs on ward, resulting in high uses of restrictive practice
- Kingfisher – high vacancies/high agency use/high sickness – fill rate challenging for registered in day and unregistered at night - no specific quality flags
- Evenlode – moderate vacancies/agency use – fill rate registered in day challenging - 1 patient with very high needs on ward, resulting in high uses of restrictive practice

6. Community Teams Highlighted at Alert Status

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

Two teams/services have been highlighted which are particularly struggling; District Nursing Service and Oxon City and NE AMHT. Further details are on the next page with the mitigations and actions being taken.

In addition the following teams/services are mentioned to 'keep a watching eye' for the majority the quality flag relates to access and waiting times due to demand being above capacity;

• Minor Injury Units	• Bucks and Oxon CAMHS Neuro Diversity
• GP OOH	• Bucks and Oxon Adult Neuro Services
• Podiatry	• Bucks and Oxon Complex needs service
• Bucks Adult Crisis Teams (Aylesbury and Chiltern)	• Oxon CAMHS getting help and getting more help teams
• Bucks Chiltern AMHT	

The below highlighted teams have a reported high number of patients currently waiting to be seen, beyond the expected target time (as of 12th April 2024);

- Oxon CAMHS Neuro Diversity n=3577 most for diagnostic (high number of related complaints, concerns and MP queries)
- Oxon Adult Neuro n=3119 (current pause on new referrals to walk through triage and develop service model)
- Oxon CAMHS getting help and getting more help teams, total n=1043
- Oxon and BSW Adult Eating Disorders n=109
- Oxon Complex Needs Service n=1074 most for triaging and assessment
- Bucks Complex Needs Service n=748 most for triaging and assessment
- Bucks CAMHS Neuro Diversity n=2837 most for the collab service
- Bucks Adult Neuro n=1319 (current pause on new referrals to walk through triage and develop service model)
- Bucks OA Memory clinic service n=825
- Bucks Adult Psychological Therapies n=609

Note the activity and waits information from EMIS for the Primary, Community and Dental services Directorate is not yet available. The new data feed is scheduled to be tested in the first week of May so should be available soon.

The waiting time for specialist dental treatment under general anaesthetic was reported by the service to the Quality and Clinical Governance Sub-Committee on 30th April as 263 children waiting and 49 adults.

Highlighted teams:

Teams/Service	In last Dashboard under ALERT status?	Reason for Highlighting	Mitigations & Actions
District Nursing	Yes	Demand is exceeding capacity/service establishment. - 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. Compared to services in the BOB and nationally the service has a low establishment of staff for the population served. 28% deficit in staff establishment = 60+ WTE staff. The Service receives about 2000 new referrals a month and carries a caseload of around 7000-8000 patients. - Lower, medium and some high priority patients are being delayed and experiencing extended delays to be seen. Around 350 visits are being delayed daily. - Vacancies are very low, service held information show overall vacancies as of 17th April 2024 at 0.09 WTE. The budget establishment for the service is 242.39 WTE. There are vacancies in the City locality which is harder to recruit to and some over recruitment in South, West and North to enable the service to stop using agency staff while new starters are in the pipeline. 73% compliance against mandatory training courses 54% compliance against supervision requirements 2 complaints, 3 concerns and 0 MP concerns received over 3 months from Jan-March 24. Themes; insufficient care and communication. 72 patient incidents with moderate harm or above over 3 months from Jan-March 24 (excluding inherited PU), this includes cases where we have found no issues in care which could have prevented the harm. Important to note the high number of patients on the DN service caseload, approx. 7000-8000 patients. Incidents are spread across all locality teams, with the most in SW and West localities. Majority of the harms are pressure ulcers	<u>Actions</u> - Options appraisal paper being developed to explore possibilities in light of staff establishment gap and system constraints. - A comprehensive District Nursing Improvement Plan has been completed and brought to an end in March 2024, with a new Transformation Programme starting. Completed workstreams include; setting up ambulatory clinics, developing an anticipatory care model, goaguchek XS system for point of care testing and EMIS prescribing has been scoped. The projects under the Transformation Programme include; workforce retention, continence recovery plan, wound care and end of life care. - New recruitment campaign started from Feb 2024 – bus advertisement, social media and local press advertising 3 open days in March 2024. More activities planned in June 2024. Campaign has been successful, 19 new staff in pipeline various starting dates from 22nd April to October 2024. NHSP staff being used but no agency staff. - Currently preparing roll out of electronic notes on EMIS. Delayed visits are now managed via EMIS. <u>Mitigations</u> - Clinical prioritisation framework in place, agreed BOB wide with ICS 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.

Teams/Service	In last Dashboard under ALERT status?	Reason for Highlighting	Mitigations & Actions
		developed in service (48 of 72 incidents), particularly category 3. There have been 0 cases identified under the Trusts PSIRP since Dec 2023, where serious/significant concerns about care have been identified. DN teams are using learning huddles to make improvements where indicated.	• Monthly meetings with BOB ICB commissioner/GP leads to monitor situation. • All pressure ulcers developed in service are reviewed for lapses in care. A monthly report is updated and reported quarterly to the Directorate clinical standards group.
Oxon City and NE AMHT	Yes	The team has high vacancies combined with demand being high. • 38.3% vacancies (slightly worse than last month), with agency staff use at 7.6% (March 24) • 69% compliance against mandatory training courses. • 59% compliance against supervision requirements. • As of 12th April 2024 - 315 patients waiting for assessment or treatment and gone beyond expected target time. 5 of the patient incidents Jan-March 24 were about communication of delay in providing care/treatment. • To put in context team received 445 referrals in 3 month period (Jan-March 24) and have an open caseload of around 1,300 patients. • 5 complaints (majority received in Jan 24), 7 concerns and 3 MP concerns over 3 months from Jan-March 24. Complaints have reduced but concerns have increased in the 3 month period. Main theme; insufficient care. • 6 out of 32 incidents reported in the last 3 months with moderate harm and above, from Jan-March 24. The 6 incidents with moderate/severe harm related to patient self-harm, poor discharge, treatment delay, and damage to property. The number of incidents is not dissimilar to other AMHTs such as the North and West AMHT. • 3 unexpected deaths in last 3 months (Jan-March 24); 1 death from natural causes and 2 unnatural causes (suspected suicides). 7 unexpected deaths in the last 6 months.	• Active recruitment campaign is continuing. LinkedIn campaign for B6 nurses in AMHT and primary care hubs. Recruitment video developed for AMHT. • New recruitment and retention bonus agreed for all mental health and learning disability services for 2024/25 to incentivise people joining to work in the Trust. Started from 1st March 2024. • There is also a focus on retention and ensuring every team has an away day to support the team. • Sessional staff helping to work through assessment waiting list. Number of patients waiting to be assessed has declined. • Plan to use permanent recruitment agency to fill 1-3 B6 posts which have been difficult to recruit. • 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.

For Information

Finance Report

March 2024 (Month 12), FY24

Report to Board of Directors

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Executive Summary

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12. Statement of Position
13. Cash-flow
14. Working Capital Indicators

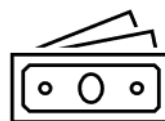
A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.

Executive Summary



Income & Expenditure position

- Adjusted financial performance £1.3m better than plan and £0.1m better than forecast



Capital Expenditure

- £0.7m (4%) underspend against funded capital allocation

Cash

- Actual £85.6m, £26.0m better than plan

Key messages:

- The adjusted financial performance is a surplus of **£4.6m**, which is **£1.3m** better than plan and **£0.1m** better than forecast equivalent to 0.02% of turnover.
- Capital was **£743k** underspent against the Trust's funded capital allocation, driven by an underspend on Estates projects.
- Directorates with significant variances to budget at the year-end were:
 - Corporate £3.1m overspend (including approved overspends of £1.8m)
 - Block income £2.3m adverse variance
 - Learning Disabilities £0.9m overspend
 - Oxfordshire and BSW Mental Health £1.8m underspend
 - Primary, Community & Dental £1.1m underspend
 - Oxford Pharmacy Store £0.5m favourable variance

1. Income Statement

	INCOME STATEMENT							
	Month 12				Year-to-date			
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Actual £m	Variance £m	Variance %
Clinical Income	42.8	59.3	16.5	39%	513.8	525.9	12.1	2%
Other Operating Income	4.7	9.2	4.6	98%	85.2	101.2	15.9	19%
Operating Income, Total	47.4	68.5	21.1	44%	599.0	627.1	28.0	5%
Employee Benefit Expenses (Pay)	31.3	42.1	(10.8)	-34%	369.6	374.8	(5.3)	-1%
Other Operating Expenses	14.6	24.0	(9.4)	-64%	210.4	230.9	(20.5)	-10%
Operating Expenses, Total	45.9	66.1	(20.2)	-44%	580.0	605.7	(25.8)	4%
EBITDA	1.5	2.4	0.9		19.1	21.3	2.2	
Financing costs	1.3	10.7	(9.4)	-710%	15.9	24.7	(8.8)	-36%
Surplus/ (Deficit)	0.2	(8.3)	(8.5)		3.2	(3.4)	(6.5)	
Adjustments	0.0	0.0	0.0	0.0	(0.1)	8.0	7.8	0.0
Adjusted Forecast Surplus/ (Deficit)	0.2	(8.3)	(8.5)		3.1	4.6	1.3	
Amounts held for year-end pressures or PFI changes								
Forecast Surplus/ (Deficit)								

Year-to-Date Performance

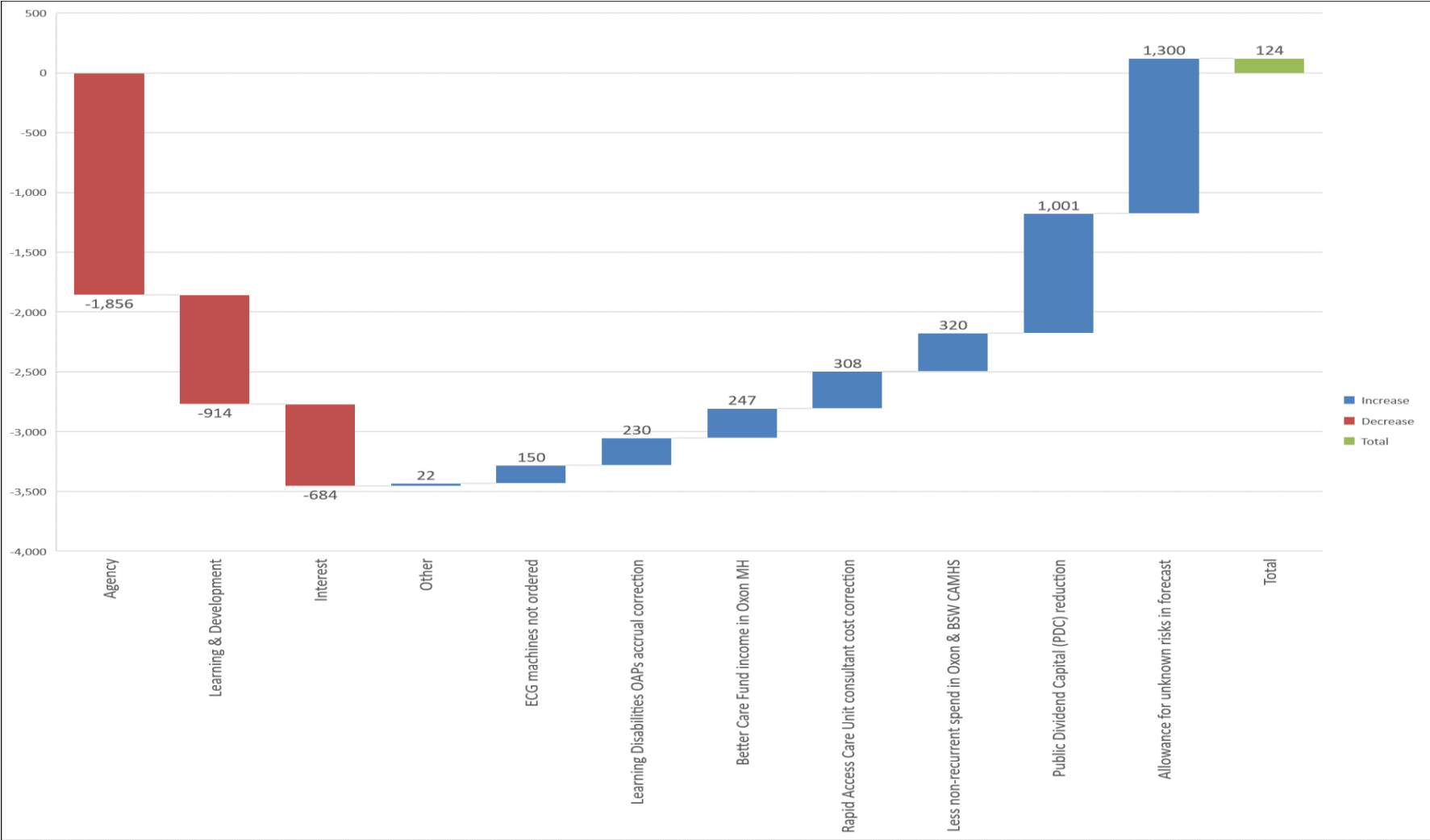
The year-end position is a deficit of **£3.3m**, but this includes asset impairments of **£7.8m** (due to revaluation of assets at lower values) and other smaller amounts which are adjusted for in the financial performance the Trust is monitored against. The adjusted financial performance is a surplus of **£4.6m**, which is **£1.3m** better than plan and **£0.1m** better than forecast.

EBITDA is **£2.2m** favourable to plan. The adverse variance of **£8.8m** in financing costs is made up of **£7.8m** asset impairments, **£2.2m** additional interest relating to a prior period adjustment for the PFI and **£0.6m** on depreciation. These are offset with favourable variances of **£1.5m** on interest receivable and **£0.4m** on the Public Dividend payment.

The favourable variance on income (**£28.0m**) is made up of **£13.7m** year-end pension adjustment (offsets with expenditure), **£7.8m** higher sales in Oxford Pharmacy Store, **£4.5m** education and training income above budget, **£1.8m** PICU double running costs income from NHS England, **£0.7m** in R&D partly offset with higher expenditure and **£2.8m** across other services mainly one-off income or released deferred income. These are offset by a **£3.3m** adverse variance in Provider Collaboratives where income has been deferred to match lower than planned spend.

The adverse variance on expenditure (**£25.8m**) is made up of **£13.7m** pension adjustment (offsets with income), **£7.4m** higher cost of sales in Oxford Pharmacy Store, a **£3.7m** overspend in Estates and Facilities (including **£0.6m** agreed non-recurrent spend), a **£3.6m** overspend on Mental Health out of area placements and a **£1.0m** overspend on Learning Disabilities out of area placements. These are offset by a **£3.6m** underspend in Provider Collaboratives (offset with income).

2. Changes from Month 11 Forecast



Agency

Agency increased by **£1.9m** from what was forecast. **£0.6m** was due to an increase in costs in March (half of which was retro-shifts). **£0.1m** was due to Housekeeper agency costs that have not been going through ID Medical. The remaining increase was a result of reviewing the overall accrual value and comparing with unpaid invoices which resulted in increasing the accrual.

Finance have much more confidence in the data provided by ID Medical now but the FY24 accrual is affected by what happened in the first half of the year. It has been a struggle to report agency accurately all year because of the teething issues involved with transferring to ID Medical, including being able to code invoices correctly to services. For FY25 we have much better data and will change our methodology of accruing which should prevent similar issues happening again.

	Forecast	Year-End Actual	Change
FY23	-3,500	-3,498	-2
FY24 - using IDM data as per methodology we have been using	36,996	37,612	-616
Housekeepers not on Clarity		122	-122
Additional FY24 accrual		1,116	-1,116
Total Agency Spend	33,496	35,352	-1,856

Learning and Development

The month 12 costs in Learning and Development (L&D) were **£0.9m** higher than forecast. Finance had agreed with L&D that they could spend their underspend in March and this was not reflected in the forecast in error. However, L&D spent more than this and ended the year with a **£0.4m** overspend. Finance will discuss this with L&D to understand the reasons for this.

PDC Reduction

Public Dividend Capital (PDC) reduced by **£1.0m** from forecast due to the reduced asset base as a result of the year-end re-valuation.

3. Capital Investment Programme

FY24 Budget		FY24 Final Outturn	
Project Names	Latest Budget £,000	Actual Expenditure £,000	Variance Bud vs Act £,000
Estates - Projects c/f	193	14	179
Estates - Highfield PICU	1,810	3,123	(1,313)
Estates - Jordan Hill	500	287	213
Estates - PDC Projects	2,314	965	1,350
Estates - MH Projects	5,051	2,041	3,010
Estates - Community Projects	1,494	782	712
Estates - Life Cycle & Back Log Works	1,742	1,594	148
OPS- Oxord Pharmacy Store	1,157	1,608	(451)
Sub Total - Estate Improvements & Transformation	10,607	6,614	3,993
Sub Total - Operational Capital	2,498	2,192	306
Sub Total - Oxford Pharmacy (MXL Centre)	1,157	1,608	(451)
Grand Total - All Estates	14,262	10,414	3,847
IT Capital	1,140	937	203
IM&T Clinical Systems	3,445	4,009	(564)
IM&T - PDC Projects	709	542	166
Grand Total - IM&T	5,294	5,488	(194)
PFI	-	10	(10)
Grand Total	19,555	15,912	3,644

Funding Sources	Latest Funding
Total Funding Available	16,654
Actual Outturn - Funding Surplus /(Funding Deficit)	743

	£,000 Lease Liability	£,000 Dilaps Liability	£,000 Total IFRS16 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
Cowley Road CMHF Hub (5 yrs - 4.72% disc rate)	298	90	388
Kidlington CMHF Hub - (5yrs - 4.72% disc rate)	158	TBC	158
Murray House, Jordan Hill - (20 yrs - 4.72% disc date)	6,000	1,600	7,600
Other Increases in Dilapidations Provision TBC	-	1,633	1,633
	7,826	3,667	11,493

The Trust spent **£15,912k** on its core capital programme in FY24, £743k less than the funding available, which equates to a 4% underspend.

£11,493k of leased assets were capitalised as 'Right of Use Assets' in year, including £7.6m for Jordan Hill.

4. Directorate Financial Performance Summary

Directorate	Month 12				Year-to-date			
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Actual £m	Variance £m	
Oxfordshire & BSW Mental Health	(9.9)	(9.0)	0.9	-9%	(113.4)	(111.7)	1.7	-1%
Buckinghamshire Mental Health	(4.5)	(4.9)	(0.4)	9%	(52.9)	(53.0)	(0.1)	0%
Forensic Mental Health	(2.7)	(3.3)	(0.6)	23%	(31.1)	(31.2)	(0.1)	0%
Learning Disabilities	(0.6)	(0.4)	0.1	-26%	(5.8)	(6.7)	(0.9)	16%
Provider Collaboratives	0.7	0.9	0.3	37%	11.2	11.5	0.3	2%
MH Directorates Total	(16.9)	(16.6)	0.3	-2%	(192.0)	(191.2)	0.8	0%
Primary Community & Dental Care	(8.0)	(7.4)	0.6	-7%	(99.1)	(98.0)	1.1	-1%
Corporate	(7.2)	(12.1)	(4.9)	68%	(76.4)	(79.5)	(3.1)	4%
Oxford Pharmacy Store	0.0	0.2	0.1	261%	0.4	0.8	0.5	133%
Research & Development	(0.1)	(0.2)	(0.1)	235%	(0.5)	(0.3)	0.2	-45%
Covid-19 Costs	(0.0)	0.0	0.0		(0.0)	0.0	0.0	
Reserves	1.3	6.2	4.9	394%	(2.7)	2.3	5.0	-185%
Block Income	32.3	32.2	(0.1)	0%	389.4	387.2	(2.3)	-1%
EBITDA	1.5	2.3	0.8		19.1	21.4	2.3	
Financing Costs	1.3	10.7	(9.4)	-713%	15.9	24.7	(8.8)	-55%
Adjustments	0.0	0.0	0.0		(0.0)	(0.0)	(0.0)	
Adjusted Surplus/(Deficit)	0.2	-8.4	-8.6		3.2	(3.2)	(6.5)	

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.

5. Provider Collaboratives Financial Performance Summary

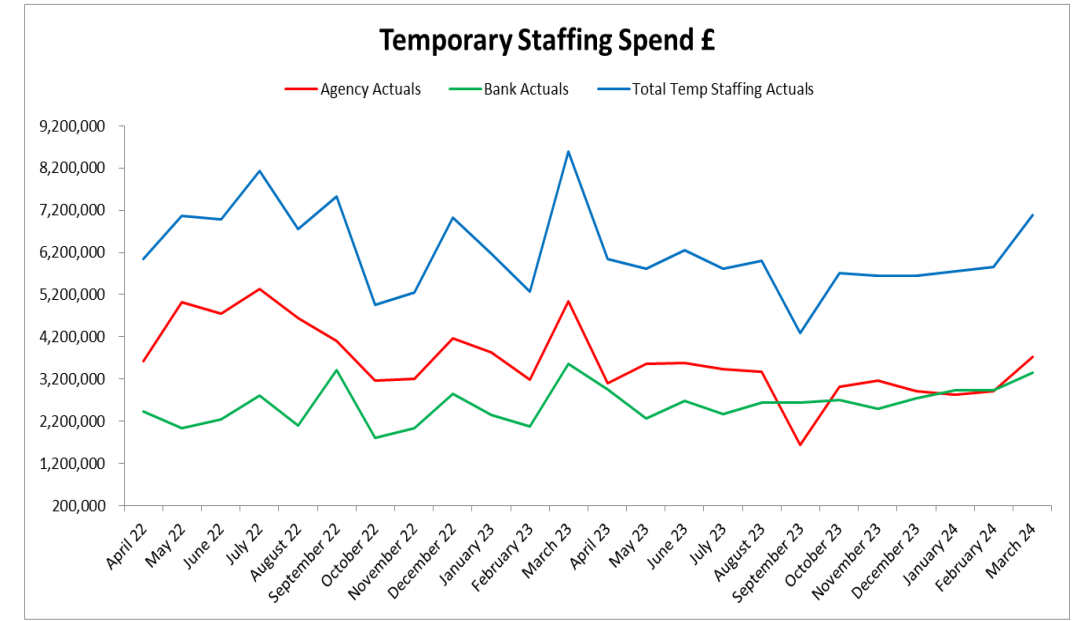
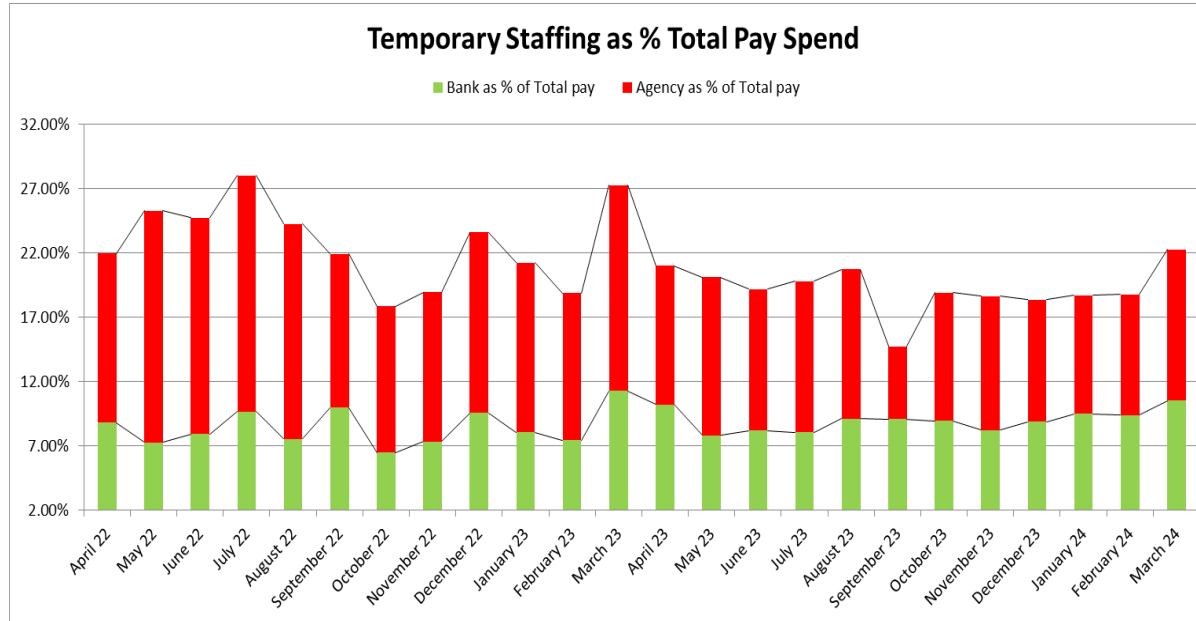
	INCOME STATEMENT					
	Month 12			Year-to-date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Secure	7.7	7.2	0.5	92.5	89.2	3.3
CAMHS	2.3	(0.3)	2.6	28.1	22.2	5.9
Adult AED	0.8	0.8	(0.0)	9.0	9.0	(0.1)
Provider Collaboratives Total	10.8	7.8	3.1	129.5	120.4	9.2

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 **£9.2m** favourable to plan.

Secure and CAMHS (**£9.2m** 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 **£0.1m** adverse is reported as such in the Trust overall position.

6. Agency Analysis



At year-end **£35.6m** has been spent on agency staff, which is **9.0%** 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 was **£32.2m** and the actual spend is **£3.4m** higher. This includes the release of **£2.4m** agency accrual related to FY23 which reduced from the previous figure of **£3.5m** due to further review of accruals at year-end.

7. Pay Spend Analysis

	Month 12 WTE					Month 12 (£'000s)					Year-to-Date (£'000s)			
Category of Spend	Budget	Actual	Variance	% Variance		Budget	Actual	Variance	% Variance		Budget	Actual	Variance	% Variance
Agency	0.00	380.39	-380.39			2	1,381	-1,379			24	35,352	-35,328	
Bank	44.82	618.53	-573.71	-1280.0%		523	3,353	-2,830	-541.1%		6,273	32,707	-26,433	-421.4%
Substantive	6,971.20	5,807.24	1,163.96	16.7%		30,782	37,365	-6,583	-21.4%		363,283	306,786	56,496	15.6%
Total	7,016.02	6,806.16	209.86	3.0%		31,307	42,098	-10,792	-34.5%		369,579	374,845	-5,265	-1.4%

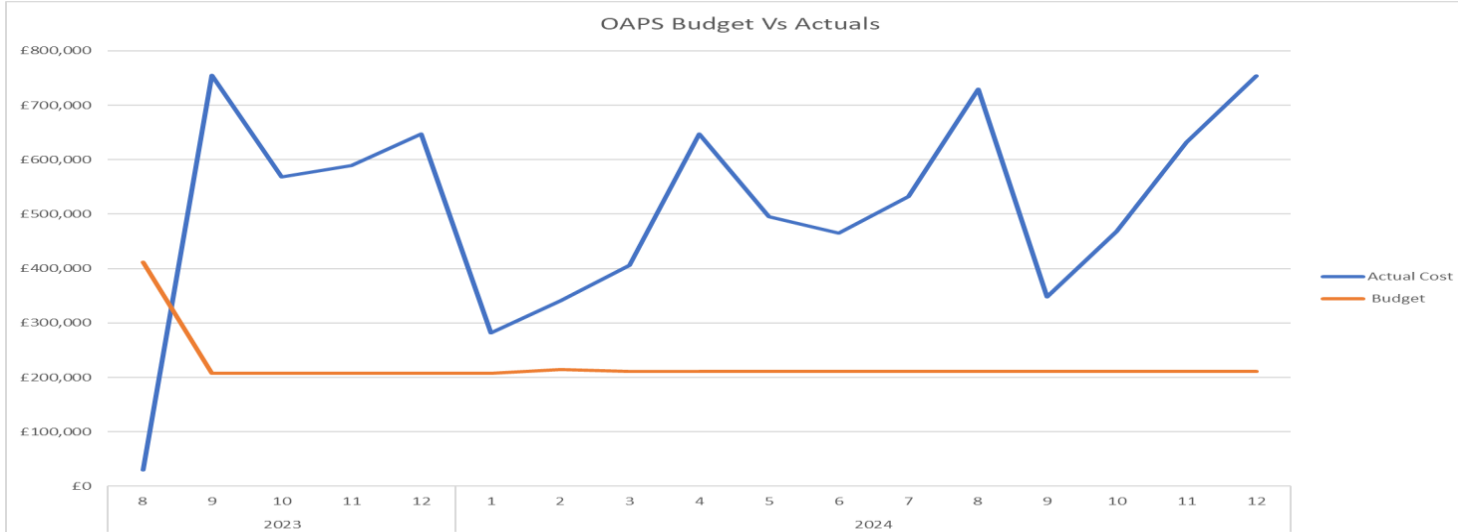
Pay is overspent by **£5.3m** at year-end. This includes **£13.7m** for the pension adjustment notified to us by NHS England which is offset with income. Excluding this there is an underspend of **£8.4m**. This is driven by vacancies partly offset with agency and bank spend. The net vacancy figure in month was 210 WTE.

8. Non-Pay Expenditure Analysis

£'000s	Month 12				Year-to-Date			
Category of Spend	Budget	Actual	Variance	% Variance	Budget	Actual	Variance	% Variance
Clinical Supplies & Services	1,726	2,514	-789	-46%	19,990	26,212	-6,222	-31%
Drugs	350	468	-118	-34%	4,198	5,020	-822	-20%
Establishment	951	4,131	-3,180	-334%	10,660	14,296	-3,636	-34%
General Supplies And Services	451	735	-284	-63%	3,622	4,162	-540	-15%
Other	802	1,199	-397	-49%	15,668	17,279	-1,612	-10%
Oxford Pharmacy Store Cost of Sales	3,384	5,024	-1,640	-48%	38,819	47,103	-8,283	-21%
Premises	2,001	2,941	-941	-47%	13,844	20,537	-6,693	-48%
Provider Collaborative Contracts	6,043	6,682	-639	-11%	69,406	65,869	3,537	5%
Purchase of Services	847	463	384	45%	10,169	12,199	-2,030	-20%
R&D non-staff costs	-1,346	-840	-506	38%	14,151	12,104	2,047	14%
Reserves	-1,040	6	-1,046	101%	3,712	38	3,674	99%
Transport	433	534	-101	0%	6,130	5,923	208	0%
	14,601	23,858	-9,257	-63%	210,370	230,741	-20,371	-10%

- Clinical Supplies & Services are overspent by **£6.2m** at year-end driven by **£1.0m** in Childrens Continuing Care (offset by additional income), **£1.0m** 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), **£1.5m** for equipment and supplies spend in the Primary, Community and Dental Care directorate and **£2.9m** in the Oxfordshire & BSW and Buckinghamshire Mental Health directorates mainly on sub-contracts with providers to assist with waiting lists where services have vacancies. These are offset with a **£0.4m** underspend on pathology costs.
- The overspend on Drugs costs is made up of overspends across all clinical areas.
- Establishment costs are overspent by **£3.6m** driven by IT spend on hardware and software. **£0.6m** of this is agreed additional non-recurrent spend.
- Other costs are overspent by **£1.6m** due to R&D costs and offset with the underspend of **£2.0m** in the R&D non-staff costs category.
- The overspend on Oxford Pharmacy Store Cost of Sales is offset by additional sales income.
- The overspend on Premises costs is driven by a **£4.4m** overspend in Estates & Facilities costs due to pressure on contracts, property and maintenance costs (including £0.6m agreed overspend for non-recurrent items), **£1.1m** spend on furniture and office equipment, **£0.2m** due to prior year electricity costs for the Covid vaccinations centres, **£0.5m** on clinical sub-contracts (in wrong category) and a **£0.5m** net overspend 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 **£2.0m** YTD driven by Mental Health Out of Area Placement costs - **£1.9m** overspent in Oxfordshire and **£1.7m** overspend in Buckinghamshire. These are offset by extra packages of care income in Forensics (**£1.0m**) and CAMHS (**£0.7m**) (reported in non-pay as it is a transfer from Provider Collaboratives).
- The Reserves budget is the contingency held by the Trust to offset pressures elsewhere.

9. Out of Area Placements (OAPs)



Out of Area Placements are **£3.5m** adverse at month 12, **£1.8m** adverse in Oxfordshire and **£1.7m** adverse in Buckinghamshire.

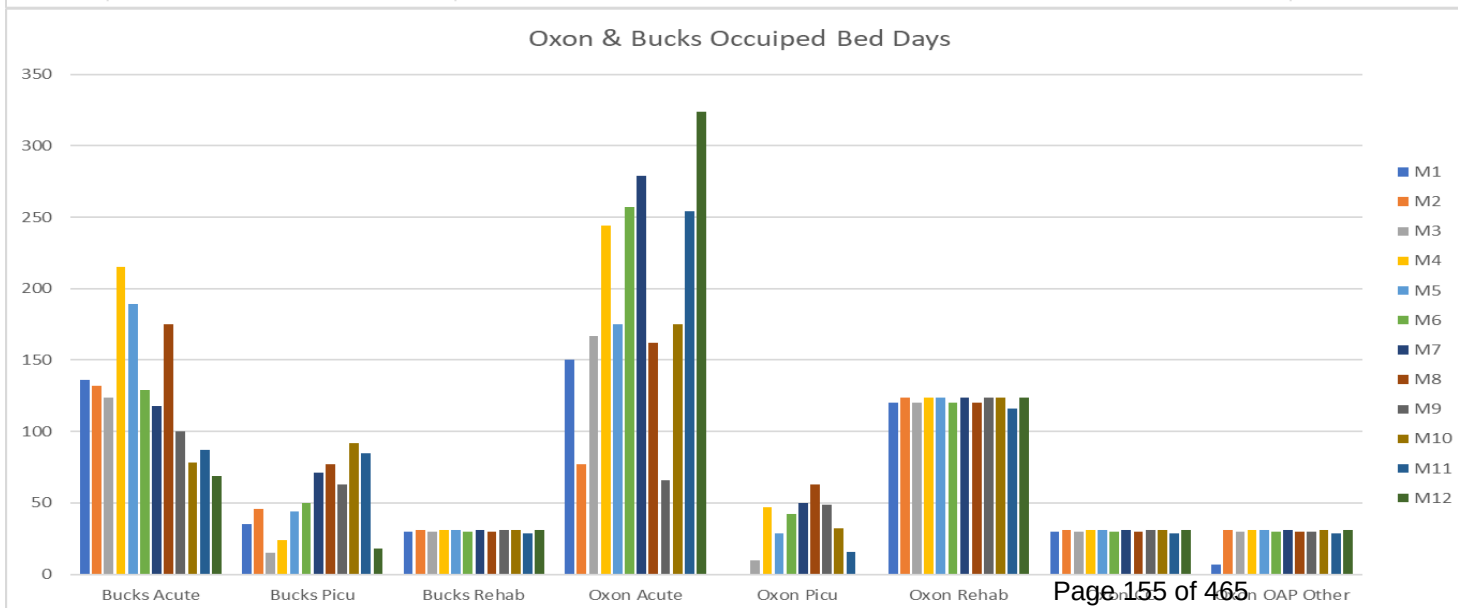
This includes the cost of the 4 block beds contract with Elysium. Plus, a further 2 block beds which were added to the contract in month 6, originally for 3 months but this has now been extended into the new year, until the 30th June 2024.

The large drop in actuals in month 9, is driven by the release of a provision relating to FY22 in Oxfordshire.

These costs exclude Secure Transport spend which is currently **£167k** across the two directorates.

Oxfordshire Acute beds days are up by 70 days compared to month 11 but PICU beds days have decreased to zero. Rehab, Continuing Care & OAP Other remain stable.

Buckinghamshire Acute & PICU beds days have decreased, Acute by 18 days and PICU by 67 days compared to month 11 and their Rehab placement remains the same.



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 full delivery of the **£16.1m** to NHS England on the assumption that any shortfall in these programmes has been mitigated by other non-recurrent benefits in the Trust's position.

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**.

£5.6m of the **£7.2m** CIP target has been delivered 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.

£'000s	Full Year Plan	Full Year Actual	Variance
Community	1,937	1,100	-837
Oxon & BSW MH	1,778	1,778	0
Bucks MH	803	803	0
Forensics	615	615	0
Learning Disabilities	106	106	0
Provider Collaboratives	29	29	0
Corporate	948	155	-793
NHSP transfer (internal bank team costs)	1,000	1,000	0
Total CIP	7,216	5,586	-1,630

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 agency to 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 year-end **£6.4m** of savings have been made, which is **£4.6m** lower than the target. This shortfall was offset by vacancies. The higher savings in month 12 is due to the release of a **£2.4m** agency accrual relating to FY23.

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	M9	M10	M11	M12	Full Year Actual
FY23 Bank	2,463	2,008	2,218	2,803	2,135	3,366	1,793	2,021	2,848	2,339	2,074	3,558	29,627
FY23 Agency	4,322	3,417	5,041	3,681	3,920	3,760	4,741	2,563	3,395	3,058	2,922	3,944	44,761
Total FY23	6,785	5,425	7,259	6,484	6,055	7,126	6,534	4,584	6,243	5,397	4,996	7,502	74,388
FY24 Bank	2,946	2,390	2,542	2,493	2,667	2,499	2,680	2,491	2,752	2,892	2,933	3,355	32,640
FY24 Agency	2,922	3,253	3,351	3,127	2,594	3,474	3,275	2,810	3,207	2,901	3,030	1,381	35,325
Total FY24	5,868	5,643	5,893	5,620	5,261	5,973	5,954	5,301	5,959	5,793	5,963	4,735	67,965
Savings	917	-218	1,366	864	794	1,153	580	-717	284	-396	-968	2,767	6,423
Target	920	920	920	920	920	920	920	920	920	920	920	920	11,043
Variance	-3	-1,138	446	-56	-126	233	-341	-1,637	-636	-1,316	-1,888	1,847	-4,620

12. Statement of Financial Position

31 March 2023		Month 11 FY24	Month 12 FY24	Movement Year to date	In month	
£'000		£'000	£'000	£'000	£'000	
	Non-current assets					
4,977	Intangible Assets	6,260	7,012	2,035	752	
215,796	Property, plant and equipment	216,092	207,308	(8,488)	(8,784)	
30,850	Right of Use Assets	29,774	34,744	3,894	4,970	
1,125	Investments	1,125	1,125	0	0	
512	Trade and other receivables	519	412	(100)	(107)	
485	Other Assets	486	651	166	165	
253,745	Total non-current assets	254,256	251,252	(2,493)	(3,004)	①
	Current Assets					
2,932	Inventories	3,099	3,184	252	85	
35,215	Trade and other receivables	22,917	21,722	(13,493)	(1,195)	②
840	Non-current assets held for sale	0	200	(640)	200	③
74,610	Cash and cash equivalents	90,508	85,628	11,018	(4,880)	④
113,597	Total current assets	116,524	110,734	(2,863)	(5,790)	
	Current Liabilities					
(83,398)	Trade and other payables	(76,538)	(76,194)	7,204	344	⑤
(25,529)	Borrowings	(25,709)	(26,098)	(569)	(389)	
(2,249)	Provisions	(2,743)	(3,182)	(933)	(439)	
(23,002)	Deferred income	(29,097)	(24,222)	(1,220)	4,875	⑥
(134,178)	Total Current Liabilities	(134,087)	(129,696)	4,482	4,391	
	Non-current Liabilities					
(34,622)	Borrowings	(30,250)	(34,713)	(91)	(4,463)	⑦
0	Other Liabilities	(1,500)	(1,500)	(1,500)	0	⑧
(6,086)	Provisions	(7,026)	(8,156)	(2,070)	(1,130)	⑨
(40,708)	Total non-current liabilities	(38,776)	(44,369)	(3,661)	(5,593)	
192,456	Total assets employed	197,917	187,921	(4,535)	(9,996)	
	Financed by (taxpayers' equity)					
109,631	Public Dividend Capital	110,080	113,336	3,705	3,256	⑩
82,587	Revaluation reserve	82,149	77,072	(5,515)	(5,077)	⑪
1,125	Other reserves	1,125	1,125	0	0	
(886)	Income & expenditure reserve	4,563	(3,612)	(2,726)	(8,175)	⑫
192,456	Total taxpayers' equity	197,917	187,921	(4,535)	(9,996)	

- Non-current assets have decreased by **£2.5m** over the year. Capital additions of £26.0m (including £11.5m of leased assets) which have been offset by £15.0m of cumulative depreciation and a downward end of year valuation of the estate of £12.8m
- Trade and other receivables have decreased by **£13.5m** in year. Most of the decrease is due to a net decrease in outstanding debt of **(£1.5m)** and accrued income of **(£12.6m)**.
- Non-current assets held for sale have decreased by **(£0.6m)** in-year. The movement is represented by the sale of Harlow House for £0.8m and the addition of Shrublands which is now held for sale at £0.2m.
- The cash balance has increased by **£11.0m** over the year. This is largely due to an improved working capital position and an adjusted financial performance surplus.
- Trade and other payables have decreased by **£7.2m** in year. The decrease in-year is largely due to a reduction in payroll (FY23 pay offer) and agency accruals, which was offset by an increase in creditors due to the restatement of normal credit terms in FY24 after a reduction in credit terms during covid.
- Deferred income has increased by **£1.2m** in year. £19.4m of the deferred income held at the end of FY24 relates to the Provider Collaborative.
- Non-current borrowings have increased marginally over the year.
- Other Liabilities have increased by **£1.5m** in year. This £1.5m represents a payment on a/c by the University Of Oxford re: the Warneford Redevelopment. This balance will be utilised or repaid if certain key milestones are satisfied or not satisfied.
- Non-current provisions have increased by £2.0m in year. Most of this increase is due to an upward revaluation of the Trust's dilapidation provisions.
- £3.7m of PDC received in year to support the capital programme.
- The downwards movement represents the downwards revaluation of the estate in FY24
- The £2.7m downward movement in year reflects the Trust's reported deficit in year (£3.3m) less other reserve movements of £0.5m

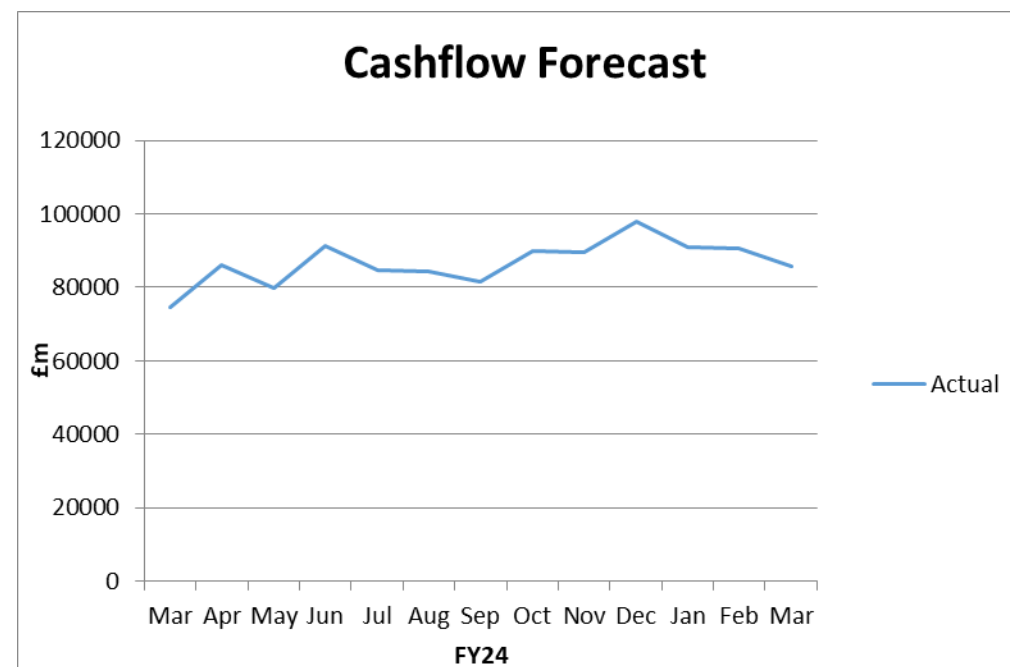
13. Cash Flow

STATEMENT OF YEAR TO DATE CASH FLOWS

	Month 12 FY24		
	Actual	Plan	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations	(1,566)	869	(2,435)
Operating surplus/(deficit)	(1,566)	869	(2,435)
Non-cash income and expense:			
Depreciation and amortisation	15,161	14,340	821
Impairments	7,850		
(Increase)/Decrease in Trade and Other Receivables	13,735	3,587	10,148
(Increase)/Decrease in Inventories	(252)	245	(497)
Increase/(Decrease) in Trade and Other Payables	(8,447)	(11,078)	2,631
Increase/(Decrease) in Deferred Income	1,220	(3,241)	4,461
Increase/(Decrease) in Provisions	(371)	18	(389)
Other Movements in Operating Cashflows	(14)	0	(14)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	27,316	4,740	14,727
Cash flows from investing activities			
Interest received	5,414	3,601	1,813
Purchase of Non Current Assets	(13,256)	(12,010)	(1,246)
Sale of PPE	1,200	0	1,200
Net cash generated from/(used in) investing activities	(6,642)	(8,409)	1,767
Cash flows from financing activities			
Public dividend Capital Received	3,705	0	3,705
Loans repaid	(1,338)	(1,338)	(0)
Capital element of lease rental payments	(6,035)	(4,932)	(1,103)
Capital element of Private Finance Initiative Obligations	(657)	(600)	(57)
Interest paid	(687)	(635)	(52)
Interest element on leases	(204)	(252)	48
Interest element of Private Finance Initiative obligations	(1,481)	(963)	(518)
PDC Dividend paid	(2,959)	(2,620)	(339)
Net cash generated from/(used in) financing activities	(9,656)	(11,339)	1,683
Increase/(decrease) in cash and cash equivalents	11,018	(15,008)	26,027
Cash and Cash equivalents at 1st April	74,610	74,610	0
Cash and Cash equivalents at	85,628	59,602	26,027

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 March was £85.6m.



14. Working Capital Indicators

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	18	
Debtors % > 90 days	5.0%	11.3%	
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	88.6%	
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	93.6%	
Cash (£m)	69.6	85.6	

Summary Notes

- Debtor days ahead of target.
- Debtors % over 90 days is below target, due to unpaid invoices. These are mainly various ICB's £119k, Salary overpayments £326k, NHS Property Services £154k, OUH £101k, East London £70k, Practice Plus Group £355k and other £428k.
- NHS BPPC (Better Payments Practice Code) below target for the year.
- Non-NHS BPPC (Better Payments Practice Code) marginally below target for year.
- Cash is better than plan, as outlined in section 9.

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

Board of Directors

22 May 2024

BOD 35(i)/2024
(Agenda item: 11(a))

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

Executive Summary

The Quality Committee continues to meet five times a year and at its' last meeting on 2nd May considered the agenda in the Reading Room. Minutes are not yet available.

For Alert (may require discussion)

The Committee wish to alert the Board that there continues to be a focus on **services with a shortage of substantive nursing, medical and therapy staff. Those services (District Nursing and the City/NE AMHT)** with over 30% vacancy rate and triggering other quality concerns are under executive surveillance. There were 72 patient incidents with moderate harm over the period Jan-Mar 24, predominantly related to pressure damage in community services (0 cases of severe or significant harm). In relation to District Nursing there is shared ownership with the integrated care system supporting triage and caseload prioritization, due to funding shortfalls. The Committee will further review mitigating actions in the Oxford/NE AMHT at its next meeting in July. The latest data is presented in the Quality and Safety Dashboard available in the reading room. Staffing on mental health wards is improving.

In addition, whilst it is pleasing we are able to report waiting times for the second month in a row, we want to alert the Board that there are an extensive **number of services with long waiting times** including District Nursing, Podiatry, Childrens

integrated therapy, dental procedures for children, and a range of neurodiversity, CAMHS, Eating Disorders, Complex Needs, and Older adult Memory Clinic services. Long waits are precipitated by staffing shortages and increasing referrals. Patients on the waiting list are being reviewed clinically to reduce harm, whilst services themselves strive to improve triage, provide support while waiting, and different recruitment approaches.

To Advise (to monitor)

The Committee wish to advise the Board that we continue to monitor **action to improve resus training uptake**, including increased capacity and accessibility. All wards are reviewed daily to ensure there are appropriately trained staff on shift.

Other services under active monitoring include inpatient CAMHS (Highfield Unit) and PICU (Meadow Unit) which have high vacancy rates and episodes of increasing restrictive practice. A more detailed report will come back to QC in July.

Overall, the Trust is **making gradual reductions in restraint, but these are difficult to sustain** and we are seeking more information at our next meeting to better understand the use of rapid tranquilization on some wards (Older adults and CAMHS). The use of seclusion has risen over time, but facilities have significantly improved. Predominantly seclusion is used to mitigate violence and aggression – towards self or staff.

The Committee also reviewed the **Trust Complaints and PALS Annual Report 23/24**. Largely we are compliant with meeting agreed timelines, but we noted the large number of requested extensions for investigations and replies. The Trust is moving towards early resolution of concerns to improve experience, in line with national policy. Patients express dissatisfaction with staff attitudes and behaviours, lack of care or support in the community, lack of information shared with families and patients and waiting times. These are being taken forward in QI programmes across wards and teams.

For Assurance (to note)

The Committee wish to assure the Board that in reviewing the **Director of Infection Prevention and Control's report for 23/24** we were assured that we remain compliant with infection control procedures and national guidance. The Committee acknowledged the capability and leadership of this function.

We also reviewed the **Trust's response to the newly commissioned 0-19 service in Oxfordshire**. We can report a positive and confident implementation which has required significant transformation and service change in our delivery. There has been very good feedback from partners and stakeholders, staff themselves have embraced the changes. We agreed to review delivery in 12 months' time. There is a more **cautious response to the SEND review** with accountability for delivery of the plan sitting with the ICB and County Council. Legal and regulatory requirements are taking priority at this stage.

The Committee sought assurance from new governance arrangements established to oversee **the Oxford Pharmacy Service**. We await final confirmation of the appointment of our third Responsible Person (RP) from the MHRA. Furthermore, we await a date for our new premises inspection date to complete MHRA compliance on the new premises in Banbury.

The Committee also received its first draft of **Board to ward clinical governance arrangements**. This provides assurance that quality governance is in place across each directorate and at Trust level. However, there is a lack of consistency or standardization. This will come back to the Committee in July once further work has been completed on the Trust operating model (enabling workstream in the strategy).

Finally, the Committee reviewed the **Board Assurance Framework Risks on Utilising Digital, Data and Technology (1.1)** and confirmed the redrafted risk better expressed strategic risks and necessary mitigations. It was agreed this risk should continue to remain under the purview of the Quality Committee with Finance and Investment Committee engagement. We also **reviewed the risk descriptor relating to Lack of Admission beds due to demand outstripping capacity in mental health and learning disability services (1.5)** and agreed that with revised mitigations this risk remains at the highest rating of 16.

Recommendation

The Board is asked to confirm it is assured with progress on actions addressing compliance matters and where there is further work underway to strengthen our quality management.

It is also asked to confirm that **Quality Committee should remain the board oversight committee for BAF risk 1.1** as the impact of data quality, whilst having a financial impact also seriously affects the management and delivery of safe patient care.

The Board is asked **to approve the Research and Development policy** which has been agreed by the Quality Committee (Policy in the reading room).

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

1. **Strategic Objectives/Priorities and strategic Board Assurance Framework (BAF) risk themes** – *this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust [OR N/A – no Strategic Objectives/Priorities apply] (please delete as appropriate):*
 - 1) *Quality - Deliver the best possible care and health outcomes*
Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).
 - 2) *People - Be a great place to work*
Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.
 - 3) *Sustainability – Make best use of our resources and protect the environment*
Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects.
 - 4) *Research and Education – Become a leader in healthcare research and education*
Strategic risk themes: failure to realise Research and Development potential.

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

Board of Directors

BOD 35(ii)/2024
(Agenda item: 11(a))

22 May 2024

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

Executive Summary

The Charity Committee met on 7 May and considered the agenda in the Reading Room.

For Alert (may require discussion)

There is no reason to alter fundamentally the Alert given by the Committee to the November and March meetings of the Board, i.e. that there is a growing risk to the financial health of the Charity but that there is no immediate risk of financial difficulties and the situation is being addressed in the fundraising framework (and targets) currently being developed. I would also note that the review of the investment approach and of the investment fund manager is ongoing and may have positive effects on the income and expenditure of the Charity.

To Advise (to monitor)

The Committee wish to advise the Board that:

- The review of investment approach and investment fund manager is ongoing: further efforts are being made to conclude the review with the assistance of an additional meeting of the Committee.

- The Corporate Trustee has now approved the Committee's revised Terms of Reference.
- The Committee has approved its annual report to the Corporate Trustee
- The Committee noted progress made by the Charity in relation to Charity Governance Code Analysis.
- In addition to reviewing risks at each meeting, the Committee is considering having an annual review of risks.
- The Committee is continuing to investigate ways of improving the data necessary to assess the Impact of grants made by the Charity.
- Having reviewed substantial progress made during financial year 2023/24 in relation to the Charity's Strategy, the Committee has reviewed the KPIs (and a relevant Action Plan) which have been developed for the remainder of the 2024/25 financial year. A separate Communications Plan and Financial Management Plan are being developed for 2024/25.
- Under the new Charity Guidance and Application, the Charity is introducing quarterly windows for reviewing requests for funding.
- The Committee has agreed in principle to implement Oxfordshire Health Services Research Grants (OHSRC) which will enable salaried OH staff to conduct research, for the benefit of patients, closely related to the day-to-day practice of staff.

For Assurance (to note)

The Committee wish to assure the Board that:

- The Committee expects to consider, at its September meeting, a report from consultants The More Partnership concerning longer term ambitions, particularly with regard to enhanced fundraising.

Recommendation

The Board is asked to note and discuss as it sees appropriate.

Author and Title: Rick Trainor
Chair, Charity Committee

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

Board of Directors

BOD 35(iii)/2024
(Agenda item: 11(a))

22 May 2024

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

Executive Summary

The agenda of the Committee's most recent meeting - on April 23 of this year - is available for information in the Reading Room. From the Committee's scrutiny of papers, and reflecting on the matters discussed at the meeting, I would draw the Board's attention to the following matters:

For Alert (may require discussion)

The Board is asked to note the following:

- No alerts identified for the Board's attention.

To Advise (to monitor)

The Board is asked to note that:

- Following on from the discussion at its February meeting, the Committee continued its deep dive review of the following **BAF risks** - 2.6 Adequacy of Staffing; and 3.6 Governance & Decision Making Arrangements. It concluded that these risks (and the related mitigations) are now more accurately captured in the BAF; and that it is now satisfied these risks are being appropriately and robustly managed.
- The Committee received and discussed the **Clinical Audit: Audit Committee Assurance Report**. The Committee noted that, while the latest format and content of the report is now of greater utility, it requires the content to be further developed for the Audit Committee to be

assured that the relevant processes, controls, and audits are operating as designed and effectively. It was agreed that these further refinements will be completed in time for the next 6 monthly report to the Committee. However, the Committee asked the team to discuss progress and proposals with Committee members outside of (and in advance of) the next meeting to ensure that the next iteration meets the Committee's requirements.

For Assurance (to note)

The Board is asked to note the following:

- The Committee received and discussed the **draft 2023-24 Annual Accounts** and the Trust's **draft Going Concern Statement** - the draft accounts being due for submission to the Department of Health by April 24.
- The requirements for NHS trusts to demonstrate their accounts have been prepared in the context of the organisation operating as a "going concern" have changed this year. The test is now posited on a trust providing reasonable assurance that its services can be expected to continue to be provided into the near future.
- The agreed **programmes of both internal and external audit** continue to be running on time and the Committee expects all reports to be completed in time for the external auditor's opinion to be issued by the appropriated deadline (note: NHS trust final accounts and report are due for submission by June 28).
- KPMG also shared with the Committee its **draft Head of Internal Audit Opinion for 2023/24**, which is summarised as – *"Significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control."*
- The Committee received and discussed the **Internal Audit team's latest reports** and the Board is asked to note the following findings:
 - Bank Booking - no significant findings to highlight, however the review provided only partial assurance and identified some improvements are required (7 medium and 3 low findings). The agreed management action plan targets completion of all actions by August 31.

- Operational Risk Operational Risk Management – overall, the review provides the Trust, with “*significant assurance with minor improvement opportunities*” (resulting in 1 medium and 5 low recommendations). The agreed action plan targets completion of all actions by July 31.
- The latest draft of the **Annual Governance Statement** (which is required to sit alongside the final accounts) was shared with the Committee – working is ongoing to complete the document.
- The Committee approved the final **internal audit and counter fraud audit plans for 2024-25**; and received the **2023-24 Counter Fraud Annual Report**.

Sharing of learning

None identified.

Recommendation

The Board is asked to note the above.

Author and Title: Chris Hurst, Chair of Audit Committee

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

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

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

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

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

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

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

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

Board of Directors

BOD 35(iv)/2024
(Agenda item: 11(a))

22 May 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 30 April 2024 and considered the agenda attached (minutes attached). In our last report, we raised the following for Alert to the Board:

NHSE/I Agency spend target

- ***Current forecast is 10% over NHSE/I Agency ceiling. by year end***
UPDATE: The outturn at M12 has been 10% over target, an overspend of £3.35M. While substantial savings (£6M vs FY22-23) have been achieved in the use of staff covered by Agenda for Change, this has been overshadowed by an £1.4M increase in medical agency spend compared to last year. The Committee was assured work is underway to further embed a 'Bank-first' approach and to understand how we can work better with our Managed Service Provider (IDM) for medical locums to secure better rates. Work of course continues in relation to medical recruitment. It is anticipated that the overspend will be added to the target savings for this FY but the ceiling target is still under discussion.
- ***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
UPDATE: The Committee was advised a global fix should be introduced in autumn 2024 to allow this information to be transferred between systems.

Until then, the Committee was advised proportionate measures are in place to minimise this risk.

- **Ongoing implementation challenges in relation to NHSP:** Despite improved fill rates, colleagues continue to report difficulties operating the NHSP (bank)
UPDATE: The Committee was advised fill rates at M12 had improved to 65% and is assured that significant work is underway to properly diagnose issues and improve the interface through both additional dedicated resource to work on the NHSP contract and the operationalisation of an NHSP Improvement Plan.

For Alert

There are no new matters for Alert to the Board.

To Advise

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

- **Not on track to complete 5 of the 15 of the recommended sub-actions which had deadlines of March 2024:** 7 of the 15 actions are complete and 3 of the 15 actions are partially complete. The Committee asked that the EDI highlight report for the next meeting set out the estimated completion dates for all outstanding actions
- **A reminder that two NHS EDI 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. This is being progressed through the current round of PDRs (season concludes in July)
 - *By March 2025:* Board members should demonstrate how organisational data and lived experience have been used to improve culture.

2. Medical wellbeing & engagement

- A programme of work is underway in response to consultant concerns raised in the previous survey and through other feedback. However,

reported levels of engagement and wellbeing remain broadly unchanged.

The Committee will consider this again in October.

3. NHSE Funding for CPD

- The Committee was advised that NHSE has yet to confirm funding levels for CPD for the current FY and the Trust will necessarily incur CPD costs in the interim.

For Assurance

1. Growth in staff establishment

- The Committee considered the workforce changes between 2019/20 and 2023/24. This equates to a growth of 21% (1141 WTE). The Committee was assured that this growth in substantive posts has been funded. The majority of growth (64%) has been funded by MHIS/SDF via BOB/BSW ICBs, with additional growth linked to community safer staffing and provider collaborative funds. Corporate posts have increased modestly and account for 5% of the total. The Committee will consider staff establishment by role type in light of our aim to support colleagues to work to the top of their licence.

2. BAF and TRR Updates

- **BAF 2.5 Retention:** The Committee undertook a deep dive into Retention. It was noted that both early and regular turnover are now under our target of 14%. We have asked the team to reflect on whether this tracks at/above/below national improvements and why. More generally, the Committee concluded efforts to date had - appropriately - been short-term and tactical but that the Trust was now able to develop a segmented strategic approach to staff retention, and this will come back to the Committee for review later in the year. It was also noted that exit questionnaires are completed by fewer than 1/3 of staff; this is a valuable source of intelligence being left untapped. It was agreed that we would review the updated BAF 2.5 at the July committee.

3. Staff Wellbeing, Culture & People Systems

- **Employee Relations and Casework:** There was a sharp rise in disciplinary cases (27%%) and grievances (51%) in 2023 vs 2022. The team are working to understand this. More welcome has been the increase in the number of cases which are being resolved informally reflecting a move to a restorative and just learning culture (eg 47% vs 72% of Disciplinary cases). The Committee learned

that the CPO and CEO are now reviewing all preliminary fact findings reports involving ethnic minority staff as there continues to be a disproportionate number of ethnic minority staff involved in disciplinary proceedings.

- **Staff survey:** The Committee received an update on the survey analysis and the final report will be considered at July PLC.
- **Medical education:** The Trust will see an increase in student placements from 120 to 130 from August 2024 bringing the total number of doctors and dentists in training as 215 within a 12 month period. This has the potential to feed through into increased recruitment. However, this does challenge existing consultant capacity to supervise. The Committee noted the growing reputation of the Trust in leading simulation-based learning and congratulated the number of colleagues receiving external recognition for their work.
- **HR Policies:** The Committee received a report on the HR policies completed in 22/23, the work programme for the upcoming year, and the guiding principles for policy development.
- **Guardian of Safe Working hours:** The Committee received the Guardian's report and was reassured that issues were being constructively engaged with by colleagues. The Committee has asked going forward for a written response from the Trust medical leadership in how its responding to the Guardian Safe Working Hours report and what action, if any, needs to be taken.
- **Development of performance assurance:** The Committee received the first version of a 'People dashboard' aimed to enable early identification of hotspots. The Committee agreed this was a positive development and the opportunity to see disaggregated data was welcome. The next iteration of the dashboard will be considered by the People Steering Group before July PLC.
- **BAF 2.4 Culture:** The Committee plans a deepdive on this risk at October PLC or a separate workshop.

Author and Title:

Mindy Sawhney

Chair of People Leadership and Culture Committee

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

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

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

2) People - Be a great place to work

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

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

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

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

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

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

Board of Directors

BOD 35(v)/2024
(Agenda item: 11(a))

22 May 2024

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

Executive Summary

The Finance and Investment Committee continues to meet five times a year, most recently on 9 May and considered an agenda, which is attached.

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

For Alert (may require discussion)

The Committee wish to alert the Board that:

- **PFI exit cost** – the break clause cannot be enacted until the 25th anniversary of the contract on 6 September 2024. The final exit cost negotiations are thus yet to be concluded, leaving a risk to the current year capital budget and a decision on last year's accounting treatment which needs to be agreed with our external auditors.

HR and Estates due diligence are under way to facilitate a smooth transfer of both operations and assets.

The ICB and NHSE are fully briefed on these issues. Since this negotiation is commercially sensitive, details will be provided in private session.

- **Annual plan and budget** – work continues to negotiate the final resourcing position with the ICB, with the annual plan being finalised alongside. The latest position will be reported by the Chief Finance Officer in this meeting.

Annual budgets remain challenging, despite a proposed £4.3m deficit. This deficit position includes significant cost pressures, including £38.6m savings from Cost Improvement Programmes (CIPs, of which £7.9m are expected to be recurrent), £7.4m of covid funding previously reallocated to investment but now withdrawn, £7.9m cost pressures from inflationary pressures, transformation plans and rising depreciation costs, offset by £3.6m additional funding predominantly for Community service provision cost pressures. Plans to address these pressures are well underway and will be closely monitored.

FIC wish to flag that oversight arrangements over elements of the annual plan remain to be agreed. FIC are happy to provide oversight over the annual plan and budget as a whole; the former currently scoped to report to FIC and Board every six months. It was queried whether relevant sub committees might be better placed to provide more informed oversight of new strategic work streams, in particular the Enabler priorities, where this work aligns with their terms of reference. A shared understanding of principles and parameters at the outset would also be advantageous.

It was noted that the proposed integrated performance measures which sit behind the annual plan are yet to be received/approved by Board/sub committees.

To Advise (to monitor)

The Committee wish to advise the Board that:

- **Jordan Hill** lease has been signed
- The full year result of the **Improving Quality Reducing Agency (IQRA)** programme was a saving of £4.6m a year compared to last year. This represents a £6m saving on nursing, AHP, admin and estates costs, offset by a £1.4m increase in medical agency costs.

The total temporary staffing spend of £35.4m was 10% above the NHSE ceiling target of £32m. Work is ongoing to meet the NHSE ceiling in the current year, but the position remains challenging.

- The **Information Management Group** advise the implementation of new electronic records in Primary, Community and Dental Care directorate is not complete and paper records continue to be used in some services.

- **BAF and risk management** – the committee did deep dives on two revised risks and discussed the approach to a third:
 - **Delivery of the financial plan and maintaining financial sustainability** – the committee reviewed a revised articulation of the actions required to reduce this risk to target. It was agreed to maintain the red rating, given ICB financial challenges being played out in Trust funding allocations. Several programme and enabler work streams are planned to deliver traction against Value for Money priorities, although any additional financial capacity will likely be absorbed by demand, rather than solving sustainability risk per se.
 - **Major projects** – the committee received an updated approach to risk reduction, following the successful completion of a number of actions which resulted in no reduction in risk score. Programme governance has now been mapped for the Trust's highest priority strategic programmes, supported by a portfolio approach to monitor success at Exec, FIC and Board and a new Strategy Delivery Group. This process is not yet embedded and will require additional focus and discussion to deliver value. The risk of poor engagement in change and change load management will be addressed in the culture enabler workstream.
 - **Using digital, data and technology to drive quality, efficiency, research and innovation** – this risk is undergoing further review. It is suggested that a joint discussion between Chairs and Lead Execs of Quality Committee and FIC be held to ensure completeness and agree oversight approach. Work continues to address the risk at pace through the Frontline Digitisation Programme.

For Assurance (to note)

The Committee wish to assure the Board that:

- Executive Managing Directors for both Primary, Community and Dental Care and Mental Health, Learning Disability & Autism Services presented their **annual plans and budgets** to the committee, outlining directorate priorities, known operational and budget pressures, confidence in meeting plans, budgets and CIPs and reflections on longer term efficiency improvement opportunities. The committee were pleased to hear the level of confidence in plans and budgets being delivered and the proactive approach being taken to both known pressures and longer term improvement opportunities, with the Community directorate transformation plans being particularly advanced.
- The **full year financial position for 2023/4** settled at a surplus of £4.6m (£1.3m better than budget and £0.1m better than M10 reforecast),

although the capital position was £743k underspent against the funded budget, driven by Estates project underspends. This has knock on implications for capital budgets in the current financial year. Work continues to improve the organisational financial management culture, (including around financial discipline, control environments and the knitting together of operational plans within budgetary envelopes), which will minimise future risks of unexpected variances against plans.

- The **Warneford Park Hospital Project** is proceeding well against plans, with a decision to be made imminently about the timing of public consultations to inform the planning submission. The JV is considering redesigning the research building to accommodate early planning feedback. Engagement with key stakeholders continues apace to address the most significant risk of securing funding.
- The Trust **business case process** has been comprehensively reviewed by a DHSC economist following Trust learning from recent experiences. Changes to the process, documentation and support structure have been proposed and will be implemented shortly.

Recommendation

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

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

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

Board of Directors

BOD 35(vi)/2024
(Agenda item: 11(a))

22 May 2024

**Report from Mental Health & Law Act Committee on matters to Alert,
Advise or Assure**

Executive Summary

The Mental Health & Law Act Committee continues to meet quarterly and has considered an agenda, which covers Trends and updates on the Patient Participation Group, mental health Advocacy, the Use of Force Act and the Mental Capacity Act & DOLS. The minutes of the last meeting are in the Reading Room.

For Alert (may require discussion)

The Committee wish to alert the Board that:

1. The Committee was provided with an update on the introduction of the Trust's new advocacy providers "Voiceability". Unfortunately there appears to have been a gap in the communication between Oxfordshire County Council (responsible for commissioning of the service) and the Trust, which meant that little information was provided about the introduction of Voiceability. David Walker has agreed to liaise with OCC to address this relationship going forward.
2. The patient feedback survey has highlighted 29 more complaints in 2023/2024 than 2022/2023. Areas of concern highlights:
 - Insufficient care and support
 - Unfriendly staff
 - Poor information sharing
 - Poor support of family/carers
 - Waiting times and access

However, it must be noted that the feedback also saw an increase in 500 compliments more than 2022/2023.

To Advise (to monitor)

The Committee wish to advise the Board that:

1. NHS England has launched its first ever Patient and Carer Race Equality Framework (PCREF) to take effect in 2025. The aim is to support Trusts to become actively anti-racist. Improvement is to be supported in 3 key areas:
 - a) Leadership and governance: for trusts boards to leading on establishing and monitoring solid plans to reduce health inequalities.
 - b) Data: new data set on improvements in reducing health inequalities to be published, as well as details on ethnicity in all existing core data sets.
 - c) Feedback mechanisms: visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback.OHFT has started to implement the Framework with a Board, of which Britta Klinck is the SRO. Key actions include the formation of a project plan, monthly mentoring on how to develop the framework from NHS England.
2. Our Use of Force Act Policy now sits on the Intranet, and I would invite colleagues to review this.
3. On the horizon for the Committee to consider the Government's respond to the rapid review into data on inpatient settings.

For Assurance (to note)

The Committee wish to assure the Board that:

1. I am pleased to confirm that we have seen a fall in lapses in detention to 3.5% (Q4- 2023/2024).
2. Greater steps have been taken to improve the facilities for mental health tribunals, including the Phoenix and Ashurst ward areas, and at the Warneford.
3. All recommendations arising from the Trusts CQC visits have been completed.
4. There are no significant outliers in relation to restraints, and out of area placements, remain variable, albeit in my view there is no significant cause for concern.

Recommendation

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

- Geraldine Cumberbatch - Non-Executive Director

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

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

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

- 2) People - Be a great place to work

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

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

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

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

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

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

Trust Board Meeting

22 May 2024

BOD 36/2024 (Agenda item: 12)

**Freedom to Speak Up Guardian Annual Report,
April 2023- March 2024**

This annual report is for information regarding the activities of the Freedom to Speak Up Guardians (FTSUGs) for the period of April 2023 to March 2024. The Board is asked to consider the information within this report and use it to determine its level of assurance with the current FTSU work activity and future program.

Executive Summary

The FTSU Guardians continue to work within the remit of National Guardian Office (NGO) guidance and contribute to meeting the key objectives set out by People Promise and the delivery of "Quality and People" Trust Strategic Objectives.

FTSUGs have worked with senior leaders at board level to assess the FTSU arrangements and completed the Self-Assessment Tool for the trust. As a result, a 2 year program of work was developed by the Guardians and approved by the Board. This includes some of the key priorities such as launch of the new FTSU policy and embedding FTSU E learning Modules as compulsory within training matrices for all staff to support positive culture change.

During this 12-month reporting period, 290 cases were raised with the Guardians. This is compared to 258 cases raised last year, showing a gradual increase in the volume of cases raised. 94% of cases are now closed, having reached resolution. 26% of concerns in this period have been raised by registered nurses. 74% of the cases raised contained elements of worker safety or wellbeing and this remains the

highest thematic issue raised via reporting to the Guardians. 'Other inappropriate attitudes or behaviours' is the second most common category of concerns raised.

Many staff have shown courage to speak up, however they have described lack of leadership support and a feeling of futility in doing so, such as concerns not being taken seriously and a perception that nothing is being done about the concerns that are raised. This appears to be one of the main barriers for FTSU Guardians to be increasingly effective within the Trust. Throughout the year, the Guardians have continued to work hard to empower staff to create a positive speak up culture and during Speak Up October Month 2023 focused on breaking barriers. This remains an area of focus for the forthcoming year (and beyond).

Governance Route/Escalation Process

This is an annual report which will be shared with Staff Partnership, Negotiation and Consultative Committee (SPNCC) and Local Negotiating Committee (LNC). Regular quarterly FTSU reports are submitted to Executive Team Meetings to highlight emerging themes, activities, and key learnings and actions are taken on areas discussed.

Statutory or Regulatory responsibilities

In 2016-17, it became a contractual requirement for all NHS Trusts to have a Freedom to Speak Up Guardian. The FTSU Guardians are supported by the National Guardians Office (NGO), and they follow its guidance to deliver the service.

The Care Quality Commission assesses the Speak Up culture of Trusts during inspections under the key line of enquiry (KLOE) 3 as part of the well-led question.

Recommendation

1. The Board is asked to note the work undertaken across the year by the FTSUGs and seek any necessary assurances arising from the report.
2. The Board is asked to consider the 4 key recommendations outlined in the report relating to leadership, culture, communication and sustainability of FTSUG role.

Author and Title: Lianne Bowes & Rita Bundhoo-Swift, FTSUGs
Lead Executive Director: Charmaine Desouza, CPO

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
 - 1) Quality - Deliver the best possible care and health outcomes
 - 2) People - Be a great place to work

Freedom to Speak Up Guardian Annual Report

April 23 – March 24

Introduction

This is an annual report related to the activities of the Freedom to Speak Up Guardians (FTSUGs) for the period between April 2023 and March 2024. The Guardians continue to work within the remit of National Guardian Office (NGO) guidance and contribute to meeting the key objectives set out by People Promise and support the delivery of “Quality and People” Trust Strategic Objectives.

We have established strategic links with each directorate and meet regularly with directors and other key stakeholders to triangulate emerging themes/gaps for learning and improvement. Regular quarterly FTSU reports are submitted to Executive Team Meetings to highlight emerging themes, activities, and key learnings.

Reactive and Proactive key activities highlights

The Guardians actively contribute to various networks locally, regionally, and nationally. We continue to deal with cases, deliver a variety of trainings and visit teams/ site trustwide.

Type of reactive & proactive activities	FTSU cases	Training delivery	Team / site visit
No. of activities undertaken	290	80	58

Some of the highlights of work undertaken by the FTSUGs during this reporting period are summarised below:

- A FTSU Board assessment was completed in March 2023 outlining a 2 year programme to implement various priorities about our OHFT speaking up culture. The next board review of progress against this plan is due in March 2025.
- Our method of FTSU data reporting was redesigned and amended to include changes recommended and/or mandated by the NGO and also recommendations made the NHSE EDI Improvement Plan.
- The new FTSU policy was completed and launched as part of Speak Up month October 2023 and continues to be promoted.

- FTSU E learning modules have been implemented as part of each staff compulsory training matrix.
- FTSUGs established stronger working relationship with Service Directors from each directorate and Human Resources (HR) colleagues with each Guardian assigned to a directorate as the primary contact so that Service Directors and Guardians can work closely together.
- FTSUGs have worked collaboratively with communication colleagues to promote speaking up in various ways and a regular slot promoting the work of the Guardians is incorporated into the monthly face to face induction and other formal trainings.
- A new FTSU questionnaire to benchmark trust culture has been designed and implemented in the most recent Trust Pulse survey, Jan 24 (see Appendix 1 for details).
- A guideline on tackling detriment has been developed for implementation and will be launched shortly.

Speak Up Month 2023 Highlights

During October Speak Up Month 2023 the Trust joined in the NGO national campaign “Breaking Barriers”. Here are some of the highlights:

- FTSU focussed leadership briefing open to all OHFT staff supported by senior leaders.
- Weekly FTSU focus communications to all staff.
- Speak up suggestion boards to help teams tackle barriers.
- Launched of new FTSU policy with clear guidance of zero tolerance to blame culture and detriment.
- Collaborated to deliver a Schwartz round session with the theme: “I spoke up and felt empowered” – staff shared their powerful lived experience of speaking up.
- Engaged with staff face to face during various site visits; collaborated with Organisational Development (OD) roadshows to promote staff survey and FTSU profile.

As a result of raising awareness during this month we recorded the highest number of cases since the FTSUGs came into post during this quarter (96). This demonstrates the more visible we are, the more staff will feel safe to speak up. We would like to increase visibility as business as usual, however this is limited due to FTSUG capacity. We recognise that increased visibility and awareness of FTSU

routes will be fundamental to culture change, and to embedding a restorative and just learning culture across the Trust.

NGO (National Guardians office) update

Revised recording cases and reporting data guidance was issued for 2024/25 from the NGO office. We have implemented these changes at OHFT, particularly relating to protected characteristics.

FTSUGs attended the NGO 2-day conference/ networking event in March 24, where the focus was breaking barriers to speaking up.

The NGO will be carrying out a speaking up review into the experiences of overseas-trained workers from May 2024.

National Staff & Pulse Survey Results

The 2023 staff survey indicates that at Oxford Health 79.1% of staff would feel secure to raise concerns about unsafe clinical practice compared to other benchmarked organisations (which are reported as 76.8%). This shows that the performance at OHFT is above average, which is consistent with previous years' data. FTSU specific questions in the January 2024 Pulse Survey show an overall positive speak up culture becoming embedded (88-92%) across the organisation (see Appendix 2 for questions asked). Gradual increase in speak up numbers and survey results are indicating a positive cultural shift.

BOB staff survey comparison

The table below compares the National staff survey 2023 results for "we have a voice." We scored higher in this question than the other benchmarked organisations.

National staff survey average " we have a voice " 2023 result %	6.72
Similar (benchmarked) organisations	6.98
BOB average	6.39
Oxford Health NHS Foundation Trust	7.08
Buckinghamshire NHS Trust	6.85
Berkshire Healthcare NHS Trust	7.27
Oxford University Hospitals	6.84

Number of FTSU Cases

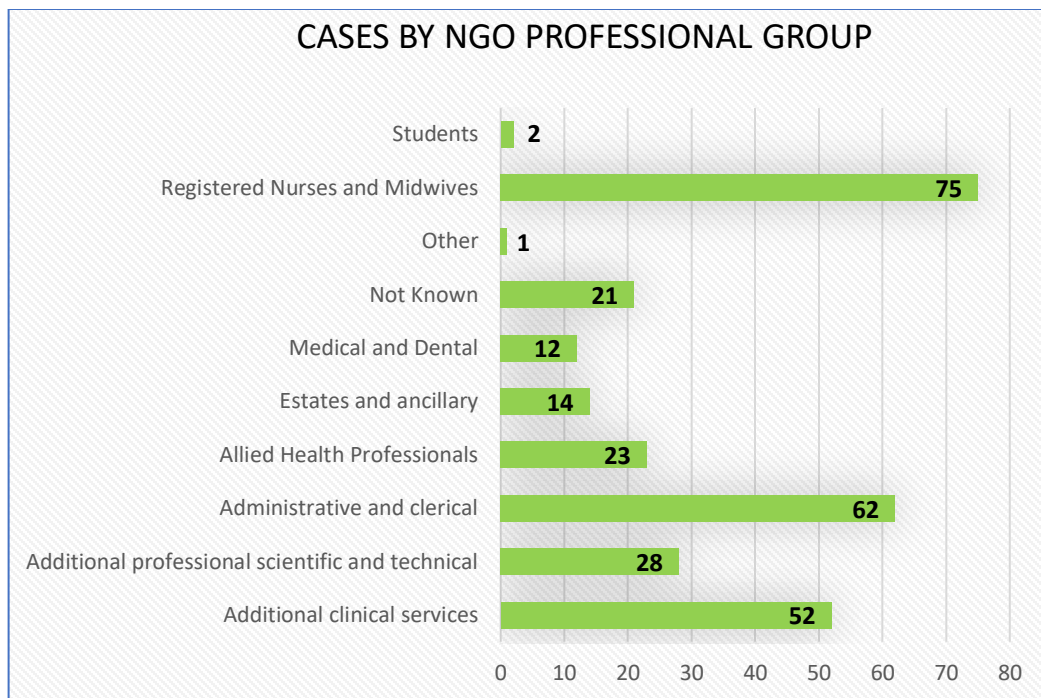
Overall, there is a correlation between higher speak up numbers and a good or outstanding CQC rating (NGO 22/23). Nationally cases are rising, and there is a gradual increase at Oxford Health year on year indicating a positive culture shift, compared to other organisations within BOB. During this reporting period, a total of 290 cases (less than 0.5% of our workforce) have been raised with the Guardians. The table below shows an increase from previous years.

Number of cases across BOB & Nationally (taken from NGO data portal)

Year	OHFT cases	OUH cases	Bucks cases	Berks cases	No of NGO cases
2017 / 18	43				7,087
2018 / 19	42				12,244
2019 / 20	67				16,199
2020 / 21	100				20,388
2021 / 22	235	116	132	56	20,362
2022 / 23	258	94	91	67	25,382
2023 / 24	290	Not avail	Not avail	Not avail	Not avail

Professional Group

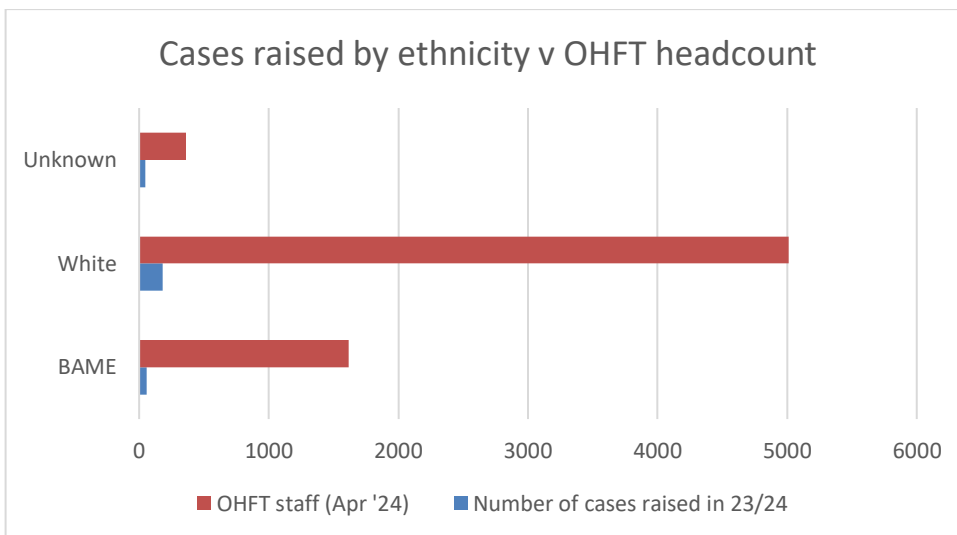
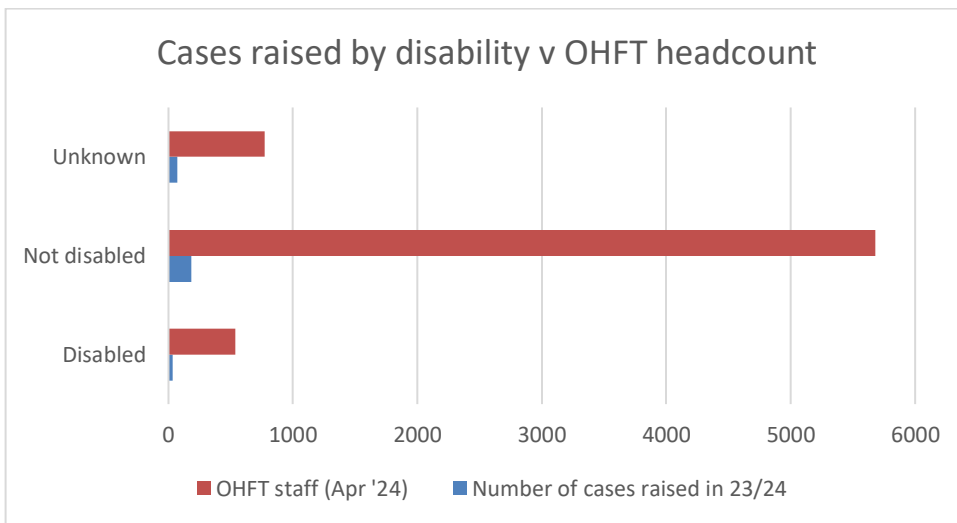
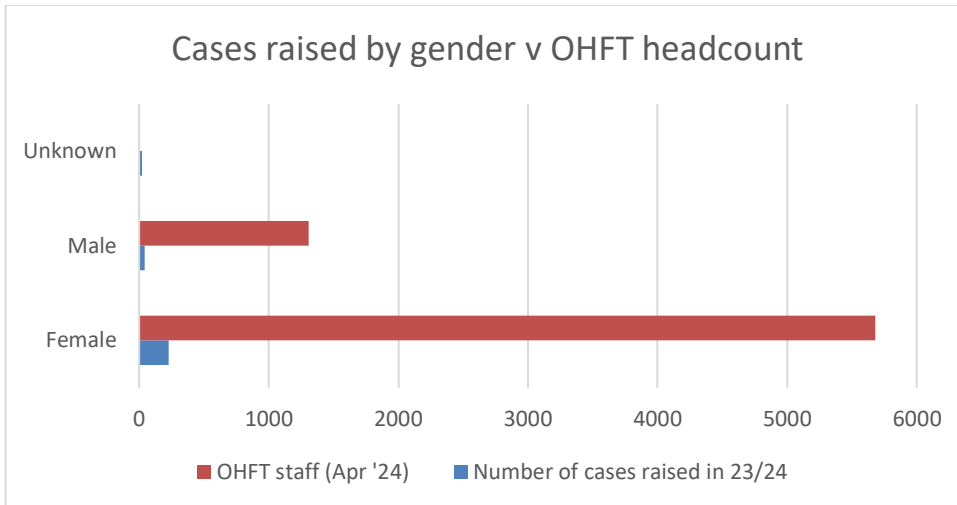
The chart below shows that the Registered Nurses and Midwives professional group raised the highest number of cases (75) during this period, this equates to around 1% of this professional group of our workforce. This trend is also observed nationally. About 1% of our staff from the administration and clerical; and additional clinical services are speaking up which is consistent with the headcount within these professional groups.



Numbers of cases by Protected Characteristics

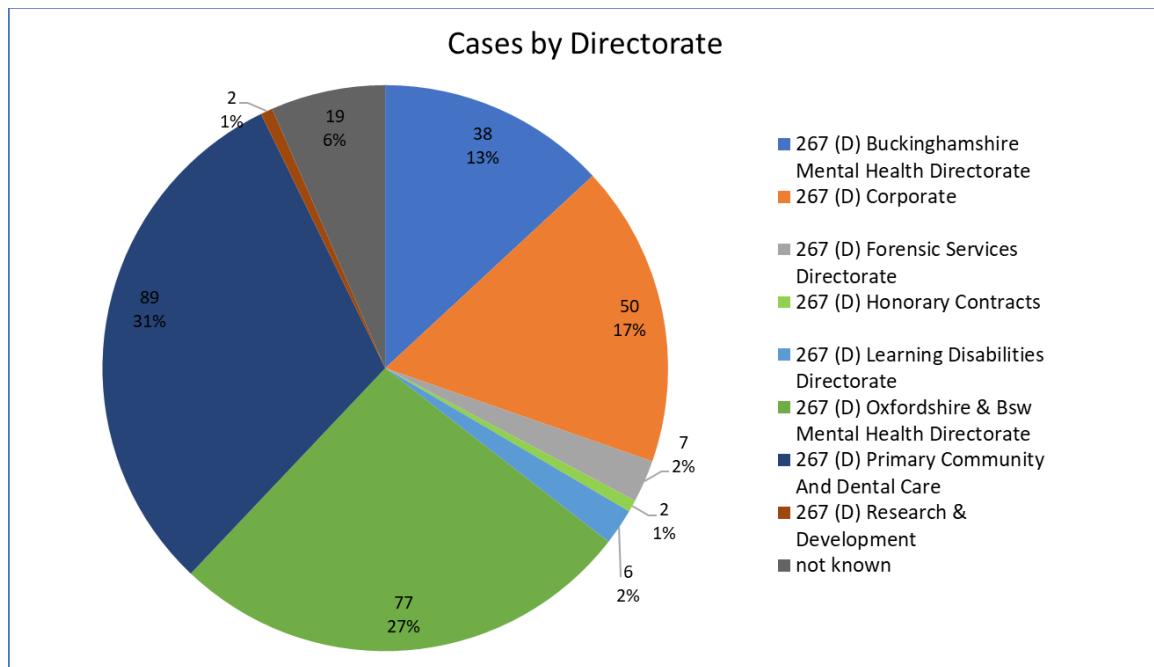
We are including Protected characteristic figures for the first time in this FTSU annual report. We understand that there are barriers to speaking up in relation to certain protected characteristics. However, we are not able to see direct evidence of this issue within our speaking up figures. It is not yet possible to access national information on the protected characteristics of colleagues raising concerns, and we are therefore not yet able to draw any comparisons. Regardless, we will continue our efforts to ensure that all staff feel comfortable and able to raise concerns with our FTSUGs, and this links with the High Impact actions as part of our EDI improvement plan.

Within Oxford Health, 20.6% of those that spoke up were BAME, and 63.1% were White and this is line with the overall demographics of the Trust where, BAME staff represent 22% of workforce and 71% of the workforce identify as White. This is also the case for gender figures these show consistent speak up rates in comparison to those employed.



FTSU Cases by Directorate

The chart below shows the breakdown of total number of cases reported by each directorate. The highest number of cases raised is from Primary Community & Dental care (89). This is closely followed by Oxon & BSW MH (77) and then Corporate (50). Numbers from other directorates remain reasonably low.



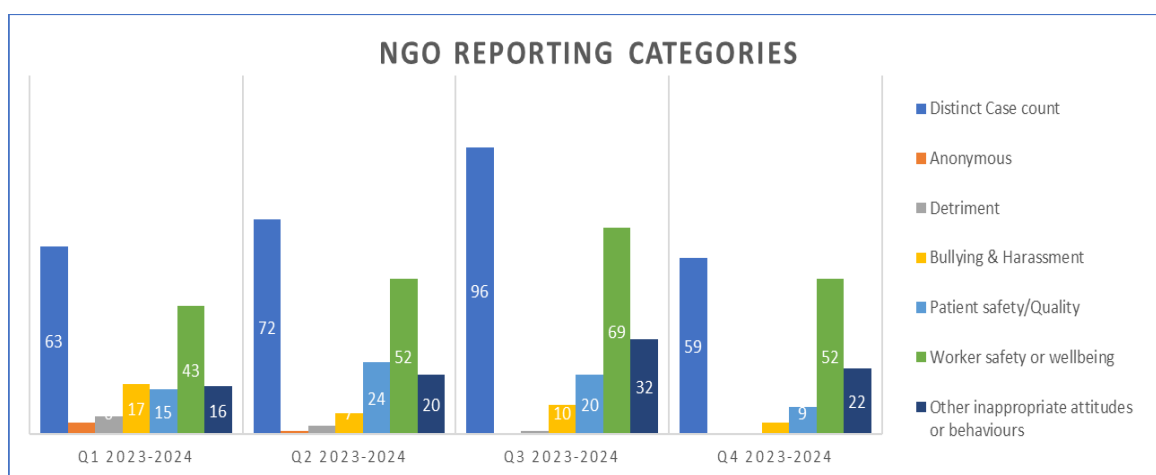
Directorate	Percentage of staff that spoke up by headcount
Buckinghamshire Mental Health Directorate	4%
Corporate	4.2%
Forensic Services Directorate	1.5%
Learning Disabilities Directorate	6.3%
Oxford Pharmacy Store	0%
Oxfordshire & BSW Mental Health Directorate	4.2%
Primary Community and Dental Care	4.4%
Research & Development	2%

The table above shows the percentage of staff that have spoken up within each directorate in relation to headcount.

FTSU Cases by Category

All cases have been followed up either by empowering the staff to raise with their managers or escalated to senior managers / leaders by the Guardians on behalf of the concern raisers. Staff were kept up to date and given feedback regularly by the Guardians during the speak up process. 94% of cases are now closed having reached resolution, whereby the staff felt listened to and that appropriate actions have been taken to address their concerns.

Please note that the total number of cases raised by staff is not the same as the total number of cases raised by each category. According to NGO, 2022 guidance, an individual case may include various categories. Each category is detailed further with emerging themes.



Emerging themes from each Category

Worker safety or wellbeing remains our highest reported category. The most common factors are relating to communication and leadership style impacting on staff. This includes unclear/lack of communication regarding organisational changes, staff feeling stressed, unsupported within their role and feeling that they aren't being listened to or unfairly treated during HR procedures. We have escalated a theme relating to international nurses' lack of cultural competencies whilst supporting them and vice versa, thus impacting staff retention (including themes such as clarity of role expectation, lack of pastoral care to Executive leaders, which has prompted a review of cultural competency training led by the CPO. We as Guardians regularly facilitate bespoke sessions to senior leaders/ managers to look at culture, leadership and speak up barriers.

Patient safety & Quality concerns which have been raised are mainly relating to processes and procedures not being followed appropriately by staff; when escalated to relevant team actions are being taken which ties in with our CQC improvement action plan. The impact of this includes staff shortages, increased workload, increasing demands, which all affect the delivery of high-quality care. No cases of severe patient risk or harm have been raised with the Guardians during this reporting period.

Inappropriate attitudes or behaviour continues to be a common theme reported to Guardians. This includes toxic culture,, uncivil behaviours by staff; inappropriate communication; and non transparent and non-compassionate implementation of HR processes. Our CEO is directly leading a focused piece of work on how we do things to improve organisational cultures. We are working with our restorative and just learning culture lead to remain closely aligned to this work.

Bullying and harassment - there have been a few cases reported with element of perceived bullying behaviours, however, there has been an overall reduction in cases raised within this category. This may well be attributed to the recent NGO category differentiation between B&H and inappropriate behaviours. Often this includes derogatory, unpleasant remarks to each other; subtle /micro-aggression; exerting excessive control and undermining others autonomy. Many of these cases are being followed up by formal HR processes.

Detriment - Ten staff have reported that they have suffered detriment (actual or perceived) when they have spoken to their line managers and as a result have been treated differently, subjected to performance reviews / HR procedures. Staff often fear future retribution and choose to raise concerns anonymously. These cases have been reported to relevant senior leaders for further actions. We are currently working on a process on how to tackle detriment across the trust. All cases have been escalated to NED/ FTSU lead (CPO).

Raised Anonymously - Five cases have been raised anonymously with the Guardians. Few of them have been investigated via whistleblowing process, others were escalated to the appropriate directors for investigations. These small numbers are closely related to a national decline in anonymous reporting.

Positive changes as a result of speaking up.

- One of our concern raisers took part in National support scheme and has been a key advocate for promoting this service.
- Teams have benefitted from our input in receiving clear, transparent communication and engagement when going through organisational change.
- Some managers have acted on our suggestions to offer additional leadership support to their staff to help improve communication and team culture.
- Many individual staff have achieved better outcomes that has made a difference to their wellbeing and patient care.
- Empowered staff to showcase their lived in FTSU experience via different routes (story telling, Schwartz round, webinar, video)
- We are collaborating with the culture work being led by CEO.
- Work ongoing to review support for international nurses (bridging program/ competencies)

Feedback from staff who have used the FTSU service.



Key recommendations for improvement based on observation and learning.

- **Leadership**
Leaders/ managers to be more compassionate when having courageous conversations, ensuring that speak up, listen and follow up process is followed thoroughly. Speak up E-learning modules would be beneficial.
- **Culture**
Promote more positive speak up culture by tackling barriers and by being inclusive.
- **Communication**
Clear compassionate and transparent communication when going through HR processes/ organisational change.
- **Unsustainable FTSU provision**
given increase in FTSU numbers and requests for more bespoke training for culture and leadership.

Some of the key focus areas for the coming year include:

- Implementing trust process for tackling detriment and issue guidance as an appendix to the FTSU Policy
- Collaborate on culture workshop for joint PLC & Quality Committees and determine whether a trust FTSU strategy is required and undertake any associated work moving forward.
- To repeat FTSU related questions within the Pulse Survey Jan 2025
- Continue to meet the needs of the reactive and proactive nature of the FTSUG role.
- Further understand barriers particularly in areas where speak up rates are low as identified by staff survey.
- Continue to work with key stakeholders to understand gaps and consider other way to improve speak up culture. (bespoke training to empower leaders/staff for positive culture change)

Appendix 1

FTSU Pulse Survey Result January 2024

In January 2024, for first time we asked 5 FTSU specific questions to try to understand and benchmark our speak culture. We have results from 455 respondents. Here are the questions with responses:

1. Do you know what Freedom to Speak Up (FTSU) is about?
Yes - 92%
2. Are you aware of different routes to speak up within your organisation?
Yes- 88%
3. Does fear of retaliation / detriment act as a barrier for you to speak up?
Agreed -33%
Disagreed – 45%
Neither agreed or disagreed – 22%
4. Do you feel confident that your organisation would address concerns you raise?
Agreed -41%
Disagreed – 28%
Neither agreed or disagreed – 31%
5. Do you feel safe to speak up in your organisation?
Agreed - 54%
Disagreed – 23%
Neither agreed or disagreed – 23%

This survey shows an overall positive speak up culture getting embedded (88-92%) across the organisation and 54% of staff said they feel safe to speak up. This culture shift is also demonstrated by the gradual increase in Speak Up numbers over years and the willingness of staff to speak to us more openly during our face to face visits and accessing other routes to speak up.

However, some teams are more open and transparent than others. We need to focus on tackling barriers, listening to the silences and following up when concerns are raised by giving feedback.

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

Board of Directors

22nd May 2024

BOD 37/2024
(Agenda item: 13)

Patient Safety Incidents reviews March and April 2024
For: Assurance

Executive Summary

It is crucial that we learn from every incident and near miss that happens to identify and address system issues to continually improve the safety of care. We transitioned and started working under PSIRF from 4th December 2023. The documents setting out our approach and local incident response plan have been published and are available here [Patient Safety Incident Response Framework \(PSIRF\) - Oxford Health NHS Foundation Trust](#).

The report focuses on the period March and April 2024 following on from the last report. Ten reviews within our new local incident response plan have been identified in the period:

- ❖ Self-harm of patient following discharge.
- ❖ Violence and aggression of patients in community.
- ❖ Unexpected death of patient.
- ❖ Death of patient with custody order in community in road traffic incident (mandated national required review).
- ❖ Three unexpected unnatural deaths (suspected suicide).
- ❖ One unexpected death due to physical health issues in mental health inpatient setting.
- ❖ One pressure ulcer with development of sepsis in mental health setting. Admitted with pressure damage – system review.
- ❖ Thematic review of unexpected deaths in Crisis Team over past 6 months.

The key areas of learning we have identified from the 11 PSI reviews completed in March and April, is summarised within the report. Learning is shared in various ways and formats with clinical teams, ward/team managers, senior clinicians, as well as through a series of Trust-wide forums. The key Trust-wide forums are; the Weekly Review Meeting, weekly Executive Director patient safety panel, monthly Quality and Clinical Governance Sub-Committee, quarterly Quality Improvement and Learning Forum and the quarterly Quality Committee.

Governance Route/Escalation Process

The Trust has a series of weekly and monthly patient safety forums which review the details of the information summarized in this report.

Recommendation

For the Board to be assured regarding the current processes and structures for the identification, review and learning from patient safety incidents.

Author and Title: Victoria Harte, Patient Safety Service Manager

Lead Executive Director: Britta Klinck, Chief Nurse

1. *A risk assessment has been undertaken around the legal issues that this report presents and [there are no issues that need to be referred to the Trust Solicitors]*
2. *Strategic Objectives/Priorities – this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust:*
 - 1) *Quality - Deliver the best possible clinical care and health outcomes*

1.0 Patient Safety Incident reviews

As part of the national Patient Safety Strategy around developing a safer culture, safer systems, and safer patient care was the development of the Patient Safety Incident Response Framework (PSIRF). This was a welcome but significant change in how we think and behave in relation to developing how we learn and improve from patient safety incidents. The Trust transitioned and started working under PSIRF from 4th December 2023, following support from the ICB, Provider Collaboratives and BOB ICS system Quality Forum. A summary of our approach and new way of working under the PSIRF as well as our new local incident response plan is published on the Trust's website and available here [Patient Safety Incident Response Framework \(PSIRF\) - Oxford Health NHS Foundation Trust](#).

Following the last report there have been ten reviews identified meeting our new incident response plan (local safety areas we identified to focus on), in total this takes us to 22 reviews under PSIRF from 4th December 2023 to 30th April 2024. These 22 reviews have taken various learning response forms for example thematic reviews, incident learning huddles, observational audits, system reviews, in-depth investigations, and work using the Triangle of Care tool developed by the Carers Trust. We have found we have been able to identify and start learning quicker with 7 out of the 22 reviews already completed. These are some of the early benefits we have seen with the implementation of PSIRF. Whilst we are excited about the new approach there are still seven reviews underway that were declared in the old process of the Serious Incident Framework (pre-4th December), all but two are completed. For the two outstanding cases, both to be completed in May 2024.

The recent patient incidents under PSIRF identified in March and April 2024 are described below;

- ❖ Self-harm of patient following discharge.
- ❖ Violence and aggression of patients in community.
- ❖ Unexpected death of patient.
- ❖ Death of patient with custody order in community in road traffic incident (mandated national required review).
- ❖ Three unexpected unnatural deaths (suspected suicide).
- ❖ One unexpected death due to physical health issues in mental health inpatient setting.
- ❖ One pressure ulcer with development of sepsis in mental health setting. Admitted with pressure damage – system review.
- ❖ Thematic review of unexpected deaths in Crisis Team over past 6 months.

Previous reports have provided data over time on the number of incidents declared as 'serious incidents'. This criteria and term for incidents no longer exists under the PSIRF therefore the format and content of this report will evolve over the next few months with a greater focus on demonstrating the learning and improvements we make linked to our incident response plan.

2.0 Completed Investigations and Learning

We use a systems-based methodology to identify and act on learning. A summary of the key actions from the investigations and reviews completed in March and April 2024 is shared below.

Learning is shared in various ways and formats with clinical teams, ward/team managers, senior clinicians, as well as through a series of Trust-wide forums. The key Trust-wide forums are; the Weekly Review Meeting, weekly Executive Director patient safety panel, monthly Quality and Clinical Governance Sub-Committee, quarterly Quality Improvement and Learning Forum and the quarterly Quality Committee. Individual actions from each review are monitored centrally with progress against these reported through various reports and forums.

Improvement area	Action(s)
Community Learning Disability – client not needed to be seen for over 12 months, consideration if discharge from service would be more appropriate	Reviewing discharge processes.
Community Learning Disability (LD) – pathways for End Of Life (EOL) care	Developing clear EOL pathway across services. Training on palliative care being arranged for LD teams.
District nursing – communication with SPA from primary care, gap of time between District Nurse service finishing and Hospital at Home (H@H) starting	Single Point of Access (SPA) Standard Operating Procedures being updated to be aligned to the District Nursing Service. Directorate have added gap in service provision between DN service end of shift and start of H@H/111 to the Directorate Risk Register.
Good practice identified as theme – communication across teams	Three of the Incident learning huddles identified good practice of communication/co-ordination across teams internally and externally
Stoke Rehabilitation Ward – adapted communication with patients	The ward to have training around brain injury and stroke, with the impact on speech and comprehension.
System review – multiple ambulance services and OHFT – learning around how to communicate change of clinical treatment plan to other organisations	SCAS altering policy of how onward communication takes place when change of plan occurs.
System review – SCAS, Police, AMHP, OHFT – how coordinated escalation can happen across organisations	System to review how coordinated escalation across different organisations works.
Suspected suicide of patient after AWOL from ward.	No recommendations identified. Good response to AWOL completed by ward and other teams.
Medication thematic review – use of drug chart, 6 rights of medication, checking of patient's medication if expired, training of rotating medics, use of medication trolleys	The ward where medication thematic review focus has developed a series of actions to help improve medication management. This will be supported by looking at it in a quality improvement way, this will be supported by QI facilitator. Then the ward will share what they learn with the other community hospital wards.

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

BOD 38/2024
(Agenda item 14)

22 May 2024

Corporate Registers – Gifts, Hospitality & Sponsorship

For: Assurance

The Board is asked to note the following updates to the report on the Register of Gifts, Hospitality & Sponsorship presented to the Board on 27 March 2024.

GIFTS AND HOSPITALITY (INVESTIGATION/BREACHES)

Investigations referred to in March 2024 have since concluded. If vouchers were accepted from patients/families then this breached policy and was discussed with staff who were reminded of the guidance to follow; such breaches are included in this report.¹ In one instance, detailed below in the 'Breaches' section, a breach of policy was approved and supported as it related to a group of 58 staff rather than to an individual, which may influence future revisions to policy and procedures.

Alternatively, where vouchers were not received from patients/families or could be redirected to the Trust's Charity then these were not classed as breaches. Reminders of the guidance to follow have also been published in the Communications Bulletin to all staff over April and May, and staff will be reminded again nearer Christmas.

INVESTIGATED CASES – NON-BREACHES

	Details	Est. Value	Date Reported	Investigation outcome
1	£50 John Lewis voucher from the Trust to all	£50	07/02/2024	As confirmed that voucher was from the Trust to staff, not from a

¹ NHS England guidance – gifts of cash and vouchers to individuals from patients/families/service users should always be declined <https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf>

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	consultant appraisers (regifted/passed on to secretary in the team)			patient/family, this was determined not to be a declarable item.
2	M&S voucher from the relative of a former patient	£50	Reported on Medical and Dental register	It was confirmed that this gift voucher had been donated to the Trust Charity so not recorded as a breach.

INVESTIGATED CASES – BREACHES

	Details	Est. Value	Date Reported	Investigation outcome
1	M&S voucher from a patient	£15	Reported on Medical and Dental register	Following further investigation, this voucher had been spent, therefore is reported as a breach
2	Wagamama Gift Voucher received from a patient	£20	Declared to the Director of Corporate Affairs & Company Secretary	Following further investigation, this voucher had been spent, therefore is reported as a breach
3	Wagamama Gift Voucher received from a patient	£20	Declared to the Director of Corporate Affairs & Company Secretary	Following further investigation, this voucher had been spent, therefore is reported as a breach
4	Bicester Community Hospital Ward received 58 M&S Gift Vouchers addressed to individual staff from a family of a patient they had cared for	£10 x 58 = £580	Declared to the Director of Corporate Affairs & Company Secretary	This was approved as a one-off breach of policy by the DoCA/CoSec in consultation with the Chair of the Audit Committee and the Chief Executive. The vouchers were approved to be received by this staff group on the grounds: • for each individual member of staff, a £10 voucher is a modest sum; • staff group involved; and

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				• positive impact upon staff morale, sense of being valued and well-being.

Recommendation

The Board is asked to note the outcome of the investigations and to ratify the breaches of policy.

Author and Title: Nicola Gill, Corporate Governance Officer
Hannah Smith, Assistant Trust Secretary

Lead Executive Director: Kerry Rogers, Director of Corporate Affairs and 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** – *no Strategic Objectives/Priorities apply to this report.*

BAF SUMMARY Contents of this summary table (p.1-4) are hyperlinked to full BAF (at p.5 onwards).						
REF.	LEAD EXEC. DIRECTOR (ED)	RISK	CURRENT RATING	TARGET	MOVEMENT	REVIEW Date
	MONITORING COMMITTEE					
1. Quality - Deliver the best possible care and outcomes						
1.1	Chief Nurse/ Chief Finance Officer	Utilising digital, data and technology to drive quality, efficiency, economy, research, and innovation (formerly Triangulating data and learning to drive Quality Improvement and still subject to review)	9	8	↔	23/02/24
	Quality Committee / Finance & Investment Committee	A failure to utilise and engage with digital, data and technology to drive quality, efficiency, economy, research, insights and innovation resulting in poorer patient outcomes and/or poor patient experience, lack of insights to support decisions, lower return on investments, lack of insights driving quality improvements.				02/05/24
1.5	Exec MD for MH & LD	Unavailability of beds/demand and capacity (Mental Health inpatient and LD)	16	8	↔	22/03/24
	Quality Committee	Lack of local admission beds due to demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge could lead to: (i) increase in Out of Area Placements (OAPs) further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations.				02/05/24
1.6	Exec MD Primary Care & Community	Sustainability of the Trust’s primary, community & dental care services	12	9	↔	23/04/24
	Quality Committee	There is a risk that the inability to progress, with key partners, the re-design and re-commissioning of primary, community and dental care services across Oxfordshire threatens the medium- and long-term sustainability of these services. In this scenario, waiting lists/delays will continue to grow, quality and safety of care will be increasingly compromised, the financial position will deteriorate, the needs of the service users will be insufficiently met and there will be poorer health outcomes and experiences. The successful mitigation of this risk requires the Trust to work effectively with a wide range of ICB partners and stakeholders to deliver a number of priority strategic actions and enablers (set out below), which in turn will enable the successful transformation of key primary and community care pathways.				02/05/24
2. People - Be a great place to work						

<u>2.3</u>	Chief People Officer	Succession planning, organisational development and leadership development Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; 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
	People Leadership and Culture Committee					30/04/24
<u>2.4</u>	Chief People Officer	Developing and maintaining a Culture in line with Trust values A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	9	4	↔	11/01/24
	People Leadership and Culture Committee					30/04/24
<u>2.5</u>	Chief People Officer	Retention of staff A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	12	9	↔	11/01/24
	People Leadership and Culture Committee					30/04/24
<u>2.6</u>	Chief People Officer	Adequacy of Staffing [will be subject to minor refinements led by future committee discussions] Inability to plan for, attract and secure sufficient and appropriately trained staff may lead to inadequate levels of staffing to provide: i. safe and/or quality patient care; or ii. the range of services which the Trust aspires to. If the Trust cannot secure adequate levels of permanent staffing, then it may turn to planned bank staff or temporary agency staffing which may be unsustainable in the medium to long term and could, without adequate controls, have financial and quality of care implications. [Replaces former BAF risks 2.1 and 2.2]:	16	9	↔	11/01/24
	People Leadership and Culture Committee					30/04/24

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

3.1	Executive Director of Strategy & Partnerships	Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level.	12	9	↔	23/10/23
	Quality Committee	Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.				02/05/24
3.4	Chief Finance Officer	Delivery of the financial plan and maintaining financial sustainability	16	12	↔	09/05/24
	Finance & Investment	Failure to deliver financial plan and maintain financial sustainability over the short (1-2 years) or medium-term (3-4 years), including, but not limited to: through funding reductions; non-delivery of CIP savings; budget overspends; and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England; and insufficient cash to fund future capital programmes.				09/05/24
3.6	Director of Corporate Affairs & Co Sec	Governance and decision-making arrangements	8	4	↓	19/03/24
	Audit Committee	Failure to maintain and/or adhere to effective governance and decision making arrangements, and/or insufficient understanding of the complexities of a decision may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.				23/04/24
3.7	Executive Director of Strategy & Partnerships	Ineffective business planning arrangements	12	6	↔	24/04/24
	Finance & Investment	Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.				09/05/24

3.10	Chief Finance Officer	Information Governance & Cyber Security	12	9	↔	08/03/24
	Finance & Investment	Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions), cyber-attacks which could compromise the Trust’s infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; reputational damage.				09/05/24
3.12	Director of Corporate Affairs & Co Sec	Business continuity and emergency planning	9	9	↓	16/02/24
	Emergency preparedness, resilience and response committee (sub-group to Executive Management Committee) and Audit Committee	Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.				23/04/24
3.13	Chief Finance Officer	A failure to take reasonable steps to minimise the Trust’s adverse impact on the environment , maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties (Health & Care Act 2022), national targets, the NHS Long Term Plan and ‘For a Greener NHS’ ambitions (Reach net zero NHS Carbon Footprint	9	3	↔	12/01/24
	Finance & Investment	by 2040, reducing emissions by at least 47% by 2028 – 2032. Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036 2038) could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.				09/05/24
3.14	Chief Finance Officer	Major Projects	16	6	↔	09/05/24
	Finance & Investment	Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; non-delivery of required savings, unplanned expenses, delays and wasted resources.				09/05/24
4. Research & Education - Become a leader in healthcare research and education						
4.1	Chief Medical Officer	Failure to realise the Trust's Research and Development (R&D) potential.	6	3	↔	26/01/24
	Quality Committee	Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.				02/05/24

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

Strategic Objective 1: Deliver the best possible care outcomes

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

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

Risk Description:

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

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

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

	NHSE compliance around DD&T - DTAC / MFA . Performance against national NHS Oversight Framework indicators.		

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

Date added to BAF	Pre-Jan 2021				
Monitoring Committee	Quality Committee		Impact	Likelihood	Rating
Executive Lead	Executive Managing Director for Mental Health & Learning Disabilities	Gross (Inherent) risk rating	4	5	20
Date of last review	22/03/24	Current risk rating	4	4	16
Risk movement	↔	Target risk rating	4	2	8
Date of next review	June 2024	Target to be achieved by			

Risk Description:

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

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

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

4) Adults and older Adults: Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors; - Proactive management of flow and OAPs; - Care Planning; - System partner calls to improve discharge; - Roll out of Crisis Resolution, Home Treatment, Early Intervention, Intensive Support and Hospital at Home teams to prevent admission and support earlier discharge;		4) Shortage of substantive nursing and therapy staff across the Trust (and in some team's difficulties in recruiting medics e.g. CAMHS community, adult acute mental health and Adult Eating Disorder services) i.e. vacancies continue to result in capacity pressures and increased reliance on agency staffing at a time when demand is increasing. Ultimately can reduce capacity to see patients and families. Waiting lists and access to some services are rising as a result of increased demand, pressures in the wider system i.e., housing, shortage of staff and the aftermath of COVID-19. Some mental health community teams are also managing high numbers of patients unallocated to a care coordinator due to demand being higher than capacity. This impacts inpatient areas and creates the need to use Out of Area Placements (OAPs).	waiting longer than agreed standard as captured in TRR 1001 (OAPs). Directorates will continue to focus on reducing use of OAPs to improve the quality of patient care and improve cost control. LD services to continue to provide specialist LD support to mainstream MH health wards to facilitate reasonable adjustments. OWNER: Executive MD for Mental Health & Learning Disabilities 4) Vacancies continue to be high. Details reported in the Quality and Safety Dashboard provided to the Quality Committee (and to the Board), as well as in highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. Mitigations via Retention and Recruitment workstreams and the Improving Quality Reducing Agency programme (monitored through the People, Leadership & Culture Committee). Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate Senior Management Team. Operational risks also monitored through the Trust Risk Register at

			1068 (mental health waiting times) Directorate Harm Minimisation Groups well established and will report findings to Directorate SMTs to inform Transformation Programme Demand and Capacity projects, 1024 (reporting on waits) work with operational services has been undertaken to identify and document clinical waiting time standards re emergency, urgent and routine referrals to develop waits reporting to 'red flag' patients waiting longer than agreed standard. 1001 (OAPs). Monitoring also through highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control.

Strategic Objective 1: Deliver the best possible care outcomes

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Executive MD for Primary Care and Community
Date of last review	23/04/24
Risk movement	↔
Date of next review	June 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	Level 1: reassurance	• Limited capability and capacity in Community Services for innovation and quality improvement. • Senior Clinical Leadership gaps in some services. • Quality and Risk issues in some services linked to insufficient capacity to maintain urgent care and non-urgent planned care (e.g., pressure-related harms, podiatry, CTS/district nursing). • Limited workforce planning and high staff vacancy rates in specific services linked to local or national workforce shortages (e.g., podiatrists, dieticians).	<i>Short-term:</i> Daily system calls are held 7-days-a-week on how to balance the risks across different provider organisations, including ambulance and acute services, and how to free up space to provide for patient discharge or flow through the system. The challenge of balancing demands on staff, finances, and achievement of longer-term strategic goals are regularly discussed and monitored through Trust Weekly Review Meetings (safety / complaints / incidents review) • Monthly Directorate Quality SMT Board • Monthly Finance Review meetings with each Head of Service • Monthly Directorate Performance Board • Quarterly Executive Performance Review To manage unexpected surges in demand, Mutual Aid arrangements have been put in place across the BOB
	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.		

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 through Directorate and Trust reporting processes (including monitoring of relevant Directorate Plan objectives) Delivery and monitoring of Frontline Digitisation Plan	Level 3: independent At Place level, the work will report into the Oxfordshire Integrated 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).	• Fragmentation of care pathways across siloed service management and support structures (e.g., H@H, OOH services, IT systems). • Change management capability gaps – limited mid-tier experience in change management and QI. • Substantial need for re-design of costed service 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	ICS to help manage capacity challenges. Staffing risks are being managed via a people plan (workforce & wellbeing meeting) reported to PLC. A Trust pay framework for substantive GP roles is being developed and will be discussed with LNC colleagues shortly. A Transfer of Care hub operates daily to deliver the nationally recommended Discharge-to-Assess process, jointly with Adult Social Care (Oxfordshire County Council) and Oxford University Hospitals NHS FT (OUH) colleagues to develop a jointly managed Transfer of Care team to facilitate more effective and timely hospital discharges and best use of community bed resources. The performance data for this Hub, and the other services in the acute admission and discharge pathway, is reviewed regularly at Oxfordshire UEC Board. A second programme of work has started. This is focusing on improving the sustainability of the UEC pathway to be delivered during 2024. There have been unexpected delays to the FY24 Estates work programme delaying on our ability to increase the capacity and sustainability of services in the UEC pathway into FY25. <i>Longer-term:</i> A community service transformation programme is underway with system partners at Oxfordshire Place to improve patient outcomes and service sustainability, supported by external programme management team. This will align closely to the Frontline Digitisation Programme which will also improve sustainability. Resources have been identified by the Trust to establish a community services transformation team to deliver this

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

		their intention to extend the contract until 2026.

Strategic Objective 2: Be a great place to work
2.3: Succession planning, organisational development and leadership development

Date added to BAF	Pre-Jan 2021			
Monitoring Committee	People Leadership and Culture Committee		Impact	Likelihood
Executive Lead	Chief People Officer	Gross (Inherent) risk rating	4	4
Date of last review	11/01/24	Current risk rating	3	4
Risk movement	↔	Target risk rating	2	2
Date of next review	April 2024	Target to be achieved by		
				Rating
				16
				12
				4

Risk Description:

Failure to maintain a coherent and co-ordinated structure and approach to **succession planning, organisational development and leadership development** may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; 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 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	Level 1: reassurance	GAP	The first PDR season (supported by a brand new codesigned form with staff 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)
	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 88.2% in January 2024 compared to 91% in October 2023. - Clinical supervisions 74% in January 2024 compared to 70% in October 2023. - Mandatory training performance 90.1% in	The L&D team will continue to monitor the new system and revise the 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	

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 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	January 2024 compared to 88.8% in October 2023.	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.	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. 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.
	Level 3: independent - CQC reviews - a rating of "good" was achieved in the Well Led domain in 2015 CQC inspection.	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.	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
Risk movement	↔
Date of next review	April 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	3	12
Current risk rating	3	3	9
Target risk rating	2	2	4
Target to be achieved by			

Risk Description:

A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, **health, safety & wellbeing of staff, working flexibly**, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture.

The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

Key Controls	Assurance	Gaps	Actions
- HR Policies & strategies, include. Workplace Stress Prevention & Response, Equal Opportunities,	Level 1: reassurance	GAP Need to improve staff experience and respond to	Promotion and embedding of a "civility and respect including: Team and manager focus on Health
	- Health and Wellbeing Group; - Stress Steering Group;		

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.	- 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.	issues identified by Staff Survey results in order to improve retention. 6.	& 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;	Level 1: reassurance	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.	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.
	- 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:		

- 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;	- Turnover 12.92% in January 2024 (target <14%); - Vacancies 12.5% in January 2024 and 15.5% in October 2023 (target <9%); - Quarterly People Pulse checks (measures of staff engagement)		Onboarding QI project; and Career Conversations QI project.
	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.	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 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.	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 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 [will be subject to minor refinements led by future committee discussions]

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	Sept 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:

- ii. safe and/or quality patient care; or
- iii. the range of services which the Trust aspires to. If the Trust cannot secure adequate levels of permanent staffing, then it may turn to planned bank staff or temporary agency staffing which may be unsustainable in the medium to long term and could, without adequate controls, have financial and quality of care implications.

This is a current, live risk and the scale of the challenge could increase in the future, further to national challenges outside of the Trust's immediate control around cost of living, national pay scales, industrial action, education and training, and nationally available supply of key professions. We accept, and plan for a tolerance of temporary staffing usage to enable flexibility in our workforce to respond to ebbs and flows in demand, but the current levels of temporary staffing usage places the Trust under increased financial pressure and additionally potentially impacts upon the quality of care to patients. Our strategic plan for the medium and longer term incorporates measures to reduce temporary staffing usage, such as development of more sustainable workforce models, working with universities on clinical training, better demand and capacity modelling, career and organisational development interventions to link to retention and linking with national and regional teams to maximise learning from other Trusts and national exemplars. We are also aligning more closely, through the Annual Planning process for 24/25, the OHFT People Plan with the NHS Long Term Plan.

Even if the Trust succeeds in Recruitment, if it fails at Retention then it jeopardises those gains. Recruitment and Retention in proportion will be key to mitigating the risk, with a focus upon:

- Recruitment: Trust to be seen as employer of choice, marketing, induction, rewards and benefits; and
 - Retention: organisation culture, personal and leadership development, training, appraisals, staff support and wellbeing, and rewards and benefits.
- [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 - TRAIN; - RETAIN; - REFORM. A summary of the themed key actions (train, retain, and reform) are set out below. The assurance routes are broadly consistent across each element, and so are consolidated. Train theme: This relates to how we grow the workforce in the Trust and strengthen our pipelines for the professions where we are carrying the highest vacancies. There is a focus in the NHS Workforce Plan on increasing the supply of domestic education and training and therefore reducing our reliance on internationally educated staff. Enhanced Education and Training initiatives, including Apprenticeship programmes, and career development	Level 1: reassurance	Elements of the OHFT People plan will remain challenging to deliver. Examples of where this is the case are set out in the subsequent sections. Not enough capacity to deliver as many places as could be utilised by OHFT Staff (both in internally provided programmes, and for places within programmes provided by external providers) Vacancies make it very difficult for clinical teams to release staff to undertake education programmes. However, inability to enable this release in the short term exacerbates the issue in the medium and longer term. Lack of sufficient centrally understood data on learning needs (training needs analyses) and aspirations for career development.	Development of non-clinical career pathways Establishment of other clinical apprenticeship offers including pathways in dental, pharmacy and social worker. Complete Training Needs Analysis based on information gathered from a variety of sources (PDRs, individual feedback, discussions with leaders and managers) Hold Workshops for Managers and Staff to promote L&D opportunities prior to PDR season. Refreshed Study Leave Policy (particularly to make expectation of release clear) Educational experience programme to review effectiveness and impact. Improved engagement with school/colleges - development of Trust work experience policy. With a continued focus on our development offer to staff who wish to join the Trust which can be highlighted at recruitment fairs. Development of Education career pathway for all staff including L3 – L7 qualification offer in response to the newly

pathways from HCA to Advanced Practice.			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. Review of other pathways for professionals which are hard to recruit to. Establishment of Peer support worker apprenticeship offer including gaining agreement for PSW role to be included in team establishments and budgets in line with expansion of role in NHS workforce plan. Increase uptake of Nursing Associate apprenticeship programme to ensure consistent pipeline to Nurse degree as well respond to NHSE workforce plan to increase overall numbers in NHS workforce. Launch of 'Braver than before' Leadership programme Launch of 'Our Leadership way' Leadership behavioural framework and development of Leadership training offer. Development of a just and restorative culture through which people feel supported and enabled to do their best work.

Retain Theme This relates to embedding the right culture and improving retention and in particular reducing the leaver rate which is the numbers of staff who leave the NHS (as opposed to moving internally within the NHS sector). With a continued focus on making the NHS People Promise a reality for staff utilising tools such as the NHS EDI Improvement Plan and High Impact Actions; publicising pension reform changes and continuing investment in wellbeing. Ongoing and consistent work to ensure that our people recognise OHFT as a good place to work and choose to stay working with us.		Lack of assurance that all 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.	Further expansion of Psychological professionals including EMHP's who will be working in Mental health support teams in schools Enhanced health and wellbeing offer including the promotion of the new resource that in Occupational health to support psychological wellbeing for staff. Targeted support to deliver actions relating to outcomes from the annual staff survey (and ongoing regular pulse surveys) with a focus on year on year improvement. Refreshed annual awards approach from 23/24 which will be continued for 24/25 to recognise exceptional individual and team achievements and contributions. Better local induction and candidate and new starter experience to ensure our people have the best start. Design and delivery of Successful bid accepted to become part of Cohort 2 of Delivering the People Promise which will bring additional funding and support from NHSE. Embedding Flex working into 'Delivering the People Promise' Training for managers. TRiM business case being reviewed pending Trust wide roll out.

		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.	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

Reform Theme - working and training differently. New approach to recruitment and onboarding to better attract and secure talent to the Trust. Together with planning for future technologies and a focus on data quality and systems that enable and empower staff to make better decisions. Continued focus on embedding a culture reflects a restorative, just and learning culture.			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. Deliver the 6 High Impact Actions as set out in the NHSE EDI Improvement Plan as part of a wider programme of EDI work. Invest and grow staff membership of equality networks so that we support employee voice. Continue to invest in Employee Assistance Programmes. One of our 4 Enabling Workstreams will focus on the “Supporting Our People and Teams” and will aim to put in place interventions that shape our culture based on positive behaviours that are drawn from the overarching concepts of civility, respect and fairness. Improved access to HR through: • Implementation of HR Service Desk for all HR queries • Rebuild of HR and L&D Intranet

			• Implementation of new Document Management system and transfer of data Increased workforce efficiency through: • Continued Implementation of E-Rostering system • Inpatient E-Rostering Improvement work • Implementation of medicals E-Rostering Continued system optimisation and efficiency through: • Expenses system review • Implementation of new Occupational Health system • Transition of absence management from Goodshape to E-Rostering system • Continued advancement of Learning & Development system Continue the work on reforming our HR policies and guidance (including development of employee handbook) in line with restorative, just and learning culture principles. Incidents and Complaints working group – focused on safety, learning & patient care. Continue to work with ICB on Scaling people services to understand if automation and

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.			process redesign at system level can bring about efficiencies across provider boundaries. A review of our current Workforce Planning requirements has been done by the Director of S&P and Executives agreed we need a Trust wide approach to workforce planning that considers supply and demand and current workforce model. This is to be taken forward by the Chief People Officer and will draw from best practice models such as those published by the CIPD. It will also be one of our 4 Enabling Workstreams – whereby we will develop our approach to workforce planning with attention to effective clinical models and we will develop clinical models with attention to the available workforce., Further detail to be added once objectives for 24/25 are confirmed.

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

3.1: Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level

Date added to BAF	Pre-Jan 2021 Refocused and revised in July 2022				
Monitoring Committee	Quality Committee		Impact	Likelihood	Rating
Executive Lead	Executive Director of Strategy & Partnerships	Gross (Inherent) risk rating	5	5	25
Date of last review	23/10/23	Current risk rating	4	3	12
Risk movement	↔	Target risk rating	4	2	8
Date of next review	April 2024	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 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	Level 1: reassurance - Reporting through Directorate SMTs and OMT.	Performance and planning: Absence of system-wide data sets and aligned reporting. ICS and Place-level 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	Work ongoing to agree performance reporting at System, Place and Trust levels, aligned with Internal Planning process. Owner: Executive Director of Strategy and Partnerships 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 &
	Level 2: internal - Reporting through: Executive Management Committee; and Trust Board.		
	Level 3: independent - ICS-level and Place-level emerging governance for Mental Health, Learning Disability and Autism (MH, LD&A) and Community - Partnership and Alliance arrangements with other organisations, including the voluntary sector; - Provider Collaborative Governance		

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.		required MH & LD investment. No systematic approach to support partnership working in Place.	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		Impact	Likelihood
Executive Lead	Chief Finance Officer			Rating
Date of last review	09/05/24	Gross (Inherent) risk rating	5	5
Risk movement	↔	Current risk rating	4	4
Date of next review	July 2024	Target risk rating	4	3
		Target to be achieved by	2027	

Risk Description:

Failure to deliver financial plan and maintain financial sustainability over the short (1-2 years) or medium-term (3-4 years), including, but not limited to: through funding reductions, non-delivery of CIP savings; budget overspends; and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England; and insufficient cash to fund future capital programmes.

Controls	Assurance	Gaps	Actions
- Financial culture, meaning the skills and ownership, systems and incentives to manage budgets over the medium term across the Trust; - Annual Financial Plan and Budget produced, and approved by FIC and the Board; - Medium-Term Financial Plan produced annually and reviewed by FIC and the Board. - Monthly cash-flow and Balance Sheet reports; - Established Finance and Business Services teams and recently deepened Procurement team capability; - Standing Financial Instructions and Financial Policies; - regular reporting on Financial position and impact of wider	Level 1: reassurance	a) Funding pressures – BOB system faces significant shortfalls and financial capability challenges and Oxfordshire community services contract is known to be under-funded. Although there appears to be commitment to the Mental Health Investment Standard, there is uncertainty on the level of new funding for mental health going forward. b) Agency spend – the Trust's workforce challenges have led to excess agency usage and spend which puts pressure on ability to remain within budget. Workforce planning is not universally well-	a) Financial challenges escalated to the ICS and NHSE. Offer support to ICB financial capability building and improved cross system-working. Handed back loss-making contracts (CHC and s117). <u>FY25 plans currently remain a deficit.</u> Owner: Chief Finance Officer b) Deliver plans to reduce agency spend further in FY25. Improve workforce planning capability. Owner: Chief People Officer c) Use Community Transformation
	- Monthly finance review meetings within Finance team and with directorates; - Monthly analysis of forecast, run rates, risks and opportunities; - Reconciliations of ledger accounts; - Monthly Capital Programme Sub-Committee review.		
	Level 2: internal		
	- Monthly Exec scrutiny of overall financial position with Quarterly Deep Dives; - Quarterly Exec scrutiny as part of Service Directorate performance reviews. - Finance and Investment Committee (every 2 months);		

financial system risks to FIC and Board; - temporary-staffing programme; - active management of Capital Programme.	- Monthly Finance reporting to the Board to provide assurance on progress and recovery actions. - Monthly Directorate agency review panels	supported across the Trust. c) Cost Improvement Plans process does not yet capture all efficiencies or look ahead to future years. More use of costing data, benchmarking and challenge of underlying cost base is required. Better linkage of costs to activity is needed as is improved analysis of gross over and underspends and intentionality of resource allocation decisions.	programme, Mental Health Improvement programme and the Corporate Services and Central Teams enabler work to determine medium-term CIP programmes informed by regularly reported costing analysis. Embed and develop CIP reporting process begun in FY24. Better link workforce, activity and resources in Annual Plan FY26 and factor in time for early analysis of resource analysis. Owner: Chief Finance Officer
	Level 3: independent		
	- Internal Audit reviews including annual review of financial controls; - External Audit review of financial statements; - Monthly reporting to, and monitoring by, NHSE and the Integrated Care Board (ICB).		

Strategic Objective 3: Make the best use of our resources and protect the environment
3.6: Governance and decision-making arrangements

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Audit Committee
Executive Lead	Director of Corporate Affairs & Co Sec
Date of last review	19/03/2024
Risk movement	↓
Date of next review	June 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	4	2	8
Target risk rating	2	2	4
Target to be achieved by			

Risk Description:

Failure to maintain and/or adhere to **effective governance and decision making arrangements**, and/or **insufficient understanding of the complexities of a decision** may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.

Controls	Assurance	Gaps	Actions
	Level 1: reassurance		

In accordance with the NHS Code of Governance, the delivery of good governance is controlled through an effective Board of directors, with an appropriate balance of skills and experience to enable them to discharge their respective duties and responsibilities effectively. The purpose of the organisation and the vision set by the Board are the starting point for the system of governance which is set out in the Integrated Governance Framework (IGF). 2024 'spring clean' of IGF and reframing so as to simplify description of the governance architecture and include clarity of accountabilities (individuals and committees). Systematic approach to strategic planning, risk management and performance management – enhanced through Enabler 1 – visualising the organisational structure, governance and assurance framework and performance management framework – collectively, the 'Operating Framework'. Board and Executive Team Development programme to ensure balanced and collaborative relationship	The Nominations, Remuneration and Terms of Service Committee (NEDs) and Nominations and Remuneration Committee (Governors) review the composition, balance, skills and experience annually as per minutes of meetings and Board refresh. Jan 2024 reshuffle of Committee Chairs / members to protect independence of judgement. Board self-assesses (and CoG) against various statements and declarations with evidence of compliance to include – AGS, Corporate Governance Statement (2022). Annual Report declarations, Code of Governance comply or explain, EPRR statement and various Annual Reports – H&S, Infection Control, Safeguarding, Quality Accounts, Modern Slavery Statement etc Level 2: internal - Annual Governance Statement reviewed by Audit Committee and Auditors annually, next review due Apr-Jun 2024; - Strategic Objectives approved by Board, with progress against objectives reported to Board Committees and Board; - Quality Committee, Finance & Investment	GAP (Controls): Not resolving longer term issues around operational performance management or taking a longer view of achievement of Strategy (rather than fire-fighting issues). Potential gap in governance structure and not yet being plugged by improved Integrated Performance Reporting to the Board since 2021/22 – discussion can still focus on way the data is presented rather than what it says in terms of issues or sub-optimal performance. Lack of Board discussion on long-term operational impact upon services of performance issues or risks may lead to lack of decision around whether or how to continue to run certain services. Risks could cycle and stall on risk registers. Gap remains relevant in February 2024 until IPR developments complete and strategy and risk better integrated. The gap has been exacerbated by the clinical outage from which the Trust has not yet fully recovered - report due to April IMG meeting. Until recovered there is an ongoing reliance on manual interventions to collect full suite of data which compromises timely data collections for	Risk rating increased to 12 in November 2021, pending assurance that capital project (PICU) gaps resolved. Finance & Investment Committee (FIC), Audit Committee and Board) during 2022 received assurance that programme and project governance strengthened Major Projects is now a separate risk included on the BAF at 3.14 to monitor major projects e. g. Warneford redevelopment (see 3.14 for more detail). PICU learning presented to Audit Committee and embedded in project oversight process. Action closed. Consequently, overall risk Likelihood is agreed to be reduced back to 2 from 3. However, risk rating to remain under review if clinical outage gap not closed by the next review date. ACTION: review after April IMG meeting and return rating to 12 if not resolved and our ability to govern performance confidently not restored. Enabler 1 – Operating Framework – simplifying description of governance architecture – Governance Framework to be approved by Board, and description of organisational structure. OWNERS: Director of Corporate Affairs & Co Sec (Governance Framework) Director of Strategy and Partnerships (Delivery/Op F

and to question status quo. Honest self-reflection through such as 'True for Us' curiosity and Well Led Framework self-assessments. Policy and Procedure frameworks to include: - Trust Constitution and Standing Orders for the Board and Council (CORP01) (next review due 2025); - Standing Financial Instructions and Scheme of Delegation. (next reviews due Sept 2024) - Integrated Governance Framework (IGF); reviewed as above; - Engagement Policy (significant transactions); - Procurement Policy (CORP04) and Procurement Procedure Manual; Investment Policy (CORP10), Treasury Management Policy (CORP09) review dates monitored through policy oversight process; - Annual Planning process linked to strategic delivery; - Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts / hospitality); - Processes for capturing meeting minutes to log: consideration of discordant views, discussion of risks, and decisions;	Committee, People, Leadership & Culture Committee and Audit Committee at every meeting review management of significant risks and key governance issues; - Escalation reports from the Sub Committees to Board Committees and on to Board (3 As reports); - Annual Report and reports for Council of Governors to demonstrate engagement with Governors and FT members. Level 3: independent - Internal Audit review of governance arrangements; Internal Audit reviews have included reviews of Quality Strategy & Governance, Clinical Audit, Electronic Health Record Programme Governance, the Research Governance Framework, Information Governance, the Board Assurance Framework, Risk and Quality Governance and the Feb 2024 Counter Fraud review of conflicts of interest – minor improvements; - Annual External Audit (including review of risk management /governance) informing the Head of Internal Audit Opinion;	national reporting and local intelligence	TARGET: first phase March 24 Governance Framework Executive Director of Strategy & Partnerships in post from April 2022 and has refocused BAF risk 3.7 on ineffective business planning arrangements which may lead to the Trust failing to achieve its strategic ambition etc. Next Annual Plan 24/5 due to Mar CoG and BoD - Bringing together draft Directorate service priorities and financial position. Once finalised by the end of March 2024, the Annual Plan will provide a single view of the Trust's key priorities for 2023/24 to inform internal decision-making and better influence the healthcare systems in which the Trust operates. The finalisation of the strategic planning work with the Board will drive reviews of the BAF and the IPR including the focus of the Board on variance/exception. Feb 2024 Audit Committee – supported following finalisation of annual plan a review as to whether the Trust's business cycle appropriately aligned with and attuned to the system (e.g. winter pressures, system strategy/planning etc) OWNERS: Director of Corporate Affairs & Co Sec, and Executive Director of Strategy & Partnerships. TARGET DATE: April 24; BAF review against agreed strategic plan Feb 2024

- Risk Management Strategy/Policy; - Board Assurance Framework; - Trust Risk Register and local risk registers at directorate and departmental levels; - Business continuity planning processes and emergency preparedness; - Council of Governors (COG), COG Working Groups and development sessions and involvement in Trust forward plans and CoG agendas. - Speak up systems embedded – whistleblowing policy, F2SUG, Wellbeing Guardian (NED), PALS & Complaints and policies, compliments, surveys, IWGC, governors. SID role attached to NED lead role for Whistleblowing processes. F2SU Guardians in place and report frequently to Board on trends/themes	- Well Led inspection (CQC) March 2018/19; and - Positive Well Led review focused on Quality Governance, conducted by the Good Governance Institute (reported in December 2022, presented to the Board in December 2022-January 2023) (semi 'independent') – Reports from F2SU Guardians directly to the Board of Directors to include Annual Report	GAP (Controls): Risk Appetite Statement agreed by Board to support sound decision making and avoid inopportune risk taking or overly cautious approaches stifling growth/development. GAP (Controls): COG working groups paused for COVID-19 pandemic. Gap closed. GAP (Controls): Effectiveness of processes in identifying if systems have failed an individual thereby being compelled to use F2SU Guardian or whistleblowing routes – impedes opportunities to improve management /leadership systems.	Risk Appetite considered with Board and Audit Committee (last in March 21). Latest version shared with ExELT Feb 2024 and Feb 2024 Board workshop. OWNER: Director of Corporate Affairs & Co Sec/Board of Directors TARGET DATE: approval to Board in Q1/Q2 FY25. COG working groups reinstated and now reestablished. <i>Gap & Action Closed</i>. Invitations to observe Board Committees will continue with ongoing potential to make old subgroup structures redundant. Effectiveness of Speaking up arrangements to be 'tested' with Board to include how well the Board 'listens up' Discussed at Board workshop on 28 February 2024.

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

3.7: Ineffective business planning arrangements

Date added to BAF	Risk description revised July and September 2022			
Monitoring Committee	Finance and Investment Committee		Impact	Likelihood
Executive Lead	Executive Director of Strategy & Partnerships			Rating
Date of last review	24/04/24	Gross (Inherent) risk rating	4	4
Risk movement	↔	Current risk rating	4	3
Date of next review	July 2024	Target risk rating	3	2
		Target to be achieved by	2024	

Risk Description:

Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.

Potential enablers in order to mitigate the risk:

- develop a strategic plan and an integrated business plan for the organisation;
- realign performance management metrics to these plans; and
- monitor and align the delivery of strategic programmes across the Trust.

Controls	Assurance	Gaps	Actions
- Strategic Framework including 5-Year Strategy 2021-26 and Digital Health and Care Strategy 2021-26; First iteration of Strategy Delivery Plan being finalised for use by Trust Leadership Team to guide delivery of current strategy and as basis for engagement process with staff, patients, carers and partners to develop next Trust's strategy. Strategy team fully resourced as of April 2024 and is implementing and embedding the strategic delivery approach for the Trust.	Level 1: reassurance	Service Change and Delivery (SCAD) Team disestablished (Oct 2023) following consultation process and resources now embedded in directorates. Data outage means that planning work for 2024/25 will not include robust and systematic trajectory-setting process for all directorates and that objectives will not be as SMART as required. Although process to make plan more quantitative will start as part of 2024/25 planning process, it will require further trajectory	Following disestablishment of SCAD team, develop new reduced central approach for Change and Programme Management oversight and implement. OWNER: Exec Director of Strategy & Partnerships and relevant Executive Leads for each delivery area. Change Management Group established to develop a central model to change identification and management. Project and Programme best practice
	1 year cycle of strategy development completed with Trust Board resulting in first iteration of Strategy Delivery Plan now finalised. Corporate Strategy Governance is being set up to oversee the progress of the Strategy Delivery Plan.		
	Level 2: internal		
	Integrated Performance Report to the Board in public currently being revised with focus on delivery against the strategic objectives via the strategic dashboard and performance against		

Annual Planning process (jointly led by Finance and Strategy and involving: Performance & Intelligence, HR, Capital and Business Services team) is near competition. Final draft of the 24/25 Annual Plan to be submitted to the Trust Board in May 24 for sign off.	key performance measures. Integrated Annual Planning Process co-lead by Finance and Strategy and reporting to Executive Management Committee Bi –annual reporting to the Board to provide oversight of Trust Annual Plan. Board strategy workshop scheduled for November 24 to develop strategic planning.	and metrics development work as part of 2025/26 planning process. ICS Planning process not fully established, also limiting ability to progress this work in the Trust. Workforce Planning function and leadership is a gap. Need to clarify performance processes, resources and leadership. Trust could benefit from medium term (3 year) plan to tie together finance and service	frameworks reviewed for Trust wide approach. Develop Annual Plan for 2024/25, iterate process for 25/26 aiming to embed trajectory setting and more quantitative approach. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. Limited quantitative measures included within the 24/25 Annual Plan. Continue to iterate process for 25/26 aiming to embed trajectory setting and more quantitative approach.
	Level 3: independent	improvement/sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an implementation for the Trust strategy.	Track delivery of 2023/24 Annual Plan and report to the Board, aim to iterate this reporting process so it becomes more quantitative in 2024/25 and 2025/26. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. Board updated on the progress of the 23/24 Annual Plan (Nov 23 and March 24). Support development of ICS Planning process (link with BAF risk 3.1). OWNER: Exec Director of Strategy & Partnerships. Collaborative process in place for National planning 24/25 (Mental Health activity). Collation and alignment of priorities, MH trajectories and support to systems

		goals through from MH place-based board to ICB. Put in place Strategic Delivery approach to identify and align strategic programmes of work to current Strategy Delivery Plan and report to Trust's Leadership and Board. Put in Place new Board Strategy development cycle and governance. OWNER: Exec Director of Strategy & Partnerships. Corporate Strategy Governance is being set up. Strategic Programmes have been identified and are being aligned to the delivery plan. Regular reporting is in place through the Strategic Delivery Group (SDG), Executive Forum and Board. Workforce Planning approach and leadership to be identified. OWNER: Executive Team Proposal for Performance processes, resourcing and leadership to be developed. OWNER: Executive Director of Strategy & Partnerships. IPR to be iterated to reflect Strategy development and performance work. OWNER: Executive Director of Strategy & Partnerships. Strategic Dashboard developed to show strategic ambition and outcome measure for

			each strategic objective as well as performance against key performance measures. This will be signed off as part of the 24/25 Annual Plan.
Strategic Objective 3: Make the best use of our resources and protect the environment			

3.10: Information Governance & Cyber Security

Date added to BAF	12/01/21				
Monitoring Committee	Finance & Investment Committee		Impact	Likelihood	Rating
Executive Lead	Chief Finance Officer	Gross (Inherent) risk rating	5	4	20
Date of last review	08/03/24	Current risk rating	4	3	12
Risk movement	↔	Target risk rating	3	3	9
Date of next review	June 2024	Target to be achieved by			

Risk Description:

Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions); cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; and reputational damage.

Controls	Assurance	Gaps	Actions
- Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing; - Information assets and systems are risk assessed using standard Data Protection Impact Assessment (DPIA) tool; - 'Third Party Cyber Security Assessment' (checklist & questionnaire) developed, to provide a systems requirement specification and to ensure any new Information Systems being procured adhere to DSPT Cyber Security standards;	Level 1: reassurance	In August 2022, IT failure with patient record systems provided and externally hosted by a third-party supplier led to staff being unable to access patient record systems and clinical information, thereby leading to risks to staff and patient harm. Trust internal operational and cyber security not compromised. The clinical system outage, which resulted from the failure with third party supplier-hosted patient record systems,	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
	Level 2: internal		
	- Information Management Group (IMG); - Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group - Finance & Investment Committee receives reports from IMG - Monitoring of IG training attendance; - Incident management and response process (enhanced to meet DSPT requirements) - NHS Digital Data Security and Protection Toolkit (DSPT) annual self-assessment.		

Systems access control and audit managed by way of: programme of penetration testing (annually from 2020); cyber security assessed and tested prior to 3rd party contracts being awarded; Implementation of new Security information and event management system (SIEM) has taken place. Event logs are now being automatically monitored for suspicious activity; Microsoft Defender for mobile has been applied to mobile devices managed by InTune. Those devices now have malware and web filtering applied.; Privileged Access Management (PAM) has been implemented which controls and constrains access to elevated administrative accounts on the network; USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender Advanced Threat Protection); - Mail filtering system to flag or block suspicious, malicious or unsafe communications, to limit the flow of phishing emails, malware and/or unsafe URLs;	- Programme of Phishing simulation/testing of all staff and subsequent report (annual from 2023)	has prevented the Trust from submitting mandatory data-set information and contractual information to commissioners, which could lead to contractual and reputational consequences. R&D Trials are also facing delays due to gaps in data.	recovery work will report on the data available but some gaps in data will continue because: (i) whilst mitigations have been put in place to ensure that the data that was captured during the outage is accessible to clinicians, it will not be possible to use this data for external reporting; and (ii) reduced functionality of the new systems RIO and EMIS, due to the pace at which these needed to be implemented, means that some data will not be available for reporting and analysis purposes until the full functionality is implemented.
	Level 3: independent	Penetration testing undertaken in Feb 2024 identified several risks which are being remediated as a priority by the operational IT teams involved.	Funding and approval to recruit to enhance the cyber security team has been secured and recruitment is ongoing. ICO Data Protection audit (achieved 'Reasonable' assurance), November 2021. ICO published Audit completed. BAU for partially accepted actions. Lack of Cyber Security specific awareness training has been raised at ICS level to explore the potential for a joint approach and will be a subject covered by the ICS collaborative working group. Direction and guidance is being sought from the SIRO before any work begins on an awareness training solution, which would likely need to be a collaborative effort between L&D and Cyber. Phishing Simulation Report (Aug 2023) produced for the SIRO and next steps being discussed for IMG, Execs and Audit Committee awareness. OWNER: Head of IT User account deletion process is being strengthened to ensure timely disablement and deletion of leavers accounts. A new process ensuring NHSP provided resources are known and all have end dates supplied at the beginning of their assignments
	- Improved NHS Digital's BitSight cyber rating, which exceeds peers in benchmarking and is in top 30% of organisations globally. - VMS Vulnerability Scanning, and NCSC WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated; -Independent, annual penetration test planned for Q1 annually; Independent DSPT annual audit for external assurance; -Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. - Secure messaging accreditation achieved/maintained (NHS Digital DCB1596);		

- Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises; - Cyber Security Awareness and Cyber Security SharePoint sites		handling suspicious Web, Teams, and Email content, Staff awareness of such threats is only partially mitigated via existing guidance. The Trust needs a dedicated mandatory customisable targeted Cyber Security Awareness Training solution, providing audited participation, knowledge validation and success metrics and reporting, to significantly mitigate the risks from poor cyber security behaviours. Desktop Third Party Software Patch 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.	has been created. Further analysis and actions to ensure all leavers are identified and removed is taking place. OWNER: Head of IT All Trust managers ensure mandatory Training completed. OWNER: Head of IG

Strategic Objective 3: Make the best use of our resources and protect the environment**3.12: Business continuity and emergency planning**

Date added to BAF	19/01/21			
Monitoring Committee	Emergency preparedness, resilience and response (EPRR) committee (sub-group to Executive Management Committee) and Audit Committee		Impact	Likelihood
Executive Lead	Director of Corporate Affairs & Company Secretary	Gross (Inherent) risk rating	5	3
Date of last review	13/02/2024	Current risk rating	3	3
Risk movement	↔	Target risk rating	3	3
Date of next review	August 2024	Target to be achieved by		
				Rating
				15
				9
				9

Risk Description:

Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.

Key Controls	Assurance	Gaps	Actions
- Accountable Emergency Officer (currently Director of Corporate Affairs & Company Sec), supported by a clinical director; - Designated Emergency Planning Lead, supporting the executive in the discharge of their duties; - EPRR committee 3 x per year oversees emergency	Level 1: reassurance		
	- Emergency Preparedness Resilience and Response (EPRR) Committee 3 x per year; - Psychosocial response group (sub-group of EPRR committee); - Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee.		
	Level 2: internal		

preparedness work programme with representation from directorates, HR, and estates & facilities. - Psychosocial Response Group (subgroup reporting to EPRR committee. - Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic; - EPRR Response Manual incident response plan - (updated February 2024) provides emergency response framework; - On call system; - Directorate/service specific Business Continuity Plans (BCPs) in place for services, in respect of: Reduced staffing levels (for any reason e.g., pandemic); evacuation; technology failure; interruption to utility supplies (gas & electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown;	- Annual EPRR report (most recently to the Audit Committee and the Board in Nov 2023); - EPRR Committee ensures that learning from EPRR Exercises, and live incidents, are incorporated into policy / procedure / practice. This is in addition to learning being incorporated into major incident plans, business continuity plans and shared with partners; - Self-assessment against NHS EPRR Core Standards. 2023 Full compliance Based on the quality of response to the following, reputation and resilience have been safeguarded through 'no surprises' – No serious harms from Major Incident of IT clinical systems outage; from Industrial Action; from COVID response, from OOH business continuity incident, from locality floods etc Level 3: independent - 2023 Self-assessment (as set out in annual report to the Audit Committee and the Board in November 2023) examined and accepted by BOB ICB on behalf of NHSE - There is no formal mechanism in place to		

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, 2022)). Lessons incorporated into incident response plans, business continuity plans and shared with partner organisations; - training scenarios on intranet for services to use to exercise business continuity plans; - Engagement with Local Health Resilience	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.		

partnerships, and Membership of Oxon & Bucks Resilience Groups; - Horizon scanning and review of National and Community Risk registers by Emergency Planning lead.			

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	June 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);	Level 1: reassurance	Trust is not meeting annual carbon budget FY 23 (Actuals 4960 Tco2- Target 4508 Tco2) GAP: current resource may be insufficient to implement Green Plan.	Sustainable travel Trial (EV for Community Nursing Team) commenced in May 2023, data from trial will be used to inform Trust long term sustainable travel plan. Executive team have approved Target temperature for non-inpatient areas of 20-degree C
	- 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;		

- 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	- Annual staff Travel Survey monitoring against base-line; - Annual CO2 emissions against previous year; FY23 has seen 19% reduction in carbon emissions when compared to the 2019 baseline year. Annual target of 5% reduction when compared to FY22 not met due to increase in Business mileage. - The modal shift of staff travel into more sustainable alternatives will be focus of the next iteration of Green Plan in 2025. Level 3: external - BOB ICS Net Zero Program Board - Total Carbon Footprint Plus now reported by NHS England (54,000Tco2) Trust is leading on the BOB ICS Sustainable Travel Group . - The Trust is also part of ZCOP sprint group with Oxford University to review how to adapt our building estate to climate change risk e.g., extreme heat, floods.		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)

3.14 Major Projects

Date added to BAF	20/09/22				
Monitoring Committee	Finance and Investment Committee	Impact	Likelihood	Rating	
Executive Lead	Chief Finance Officer	Gross (Inherent) risk rating	5	4	20
Date of last review	09/05/24	Current risk rating	4	4	16
Risk movement	↔	Target risk rating	3	2	6
Date of next review	November 2024	Target to be achieved by	December 2024		

Risk Description (revised June 2023):

Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; non-delivery of required savings, unplanned expenses, delays and wasted resources.

Key Controls	Assurance	Gaps	Actions
- Programme Boards for key projects. - Standing Financial Instructions and Scheme of Delegation. - Senior teams' leadership of change and focus on ensuring delivery. - Recent increases in internal programme leadership capability and reform of former Strategic Change and Delivery (SCAD) model, complemented where needed by external resource.	Level 1: Reassurance - Programme governance has been mapped out for Trust's highest priority strategic programmes. - Warneford Park Programme Board with partners chaired by Non-Executive Director of Trust Level 2: Internal - Portfolio management of Strategic Programmes and enablers being introduced in FY24 for Execs, FIC and Board; - Strategy Delivery Group introduced to support delivery of the portfolio and	a) Portfolio oversight has been designed but is not yet embedded. b) User engagement in change and change load management not always well-managed. c) Patient voice and experience is not yet routinely embedded in programmes. d) Specific challenges in Estates resourcing and model. e) Methodology for major capital programmes investment appraisal and	a) Board, Committee and Exec to feedback on and help develop new portfolio management approach. b) Enabler work on the Trust's Culture is engaging staff across the Trust on our approach to change management. c) Patient Experience and Involvement strategic programme to be implemented. d) Estates model to be developed, communicated and implemented. e) Publish new capital programmes investment

	to consider impact of changes in the round. Capital Programme sub-committee (reviews capital project progress, attended by Services, IM&T and Estates leaders) and reports to FIC; and - FIC receives specific updates on Major Projects including the Warneford programme. - Lead Non Exec for Digital in process of being appointed. Level 3: Independent - Internal audit reviews. - KPMG assurance over Frontline Digitisation programme. - ICB representation at Digital and Data Strategy Board.	project management not yet issued.	appraisal methodology before August. Owner: Chief Finance Officer

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	26/01/24
Risk movement	↔
Date of next review	May 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;	Level 1: reassurance	GAP: The clinical system outage from August 2022,	The loss of CareNotes and the move to RiO has the
	Level 2: internal		

- NIHR Infrastructure Managers meetings provides an opportunity for managers of the OH hosted NIHR awards and the R&D Director to meet regularly to ensure alignment and discussion future opportunities. On a quarterly basis these meeting will be augmented by the OUH BRC and CRF Managers. - Clinical Research Facility (CRF) steering committee - Biomedical Research Centre (BRC) Steering Committee and Partnership Board; - Oxford Applied Research Collaboration Oxford and Thames Valley (OxTV) (ARC); - 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	- Research updates and R&D reporting into the Quality Committee; - R&D reports to Board (at least twice a year), - BRC reports to Board on a regular basis Toronto - Oxford Psychiatry Collaboration also provided to the Board Level 3: independent - The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR); - Annual Statement of Expenditure Reports are submitted to DH for the BRC, CRF, ARC and MIC - 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;	which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting data-set information and contractual information which could lead to contractual and reputational consequences. R&D Trials will also face some delays due to gaps in data. GAP: Owing to the clinical system outage and issues with migration and recording of diagnosis within RIO the ability to produce accurate recruitment lists has caused severe delays in meeting recruitment 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	potential to impact all areas of research from set-up and participant recruitment through to study delivery. The Head of Research Informatics is part of the RiO programme board. • Optimisation is well underway for the Trusts new Clinical Systems, RIO & EMIS, with over 60 items going live during the period July – Dec 24, including key assessments / templates, data migration, clinics; • Over 8000 users set up on RIO & EMIS including partner organisations; • Integration now in place from RIO to EPMA, Truecolours, ICE, TVS SCR; • 64 out of 70 Oxfordshire GP Practices now sharing with EMIS Community Services; • EMIS Mobile App pilot started Dec 23; • Thames Valley and Surrey Shared Care Record is live in RIO. Monitoring through reporting into the Finance & Investment Committee (FIC) and the Board. FIC also monitoring BAF risk 3.14 on delivery of Major Projects, such as the Warneford. The R&D operational plan will be developed as part of the OH Planning process.

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.		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"	

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Table 1a: Risk Matrix

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

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

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

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

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

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

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

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

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Additional examples	Incorrect medication dispensed but not taken Incident resulting in bruise/graze Delay in routine transport for patient.	Wrong drug or dosage administered with no adverse effects Physical attack such as pushing, shoving or pinching causing minor injury Self harm resulting in minor injury Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare acquired infection (HCAI)	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure sore Long term HCAI Loss of a limb Post-traumatic stress disorder	Unexpected death Suicide of patient known to the service in the last 12 months Homicide committed by mental health patient Incident leading to paralysis Rape/serious sexual assault Incident leading to long term mental health problem



Charity and Involvement Team – Impact and Updates, May 2024

- Oxford Health Charity
- Volunteering
- Oxford Health Arts Partnership
- Involvement

Recent Projects – Oxford Health Charity

- Charity Impact and Fundraising reports are circulated at each Charity Committee and highlights have also been added to the new impact portal on the intranet:
 - [Charity Impact \(sharepoint.com\)](https://sharepoint.com)
- The ROSY Walk took place in April (alongside St Luke's Hospital) and the anticipated fundraising income is £13k (other upcoming fundraising events are highlighted on this slide)
- Strategy reports for the 23/24 end of year and 24/25 action plans were presented at the Charity Committee in May
- Philanthropic/Major Gift consultation project underway with More Partnership – interviews have commenced with key stakeholders in the Warneford Park project and other potential large scale projects across the Trust
- The new request/grant approach launched on 1 April and 22 requests were received – the initial review panel has met to discuss the requests and these will be sent on for funding shortly
- Grants and Legacies continue to be an area of focus with 3 legacies currently being worked through with solicitors and 4 grant applications submitted in the last couple of months



Blenheim Fun
Run/Walk/Jog/Wheel/with your dog!

Sun, May 19, 9:00 AM

Blenheim Palace, Woodstock, England



Bike Oxford for Oxford Health

Sun, Jun 23, All day

Oxford, England



Oxford Half for Oxford Health

Sun, Oct 13, All day

Oxford, England



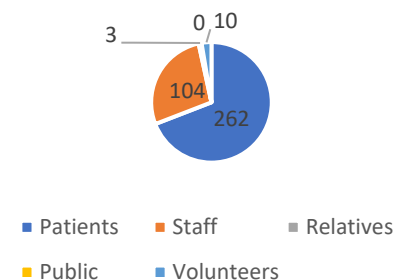
Recent Projects – Volunteering

- Completed our filming project in collaboration with Oxford Brookes post grad students – including a volunteer at OSRU, the 2023 Volunteer of the Year and staff within several departments. The aim of the video is to highlight Volunteering and Volunteer to Career within Oxford Health
- Recruitment fair attendance – Whiteleaf was positive and has resulted in some new role development ideas, all other areas booked in
- Role development discussions underway with:
 - AIM Home Art Project role – part of a research into the impact of art on pain and isolation
 - Speech and Language Therapy support role – initial discussions with OSRU and AHP leads
 - EDI project support
- Redeveloped the Volunteer training induction following the changes to the National Volunteer Certificate – accreditation has been withdrawn but NHS England are still promoting and supporting the training
- Volunteer of the Year nominations positively received for the 2024 Staff Awards
- Current Roles being recruited for:
 - Admin Support- a volunteer to help the Community Nutrition and Dietetics team gain more feedback from patients on their experience of the service.
 - Patient/Carer experience CAMHS - Raglan House
 - Patient-carer experience - Saffron House - supporting the memory clinic
 - Keystone Hub Support at both Banbury and Abingdon
 - Patient Liaison (Marlborough and Swindon)

Recent Projects – Oxford Health Arts Partnership

- 45 Art works have been placed in Saffron House
- Two new murals at Wallingford Community Hospital completed
- An Ecotherapy programme at Littlemore has been completed
- 1000 trees planted across trust sites with the support of Estates
- EIS Project at the Natural History Museum, Oxford has been completed and planning is underway for a service user exhibition at the museum in September '24
- A face to face arts course has started at Oxford Recovery College and an online arts course started with Buckinghamshire Recovery College
- Green spaces workshops at Ruby and Sapphire wards underway as well as weekly drop in sessions at the Warnford Allotment initiated for ward patients and staff
- The team welcomed volunteer medical student Thiylviaa Gangatharan for four weeks to work alongside them on research projects
- Angela and Thiylviaa won the poster competition at the QI conference for the AIM (Arts Impact Measured) home research project

OHAP Activity
Participation 2024 -
379 people engaged to date





Recent Projects – Involvement Focus

- WOMAD Grant confirmed for African Drumming workshops at Cotswold House, Marlborough and Marlborough House, Swindon
- Involvement with the Warneford 200 project team initiated
- Grants discussions and expressions of interest for Oxfordshire Community Foundation – Mental Health and Green Spaces
- Proposals to local council/developer support for
 - S106 funding for Wallingford Community Hospital for an outdoor public art project for £6250
 - SPF-06 Funding (SODC) for an arts and nature project for the outdoor space by the out of hours entrance at Didcot Community Hospital for £8,500
- GWR Grant for a partnership project with the Station, Hospital and District Council in Didcot for £10,000 (an extension of Didcot's Brilliant) applied for
- The OHAP team attended the first meeting of the newly formed National Arts Health Network at Chelsea and Westminster Hospital
- The Charity team attended the NHS Charities Together Conference
- The Volunteer team re-engaged with the NAVSM (National Association of Volunteer Services Managers)



Looking Ahead

- Assemble roll out continues for volunteers – new work around data collection for NHS England and DBS reviews under discussion and development
- Following the NHS Charities Together Innovation Grant work – initial discussions with the Melksham CAHMS/MHST on volunteering being initiated
- Confirmation of ROSY Appeal fundraising opportunity at the Wilderness Festival over the summer – approach, volunteers and fundraising targets to be set
- Oxford Health Charity Annual Report for the Charity Commission under development – impact section to cover 23/24 activity and finance section to cover all required data
- Communications Plan for Charity and Involvement under development to improve awareness and engagement with all elements of the team
- Volunteer Programme policy and toolkit review to be presented for final sign off
- Attendance at the BRC (Biomedical Research Centre) Open Day – Shaping the Future of Healthcare – alongside the Oxford Hospitals Charity and AIM project stands

Appendix 3

Communications and engagement report March and April 2024

Staff engagement

We celebrated the following winners of our Exceptional People Award with an event hosted by Grant Macdonald, CEO, and Anna Gardner, Lead Governor, in March.

Senior Care Coordinator and Cognitive Behavioural Therapist Keeley Nichol won January's Individual Award for her work to support vulnerable children, young people and their families and carers. The team award for January went to the Buckinghamshire Psychological Therapies Admin team who have supported one another during tough times.

The February individual award was won by Senior Community Learning Disability Nurse, Tracy Scott. Tracy works in the North Community Learning Disabilities team in Oxford. The team award for February was won by the Witney Community Hospital Housekeeping/Porters Team who go above and beyond to maintain cleanliness and safety on the front line at Witney Community Hospital.

During March and April, we marked International Women's Day with a themed all staff briefing, celebrated Neurodiversity week, and Autism Acceptance week with recognition for staff working in those services and the adjustments we can all make to ensure our patients and staff with neurodivergency are accepted and welcomed. We recognised Stress Awareness month in April with sessions on how to maintain wellbeing and the services available to staff to support them.

Twelve colleagues have been named as finalists for the Royal College of Psychiatry awards, including Dr Monty Lyman who will be guest speaker at our Annual Members Meeting in September [Oxford Health psychiatrists take the podium at RC Psych Awards - Oxford Health NHS Foundation Trust](#)

Personal Development Review season was launched and over 800 PDRs were recorded in April alone. We also fed back to staff about the outcomes of the 2023 Staff Survey, and launched the latest People Pulse survey, and Travel survey. We ensured staff observing Ramadan were recognised and supported while fasting, and marked the other religious festivals of Pesach and Easter at the relevant times.

Accessibility training has been launched across the Trust, hosted by the communications team, enabling colleagues working in all professions to understand how to create information which is accessible to all, and these have been very well received. Further sessions are planned.

Media

The Trust gained national media attention for the research work on blood biomarkers in dementia which featured Dr Vanessa Raymont. Dr Raymont is R&D Director for the Trust, Senior Clinical Researcher and Honorary Consultant Psychiatrist at the University, and was interviewed on BBC Breakfast, 6pm news, 10pm news and BBC Radio 4, speaking about the work Oxford is doing in this important area. Coverage was uniformly positive across all BBC channels including their website [Alzheimer's: Thousands to trial blood tests for dementia - BBC News](#).

The Trust provided statements for the relevant inquests over this period.

Stakeholder engagement

The Meadow Unit (PICU) for young people was formally opened in March by Anneliese Dodds, local MP and Chair of the Labour Party. Ms Dodds toured the unit, met the ward teams, learnt about the background to the new build and the demand for its services, and heard about the work of the Thames Valley provider collaboratives. Representatives of the Oxford Health Charity and the artists who contributed to the visuals inside the building also met with Ms Dodds and discussed their work with her. She commented favourably about the work of the Trust and this service on her social media channels.

The Trust widely publicised the elections to our Council of Governors seats throughout March to engage with the public, service users and carers and staff, ensuring the elections to proceed successfully. The relaunched Members newsletter ensures FT members are updated on all of the Trust's activity.

Work continues to communicate a range of transformation programme projects within the Community Health Services, Dentistry and Primary Care Directorate. The 0-19 integrated care service for children and young people began to be rolled out from April 2024, with refurbishment timelines now confirmed for the estates works at Witney Community Hospital and The Fiennes Centre in Banbury. Progress continues to be made in the development of Oxford's three new City Healthcare Hubs, with the lease on Murray Hill in Jordan Hill signed at the end of March 2024.

Finally, progress continues to be made - through on-going local community engagement - in confirming the additional services that will be provided through a refurbished ground floor at Wantage Community Hospital, subject to a successful community investment levy bid with the local council.

The Trust also marked five years of partnership with the Mental Health First Aid (MHFA) project, which aims to support people to have supportive conversations with those experiencing mental ill-health, either in crisis or calmer circumstances. 542 colleagues have received this training, with the continued aim of having one in every ten staff trained in mental health first aid.

Audit Committee
Minutes of the meeting held on
22 February 2024 at 09:30
via MS Teams

Present¹:

Chris Hurst	Non-Executive Director (the Chair/CMH)
Rick Trainor	Non-Executive Director (RT)
Mohinder Sawhney	Non-Executive Director (MS)

In attendance:

External Audit - Ernst & Young LLP (EY)

Maria Grindley	External Audit – Partner, Ernst & Young (MG)
Claire Mellons	External Audit - Senior Manager, Ernst & Young (CM)

Internal Audit and Counter Fraud – KPMG

Adam Makda	Local Counter Fraud Specialist (LCFS) – KPMG (AM)
Jack Stapleton	Internal Audit – KPMG (JS)
Neil Thomas	Internal Audit – Partner, KPMG (NT)
Katrina Tumilty	Internal Audit- KPMG (KT)

Oxford Health NHS FT

Attending Board members

Grant Macdonald	Chief Executive (the CEO/GM)
Kerry Rogers	Director of Corporate Affairs & Company Secretary (the DoCA/CoSec /KR)
Heather Smith	Chief Finance Officer (the CFO/HeS)

Other Trust staff in attendance

Brian Aveyard	Risk, Assurance & Compliance Manager (BA)
Ben Cahill	Deputy Director of Corporate Affairs (the Deputy DoCA/BC)
Peter Milliken	Director of Finance (the DoF/PM)
Tara O'Brien	Head of Resourcing (TOB) – <i>part meeting</i>
Hannah Smith	Assistant Trust Secretary (HaS) (Minutes)

The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members and Auditors and Counter Fraud.

¹ The quorum is 3 members (all Non-Executive Directors) and may include deputies.

1. a b c	Welcome and Apologies for Absence The Chair welcomed attendees to the meeting. Apologies for absence from Committee members were received from David Clark, Non-Executive Director. Apologies from non-Committee members were received from: Charmaine De Souza, Chief People Officer; Will Harper, Head of IT; and Michael Williams, Financial Controller.	
2. a b c	Minutes of the Meeting on 21 November 2023 and Matters Arising The minutes of the Audit Committee meeting on 21 November 2023, at paper AC 01/2024, were approved as a true and accurate record subject to: - amending the reference at item 6(f) to refer to significant demand for district nursing and community services; - amending item 7(b) to refer to 'control' not 'controller'; and - creating an action at item 15 for the Director of Finance to provide an update on changes in agency fee structures. Matters Arising The following actions were noted as complete (with supporting detail in the Summary of Actions document) or on the agenda for this meeting: - item 6(g) – check staff clear on process to reduce risk ratings (see detail in response in the Summary of Actions); - item 6(j) – updates to BAF 2.1 and 2.2 on Workforce Planning and Recruitment – risks now replaced by BAF 2.6 on Adequacy of Staffing, see item 4(b) below; <i>September 2023</i> - item 9(b) Cyber Security reporting – on the agenda, see item 9 below; <i>June 2023</i> - item 4(c) Health & Safety training – included in Internal Audit planning, confirmed by Neil Thomas to the meeting; and - item 5(e) People, Leadership & Culture Committee oversight and further review of the Internal Audit of Learning & Development – complete, confirmed by the Chair. The remaining actions were noted as in progress or not yet due: - item 14(f) – Committee self-assessment – hold for workshop discussion from September/October 2024 when impact of change of Chair can also be considered alongside work on how the various Board Committees interact and report to the Board; <i>September 2023</i> - item 5(c)&(e) BAF 3.4 (delivery of the financial plan and maintaining financial sustainability) scheduled for Q4 FY24 – anticipated for June 2024 meeting; and <i>June 2023</i> - item 6(a) Risk Management policy, scheduled for April-May 2024.	HaS

3. a	Committee workplan Maria Grindley, EY, to provide some updates out-of-session.	MG(EY)/ HaS
RISK & ASSURANCE		
4.	Board Assurance Framework (BAF) - Audit Committee risks and areas of interest to support the Annual Governance Statement	
a	The Director of Corporate Affairs & Company Secretary presented the report at AC 02/2024 which set out: - the risks which the Committee had monitoring oversight of (BAF 3.6 on Governance and decision-making arrangements and BAF 3.12 on Business Continuity and Emergency Planning); and - the new risk at BAF 2.6 on Adequacy of Staffing, which replaced former BAF risks 2.1 and 2.2 on Workforce Planning and Recruitment and which the Committee had previously requested further work on. BAF 2.6 (Adequacy of Staffing)	
b	The Committee noted apologies from the Chief People Officer for the meeting and discussed BAF 2.6 which had replaced BAF 2.1 and 2.2 on Workforce Planning and Recruitment to achieve greater interconnectivity between these themes and their mitigations. The People, Leadership & Culture (PLC) Committee in January 2024 had already reviewed and commented upon an earlier version of BAF 2.6. Mohinder Sawhney, Chair of the PLC Committee, commented that BAF 2.6 represented a good step forward in the articulation of this risk area and although there would be more work to do in order to refine it, the version presented to this Committee had incorporated feedback from the PLC Committee. The Chair commented upon the more holistic approach being taken to addressing Workforce and Recruitment enduring challenges and progress being made across a number of different fronts; the approach being taken over the last year to broaden the Trust's response in this area was overall encouraging. In addition, the Committee would be receiving an Internal Audit review report on the Recruitment Process at item 7(d) below.	
c	The Chief Executive noted that the next review date should be updated. Mohinder Sawhney added that BAF 2.6 would be reviewed at the next PLC Committee meeting on 30 April 2024. The Chair requested that BAF 2.6 also be brought back for a deep dive by the Chief People Officer at this Committee's next meeting on 23 April 2024. BAF 3.6 (Governance and decision-making arrangements) and BAF 3.12 (Business Continuity and Emergency Planning)	CDS
d	The Director of Corporate Affairs & Company Secretary explained that the Current Risk Rating for BAF 3.6 had been reduced from 12 to 8 (but was still an overall orange/high risk) further to learning from the Psychiatric Intensive Care Unit (PICU) project having taken place and ongoing monitoring of major project risks through BAF 3.14 (Major Projects)	

	which was monitored by the Finance & Investment Committee. The risk retained an overall orange/high Current Risk Rating and had not yet progressed further towards its yellow/medium Target Risk Rating as there was still work to do to strengthen operational performance management: (i) so that risk management did not take on a performance management role; and (ii) whilst the Integrated Performance Report to the Board was being re-worked, although it was promising that Enabler 1 of the Operating Framework (visualising the organisational structure, governance and assurance framework and performance management framework) had been developed.	
e	The Chair acknowledged that BAF 3.6 was now at a stage when it was necessary to stand back and synthesise the good work and learning that had taken place. The Chief Finance Officer referred to the first Gap listed against the risk's Controls, around a systemic tendency towards short-termism/not looking around corners and noted that she no longer recognised this in terms of Board and Committee behaviours. Mohinder Sawhney suggested that it might be helpful to: (i) have a broader conversation about some of the pressures of the business cycle and the way provider organisations were led to focus on particular areas such as winter pressures; and (ii) consider what drivers may mitigate against the risk of having insufficient understanding of the complexities of decisions which the Board needed to make. The Chief Finance Officer noted that whilst the NHS was vigilant in relation to potential winter pressures, these were accounted for in financial planning, and she had yet to see any unplanned for winter pressures emerging at this organisation.	
f	The Chief Executive challenged the reduction in the scoring of the Current Risk Rating on the basis of learning from the PICU project, noting that this may have been overtaken by the ongoing impact of the clinical systems outage, combined with recovery from the pandemic. The Chair acknowledged that the clinical systems outage had had a longer than expected impact and it would be timely to refresh the risk accordingly. The Chief Finance Officer added that BAF 1.1 was being updated from its former focus upon triangulating data and learning to drive Quality Improvement to a revised focus upon utilising digital, data and technology to drive quality, efficiency, economy, research and innovation. BAF 1.1 (monitored through the Quality Committee) would therefore pick up Gaps in more detail on the impact of the clinical systems outage. The Director of Corporate Affairs & Company Secretary took an action to further refresh and refine BAF 3.6, in particular focusing upon updating the first Gap against Controls/Assurances and including reference to the impact of the clinical systems outage, whilst acknowledging that more detail on the outage would be contained within BAF 1.1.	KR
g	The Committee reviewed BAF 3.12 (Business Continuity and Emergency Planning) and noted that recent power outages had confirmed the effectiveness of the arrangements.	
h	The Committee noted the report and that BAF risks 2.6 (Adequacy of Staffing) and 3.6 (Governance and decision-making arrangements) would be brought back to the next meeting on 23 April 2024.	

YEAR-END PLANNING FOR ANNUAL REPORT & ACCOUNTS WITH EXTERNAL AUDIT		
5.	Timetable and process planning for Annual Report & Accounts	
a	The Deputy Director of Corporate Affairs and the Director of Finance presented the report at AC 03/2024 which set out key dates and processes to support the production of the Annual Report & Accounts FY24. The Director of Finance highlighted that the draft Remuneration Report, part of the Annual Report, would be considered for approval by the Nominations, Remuneration and Terms of Service Committee over April 2024. The Chair noted that the level of ambition was broadly the same as for the previous year. The Committee commented upon the key facts and figures document ('Oxford Health in Numbers') which had accompanied the Annual Report & Accounts FY23 and noted that it had been an accessible and valuable accompanying document which would be useful to provide again and would help readers to understand the Trust's business and operations.	
b	The Committee noted the report.	
6.	External Audit FY24 Planning Report	
a	Maria Grindley, EY, presented the report at AC 04/2024 which set out the External Audit approach and scope for the FY24 audit of the financial statements; she noted that the planning was further progressed this year, a final plan was being presented and interim work was already underway or had been completed. An initial assessment of the fraud or significant risk areas to be considered included: misstatement due to fraud or error; risk of fraud in revenue and expenditure recognition; and valuation of land and buildings. Inherent risks which would also be considered included: International Financial Reporting Standard (IFRS) 16 (Leases) which would be relevant for any amendments to current leases or to new leases such as for the Warneford site; deferred income; and the Annual Report including the Remuneration report and exit packages. She noted that the planning report could still be updated and if there were any additional implications from the Warneford project or Private Finance Initiative (PFI) arrangements (in FY24 there was a national mandate to transition PFI liabilities from International Accounting Standard 17 to IFRS 16) then these could be included and the Committee would be updated if there were any implication for the Audit Opinion or the Value For Money assessment. The Chief Finance Officer noted that the national mandate on PFI arrangements was likely to be relevant if it required recognition this financial year, even if it may not be of significant materiality.	
b	The report also noted that Going Concern disclosure and Opening Balances risks which had been identified in the prior year audit for FY23 were no longer significant accounting and auditing matters for the current year. Planning materiality had been set at £12.2 million, representing 2% of FY23 operating expenditure, whilst performance materiality had been set at £6.08%, representing 50% of materiality.	
c	The Committee noted the report.	

INTERNAL AUDIT & COUNTER FRAUD	
7.	Internal Audit progress report and approach to the development of the FY25-26 Plan
a	Neil Thomas, KPMG, presented the report at AC 05/2024 which provided an update on the progress of the Internal Audit Programme for FY24 and a review report on the Recruitment Process. Fieldwork had been completed for the Bank Booking Process review and had commenced for the reviews into Risk Management and Data Quality. An initial shortlist of topics for the FY25 and FY26 Internal Audit Plan had been discussed with the Executive and appended to the report.
b	The Chair emphasised the importance of the Internal Audit service and of following up on Internal Audit recommendations in order to be of most value to the organisation. He referred to the proposed topics for the FY25 and FY26 Internal Audit Plan and noted that these looked sensible. In relation to the proposed FY25 review of Patient Experience, he asked whether it could consider the adequacy of arrangements for identifying and triangulating common themes between various sources, such as complaints. Although the complaints process might be geared towards providing a meaningful response and resolution for a particular individual who was raising a complaint, the organisation should be able to stand back and identify any patterns or common themes arising from complaints investigations. Mohinder Sawhney added that the Trust's capability and capacity to triangulate data from across various sources would be key in strengthening the organisation. Neil Thomas acknowledged the importance of triangulating and understanding information from various data sets, noting that in the field of Counter Fraud the Trust may find that concerns were being raised through various channels including Freedom to Speak Up, employee relations, HR grievance cases and Counter Fraud.
c	The Chair referred to the proposed FY26 review of Provider Collaboratives and asked whether this could consider any particular risks for the Trust as host of the Provider Collaboratives, including any fraud exposure. Mohinder Sawhney added that in addition to considering financial exposure, other forms of exposure such as quality exposure arising from the Provider Collaboratives might also be useful to include. Neil Thomas replied that there was still some time to develop the FY26 review list and this would be discussed in more detail with the Committee. The Chief Executive reminded the meeting that an initial review on the Forensic Provider Collaborative had already taken place but it was still early days for Provider Collaboratives generally and the outcomes which they could achieve across a variety of services; an initial status report may be more suitable along with careful consideration of what was intended to be achieved through the various Provider Collaboratives before measuring whether this was happening. The Chair concurred.
	<i>Recruitment Process review report (significant assurance with minor improvement opportunities)</i>
d	Tara O'Brien, Head of Resourcing, joined the meeting and presented the Recruitment Process review report which had 2 medium and 4 low risk recommendations. In relation to

	the two new starters who had been found not to have had their right-to-work documents verified in person by their hiring manager, she confirmed that processes had been put in place to ensure that this would not happen in the future. She also reported that the other findings from the report were in progress and a new phone/call centre system for the Recruitment team would be implemented in the next 2 weeks which would enable more monitoring of call volumes. Jack Stapleton, KPMG, added that the Committee could take assurance from the report that overall recruitment processes and controls were working and the new People Steering Group would address the timeliness of some recruitment activity. In response to a question from Mohinder Sawhney on opportunities to improve further or learn from good practice in other comparable organisations, Jack Stapleton noted that there could be opportunities to increase efficiencies and speed up processes for approvals of vacancies for hiring managers and pre-employment checks. The Head of Resourcing added that there was a Quality Improvement project underway to speed up the offer process and support hiring managers. The Chief Executive noted that the Extended Leadership Team had also reviewed the recruitment process; the review report was acknowledged as a fair reflection but it was noted that hiring/recruiting managers could also sometimes be responsible for contributing to delays in the process and were as much a part of the timeliness of the process as the Recruitment team.	
e	The Chair asked about passporting staff between organisations, noting that there may be opportunities to do this more efficiently across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS). The Head of Resourcing replied that she was currently working on moving to a mandatory Disclosure and Barring Service update service for staff which would facilitate moves across the BOB ICS and with other trusts.	
f	The Committee noted the progress report, the approach to the development of the FY25 and FY26 Internal Audit Plan and the findings of the Recruitment Process review. <i>Tara O'Brien, Head of Resourcing, left the meeting.</i>	
8.	Counter Fraud progress report and approach to development of the FY25 Plan	
a	Adam Makda, KPMG, presented the report at AC 06/2024 which provided an update on the progress of the Counter Fraud Programme for FY24 and a Conflicts of Interest (including gifts and hospitality) review report. An initial shortlist of topics for the FY25 Counter Fraud Plan had been discussed with the Executive and was appended to the report; a final Counter Fraud Plan would be provided to the next meeting in April 2024. <i>Conflicts of Interest (including gifts and hospitality) review report</i>	
b	Adam Makda summarised that the report had identified good practice and made three low risk recommendations. He highlighted that the 75% decision-maker compliance rate for declarations of interest was not necessarily low for the NHS nor was it unusual to see that the majority of unsubmitted declarations related to consultants; work had already been taking place to improve upon declarations from consultants through a dedicated online form for consultants and senior dentists to use as part of their annual job planning.	

c d e	<i>FY24 progress report and approach to the FY25 Counter Fraud Plan</i> The meeting reviewed the recently closed cases listed on page 8 of the report, in particular the allegation of a staff member working elsewhere whilst reported as on sick leave from the Trust. The case had been closed and the subject no longer worked for the Trust however it had highlighted the importance of properly managing sickness absence and issues with outsourcing monitoring of sickness absence to a third party. The Chief Executive reported that the Extended Leadership Team had agreed to revert from outsourcing to managing this internally and thereby increase ownership from managers. Adam Makda presented the initial shortlist of topics for the FY25 Counter Fraud Plan including Cyber Security, Core Financial Controls, Reporting Culture and Secondary Employment. He explained that the potential focus upon Secondary Employment was to cover scenarios when staff were permitted secondary roles, not for working whilst off sick which had a separate set of controls. The Chair noted that Secondary Employment in this context would be a relevant area for review. The Committee noted the report and that a final Counter Fraud Plan would be provided to the next meeting in April 2024.	
GOVERNANCE & ASSURANCE		
9. a b	Cyber Security report The Chief Finance Officer presented the report at AC 07/2024 which provided an update on the Trust's Cyber Security preparedness, significant items which were being monitored and risks being mitigated. Further to previous comments, the report was presented in a risk-based format highlighting the risks and corresponding mitigating activities. She added that changes which the Committee had previously supported were beginning to happen and be embedded, including increasing resource in the Cyber Security team. The Chair noted that whilst preventative and risk reduction measures might never fully eliminate all cyber risks, the progress which had been made and the investments in software and to increase resilience in the team were encouraging. However, as the clinical systems outage had demonstrated, the potential impact of third party cyber security weakness remained a risk to be cautious of. Rick Trainor was encouraged by the direction of travel and the Trust's global security score. The Committee noted the report and was assured by the progress which had been made.	
10. a	Governance Framework revision and Board of Directors' Standing Orders The Deputy Director of Corporate Affairs provided an oral update on the work progressing to revise the Governance Framework, as part of an overarching Operating Framework, and presented the report at AC 08/2024 on the Board's updated Standing Orders. He shared his screen to highlight the minor updates which had been made to the Standing Orders.	

b	The Committee recommended the updated Standing Orders for approval by the Board and noted that separately a tracked changes version would be circulated setting out the minor updates which had been made.	BC
11.	Losses & Special Payments report	
a	The Chief Finance Officer presented the report at AC 09/2024 for the period 01 April to 31 January 2024 and highlighted that it provided an update on the payments which had been made to staff whose cars had been damaged by sub-contractors (as the Trust had been keen to ensure that staff were not disadvantaged due to the actions of the sub-contractors). All the payments had now been processed and the report set out the total payments over FY23 and FY24, which were within estimate. Recovery from the sub-contractors was ongoing and would be updated to the Board separately.	
b	The Committee noted the report.	
12.	Single Action Tender Waivers report	
a	The Chief Finance Officer presented the report at AC 10/2024 for the period 01 November 2023 to 31 January 2024 and highlighted the continuing actions being taken to strengthen the processes in relation to Single Action Tender Waivers/Quotation Waivers and the use of Purchase Orders, noting that trends were improving.	
b	The Committee noted the report.	
13.	Charity annual report	
a	The Director of Corporate Affairs & Company Secretary presented the Charity's annual report FY23, noting the delay due to needing to find an auditor to undertake an audit of the Charity. She confirmed that, further to approval by the Corporate Trustee, it had been submitted to the Charity Commission.	
b	The Committee received the Charity's annual report.	
Any Other Business		
14.	Any Other Business	
a	None.	
	Meeting Close: 11:09	
	Date of next meeting: 23 April 2024	

Meeting of the Audit Committee

Tuesday, 23 April 2024

09:30-12:30¹

Microsoft Teams virtual meeting (live video streaming – invitation only)

Apologies to Hannah Smith, Assistant Trust Secretary, hannah.smith@oxfordhealth.nhs.uk

AGENDA

		Start time	Allocated (mins)
1. Welcome and Apologies for Absence ²	CMH	09:30	10
2. Minutes of the Audit Committee Meeting on 22 February 2024 and Matters Arising (paper AC 12/2024)	CMH		
3. Committee workplan (see overview plan at the end of this agenda)	CMH		
Internal Audit and Counter Fraud			
4. Internal Audit updates (paper AC 13/2024):	KPMG/	09:40 ³	25
a. progress report;	PM/HeS		
b. Bank Booking process review report (partial assurance with improvements required);	CDS		
c. Operational Risk Management review report (significant assurance with minor improvement opportunities); and	KR		
d. Final Internal Audit Plan FY25			
5. Counter Fraud (paper AC 14/2024):	KPMG/	10:05	10
a. Local Counter Fraud Annual Report FY24 (and progress report); and	PM/HeS		
b. FY25 Counter Fraud Plan			

¹ 09:00-09:15 Non-Executive Directors only pre-meeting;
09:15-09:30 Auditors and Non-Executive Directors' pre-meeting; and
09:30 main meeting starts.

² Apologies from: Karl Marlowe, Chief Medical Officer; and Adam Makda, KPMG (LCFS)

³ Neil Thomas and Jack Stapleton from KPMG will need to leave the meeting by 11:00 therefore the Internal Audit and Counter Fraud items have been brought forwards on the agenda. Katrina Tumilty will be able to stay and represent KPMG for the remainder of the meeting.

Draft Annual Report & Accounts and Supporting Documents

6. Draft Financial Statements and Accounts (paper AC 15/2024) including:	HeS	10:15	25
a. Analytical Review;			
b. PFI Accounting; and			
c. Draft Financial Statements			
7. Preparation of Statutory Accounts on a Going Concern basis (paper AC 16/2024)	HeS	10:40	5
8. Draft Annual Governance Statement ⁴ (paper AC 17/2024)	KR	10:45	20
9. Update on approach to 'Oxford Health in numbers 2024-27' from the Annual Report & Accounts to provide a preview of the graphics once the Financial Statements are finalised (paper AC 18/2024)	HeS	11:05	10

5 minutes break (if required)

11:15

External Audit

10. External Audit progress report (oral update)	EY	11:20	10

Risk

11. Board Assurance Framework and Trust Risk Register update (paper AC 19/2024) including risk deep dives on:		11:30	20
a. BAF 2.6 Adequacy of Staffing (replaced BAF 2.1 and 2.2 Workforce and Recruitment); and	CDS		
b. BAF 3.6 Governance & Decision-making	KR		

⁴ Although the Draft Quality Report and Quality Account used to feature at this meeting as part of the Annual Report, since FY20 and the response to the coronavirus/COVID-19 situation, the annual audited Quality Report is no longer a regulatory requirement and NHS England/Improvement have confirmed that, continuing the revised arrangements put in place since FY20, NHS FTs are no longer required to include a Quality Report in their Annual Report. Instead, NHS FTs are to provide a separate Quality Account, but there is no national requirement for external auditor assurance to be obtained on it. The Trust's Quality Account is developed by the Clinical Quality Governance team and will be reviewed through the Executive, the Quality Committee and the Board; ultimately it will be published on the Trust's website by the end of June 2024.

Governance & Assurance

12. Clinical Audit annual assurance report (paper AC 20/2024)	AW/CF	11:50	15
	[KM]		
13. Risk Management Policy (oral update)	GD	12:05	10
14. Audit Committee annual report (paper AC 21/2024)	KR	12:15	10

Any Other Business

15. Any Other Business (oral discussion)	CMH	12:25	5
16. Review of the Meeting (oral discussion)			
a. any escalations to the Board or any risk escalations to the Trust Risk Register or Board Assurance Framework; and			
b. content and behaviours.			

Meeting Close 12:30

Date of next meeting: 19 June 2024 09:00-12:30

Audit Committee – overview plan for 2024/25⁵

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
INTERNAL AUDIT									
Internal Audit progress report, action tracker and review reports	KPMG	x	x	x	x	x	x	x	x
Internal Audit Plan	KPMG	x					x		
Internal Audit annual report and Head of Internal Audit Opinion	KPMG		[x]	x				[x]	x
EXTERNAL AUDIT									
External Audit progress report	Ernst & Young	x	x	x	x		x	x	x
External Audit Plan and Informing the Audit Risk Assessment	Ernst & Young	x					x		
External Audit – Audit Results Report on the financial statement audit (including draft letter(s) of representation)	Ernst & Young			x					x
External Audit Value For Money/ 'Auditor's Annual' report	Ernst & Young			x					x
COUNTER FRAUD									
Counter Fraud progress report	KPMG	x	x		x	x	x	x	
Counter Fraud Work Plan and Risk Assessment	KPMG	[x]	x				x		
Counter Fraud annual report	KPMG		x					x	
YEAR-END & FINANCE REPORTING									
Timetable for Annual Report & Accounts	Finance / Heather Smith	x					x		

⁵ Summarises the Committee's more detailed Work Plan

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
Financial Statements and Accounts	Finance / Heather Smith		X	X				X	
Going Concern Statement	Finance / Heather Smith		X	X				X	
Annual Report and Annual Governance Statement	Corporate Governance / Kerry Rogers		X	X				X	
Losses & Special Payments Report	Finance / Heather Smith	X			X		X		
Single Action Tender Waivers Report	Finance / Heather Smith	X			X		X		
RISK MANAGEMENT									
Board Assurance Framework and Trust Risk Register report and/or deep dive. Forward look: - April 2024 – Governance & Decision-Making; and Adequacy of Staffing - June 2024 – Financial Plan	Brian Aveyard/ Neil McLaughlin / Hannah Smith / Kerry Rogers	X	X	X	X	X	X	X	
OTHER ASSURANCE FUNCTIONS AND MANAGEMENT REPORTING									
Assurance from Committee Chairs on themes previously identified in audits	NED Committee Chairs	X	X		X	X	X	X	
Clinical Audit update report	Claire Forrest/Angela Ward/Karl Marlowe					X			
Clinical Audit annual report	Claire Forrest/Angela Ward/Karl Marlowe		X					X	
Cyber Security	IT/Heather Smith	X			X		X		
Whistleblowing arrangements	HR/ Charmaine De Souza				X	[X]			
Emergency Planning annual report	Emergency Planning/ Kerry Rogers				[X]	X			
POLICIES & STRATEGIES									

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
Standing Financial Instructions (on a 2 years cycle, last done 2023 – next due 2025)									
Scheme of Delegation	Corporate Governance / Kerry Rogers								
Risk Management Policy	Neil McLaughlin / Hannah Smith / Kerry Rogers		x						
Counter Fraud Policy	Finance & KPMG								
GOVERNANCE									
Minutes	Corporate Governance	x	x	x	x	x	x	x	
Audit Committee annual report	Corporate Governance		x	x				[x]	
Quality Committee annual report	Corporate Governance				x				
Charity Committee annual report	Charity				x	[x]			
Other Committee annual reports may be more optional/depending upon when/if called for – all will in any event always be available as part of Board packs									
OTHER REQUESTED ITEMS									

Minutes of the

Oxford Health Charity Committee – Governance Meeting

Wednesday 7th February 2024 10.00-11.00am, held via. Microsoft Teams

Present:

Rick Trainor (RT)	Non-Executive Director (Chair)
Charlotte Evans (CE)	Executive Assistant (Minutes)
Alison Bourne (AB)	Head of HR Policy, Reward and Projects (attending as deputy)
Michelle Evans (ME)	Development Manager – Oxford Health Charity
Julie Fulea (JF)	Associate Director of Nursing (attending as deputy)
Chris Hurst (CH)	Non-Executive Director
Hemashu Kotecha (HK)	Community Fundraiser
Chris Langridge (CL)	Oxford Health Charity Administrator
Danielle Manning (DM)	Oxford Health Charity Finance Manager
Julie Pink (JP)	Head of Charity & Involvement
Kerry Rogers (KM)	Director of Corporate Affairs & Company Secretary
Olga Senior (OS)	External Non-Voting Member
David Walker (DW)	Chair - Oxford Health NHS FT
Michael Williams (MW)	Financial Controller

Apologies:

Jane Appleton (JA)	Associate Director of Communication & Engagement
Amelie Bages (AB)	Executive Director of Strategy & Partnerships
Charmaine Desouza (CD)	Chief People Officer
Britta Klinck (BK)	Chief Nurse

1	Introductions and Apologies	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. RT is the new chair of the committee and welcomed other new members including Hemashu Kotecha (HK), Alison Bourne (AB) and Julie Fulea (JF). As AB is deputising for Charmaine Desouza and JF is deputising for Britta Klinck, the meeting was confirmed to be quorate.	
2	Declarations of interest	

	No new declarations of interest were received pertinent to matters on the agenda of today's meeting.	
3	Minutes of the Meeting on 22nd November 2023 and Action Updates	
	The minutes for the Governance Charity Committee Meeting on 22nd November 2023 were accepted as an accurate record of the meeting. There were no comments or amendments to be made and they were formally approved. In regard to matters arising, please see separate action tracker. - Action regarding investment report: Comments from Michael Williams (MW), action still in progress at the moment. We are working with investment company to refine reporting to make it more appropriate for internal reporting but not finalised yet. - Action regarding investment proposal: Comments from MW, action still in progress at the moment. Advised contract has formally ended and in a 'roll-over' situation at the moment. Needs to be re-visited at the next committee meeting in terms of options going forward as would have an impact on the finance team etc. Chris Hurst (CH) highlighted the cost of external support and the associated benefits which have reduced recently, hence looking at in-house management. Advised both these actions seem quite old in terms of governance and would be good to provide a timescale for these actions. MW agreed to bring options and an investment proposal to the next meeting (7th May 2024). ACTION MW.	MW
4	Financial Management Accounts	
	MW advised the format provides figures now for the last two years to provide a broader picture on income and expenditure. Also had previously reported on April – October figures at the last committee meeting, so this time there is a new column for the months since the last meeting that we will review today (November to December). The charity generated £67,000 in terms of income in November and December and spent around £182,000. £44,000 of which was for Lucy's Room, £70,000 for Charities Together. RT asked if the reduction reflected in the balance sheet in	

	terms of total funds of the charity was anticipated? MW advised it was anticipated in terms of commitments we have been carrying against funds. Kerry Rogers (KR) was in agreement about the anticipation and advised Lucy's Room has been cumulated over a period of time. KR also spoke about the growth strategy for the Charity and that we need to get income in to match the funds we spend/requests by fundraising etc. More information on Pennies From Heaven will be provided later on the agenda. In terms of investment, the Charity made a positive £38,000 gain on its investments during November and December. Overall, in November and December there was an outflow of £78,000 and overall for the year to date (9 months) there was an outflow of £126,000. Assets value is currently £815,000, 58% of net assets of the charity are held in investments. The other 42% are net current assets, the 'cash in hand' and creditors in the system. In terms of salary and admin costs, November to December total cost was £13,287 for Charity staff, and ROSY staff cost was £39,334. Julie Pink (JP) advised that this is an estimated figure for ROSY staff that has been accrued, and it will be less than the total at the moment. We are currently accruing at the previous level of invoicing so the funds are protected. A correct invoice and total have been requested to be submitted by the end of the financial year. <i>Please note the overall totals on the document provided are incorrect and need correcting.</i> ROSY is the biggest fund in terms of income over the last year. In terms of inactive funds, the list was refined to remove funds we had commitments to. The list is now of 7 funds that have been inactive for over a year with no commitments. There is more information which will be provided later on the agenda. The fund advisors for the inactive funds have been given a deadline of the end of the financial year to submit plans or be reinvigorated with a fundraising plan. The Charity received a legacy of £14,558 in respect of Rosemary Pryor (Didcot Community Hospital). The	

	previously reported legacy income is £51,199 in the period of April to October 2023. There are two further legacies expected in respect of Community Health in Kidlington and one for mental health services. Apportionment/Reserves Discussion MW provided a verbal update, apart from the dedicated Charity funds that the committee are already aware of, there are 4 other control account funds which the Charity has which historically have supported the running costs of the Charity. These are the admin cost control account (salary), investment control account (investment gains and losses), dividend control account and the banking interest control account (interest accrued on cash balances). When these four are combined, the total can be positive or negative depending on the drive of the Charity investments. We have not been apportioning them over any particular part of the Charity's funds and kept 'outside'. We are proposing going forward to apportion the balances of these control accounts over all of the Charity's funds with the following exceptions: - Less than £500 - Restricted funds This will be done by the end of the financial year and continue to be done. The formats of the finance report may change to reflect the figures for added transparency. Olga Senior (OS) requested getting advice from the Charity Commission as there could be potential issues regarding restricted funds/staffing. MW was in agreement with this. The Committee is asked to note this information provided in the papers and discussion.	
5	Legacies and Inactive Funds	
	As discussed earlier, in terms of inactive funds, the list was refined to remove funds we had commitments to. The list is now of 7 funds that have been inactive for over a year with no commitments. The fund advisors for the inactive funds have been given a deadline to the end of the financial year to submit plans or reinvigorate with a fundraising plan. JP advised she is in regular contact with fund advisors who have inactive funds. Feedback has been given about what	

	they want to do and financial expenditure which will close an inactive fund. JP also has a meeting regarding the Oxon and West management as they have a couple of funds where needs may have shifted. The Charity received a legacy of £14,558 in respect of Rosemary Pryor (Didcot Community Hospital). The previously reported legacy income is £51,199 in the period of April to October 2023. There are two further legacies expected in respect of Community Health in Kidlington and one for mental health services. The Committee is asked to note this information provided in the papers and discussion.	
6	Risk Register	
	JP advised of the new risk in regards to ROSY management after discussion at the November meeting. At the moment we do not know what the invoicing will look like. This is with the CCN Team and Transformation Team which makes it difficult to make a plan for fundraising and support as we do not know what the annual requirement will look like in their new way of working. JF asked what is needed and what can be done to help this move forward – JP advised it is a complex time due to the team changing significantly and going through a further transformation. They need to agree as a team what makes a family a ROSY family and how do they demonstrate the level of service/attendance they would get, which seems to be an ongoing debate and they cannot give a clear figure of how much it costs to support a ROSY family compared to business as usual. JP is unwilling to receive invoices until that clarity is in place as we are not sure if what we are being asked to pay for is a charitable request. There is also a new risk in terms of reserves which we hope will be removed as part of the new guidance provided that details reserves. There is a new risk of fund availability due to reducing capital and large requests for expenditure where we do not have capacity to spend at that level. An example was given of a very large garden at the Warneford.	

	RT asked about the risk register as a standing agenda item. JP advised that the risk register comes to every meeting. Before each meeting it is reviewed by JP, KR and the charity team, however JP would like a separate risk discussion as a committee at least once a year. RT advised this can be discussed outside of today's meeting. ACTION JP/RT. RT also asked for clarification on the colour coding and was advised the red in the final column means the risk is not at its target rating and these are the ones we are most concerned about. The Committee is asked to note this information provided in the papers and discussion.	JP/RT
7	Terms of Reference	
	These are for view and final approval. Alterations made as discussed at the November meeting (to the purpose meeting). OS highlighted a typo which will be corrected (changing trust to trustee). JP reflected that these may need review as the Terms of Reference were drafted with the input of the previous chair. However, these will be reviewed annually. The Committee is asked to approve the final version of the Terms of Approval. These were approved subject to the typo being corrected. As approved, these will go to the corporate trustee for further approval. ACTION JP/KR.	JP/KR
8	Charitable Funds Guidance Update	
	Guidance was last amended in 2021 and needed a full review which has now taken place internally with JP, KR and the charity team. It is now out for consultation until 25th February. It has been brought to today's meeting to highlight and allow attendees to participate in the consultation/review. It will then be brought to the next meeting in May, or circulated out of session for approval. If approved out of session the new processes will come into place for the 1st April, otherwise it will be brought to the next meeting in May. The Committee is asked to note the information provided in the papers and discussion and participate in the consultation/review where appropriate.	
9	Any Other Business/Close	

	Pennies From Heaven Information was provided on Pennies From Heaven. It can be a way of promoting the Charity, what difference the funds can make to staff and wellbeing etc. KR advised that we have wanted to have this happen in place for a while, but this was paused. This was taken to the Extended Executive Management Committee meeting on Monday, with everyone feeling we should try to do this but approach it cautiously. There are a number of other organisations and Trusts that use Pennies From Heaven. It would be an opt-in scheme and promoted to new members of staff. OS asked if a member of staff could pick another charity – there are some Trusts that have set up and allowed a selection of charities. We would not be doing this in the first instance as it is for the benefit for Oxford Health Charity. AB advised on setting up Salary Finance and how this may make the setting up of Pennies From Heaven easier/less of a burden. The Committee is asked to approve the implementation of Pennies From Heaven. This was approved and supported.	
10	Date of Next Meeting(s)	
	- 7th May 2024, 9.30am-10.30am Governance Meeting, 10.30am-12pm Development Meeting. - 4th September 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting. - 4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting.	

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓
Non-Executive Director	<i>Chris Hurst</i>		<i>Chris Hurst</i>	<i>Chris Hurst & David Clark</i>	Non-Executive Director	<i>Chris Hurst</i>
Amelie Bages					Amelie Bages	
Marie Crofts	✓	✓			Britta Klinck	✓ <i>Deputy</i>
Kerry Rogers	✓	✓	✓	✓	Kerry Rogers	✓
Ben Riley					Ben Riley	
David Walker		✓			David Walker	✓
Julie Pink	✓	✓	✓	✓	Julie Pink	✓
Michelle Evans	✓	✓	✓	✓	Michelle Evans	✓
Michael Williams		✓		✓	Michael Williams	✓
Olga Senior	✓	✓	✓	✓	Olga Senior	✓
Donna Clarke	✓				Donna Clarke	
Donna Mackenzie/ Beth Morphy					Donna Mackenzie/ Beth Morphy	
Zoe Moorhouse	✓				Zoe Moorhouse	
Sg Learning & Development					Learning & Development	
Jane Appleton/Comms			✓		Jane Appleton/Comms	
Mark Waring/Ellyn Carnall	✓	✓ & Claire Dalley			Mark Waring/Ellyn Carnall	

Minutes of the

Oxford Health Charity Committee – Development Meeting

Wednesday 7th February 2024 11.00-12.30pm, held via. Microsoft Teams

Present:

Rick Trainor (RT)	Non-Executive Director (Chair)
Charlotte Evans (CE)	Executive Assistant (Minutes)
Alison Bourne (AB)	Head of HR Policy, Reward and Projects (attending as deputy)
Ellyn Carnall (EC)	Operational Support Officer
Michelle Evans (ME)	Development Manager – Oxford Health Charity
Julie Fulea (JF)	Associate Director of Nursing (attending as deputy)
Rose Hombo (RH)	Deputy Director of Nursing
Chris Hurst (CH)	Non-Executive Director
Hemashu Kotecha (HK)	Community Fundraiser
Chris Langridge (CL)	Oxford Health Charity Administrator
Danielle Manning (DM)	Oxford Health Charity Finance Manager
Julie Pink (JP)	Head of Charity & Involvement
Kerry Rogers (KM)	Director of Corporate Affairs & Company Secretary
Olga Senior (OS)	External Non-Voting Member
David Walker (DW)	Chair - Oxford Health NHS FT

Guests – present for relevant agenda item:

Angela Conlan (AC)	Project Lead, Oxford Health Arts Partnership

Apologies:

Katrina Anderson (KA)	Service Director, Oxon & BSW Mental Health
Jane Appleton (JA)	Associate Director of Communication & Engagement
Amelie Bages (AB)	Executive Director of Strategy & Partnerships
Claire Dalley (CD)	Director of Estates & Facilities
Charmaine Desouza (CD)	Chief People Officer
Britta Klinck (BK)	Chief Nurse
Zoe Moorhouse (ZM)	Head of HR, Mental Health & Specialised Services
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care

1	Introductions and Apologies

	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. As Alison Bourne (AB) is deputising for Charmaine Desouza and Julie Fulea (JF) is deputising for Britta Klinck, the meeting was confirmed to be quorate.	
2	Oxford Health Arts Partnership Annual Report	
	Angela Conlan (AC) gave an overview of the Oxford Health Arts Partnership. This covers a huge breadth of work carried out in the Trust including on different wards and different art forms. The team have wanted to grow what they do to include more people and grow the team. As part of this they have recruited a Green Spaces Co-ordinator, and the work is now part of creative health. Creative health is in line with national research around the benefits of creative health. The team have pulled together a research team to work with external valuations and arrange a research project for next year. AC gave a statistic based on an evaluation of our work last year that the art projects boost mood by 224%. When looking at I Want Great Care, and the forms completed when there was no art intervention and when there was, the involvement score largely increases when there is art intervention. AC highlighted recent work, such as the work on the Meadow Unit co-producing with young people at the Highfield Unit and staff to create the artwork. AC also noted that they are working towards building upon the intervention they offer, as well as offering community work and work in patient's homes (not just whilst an inpatient). This is an important as an additional element of recovery and moving people in their recovery journey. Attendees of today's meeting were very complimentary and appreciative of AC and her team, especially her smile and enthusiasm. They were also reflective of how positive AC made them feel and how this would make patients feel.	
3	Declarations of interest	
	No new declarations of interest were received pertinent to matters on the agenda of today's meeting.	
4	Minutes of the Meeting on 22nd November 2023 and Action Updates	

	The minutes for the Development Charity Committee Meeting on 22nd November 2023 were accepted as an accurate record of the meeting. There were no comments or amendments to be made and they were formally approved. In regard to matters arising, please see separate action tracker. There are currently no outstanding actions.	
5	Charity Strategy Update	
	JP advised that following on from the November meeting, the documents have been reformatted. The KPIs for 23-24 are the first set of data, followed by actions that have been completed and then the actions still being worked on as the third set of data. This makes the document read easier and possible to navigate with ease. We are progressing on all actions, and some that were showing as amber have been achieved since this paper was shared. JP does not anticipate anything to carry over but advised actions will grow into 24/25 actions, with the view to continue growth and development over the next few years. JP advised that the KPIs for 23/24 are around setting baselines as the strategy was approved late last year. We will then have a set of data moving forward with the strategy that runs until 2028. There are baseline areas for involvement, volunteering and donations, fundraising events, contactable supporters (including high net worth individuals), for innovation and/or research focused funding. JP advised we are setting baselines in terms of impact reporting, this is improving but still a struggle and this will be covered in more detail later on the agenda. We will know more about the annual fundraising income with figures after April, but the figures included are indicative depending on legacies and grants. Olga Senior (OS) reflected that it is much easier to read and make your way through it. However, OS did advise she could not find the fundraising calendar on the website. JP advised this has been circulated internally with posters and communications.). OS requested that external committee members should be copied into these sorts of things to keep in the loop. Promotion around individual events will be added to the website on an ongoing basis, with Blenheim	

	and Bike Oxford being pushed live next week (commencing 12 February). Kerry Rogers (KR) reflected that it is great how the reporting is developing and the impact this is having. KR also highlighted that the charity team is relatively small compared to volume of activity.	
6	Impact Reporting	
	Michelle Evans (ME) provided a summary of project and impact reporting. There were 25 requests in November for a total of £8,100, 16 in December for a total of £35,000 and 15 in January for a total of £12,000. In addition there was also the fundraising for Christmas gifts/food for inpatient wards for £5,360. Reasons for requests being declined included: – Team away days. – Staff thank you gifts. – Not in the charity remit (staff food back and period poverty products). Recent projects/specific appeals have included: – Wintle Ward patient activity items, including a pamper kit, garden games and a grab and go art box. – Vaughan Thomas Ward resources to encourage physical activity, including pool cues, gym weights, frisbees, sports netting and equipment for consoles. – Staff attendance at the British Society of Heart Failure Annual Conference. – Festive themed activities on Phoenix Ward. – A Warneford Orchard Wassail Event. – OSRU have been successful in their appeal to raise £7,500 to purchase arm rehabilitation equipment to enhance stroke patient recovery. JP advised about the difficulties the team have with impact reporting and the lack of impact reporting forms being returned. An example was given about the funding for Christmas gifts/food for inpatient wards. Whilst the team received feedback about the disappointment that the amount given was lower than previous years, they did not receive any feedback about the impact this had on patients or staff. The committee discussed this and whether the wards should have to apply for this funding (rather than it being expected) and whether the impact of funding or	

	comments from patients based on previous years should be included in the application form. There was also a suggestion to see if the charity team can attend a weekly team meeting or business meeting after the event has happened, but appreciate this is time consuming. Attendees of today's meeting were asked to encourage their teams to complete the impact reporting forms. The Impact Report and Fundraising/Income Generation presentations from today's meeting will be circulated within the next couple of weeks. The Committee is asked to note this information provided in the papers and discussion.	
7	Fundraising Update	
	ME advised we have now registered with the Fundraising Regulator. The next steps including obtaining a Fundraising Regulator ID and the logo which we can use on documentation, websites etc. There have been successful grant applications from local councils (VOWHDC and SODC). The grant applications will be used for art projects in Abingdon, Wantage and Didcot. There were two unsuccessful grant applications from Christ's Hospital of Abingdon and Greener Communities Fund. There is also the potential for grant applications in 2024 with the NHS Charities Together and the Masonic Charitable Foundation. There have been fundraising activities including: • A member of staff shaving their head raising money for Wallingford Hospital. • Pedalling to Penzance which raised money for the Positivity Pot. • Christmas Cards sold and a Christmas Choir Event, both raising money for the Highfield Fund. • The presence of the ROSY team at the Cowley Christmas Tree Festival. • There is also the use of Easy Fundraising. Easy Fundraising partners with over 7,000 brands will donate part of what is spent to a choice of causes (including Oxford Health Charity). This will not cost the individual any extra as the cost is covered by the brand.	

	There are future fundraising activities arranged with a 2024 poster created to help engage with staff. Activities include: – The ROSY Walk in April. – The Blenheim 7k in May. – The Bike Oxford in June. – The Oxford Half in October. There is also the potential of future fundraising activities including a tombola organised by PALs and the Wolf Run. Information was also provided on legacies, which are being worked through by the charity team and solicitors as appropriate: – The Pryor Legacy for Didcot Community Hospital. – The Baker Legacy which has been referred to the Charity Commission as it was intended for Kidlington/Yarnton Health Centre who do not have their own charity. – Lansbury Legacy which is being worked through as this was to support the Park Hospital which no longer exists and the site is now owned by the University. The Impact Report and Fundraising/Income Generation presentations from today's meeting will be circulated within the next couple of weeks. The Committee is asked to note this information provided in the papers and discussion.	
8	Any Other Business/Close	
	Advised it is the last meeting with KR attending as she is due to leave the Trust. Many thanks given to KR for her various and huge contributions to the Trust and the Charity Committee.	
9	Date of Next Meeting(s)	
	– 7th May 2024, 9.30am-10.30am Governance Meeting, 10.30am-12pm Development Meeting. – 4th September 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting. – 4th December 2024, 1.30pm-2.30pm Governance Meeting, 2.30pm-4pm Development Meeting.	

Attendance – Development Sub-group

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓
Non-Executive Director	<i>Chris Hurst</i>		<i>Chris Hurst</i>	<i>Chris Hurst</i>	Non-Executive Director	<i>Chris Hurst</i>
Amelie Bages				✓	Amelie Bages	
Marie Crofts	✓	✓			Britta Klinck	✓ <i>Deputy</i>
Kerry Rogers	✓	✓	✓	✓	Kerry Rogers	✓
Ben Riley					Ben Riley	
David Walker		✓			David Walker	✓
Julie Pink	✓	✓	✓	✓	Julie Pink	✓
Michelle Evans	✓	✓	✓	✓	Michelle Evans	✓
Michael Williams		✓			Michael Williams	
Olga Senior	✓	✓	✓	✓	Olga Senior	✓
Donna Clarke	✓			✓	Donna Clarke	
Donna Mackenzie/ Beth Morphy				✓	Donna Mackenzie/ Beth Morphy	
Zoe Moorhouse	✓				Zoe Moorhouse	
Learning & Development					Learning & Development	
Jane Appleton/Comms			✓		Jane Appleton/Comms	
Mark Waring/Ellyn Carnall	✓	✓ & <i>Claire Dalley</i>		✓	Mark Waring/Ellyn Carnall	✓

Meeting of the Oxford Health Charity Committee – Governance

Tuesday 7th May 2024 9.30am – 10.30am via. Microsoft Teams

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

AGENDA

	Agenda Item	Lead	Indicative Time
1	Welcome and apologies for absence	RT	9.30
2	Declarations of interest/related party transactions	RT	9.30
3	Minutes of the Meeting on 7th February 2024 (1) and Action Updates (2)	RT CCG 003i_24 & 003ii_24	9.35
4	Annual Committee Report	CE CCG 004_24	9.40
5	Investment Report	DB/MW CCG 005_24	9.45
6	Financial Management Accounts	MW CCG 006_24	9.50
7	Investment Portfolio Proposal	MW CCG 007_24	9.55
8	Legacies and Inactive Funds	JP Paper to follow	10.05
9	Risk Register	JP CCG 009_24	10.10
10	Governance Code and Policy Review	JP CCG 0010_24	10.15
11	Any Other Business/Close	RT	10.20

Date of Next Meetings:

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

Attendance – Governance Sub-group

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓
Non-Executive Director	<i>Chris Hurst</i>		<i>Chris Hurst</i>	<i>Chris Hurst & David Clark</i>	Non-Executive Director	<i>Chris Hurst</i>
Amelie Bages					Amelie Bages	
Marie Crofts	✓	✓			Britta Klinck	✓ <i>Deputy</i>
Kerry Rogers	✓	✓	✓	✓	Kerry Rogers	✓
Ben Riley					Ben Riley	
David Walker		✓			David Walker	✓
Julie Pink	✓	✓	✓	✓	Julie Pink	✓
Michelle Evans	✓	✓	✓	✓	Michelle Evans	✓
Michael Williams		✓		✓	Michael Williams	✓
Olga Senior	✓	✓	✓	✓	Olga Senior	✓
Donna Clarke	✓				Donna Clarke	
Donna Mackenzie/ Beth Morphy					Donna Mackenzie/ Beth Morphy	
Zoe Moorhouse	✓				Zoe Moorhouse	
Sg Learning & Development					Learning & Development	
Jane Appleton/Comms			✓		Jane Appleton/Comms	
Mark Waring/Ellyn Carnall	✓	✓ & Claire Dalley			Mark Waring/Ellyn Carnall	

Meeting of the Oxford Health Charity Committee – Development

Tuesday 7th May 2024 10.30am – 12pm via. Microsoft Teams

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

AGENDA

	Agenda Item	Lead	Indicative Time
1	Welcome and apologies for absence	RT	10.30
2	Declarations of interest/related party transactions	RT	10.30
3	Minutes of the Meeting on 7th February 2024 (1) and Action Updates (2)	RT CCD 003i_24 & 003ii_24	10.35
4	Charity Strategy Update	JP CCD 004i_24, 004ii_24 & 004iii_24	10.40
5	Oxfordshire Health Services Grant	KS CCD 005_24	10.50
5	Impact Reporting	ME/JP <i>Presentation</i>	11.05
6	Fundraising Update	ME/JP <i>Presentation</i>	11.20
7	Spring Requests Update	JP <i>Verbal</i>	11.35
8	Any Other Business/Close	RT	11.50

Date of Next Meetings:

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

Attendance – Development Sub-group

	Feb 2023	June 2023	Sept 2023	Nov 2023		Feb 2024
Lucy Weston	✓	✓	✓	✓	Rick Trainor	✓
Non-Executive Director	<i>Chris Hurst</i>		<i>Chris Hurst</i>	<i>Chris Hurst</i>	Non-Executive Director	<i>Chris Hurst</i>
Amelie Bages				✓	Amelie Bages	
Marie Crofts	✓	✓			Britta Klinck	✓ <i>Deputy</i>
Kerry Rogers	✓	✓	✓	✓	Kerry Rogers	✓
Ben Riley					Ben Riley	
David Walker		✓			David Walker	✓
Julie Pink	✓	✓	✓	✓	Julie Pink	✓
Michelle Evans	✓	✓	✓	✓	Michelle Evans	✓
Michael Williams		✓			Michael Williams	
Olga Senior	✓	✓	✓	✓	Olga Senior	✓
Donna Clarke	✓			✓	Donna Clarke	
Donna Mackenzie/ Beth Morphy				✓	Donna Mackenzie/ Beth Morphy	
Zoe Moorhouse	✓				Zoe Moorhouse	
Learning & Development					Learning & Development	
Jane Appleton/Comms			✓		Jane Appleton/Comms	
Mark Waring/Ellyn Carnall	✓	✓ & <i>Claire Dalley</i>		✓	Mark Waring/Ellyn Carnall	✓

**Meeting of the Oxford Health NHS Foundation Trust
Finance and Investment Committee**

**Minutes of a meeting held on
Tuesday 12 March 2024 at 09:00
Via Microsoft Teams Virtual Meeting**

Present:

Core members and attending Board members included in quorum

Lucy Weston	Non-Executive Director (LW) (the Chair)
Rob Bale	Executive Managing Director for Mental Health & Learning Disability Services (RB)
Amélie Bages	Executive Director of Strategy and Partnerships (AB)
Philip Rutnam	Non-Executive Director (PR) - <i>part meeting</i>
Heather Smith	Chief Finance Officer (HeS)

In attendance:

Brian Aveyard	Risk, Assurance and Compliance Manager (BA)
Kelly Bark	Associate Head of Property and Clinical Design Lead (KB) - <i>part meeting</i>
Ben Cahill	Deputy Director of Corporate Affairs (BC)
Ali Corfield	Programme Director Clinical Systems & Interim CIO (AC) - <i>part meeting</i>
Simon Cook	Warneford Park Programme Director (SC) - <i>part meeting</i>
Charmaine De Souza	Chief People Officer (CDS) – <i>part meeting</i>
Nicola Gill	Corporate Governance Officer (NG) (minutes)
Alison Gordon	Head of Financial Management (AG) – <i>part meeting</i>
Stacy Hennessy	Finance Business Partner (SH)
Peter Milliken	Director of Finance (PM)
Jeremy Philpot	Interim Director of Estates and Facilities (JP) – <i>part meeting</i>
Dr Ben Riley	Executive Managing Director for Primary, Community & Dental Care (BR)
Hannah Smith	Assistant Trust Secretary (HaS) – <i>part meeting</i>
Priya Thompson	Head of Strategy (PT)

Observers:

Governor Observers:

Vicki Power	Staff Governor

1. a b	Apologies for Absence Apologies were received from members and attending Board members: Kerry Rogers, Director of Corporate Affairs & Company Secretary; Matt Edwards, Director of Clinical Workforce Transformation; Grant Macdonald, Chief Executive; and David Walker, Trust Chair The Chair welcomed all to the meeting and confirmed it was quorate.	
2. a b	Minutes of the Meeting held on 23 January 2023 and Matters Arising The minutes at FIC 12/2024 of the Finance and Investment Committee meeting held on 23 January 2024 were approved as a true and accurate record. Matters Arising The Committee noted that the following actions were complete: • 3(g) - Financial Report, PFI analysis update – on agenda; and • 3(k) – Estates finances deep dive – on agenda. • 5(c) – Improving Quality Reducing Agency (IQRA) – it was agreed that PLC would have oversight of IQRA and FIC would maintain oversight of the financial performance via the standard monthly reporting. A benefits realisation paper would be brought to May's meeting. The Committee noted that the following actions were still in progress: • 2(a) – Update on capital authorisation processes and business case processes – to be brought to May's meeting; • 7(e) – Warneford Park Programme – governance update to be brought to May's meeting; and • 15(e) – Review of cover sheets to be brought to the July meeting.	
3. a b c	Annual Planning & Budget setting The Executive Director of Strategy and Partnerships presented the paper at FIC 13/2024 noting it covered the End of year update for FY23/24 Annual Plan; the Draft FY24/25 Annual Plan; and the Financial and Budget update. She highlighted that the planning process this time was more robust in terms of linking with the strategy. End of year update for FY23/24 Annual Plan The Head of Strategy explained that over the course of the year directorates had reviewed their plans systematically and were reporting to the Executive team to highlight achievements, next steps and escalate any concerns. The mid-year review of the FY23/24 plan was presented to the Board of Directors in November 2023, and this was an end of year review of progress against priorities and would be shared with the Board of Directors at the public meeting on 27 March. The Committee were asked to review the end of year update for FY23/24 Annual Plan and recommend the approval in principle of the Draft FY24/25 Annual Plan at the Board of Directors meeting in public in March 2024. Draft F24/25 Annual Plan	

d	Since the Plan was presented to this Committee and Board of Directors in January it had been developed following executive discussions and feedback and now included the following: • The Strategic Dashboard – what we want to achieve by 2026; • The Strategic Principles and Strategic Programmes – how we work to achieve our objectives; • The Strategic Enablers – how we set up for success; • OHFT system planning; • OHFT quality priorities (DRAFT); and • Clinical Directorates’ high-level priorities.	
e	Philip Rutnam commented on the thirteen strategic programmes and questioned the fact that IQRA did not appear as one of those as was subsumed within the People Plan and noted that he felt this was worth considering given its prominence in the life of the organisation. He also commented about the appearance of the quality priorities as he felt they were slightly detached from the rest, he acknowledged this was not the reality or how the Trust would want to appear in front of other organisations. Was there a way of synthesising the quality priorities or making it clear they are embedded within other priorities.	
f	The Executive Director of Strategy and Partnerships responded acknowledging the point made on the quality priorities and would review the presentation and embedding the quality priorities with the planning. In terms of IQRA, she noted it was a conscious decision not to include it due to the way the programme was structured it would evolve, however the priority did not go away and temporary staffing could be highlighted in the plan.	AB AB
g	The Chair wondered whether going forward and regarding Board and FIC’s monitoring of this plan if there was an argument for taking the first half of the document up to quality priorities and treating that as a strategic plan and then the directorate priorities be managed at directorate or exec level. Was Board level oversight of the whole piece needed? The Executive Director of Strategy and Partnerships commented that there would be a specific infrastructure looking at the strategy programme and would be managed separately however as the integration was not fully complete there were some critical deliverables that the Board did need sight on and noted the need for a year to test this before changing it. The Chair concurred.	
	Financial Plan and Budget Update	
h	The Chief Finance Officer presented the FY25 Financial Plan & Budget Update highlighting that with regards to optionality the Trust was a stage ahead of where it was last year regarding making organisational level decisions on what to prioritise and this had been discussed during a Board Away Day.	
i	Philip Rutnam asked if there was any funding from the Talking Therapies announcement made in the Autumn Statement by the Government for the next financial year and if so, did we know the detail. The Director of Finance responded that we knew at an ICB level and therefore how much should be allocated out. Although not agreed with the ICS yet	

j	it should be straightforward and had flowed through in terms of planning. It was not material in the scheme of the usual mental health monies received but was helpful. The Director of Finance talked through the Plan in System Submission and Draft Plan slides highlighting the key areas for the Trust noting the plan for this financial year was a £4.5million surplus with our underlying position was breakeven. The surplus FY24 plan was a surplus due to non-recurrent income from the ICB including Covid funding. The current ICS planning assumptions are that this is taken out for FY25. This creates a bigger deficit for all providers and is being worked through as part of planning discussions. She noted the slides were a work in progress in terms of the financial position.	
k	The Chair commented that it looked challenging and noted her interest in the Covid funding being in our baseline and asked if that spoke to our own financial management as the narrative had always been that we needed to be careful about not allowing this to get into baseline funding. The Director of Finance commented it was right and was what we should have done throughout that period when the Covid regime was implemented and felt we were in the same position as every other provider. Pre Covid we were in a deficit so in reality although we say it is in our baseline it is part of what brought us back to financial balance. She felt we had managed our cost base and stability well.	
l	The Committee APPROVED in principle the Draft FY24/25 Annual Plan and the Capital Plan for FY25 and delegated authority for approving the Financial draft plan to the Chief Executive Officer and Chief Finance Officer due to the brief time available to agree this.	
4.	Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF)	
a	The Assistant Trust Secretary presented the paper at FIC 14/2024 alerting the Committee that BAF 1.1 Utilising digital, data and technology to drive quality, efficiency, economy, research and innovation (formerly Triangulating data and learning to drive Quality Improvement) had been the subject of significant change to amalgamate risks around digital, data and triangulation of information. She noted that BAF 1.1 was initially monitored by the Quality Committee. However, given its closer relationship to BAF 3.10 (Information Governance & Cyber Security), it may be relevant for the Finance & Investment Committee to be made aware of the development of BAF 1.1 and to potentially share monitoring oversight with the Quality Committee.	
b	The Assistant Trust Secretary also noted that a deep dive was planned on BAF 3.4 Delivery of the financial plan and maintaining financial sustainability at the May meeting.	LW/ HeS
c	The Chair sought clarification on the follow-up work that had been undertaken by the Board on risk at their workshop was being translated into the BAF. The Deputy Director of Corporate Affairs noted at the workshop on 28 February, a workshop discussion had looked at identifying strategic risks (as if the BAF did not exist). The output of the discussion has created a set of strategy risk categories that can be used to inform / add	

d e f	to existing BAF risks and/or be a source of information for any future review of the BAF. The other workshop discussion was on developing a Risk Appetite statement which resulted in good discussions and support for the inclusion of a Risk Appetite Statement in a revised Risk Management Strategy (scheduled over Q1 2024/25). The Chair asked for sight of this work to inform future FIC discussions. Philip Rutnam sought a brief explanation about the Oxford Pharmacy Store (OPS) licence which was an extreme risk in the TRR as the committee was responsible for the OPS oversight. The Chief Finance Officer noted that the rating may be high for the impact of this risk. She went on to explain that the near time impact was we had approved OPS to move warehouses, the new warehouse is procured, has power and fitted out however it did not have its licence from the Medicines and Healthcare products Regulatory Agency (MHRA) and until it gets this it cannot operate as a pharmaceutical wholesaler. The risk is regarding the timings. Philip Rutnam thanked the Chief Finance Officer for the clarification and asked whether the committee should be planning to have a deep dive into OPS at a future meeting to help give a focal point to the range of issues. The Chair and Chief Finance Officer concurred. The Programme Director Clinical Systems & Interim CIO noted that BAF 1.1 had been reframed to focus on digital, data and technology and realising the benefits of this. The Chair asked for further detail on the gaps and actions in relation to driving down the risk rating and it was agreed to pick this up outside the meeting. Any update on this would be brought to the May meeting. The Committee noted the report.	BC HeS AC/ HeS
5. a	Estates Deep Dive The Interim Director of Estates & Facilities presented the report at paper FIC 15/2024 noting that since joining the Trust he had been reviewing how the department had been working and it was clear that work was needed to review the structure and ensure accountability along with aligning finances to a new structure. He highlighted the estimated financial forecast for FY25 for pay and non-pay was estimated at £2.8million adverse variance (including £1.7million as noted in the presentation). Financial risk mitigation was currently being undertaken to review numerous opportunities to reduce this variance in FY25. He also planned to review the current estates workforce and in relation to the work they are doing against the work contractors are doing to ensure they are working efficiently and cost effectively. Cost avoidance and mitigation would be reviewed and undertaken as per the below: • Risk management matrix to support reactive maintenance and remedial decision making, to ensure VFM. • Review current estates workforce activity against contractor usage to reduce ongoing costs. • Reduce Energy costs by procuring new fixed rate tariffs with Crown Commercial Services framework. • Review contract service costs by procuring new contracts that align to service requirement that enables procurement of services in lots, which will help realise	

	economies of scale. This will eliminate the need for lower value for money contract extensions. • Review processes to ensure when additional services, space, operational change is captured within business justifications, to ensure additional funding needs are recognised. • To recruit a dedicated Finance & Performance manager to support the financial effectiveness and management of costs being incurred by the department.	
b	In conclusion, the team would continue to investigate potential areas of saving to reduce the overspend and would also look to other funding opportunities.	
c	The Chair welcomed the report and thanked him for the level of detail.	
d	The Finance Business Partner, Stacy Hennessy presented the Estates Finance Deep Dive and noted on the CIP specifically for Estates, the estimated FY25 CIP target was £438,000. There is a budget of £1.1million allocated to non-pay reserves within the Estates budget which they suggest is used to offset the CIP target and partially fund the expected forecast pressures illustrated in the presentation.	
e	The Committee noted the report.	
6.	Oxford Clinic PFI	
a	The Chief Finance Officer provided an update and noted that an accounting PFI paper had been added to the reading room which provided a degree of explanation around the background of the PFI.	
b	The Chief Finance Officer went on to explain that broadly the Trust had entered the contract for the Littlemore site which included the Oxford Clinic and some of the residential space on the site back in 1999, making it one of the earlier PFIs that the NHS entered. On joining the Trust, it had been brought to her attention there was an Exit decision due for September 2024 and teams were put in place to review transfer of staff, commercial and variation considerations etc. However, in September it was brought to her attention by the legal advisers that the Trust had to serve notice within a week if they were going to exit. Looking at the balance of the legal advice it became clear that they did need to serve it as if not we could not guarantee we had legal access to the building from October onwards and given they are medium secure inpatient units it would be unacceptable to not be able to access the building or operate services. Notice was given.	
c	Legal advice was sought from Capsticks and an initial view from another legal team, Ward Hadaway and she felt that giving notice was the correct action. The PFI contractors have been making significant profits year on year and the political climate is not to extend existing PFIs. There is no intention of revisiting the decision and the significant relevance for this Committee now is the accounting treatment and budgetary impacts of the exit. KPMG were commissioned to provide accounting advice and their basic advice is that the Trust's accounting as it stands is wrong. It is conceptually either the	

	case that we should be accounting for the liability on the assumption its running for a longer period or we are going to exit and there is a compensation payment. The fact we are currently accounting for it without expecting to exit next year but also not expecting a compensation payment is incorrect. If we were to say we were not expecting to exit and we expected it to run forever, then the exit value is overstated. Their view is what we have currently is not right, the question is how we put it right. There are a range of options around how we approach it. If it is material in our judgement, then some of this may be able to be addressed through a prior year adjustment which she felt would be helpful from a budgetary perspective. If it was not material then whether it was a lease or a service concession would make a difference to some of the accounting treatments but they do mostly end up a capital charge, the scale of which is currently unclear, so orders of magnitude of between £10-15million are not impossible but the valuation work needs to be completed and ensure we have considered everything. There is little guidance in the contract about what counts as market value so there is lots to negotiate on with her goal being to achieve as low amount as possible so that it becomes single figure millions. There is no suggestion the payment can be avoided altogether as the contract is clear there is a compensation figure on exit.	
d	The Chief Finance Officer flagged that they would try and manage the year-end position as effectively as possible but could not manage a significant PFI hit. The next steps were to get valuation reports back to be able to quantify better and make decisions.	
e	The Chair noted that the decision taken could have impacts on our capital budgets for a number of years and so was potentially a wider decision-making space. If we were looking at the strategic balance of Jordan Hill, for example versus exiting the PFI we might do that in a different way. We were approaching it this way on the assumption that someone somewhere would find budgets to absorb it and we will benefit from the upside. There was a separate issue around accounting treatment that has been wrong and would need to be change (and other PFI/lease accounting treatments reviewed) but the current financial decision-making sounds like it is contingent on whether we take it in the current financial year or future financial years. The Chief Finance Officer concurred noting that if there was a significant opportunity costs at Oxford Health there was a decision to be made about whether we seek to reverse the notice or negotiate something different rather than a one-off payment for example. The Chief Finance officer agreed to bring a further update to the May meeting.	HeS
f	The Committee noted the update.	
7.	Business Case Review	
a	This paper was deferred to the May meeting.	PM/ HeS
FINANCIAL MANAGEMENT		

8.	Review of current financial performance Financial Report a The Chief Finance Officer presented the report at FIC 17/2024 on Month 10 financial performance and explained the underlying position at Month 11 was better than forecast as £3.8million had been provided for as a balancing number for potential early recognition of PFI Exit costs. The root cause of the unanticipated underspend was that reconciliation of our temporary staffing invoices revealed we had over-accrued in FY23. Now that no further invoices would be received for that period that accrual could be released. b An addition since the paper was submitted was that as a Trust they had come to the conclusion that they were not able to take forward the modern-equivalent asset valuation seen in slide 4 of the presentation benefiting our position in Month 10 and therefore that benefit is no longer available. c She felt that at Month 11 there was an understanding of the risks and opportunities appropriate to estimate the position. d An extension of the approval on the conditions given to us for Month 10 from now until the end of the year was requested in the cover note. e The Chair commented on the volume of risk and opportunity that was within ICS hands and that from a Trust perspective there was an argument that any PFI cost would be much better mitigated should these commitments be met. Was there a narrative therefore that if the ICB wanted to renege on pre-agreed funding agreements, it would merely exacerbate any PFI overspend. The Chief Finance Officer noted this was a fair point. f The Committee noted the report.	
PRODUCTIVITY & INNOVATION		
9.	Improving Quality Reducing Agency (IQRA) - benefits realisation update a The Chief People Officer took the report at FIC 18/2024 as read. The Chair noted that at the start of the meeting there was an action around getting clarify around the role that FIC plays in oversight of IQRA and what was in the remit of PLC versus FIC to avoid double presentations. The Chief People Officer commented this had now taken place and the action should be closed. b The Chief People Officer commented that IQRA was at a crossroads, temporary staffing had to remain as a key part of any strategic programme going forwards but need to consider the structure of IQRA as we move into a new financial year. We now have a much stronger retention and recruitment function, so we need to focus on the actual temporary staffing spend, the controls over the temporary staffing spend and how we join up with the Southeast temporary staffing programme.	

	The Chair requested that at the next meeting the Committee receive a paper that outlines the benefit realisation of the programme to date.	CDS/ PM
c	The Chief People Officer noted that they were going to come in this financial year between 5-6% above NHSE's ceiling which was an achievement despite some of the challenges faced. The focus would now be on how to achieve greater savings for the next financial year. She highlighted the following three areas for focus in the new financial year: • Medical spend had gone in the wrong direction – they would be working with ID medical to understand this situation; • Improvement plan to be put in place on NHSP; and • Opportunities working with the Southeast temporary staffing team.	
d	The Director of Finance noted that agency spend had been brought down by approximately £10million this year compared to next year which was a good reduction. Reducing the spend next year would be more challenging. The national target for next year was 3.2% of our staff bill, approximately £12million. We need to set ourselves a challenging but realistic target that we can achieve and agree that with the ICS. £19million is the figure used within the presentation on the basis that that is what it would take for us to not be in the NHSE's high scrutiny trusts. There was still a long way to go and would require engagement with the services than seen this year. There was an NHSE Framework that can be used to measure ourselves against.	
e	Discussions ensued about how the directorates viewed the challenges. The Executive Managing Director for Mental Health & Learning Disability Services felt directorates were now engaging with this and developing plans to replace roles currently covered by temporary staffing with substantive staff. The Executive Managing Director for Primary, Community & Dental Care felt their challenge was slightly less as they did not have the same numbers of agency use but this was now being focussed on by services.	
f	The Committee noted the report. <i>The Committee took a break for 10 minutes</i>	
CAPITAL INVESTMENT		
10.	Capital Programme <i>FY24 Capital Report – spend against budget and forecast</i>	
a	The Chief Finance Officer presented the report at FIC 19/2024 noting the report set out the progress against the FY23/24 allocations, with YTD expenditure running behind forecast, however the end of year forecast was ahead of what was projected therefore forecasting a pressure of £1million. She highlighted the Annex at the bottom of the report which summarised the position in detail.	
b	At Month 11 there were no material changes to the forecast with the estimate still being it was likely some of the spending would be deferred to bring us back closer to budget. She had flagged to the ICB that there was a sub £1million overspend against this	

	budget., given the wider capital position, on its own that is the sort of level that would not be unmanageable at system level. The Trust was in a reasonable budget control position and in terms of the underlying processes and ways of working she would like to see a closer alignment between the plan and what is delivered in the year.	
c	The Jordan Hill Lease was the largest impact on IFRS16 costs and had to be signed this month. The Trust was pressing for more certainty about the process of getting the title registered as the freehold was never registered for this site. The advice from lawyers was that we had good title but not as clear as if the freehold were registered and our lease registered on the back of this.	
d	The Chair commented that within Estates there was a balance to be struck between over programming because we know things will get delayed versus how quickly we can shift culture change around financial management, so we don't need to over programme.	
e	The Chair asked if this position was excluding PFI and the Chief Finance Officer confirmed it was with the caveat being noted in the report.	
f	The Committee noted the report and update.	
11.	IM&T update including update on Frontline Digitisation programme	
a	The Programme Director Clinical Systems & Interim CIO presented the report at paper FIC 21/2024 noting that the Frontline Digitisation Programme Information Agreement and Information Justification (Business case) had to be resubmitted based on the feedback from NHSE. The new business case focussed on EMPA, Interoperability, Single Sign on, Virtual Smartcards, dashboards for MHA and infrastructure. NHSE agreed to fund FY24 as planned but reduced FY25 funding by £2.29million across capital and revenue, resulting in total funding from NHSE at £5million, reduced from £7.29million. The Trust match funding was shown as £5million in the business justification but the assumption is the Trust will continue with the agreed £7.29million match funding.	
b	By reducing the scope on some projects and by procuring devices and network equipment in advance utilising funding opportunities FY24, the funding gap has been reduced by £971k to £1,375k across capital and revenue. This also assumes a total capital allocation into IM&T of £2million in FY25.	
c	The team will continue to investigate potential areas of saving to reduce the overspend and will also look to other funding opportunities.	
d	The Chair asked to what extent this funding issue had been escalated. The Programme Director Clinical Systems & Interim CIO responded that it had been escalated internally and in NHSE and advice had been sought from Capsticks. She did not feel the challenge back to NHSE was complete, but this was the position to date.	
e	The Chair asked if there were elements of the digitisation programme that were important to delivery of the strategic plan, but which currently have a question mark	

f	over them due to the reduction in funding. The Programme Director Clinical Systems & Interim CIO commented that there had to be a change to the Frontline Digitisation Plan for next year, prioritising our digital strategy. The Chair asked if the funding was dictating a re-prioritisation of what was being delivered and when. The Programme Director Clinical Systems & Interim CIO felt this was the case but noted it was difficult to identify areas to de-scope in the programme to accommodate for this. She did highlight that there would be other funding opportunities to close the gap and enable us to move forwards as planned. The Committee noted the report.	
12. a b c d e	Warneford Park Programme: update on the Conditional Options Agreement (COA) Simon Cook took the report at paper FIC 22/2024 as read, noting that since the signing of the COA in December they were now at the stage of re-setting the programme slightly with the planning application for planning submission likely in March 2025 and this will be taken to the External Programme Board at the end of this month for agreement. Simon asked the Committee to think about what it would like to see reported in terms of scrutiny and visibility of the programme. The Chair felt this report, whilst interesting, included too much detail. She found the commentary and analysis most helpful but putting it into a context of milestones, challenges and associated risks would be useful. Philip Rutnam suggested that as well as regular reporting the Committee could also undertake occasional deep dives on certain topics within the project. The Chair suggested a comprehensive list of areas that should be on our radar, along with various timescales would assist with this. The Committee noted the report.	LW/SC
13. a b	Capital Plan Update The Chief Finance Officer summarised the Capital Plan noting the proposed funding deficit was a similar amount to that taken into FY24 (£694k). There was a risk of an additional pressure from anticipated Frontline Digitisation funding being withheld, as set out in the IM&T report. VAT risks and opportunities were also being carried forward into FY23 and the PFI exit may also create pressures. The FY25 capital programme was illustrated on Slide 7 of the FY25 Financial Plan & Budget update presentation tabled at the meeting. The Chief Finance Officer proposed the Committee approved the plan and take it into the beginning of the year, so people had something to work to and then ask CPSC to agree the contingency plan to reduce or defer spend.	

c	The Chair commented that she was reluctant to agree on that basis. She asked to what extent was this list had not been sufficiently challenged or put into a wider strategic context, for example the £300k spend on the Tribunal Room relocation which would only be used occasionally. The Chief Finance Officer provided more detail on the schemes planned, assuring the Committee that all items on the list had been appropriately challenged and put into a strategic context and that she was confident that spend reduction contingency plans could be put in place.	
d	The Committee APPROVED the Plan and noted the update.	
INFORMATION GOVERNANCE, FINANCIAL GOVERNANCE & OTHER MATTERS		
14.	Information Management Group (IMG) highlight and escalation report	
a	The Deputy Director of Corporate Affairs noted there was nothing currently to escalate.	
b	The Committee noted the update.	
15.	Any Other Business (AOB)	
a	None.	
16.	Brief reflections on today's meeting	
a	The Chair requested that any reflections on the meeting be emailed to her out of session.	
Meeting close: 12:04 Date of next meeting: 09 May 2024 09:00 -12:00 via Microsoft Teams		

Meeting of the Finance and Investment Committee

Thursday, 09 May 2024

09:00 – 12:00

Microsoft Teams virtual meeting

Apologies to nicola.gill@oxfordhealth.nhs.uk

AGENDA

		Start time	Allocated time (mins)
1. Apologies for Absence, ¹ and quoracy check	LW	09:00	
2. Minutes of Meeting held on 12 March 2024 and Matters Arising (paper – FIC 23/2024)	LW		5
3. Annual Planning & Budget setting			
• Annual Plan and oversight arrangements (paper – FIC 24/2024)	HeS/PT/PM	09:05	45
• Budget			
• Mental Health & Community Directorate spotlights	RB/BR		
4. Financial Management			
• Financial Report M12 (paper – FIC 25/2024)	PM/HeS	09:50	30
• Analytical Review of Financial Accounts Year End (paper – FIC 26/2024)	HeS		
• Capital Report M12: (paper – FIC 27/2024)	HeS		
• Estates Update (paper – FIC 28/2024)	JP		
• IM&T Update (paper – FIC 29/2024)	AC		
<i>Supporting information: Capital Programme Sub-Committee minutes and agenda (to note) - see Reading Room/Appendix (papers – RR/App 09/2024)</i>			
5. Major Projects			
• Warneford Park Programme update (paper – FIC 30/2024)	SC/HeS	10:20	30
<i>Information to note: Warneford Park Internal Programme Board minutes and agenda - see Reading Room/Appendix (papers – RR/App 10/2024)</i>			
• Business Case Review (paper – FIC 31/2024)	PM/HeS		
<i>Supporting information – see Reading Room/Appendix (papers – RR/App 12/2024)</i>			
• Oxford Clinic PFI Exit – Sept 2024 (paper – FIC 32/2024)	JP/HeS		

¹ The quorum for the committee is three members to include at least two non-executive directors (which could include the Chair of the Trust) and at least one executive director to be the Chief Finance Officer or nominated Deputy.
Apologies: None received

- Improving Quality Reducing Agency benefits
realisation update (paper – FIC 33/2024)

PM/CDS

Break 10:50 – 11:00 (10 minutes)

6. Operational & Strategic Risks (paper – FIC 34/2024)

- Deep Dive BAF 3.4 Delivery of the financial plan & maintaining financial sustainability (*focus on gaps and actions*)
- BAF 3.14 Major Projects – Insufficient capacity and capability to deliver major projects effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; and unplanned expenses, delays and wasted resources.

HeS/PM

11:00

25

HeS

7. Information Governance, Financial Governance & Other Matters

- Information Management Group (IMG) 3As report (paper – FIC 35/2024)

MU/GD/
BC

11:25

25

*Supporting information: IMG Minutes and agenda – see **Reading Room/Appendix (papers – RR/App 11/2024)***

- FIC Draft Annual Report/Workplan/ToR (paper – FIC 36/2024)

LW

8. Any Other Business: *to include matters referred to FIC from other sub committees*

LW

11:50

9. Brief reflections on today's meeting

LW

Meeting Close

12:00

Date of next meeting: 23 July 2024 09:00 - 12:00 via Microsoft Teams virtual meeting

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted -

10. Capital Programme Sub-Committee minutes and agendas: February 2024 and March 2024 (to note) (papers – RR/App 09/2024)

11. Warneford Park Internal Programme Board minutes and agenda: March 2024 (to note) (paper – RR/App 10/2024)

12. Information Management Group minutes and agenda: January 2024 (to note) (paper – RR/App 11/2024)

13. Business Case Review attachments (papers – RR/App 12/2024)

FIC Attendance 2024/25

FIC - Core members (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Jan-25	Mar-25
Rob Bale						
Amélie Bages*						
Philip Rutnam						
Ben Riley						
Heather Smith						
Lucy Weston						
Attending Board members (voting & non-voting included in quorum)						
Georgia Denegri*						
Grant Macdonald						
David Walker						
Regular Attendees (non-voting)						
Brian Aveyard						
Peter Milliken						
Priya Thompson						
Hannah Smith						

* = non-voting

MINUTES of the Mental Health & Law Committee meeting held on Thursday 29 February 2024 at 0900 hrs via Microsoft Teams

Present:	
Geraldine Cumberbatch (The Chair) (GC)	Non-Executive Director
David Walker (DW)	Trust Chair
Karl Marlowe (KM)	Chief Medical Officer
Kerry Rogers (KR)	Director of Corporate Affairs & Company Secretary
Mark Underwood (MU)	Head of Information Governance

In attendance:	
Nicola Gill (NG)	Executive Project Officer (<i>minutes</i>)
Amy Allen (AA)	Mental Capacity Act and LPS Lead
Brian Aveyard (BA)	Risk, Assurance and Compliance Manager
Rose Hombo (RH)	Deputy Director of Quality
Leanne Dunkley (LD)	Corporate Governance Officer (<i>minutes</i>)

Item	Discussion	Action
1.	Welcome and Apologies for Absence (GC)	
a	The Chair welcomed members of the Committee.	
b	Apologies were received from Britta Klinck, Chief Nurse.	
2.	Minutes of previous meeting held on 17 October 2023 and Matters Arising (GC)	
a	The minutes of the meeting held on 17 October 2023 were approved as a true and accurate record.	
b	Matters Arising No matters arising.	
3.	Trends in Mental Health Act (MU)	
a	MU presented the Trends in Mental Health Act report at paper MH&LC 02/2024, highlighting the following: Detentions have risen slightly compared with the previous year to date (YTD), relating to technical deficiencies, such as forms not being signed, which resulted in the application not being honoured;	

	• Nearest relative discharges have increased; • Proportion detained down to 86% from 89% in previous year, with 301 detained out of 350 inpatients. • Community Treatment Orders (CTO) down to 86% from 96% previous YDT, showing a steady decline; • one Section 4 application, which is an emergency application, whereby the individual requires admission within 24 hours. An application and one single medical recommendation are required to reflect the admission; • the snapshot of the detained patients shows that there is low use of Section 5(4) currently; • CTO's currently equally split between Oxfordshire and Buckinghamshire, with high concentrations in the popular areas of Oxfordshire and Buckinghamshire, which have high levels of deprivation; • Associate Hospital managers perform a function under Section 23 of the Mental Health Act (MHA), which gives them the authority to discharge detained patients, which is slightly less than the previous years. There were 56 that did not go ahead, and 13 cases adjourned, which happens when no reports have been submitted, or when a patient does not turn up to the appeal; • Currently processing 33 managers hearings and 59 mental health tribunals; • 454 tribunals have been completed over the past 10-month period; • Managers confidence in discharging patients has increased, with 6 discharges taking place, 2 each quarter, following ongoing training with input from solicitors and consultant medical staff on items of interest such as medications, major mental illness with upcoming sessions arranged to cover eating disorders and Learning Disabilities; • Legislation group is functioning well and getting good attendance; • Staff training summary shows an improving picture, particularly in the Primary Community and Dental services, which relates to documentation of capacity, assessment of capacity and the deprivation of liberties safeguard processes on community wards; • Proposals have been made to learning and development, following input from clinical staff to increase the duration of the training to two hours, which is due to be implemented from April 2024; • Training has started on a face-to-face basis for Doctors in training; • Continue to run the online sessions which have had great attendance, often over 150 individuals, however, still need to increase attendance to achieve 95% training level; • Section 17 leave shows a decreasing trend, with long term leave of two months or more, currently reporting 9, which reflects a	

	positive change in practice. For the April meeting an in-depth analysis will be completed; • The delivery of second opinion appointed doctor's certificates authorising medication and/or ECT has been an issue, with twelve pending, the remedy for this was to use Section 62 for medications or Section 64G for CTO patients, which is not the best practice, however this reflects a national picture; • The use of Place of Safety, which is a manually run report, which relates to the Section 135/136 detentions in Oxfordshire and Buckinghamshire, the number of people who are either subsequently detained or admitted to hospital informally and those who are discharged from Section 136 and leave, approximately a third of individuals are detained under Section 2 or 3 and the other two thirds proceed with either no care needs or care needs associated with their current care plan. MU has agreed to submit an updated report including this detail to be added to the reading room after the meeting; • There have been 800 uses of Section 135 or 136, with only 3 cases where an individual has had to go to police cells; • On target with completed actions from CQC recommendations, awaiting report from Amber Ward. The themes are related to the training delivered and seeing improvement; • Continue to work with both the access group and colleagues from the electronic health records team to develop the RiO functionality that will support the mental health act office and clinical staff in terms of accessing information; • Slide 2 shows the 4 principal risks, with the top one being tribunal hearings and the trust has been issued with directions from the Tribunal in relation to facilities and there have been some positive developments in this area, Paula Courtney the Mental Health Act office services manager has accessed some resources and levered change in the rooms and the way in which they are used. She has obtained the promise of £300,000 to make adjustments around Phoenix and Ashurst, to enable them to be used for Tribunal purposes if required; • The function for obtaining standard authorisations is not working effectively across the counties. Affecting patients in community wards and occasionally on mental health wards who become subject to an urgent authorisation and deprivation of liberty safeguard regulations never get the full authorisation in place. AA confirmed this was difficult as was out of our control due to the requests going to local authorities to complete the assessments. We ensure these patients remain under review at weekly meetings to maintain oversight and mitigate risk; and	

	There is a potential risk in relation to Tribunal's and rooms, impacting on patients due to some of the rooms occasionally giving rise to safety. If the Tribunal issued directions that a court attendance was required for it to proceed this would require transport and a clinical escort to attend thereby creating a potential resource issue.	
b	DW asked if acute trusts had the same legal responsibility to provide places of safety? MU responded saying that there were slightly different arrangements, OUH does not have a place of safety on site and if it was required an individual would be transferred to one of the ones in Oxfordshire. Buckinghamshire have slightly different provisions and at times use areas around A&E as places of safety, until they can be transferred under Section 136. The provision of a place of safety at the Meadow Unit at Warneford has made a big difference across Oxfordshire and Buckinghamshire.	
c	KM noted that Section 136 and places of safety was likely to be an area of focus as a project for the Trust and this committee over the coming year. A&Es along with police cells should have an area that could be used as a place of safety, it may not reflect all the requirements but could still be recognised as a place of safety in an emergency. MU responded saying that the law has changed to allow more flexibility as what can be classed as a place of safety and being able to assign areas with the agreement of management and leaseholder. People can be admitted to a hospital bed within the acute sector where necessary. There is work to be done on this and ensuring we have the correct pathways in place.	
d	The Chair asked if the Board could be assured that the Trust has got sufficient resources and facilities in place in relation to Tribunals, as using other facilities could have a financial impact. MU noted that in the last year there had been two incidents of tribunals being adjourned due to room arrangements. He offered assurance that the developments planned would address these issues.	
E	The Committee noted the report.	
4.	Trust Risk Register update (KM/BA)	
a	BA introduced the paper at MH&LC 03/2024, explaining that the risks are held by the Executives, and it is therefore an Executive decision as to whether a risk should or should not be on the risk register.	

b c d	This risk relates to TRR 1033, The Mental Capacity Act and the Deprivation of Liberty Safeguards, which has been tracking down to its target risk, which it had achieved. If the committee were assured around the management of this risk and that it was stable, they could decide to leave it on the TRR or move it to a local directorate risk register. KM added that as the change in legislation has been delayed the risk is not as predicted at the beginning. AA concurred noting that the Trust could continue with the current processes. Work continued to improve this process through training, in line with CQC themes. MU echoed these comments highlighting that this is reviewed on a weekly basis at the weekly review meeting. BA added that there is a daily check of DoLS in line with the Mental Health Act ensuring robust controls are in place and suggested it therefore was removed from the TRR. KM agreed it should be removed from the TRR. The Chair commented that it is clear that a lot of work has taken place in relation to this risk and asked for clarity as to whether the committee is being asked to remove this from the TRR or whether it needed to go to Executives to decide. KR replied by saying the committee is being asked to support its removal from the TRR. The Committee supported the removal of this risk from the TRR.	
5. a	Advocacy Update (RH) RH presented the report at MH&LC 04/2024, taken as read, highlighting the following: • This report reflects the access and activities of the independent mental health advocate to all inpatient wards over the past quarter; • Issues identified through PALS/complaints regarding access to mental health advocacy; • Asking directorates and the complaints team to identify themes, along with the themes identified by the independent mental health advocates to help improvement work; • The themes identified in Buckinghamshire show that activities are consistent with the previous quarter, with a slight drop in the number of new cases/activities, possibly due to wards/managers running local level surgeries and PALS surgeries. It is helpful to identify these and use the data to triangulate learning; • In Buckinghamshire the Community Treatment Order (CTO) is the highest used, with Section 3 being the next frequently used; • The introduction to advocacy is the top theme identified in Buckinghamshire. The number of advocacy ward visits dropped	

	during the pandemic and are now being reintroduced, which is positive, which should continue to increase; • The weekly report shows that the trust is doing well at reading people's rights and patients understanding their rights under the Mental Health Act, on the few occasions where this is not repeated or missed, patients would pick this up with the advocates on the ward; • In Oxfordshire, we have similar themes with ward rounds featuring highly, and associate directors of nursing and ward managers have been asked to consider what are the issues with ward rounds, what is causing the anxiety around these for patients; and • Care Programme Approach (CPA) has been identified as a theme in Oxfordshire, numbers are quite low, however it has been raised as an issue over the past 3 quarters.	
b	RH asked the committee for feedback on how to preset the report in the future, to focus on the learning and triangulate that data, to understand whether there is a need to increase the level of activities to improve the experience for people using our services.	
c	The Chair expressed an interest in seeing further analysis on the intersection between ethnicity and gender, to see how that is impacting patients. A more thematic angle would be useful to help understand what the issues are in CPA and ward rounds, through a deep dive analysis as this would focus the committee on the issues that are driving these themes.	
d	KM noted that introduction to advocacy was positive and means people are going onto the wards and advocating for people, noting that 80% of our mental health inpatients are detained under the mental health act.	
e	MU noted that the Pheonix unit were good at introducing people to the Independent Mental Health Advocate service, along with the Whiteleaf Centre, and there may be learning which would be beneficial to other wards. In training we are ensuring that we are being enthusiastic about the service. There is a high level of self-referral to the service, are we ensuring there is adequate information available on wards. Communication features highly at the weekly safety review from complaints, what happens when patients feel concerned about the care they receive. KM concurred noting that communication is crucial to the role of independent mental health advocates as they are the patients voice when they are unable to understand the circumstances of their detention, they are speaking the views of the patient and being a support	

f	to the patient. It is good to see them getting back to the wards and providing that support face to face.	
g	RH commented that the number of advocates is increasing and is significant as they are now frequently on the wards supporting patients.	
h	MU noted that the service is commissioned through the local authority, which results in them being under capacity pressure, which is a significant issue. If legislative changes increase the scope of their role, a significant uplift in funding for the service would be required.	
i	DW commented that he is trying to develop the Trusts relationships with voluntary bodies and charities and has had a conversation with POHWER, the national provider of the service, who gave the impression that the organisation was robust.	
j	The Chair thanked RH for the report and agreed to pick up offline how to best present the data moving forward, asking committee members to email her with any thoughts. The Committee noted the update.	
6.	Patient Participation Group Update (RH)	
a	RH provided an oral update on the Patient Participation Groups that have been set up across the Trust having developed “Your Voices” in various pathways across Buckinghamshire and Oxfordshire highlighting: • New groups are due to start in Young People and neurodivergent groups, which are going well; • The Trust is now increasing the involvement and numbers of experts by experience increasing co-production in projects. They made great progress in quality improvement projects and there is a target to increase the pool of experts by experience patients, increasing from the previous two quarters of a starting position of around 14% involvement to 41% currently; • For the Adult pathways, particularly mental health the groups are well established, there has been issues with the CAMHs pathway, work has been commissioned by a company called Onlog, which is to develop the young people’s pathway to visit schools to engage in wellbeing discussions to consider prevention work in order to prevent crisis situations. They have developed the young people’s board and run summits across the county, with 2 specific projects to deliver this year;	

	• In mental health the peer support initiative has increased significantly, this is still awaiting to be rolled out to the community; and • The Patient Carer Race Equality Framework is due to commence in 2025, which would be helpful to present to this committee in a future meeting.	
b	RH summarised by saying the Trust collects a lot of data however gaps remain, such as recording of ethnicity, which is improving, which makes it difficult to know the needs of the community to personalise and wrap care around individuals. The themes that are emerging from PALS and complaints remain similar around unhappiness around standard of treatment people have received, communication, access to services and waiting times, which can be out of our control.	
c	The Chair thanked Rose for the update, noting there is clearly a lot emerging particularly on the point about Patient Carer Race Equality Framework, that it would be useful to pick up in this committee as to how to embed this and look at how that reporting will feed into this committee.	
d	The committee noted the update.	
7.	Mental Capacity Act & DoLS update: (AA)	
a	AA took her report at MH&LC 05/2024 as read, highlighting: • she had included more detail regarding the risk mitigations factors, the control and process the Trust has in place for the Mental Capacity Act and DoLS; • There has been an increase in compliance with mental health act training across all directorates achieving 73-75% training compliance; good attendance at the training sessions with the online sessions often getting over 150 participants with good engagement; and • Training for community hospitals has increased and delivering these sessions on the wards and in the day rooms.	
b	AA asked whether the committee wanted further information or analysis on DoLS for future reports if interested in relation to location, gender and ethnicity. The Chair felt this would be useful.	
c	KM thanked AA for the report and commented that it is good to see the community health services directorate are taking up the training, we would expect more mental capacity act framing of care in community wards so really helpful to have that analysis.	

d	MU commented that he would be happy to work with AAto develop that level of analysis.	
e	The Committee noted the update.	
8.	Use of Force Act update: (KM)	
a	KM provided an oral update to the committee to reassure them that work continues to progress, and the policy has now gone live on the Intranet.	
b	The Committee noted the update.	
9.	Legal and Regulatory update (KR)	
a	KR provided an oral update highlighting: - the Terms of Reference have been announced for the Health Service Safety Investigation Branch, who conduct investigations into mental health inpatient settings, which was directed by the Secretary of State. That will look at how we learn from inpatient deaths and use that learning, the provision of safe care, out of area placements and the impact on safety and working conditions of staff. This will be given full protection from disclosure to allow staff to respond honestly to it, the committee may wish to review the results to understand the outcome of the review and whether we have an improvement plan associated with this; - The Department of Health have recently released new guidance to provide greater clarity on the duty to co-operate on discharge, in terms of working with local authorities to ensure that there are safe places in the community; and 13 trusts including ourselves were affected by the cyber-attack, and so the data of quality and data completeness is compromised, however the 2022-2023 statistics have been released. The data shows higher rates of males are detained per 100 thousand of population, among adults the detention rates start to fall, black persons are more likely to be detained than a white person. Due to the data issues, it may be more beneficial to wait for the next years data to be published as that should be more reliable.	
b	MU circulated the report mentioned to committee members. We are one of the few Trusts that due to the outage have not been able to submit the data to the report. Trends continue, with a slight reduction in the number detained. For the next committee meeting he will provide some comparative data in relation to gender and ethnicity.	

c	DW commented that it was good to receive updated guidance and standards of care, however there is a physical infrastructure on which they depend, and so the resource base needs to be there.	
d	The Chair commented that now we are in the recovery phase post cyber-attack t we can build a better basis of data. As a Trust we do need to draw a line if necessary and set out our position on resourcing.	
e	The committee noted the update.	
OTHER BUSINESS		
8.	Any other business	
a	AA highlighted that she provides a monthly article of newsletter/guidance and webinars about mental health and DoLS and asked if the committee would like to see this? The Chair commented that would be beneficial.	
b	KM commented on the Right Care Right Place issue with the Police services across the country and the Royal Collage of Psychiatry has raised concern about the impact of this on people not being able to access support in times of crisis and the responsibility is falling on mental health and community trusts for situations they are not in control of. The Nottingham Case was discussed at Board, it led to the family questioning both the police and NHS actions. As a committee it would be useful to bring the learning from this case back and consider what we as a Trust can improve. The Chair commented that from a legal perspective this case was a bit of an outlier due to the way in which the CPS managed it, she agreed to discuss with KM offline.	
c	MU noted in relation to the associate hospital managers, their meetings have been reviewed and the way they conduct themselves and are about 50% compete. An advert is currently live for more associate hospital managers, he encouraged the committee to let anyone they know with an interest in mental health and participating in quasi-judicial process to apply on NHS jobs.	
d	KR noted that a recent employment tribunal outcome has been published with regard to Lancashire and South Cumbria NHS Foundation Trust, whereby someone has made a claim as an associate hospital manager having workers status. It was a risk for them as the individual whistle blew and was trying to claim under the public interest disclosure act and was prevented from doing so as a non-member of staff, however it looks as if they have won their case due to the shape of their honorary contract. KR	

	will circulate the link, and it would be worth as a Trust considering how we contract our associate hospital managers to ensure we are not at risk of the same. DW commented that their independence would be compromised if they were employed by the Trust. MU agreed with DW's point and that if they strayed into the employment category then it would compromise the mental health act and associate hospital managers, with potential for far reaching implications.	
9.	Meeting Review (ALL)	
a	None.	
10.	Meeting Close	
a	There being no other business the meeting closed at 10:28 hrs.	

****The next meeting is scheduled to be held on Thursday 18 April 2024 at 0900 hrs via Microsoft Teams****

Meeting of the Mental Health & Law Committee

~~Thursday, 18 April 2024~~ deferred to Monday, 13 May 2024
0900-1100 hours

Microsoft Teams Virtual meeting (invitation only)

Apologies to Leanne Dunkley, Leanne.dunkley@oxfordhealth.nhs.uk

AGENDA

1. Welcome, apologies for absence and quoracy check <i>(defined as 4 of the membership to include at least one Non-Executive Director and at least one Executive)</i>	Chair	09:00
2. Minutes of the Previous meeting (paper – MH&LC 06/2024)	Chair	09:00
3. Trends in Mental Health Act (paper – MH&LC 07/2024) <i>To include updates on:</i> • Mental Health Act Managers • CQC Activity/Compliance • Adequacy of guidance/training on MHA legislation	MU	09:05
4. Trust Risk Register update (paper – MH&LC 08/2024)	KM/BA	09:30
5. Draft Annual report (paper-MH&LC 09(i) /2024) • Draft Terms of Reference (paper MH&LC 09(ii)/2024 • Workplan 2024-25 v1 (paper MH&LC 09(iii)/2024	GC/KM/GD	09.50
6. Patient Participation Group & Pals update (oral update)	Rose Hombo	10.20
7. Mental Capacity Act & DOLS update (paper – MH&LC 10/2024)	Amy Allen	10:25
8. Use of Force Act & Restrictive practice Update (oral update)	BK	10:35
9. Legal & Regulatory Update (if required)	GD	10:40
Any Other Business		
11. Any Other Business (oral discussion)	All	10:45
Meeting close		11.00

Date of next meeting: 16 July 2024, 09:00-11.00

Mental Health & Law Committee
Member Attendance 2024 - 2025

Name	18 April 2024	16 July 202	15 Oct 2024	2025
Geraldine Cumberbatch (Chair)				
Amy Allen				
David Walker (Trust Chair)				
Britta Klinck	Apologies			
Karl Marlowe				
Georgina Dengie				
Mark Underwood				

Regular attendees

Rose Hombo				
Leah Awi				
Brian Aveyard				

People Leadership and Culture Committee
Minutes of a meeting held on
Tuesday 30 April 2024 at 13:30
At Whiteleaf Centre, Aylesbury

Present:	
Mindy Sawhney	Non-Executive Director (Chair) (MS)
Geraldine Cumberbatch	Non-Executive Director (GC) (part meeting, from 13:54)
Charmaine De Souza	Chief People Officer (CDS)
Rob Bale	Interim Managing Director for MH and LD Services (RB)
Britta Klinck	Chief Nurse (BK)
Ben Cahill	Deputy Director of Corporate Affairs (BC)
Emma Leaver	Service Director Community (EL)
In attendance:	
Sigrid Barnes	Head of HR Systems & Reporting (SB)
Joe Smart	Head of Organisational Development (JS)
Brian Aveyard	Risk Assurance and Compliance Manager (BA)
Kezia Lange	Deputy Chief Medical Officer, Professional Standards (KL)
Alison Bourne	Head of HR Policy, Reward and Projects (ABo)
Alastair Reid	Director of Medical Education (AR)
Jane Blacklock	Programme Improvement Manager - Temporary Staffing (JB)
Shirley Innes	Executive Assistant to Chief People Officer (SI) (<i>note taking</i>)
Apologies:	
Andrea Young	Non-Executive Director (AY)
Grant Macdonald	Chief Executive Officer (GM)
Georgia Denegri	Interim Associate Director of Corporate Affairs (GD)
Hannah Smith	Assistant Trust Secretary (HSm)
Ben Riley	Executive Managing Director Primary, Community & Dental Care (BR)
Peter Milliken	Director of Finance (PM)
Rebecca McKnight	Guardian of Safe Working Hours (RM)
Christina Foster	Head of Health & Safety (CF)

1.	Introductions and apologies The Chair welcomed the Committee members.	Action
2.	Declarations of Interest No interests were declared.	
3.	Minutes of the meeting 17 January 2024	

a.	The Chair proposed the minutes of the previous meeting were noted as an accurate record.	
b.	The Chair handed over to the Chief People Officer (CPO) to update on the open actions on the log,	
c.	6.z/7.h Outstanding NHSP issues. These will be discussed under Agenda item 11. Actions to remain open	CDS
d.	10i Action to provide data by protected characteristic in next H&S Report to PLC. CF is away from work, there is a Highlight and Escalation Report in the Reading room but this has not been progressed. Action to remain open	CF
e.	AC 53/2022 (item 8a) Mandatory Training - action to remain open until compliance of 95% is reached. Oliver McGowan training will become part of the S&M training from May 2024. The Executive will be focussing on RESUS training and the discrepancies of training places vs attendance. Action to remain open The Interim Managing Director for MH and LD Services (MDMH) added this is reviewed in other settings too.	BE
f.	11.j Gender Pay Gap Reports - statistical analysis to be sourced. The Chair and CPO to discuss how we can obtain intersectional analysis and what alternatives exist if we cannot source this resource. The Chair has sent some thoughts to The Head of OD (HOD). Action to remain open	MS/CDS
g.	6.u The Chair reflected that the PLC are seeking assurance that appropriate data have been gathered, triangulated and analysed, not for the PLC to do that analysis. CPO to consider how analysis of data can better be presented This is an ongoing action, we are working towards a better balance of analysis and data. given we have controls on Corporate spend. 30/4 We are looking to triangulate data through the People Insights Report. Action to remain open	CDS
h.	11.o The Chair observed that the Medics' regime is not included and originally had asked for this to provide a complete overview and requested the CPO to ensure that this is included. HLD to add to next update working with colleagues in Medical workforce. To be kept open until the next update on Mandatory Training and Supervision comes to PLC so that we can be assured that the Committee is able to understand the position with Medics. 30/4 Learning & Development are not involved in relation to Medics in Medics and their Stat and Mandatory training and supervision. The MDMH confirmed that through their Appraisal process, Medics have to report on various elements of training and peer supervision. The Chair confirmed that PLC requires oversight so we can assure the Board we are compliant so asks that L&D liaise with the CMO and his team to provide oversight of this. Action to remain open	
i.		

j. k. l.	12.d The Chair referred to the draft Wellbeing strategy (page 4) and suggested it would be helpful to formulate and take to the Board as a way of stimulating a more reflective conversation. Action to progress offline. The Chair has advised that this workshop needs to be taken forward by PLC members. CPO and Chair to discuss how best to do this. 30/4 The CPO advised that the Interim Associate Director of Corporate Affairs (IADCA) is taking a review of Board activity and will determine if this should be done at Board level or PLC level. Action to remain open 12.i The Chair and the CPO to provide a cover note and paper to the Board for assurance of staff welfare, to include details of the offer of support from DDCA around evidencing, the overarching health and wellbeing strategy and the CFO's reference to the food strategy. Action to remain open The Chair advised that the actions from the Internal Audit on Temporary Staffing need to be added to the PLC Action Tracker. Action for Executive Assistant	BE/AB MS/CDS MS/CDS SI
4. a. b. c. d. e. f.	Workforce Reports Purpose – To assure the Committee of escalations of actions/interventions that haven't been delivered against the people element of the 2023/24 Annual plan. The Chair advised that we have a number of data packs but not yet an analysis pack. The job of PLC is to seek assurance that these data are being reviewed, triangulated, insights drawn, and actions taken – not for the Committee to do this; we are working towards an analytical summary being provided. Summary data pack The CPO advised that a similar data pack is considered monthly by the Executive; this month's focus was on Long term Sickness, next month will be RESUS training. The Chair welcomed the improvements in retention and added that the analytical narrative needs to consider - are we narrowing the gap between white and BAME Staff leaving the Trust - are we improving the experience of BAME colleagues through casework process - what is our target for 'time to hire' Whole Trust data pack The Chair advised we need to be cautious how we are attributing improvements in retention, given the improving national picture, and to understand if we are tracking level with/above/below this.	

g. h. i. j. k. l. m. n. o. p. q.	We have a lot of initiatives incl. our Restorative Just and Learning Culture work, Braver than Before etc, but we need to ensure they are fully aligned and determine how we are using them to build the Culture of the Trust and manage the risks identified in the BAF. The Chair suggested we have a deep dive at the next PLC or hold a separate Workshop. Action: CPO to advise whether to hold Risk Workshop on Culture or do as part of PLC meeting The CPO and HOD confirmed that as part of the Enabler 3 programme, a PID is being prepared for the CEO to review. This can be brought to a future PLC. Community Services Directorate data pack The Service Director, Community (SDC) advised there is some very challenging, complex casework, Staff are struggling. We need to consider how we integrate a RJLC culture in practice. The Chair enquired can we roughly quantify the risks of HCA sponsorship and right to work changes? The CPO confirmed that the number of staff affected is approx. 300 and that we have renewed as many visas as we could prior to the new legislation coming into effect in April. We would now need to take stock and understand what the medium to longer term impact is as we work through the visa rule changes which are complex. The CPO advised that new Government rules came in from April, work has been done to gather information and all Staff that we were able to, have been extended, and all Service Directors advised. We have future proofed as much as we can, but the numbers in scope will increase due to changes in legislation. The Chief Nurse (CN) asked how this affects overseas students, as c.80% of Brookes nursing students are from overseas and this could affect our pipeline. The Risk Assurance and Compliance Manager (RACM) advised that more risks have been added in relation to this. The SDC acknowledged that Sickness remains a challenge, but there is strong HR support and it is heading in the right direction. We don't yet understand our early turnover and are deep diving into this. Geraldine Cumberbatch (GC) asked when we are likely to come back with the deep dive results? The SDC suggested October PLC would be suitable to share findings. Action to add to Workplan	CDS SI ✓

r. s. t. u.	Mental Health Directorate data pack The MDMH advised that although the Learning Disability team had red Staff survey scores, there were no real surprises and he was not unduly concerned; there have been a lot of changes. The data is helpful and better than expected with the financial impact, vacancies, and demand and capacity. The HOD advised that the Retention team have been in post for a year, the next step is for them to work much closer with teams and develop work around Exit interviews. The Chair commented that we do have a QI project on Retention and early turnover. The CPO added that we are also looking at early turnover in relation to race in particular.	
5. a. b. c. d. e. f. g.	People Dashboard: Purpose – 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. The Chair observed that most of our data is backward looking and we are developing our capability to look forward using lead rather than lag indicators to be able to identify areas of the organisation where issues may be developing. As identified in the learnings from failures at other Trusts, we need to be sure we're looking at desegregated data to encourage us to be 'problem sensing' rather than 'comfort seeking'. The Chair confirmed that the Quality Dashboard considers all services and that the People Dashboard includes all Trust teams including Corporate. The Chair invited observations and suggestions. Colleagues agreed this view of the data was very helpful and would be helpful at all levels of the Trust. The CPO advised this is the first cut of this data and she will compare with the Quality Committee dashboard to see if any Teams overlay. Action for CPO Forensic Services will soon be at full capacity with Band 5s. The MDMH reflected this data was useful, but it would also be helpful to have trend lines, to make it easier for people to understand.	CDS

d.	Corporate posts have increased by a relatively modest amount, approximately 5% of the total and nearly all growth has been funded by MHIS and SDF Investment.	PM
e.	The Chair suggested it would be helpful for our own strategic purposes to have total figures and by role type, and to see non-clinical roles separated. Action for update to come to next PLC	
f.	The MDMH confirmed that Admin roles in a Clinical setting would be classed as Clinical. The Chair clarified that the purpose of the work is to help us discuss.	
7.	Retention deep dive:	JS
a.	Purpose - To assure progress. To provide detail of workstreams, what results are being targeted and timescales. To cover hotspots in relation to retention and detail actions to reduce early turnover, particularly with BAME Staff	
b.	The Chair thanked the HOD for the significant amount of work involved. Going forward it would be good to be clear about where we are tracking the national trend and whether we are above or below.	
c.	The HOD advised there has been a national down trend in NHS Retention.	
d.	GC asked what the cut-off point is for a true leaver from the NHS?	
e.	The HOD confirmed that over a 12 month break is considered to be a leaver.	
f.	The HHRSR added that national data does come into the Model Hospital but there is an approx. 6 month lag so its usefulness is limited if we are looking for real time information.	
g.	Locally we are only able to pull data at the point of leaving if Staff advise of their destination, it is only nationally they can pull leaver data after a break.	
h.	The MDMH added that again, trend data would be helpful.	
i.	The HOD to provide a trend update at the next PLC. Action for HOD	
j.	The CPO confirmed that we are going to be an Exemplar this year and have appointed a new People Promise Manager who will start in June. We can learn from the first cohort and will be able to hone in on specific retention elements.	
k.	The Chair commented it is a real achievement to have under 14% turnover.	
l.	We do only have approx. 1/3 of leavers completing Exit Questionnaires, and it is really important to hear the difficult to hear voices.	

m.	We need to think strategically and use a segmented approach – how do we approach different staff segments, what are our interventions to support managers etc.	
n.	Across all sectors, 60% of Staff leave jobs because of their immediate supervisor.	
o.	The MDMH added local ownership is needed to understand and develop strategies for individual services.	
p.	The RACM questioned how much we focus on training Managers appropriately. The Chair added that there is a risk in new recruits having expectations re the People Promise and coming into Teams where there is no knowledge of it.	
q.	The HOD advised that the 'brand' is the People Promise, there is a 30minute slot covering it at Induction but isn't necessarily sold across the Trust.	
r.	Staff are encouraged to contact the HOD or CEO directly if the Trust doesn't deliver the People Promise to them within their first 6 months.	
s.	New leadership training is focussed on delivering the People Promise.	
t.	There was a general discussion of the challenges of asking Staff to complete surveys.	
u.	The Chair summarised that to date the Trust has focused its efforts on short term, tactical improvements which was a reasonable course of action given the challenge. However the Trust was now in a position to develop a Retention strategy that takes a segmented approach to staff (life stage, career stage etc) and to service requirement (location, role type). Action: CPO/HOD to update with timeline and approach for a Retention strategy	CDS/JS
8.	Strategic and Operational Risks	
a.	Purpose - To provide an update on revised Workforce risk. To provide a summary paper of changes to approval of risks (from Committees to Exec)	
b.	The CPO advised that the Retention BAF risk has not been updated but the deep dive provides discussion points to allow us to focus on specific areas.	
c.	The Chair asked if we think the risk description adequately captures our risks given the conversation we just had?	
d.	The CPO and Deputy Director of Corporate Affairs (DDCA) agreed they recognised those indicators and provided an accurate description.	

e.	The Chair suggested we add controls and actions, segment our training and retention offers, develop our strategy for exit interviews, and include initiatives to improve PDR quality.	CDS
f.	The Chair enquired as to when the new starters QI project will be complete?	
g.	The HOD advised the project to improve the onboarding process is ongoing, including trying to streamline and ensure quality of Local inductions.	
h.	The CPO confirmed we will update the BAF with comments and align with the Long Term plan. Action for BAF to be updated	
i.	The SDC raised concerns of delivering care in Oxford City from a retention perspective. The Chair commented this added further force to the need for the development of a segmented approach.	CDS
j.	The Chair enquired if there were any comments re TRR 1020 to share with the Executive? There were not.	
k.	The CPO advised the next PLC would be too soon for a deep dive on the Culture risk given our work on Enabler, and that this should be considered either at the Oct PLC or a separate workshop. Action: CPO to advise	CDS
l.	It was agreed the Retention risk would be updated to reflect the discussion and the most recent work and be brought back to July PLC. Action for CPO/RACM	CDS/BA
9.	Staff Survey update:	
a.	Purpose - To advise of Performance against Trust improvement plan. To provide analysis vs previous year, vs Trust, vs Bob, vs national. To advise of key topics of concern, key organisational units of concern and plans to address these.	
b.	The Chair introduced the Overview has been considered by the Board, and we are reviewing in a more granular way. She noted that The overall results are a real credit to all colleagues in the Trust, with almost every measure showing improvement even though Staff have been through a difficult time.	
c.	The HOD confirmed the internal approach to communicating results has changed and we were placing emphasis on how we have compared year on year to show where there have been improvements. Our response rate in 2023 was 51.43% which had decreased from 2022 where the response rate was 53.40%.	
d.	The Chair advised that there was a relatively small decrease in response rate this year vs last year, but a significant fall from 2 years ago. While survey responses show improvement, we need to be attentive to response rates being a primary	

	marker of engagement, and we need to be curious about who is not completing the survey and why.	
e.	The Chair noted her warm support for the improvement narrative internally. However, it was important that we did not conflate management's approach with assurance requirements to the Board. PLC does need to see – alongside the improvement position - comparative data within the Trust, as well as local and national comparators. Action: HOD to update analysis	JS
f.	The Corporate results are worse than last year, the HOD advised we need to split out and work through; it is important we understand the detail behind it.	
g.	The CPO advised that the 594 Admin & Clerical Staff have many different Managers; there have also been a lot of Leadership changes in Corporate.	
h.	The HOD advised that when coaching is done, Teams are shown how to interrogate the data in TOBI.	
i.	The Chair requested an update on the coaching of Corporate Teams at the next PLC. Action for HOD	JS
j.	The Chair advised that PLC needs to be assured that staff survey data has been analysed and used to feed into improvement actions. The SDC and MDMH advised they needed to see the data cut at Team levels to enable them to have oversight and to identify priorities.	
k.	The HHRSR advised that once all the data is in TOBI, we will be able to triangulate data with Freedom to Speak up Involvement, Casework etc.	
l.	The Chair raised that Students scored very low on confidence the organisation would address their concerns, is it Medical students? Action for HOD to clarify	JS
m.	The Chair requested an update is brought back to PLC, with assurances that Executive colleagues have what they need. Action for HOD	JS
n.	We must also have FTSU comparators nationally and locally. Action for FTSUG	RBS/LB
o.	Actions identified to be taken forward include the OD team presenting results to directorate senior manager teams; insights to be identified in relation to professions and protected characteristics (with ongoing engagement with Staff Networks); support to teams to develop their "one action" approach which will be complemented by coaching support to managers and teams with results being more easily available on our TOBI platform. Actions for HOD	JS

10. a. b. c. d. e. f.	EDI 6 high impact actions update To provide assurance of activity in the Trust to meet the actions, and for any of the actions with a March 2024 deadline that haven't been met, to provide a revised forecast date. The HOD confirmed that the HIA to support EDI efforts are strongly recommended by NHSE. The HOD outlined that of the 15 actions with a March 2024 deadline, five are currently red rated as not complete, seven are marked green as completed and three are marked as Amber as some elements have been completed while others are still pending. The HOD has summarised what is actively being worked on as well as looking ahead to next set of deadlines in June. In relation to HIA 1.3: <i>"NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework"</i> The CPO raised that the National team have suggested this be monitored through our BAF. The Chair asked for the CPO and Governance Team to develop a recommendation for how this will be done via the BAF. Action for CPO and RACM The Chair questioned if all 7 recommendations of actions 3.1 Mend the Gap had been completed as they were wider than just the Clinical Excellence Awards. Action for HOD to confirm at next PLC that all actions are completed and to provide an audit trail for this as it is wider than just the CEA awards. The Chair summarised that it was to be warmly welcomed that the CEO and CPO were leading the EDI Group and that the intention of the group was to use the high impact actions as an improvement plan rather than only for assurance. She added it would be useful for the tracker document to have an additional column for improvement and one for meeting of the requirement. Action for HOD	CDS/BA JS JS
11. a. b.	Temporary Staffing update Purpose - 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 on reduction of long lines of Agency and related actions e. Overview of NHSP Improvement plan f. Update on plan to improve e-rostering The Programme Improvement Manager, Temporary Staffing (PIM) advised the experience has been very poor for staff with NHSP onboarding and interactions.	

c.	We have action plans, we now offer onboarding to NHSP for our new substantive starters. There will be more NHSP on site presence from end of May, and a more joined up approach.	
d.	The Chair requested that a summary of the Internal Audit findings and actions are added to the Reading room for the next PLC.	
e.	The SDC and MDMH feel more confident that we are identifying problems and moving in the right direction.	
f.	The CN commented that people have found a way to work with it, but consideration needs to be given to the unintended consequences of moving tasks, managing rotas is a full time job which is now carried by our frontline staff.	
g.	The MDMH added consideration is needed of the skill mix in front line teams, do we need to bring in non-clinicians for admin support.	
h.	The CPO acknowledged the initial assessment was lacking, the work involved and how NHSP would interact were underestimated.	
i.	The PIM advised the Health roster system is being rolled out across the remainder of the Trust. NHSP have a new interface that will interact with our roster system and this will be automated from the Autumn.	
j.	The Chair concluded we do now have a robust listening mechanism, and reflection would be good once we are through thick of learning.	
k.	The Chair agreed that we do need to question Staff systematically picking up tasks, are we just displacing costs and what effect this has on the quality of the staff experience.	
l.	The CPO set out that the Month 12 data sets out that our agency spend for 23/-24 will be £35.371m which is made up of £37.733m on agency staff offset partially by the release of an old year provision of £2.4m. The total spend is 10.46% above the ceiling target set by NHSE of £32.022m. The year end position is worse than forecast by £1.8m, £1.1m of this is due to a change in the available old year provision release for previous cost, £0.3m retrospective shift bookings, £0.3m of increased staffing demand and £0.1m for legacy housekeeper costs outside of ID Medical. Finance are working to understand what has driven the higher than expected spend in M12.	
m.	The Chair acknowledged there has been significant progress in all fill rates and displacement of Agency from 2 years ago. However, we cannot repeat being 10% over our ceiling and for this not to be anticipated before year end. We need to have assurance that we have understood the root causes and demonstrate this feeds through into robust plans to meet our targets this FY.	

n. o. p. q. r. s.	The CPO added that we have saved £6m on Agenda for Change roles in relation to Agency spend which is an improvement on the 22-23 year. However, this has been offset by the increased spend on Medics. Finance are currently working through next year's targets and we will have our ICB targets set by July PLC. The SDC raised improving the NHSP reputation within the Trust. The PIM advised NHSP will be carrying out site visits with drop in sessions available. They will contact Managers with specific issues. The SDC suggested we buddy them up with our Managers to help them land better into Services. The Chair noted that e-rostering update was also due to be provided and asked for this as part of the next report. Action e-rostering update to be included in next report The Chair asked if we believe we have adequately mitigated against repeated breaches of working time directive until we get a proper fix? The CPO confirmed we have taken all possible precautions and that we would prioritise the work to implement a new integration platform between e-rostering and NHSP systems which would be released in the Autumn.	SB
12. a. b. c. d. e. f.	Medics - update on engagement and leadership development Purpose - To provide Assurance on: - Progress of issues identified in last report to the Committee - Alignment with wider Trust strategy and people development The Chair advised Medical engagement was last reviewed at PLC a year ago and that the team had asked for some to progress key initiatives before returning to PLC to update The Deputy Chief Medical Officer (DCMO) confirmed that people feel moral injury, not being able to give the care they want to. Recruitment, retention and reward are all issues, we are in a difficult space and direct engagement been difficult. The MDMH confirmed there is now a more consistent approach and we have much better data at Team level. The CN questioned if the Consultants are being heard adequately by the Executive team. The Chair asked about the difficulties noted in repurposing budgets for different staff roles where recruitment was proving very challenging. She asked if this was being looked at by Finance and HR?	

g. h. i. j. k. l. m.	The DCMO raised that lack of incentives is an issue for current Staff retention. CEAs are disappearing due to Consultant contracts, parking issues, too many systems; Staff do not feel supported. The Head of HR Policy, Rewards and Projects (HHRPRP) suggested we review how we provide support to our more crucial roles. Action for DCMO and HHRPRP to identify a programme of work for onboarding and recruitment bonuses to be held in escrow. The Chair was concerned to see the number of medics completing the Staff survey drop significantly. It would be beneficial to see a segmented approach for Recruitment and survey results to be cut by protected characteristics. The Chair raised inflexibility on repurposing budgets and questioned how this could be resolved. She also asked if the next update could include metrics with some trend data so we can more easily be assured of the link between actions and impact. The DCMO raised the Local Negotiating Committee; the BMA is keen to finish covering colleagues policy before updating Terms of Reference and starting to co-produce Agendas. Action: next update to PLC in Oct	KL/AB KL
13. a. b. c. d. e. f.	Guardian of Safe Working Hours Report Purpose - To provide assurance to the Committee in the form of an Annual Report in relation to the work of the Guardian of Safe Working Hours The Chair asked for clarification of who receives the issues raised in the report and how might the Committee take assurance that the issues have been registered, assessed and, if necessary, a course of action undertaken. The DCMO confirmed it is taken to the Board for assurance that the system is working. The Director of Medical Education (DME) added that this is also reviewed at the quarterly Junior Doctors' forum. The Chair questioned how we can provide assurance on the Report content? The MDMH suggested we could make it simpler for some of our Clinical teams to feedback - we now have a lot of Medical Managers.	

g.	The CPO added that we are missing our response to the report. Action to return with clarification on where/to whom the issues raised in the report go and to receive a response from them on these issues	KL/RM
14.	Medical Education Report	
a.	Purpose – To provide assurance to the Committee in the form of an Annual Report in relation to Medical Education	
b.	The DME thanked the HHRPRP for her help with the Report.	
c.	The Trust has expanded to have more trainees, which should contribute to 'grow your own' but that brings the challenge of having enough Consultants to supervise.	
d.	The GMC survey is currently underway, we had some negative feedback last year. We will have this year's results in July and can bring to October PLC. Add to Workplan.	SI ✓
e.	The Chair asked if specific EDI questions were asked in the GMC survey.	
f.	The DME advised it is a National survey and we are unable to dictate questions.	
g.	The HHRPRP added that we will provide as much granularity as we are able. The Chair thanked her and added that the Committee was seeking assurance that such statistics had been analysed in order to inform actions taken.	
h.	The DME will be meeting with Finance to determine a budget for Trainees.	
i.	The DME and Head of L&D are working together on the Leadership offer for non-medical band 8bs.	
j.	The Trust is leading the way in our region for Simulation based learning.	
k.	The CPO commented it was impressive to see the scale of Education, we are such a big provider in the region, but the profile could be higher in the Trust.	
l.	The Chair congratulated the number of colleagues who have received various awards over the last year.	
m.	GC asked if a follow up meeting for CAMHs trainees at Warneford has happened?	
n.	The DME advised the survey data is most likely incorrect as there is only one person training there, but they have been assured we will act on their concerns.	

o.	GC asked for clarification re negative outliers, are they talking about just interactions with staff or patients or both?	
p.	The DME advised there were 12-15 categories with several questions in each.	
15.	HR Policies Annual Report	
a.	Purpose - To review progress of updates to Policies in 2023/24 and provide assurance of 2024/25 work programme	
b.	The HHRPRP advised a remedial review has taken place, we are working to ensure the Trust knows how to use the Policies, providing bite size training, videos etc.	
c.	The Chair commended the work that has been done.	
d.	The CN acknowledged the improvement with bullet points of what you need to know, what is your responsibility.	
e.	The HHRPRP confirmed there is a new approach where we try to have a short Policy and more detail in the guidance document.	
f.	GC asked if all Policies are discussed with Union colleagues?	
g.	The HHRPRP confirmed that all Policies are reviewed through the Policy Group which includes the Chair of Staffside and the Staffside Secretary, and that the meeting is minuted.	
h.	The DCMO acknowledged the differentiation where Policies don't necessarily apply to each Staff group.	
i.	The HHRPRP added that we need to be careful of procedures in Medical policies for Medical staff.	
j.	The DDCA asked if all Policies are on Ulysses the Trust register?	
k.	The HHRPRP confirmed that they all were.	
l.	The Chair recognised the Policies were in a much better place and asked for thanks to be passed to Goldie Prince.	
m.	The Chair commented it would be useful in the principles to make explicit the intention to balance the different needs of the Patient, the Staff and the interests of the Trust. It is good that we are drawing on the central repository, and the Chair encouraged colleagues to be pragmatic about the trade-offs between customising policies and the effort this entails with the additional utility this can provide. Action for HHRPRP	AB

n. o.	The HHRPRP advised that Staffside colleagues have requested an in person Policy away day, with Heads of HR and MDMH and SDC and part of the agenda is focused on agreeing these priorities. The Chair requested the Whistleblowing Policy to come to the next PLC meeting so that we can onward assure the Board Action for HHRPRP	AB
16. a. b.	PLC Annual Report Purpose - To provide assurance of the work of PLC ahead of Annual Report being reviewed at Board in May 2024. The Chair requested that any comments are emailed to the Chair and CPO ahead of this being reviewed at the Board meeting on 22 May 2024.	
17. a. b. c. d. e. f.	PLC Workplan and Terms of Reference review Purpose To review the Workplan and ToR for PLC Committee ahead of escalating to Board in May 2024. The Chair requested that any comments on ToR are emailed to the CPO ahead of this being reviewed at the Board meeting on 22 May 2024. The Chair advised that the Workplan has changed from a rolling list which we can draw from when setting Agendas and is now diarised The Chair requested in particular that the SDC, MDMH and CN together consider the proposed and items and confirm it covers their priorities. Action for SDC/MDMH/CN The MDMH questioned how we can reflect on items and perspectives from frontline staff and not just self-assure ourselves? The Chair responded that we usually have a 'Voice of' slot at the PLC meetings, a staff story. This year we are refocusing these to the strategic priorities of the Trust, including for example, what we are learning from our colleagues' experiences of bringing about change .She asked for additional suggestions about how we can further bring in diverse perspectives especially from frontline. The CPO noted that the Medical Appraisal and revalidation item needs to be moved to July as the data won't be available until then. Action to amend	EL/RB/BK SI ✓
18. a. b.	AOB The Chair requested that the Highlight and Escalation Reports are moved to the 3A Report format. The Chair noted the advice from the Education Strategy Group that NHSE has not yet confirmed funding for CPD and that the Trust would incur costs related to this in advance of funding being confirmed. She noted discussions regarding	

	pooling CPD bids and budgets and that this would enable a more cost-effective way of using the funding.	
c.	The Chair asked how confident we are that there is adequate input from Ox and BSW MH, Forensic and LD given that there are no Forums for them?	
d.	The MDMH was surprised to hear that and will check. Action for MDMH	RB
e.	The CPO advised that as part of Enabler 1 work, the Executive are reviewing the way we work and Committee sub groups; there are too many sub groups and we need to determine the model for the People agenda governance.	
f.	All of the current H&E Report Groups could report up to the People Steering Group (including Retention) and PSG would provide one single highlight report.	
g.	The Chair asked if the Sexual Safety Assessment results can be reported to this Committee.	
h.	The Chair asked for thanks to be passed on to the Heads of HR for providing good assurance through the Report on Employee Relations and Casework.	
i.	The Chair questioned if a wellbeing check had been carried out for the person who has been on suspension for 142 days?	
j.	The CPO confirmed that yes, they have had ongoing contact within the HR team and the Directorate.	
k.	The Chair asked if there were concerns around the very significant increases in Disciplinary and Grievance Casework?	
l.	The CPO suggested it could be a reflection of post Covid.	
m.	The SDC added that Staff are struggling at all levels with complexities, both in and out of work, cost of living challenges etc.	
n.	The Chair suggested some probing may be useful, what is driving this, are we seeing disproportionate data? Action: to include in next report	ZM/JC
o.	The HHRPRP advised that a deep review of the Disciplinary policy has been done considering RJLC.	
p.	The Chair suggested that when we do a Culture deep dive it would be good for us to consider how we are mitigating the risk of a gap between actual practice and what we espouse, including how we support colleagues to embed approaches in their actual work e.g appraisals, disciplinaries, tea meetings etc	

q.	The Chair thanked the Committee and closed the meeting at 17:05	
	Reading room <i>(for information only)</i> Highlight / Escalation Reports: a. People Steering Group b. Learning Advisory Group c. EDI Steering Group d. People Systems Program Board e. Health & Safety Committee ER Casework review Report ER Annual Report	

DRAFT

Meeting of the Oxford Health NHS Foundation Trust Quality Committee

**[DRAFT] Minutes of a meeting held on
Thursday, 08 February 2024 at 09:00**

virtual Microsoft Teams meeting

Present¹:

Core members and attending Board members included in quorum

Andrea Young	Non-Executive Director (Committee Chair) (AY)
Rob Bale	Executive Managing Director for Mental Health, Learning Disabilities and Autism (RB)
Britta Klinck	Chief Nurse (BK)
Grant Macdonald	Chief Executive (GM)
Karl Marlowe	Chief Medical Officer (KM)
Ben Riley	Executive Managing Director Primary, Community & Dental Care (BR)
Kerry Rogers	Director of Corporate Affairs and Company Secretary (KR)
Heather Smith	Chief Finance Officer (HeS)
David Walker	Trust Chair (DW)
David Clark	Non-Executive Director (DC)
Amèlie Bages	Director of Strategy & Partnerships (AB)
Lucy Weston	Non-Executive Director (LW)

In attendance²:

Brian Aveyard	Risk Assurance and Compliance Manager (BA)
Lynda Dix	Associate Director of Nursing, Forensic Services (LD) (deputising for Rami El-Shirbiny, Clinical Director, Forensic Services)
Helen Ward	Head of Quality, BOB ICB representative (HW)
Leanne Dunkley	Corporate Governance Officer (LCD) (minutes)
Benjamin Cahill	Deputy Director of Corporate Affairs (BC)
Nicola Gill	Executive Project Officer (NG) (minutes)
Mike Hobbs	Public Governor (MH)
Hannah Smith	Assistant Trust Secretary (HS)
Mohinder Sawhney	Non-Executive Director (MS)

¹ Members of the Committee. The membership of the committee will include executive director members and at least two non-executive directors. The quorum for the committee is five members to include the chair of the committee (or the vice chair of the committee in their absence), one non-executive and one executive director. Deputies will count towards the quorum and attendance rates. Deputies for the chairs of the quality sub-committees (the named vice chair of the sub-committee) will attend in an executive's absence. Non-executive director members may also nominate a non-executive deputy to attend in their absence.

² Regular non-member attendees and contributors.

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Rose Hombo	Deputy Director of Quality (RH)
Jane Kershaw	Head of Quality Governance (JK)
Angie Fletcher	Deputy Chief Nurse (AF)
Tina Malhotra	Clinical Director, Buckinghamshire Mental Health Directorate (TM)
Michael Marven	Chief Pharmacist and Clinical Director for Medicines Management (MM)
Pete McGrane	Clinical Director, Community Services (PMcG)
Ros Mitchell	Deputy Chief Medical Officer & Clinical Director (RM)
Vicki Bull	Head of Business Services, Finance (VB)
Priya Thompson	Head of Strategy
Emma Fergusson	Consultant Child and Adolescent Psychiatrist (EF)-part meeting
Claire Forrest	Head of Clinical Standards (CF)
Sarah Hill	Head of Service Adults & Older Adults (SH)
Srikesavan Sabapathy	Governor Observer (SS)
Kristen Prance	Clinical and Service Director Learning Disabilities (KP)

1.	Apologies for Absence	Action
a	Apologies for absence were received from the following Committee members/Board members: Jude Deacon, Director of Forensic Mental Health.	
b	No Apologies for absence were noted from regular attendees.	
c	The Chair confirmed the meeting was quorate.	
2.	Minutes of the Quality Committee on 9 November 2023 and Matters Arising	
a	The Chair welcomed all to the meeting.	
b	The minutes at QC 01/2024 Minutes of the Quality Committee (QC) on 09 November 2023 were confirmed as a true and accurate record.	
c	Matters Arising The Committee noted that the following actions were on today's agenda: • 3(g) Committees interest in Neurodivergent conditions and how the Trust could better utilise resources and expertise to support the individuals and their families; • 3(j) Safe Staffing report; and • 14 (c) & (e) BAF 3.1with added controls. Therefore the actions could be closed.	
d	The Committee noted the following action had been completed and closed: • 11(f) Inquest and Claims annual report.	
e	The Committee noted that the following actions remain:	

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	• 5(d) Mental Health, Learning Disability & Autism Inpatient Quality Transformation Programme- to be brought to May 2024 Committee meeting; • 6(c) Patient and Carer Race Equality Framework (PCREF) to be brought to the May 2024 Committee meeting; and • 10(d) Health and Social Care Gap analysis and Infection Prevention Control (IPC) Board assurance Framework-to be discussed whether this requires to be a stand-alone register, as was the requirement during Covid or whether this can be added to the Trust risk Register and BAF-to be discussed outside of this meeting.	KR/BK
SAFETY		
3.	Quality and Clinical Governance Sub-Committee (QCG-SC) escalation report	
a	The Chief Nurse presented the report, at paper QC 02(i)/2024 which provided a QCG-SC highlight report and the Quality & Safety Dashboard. She highlighted the following escalations: • Medicines Management and the new regulatory measures concerning the prescribing of Sodium Valproate, which were introduced on the 31st January 2024. There was a plan in place including a central register of prescribing Sodium Valproate; • Supply issues of medication, particularly those used in ADHD., which Pharmacy teams have oversight of; • Delay in the roll out of the Inpatient Medical Examiners role, hosted by OUH and BHT, due to issues with capacity, which many areas were experiencing, as these individuals were supplied to the Trust from partner organisations. The plan was to start the roll out at the beginning of April. RM updated the committee that nationally there could be a further delay in the roll out, as informed by Lead Medical Examiners; • Strengthening resus numbers in terms of training continues and a review was taking place to look at how the training was being delivered and whether it was at a suitable level;; and • Shortage of staff continues to have an impact on quality and capacity in many areas, including access and waiting times, particularly in District Nursing, where it was reported there was an improvement project taking place across the BOB partnership.	
b	The Chair asked for Clarity on the Weigh Forward Bucks (WFB) service that was mentioned on page 4 of the report. The Chief Nurse responded by explaining that it was a psychological programme to support individuals to lose weight and was part of talking therapies and psychological support in managing physical health conditions. It was reported that waiting lists are being reviewed and options on how to manage demand going forward. The Committee asked to be kept apprised of the outcome of these discussions.	BK
c	The Trust Chair asked if there was a timeline for the review of Resus Training,? The Chief Nurse responded by saying the QCG-SC had been asked to provide a timeline and should be able to provide an update in May.	

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d	Quality and Safety Dashboard: The Chief Nurse referred to the Quality and Safety Dashboard at paper QC 02(ii)/2024, highlighting that teams/wards continued to experience high vacancy rates and the following mitigations were in place to monitor these: • ongoing transformational work with the District Nursing Teams which would be tracked through this committee; ; and • pausing of referrals to the Adult ADHD service.	
e	The Chief Nurse responded to a question raised by LW by explaining that there were many indicators that could be included into the Quality dashboard, however it was important to consider that the purpose of the dashboard was to inform the committee of where they were at any given time. However ideally, as business intelligence capability improved it would be useful to see median waits and also the distribution curve of waiting for the longest times. The CN also clarified that vacancies alone do not necessarily lead to poor quality of care; it depends on whether the service triggers additional quality indicators, such as PSIs, complaints or incidents, as to whether they appear on the watch list or alert list.	
f	LW commented on the mention in the report of Buckinghamshire Healthcare withdrawing Electro cardio graphs (ECG) testing for our patients as there was no clear commissioning pathway.	
g	The Trust Chair responded by saying that the withdrawal of ECG testing relates to Mental Health patients in Bucks, at present it is not clear how many individuals were affected but could pose a risk to patients.,	
h	The Chief Nurse commented that these patients were now being sent to Emergency Departments or via their GP to have the ECG test completed. The Chair commented that this could impact on patient experience and was contradictory to providing holistic care to mental health patients. It was reported that the issue had been escalated to the ICB.	
i	In response to a question from LW KP clarified that the high vacancy rate in Learning Disability Services is partially due to a change in the team model and that the update in May would provide further clarification on the transformation project, as at present TOBI data had not caught up with the service restructure. She assured the Committee that the vacancy rate was not as high as indicated.	
j	The Chair highlighted that the wait times information will improve, once further reporting is available, she agreed to discuss this further with LW outside of this meeting.	AY/LW
k	The Chief Nurse will find out when further data on waiting times would be available.	BK/AB

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l m n o p q	The Chief Executive assured the Committee that the Trust is balancing the best interests of staff and patients, for example the adult ADHD service referrals have been paused to allow them to catch up and review the system to maintain patient safety. Since there is no capacity to triage individuals currently, anyone identified as high risk will still be seen through the community pathway. Safe Staffing Report: The Chief Nurse took the report at paper QC 03/2024 as read. The Chief Executive thanked the Chief Nurse for the Report, highlighting the following issues that were raised at the Executives meeting which the Chief Nurse had been asked to address: • The Long Days issue, there needs to be a clearer level of assurance that care hours during the overlap were being included; • The Long lines issue, needs more data to support this and provide assurance to the Committee; and • Greater assurance for the next report to provide more robust data, presented in a clearer format, including showing grades of nursing. The Chair clarified that this report is usually on a 6 month reporting cycle, however some of the assurances should be drawn out for the monthly report in May. <i>Mohinder Sawhney joined the meeting as an observer</i> Patient Safety Incident Report including Mortality and Homicide Reviews. The Chief Nurse introduced the report at paper QC 04/2024, highlighting the following: • There have been 7 serious incidents that occurred over Quarter 3; • Of note were 2 inpatient deaths during, one was a patient AWOL from a Mental Health Ward and the other a patient on a Mental Health Ward who became physically unwell and subsequently passed away in the John Radcliffe Hospital, both have gone forward for full investigation; • On the 4th December we transitioned to the new Patient Safety Incident Framework, allowing development of our own Patient Incident response plan. This practice continues to be embedded and will allow more flexibility to investigate incidents in a more meaningful way with a focus on learning; and • This report shows the work of the Mortality Group, who have undertaken 2 thematic reviews during this quarter, one concerning patients lost to follow up in Buckinghamshire and the other relating to Pressure Ulcers. The Chair noted the medication incidents on Abbey Community Hospital ward, and asked whether this was a random set of incidents or was there cause for concern? PMG responded by saying that there were no specific concerns, with excellent reporting from pharmacy colleagues. It was one of the busier wards, with the EMU	BK

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	pathway increasing volume and turnover of patients, so there would always be the potential for a higher rate of incidents.	
r	The Chair asked, in relation to the domestic homicides and the cases that we were involved in, were these our former patients who were perpetrators of violence or experiencing the violence?	
s	The Chief Nurse responded by saying that it is a mixture and that the law has now changed, to include any type of domestic abuse including coercive behaviour and emotional abuse.	
t	The Trust Chair highlighted that within the NHS individual cases cannot be generalised from, however yesterday he received a letter from a relative of a patient concerned about the care they received, quoting a section from the letter, highlighting that they felt their relative did not receive the same level of care that a patient with a physical health concern would receive. This letter argues that there remains inequity in Mental Health services.	
u	The Chief Medical Officer commented that lessons could be learnt from such correspondence. Individuals with Schizophrenia are much more marginalised than ever before, and we are trying to address this in Mortality and PSI reviews to ensure that the service focuses on physical health as well as mental health.	
v	DC noted that one of the criticisms of the NHS Long term plan was that despite bringing an extra one billion pounds a year into community mental health, it did not bring any clear pathways or clinical models. Patients therefore do fall into the gaps as highlighted within this letter; in the NHS post long term plan we should focus on developing these pathways.	
w	The Chief Nurse thanked the Chair for highlighting this letter, as it is important to pay attention to those individual cases as often these have historically changed the way in which policies are developed and, in some cases, have changed the Law. The crucial aspect here is the patient experience, which is why we are trying to involve patients to work alongside the Trust to shape services. Individuals suffering with schizophrenia are among those most disabled by mental illness.	
x	The Trust Chair echoed DC's comments by highlighting that the next NHS Long Term plan will include a practical definition of clarity between physical and mental health care, which has previously not existed. SSI, thanked the Trust Chair for highlighting this letter and asked for clarity as to whether the needs of the patient could not be met due to capacity or were the needs of the patient not identified? The Trust Chair responded that this is the detail he is seeking before responding to the letter. The Chair summarised, by thanking all for a thoughtful discussion and that we need to review pathways through the power of listening to individuals' stories.	
y	The Committee noted the reports.	

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4. a b c	Quality Compliance & Regulation Update a. CQC Compliance & Regulation The Chair took the report at paper QC 05/2024 as read, noting the actions and work taking place, and requested the committee see a Board to Ward governance flowchart to provide further understanding for Committee members. She suggested that in the deep dives the Committee reviews how that process works and what the experience feels like, what issues are being flagged, and how do they feel that Board to Ward assurance is working for them in practice. CF responded that she would add further clarity to the report for the next committee meeting to make it more meaningful. The Committee noted the report.	CF/BK/KR
CARING, RESPONSIVE & EFFECTIVENESS		
5. a b	Service deep dive into Neurodiversity Services in Buckinghamshire and Oxfordshire. Emma Fergusson, a Consultant Psychiatrist provided the Committee with an oral update on the Neurodiversity service including background understanding of neurodivergent conditions, the current situation that is driving demand and the options being developed to support patients, their families and the staff caring for them. <i>Background:</i> Neurodiversity includes conditions such as Attention deficit/hyperactivity Disorder (ADHD), Autism and Tourettes and often individuals will be diagnosed with more than one condition. Several Trusts have set up clinics for the branches of neurodiversity, however this can be a disadvantage as it does not allow for a holistic assessment. Assessment is about ensuring the individual and their families receive the correct support, and medication, if appropriate. Over the past 70 years, cases of individuals living with neurodivergent conditions has risen from one in 500 to 1 in 20 in 2022, this is partially due to the broadening concept and increased knowledge, including presentations in the female cohort, which is different to how males present. Identifying the condition/s is positive as it helps young people and those around them to understand themselves, to be better supported and to celebrate strengths. The sensory input that individuals experience now is far greater than it used to be, which if you have a sensory impairment can make everyday feel very hard work. <i>Current Situation:</i> BSW has a different commissioning arrangement to Oxfordshire and Buckinghamshire, and they do not undertake Autism Spectrum Disorder (ASD) assessments, and paediatricians manage the ADHD pathway;	

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	• In Oxfordshire, we complete all the ASD and ADHD assessments from the age of 5 upwards, we currently have young people waiting as long as 5 years, with an average mean wait of 92 weeks, median wait is 79 weeks; • In Buckinghamshire, who have recently moved to new commissioning arrangements the mean and median wait is 102 weeks; • At present the service can manage 14 new assessments per month, however receiving 120-150 referrals per month. This results in the waiting list increasing by 100 per month, each month; • When the service was commissioned, the ongoing input that these children required was not considered, so there is a caseload of over 1000 people who require ongoing management and support, among a team of 12 whole time equivalents; • To support this, non-medical prescribers have been trained, with careful supervision from Consultants who each manage an individual caseload of up to 150 children, with varying needs and input. If the child's risk increases, or complexity increases their care is transferred to the Consultant, until things are more settled; and • This reflects the national picture across England.	
c	Current Mitigations: • The team would like to try and reach agreement with the Education Authority that a diagnosis is not required to access resources and support, it should be based on needs; • Offer all resources and signpost how to access resources in Schools upon referral, rather than awaiting assessment; • Linked with Autism Oxford, so have access to a ream of resources including parent and young people's groups; • Individual family slots to discuss the issues, however this is not being accessed despite our best efforts; • Have a Duty line to offer support to those individuals on our waiting lists; • Working across BOB with Mary Evans the BOB lead for Neurodiversity, to pool resources; and • Moderated platform, Support Hope & Recovery/Resources Online Network (SHARON) which was developed in Berkshire, is about to be rolled out for parents to support one another.	
d	Future Actions: • Mary Evans calculated that it would cost approximately £10m to assess all the young people across BOB, however there isn't the money or clinicians to do this; • In Oxfordshire we are considering how we can make clinical time as efficient as possible and reduce the stigma to allow individuals to self-identify, so that we can focus on the support rather than the diagnosis; • Supported by The Chief Medical Officer, the Manging Director for Mental Health & Learning Disabilities and Nick Broughton (former CEO) to develop Artificial Intelligence (AI) to maximise clinical time. AI enables faster triaging of cases into 3 groups based on complexity and then the team match clinical resources to the complexity of those cases;	

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	• There would be the standard, the enhanced and the complex clinics, based on the individuals needs and circumstances; • The National average time it takes to complete an assessment is 13 hours, in Oxfordshire we were doing them in around 9 hours, including admin time and feedback, in the enhanced clinic we are now taking between 5 to 6 hours to complete, which is a significant saving. In the complex pathway it is between 8 to 9 hours, and we believed that once the standard pathway is running this could be done in 3 to 4 hours; • We have developed a digital form, to support this based on learning from a team in Fife, which depends on AI to open different aspects of the form. The idea is to collect as much information from parents and teachers prior to being seen to save repetition; • True Colours has been problematic, the form has been built and we are about to start using this, which will allow us to implement the fastest pathway in our clinic and that the information will be used to inform the AI what the clinician does; and • Aim to get the AI triage into the correct clinic and flag any risks identified and to tailor the early support we offer and to develop a Neurodiversity pathway.	
e	The Chair thanked Emma for the very informative oversight of the service and recognised how the team are exploring all avenues to improve their responsiveness.	
f	The Trust Chair asked if the paediatricians and neurologists in our area should be contributing more, as in BSW to help with the demand. Should there be a more flexible deployment of National Health resource to deal with this issue and if so, how would that be organised?	
g	EF thanked the Trust Chair for his question and noted that Paediatricians were trained in this and could do the assessments, however the Oxford University Hospital did not define this within their remit. She felt it was easier to recruit paediatricians compared to Child and adolescent psychologists, Paediatric neurologists could also be doing these assessments, however this was a complex area. Adopting the same pathway as BSW, whereby the ADHD assessments were completed by the paediatricians, would be a better way to manage the resources we have and adopting a more medical approach could help to de-stigmatise neurodiversity.	
h	DC thanked Emma for the insightful talk, and the innovative work with AI, and asked if there was monitoring of the outcomes for those seen in service, as it was this data that could generate funding in the future, and outcome measure were likely to feature highly in the next NHS long term Plan,	
i	EF responded that once this system was working then they would like to offer it across the NHS and would appreciate time to meet with DC to discuss how to secure funding.	

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j	LW thanked Emma for a brilliant discussion, noting the need for much wider screening across the Trust, with increasing prevalence and impact on mental ill-health beyond that.	
k	SS asked whether diagnosis needs to be completed by a consultant psychiatrist or paediatrician, and is this part of the reason for the waiting list due to difficult recruitment in these areas?	
l	EF responded by saying that it is more regarding the clinicians training, for example Speech and Language Therapists often diagnose neurodivergent conditions along with psychologists, NICE guidance is that it should be completed by a multidisciplinary assessment, which is something the Trust have had to consider to ensure that it is multidisciplinary, whilst being as efficient as possible.	
m	The Managing Director for Primary, Community, and Dental Care, commented that involving paediatricians and neurologists would likely delay assessment further as there are already huge waiting times within these services. As the Trust provides most of the children's nursing and therapy and SEND health assessments in Oxfordshire there could be a risk that we would just be moving the issue from one part of the Trust to another,	
n	EF responded she would be happy to talk to teams, noting the information had been circulated to GP's.	
o	DC noted that this could be an opportunity for funding from NIHR for a randomised control trial, and asked EF if she would like to consider this with the support of PHD students to obtain that data.	
p	The Chair summarised noting the need for a wider conversation in communities and across the system about how the Trust could move away from an assessment led constrained waiting list to better meet needs along with other partners in providing support and resources in the right place. Placed based partnerships could be a good place to start these conversations.	
q	AI used intelligently is groundbreaking and will have wider benefits to the NHS in how we manage care.	
r	Emma Fergusson left the meeting 11.02am.	
s	The Committee noted the presentation.	
6.	Quality Account (Quality priorities)	
a	The Chief Nurse took the report at paper QC 06/2024 as read, noting the following: The Trust continues to make progress in all 10 areas, however due to the legacy of the IT outage it was not able to demonstrate this in all areas, which should improve over the next 6 months;	

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b c d e	• The transformation work around district nursing is ongoing which aims to maximise capacity, manage demand and improve quality; • The use of prone restraint in clinical practice continues to fall; and • The transition to Patient Safety Incident Response Framework (PSIRF). The Chair reflected, that given the Trust's issue with tracking data, careful thought needs to be given as to what to include in the Quality account for next year and would welcome thoughts from committee members about what we have learnt from this year. The Chief Nurse supported this reflection and updated the committee that the Chief Medical Officer and herself were working on a draft document to make these more measurable so that they can be tracked throughout the year. The Chair thanked the Chief Nurse for the report. The Committee noted the report.	All/BK
7 a b c	R & D update: The Chair thanked Vanessa Raymont for her paper at QC 07/2024, which helped to assess Board Assurance Framework (BAF) issues, providing lots of detail around Governance, oversight and improvements in R&D. The Chief Medical Officer presented the report, highlighting: • The development of the Standard Operating Procedures (SOPs) that are being worked on at present to allow the R&D teams to work with a set up much quicker for research projects coming through. At present, they have a range of people lining up to work with the R&D team, however the existing process is too slow, so they are working with our support services to overcome barriers; • Currently reviewing the governance to allow us to be robust and increase the number of research projects we are undertaking with a focus on efficiency in terms of study set up; • There is a lot of work currently taking place within research Clinics, and he drew the committee's attention to the Oxford Psychological Interventions in Children and Adolescents (TOPIC) research clinic (AnDY), which provide effective, cost-effective low intensity solutions for anxiety in children and adolescents. Currently working on implementation of NICE guided technical appraisal for 2 digital tools, which are OSCAR and AUSSIE; and • Treatment resistant depression clinic led by Rupert McShane, Consultant Psychiatrist and Mike Browning Honorary Psychiatrist currently being set up. DC gave an update to the committee on AUSSIE, which is a parent training intervention for anxious children ages 5-11, a very large trial of AUSSIE was published recently in the Lancet, which demonstrated that this online training platform gets as good a result as 30 standard CBT sessions, making it a cost-effective intervention as it takes considerably less time to implement.	

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d	The Committee noted the Report. <i>The Committee stopped for an 8-minute break.</i>	
7.	Clinical Effectiveness update: a) Clinical Effectiveness Decision Group The Chief Medical Officer took the report at paper QC 08/2024 as read, highlighting the update from the Clinical Effectiveness Decision Group (CEDG), The Deputy Chief Medical officer highlighted: - the work being done within the Adult Eating Disorder service, to ensure that they are providing a full medical assessment and the recruitment of a part time Consultant Psychiatrist along with the Nurse Consultant roles, ensuring that their job descriptions are in line with national guidance; and - Medicines management continues to feature highly. b The Chair thanked the Deputy Chief medical Officer for the report and commented that it is uplifting to see people considering how to constantly improve their services. It was good to see a process in place tracking decisions and timelines for the adoption of new pathways or models. c The Chair, asked if the resource and governance implications had been considered in relation to becoming the lead agency for the National Ketamine Registry. d The Deputy Chief Medical Officer confirmed that this is being considered and a follow up meeting was being scheduled. It was recognised there is a resourcing implication. e The Committee Chair commented that holding the Registry can have a positive aspect in terms of profile, and data and knowledge sharing. f b) Clinical Audit update The Associate Director of Quality presented the paper at QC which provided a summary of: Clinical Audit and NICE activity across the Trust. She highlighted: - To provide assurance to the committee that all escalations relating to deviations in national Audit requirements and NICE are escalated through the CEDG; and - The Trust is in a good position, with a robust oversight of NICE across the Trust, with further development in train. g The Trust Chair commented that this document is beneficial to identify where the gaps and issues may be and to have visibility of these, noting the comment that NICE and clinical audit need to support the development of the Trust's QI strategy, as part of the feedback and learning loop. h The Associate Director of Quality highlighted that the Trust is considered one of the fore runners in terms of taking Audit and NICE into the improvement realm, and audit is an integral part of improvement.	

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i	The Chief Medical Officer noted that the Quality Management system the Trust has in place, as identified on page 1 of the report is something that we should be linking back to, seeing Clinical Audit as part of the assurance process as opposed to being viewed on its own and links with the Quality Improvement methodology. The next steps are embedding this system across the Trust.	
j	The Chair commented that this should be form part of our Quality narrative, that we understand how the quality Management system works and how we implement the circle of activities.	
k	The Chief Nurse suggested that this may be best displayed in a diagram to show how the governance works.	
l	c) Medicines Management report The Chief Pharmacist & Clinical Director for Medicines Management presented the report at paper QC 10/2024 noting the following key updates: • Work is taking place with our partner organisations in the ICS to develop single collaborative guidelines and formularies; • Work taking place locally with research and academic fellows to develop guidelines, that will put our clinical practice at the cutting edge of research; • New drugs scheduled to come online over the next two years, which we are planning for; • Making good progress in the prescribing of Sodium Valproate, following the national patient safety alert. The focus is on what needs to be done as a Trust to give the assurance, and we have developed the patient registry, which we are working on to make it a more systematic approach that captures real time information and developing local dashboards for teams. • Overall compliance is good; however, we need to review to ensure that assurance is presented in line with the new CQC inspection regime; • The first phase of the Electronic Prescribing and Medicines Administration (ePMA) has been completed for Mental Health Inpatient's which is going well and have received additional funding from NHSE to undertake some more integration work to develop a closed loop system ePMA is being rolled into the wider frontline digitalisation programme. The next phase of this will include Mental Health Outpatient and Community hopefully this Spring; • Shortages in the supply chain continue and work is ongoing to across the system to monitor and mitigate these. There is the potential for this to worsen; • The Trust will later this year have access to the Medicines Carbon Footprint system, which provides a validated carbon footprint rating for every medication, that can be used to develop our formulary and guidelines using an environmental impact alongside the current considerations of safety, clinical effectiveness and cost effectiveness as part of the trusts Green Plan; and	

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	The General Pharmaceutical Council (GPhC) is currently running a consultation on their draft Standards for Chief Pharmacists, following the change in legislation, which removes the threat of criminal penalties for accidental or unintentional preparation and dispensing errors by pharmacists in hospitals and similar settings. Previously it was considered a criminal offense under the medicine's legislation. A response to the consultation will be developed and submitted by the Trust.	
m	The Chief Executive asked about the financial implications around the new Alzheimer's drugs due out over the next few years, with some drugs such as Aripiprazole becoming generic which could have significant financial benefits, are we able to hold that saving to pay for the new therapeutics as they become available.	
n	The Chief Pharmacist, responded by saying yes, this was being considered. The generic prescribing will be included as a cost saving next year; however, the biggest challenge is going to be the new drugs coming in which could equate to £13-14million across BOB, it is becoming increasingly complex in planning around medicines as it also needs to include the infrastructure cost not just the cost of the medicines themselves. Conversations are taking place at present to consider these options.	
o	The Executive Managing Director Primary, Community & Dental Care asked in relation to the Sodium Valproate prescribing, as some of the epilepsy charities have raised concerns relating to harm from individuals stopping it and the new guidelines requires that 2 specialists are required to review this, given our current waiting times, are there risks there we need to be capturing, considering and reviewing.	
p	The Chief Pharmacist reported that following the audits completed to develop the registry there was an even split between where it is being used as an anticonvulsant in epilepsy and where it is being used a mood stabiliser. Generally, if it is being used for epilepsy then it is under the care of the Neurologists, outside of our Trust, so at present there are some gaps that we are trying to address. From a Mental Health consideration, we have raised the question with our services on the implications of having 2 specialists reviewing, which generally most teams do not consider will be much of an issue. If it does become an issue, there is a fallback position whereby members of the Drug and Therapeutic Group will be able to act as the second specialist.	
q	KP, to provide assurance to the committee, as we also use this medication for both mood and epilepsy in Learning Disabilities, a gap analysis has been completed, all patients taking Sodium Valproate for Epilepsy have been linked back to Neurology to take the lead for ongoing review and those taking it for mood are being reviewed by the LD specialist Pharmacist and Psychologist.	

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r	Medical Devices: The Chief Medical Officer introduced report at paper QC 11/2024, which is a collaboration between colleagues from Procurement, Pathology and medicines management, highlighting the following: • Storage for Medical devices has been a challenge; however, space has been identified in the Oxford Pharmacy Stores in Banbury from April; • To provide confidence that all medical devices to be disposed of have the correct Kite Mark, to be disposed of either via auction or have reached the end of their life; and • New head of Procurement in post, looking at all new contracts, considering disposal at the end of the device's life, so that the carbon impact is considered at the beginning of the contract.	
s	The Committee Chair thanked the Chief Medical officer for the report.	
t	The Committee noted the updates and reports.	

Policies and Governance

9.	Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF)	
a	The Committee Chair took the paper at QC 12/2024 as read, noting that the Committee is invited to: • Review the updates to BAF 1.6, relating to sustainability of the Trust's primary, Community and Dental services, where the controls have substantially been strengthened and the risk rating remains at 12; • BAF 1.1 - Triangulating data and learning to drive Quality improvement-a full review to be presented at the May committee meeting; • BAF 3.1 - to be reported back to the committee in May following the implementation of the changes agreed on 13 July 2023; and • BAF 4.1 -was discussed at the last meeting and the update paper today provides substantial assurance.	
b	LW commented on BAF 1.5, which related to the unavailability of beds/demand on Capacity (Mental Health inpatients and LD), which is the highest rated risk, which does not capture all the key risk that has been discussed in conversations. This seems to suggest that an increase in beds would reduce the risk, however the risk is different, our risk is in our approach as to how we manage the increase demand and capacity, rather than the lack of available beds. The articulation of the risk does not always match with the discussions at Board level.	
c	The Chair clarified that this risk is associated with inpatient services, however the wider point around Mental Health Capacity is valid and that would likely need to be considered a new risk.	

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d	The Chief Executive replied that maybe as a Board we need to consider the BAF and the risks, which will be discussed at an upcoming workshop.	
e	The Committee agreed to bring this back to the committee in May for review.	
f	The Chair noted that most of these risks have been recently reviewed and the Committee were going to: • review BAF 3.1 to check if the rating has improved at the July committee meeting, when we should have more evidence available; and • Risk 1.5 to be reviewed in May 2024.	
g	The Chief Finance officer suggested bringing BAF1.1 to the May Committee meeting, which considers whether we are using digital in the way we should.	
h	The Chief Medical officer commented on BAF 4.1 recommended that it's rating be held at 6, given the update report.	
i	The Chair, noted the changes to the Trust Risk Register (TRR), which is for the Committee to note and discuss if required, rather than amend.	
j	The Director of Corporate Affairs and Company Secretary commented that risk often drives the agendas of meetings and the Assistant Trust Secretary, and the rest of the team, will continue to use the information in these meetings to inform the development of the BAF and the TRR, as well as to influence the content of agendas.	KR
k	The Committee noted the report.	
10.	Provider Collaboratives:	
a	The Committee Chair took the report at paper QC 14/2024 as read. She noted that in this report only the specialist mental health provider collaboratives are mentioned, is there somewhere else where the other collaboratives are discussed? The report shows that there has been a lot of changes and improvements in the 3 specialist M/H provider collaboratives and the substantial review of the commissioning process.	
b	LW asked the extent to which we understand the differing governance requirements over the provider collaboratives from a commissioner as opposed to a provider. We have deeply embedded mechanisms and frameworks to manage the provider side, however the commissioning responsibility is very different. What assurance is there over the commissioning side of the contracts?	
c	The Chief Executive commented that a review of the governance structure and arrangements for commissioning took place and was implemented. It will also form part of a Board Workshop, scheduled for 28 February. He felt assured that the people completing this work understand commissioning.	

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d	The Chair asked for clarity as in the paper it says we have been delegated commissioning, however the next paragraph states that NHS Southeast region opted to defer delegation of specialised mental health commissioning budgets from NHSE to ICB's, can we clarify which areas we are commissioning?	
e	The Chief Executive confirmed the area that has been deferred is the NHSE ownership to ICBs, which has been delayed to April 2025. There is a legal oversight by NHSE at present.	
f		
g	The Chair drew the Committee's attention to the Forensic provider collaborative strategy for adult secure services being developed, which has an implication for our Trust strategy, and our clinical strategy so should be brought to the Board's attention once complete.	
	The Committee noted the report.	
11.	Annual planning:	
a	The Head of Strategy introduced the report at paper QC 14/2024, highlighting: Ongoing work with RH around the quality priorities, making sure that they feed into the plan, that will hopefully be signed off today, however teams have seen the draft versions and once confirmed will be added to the plan.	
b	The Chair thanked the Director of Strategy & Partnerships and the Head of Strategy for the report.	
c	The committee noted the report.	
16.	AOB	
a	The Committee Chair noted that there are two potential items that have been identified for the next meetings deep dive. These include - an oversight of the 0-19 response and how we have set up services, including the Trust's response to the SEND report - Learning Disabilities services.	
b	After consideration it was agreed that the 0-19 services should take place in May's meeting and the Learning Disability Services deep dive be deferred to the July meeting.	
17.	Review of the meeting	
a	NA	
	Meeting closed at 12:07 Date of next meeting: 02 May 2024 at 09:00 via Microsoft Teams virtual meeting	

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Meeting of the Quality Committee

Thursday, 02 May 2024

09:00 - 12:00

Microsoft Teams virtual meeting

(live video streaming – invitation only)

Apologies to leanne.dunkley@oxordhealth.nhs.uk

AGENDA

			Indicative Time
1. Apologies for Absence and quoracy check ¹		AY	09:00
Minutes and Matters Arising			
2. Minutes of the meeting of the Quality Committee on 08 February 2024 and Matters Arising (paper – QC 15/2024)	<i>To confirm & report matters arising</i>	AY	09:05
Safety			
3. Quality and Clinical Governance Sub-Committee (QCG-SC) escalation reporting including:	<i>For assurance</i>	JK/BK	09:10
a. Quality and Safety Dashboard (paper – QC 16/2024)			
b. Patient Safety Incident report including mortality and homicide reviews (paper – QC 17/2024)			
c. Positive and Safe (paper – QC 18/2024)		AF	
d. Workplan 24/25 (paper –QC 19/2024)			
4. Service Deep Dive	<i>For assurance</i>	EL/BK/B	09:30
a) 0-19 Services and response to SEND (oral update)(presentation at RR/APP 03)		R	
	<i>To note</i>	CF/BK	09:50
5. Quality Compliance & Regulation updates:			
a. CQC Compliance & Regulation (paper – QC 20/2024)			
	<i>To Approve</i>	RH	09:55
6. ~~Quality Account (quality priorities (paper – QC 21/2024)~~			
a. ~~Sign off draft Quality Account 2023-24~~			
b. ~~Approve Quality Priorities 2024-25 [paper not available]~~			

¹ Apologies received from Committee members: No apologies received.

Apologies received from regular attendees: Amèlie Bages, Director of Strategy and Partnerships, Ros Mitchell, Deputy Chief Medical Officer.

The quorum for the committee is five members to include the Chair of the Committee (or the vice chair of the Committee in their absence), one Non-Executive Director and one Executive Director.

7. Director of Infection Prevention & Control (DIPC)-IPC Annual Report (paper – QC 22/2024)	To Approve	HB/BK	10:05
8. Oxford Pharmacy Store (OPS) review of programme update (paper –QC 23/2024)	For Assurance	MB/HS/ KM/NM/ NA	10:15

Caring, Responsive & Effectiveness

9. Learning from Patients, Family and Carers (paper – QC 24/2024)	To Note	RH/BK	10:25
10. Complaints and PALS annual report (paper – QC 25/2024)	To Approve	RH/CP/ BK	10:35
11. Clinical Effectiveness updates:			
a. Clinical Effectiveness Decision Group (CEDG) report (paper – QC 26/2024)	For assurance	KM/RM	10:45
b. Clinical Audit Annual Report (paper – QC 27/2024) to include Clinical Audit Workplan & ToR	To Approve	AF/CF	
c. Medicines Management report (paper – QC 28/2024)		MM/KM	
For supporting detail: CEDG minutes & action log in the Reading Room/Appendix (papers – RR/App 02/2024)			

Break – 10 minutes

11:00

Policies and Governance

12. Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) (paper – QC 29/2024)	To discuss & for assurance	NMcL/ HS/BA/ GD	11:10
13. Provider Collaboratives (paper – QC 30/2024)	To note	BK	11:20
14. QC Annual report	To Approve		11:30
a. Annual report (paper– QC 31(i)/2024)		AY/BK?	
b. Workplan (paper– QC 31(ii)/2024)		GD	
c. Terms of Reference (paper – QC 31(iii)/2024)			
15. Integrated Governance Framework (presentation & oral update)			11:40
a) Quality management system & Developing quality governance ward to board	For Assurance	BC/CF	
16. Trust Policy Register update (paper–QC 32/2024)	To note	BK/GD	11:50
17. R&D policy update (paper QC 33//2024)	To Approve	VR/CH/	

Any Other Business

18. Any Other Business and summary of matters of interest for the Board, any key risks to escalate or actions agreed, any items to add to the plan for the next meeting.		AY	11:55

19. Review of the meeting

AY

Meeting Close

AY

12:00

Date of next meeting:

16 July 2024, 13:00 – 16:00 Microsoft Teams virtual meeting

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted –

Attendance 2023/24

QC - Core membership (Quorum)	May-23	Jul-23	Sep-23	Nov-23	Feb-24
Andrea Young	✓	✓	✓	✓	✓
Rob Bale	N/A	N/A	x	✓	✓
Marie Crofts	✓	<i>Britta Klinck deputised</i>	<i>x (Britta Klinck deputised)</i>	✓	<i>Britta Klinck</i>
Geraldine Cumberbatch	✓	✓	✓	x	✓
Grant MacDonald	✓	✓	x	✓	✓
Karl Marlowe	✓	✓	✓	✓	✓
Ben Riley	✓	✓	x	✓	✓
Heather Smith	✓	✓	✓	✓	✓
Kerry Rogers*	✓	✓	✓	✓	✓
Attending Board members (voting & non-voting included in quorum)					
Amelie Bages*		✓	x	x	✓
Charmaine DeSouza	x	x	x	x	x
David Walker	✓	✓	x	✓	✓

QC - Core membership (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Feb-25
Andrea Young					
Rob Bale					
Britta Klinck					
Geraldine Cumberbatch					
Grant MacDonald					

Karl Marlowe					
Ben Riley					
Heather Smith					
Georgia Dengei					
Attending Board members (voting & non-voting included in quorum)					
Amelie Bages*					
Charmaine DeSouza					
David Walker					

Quality Committee – overview plan for 2024 - 2025, mapped against Quality Domains

Key: ✓ on agenda
x item planned
x deferred

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
SAFETY							
Quality and Clinical Governance Sub-Committee escalation report including Quality and Safety Dashboard <i>(to include positive and safe each month and May meeting to include ToR and work plan)</i>	Jane Kershaw/Britta Klinck	x <i>(ToR & workplan included)</i> ✓		x	x	x	
Directorate/Service area 'deep dive' <i>(Presentation)</i>	Britta Klinck/Grant Macdonald/Ben Riley	x <i>0-19 service</i> ✓	x <i>Learning Disabilities</i>	x	x	x	
Quality Account (quality priorities) <i>(May meeting includes annual report)</i>	Rose Hombo	x ✓			x		
Patient Safety Incident Report (PSIs) <i>(Learning from Deaths Report, to include mortality and homicide reviews)</i>	Jane Kershaw/Britta Klinck	x ✓	x		x	x	
Safe Staffing	Britta Klinck		x			x	
Quality Compliance and Regulation update <i>(CQC, NHSE/I etc - report as and when required)</i>	Britta Klinck	x ✓	x <i>Well led guidance</i>	x	x	x	
Director of Infection Prevention & Control (IPC) – IPC annual report	Helen Bosley/Britta Klinck	x ✓					
Safety of the physical estate – annual report <i>Ligature update (BK/MC)</i>	Britta Klinck/Heather Smith		x				

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Learning Disabilities & Autism Services – access to healthcare annual report	Kirsten Prance/Rob Bale			X			
Inquests & Claims – annual report	Neil McLaughlin/ Hannah Smith/ Georgia Dengei			X			
Safeguarding Service annual report	Lisa Lord/Britta Klinck			X			
Oxford Pharmacy Store (OPS) <i>(quality assurance report around the governance and quality of medicines regulation in OPS)</i>	Natasha Arif/Nicola Mayes/Mark Byrne/Heather Smith/Karl Marlowe	X <i>(review of programme)</i> ✓			X		
EFFECTIVENESS							
Clinical Effectiveness Decision Group (CEDG) <i>(RR minutes from CEDG group, new NICE guidance)</i>	Ros Mitchell/Karl Marlowe	X ✓	X	X	X	X	
Clinical Audit updates	Angie Fletcher/Karl Marlowe	X ✓	X	X	X	X	
Clinical Audit annual plan and annual report	Angie Fletcher/Karl Marlowe	X ✓					
Medicines Management	Michael Marven/Karl Marlowe	X ✓	X	X	X	X	
Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) <i>review each one at each meeting</i>	Ben Cahill/Brian Aveyard/Hannah Smith/Neil McLaughlin	X ✓	X	X	X	X	
Health Inequalities-Quality Improvement <i>(smoking cessation/SMI Health checks/ dashboarding waiting list for Index of Multiple deprivation/ethnicity data)</i>	Karl Marlowe		X				
QUALITY IMPROVEMENT							
QI Spotlight presentation <i>(developing capability and the impact on staff and patients)</i>	Angie Fletcher/Britta Klinck		X <i>Plan for the year</i>		X <i>(projects)</i>	X <i>(projects)</i>	

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Mental Health Inpatient transformation programme	Britta Klink			x			
CARING & RESPONSIVE (patient & carer experience)							
Learning from Patients, Family & Carers <i>(Experience and involvement) update on strategy</i>	Donna Mackenzie-Brown/Rose Hombo/Britta Klinck	x ✓			x		
Experience and Involvement report <i>(update on strategy)</i>	Donna Mackenzie-Brown/ Rose Hombo / Britta Klinck				x		
PCREF Framework <i>(update on strategy)</i>	Rose Hombo/Britta Klinck		x		x		
Complaints & PALS annual report	Claire Price / Jane Kershaw / Britta Klinck	x ✓					
RESEARCH							
R&D update (Governance aspects)	Vanessa Raymont/Karl Marlowe			x			
POLICIES & STRATEGIES							
Nursing Strategy	Britta Klinck				x		
Friends, Family and Carers Strategy	Britta Klinck		x				
AHP Strategy	Britta Klinck					x	
Learning Disability Strategy (2022-2027)	Kirsten Prance/Britta Klink		x				
Trust Policies <i>(as and when – new policies for approval and certain policies for review)</i>							
Legal Proceedings Policy	Neil McLaughlin/Georgi a Dengie		x				
GOVERNANCE							

Item	Owner(s) or function	Q1 May 2024	Q2 July 2024	Q2 Sept 2024	Q3 Nov 2024	Q4 Feb 2025	
Minutes of the Quality Committee	Georgia Dengie/Ben Cahill	x ✓	x	x	x	x	
Quality Committee annual report	Georgia Dengie/Ben Cahill	x ✓					
Integrated Governance Framework (Including Quality Management system)	Ben Cahill	x ✓		x			
Provider Collaboratives	Britta Klinck	x ✓	x	x	x	x	
Partnership update	Amélie Bages				x		
Trust Policy Register	Britta Klinck/Georgia Dengie	x ✓		x			
Annual Planning Process	Amelie Bages					x	
OTHER REQUESTED ITEMS							
2024-2025 Developing Quality Governance (being clear ward to board and testing its effectiveness)	Georgia Dengie/Ben Cahill/Britta Klink	x ✓					
Number of Items on Agenda		21	17	15	18	15	

Note

NHSEI – issues for QC oversight *(Dec 2021)*

- Children & Young People
- Learning from Deaths
- Resuscitation
- Security Management – Violence & Aggression
- Palliative and End of Life Care
- Safeguarding
- Sexual safety
- Well-Led Guidance

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

Board of Directors

RR/App 24(i)-(ii)/2024 (Agenda item: 11(b) and 23(a))

22 May 2024

**Director of Infection Prevention and Control Annual Report (DIPC)
2023-24**

For Approval

Executive Summary

Each year the Director of Infection Prevention and Control (DIPC) is responsible for producing an annual report. The purpose of the report is to inform the Trust Board of progress in delivering the Infection Prevention and Control (IPC) Programme within the Trust. This includes providing assurance to the Trust that appropriate measures are being taken to maintain the safety of patients, service users, staff and visitors and to agree the action plan for sustained reduction and improvements in Healthcare Associated Infections (HCAI). The following report provides assurance on the Infection Prevention and Control Programme and activity for 2023/24.

Summary of key achievements:

- The Trust remains overall compliant with the revised Health and Social Care Act: Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance (The Hygiene Code) and CQC regulations 12 and 15.
- Implementation and progress of the gap analysis against the updated Health and Social Care Act (issued December 2022) monitored via the IPCDC.
- Resources and controls to support the prevention and control of healthcare associated infections are in place and the level of assurance is high. Assurance is provided through implementation of the annual work programme with quarterly reports and exceptions reported to the Infection

Prevention Control and Decontamination Committee (IPCDC), Trust Quality and Clinical Governance and Quality Committee.

- The Infection Prevention and Control Team (IPCT) continue to build on collaborations, with partner organisations, across the Buckinghamshire Oxfordshire Berkshire West (BOB), Integrated care System (ICS). This is in addition to the establishment of regional/national mental health/community Trust IPC networks.
- Continuation of mandatory surveillance reporting, and investigation for all organisms that are subject to mandatory reporting. These include MRSA (Methicillin-resistant *Staphylococcus aureus*), MSSA (Methicillin-sensitive *Staphylococcus aureus*), *Clostridioides difficile*, invasive group A *Streptococcus* (iGAS), and Gram-negative bloodstream infections (*Escherichia coli*, *Klebsiella* species, *Pseudomonas aeruginosa*). All cases of these infections are investigated, learning shared and action plans implemented where applicable.
- Continued development of Trust infection prevention and control (IPC) surveillance system for HCAs.
- Participation in the national point prevalence survey (PPS) into incidence of HCAs and antimicrobial stewardship (AMS) in community hospitals and older adult mental health wards.
- Completion of Trust in-house PPS, the results of which will be used to inform future IPC and quality improvement projects.
- Extensive audit program via the Trust online system (AMaT), including hand hygiene and Aseptic Non touch Technique (ANTT).
- All inpatient areas and other high-risk areas had annual infection prevention and control audits completed, which measured compliance with standards of infection prevention and control practice. Areas audited included: 33 inpatient areas, 9 Urgent Care areas, 14 Podiatry Clinics and 9 Dental Clinics. Audit results demonstrated sustained improvement.
- Infection prevention and control education continues to be a priority. Mandatory training is provided to all Trust staff as E-learning and/or online training via teams as per the training matrix.
- The IPCT undertake wider teaching including, care certificate, peer support and band 2-4 induction, intravenous therapy, application of Personal Protection Equipment (PPE) and IPC champions.

- Completion of project to improve patient hydration and reduce the risk of the development of urinary tract infections.
- The IPCT is collaborating with colleagues across BOB to improve sustainability within IPC. Part of this includes the glove reduction project, which also supports safe IPC practice.
- The IPCT held a Trustwide IPC study day, in May 2023, at Unipart. There were internal and external speakers, and the event was well attended and evaluated.
- Two posters accepted at conferences. Both were presented at the international Infection Prevention Society (IPS) conference (October 2023) and the Trust QI conference (4/10/23)- one poster won award.

The report summarises the work of the IPCT to ensure we deliver the highest standards of patient care possible whilst preventing harm to patients from healthcare associated infections.

Governance Route/Escalation Process

An annual DIPC report is a mandated Board report.

This report was presented and approved at the Infection Prevention, Control and Decontamination Committee (25/04/24). It was also presented and approved at the Quality Committee (02/05/24).

Statutory or Regulatory responsibilities

The Trust is compliant with its statutory and regulatory duties regarding compliance with the Health and Social Care Act (2008) and infection prevention and control requirements.

Recommendation

The Board is asked to approve the annual report.

Author and title: Dr Helen Bosley, Nurse Consultant, Infection Prevention and Control and Deputy DIPC

Lead Executive Director: Britta Klinck, Chief Nurse and DIPC

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

This report relates to or provides assurance and evidence against the following Strategic Objective(s) of the Trust:

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

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; Governance and decision-making arrangements; Business Planning; 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.



Director of Infection Prevention and Control Annual Report

April 2023 – March 2024



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The report summarises the work of the IPCT to ensure we deliver the highest standards of patient care possible whilst preventing harm to patients from healthcare associated infections.

Britta Klinck

Chief Nurse

Director of Infection Prevention and Control

Dr Helen Bosley

Nurse Consultant IPC

Deputy DIPC



With thanks contributions to this report were received from:

John Campbell – Head of Nursing, Community services:

- Section 5.9 - Sepsis workstream
- Section 13- Decontamination

Iga Ciesielska, lead pharmacist AMS:

- Section 9 - Antimicrobial Stewardship



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1. Introduction

The Trust continues to have a comprehensive programme of IPC activities which have supported a declaration of compliance with the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance, Care Quality Commission (CQC) regulation 12 and 15.

The Act requires that the Board of Directors have a Board-level agreement outlining the Boards' collective responsibility for minimising the risks of infection and the general means by which it prevents and controls/reduce such risks.

2. Overview of infection prevention and control activities during 2023/24

The IPCT (figure 1) is led by the Director of Infection Prevention and Control (DIPC) and the team members are:

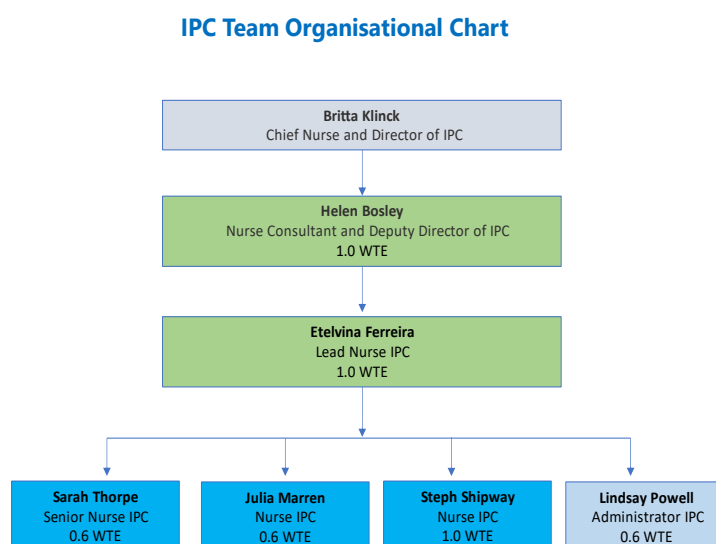


Figure 1: IPC Team Organisation Chart

Marie Crofts was Chief Nurse and Director of Infection Prevention and Control until 18/12/2023.

The IPCT continues to work hard to strengthen and develop links with all services. This has resulted in raised awareness and improved knowledge of IPC across the Trust. The IPCT is responsible for the Trust HCAI surveillance system, and for devising and reviewing/updating the Trust IPC policies, procedures, and guidelines. The team supports the IPC champions network,



and the clinical and non-clinical services in all IPC matters. The IPCT is also responsible for providing IPC advice, formal and ad hoc education, dissemination of best practice, and monitoring of practice compliance with national standards. Out of hours advice and support is provided via a service level agreement (SLA) with Oxford University Hospitals NHS Foundation Trust (OUHFT), with a designated IPC Consultant. The SLA is for two sessions from a Consultant Microbiologist every week and 24hr/7day week on call microbiology service.

3. Governance arrangements

3.1 Reporting to the Trust Board

The IPCT provides updates through the Healthcare Associated Infections (HCAI) meeting (chaired by the deputy DIPC) and the weekly governance review meeting, chaired by the Chief Nurse/ DIPC. The DIPC also directly reports any issues, by exception, to the Trust Board or through the governance structure. Quarterly IPC reports are presented at the Trust Quality and Clinical Governance subcommittee and additional reports are presented at the Quality committee as required.

3.2 Infection Prevention, Control and Decontamination Committee (IPCDC)

The Trust has an Infection Prevention, Control and Decontamination Committee (IPCDC) which meets every quarter. In 2023/24 the IPCDC met on 20th April 2023, 27th July 2023, 26th October 2023, and 25th January 2024. The IPCDC is accountable to the Quality and Clinical Governance subcommittee.

IPCDC monitors compliance with IPC and decontamination requirements. The IPCDC also monitors the IPC annual work programme (appendix 1), ensures that infection prevention and control issues are addressed and that compliance with the Health and Social Care Act are maintained. The IPCDC has terms of reference which are reviewed annually (appendix 2). Included in the committee membership are the DIPC, IPCT, Modern Matrons, Clinical leads, Pharmacy, Facilities and Estates managers, Service Leads, Occupational Health, and other departments as required according to the agenda. There are also external representations from the Integrated Care Board (ICB) IPC leads and OUH IPC Consultant.

4. Policy and Procedures

Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance details which policies and procedures are appropriate for regulated activities and provide a guide to what may be needed to demonstrate compliance. CQC regulation 12 and 15 outlines essential standards required.

Policies and procedures devised, reviewed, updated, and approved during 2023-24 were: -



- Chickenpox and Shingles Procedure (July 2023)
- Management of Patients with Hepatitis Viruses and the Human Immunodeficiency Virus (July 2023)
- Management of Parasitic Infestations - part of Trust Pest control policy- Health and Safety (October 2023)
- Specimen Collection and Transportation Procedure (January 2024)

All these procedures and 'At a Glance' guides are available to staff via the Infection Prevention and Control intranet page.

The Health and Social Care Act 2008: code of practice on the prevention and control of infections was nationally updated on 13/12/2022. The IPCT completed a comprehensive gap analysis and action plan has been developed and this is monitored through the IPCDC meetings.

The National Infection Prevention and Control board assurance framework (BAF) has been issued by NHS England for use by healthcare providers. The purpose of the BAF, updated in March 2023, is to enable organisations to ensure an evidence-based approach is used to maintain the safety of patients, services users, staff, and others. Ongoing monitoring of BAF and associated action plan is through the IPCDC meetings.

5. Local service improvement

5.1. Staff information

The intranet page is continually being reviewed, updated, and developed with new and relevant information and data for staff to access. It contains all policies and procedures, annual audit programme, relevant patient information leaflets, product information, quarterly IPCT newsletters, IPC champions resources, IPCT contact details and management of outbreaks information. It is promoted in mandatory training as an easily accessible resource for staff.

There continues to be a dedicated COVID-19 IPC page which is reviewed and updated as required. The IPCT ensure all relevant information for staff is collated and held in one easy to find place. Direct links to the dedicated pages are available via the weekly communications bulletin in order that all staff have immediate access to any changes in IPC/ PPE guidance.

5.2 Patient information

Patient information leaflets have been reviewed and updated by the IPCT and approved/finalised following feedback from Trust patient groups. The IPCT are working with the communications team to provide the patient information leaflets via QR codes. QR codes are used widely in society and reduce the need for printing, thus supporting waste reduction and sustainability agenda.

5.3 Adenosine triphosphate (ATP) testing

All community hospitals and older adult mental health wards (high risk areas) use the Clean Trace system for monitoring cleanliness of the environment and medical equipment. This system



records the level of ATP (adenosine triphosphate), or energy produced by living organisms and provides robust timely data on the efficacy of cleaning taking place. It has been used in conjunction with the cleanliness audits which are conducted by the Matrons and Facilities Managers.

From January 2024 the company providing Clean Trace changed, following a company transfer of products. Work has been ongoing to ensure a smooth transition. However ongoing issues with access to the system remains, mainly due to turnover of staff who require passwords and training. This may lead to delays in completing the ATP testing and uploading any results. The IPCT and company continue to work closely with the ward to troubleshoot any issues and resolve them as quickly as possible. Ongoing work is in progress to strengthen reporting of data and close monitoring is in place to ensure any issues are being addressed.

5.4 Patient Records

The IPCT is working with the EMIS/RIO team to review the IPC risk assessment on admission and during the inpatient stay. Completing the IPC risk assessment on admission is crucial to assess the patient's risk of acquiring or transmitting an infection and this influences safe patient placement.

5.5 Process mapping for diagnostic testing

The IPCT is involved in a project to join the laboratory requesting systems of the five Trusts providing these services to Oxford Health. These are Oxfordshire University Hospital, Buckinghamshire Healthcare, Milton Keynes Hospital, Great Western Hospital and Royal Berkshire Hospital. The joining of these systems will allow staff to review patients, accessing different laboratory services. This will enable simplification for ordering diagnostic tests and prompt reviewing the any specimen results.

5.6 Implementing the patient safety incident review framework

All patients post infection reviews have been moved to the Ulysses online reporting system. The IPCT are involved in adopting the patient safety incident review framework (PSIRF) and are working with colleagues in the trust and across BOB to standardise this process.

5.7 Health economy partnership

The Trust continues to develop and work collaboratively with other healthcare providers. The IPCT have been actively engaged in setting up, maintaining, and expanding networks locally, regionally, and nationally.

This has included:

- Regional and national meetings with NHS England (NHSE).



- National and regional specialist mental health/community forums.
- System meetings across BOB ICS from 1st July 2022.
- Foundation of a junior IPC nurse network across BOB.

Collaboration across the BOB ICS has resulted in a standardised joint patient information leaflet and a patient information leaflet regarding appropriate taking antibiotics is in progress. Improved communication and patient flow have highlighted the improved outcomes for patients and their families when the system works together.

5.8 Poster presentations in conferences

Two posters were accepted for the international Infection Prevention Society (IPS) conference (October 2023) and the Trust QI conference (4/10/23).

- These were:
 - *Use of virtual reality technology to support infection prevention and control training*
 - *Improving Urinary Tract Infection (UTI) Surveillance in a Community and Mental Health Trust*- Winner for the category 'Deliver the best possible care and outcomes' at the QI conference.

5.9 Sepsis Pathway

The Trust has identified that the early recognition and management of sepsis is a Quality Priority for 2024-25.

An electronic version of the NEWS2 tool has been developed and is embedded within the Rio electronic patient record within mental health. Future work will scope the feasibility of integrating this within the EMIS electronic patient record in community settings.

The Trust has developed a Sepsis Strategy, the implementation of which is overseen by a Sepsis Strategy Steering Group the membership of this group is made up of representatives from across all Directorates. This group reports into the Trust Physical Health Group which is chaired by the Deputy Director of Quality and Clinical Standards

The recognition of sepsis and appropriate responses will be tailored to each healthcare setting i.e. community, mental health, to ensure timely appropriate management and escalation. This approach will be supported using training provided by the Sepsis Trust which can be integrated into the Trust Learner management system for the purposes of monitoring and audit.

5.10 Aseptic Non Touch Technique (ANTT)

As part of a Quality Improvement project, the IPCT has been leading a Trust wide workstream to support and standardise Aseptic Non-Touch Technique (ANTT) practice across the clinical directorates. Initial work involved a detailed scoping exercise of current ANTT practice (GAP



analysis) and included extensive engagement with community teams, physical health leads (mental health) and learning and development teams.

Following this review several actions were taken. These included:

- Ongoing work with the L&D team to move ANTT training to the essential role matrix for appropriate clinical staff and improve compliance monitoring.
- ANTT **procedure and guidelines** which are available via the IPC intranet page.
- ANTT **competencies**, to be reviewed every 3 years, for all clinical staff performing aseptic techniques. Work in ongoing to develop a system for monitoring competencies on OTR.
- Designated training resources for the ANTT leads.
- New annual ANTT **audits** available on AMaT.

6. Healthcare Associated Infections (HCAIs) – surveillance organisms

6.1. Local Trust point prevalence survey

As the national PPS are not regularly completed, the Trust infection prevention and control team (IPCT) completed two inhouse point prevalence surveys (PPS) based on existing protocols in January and July 2023. These surveys were conducted six months apart to capture seasonal variation (figures 2 and 3).

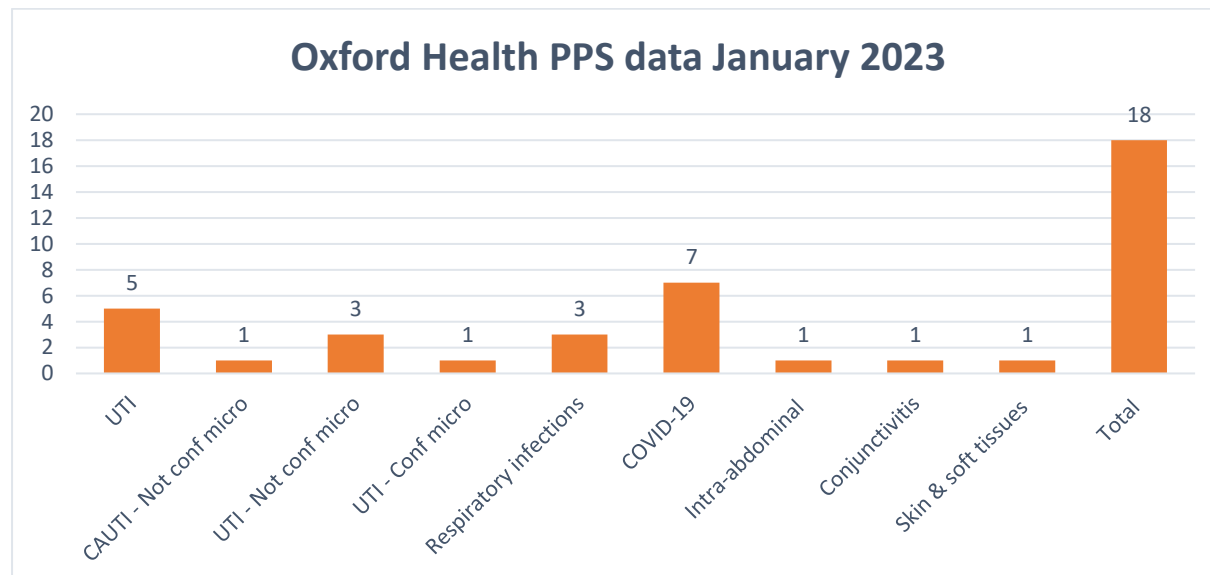


Figure 2: Trust PPS data for January 2023

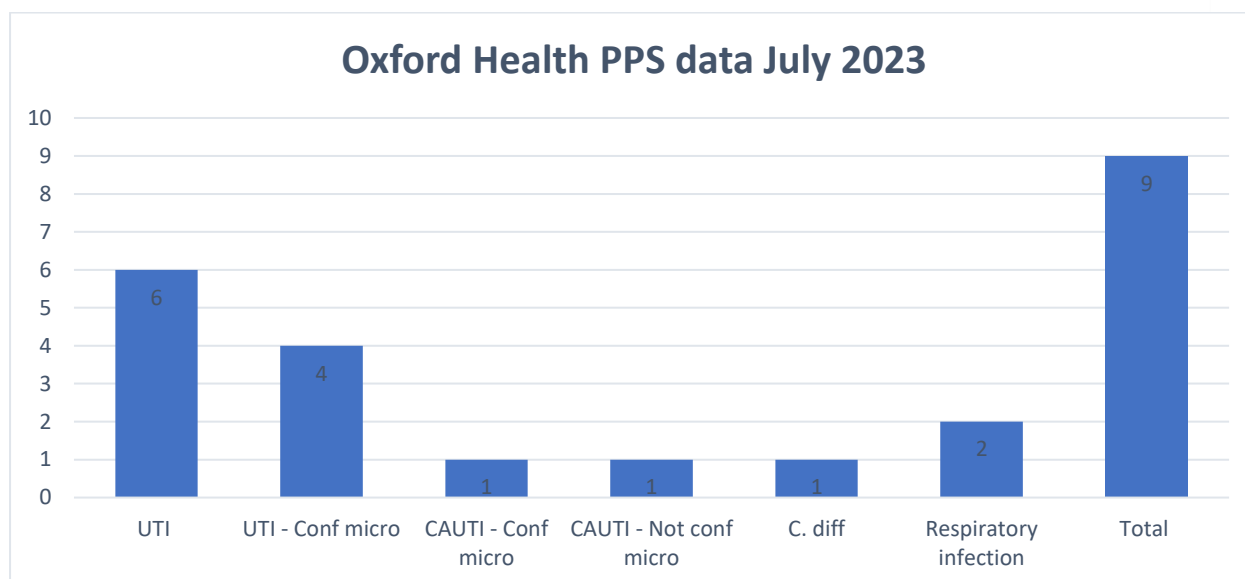


Figure 3: Trust PPS data for July 2023

A summary of the PPS data for both months is presented in table 1.

Table 1: Summary of the results for both surveys

PPS Summary Data		
	Jan-23	Jul-23
Pts average age	82	78
% female pts	61.2%	60.6%
% male patients	38.8%	40.2%
% pts on antibiotics	14.7%	17.3%
% pts receiving prophylaxis antibiotics	1.6%	3.1%
% pts with urinary catheter	24.8%	24.4%
% pts with active infection	18.6%	14.2%
No. active infections	27	18
% pts with inf – HCAs (OH)	13.2%	7.1%

The differences between both data sets may be due to seasonal variation as patients may be more susceptible to viral/bacterial respiratory infections during colder/winter months. The IPCT intend to repeat inhouse PPS data collection in order to build a comprehensive database and explore the data further.



6.2 National Point Prevalence Survey

The National Point Prevalence Survey (PPS) was completed in the Trust between September and October 2023. The survey participation was optional for all NHS Trusts, and this was the first time mental health and community Trusts were invited to participate.

The purpose is to estimate the total burden (prevalence) of HCAs and antimicrobial use for inpatients, at a given time (spotlight). Point Prevalence Surveys add unique value to IPC, AMS, and participation:

- builds multi-professional team working, strengthens networks and improves visibility of IPC and AMS teams
- will demonstrate commitment to IPC and AMS to contribute to Health Act Code of Practice requirements and evidence for CQC
- of sufficient hospitals across the UK will provide essential information for case mix adjustment models of prescribing and burden of infection.

Results will be available later in 2024.

6.3 MRSA bacteraemia

There have been no cases of MRSA (Methicillin-resistant *Staphylococcus aureus*) bacteraemia this year, which is the same as 2022/23.

6.4 MSSA bacteraemia

There has been no Trust cases and two community cases of MSSA (Methicillin-sensitive *Staphylococcus aureus*) bacteraemia this year. There was one Trust case in 2022/23.

6.4 Gram negative organism bacteraemia

The increase in gram negative bacteraemia infections is a national concern and in response the Department of Health (2016) introduced mandatory surveillance of bacteraemia infections caused by gram negative organisms including: *E.Coli*, *Pseudomonas* and *Klebsiella*.

6.4.1 *E.Coli* bacteraemia

National targets have been applied to *E.Coli* bacteraemia cases to reduce the number by 50% by 2023-24. There were eight cases of *E.Coli* bacteraemia patients identified in the Trust in 2023/24. Three cases were for inpatients, four were community patients seen in EMU and one patient was admitted from another hospital. The underlying cause for this organism is extremely hard to determine. However, the likely sources in four cases were urinary tract, two were chest and two cases were unknown. All cases were thoroughly investigated. The number of community cases last year (2022/23) was 10.



6.4.2 *Pseudomonas* bacteraemia

There were three Trust cases, and the likely underlying sources for all cases were urinary tract. There was one community case, and the likely source was cellulitis. This is an increase from 2022/23 where there was one community case, and the likely source was the urinary catheter.

6.4.3 *Klebsiella* bacteraemia

There were two cases of *Klebsiella* bacteraemia identified this year. One case was Trust acquired and one community case, where the likely sources of both were the urinary tract. In 2022/23 there were three cases of *Klebsiella* bacteraemia, one Trust case and two community cases.

6.5 Invasive Group A *Streptococcal* infection (iGAS)

The incidence of group A *streptococcal* infections has increased this year nationally and locally which has led to increased cases of scarlet fever, hospitals admissions and patient deaths.

There have been no Trust cases. There have been four community cases who were identified with iGAS on admission to the OUHFT from home. All these patients were receiving care from community services (podiatry and district nursing) for long standing leg ulcers, although the cases were not linked. No actions were identified.

6.6 *Clostridioides difficile* infection (CDI)

Oxford Health NHS Foundation Trust contributes few cases of *Clostridioides difficile* to the overall BOB prevalence.

The final number of cases by the end of March 2024 was 16 cases. Four cases were attributed to the Trust and five were community onset (ICS). There were seven cases admitted positive from the acute Trust.

This is a slight decrease for Trust cases from the preceding year (six Trust and six community). A reduction in *Clostridioides difficile* remains a national objective.

In every CDI case, a comprehensive review of the care of the patient and the ward environment is undertaken and any learning fed back to the clinicians, wards and areas concerned. Antimicrobial prescribing is reviewed by the pharmacist and OUHFT Consultant Microbiologist to ensure antibiotic appropriateness and any identified actions are taken. The learning reviews are uploaded via a Ulysess incident report for further review and discussion by the teams.

There was a patient at Didcot identified with CDI, prior to transfer to the OUH where they passed away. A full learning review was completed, led by the senior matron and learning was identified which related to earlier testing. The clinical teams have implemented action plans.



6.7 Other infections

6.7.1 Norovirus

There has been increased norovirus activity in 2023/24 (table 2) which reflects the increase in national prevalence. There were no cases in 2022/23.

Table 2: Norovirus cases in 2023/24

Ward	Month	No. of patients	No. of staff	Confirmed in laboratory
Allen	December 2023	5	1	Yes
City	March 2024	9	2	Yes
Sandford	March 2024	3	4	Yes

6.7.2 Respiratory infections

This winter has seen an increase, both nationally and locally, in the incidence of influenza A and B and Respiratory Syncytial Virus (RSV). The IPCT continued to build on respiratory infection surveillance (excluding COVID-19) (table 3). The higher cases reflect the increase in community prevalence. All cases were closely monitored by the IPC team, and safe IPC management guidance provided.

Table 3: Summary of Trust and community acquired respiratory infections in 2023/24

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	TOTAL
Trust acquired Influenza	0	0	0	0	0	0	0	0	0	2	0	0	2
Community acquired Influenza	0	0	0	0	0	0	0	0	1	0	2	2	5
Trust acquired RSV	0	0	0	0	0	0	0	2	1	0	3	0	6
Community acquired RSV	0	0	0	0	0	0	0	2	1	0	0	0	3
Trust acquired other Respiratory Infections	0	0	0	0	0	1	0	0	0	1	1	0	3
Community acquired other Respiratory Infections	1	0	0	1	1	3	3	0	0	2	1	1	13



6.7.3 Urinary tract infections

The IPCT have been developing an inhouse urinary tract infection (UTI) surveillance database. This is to understand the prevalence and underlying causes of UTI's which are a major HCAI (table 4). All cases were closely monitored by the IPC team, and safe IPC management guidance provided.

The surveillance records positive microbiology results from the OUH laboratories. It does not capture patients who are not accessing the OUH, which means some UTIs may not be captured. To address this gap, the IPCT has developed a new UTI code, which is used via Ulysses to record patients with UTI's. This process will enable the IPCT to monitor and record all patients across the Trust who are clinically diagnosed with a UTI, whether or not there is a positive microbiology specimen from the lab. Although all UTIs are reviewed, only cases acquired from day 3 of admission onward are recorded as Trust acquired.

Table 4: Summary of Trust UTIs in 2023/24

All Results	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	23	23	23	23	23	23	23	23	23	24	24	24	
Total number of patients with lab confirmed positive specimens	39	31	40	25	22	32	36	32	36	25	31	30	379
Total no. of pts with infection (HCAI, Community and other Trust)	32	26	32	18	15	24	33	25	31	24	25	23	308
Total number of pts with a UTIs acquired in service-OH	21	18	22	13	10	16	23	17	23	19	14	17	213
% HCAs to Oxford Health	66%	69%	72%	72%	67%	67%	76%	68%	74%	83%	56%	74%	70%

It will be possible to further improve the UTI surveillance system once the electronic prescribing system is fully implemented across the Trust, as antibiotic prescribing will be available to identify the treatment of clinically diagnosed infections.

7. COVID-19

The impact and prevalence of COVID-19 continues to affect healthcare services. The IPCT has maintained COVID-19 case surveillance and ensured information and guidance has remained accessible and current. This guidance is available on the intranet designated COVID-19 pages.



7.1 Classification and incidents of nosocomial infections

Daily data review is in place with verification provided by the IPCT, prior to any national reporting.

The Trust has followed the National guidance for case classification and onset.

- Community-Onset (CO) - positive specimen date ≤ 2 days after hospital admission or hospital attendance
- Hospital-Onset Indeterminate Healthcare-Associated (HO. iHA) - positive specimen date 3-7 days after hospital admission
- Hospital-Onset Probable Healthcare-Associated (HO. pHA) - positive specimen date 8-14 days after hospital admission
- Hospital-Onset Definite Healthcare-Associated (HO. dHA) - positive specimen date 15 or more days after hospital admission.

7.2 COVID cases and activity

7.2.1 Cases

Since the beginning of the pandemic (2020) there have been 1,378 COVID-19 positive patients identified whilst inpatients on our wards. Further cases breakdown is provided in the following section for 2023/24.

There have been 260 COVID-19 cases throughout 2023/24 of which 220 patients were identified as Trust onset and 40 patients were admitted as positive either from acquisition in the community or known positive on transfer from another healthcare provider.

Following the national classification there were 156 (60%) patients classified as definite hospital onset (see 7.3). During this time further COVID-19 omicron variants emerged which may have contributed to the transmissibility. Of the 220 positive patients, 87 patients were in mental health wards (figure 4) and 133 were patients in community hospitals (figure 5).

There were no recorded deaths due to COVID-19.

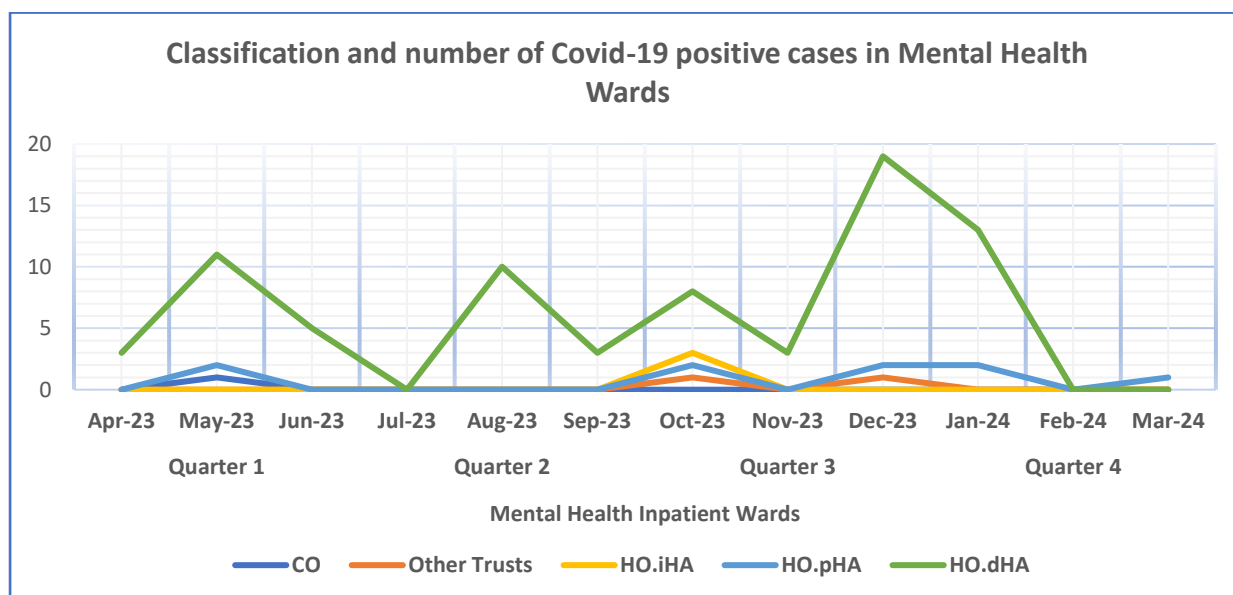


Figure 4: Classification of COVID-19 positive cases in mental health inpatient wards

Further detail of the incidence of COVID-19 cases in mental health inpatient wards is provided in table 5.

Table 5: Summary of classification of COVID-19 cases in mental health inpatients wards in 2023/24.

	Quarter	Month	Community & Other Trust Cases			Oxford Health Cases				Total Cases
			<=2 days		Others	3-7 days	8-14 days	>15 days	OH	
			CO	Other Trusts	TOTAL	HO.iHA	HO.pHA	HO.dHA	TOTAL	
Mental Health Inpatient Wards	Quarter 1	Apr-23	0	0	0	0	0	3	3	3
		May-23	1	0	1	0	2	11	13	14
		Jun-23	0	0	0	0	0	5	5	5
	Quarter 2	Jul-23	0	0	0	0	0	0	0	0
		Aug-23	0	0	0	0	0	10	10	10
		Sep-23	0	0	0	0	0	3	3	3
	Quarter 3	Oct-23	0	1	1	3	2	8	13	14
		Nov-23	0	0	0	0	0	3	3	3
		Dec-23	0	1	1	0	2	19	21	22
	Quarter 4	Jan-24	0	0	0	0	2	13	15	15
		Feb-24	0	0	0	0	0	0	0	0
		Mar-24	0	0	0	0	1	0	1	1
TOTAL			1	2	3	3	9	75	87	90
TRUST TOTAL			18	22	40	24	40	156	220	260

The number of cases in community hospitals is presented in Figure 5.

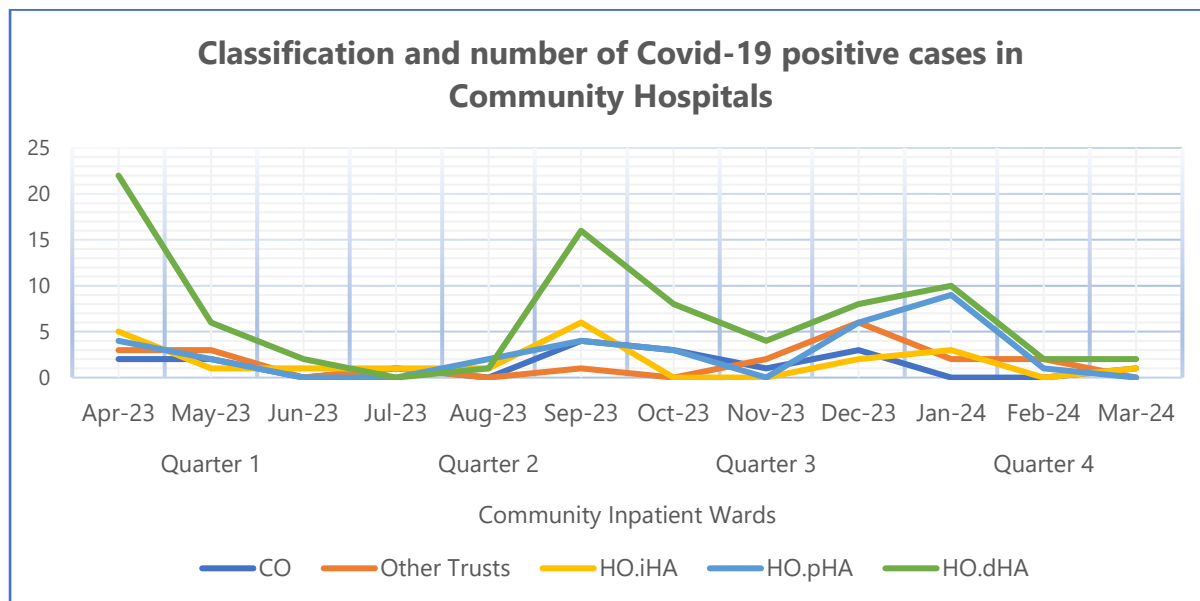


Figure 5: Classification of COVID-19 positive cases in community hospital inpatient wards

Further detail of the incidence of COVID-19 cases is provided in table 6.

Table 6: Summary of classification of COVID-19 cases in community hospital inpatients wards in 2023/24.

	Quarter	Month	Community & Other Trust Cases			Oxford Health Cases				Total Cases
			<=2 days		Others	3-7 days	8-14 days	>15 days	OH	
			CO	Other Trusts	TOTAL	HO.iHA	HO.pHA	HO.dHA	TOTAL	
Community Inpatient Wards	Quarter 1	Apr-23	2	3	5	5	4	22	31	36
		May-23	2	3	5	1	2	6	9	14
	Quarter 2	Jun-23	0	0	0	1	0	2	3	3
		Jul-23	1	1	2	1	0	0	1	3
		Aug-23	0	0	0	1	2	1	4	4
		Sep-23	4	1	5	6	4	16	26	31
	Quarter 3	Oct-23	3	0	3	0	3	8	11	14
		Nov-23	1	2	3	0	0	4	4	7
		Dec-23	3	6	9	2	6	8	16	25
	Quarter 4	Jan-24	0	2	2	3	9	10	22	24
		Feb-24	0	2	2	0	1	2	3	5
		Mar-24	1	0	1	1	0	2	3	4
	TOTAL		17	20	37	21	31	81	133	170
	TRUST TOTAL		18	22	40	24	40	156	220	260



An overall summary of COVID-19 cases in the Trust (2020-24) is presented in Figure 6.

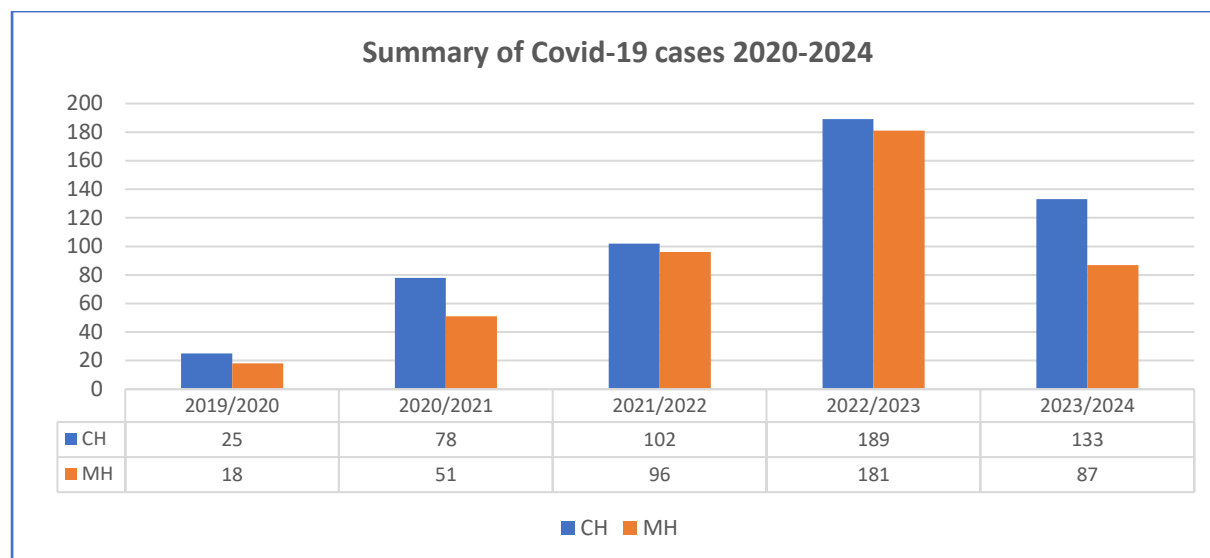


Figure 6: Summary of COVID -19 cases for the years 2020-24.

7.2.2 Outbreaks

There was a total of 23 outbreaks, 16 in community hospitals, and 7 in mental health inpatient wards (Figure 7). This is a decrease from previous years and reflects the general decrease seen nationally.

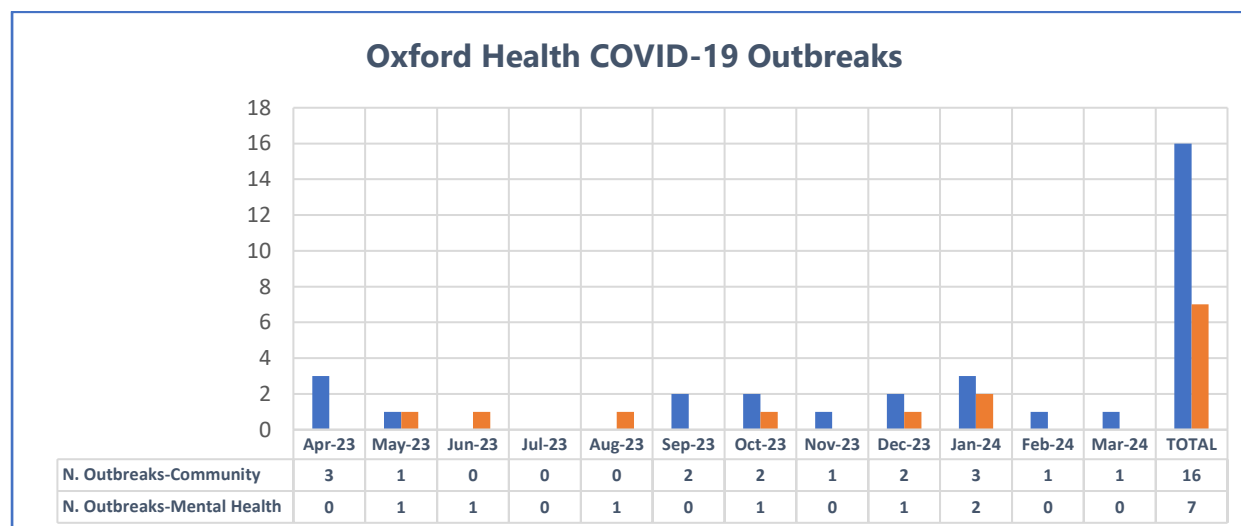


Figure 7: Summary of COVID-19 outbreaks in 2023/24



7.3 Outbreak Management Actions

- Daily management review by IPCT, with management timelines.
- Enhanced cleaning of wards (cleaning records).
- Outbreak checklists including notifications and communications.
- Twice weekly IPC led outbreak meetings (minuted) with ward staff, matrons, facilities.
- LFT screening of all patients at time of outbreak identification with exposure/contacts.
- Restriction of staff movement, including flexible workers. This was identified as a challenge to the high number of staff required to fill shifts. Close liaison with staffing solutions when booking additional staff shifts, to try and provide continuity with staff placement.
- Additional training sessions for PPE champions for whole Trust, but specifically ensuring outbreaks wards had identified champions, who attended.
- PPE champions are completing PPE assessments of staff competencies.

7.4 Outbreak Learning

- Importance of ensuring adequate ventilation to improve air quality.
- Importance of early identification of staff contacts.
- Importance of reinforcing clear messaging for PPE usage and support from PPE champions.
- Regular outbreak meetings are supportive and helpful for staff, and provide clear oversight, support, and actions which staff could work to.
- Blood Cultures

8. Blood Cultures

The IPCT continue to monitor the rate of blood culture contamination. Data analysis identified for 2023/24 identified a possible contamination rate of 4.2%, a decrease from previous years (table 7). The national rate is 6%. This is an improvement following the introduction of a new blood culture protocol, and the ANTT workstream which also targets improving sampling techniques when collecting blood cultures.



Table 7: Summary of blood culture data for last 3 years

Blood Cultures (BC)	2023/24	2022/23	2021/22
Total no. BC taken (positive & negative)	683	734	639
Total no. positive BC	8.5% (n 58)	9.3% (n 68)	10.6% (n 68)
Positive BC for a recognised pathogen	50% (n 29)	3.8% (n 28)	5.3% (n 34)
Positive BC for a common skin contaminant	4.2% (n 29)	5.4% (n 40)	5.3% (n 34)
Negative BC	90.5% (n 618)	90.6% (n 665)	89.4% (n 571)

9. Antimicrobial Stewardship

Antimicrobial Stewardship (AMS) is an approach to promoting and monitoring prudent use of antimicrobials to preserve their future effectiveness whilst ensuring the safety and quality of patient care. It plays a key role in local and national programmes in limiting the emergence of antimicrobial resistance (AMR) and decreasing preventable healthcare associated infections.

Antimicrobial prescribing standards and safety and quality indicators were monitored in inpatient setting throughout the year via quarterly antimicrobial prescribing audits. Also, for the first time, the Trust participated in the point prevalence survey (PPS). The results of the last survey have been recently circulated via clinical and managerial structures and will inform future quality improvement projects.

Stock shortages of key antimicrobial agents including commonly used antibiotics and Covid-19 therapeutics led to increased use of alternative treatments which may not have been optimal. This, as well as the decreasing Covid-19 infection burden, presented additional challenges for AMS efforts across the Trust.

The OHFT Pharmacy team are leading the work to improve antimicrobial stewardship within the Trust. This includes:

- Appointment of AMS Pharmacist who will develop, implement, and evaluate antimicrobial stewardship strategies across the Trust.
- Updating Antimicrobial Prescribing Policy MM11 which sets out the standards for prescribing and monitoring of antimicrobials within the Trust, raises awareness of AMR and provides guidance on suitable training and tools promoting prudent use of antimicrobials.
- Monitoring the overall antimicrobial consumption for the Trust and taking steps to tackle overuse.
- Implementing the key principles of the WHO Antimicrobial AWaRe recommendations and reviewing the Trust antimicrobial consumption against the AWaRe classification.



- Quarterly inpatient audits and reports presented at the IPCDC. Overall, there is good compliance with prescribing antimicrobials within guidelines. However, areas of improvement have been identified and further work is planned e.g., regular feedback on prescribing practice and action plans for teams.
- Supporting the implementation of relevant national antimicrobial guidelines and initiatives e.g., supporting the review of guidelines recommending treatment with fluoroquinolones in light of the MHRA Drug Safety Update restricting their use, and providing additional information to patients and/or carers.
- Induction for new doctors working on inpatient wards including guidance on the appropriateness of antimicrobial prescribing as specified in the Start Smart – Then Focus initiative promoted by Department of Health, the use of local antimicrobial guidance, and legal requirements and good practice surrounding prescribing of antimicrobials.
- Pharmacists ensuring that antimicrobials prescribed in inpatient setting are compliant with guidelines with respect to antimicrobial choice, dose, route of administration and duration, and that any potentially inappropriate prescribing is challenged. They also ensure that timely reviews of antimicrobials are carried out and IV antimicrobials are switched to oral as soon as clinically appropriate.
- Signposting prescribers and staff to current relevant antimicrobial guidelines – OUH guidelines for inpatient settings and SCAN guidelines for out-patient settings both available on the MicroGuide platform as an app or on the website.
- Regular reviews of medication stock lists for both inpatient and outpatient settings, to ensure that only appropriate antimicrobials are available and that restricted ones are removed from the units.
- Providing pharmacy support with the clinical screening of COVID-19 positive patients for eligibility for antiviral or neutralising monoclonal antibody treatments if needed.
- Reviewing antimicrobial prescribing for all *Clostridioides difficile* cases in the Trust and as required.
- Involvement in the COVID-19 Trust vaccination programme.
- Collaborative partnership with regular attendance at the OUH Antimicrobial Steering Group and the regional South Central Antimicrobial Network.
- Joining the new One-Health AMS Group which aim is to identify priorities, share examples of best practice and provide collaborative suggestions to drive improvement for all aspects of antimicrobial stewardship across the BOB ICB.
- Attendance to the Health Economy meetings with the IPC Team.

10. Facilities

In July 2022, the Trust implemented the new and revised National Cleanliness Standards, which includes colour coding and specification. Cleanliness monitoring is completed monthly by the Facilities teams and by the modern matrons across the Trust. The responsibility for environmental cleanliness sits with the Ward Manager.



The results are monitored by Facilities and reports are provided for the directorates and the IPCDC committee. IPCT work closely with the Facilities team, and the Head of Facilities attends the IPCDC providing service reports. The IPCT attended, supported, and participated in the annual PLACE (Patient Led Assessment of the Clinical Environment) assessments.

11. Estates

The IPCT continue to attend the Trusts' quarterly water safety meeting, to provide support and have oversight of legionella testing/results. The IPCT also advises and supports Estates with refurbishments and new builds within the Trust. This has required attendance at key design and planning meetings and the review of plans and minimum build standards.

Projects include:

- Meadow Unit PICU- new build at Warneford site
- Mental health and wellbeing hub in Banbury within Castle Quay Shopping Centre
- New lab extension at the Clinical Research Facility.
- Urgent care and outpatients service redesign at Witney hospital
- Clinical Space advice at Wallingford Hospital for the new ambulatory PICC and catheter clinic
- Wallingford podiatry treatment room refurbishment
- Banbury podiatry treatment room refurbishment
- Lambourne House extension
- Refurbishment of Ward Staff Room Wallingford
- Wantage community hospital site visit
- Physical health room Elms Centre in Banbury
- Jordan Hill relocation of services

12. Audits

12.1 Audit Management and Tracking System (AMaT)

Audits are completed via the Audit Management and Tracking System (AMaT). IPC audits include annual audits, hand hygiene, medical devices, mattress audits, matrons' checklists (appendix 3). Other audits are being added as part of the ongoing implementation in the Trust.

12.2 MRSA screening

The Department of Health for England requires all NHS Trusts to screen patients using a focussed risk-based screening programme. As a result, the Trust undertakes MRSA screening in all community hospital and older adults' mental health wards. This data was not collected for several months due to the loss of the patients' records systems. However, since December 2023, the data is recorded via the AMaT system, therefore compliance for the community hospitals is based on



the last four months only. Weekly screening compliance for the older adult's mental health wards is collated and monitored weekly by the IPCT, and quarterly reports provided to the directorates and IPCDC.

The average compliance for admission screening in 2023/24 was 87% for Older Adults Mental health and 87.3% in Community Hospitals.

12.3 Infection Prevention and Control Audits

There was a comprehensive and robust annual IPC audit programme for 2023/24, which consisted of IPC audits based on national standards. High levels of compliance have been maintained. All audits were completed during the audit year using adapted versions of the Infection Prevention Society (IPS) audit tools for monitoring IPC guidelines within the acute and community settings. The AMaT system records the audit and enable action plans to be developed for monitoring required actions. Areas of poor or non-compliance are followed up with the service by the IPCT.

The audits which were undertaken included all community hospitals wards, inpatient mental health wards (total 33), urgent care (9), dental clinics (9) and podiatry services (14).

Infection prevention and control audits carried out during 2023/24 and included:

- Management of IPC
- Hand Hygiene Facilities & Practice
- Personal Protective Equipment IPC
- Decontamination: Clinical Rooms & Equipment
- Decontamination: Dental Dec. Room
- Environment: Dental Surgery IPC
- Environment
- Management of Linen
- Laundry
- Facilities: Housekeepers Rooms & Environment Cleaning
- Estates

Across the Trust the average results for inpatient wards were 89%. Facilities areas, which fall below 85%, have action plans in place.

All audit results were reviewed, and reports provided for each directorate. Learning outcomes were shared with relevant staff directly and via IPC champions, service/ward managers and the IPC newsletter. A summary of the audits is presented to the IPCD committee quarterly and via an annual report.



12.4 Hand Hygiene audits

Hand hygiene observational audit in all clinical in patients' wards, EMU and MIU departments, Podiatry Service, Dental Services, District Nursing, and in the Clinical Research Facility (Mental Health). All audits are reviewed and monitored by the modern matrons and the IPCT. During 2023/24 the compliance average was 89%. Compliance with bare below the elbows was 100%. Any areas falling below the acceptable level are followed up by IPCT and action plans developed for improvement.

A summary of the audits is presented to the IPCDC quarterly and via an annual report.

Hand hygiene practical assessments in community-based services based continue on a risk assessment basis in:

- Children young peoples' community services
- Vaccination Service (Immunisation and COVID-19 teams)
- Speech and language services
- Luther street medical centre
- Hospital at Home
- ECT Units (Mental Health)

The IPCT also completed a review of alcohol gel and soap consumption, based on ordering from eProcurement (appendix 4). This was used as a broad indicator regarding the incidence of hand decontamination in community hospitals and older adult mental health wards, who patients are at higher risk of HCAIs. Further work is planned, by the IPCT, in the forthcoming year to review and explore the implications of this in relation to improving and optimising good hand hygiene.

12.5 ANTT Audit

Audits were introduced to monitor and support clinical practice and the correct use and management of invasive devices. Community inpatient wards, Podiatry Services and District Nurse complete annually, and results are evaluated and feedback to services by the relevant audit and governance teams. A summary of the audits is presented to the IPCDC quarterly and via an annual report.

The baseline audit following the ANTT introduction, in 2022, was 79.5%. This was the first baseline assessment prior to training being disseminated to identify the areas for improvement. The current compliance for this year is 87.1%, which is an improvement. A training pack was created and saved on a MS Teams folders to support learning and competencies assessment. Also, a required e-Learning ANTT module is available on OTR platform to be completed by all clinical staff undertaking invasive procedures.



12.6 Matrons checklists

The matron's role within IPC has been reviewed and additional work undertaken to ensure this valued role is standardised in the organisation. Matrons are completing IPC checklist audits, which are reported via AMaT (table 8). These results are monitored by the directorate governance meetings, with any issues escalated to the IPCDC if necessary.

Table 8: Summary of monthly matron's checklists

Audit	Frequency	Compliance over last 6 periods						Current
Matrons IPC Monthly Checklist	M	95.9%	92.3%	92.8%	93.5%	93.4%	92.0%	91.9%

Areas of concern with scores of 88.9% or below are:

- Are all staff up to date with infection control annual training (>95%)?
- Infection control notice board is up to date i.e. (latest hand hygiene compliance reports and posters)?
- During the shift did you observe staff performing hand hygiene 'before' donning PPE?
- During the shift did you observe staff removing gloves and aprons after each episode of patient care?
- Are all visitors asked to decontaminate their hand on arrival and departure?
- Are all staff adhering to 'Bare Below Elbows'?
- When in use, are staff wearing their PPE correctly (e.g. masks fully covering mouths, nose, and chin, non around necks, gloves only being used when risk of contact with bodily fluids or in contact with patient with a confirmed or suspected infection)?
- Are all surfaces in clinic areas clutter free and tidy?
- Are weekly medical devices record being completed?
- All products in store areas are off the floor and tidy.
- Are staff adhering to 'Bare Below Elbows' where appropriate?
- All entrances have signs requesting patients with signs/ symptoms of respiratory infection/disease to inform the staff.
- Signs on respiratory hygiene and cough etiquette are displayed at all entrances, waiting areas and by all lifts 'catch bin kill' where applicable.

13. Decontamination

13.1 Decontamination arrangements

There is a nominated Trust Decontamination lead. The lead attends and provides quarterly update reports to the IPCDC regarding overall Trust compliance with decontamination requirements. The Decontamination lead and DIPC are members of the IPCDC which reports to the Quality and



Clinical Governance Sub Committee. Most products used in the Trust are single use. However, podiatry uses reusable instruments, and these are decontaminated via an SLA with Steris. Dental services reprocess instruments via local decontamination procedures which are compliant with HTM 01-05.

13.2 Audit of Decontamination

Audits of the decontamination of patient equipment are undertaken annually and are incorporated in the IPC audit programme. Any results obtained are reviewed and monitored by the IPCT monthly and quarterly reports.

The Trust uses the AMAT system to report on audits related to decontamination. This provides a robust process for monitoring compliance with completion and the tracking of actions. During 2023/24 there have been challenges with lack of reliability of the software used for ATP testing and this will be reviewed in 2024-25. During 2023/24 the average score for ATP testing was 82%.

Mattress audits are completed monthly, and the results recorded on AMAT for easy review and access to data. Mattress check records are completed by all wards/areas. This is managed locally by wards and reported by Directorates to the IPCDC quarterly.

Medical devices decontamination records are completed by all wards/areas and reported to the IPCDC quarterly meetings and actions identified where required.

The introduction of AMAT has significantly improved the reliability of data and effectiveness of governance systems in relation to decontamination.

14. Training activities

14.1 Training sessions

Training is provided for clinical staff via online teams teaching sessions. Training is provided by an updated online training programme which is in line with national IPC education requirements. The programme provides two training modules- one for clinical and one nonclinical staff.

The final years training numbers for 2023/24 was 83 %, against the Trust target of 95%. This data is collated by the learning and development department and the training is delivered by the following methods: online virtual classroom via MS teams, face to face and E-learning. All forms of training and their content are annually reviewed and updated to meet the learning outcomes of the current UK Core Skills Training Framework and training requirements of staff.



In addition to mandatory training, the IPCT provided an additional 41 hours of staff training, which equated to 35 sessions. These included:

- Bespoke training on request including training sessions on hand hygiene, isolation, and PPE application
- Bimonthly meetings and training sessions for the IPC champions on MS teams.
- Cadets' Band 2/3
- Nursing Associates
- Senior HCA
- Peer support workers and volunteers' induction
- Band 2-4 induction.

14.2 Infection Prevention and Control Study day

The IPCT held a Trustwide IPC study day, in May 2023, at Unipart. There were internal and external speakers, and sessions included PPE/sustainability, using surveillance data to improve patient safety, dry surface biofilms and AMR. The event was well attended and evaluated.

15. International Infection Prevention Week 17-21st October 2023

International Infection Prevention Week (IIPW), established in 1986, aims to shine a light on infection prevention each year. The theme for 2023 was "The Future is Infection Prevention: 50 Years of Infection Prevention". The IPCT led a collaboration with the BOB NHS Trusts and ICS leads to produce shared educational materials, which included three webinars: hand hygiene, antimicrobial resistance, and occupational health. There were over 100 attendees.

16. Risks and future investments

The IPCT will continue to work in partnership with other allied services in the Trust to promote safe practice, in particular Health and Safety, Estates and Facilities and Occupational Health teams. Work continues to mitigate and improve the air quality /ventilation within the Trust estate.

The team will also continue to develop and work in partnership with external organisations to strengthen and support the patient pathway across the health economy.

The IPCT access the OUH laboratory surveillance system known as ICE, which provides email alerts and allows reports to be generated. This supports prompt action and timely interventions for managing patients with infections safely. Unfortunately, this system now needs urgent replacement and the OUH are sourcing alternative equivalent systems. The Trust needs to ensure the IPCT retain access to any replacement surveillance system.



17. Conclusion

The DIPC Annual Report summarises the extensive work completed in 2023/24 by the IPCT and within Trust services. The annual work programme for 2024/25 will continue to deliver against key national standards including The Health and Social Care Act 2008: code of practice on the prevention and control of infections, and the NHS England IPC Board Assurance Framework.

COVID-19 has remained a challenge throughout 2023/24, although it is not the only infection affecting patient safety. Effective IPC practice remains vital in safely managing the risks from all infections, which include other respiratory viral infections (influenzas A and B and respiratory syncytial virus (RSV)), group A *streptococcus* (iGAS), *Clostridioides difficile*, gram negative bacteraemias, measles and monkeypox, to name a few.

The continued emergence of resistant organisms and antimicrobial resistance remains a significant threat to modern healthcare. The IPCT remain committed to reducing HCAs and improving infection prevention and control standards, supporting a zero tolerance of avoidable infection and harm to patients and staff.

The reduction of gram-negative bacteraemia infections is a constant challenge. Most cases of infection develop in the community rather than inpatient services and therefore further work nationally and locally is ongoing to understand the underlying causes. This understanding will inform the development of effective and appropriate intervention strategies to try and reduce infections.

Robust and proactive approaches to IPC remain key to strengthening IPC practice in all areas of the Trust and the IPCT continues to provide an efficient and effective service to the Trust. Therefore, the focus for the IPCT and the Trust remains on improving and maintaining IPC practices, supporting patient care pathways across the health economy, and enhancing and improving safe clinical practice. The IPCT will continue to undertake robust reviews and scrutiny of each case of infection, working with colleagues and clinicians, to identify learning and ensure the continued high standard of patient care.



Appendix 1: Annual work programme



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Appendix 2: IPCDC Terms of reference



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Appendix 3: Annual audit programme

Oxford Health Infection Prevention & Control Audit Programme				
	Frequency	Management	Process	
Matrons Checklist: <i>Only Inpatient Wards</i>	Monthly	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
IPC Coordinator Checklist: <i>Outpatient Areas, Urgent Care Treatment Units & Minor Injury Unit, Dental and Podiatry Services</i>	Monthly	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Mattresses Audit: <i>Only Inpatient Wards</i>	Monthly	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Observational Hand hygiene Audit: <i>Inpatient Wards, Urgent Care Treatment Units & Minor Injury Units</i>	Bimonthly	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Observational Hand hygiene Audit: <i>District Nurses & Podiatry</i>	Quarterly	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Observational Hand hygiene Audit: <i>Dental Services</i>	Bi-annual	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Practical Hand Hygiene Assessment: <i>Community Teams including District Nurses</i>	Annual	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Aseptic Technique (ANTT) Audit: <i>Community Inpatient Wards, Urgent Care Treatment Units & Minor Injury Units, District Nurses, and Podiatry Services</i>	Annual	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT
Non-sterile glove use audit* <i>(Community and MH Older Adults Wards)</i>	Bi-annual	Corporate IP&C Team	Carried out by & reported by IPCT	AMaT
Annual IPC audit*	Annual	Corporate IP&C Team	Carried out by & reported t by IPCT	AMaT
IPC Dental Audits	Bi-annual	Corporate IP&C Team & Dental Team	Carried out by IPCT and Dental Team and reported by IPC Team	
MRSA Audit** <i>(Community and MH Older Adults Wards)</i>	Quarterly	Directorate	Results sent to Gov. Team & reported to the IPCDC	
ATP Testing <i>(Clinical Team: Cleanliness)</i>	Monthly	Directorate	Results sent to Gov. Team & reported to the IPCDC	
ATP Testing <i>(Facilities: Cleanliness)</i>	Monthly	Facilities	Reported to Facilities & reported to the IPCDC	
Medical devices Checklist	Weekly	Directorate	Results sent to Gov. Team & reported to the IPCDC	AMaT



Appendix 4 : Consumption of alcohol gel/soap over last 2 years

Alcohol gel

	GEL GRAND TOTAL (mls)		mls Per Day
	2022/23	2023/24	
CITY WARD	52,800	42,500	116
SANDFORD WARD	36,180	15,500	42
CHERWELL WARD	19,060	16,820	46
ABBAY WARD	57,720	37,840	104
OSRU WARD	24,780	369,600	1,013
LINFOOT WARD	32,320	37,000	101
WENRISC WARD	89,400	44,800	123
BICESTER WARD	22,000	30,000	82
DIDCOT WARD	45,300	37,500	103
WALLINGFORD WARD	49,580	30,500	84
AMBER WARD	51,400	3,000	8

	GEL GRAND TOTAL (litres)	
	2022/23	2023/24
CITY WARD	52.8	42.5
SANDFORD WARD	36.18	15.5
CHERWELL WARD	19.06	16.82
ABBAY WARD	57.72	37.84
OSRU WARD	24.78	369.6
LINFOOT WARD	32.32	37
WENRISC WARD	89.4	44.8
BICESTER WARD	22	30
DIDCOT WARD	45.3	37.5
WALLINGFORD WARD	49.58	30.5
AMBER WARD	51.4	3

Soap

	SOAP GRAND TOTAL (mls)		mls Per Day
	2022/23	2023/24	
CITY WARD	134,000	90,000	247
SANDFORD WARD	86,000	60,000	164
CHERWELL WARD	122,000	54,000	148
ABBAY WARD	171,000	153,000	419
OSRU WARD	201,000	165,000	452
LINFOOT WARD	19,500	213,000	584
WENRISC WARD	19,500	183,000	501
BICESTER WARD	85,200	87,000	238
DIDCOT WARD	222,000	144,000	395
WALLINGFORD WARD	168,000	150,000	411
AMBER WARD	48,000	54,000	148

	SOAP GRAND TOTAL (litres)	
	2022/23	2023/24
CITY WARD	134	90
SANDFORD WARD	86	60
CHERWELL WARD	122	54
ABBAY WARD	171	153
OSRU WARD	201	165
LINFOOT WARD	19.5	213
WENRISC WARD	19.5	183
BICESTER WARD	85.2	87
DIDCOT WARD	222	144
WALLINGFORD WARD	168	150
AMBER WARD	48	54

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

Board of Directors

RR/App 24(iii)-(iv)/2024
(Agenda item: 23(b))

Wednesday, 22 May 2024

Complaints, Compliments & PALS
Annual Complaints & PALS Report 2023 -24

For: Information & Assurance

Executive Summary

The annual Complaints and Patient Advice and Liaison Service (PALS) includes formal complaints, patient advice and liaison service (PALS) contacts, MP enquiries and compliments includes received by Oxford Health NHS Foundation Trust (OHFT) between 1 April 2023 and 31 March 2024.

The paper provides assurance that the Trust is meeting the legal regulations for the Care Quality Commission's regulation 16: receiving and acting on complaints. It is a national requirement for NHS Providers to publish an annual complaints report.

The Report covers the following:

- Key highlights for the year
- The key themes/learning from complaints and concerns
- Activity across the team
- Formal Complaints
- Timeliness of responding
- Grading of complaints
- Outcome of complaints
- Learning from complaints
- MP Enquiries
- Training
- Parliamentary Health Service Ombudsman (PHSO) & Local Government Ombudsman (LGO)

- Improving the complaints process
- Informal Concerns
- Analysis of themes from concerns and complaints
- Compliments

The key learning from formal complaints remains fairly the same compared to 2022-23.

The themes were:

- Insufficient care and support provided in the community.
- Staff attitude/behaviour (unfriendly, uncaring, uncompassionate).
- Lack of communication/information sharing with patients and families.
- Poor sharing of information across teams, providers and agencies.
- Waiting times and access to services.

Three main improvement areas to focus on to enable improvement and better experience have been identified as:

- Early resolution.
- Extensions process.
- Learning from complaints and sharing learning
- The areas for improvement are being addressed through the rollout and embedding of the new NHS complaints standards. The roll out starts this month of May.

Governance Route/Escalation Process

The report has been received and reviewed by the Quality and Clinical Governance Group meeting held 30th April 2024.

Statutory or Regulatory responsibilities

The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), requires that all Trusts provide an annual report on the handling and consideration of complaints.

Recommendation

The Board is asked to note the report and all the various activities happening across services to meet the complaints standards. There is no risk to escalate but to note that our response times to complaints has not improved and the numbers of extensions for the year is higher than in the previous. Work is underway to use the new Complaints framework and standards to improve on this.

Author and Title: Claire Price, Complaints & PALS Manager
Lead Executive Director: Britta Klinck Chief Nurse

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.

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/Priorities of the*
 - 1) *Quality - Deliver the best possible care and health outcomes*
Strategic risk themes: triangulating data and learning to drive Quality Improvement; Demand and Capacity (Mental Health inpatient and Learning Disabilities); and Demand and Capacity (Community Oxfordshire).
 - 2) *People - Be a great place to work*
Strategic risk themes: Workforce Planning; Recruitment; Succession Planning, Organisational and Leadership Development; Culture; and Retention.
 - 3) *Sustainability – Make best use of our resources and protect the environment*
Strategic risk themes: planning and decision-making at System and Place level and collaborative working with Partners; governance of external Partners; Financial Sustainability; Governance and decision-making arrangements; Business Planning; Information Governance & Cyber Security; Single Data Centre; Business Continuity and Emergency Planning; Environmental Impact; and Major Capital Projects.
 - 4) *Research and Education – Become a leader in healthcare research and education*
Strategic risk themes: failure to realise Research and Development potential.

**Report to the Meeting of the
Oxford Health NHS Foundation Trust
Board of Directors
Wednesday, 22 May 2024**

**Complaints, Compliments & PALS
Annual Complaints & PALS Report 2023 -24**

For: Information & Assurance

Annual Complaints & PALS Report 2023 -24 for Assurance for Regulatory Compliance

Executive Summary

This is the annual report on formal complaints, patient advice and liaison service (PALS) contacts, MP enquiries and compliments received by Oxford Health NHS Foundation Trust (OHFT) between 1 April 2023 and 31 March 2024. This paper provides assurance that the Trust is meeting the legal regulations for the Care Quality Commission's regulation 16: receiving and acting on complaints. It is a national requirement for NHS Providers to publish an annual complaints report. The report also demonstrates some of the key activities taking place across the Trust for 2023 to improve the experiences of people using our services.

The Report covers the following:

- Key highlights for the year
- The key themes/learning from complaints and concerns
- Activity across the team
- Formal Complaints
- Timeliness of responding
- Grading of complaints
- Outcome of complaints
- Learning from complaints
- MP Enquiries
- Training
- Parliamentary Health Service Ombudsman (PHSO) & Local Government Ombudsman (LGO)
- Improving the complaints process
- Informal Concerns
- Analysis of themes from concerns and complaints
- Compliments

Governance Route/Approval Process

Quality Committee

Statutory or Regulatory responsibilities *[if section required]*

Nil

Recommendation:

The Board is asked to note the report and all the various activities happening across services to meet the complaints standards. There is no risk to escalate but to note that our response times to complaints has not improved and the numbers of extensions for the year is higher than in the previous. Work is underway to use the new Complaints framework and standards to improve on this.

**Authors and Title: Claire Price, Complaints & PALS Manager
Rose Hombo [Deputy Director of Quality & Clinical Standards]**

Lead Executive Director: Britta Klinck [Chief Nursing Officer & CNO]

Introduction

The Trust continues to value all complaints and concerns raised to use these as opportunities to make improvements. We actively monitor the key themes identified within complaints received alongside information from other sources of feedback such as Patient Safety Incidents, Legal Claims, Inquests and HR investigations. Discussions to triangulate the information take place on a weekly basis at the Trust-wide Clinical Weekly Review Meeting and monthly at the Trust-wide Quality and Clinical Governance Sub-Committee.

Key highlights from the report are as follows:

- In 2023-24, OHFT received 229 complaints which is an increase compared to the previous year when 200 complaints were received. The number of complaints received by quarter is broken down as follows:
 - 54 complaints in Q1 (April to June 2023)
 - 66 complaints were received in Q2 (July to September 2023)
 - 54 complaints in Q3 (October to December 2023)
 - 55 complaints were received in Q4 (January to March 2024).
- Most complaints were received from patients and relate to our mental health services.
- 100% of complaints were acknowledged within three working days.
- 99% of complaints were responded to within a timescale agreed and communicated with the complainant. This means we had to agreed time scales outside standards due to high number of extensions request which has become a routine occurrence with services. We also had three complaints that were responded to outside of 6 months, in all cases the complainant was given regular updates on progress and a written explanation for the delay. We are addressing the timeliness of responses using the new complaints framework.

The key themes/learning from complaints and concerns are:

- Insufficient care and support provided in the community.
- Staff attitude/behaviour (unfriendly, uncaring, uncompassionate).
- Lack of communication/information sharing with patients and families.
- Poor sharing of information across teams, providers and agencies.
- Waiting times and access to services.

There are four current open cases with Parliamentary Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO). Three of these need full investigations and one preliminary investigation. In 2023-24, the PHSO/LGO made seven enquiries relating to closed complaints which were not investigated any further.

After the investigation into each complaint, if there are any upheld elements or any improvements in practice identified then an improvement plan is developed by the relevant Service Manager. An example of some of the actions taken in 2023-24 are detailed in the report.

In addition to complaints, OHFT received and responded to 137 formal MP enquiries in 2023-24 and 658 local concerns in 2023-24.

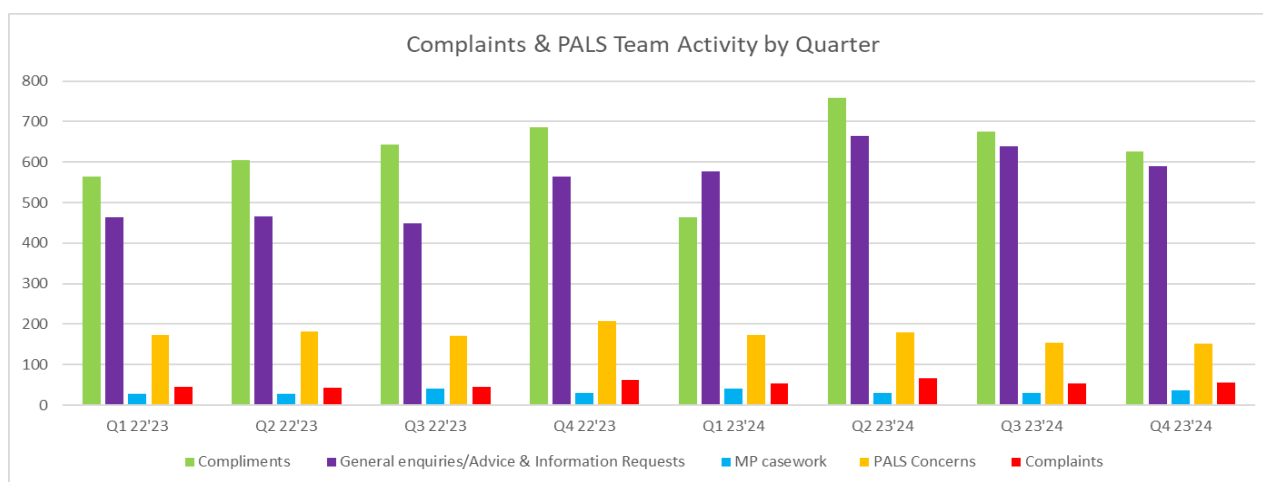
The Trust continues to provide 35 PALS surgeries across wards and day hospitals. Some of the surgeries use volunteers to listen and gather feedback.

The Trust received 2,947 compliments in 2023-24 which is an increase when compared to the previous year.

Activity across the Trust

The Complaints and PALS data continues to show a sustained high level of activity, with many of the contacts having complex elements associated with them. The consistent complexity of cases and staff activity, not always reflected in the numerical data, continues to generate significant work and pressure for the team and operational colleagues. We are exploring how we can capture 'complexity' in some meaningful way which gives an indication of the volume of such cases and their impact on team resource. Once established this measure will be reported at key forums.

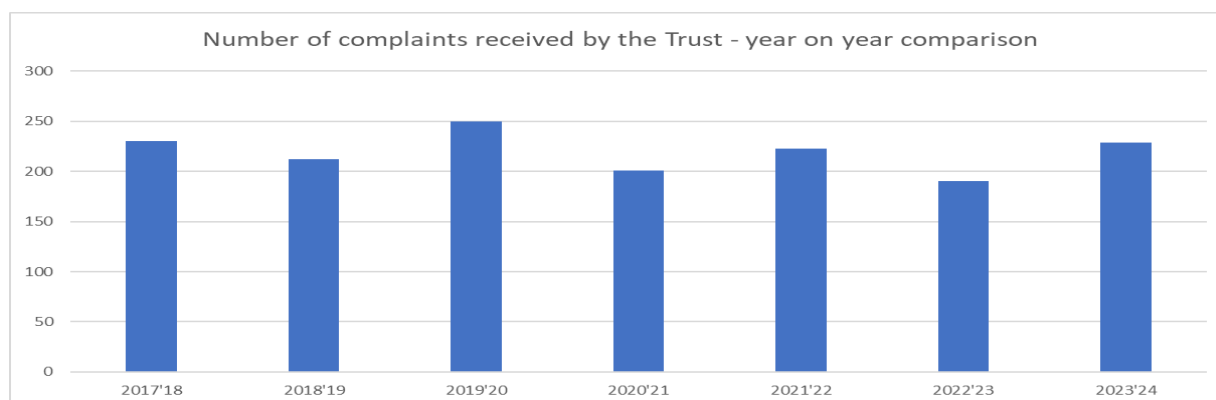
The graph below shows activity across the complaints, PALS, MP casework and compliments.



Formal Complaints

Number of complaints received.

There has been an increase in the number of complaints in 2023-24 when 229 complaints were received, compared to the previous year when 200 complaints were received. The figure below shows the number of new complaints received year by year, this excludes re-opened complaints. There has been little variation over time in the number of complaints received by month, however the number of complaints received this year is higher than last year. Across 2023-24, 54 complaints were received in Q1, 66 in Q2, 54 in Q3 and 55 in Q4.



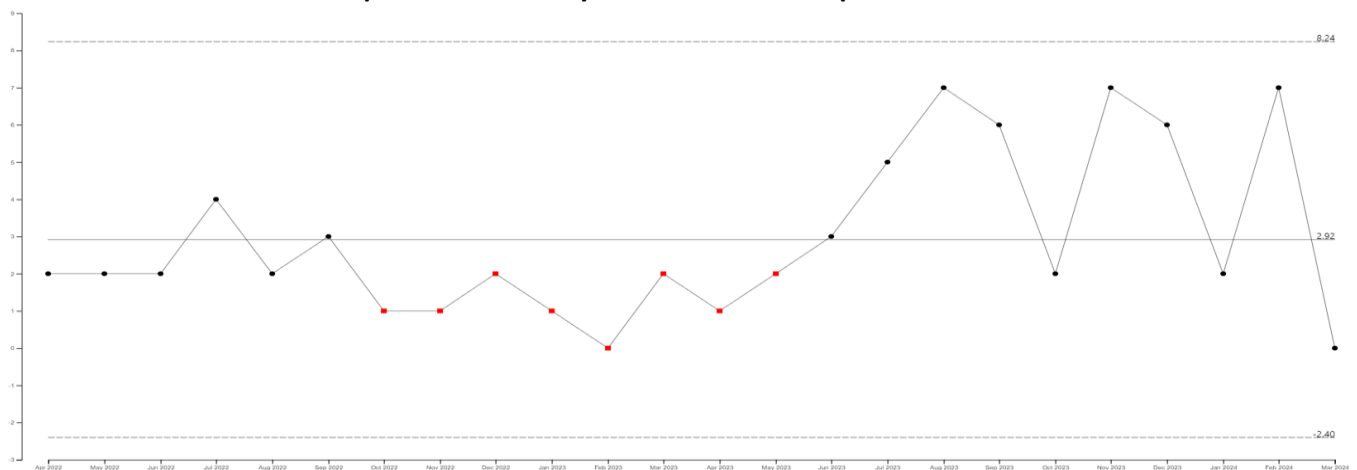
Most complaints were received from patients (n=106) and 96 complaints were received from carers/family members. In Q4, 28 complaints were received from carers/family and 21 complaints were received from patients.

Oxfordshire, BaNES, Swindon, and Wiltshire Mental Health Services received the highest number of complaints (Q4 = 21, yearly total = 92), followed by Buckinghamshire Mental Health Services (Q4 = 20, yearly total = 66), Primary, Community and Dental Services (Q4 = 12, yearly total = 58), Specialised Services (Q4 = 1, yearly total = 7) and Corporate Support Services (Q4 = 1, yearly total = 6).

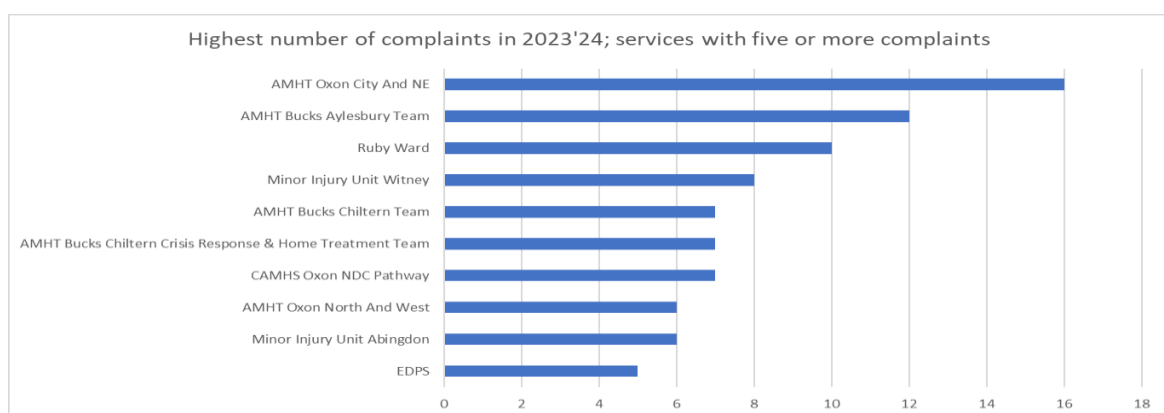
During 2023-24, 15 complaints (Q4 = 0) complaints were re-opened, and further investigations were completed. This is an increase when compared to the previous year with seven complaints were re-opened. During the reporting period, 12 complaints were withdrawn and were dealt with locally through the PALS route.

The graph below shows the number of new complaints received month by month, this excludes re-opened complaints. There has been variation over time in the number of complaints received by month, with significant increases in August, November 2023 and February 2024 which is seen in the SPC graph below.

Number of complaints received by month between 1 April 2022 to 31 March 2024

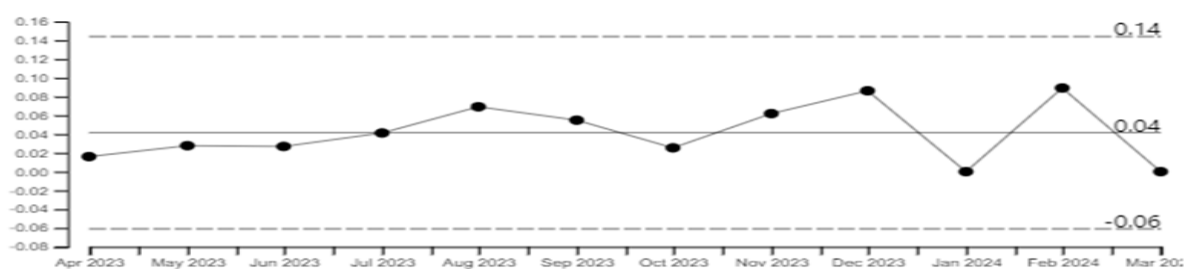


Trust-wide the teams with the highest number of complaints (five or more) during the reporting period were as follows;

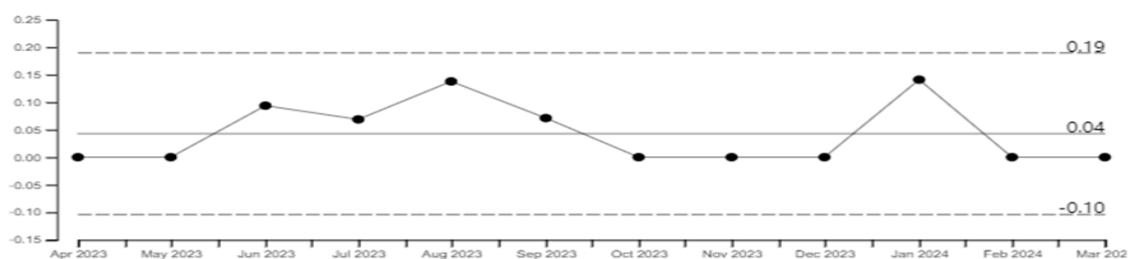


To put the number of complaints received in context of activity levels, the below graphs show the number of Trust-wide complaints by 1,000 occupied bed days. The number of complaints received is low against the amount of activity.

How many formal complaints were there per 1000 attended appointments? (includes community teams only)



How many formal complaints were there per 1000 occupied bed days? (includes wards only)



Timeliness of responding

In 2023-24, 229 complaints have been received, of which 100% were acknowledged by the Complaints & PALS Team within the NHS Complaints Regulations (2009) of three working days.

Of the 183 complaints which have been investigated and responded to, 182 of these (99%) were responded to within a timescale agreed and communicated with the complainant. However, there does continue to be a high number of extension requests across the Trust and 105 (57%) complaints were responded to with an extension in place. This number will increase, as 46 complaints remain open at the time of writing this report. The main reasons for extension requests are as follows; delay in allocation, annual leave/sickness, an investigating officer being unable to complete the investigation within time due to their workload. The number and themes from complaints, as well as extensions and delays are monitored and reported on a weekly basis to the Trust-wide Weekly Clinical Review meeting.

Q4 breakdown of response times is as follows; within time = 8, within agreed extension = 7, outside of time = 1, open = 39.

The table below shows Trust-wide performance on the number of cases which were responded to within the original 35 working day deadline, within an extension, outside of time and withdrawn.

Response performance	Q1 22'23	Q2 22'23	Q3 22'23	Q4 22'23	Q1 23'24	Q2 23'24	Q3 23'24	Q4 23'24
Within 35 w/days	16	6	11	21	21	31	18	8
Within agreed extension	28	35	32	39	32	33	34	7
Extension not agreed (Outside of timescale)	0	0	1	1	0	0	0	1
Withdrawn	7	6	10	8	5	1	4	0
Open	0	0	0	0	1	2	2	39

The table below show performance by Directorate during 2023-24.

Directorate	Total Number	Within time	Within agreed extension	Out of time	Open
Oxfordshire, BaNES, Swindon, and Wiltshire Mental Health Services	92	28	46	1	17
Buckinghamshire Mental Health	66	13	37	0	16
Primary, Community and Dental Services	58	30	17	0	11
Specialised Services	7	2	5	0	0
Corporate Services	6	5	0	0	1
TOTAL	229	78	105	1	45

In 2023-24 we had five (3%) complaints that were responded to outside of the 6-month complaints regulation due to complexity. In all cases communication was maintained with the complainant throughout and a written explanation for the delay was provided.

Grading of complaints

All complaints are graded based on severity of harm to the patient using a national risk matrix with a rating of green, yellow = low level complaint and orange or red = high level complaint. Every new complaint and all re-opened complaints are screened for any safeguarding concerns, sent to the Clinical Director and Associated Director of Nursing, and discussed at the Trust-wide Weekly Clinical Review Meeting. From the 229 complaints received, 219 (96%) were graded low level and ten (4%) were graded high level. In Q4, 54 complaints were graded low and one complaint was graded high.

Outcome of complaints

183 complaints have been responded to for 2023-24 with following outcomes:

- 32 were upheld (19%), Q4 = 4 (19%)
- 73 complaints were partially upheld (40%), Q4 = 10 (48%)
- 70 complaints were not upheld (39%), Q4 = 7 (33%)
- Seven cases there was no evidence to prove or disprove the outcome of the investigation (3%).

Learning from complaints

After the investigation into each complaint, if there are any upheld elements or any improvements in practice identified then an improvement plan is developed by the relevant service manager. Between 1 April 2023 to 31 March 2024, of the 242 complaints which have been responded to, 266 actions were identified across the Trust. These actions are broken down per directorate as follows:

- Oxfordshire, BaNES, Swindon, and Wiltshire Mental Health Services - 90
- Primary, Community and Dental Services - 75
- Bucks Mental Health Services - 96
- Specialised Services - 5
- Corporate Services - 0.

The current open actions across the Directorates

There are 45 actions, of which eight are out of time, across six cases.

The number of open actions broken down by Directorate are as follows:

- Buckinghamshire Mental Health Services - 9
- Oxfordshire, BaNES, Swindon, and Wiltshire Mental Health Services - 21
- Community Services - 13
- Specialised Services - 2.

The complaints team also monitor the number of improvement plans requested where concerns are upheld – there are four plans outstanding (Q2 = 2, Q3 = 2) where they have been escalated and the position is being overseen by the Trust-wide Regulatory Action Monitoring Group.

Detailed below are some actions which have been taken following the completion of an investigation:

- Reminders to all staff that while we need to have difficult conversations with families these should be in line with Trust values in a way that ensures the families feel safe and cared for (CAMHS Bucks Getting More Help)
- The ward team to implement local ward based in house refresher training (practice scenarios and Peace techniques), regular reviewing of PEACE exemptions to ensure the ward has enough staff that are effectively trained (Opal Ward)
- AMHP services (Bucks & Oxon) to consider post assessment discussions with patients detained under the Mental Health Act (MHA) to check their level of understanding and provide the opportunity to discuss any concerns or misconceptions they might have. This initiative could be developed jointly with acute admission wards (AMHP Service Bucks)
- Identification of progression should be clearly documented. This should include potential rationale (i.e. patient/staff factors). If there is a change to plan or expected goals, or if goals have been achieved, these should be documented and communicated to the patient and family where necessary (CHos City Ward)
- Review how administrators handle difficult conversation phone calls and complaints phone calls process. There needs to be nil phone calls which are ended prematurely by staff member. Recommend calls to be passed on to someone else or escalated to management. Check if staff need retraining on this aspect (Single Point of Access)
- Therapists to involve patients in their goal setting and spend time understanding any rationale for not wishing to do what may appear simple tasks, paying attention to psychological aspects of their recovery as well as the physical (CHos Witney Linfoot Ward)

In Q4 59 complaints were received and responded to, 76 actions were identified across the Trust with following breakdown:

Oxfordshire, BaNES, Swindon, and Wiltshire Mental Health Services- 32 and Community Services - 25 and Bucks Mental Health Services -19 and Specialised Services - 0). We are currently awaiting one action plan from complaints that were responded to Q4.

The Complaints and PALS Team centrally monitor the completion of all actions. The progress with actions is reported regularly and any overdue actions are overseen by the Trust-wide Regulatory Action Monitoring Group.

The key themes/learning from complaints and concerns are:

- Insufficient care and support provided in the community.
- Staff attitude/behaviour (unfriendly, uncaring, uncompassionate).
- Lack of communication/information sharing with patients and families.
- Poor sharing of information across teams, providers and agencies.
- Waiting times and access to services.

In relation to the major theme on improving how we involve families, including related matters around confidentiality, information provided and communication, a Trust-wide Quality Improvement programme led by Buckinghamshire Mental Health Directorate was completed with following recommendations:

- Roll out of Triangle of Care
- Roll out of Family Behavioural Intervention Training
- Guidance for staff on sharing consent

MP Enquiries

During the reporting period the Trust received 137 MP enquiries. During Q4, 36 MP enquiries were received.

Training

The Complaints and PALS Team are part of the Trust's induction programme for new starters. They also provide regular complaints training for nominated investigating officers. In 2023-24, 55 staff had been trained as an investigating officer. The content of the investigating officers' complaints training is currently under review, as part of the implementations of the NHS Complaints Standard which will be rolled out over the coming months.

Parliamentary Health Service Ombudsman (PHSO) & Local Government Ombudsman (LGO)

At the time of writing this report, there are four current open cases with Parliamentary Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO). Of these, three full investigations are being undertaken and one preliminary investigation is being undertaken prior to a decision being made about whether a full investigation needs to be commenced. In 2023-24, the PHSO/LGO made seven enquiries relating to closed complaints which were not investigated any further. One investigation relating to a Buckinghamshire complaint was completed in Q4 and no further action was taken. Two investigations were closed where the complaint was partially upheld, and the Trust wrote to the complainants to acknowledge the failing and the learning identified.

Improving the complaints process

In September 2020 we introduced a feedback form for complainants to gain an understanding of people's experiences of using the complaint process and ways of improving this. Currently we have received a very small number of responses (23) through 2023'24, however each response is reviewed to identify any changes that can be made. Where complainants responded and said they remained unhappy with the outcome to their complaint, we have reviewed the case to see if there is anything we can do to resolve their concerns. From discussions within our Complaints Future NHS Collaboration Platform, this continues to be an area that organisations struggle to have a good success rate in obtaining feedback about their complaints processes.

Introductions of the new NHS Complaints Standards

The Parliamentary Health Service Ombudsman (PHSO) published new guidance in December 2022 to set out how organisations providing NHS services should approach complaint handling. The Complaint Standards aim to provide a quicker, simpler, and more streamlined complaint handling service.

They identified four core pillars, which these standards are based on:

1. Welcoming complaints in a positive way.
2. Early resolution.

3. Being fair and thorough.
4. Learning from complaints.

A presentation has been made to the Extended Leadership Team Meeting to summarise the standards and proposals moving forward. The Trust will need to place a greater emphasis on early resolution of concerns to improve people's experiences of our services. Key to this new process is that we are now required to handle any "dissatisfaction" with our services as a complaint. The only exception to this would be if something can be easily resolved within 72 hours, in which case, this would not be recorded as a formal complaint. To achieve this, we are proposing to introduce 'rapid resolution complaints' which in essence are concerns previously dealt with as PALS/concern/informal matter. The advantage of this is that if enquirers remain unhappy after they have received the Trust's response to a rapid resolution complaint, we can refer them directly onto the PHSO, without first having to undertake a formal investigation (investigation outside of the immediate care team). Low and high graded complaints will continue to be managed in much the same way as we have dealt with them previously.

Over the coming weeks and months, we will be meeting with staff across Directorates and sharing the key messages of our standards.

Informal Concerns

Patient Advice & Liaison Service (PALS)

In 2023-24, the PALS Team managed:

- 658 local concerns
- 2,469 general enquiries
- 137 MP enquiries

The PALS Team hold PALS surgeries in all inpatient wards across the Trust. In Q4, the PALS Team handled 154 local level concerns, 587 general enquiries, 13 PALS Surgery feedback/comments, 4 PALS Surgery concerns and 8 pieces of feedback via social media. This is a snapshot of some of the themes/trends following the feedback received from PALS Surgeries across the Trust in Q4. Each piece of feedback is discussed and shared with the ward/team manager or deputy and resolved. Any concerning issues are also appropriately escalated.

Forensic wards – low secure

Engagement for this sector has been low across Q4, but as per previous reports, the feedback is of a positive nature relating to the staff, as well as an overall feeling of a positive well-being and safety. There has been dissatisfaction raised in relation to the quality of the food being offered, but we are aware that these issues are in hand with the wards, and some are inviting the patient representative to be included in generating new menus. When asked what they would change to make a positive difference to their inpatient stay, patients report again, that more garden time would be appreciated, especially with the better weather hopefully arriving.

Forensic wards – medium secure

When visiting face to face, participation on these wards has increased slightly, unless a gym session is in process! Some new patients continue to report that they are finding the environment hard to adapt to and it is taking longer than they'd like to settle in. Whilst the main feedback relating to staff is positive, especially regarding their level of helpfulness, some patients report that staff can be unempathetic at times, which can lead to the patient feeling uncared for. The consensus around the activities is that there are more on offer and whilst the staff encourage patients to attend, they are not forced into taking part. Whilst the food portions are of ample size, reports regarding the flavour and quality of the dishes remain of a negative nature. When asked what they would change to make a positive difference to their inpatient stay, patients report that it would be good to have more flavoursome food on offer such as a curry to taste of curry.

Mental Health wards

As usual, the feedback relating to staff is of a relatively high standard however, there are some patients who feel that agency staff are difficult to build rapport with, as some only arrive for one shift. Others who work only nights, can also be difficult to form a relationship with, due to their working hours. Whilst the protein level offered at mealtimes is still not to some patient's standard, the variety and quality of food offered is of good taste, with the portion sizes remaining a suitable size, and patients are not left feeling hungry. The housekeeping staff are continued to be held in high regard and patients visibly appreciate the level of cleanliness of the wards. The activities are picking up and the patients are looking forward to being able to incorporate outside activities, with the warmer

weather approaching. When asked what they would change to make a positive difference to their inpatient stay, patients report that it would be good if the night staff were quieter when opening and closing doors, and more considerate when carrying out nightly observations.

Community Hospitals

The feedback for this area remains of a very high standard in relation to staff, describing them as very approachable, caring, friendly and nothing being too much trouble for them. The patients are very grateful to be receiving such a high standard of care and some even compare it to being on holiday! Patients confirm that they feel very safe on the ward and that they have all they require in terms of the facilities in their ward or room. It has again, been noted how quickly physiotherapy is arranged for patients, which is more welcome to some than others as they do not feel confident in their own ability but do have every confidence in the staff. When asked what they would change to make a positive difference to their stay, the patients were not able to recall any points for this quarter.

Child & Adolescent Mental Health Services (CAMHS)

Feedback in this area remains a challenge to obtain however, we are still working closely with the young people and staff to navigate their timetable, to find a mutually convenient time to visit. We have received feedback relating to bedroom issues, which were confirmed to be in hand, as well as some patients requesting more vegetarian options at dinner time, rather than just one. We are yet to receive any feedback from the Meadow Unit and continue to visit and be visible to patients. Most patients and young people across the Trust confirmed that they are aware of the Complaints & PALS Team and of the process of how to raise concerns and complaints. They are also given PALS leaflets for awareness.

Analysis of themes from concerns and complaints

The below is an overall analysis of both complaints and concerns received by the Trust in 2023-24. The most common categories of concern/complaints:

- All aspects of clinical care (331), with most concerns about insufficient/quality of care in the community (173), insufficient/quality of care as an inpatient (53), medication (39) and diagnosis (28).
- 190 cases related to staff attitude/behaviour (64 related lack of professionalism, 39 related to uncaring/uncompassionate, and 26 related to a hostile/rude manner).
- 84 related to communication/information sharing.
- 64 related to waiting times.
- 51 related to admission/discharge/transfer.
- 48 related to appointments/referrals.

Top 5 complaints/concerns by subject	Q1 22'23	Q2 22'23	Q3 22'23	Q4 22'23	Q1 23'24	Q2 23'24	Q3 23'24	Q4 23'24
All Aspects of Clinical Care	70	66	89	101	88	91	74	77
Appointment/referrals	16	9	14	20	18	11	13	6
Communication/Information Sharing	24	32	19	41	17	20	20	24
Staff attitude/behaviour	43	35	28	24	40	59	41	55
Waiting Times	14	19	19	21	22	17	15	8

The teams below have received the highest number of complaints and concerns, an analysis of the concerns is below:

Oxon City & NorthEast adult mental health team: There has been a significant reduction in the number of concerns/complaints raised about the service area over the last couple of years from 106 cases in 2021-22, 59 cases in 2022-23 and 60 in 2023-24. Of the 60 cases received, 16 formal complaints, of which 15 were graded low and one was graded high (14 closed; one upheld, eight partially upheld and five were not upheld) and 44 concerns. 36 cases related to all aspects of clinical care (24 of these were about insufficient care in the community), ten related to staff attitude/behaviour and four related to communication/information sharing.

Bucks Aylesbury adult mental health team: 42 cases were received, there were 12 formal complaints which were all graded low level (11 closed, 4 upheld, 4 partially upheld and 5 were not upheld) and 30 concerns. 16 related to insufficient/quality of care in the community, 14 related to staff attitude/behaviour and three related to medication issues.

Ruby Ward: 30 cases received, 10 formal complaints, all graded low (7 closed, 4 partially upheld and 3 were not upheld) and 20 concerns. 15 cases were about insufficient care received on the ward, 5 related to staff attitude/behaviour and 3 related to communication issues.

CAMHS Bucks Neuro: 26 cases received, there were 3 complaints, all graded low (all partially upheld) and 23 concerns. 10 related to waiting times, 10 related to communication/information sharing and 3 related to insufficient care in the community.

Bucks Chiltern adult mental health team: 22 cases received, there were seven complaints, all graded low (4 cases closed, 1 upheld, 2 partially upheld, and one not upheld) and 15 concerns. 7 cases related to insufficient/quality of care in the community, three related to staff attitude/behaviour, 3 related to communication/information sharing and three related to poor discharge planning.

CAMHS Oxon NDC Pathway: 7 formal complaints, all low graded (7 cases closed, 4 upheld and 1 partially upheld) and 15 concerns. 13 related to insufficient care within the community and 13 related to waiting times.

Compliments

Compliments

The Complaints and PALS Team centrally collates the compliments shared by teams including thank you letters and cards. In 2023 - 24 a total of **2947 compliments were received**, which is an increase on the previous year (2499). Oxfordshire, BaNES, Swindon and Wiltshire Mental Health Services received 1273, Primary, Community and Dental Services received 1215, Buckinghamshire Mental Health Services received 235, Specialised Services received 152 and Corporate Services received 72.

Extracts from compliments.

"I've taken a call from a parent who previously saw you many years ago when her son was diagnosed age 5 – 6 years, he's now 15 years old and mum completely lit up when I said that you are still within the service. If it wasn't for you, she would be so lost. She owes you so much, you changed their lives for better, and she is forever thankful for you!"
CAMHS SPA

"Thank you so much for all your help and all the information you have sent us. You have been a huge part of our learning 'adventure' and we couldn't have done it without you. Thank you also for being so supportive, I've seen a positive change in YP due to being listened to." North Oxon CAMHS

"As a decision maker I feel that my goal of providing both a proportionate and just outcome for youth offenders is supported greatly by the information L&D provide. This has helped enable a better understanding of the background behind each individual which is particularly important as we look to judge each youth with a holistic approach with more context rather than what would otherwise be a more reductionist one. In my experience L&D have also helped contribute to positive discussions by expressing views on suggested outcomes and identifying areas for more support – something that youths and their families are often desperate for to help manage offending behaviour. Examples of this include identifying the need of opting in for L&D two youths that had domestic concerns but were not known to the agency, and the suggestion of calling a parent to help ensure a referral was made through their GP – I made this call, and the parent was very thankful for the information and support. I have recently expressed strong concern for one youth in particular regarding his welfare. L&D have helped reassure me that our partner agencies have put in place a good support system to help his needs. I feel this has helped contribute to an ongoing positive and productive collaboration between TVP and L&D." CAMHS Youth Liaison & Diversion Team

*"To all the staff at Linfoot Ward this is just to say thank you for looking after *** so well over the last few weeks. Your efforts were very much appreciated by us all as a family."* Linfoot Ward

"I just wanted to thank you for attending X's recent annual review. It is the first time ever that a SALT professional has done so. It was really helpful to get a SALT perspective particularly around support through to the end of X's time in a school environment, GCSEs, and transition plans for college. We have been very grateful for all your support and input with X since you took over as SALT at the ORB/ Marlborough School. Your support regarding exams in particular suggesting and arranging an OLM made a huge difference." Children's Speech & Language Therapy

"So impressed, I had reason to attend the minor injuries unit at Townlands this week with ankle damage. I was so impressed at the friendly, efficient way I was triaged, x-rayed, diagnosed, and treated. All in less than 90 minutes! I would definitely recommend anyone eligible to use this service." MIU Henley

*"I really want to commend the Evenlode team for their exceptional skill and professionalism in effectively managing and providing care for all ***. Whilst doing paperwork in the office and it was so happy to see *** enjoying their time on a sunny day with staff. *** was pleasant and appropriate" Well done all, staff dedication, patience, and teamwork have made a significant difference in the patient's well-being and recovery. Such a fabulous dedication and hard work in providing exceptional care to all our patients. Their commitment to excellence is truly commendable and greatly appreciated."* Evenlode

*"Thank you very much *** and *** for working so hard to progress this move. Thank you also to all the Huntercombe staff who are working so hard to keep *** safe."* Huntercombe Prison

*"I and *** would like to thank you for all the support you have given *** throughout their time with us and during the transition. *** visited last week and is continuing to settle in well."* LD North Team

Conclusion

In conclusion, the Trust received 29 complaints more for 2023-24 more than the previous year 2022-23. The highest number of complaints was in Q2, there was 66 complaints received in Q2 (July to September 2023).

In the same period, the Trust received 448 compliments more than the previous year.

Most complaints were received from patients and relate to our mental health services.

100% of the complaints received were acknowledged within three working days, as standard practice by the complaints team.

99% of complaints were responded within an agreed timescale and communicated with the complainant. These timescales most fell outside the agreed standards set by the Trust. This means within the last 12 months, we have been working with high numbers of extensions request within our pathways. This has become a routine occurrence with services rather than a rare practice. We also had three complaints that were responded to outside of 6 months timescales, in all cases the complainant was given regular updates on progress and a written explanation for the delay. We are addressing the timeliness of responses using the new complaints framework.

The key learning themes remain fairly the same compared to 2022-23. The themes were:

- Insufficient care and support provided in the community.
- Staff attitude/behaviour (unfriendly, uncaring, uncompassionate).
- Lack of communication/information sharing with patients and families.
- Poor sharing of information across teams, providers and agencies.
- Waiting times and access to services.

There are three main improvement areas to focus on which will enable improvement and better experience- these are:

- Early resolution.
- Extensions process.
- Learning from complaints and sharing learning

The areas for improvement are being addressed through the rollout and embedding of the new NHS complaints standards. The roll out starts this month of May.

Policy control document

This ensures good version control and effective policy management. It must be completed before a policy can be uploaded to the intranet.

Policy title	Research and Development Policy
Policy code	CORP 12
Author(s) (name and title/role)	Brandy Coote, Head of Research Management
Reviewers	Natalia Jastrzebska, Research Governance and Support Manager Claudia Hurducas, Head of Strategic Recruitment and Delivery

Approval history	
Name of committee	Date
Research and Development Senior Management Team	01-02-2022
Committee which approved current version	Date of approval for current version
Research and Development Senior Management Team	24.04.2024

Date of next review	February 2026

Chair of approving committee :

Signature.....

.....

Title: R&D Director

Date: 24/04/2024

All policies are copy controlled. When a revision is issued previous versions will be withdrawn. An electronic copy will be posted on Oxford Health NHS Foundation Trust (OHFT) Intranet for information.

Change control

Number of pages (excluding appendices) 16
Summary of revisions: This policy has been updated to incorporate changes in the research landscape, to update on Research and Development (R&D) strategy and priorities and its integration with Trust.
Any change to code or merging with other policies
Consultation with: Head of Research and Development Head of Research Informatics Head of Research Delivery Research and Development Senior Management Team Clinical Research Facility Manager Senior Research Accountant Pharmacy Lead

Research and Development Policy

CORP12

V.3

Date of approval – 24.04.2024

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1. Purpose of policy (aims and objectives)

Why do we need this policy? What are its main aims?

Oxford Health NHS Foundation Trust (OHFT) endeavours to embed inclusive patient centred research within the organisation. Our aim is to generate knowledge and drive innovation, giving rise to better and more cost-effective treatments. This policy is required to protect the interests of our research participants, staff and facilities.

The aim of this policy is to articulate OHFT's expectations in relation to the proportionate and effective development and management of research activity by fostering an environment where:

- patients, service users and the public (including carers, relatives of patients, and healthy volunteers) are given the opportunity to participate in health and social care research and to be involved in its design, management, conduct and dissemination;
- safer, more efficient or more effective treatments, care and other services are developed and tested through ethical and scientifically sound research;
- applying to do research is simple, with efficient decision-making and predictable timelines;
- researchers find the conduct of research to be straightforward;
- industry partners recognise OHFT and our wider network as a great place to do research;
- money from research funders goes into carrying out research with risk appropriate bureaucracy;
- all research projects outcomes are published in a timely manner.

2. Outline of policy

What does the policy cover and what does it require the organisation and staff to do?

This policy covers the legal, quality, ethical and safety frameworks that govern research in all phases. It applies to all research being developed and undertaken within OHFT premises and includes research involving NHS employees and any non-NHS researchers accessing NHS patients (including their data and/or materials) or staff and OHFT substantive employees undertaking work on behalf of OHFT on non-NHS sites .

3. This policy covers responsibilities in relation to:

- Research Design

Careful consideration should be taken before undertaking any research. It is unethical to duplicate previous work or conduct research that is of poor quality or does not support existing knowledge.

Anyone reading a protocol should have a complete understanding of what will be expected of staff and participants. Where possible, design should be discussed with potential participants or patient groups, carers, service users or members of the public with relevant experiences or knowledge at the earliest stages. Working in this way helps to promote successful research by increasing the potential recruitment and retention for a trial.

- Ethical and Regulatory Considerations

Research governance is the responsibility of everyone involved in all stages of research processes from planning (study design), funding, applying for governance/permissions to conduct the study, undertaking study procedures, to completing and disseminating results within appropriate guidelines

and financial envelopes.

The Department of Health (DH) requires that all research involving patients, healthy volunteers, service users, care professionals or volunteers, or their organs, tissues or data, be reviewed independently to ensure it is ethical to conduct the study. [The UK Policy Framework for Health and Social Care Research](#), sets out principles and responsibilities at a high level that take account of relevant legislation in the UK.

It is against the law to start or conduct a clinical trial or to recruit participants to a clinical trial involving a medicine until there is a favourable opinion from an ethics committee and authorisation from the licensing authority.

All research studies conducted within the NHS are required to be approved by Health Research Authority (HRA). Researchers are required to complete an online form via the Integrated Research Application System (IRAS) at <https://www.myresearchproject.org.uk>.

All research studies must have appropriate consenting processes in place, with particular care being taken when recruiting children and vulnerable adults, including those with limited mental capacity. <https://www.hra.nhs.uk/planning-and-improving-research/best-practice/informing-participants-and-seeking-consent/>

- Financial Aspects of Research Projects

All funding applications for research studies must be reviewed by the OHFT R&D Finance team and approved based on agreed OHFT Standing Financial Instructions (SFI's).

The NIHR has developed a standard template for costing all commercially funded research studies. <https://www.nihr.ac.uk/partners-and-industry/industry/run-your-study-in-the-nhs/faster-costing-and-contracting.htm>

HM Treasury has set out rules and laws regarding the use of public funds, which apply to research as in other areas of the Trust. The R&D Senior Management Team will oversee the management of research project funds. <https://www.gov.uk/government/publications/managing-public-money>

- Study Sponsorship (chapter 6 see roles & responsibilities in this policy)

All research studies conducted within the NHS are required to have and provide evidence of a nominated sponsor.

Researchers wishing to have OHFT sponsor their study should approach the Research Governance and Support Team (RGST) (research@oxfordhealth.nhs.uk) at the earliest opportunity to discuss requirements and suitability. OHFT is unable to provide sponsorship for Clinical Trials of Investigational Medicinal Products (CTIMPS) or multi-site trials at this time.

OHFT may sponsor the University of Oxford clinical psychology trainees undertaking research as part of their doctorate course, where appropriate. This does not include any research that requires additional sites (unless they are Participant Identification Centres) or any research that happens exclusively at another site (these will be sponsored by the University of Oxford). OHFT will consider sponsorship of studies conducted by any of its employees dependent on the type of study and level of risk to the participants and the organisation.

- Indemnity

In order to protect the interests of study participants and researchers there is a requirement for the study to have suitable indemnity arrangements in place. OHFT will indemnify OHFT staff conducting research in an NHS environment through the NHS Litigation Authority (NHS LA). Those researchers that are employed via other organisations will require access to OHFT be authorised via an Honorary Contract or Letter of Access (these can be arranged through the RGST or the Human Resources, as appropriate).

OHFT will only provide indemnity for research studies that have been approved by R&D. The provision of research indemnity by OHFT will only cover research activity on a study by study basis.

- Research Governance

All research studies must obtain confirmation of capacity and capability (C&C) from R&D before participant recruitment or data collection can begin. The RGST has delegated responsibility on behalf of OHFT for managing this process.

Information and advice on how to apply for confirmation of C&C can be gained by contacting the RGST (research@oxfordhealth.nhs.uk).

The Principle Investigator (PI) for the study is expected to present their study at the Research Pipeline meeting, chaired by the Research Manager where a decision will be made to whether it is appropriate for the study to take place in the Trust.

The current and latest information regarding the provision of NHS Permission via the HRA can be obtained by visiting the [HRA website](#).

- Study Conduct

All research studies must be conducted in accordance with the study protocol and should adhere to the principles and guidance listed in the [UK Policy Framework for Health and Social Care Research](#), ethical approval and regulatory authorisation, where applicable.

All relevant documentation must be maintained in accordance with [The International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use \(ICH\)](#) Good Clinical Practice (GCP) (<https://www.nihr.ac.uk/health-and-care-professionals/training/good-clinical-practice.htm>) and all relevant local or trial based standard operating procedures (SOPs).

- Archiving Arrangements

All study related documents should be retained in accordance with clinical trial regulations. The length of time for which essential documents should be archived is study-specific and will be detailed in the study protocol or a site agreement.

Archiving for other research projects is the responsibility of the sponsor. Sponsor may delegate archiving activity to the study team who will coordinate with sponsor to ensure records are retained and archived in accordance with site or contractual agreements.

Where OHFT is the sponsor for the research and there is no research delivery support the RGST should be contacted for assistance research@oxfordhealth.nhs.uk

- Types of permissions required to conduct research within OHFT

All staff with the following contract types can apply to have access to OHFT staff, patients, and premises in order to conduct research:

- OHFT substantive contract
- OHFT honorary contract issued by honorary contracts team in HR (includes Clinical Academic posts)
- Letter of Access/Honorary Research Contract issued via Research Passport application form/ NHS-to-NHS Proforma
(https://www.myresearchproject.org.uk/help/help%20documents/ResearchPassportApplicationForm_F001_v5_1.doc ;
<https://www.myresearchproject.org.uk/help/help%20documents/NHS-to-NHS-confirmation-of-pre-engagement-checks.doc>)

It is the employee's responsibility to ensure that they have an up to date contract valid to conduct their research and should liaise with the HR department to renew if applicable.

- Research Passports and Letters of Access

A Letter of Access is issued in accordance with the National Institute of Health Research (NIHR) HR Good Practice Resource Pack guideline in the following scenarios -
<https://www.myresearchproject.org.uk/help/hlphrgoodpractice.aspx>

OHFT employees, including individuals with Honorary Contracts issued by HR, wishing to undertake research activity in another NHS Trust, must apply to the Trust where the research activity will take place (host) for a Letter of Access, by completing an NHS to NHS proforma (<https://www.myresearchproject.org.uk/help/help%20documents/NHS-to-NHS-confirmation-of-pre-engagement-checks.doc>). The proforma is completed by OHFT HR before being presented to the R&D department at the host Trust.

Non-NHS employees, employed or studying with a Higher Education Institution or other research employers, working in partnership with the NIHR, are required to complete a Research Passport application form, to obtain either a Letter of Access or Honorary Research Contract in order to conduct research activity within any NHS organisation.

- Working with personal data

All individuals involved in research must be made aware of their legal and ethical duties regarding the appropriate collection, use and storage of participant data.

Efficient data collection and management is an essential component of a research study. Only data that is relevant for the purpose of the study should be collected and recorded.

This relates to research data, from the point of collection from source documents, up to the point of archiving, excluding the requirements for statistical analysis, are managed, collected and verified in the appropriate manner. Please see HRA guidance on [GDPR](#)

All research staff are responsible for deleting data once it has met the requirements of the **study in accordance with the protocol and sponsor requirements**.

- Intellectual Property

If IP is expected to be generated by an OHFT employee or someone funded via a grant held by OHFT they are encouraged to seek advice from the Head of R&D as soon as practicable in such circumstances please contact research@oxfordhealth.nhs.uk

- Monitoring of OHFT Sponsored Research Studies

All research studies sponsored by OHFT will be subject to risk-based monitoring during the conduct of the study to ensure adherence with the protocol.

- Auditing of OHFT Hosted Research Studies

All research studies hosted by OHFT will be subject to risk-based auditing during the conduct of the study to ensure adherence with the protocol.

- Management of Research Breaches

Breaches in research practice may range from minor to serious and include serious breaches as defined in ICH-GCP guidelines. (https://database.ich.org/sites/default/files/E6_R2_Addendum.pdf)

Breaches may be identified during the auditing or monitoring of a study or be reported in other ways e.g. via the investigators or following a complaint by a study participant or member of staff. Please follow all local guidelines and SOPs in relation to breaches.

- Management of a Personal Data Breach

A personal data breach can be broadly defined as a security incident that has affected the confidentiality, integrity or availability of personal data. In short, there will be a personal data breach whenever any personal data is accidentally lost, destroyed, corrupted or disclosed; if someone accesses the data or passes it on without proper authorisation; or if the data is made unavailable and this unavailability has a significant negative effect on individuals.

Individuals who become aware of a potential personal data breach should take immediate steps to reduce the exposure and mitigate risk (e.g. contact any person responsible and advise them to cease the activity; securely deleting, destroying or anonymising any records received in error etc.)

It is everyone's responsibility to report concerns or details of a security incident / data breach as soon as becoming aware of it. The CI must inform the study sponsor who will then determine whether the breach needs to be reported to the Information Commissioners Office (ICO).

For studies sponsored by OHFT, individuals should report the breach via ULYSSES and send a copy of the report to the R&D department (research@oxfordhealth.nhs.uk) who will then work with the CI, trial team where appropriate, report personal data breaches to relevant parties, such as research ethics committee and competent authorities.

- Adverse Events and Safety Reporting

All adverse events (AEs) and serious adverse events (SAEs) that occur should be reported to the research team, who must report the event to the relevant regulatory authority, ethics committees and sponsor of the study. SAEs should also be reported on OHFT's Incident Reporting System called Ulysses, identifying on the system that the patient is taking part in a research study. This is required even if the event is not deemed to be related to the research study.

The AE & SAE reporting requirements for research studies are described in the protocol and in site agreements and is generally the responsibility of the sponsor but may be delegated to the Chief Investigator in some instances. In addition all SAEs will be reported to the R&D department (research@oxfordhealth.nhs.uk) for any hosted CTIMPs or Clinical Trials, including commercially sponsored studies. –

All CTIMP studies conducted at OHFT are required to submit reports of SAEs to the R&D department. These will be presented to the R&D Quality Committee, who may request further information from investigators if there is a clinical need or safety concern.

Copies of annual safety reports and Drug Safety Update Reports (DSURs) for all should be sent to the R&D department.

- Partnership with Other Organisations

OHFT will work closely with institutions such as Oxford University Hospitals NHS Foundation Trust (OUH), the University of Oxford (OU), Oxford Brookes University (OB), and the Clinical Research Network: Thames Valley and South Midlands to support the engagement and delivery of research.

OHFT will work closely with other NIHR bodies, commercial, third party, voluntary and charitable organisations to support research within the Trust.

Where OHFT will be working with other organisations, research staff should contact research@oxfordhealth.nhs.uk to review the need for collaboration agreements.

- Research Contracts and Confidential Disclosure Agreements

All contracts between OHFT and another party must be processed by the RGST research@oxfordhealth.nhs.uk before being reviewed (by the contracts team or RGST as appropriate), finalised and executed. It is expected that all contracts are based on model template agreements drawn up by the NIHR. The December 2023 model templates should be used without modification for industry-sponsored clinical trials with NHS patients in hospitals throughout the UK Health Services.

These can be found on <https://www.nihr.ac.uk/documents/model-site-agreements-model-contracts-standard-research-agreements/11612>

In a small number of circumstances, the NIHR model template agreements may not be appropriate for the purpose of a specific research project; in such cases, OHFT will ensure appropriate legal review via a third party.

Deviations from standard template agreements will be subject to external review at a cost to the research study.

- Patient and Public Involvement

Researchers should, where reasonably possible involve service users, participants and members of the general public in the design, conduct, analysis and reporting of research. Integrating consumer involvement in the development and design of research is essential.

More information, including the payment policy can be found on: [Resources for researchers – NIHR Oxford Health Biomedical Research Centre](#)

and <https://www.oxfordhealth.nhs.uk/research/>

- Management of R&D Department Funds

All research income (including NIHR Funding, grant and study income) supporting research will be managed by OHFT/R&D - Finance Business Partner and overseen by the R&D Director or relevant NIHR Infrastructure Director through OHFT budget setting and financial reporting processes both internally and externally (DHSC and funding organisations).

If sub-contracting to a third party, the use of the approved template contracts should be used where possible.

4. Summary of actions to implement policy (may be included in appendices)

It is OHFT policy to ensure that:

- all research will be conducted in accordance with the UK Policy for Health and Social Care Research (2017) <https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/uk-policy-framework-health-and-social-care-research/>
- appropriate arrangements will be in place for the management and monitoring of clinical trials/research studies, including compliance with the relevant regulations; and,
- research management and governance procedures will be conducted using a consistent risk-proportionate approach to ensure timely approval and appropriate oversight of sponsored and hosted clinical research.

5. Legal and policy framework

For an up-to-date listing of the policies, standards and legislation that apply to research and clinical trials please see appendix 2 of the UK Policy Framework for Health and Social Care Research ([UK Policy Framework for Health and Social Care Research - Health Research Authority \(hra.nhs.uk\)](#)).

6. Key responsibilities

In accordance with the UK Policy Framework for Health and Social Care Research, there should be clear designation of responsibility and accountability with clear lines of communication between all those involved in research. OHFT specific examples of these responsibilities can be found in this document; expanded details of these responsibilities can be found here:

<https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/uk-policy-framework-health-and-social-care-research/#responsibilities>

Trust Board

As lead of the Host organisation, the OHFT Board has the overall responsibility of ensuring that good quality research is being planned and conducted safely when using OHFT service users (or their materials/data), staff and premises.

As a research site, OHFT is responsible for:

- a) demonstrating to relevant approval bodies and sponsors that the location is suitable for the research;
- b) being aware of all research activity being undertaken in or through the site;
- c) ensuring that the roles and responsibilities of individuals at the site and any collaborating parties are agreed and documented for individual research projects; and
- d) demonstrating (e.g. by taking assurances from others in a position to give them) that, if expected or required, the research has approval from a research ethics committee and any other relevant approval bodies before research participants take part (including indirectly, through the involvement of data or tissue that is likely to identify them).

Executive Directors

The Chief Medical Officer is the Executive lead for R&D with the Director of R&D being the lead for the R&D department, they are jointly accountable for research within the Trust.

Senior managers

The Director of R&D is supported by the R&D Senior Management Team (SMT).

The R&D SMT is responsible for:

- The day to day running of the R&D department
- Ensuring all policies and procedures within the department are adhered to
- Ensuring appropriate treatment of R&D income and expenditure ensuring all studies are reviewed in accordance with governance procedures and appropriate approvals are in place
- The delivery of high-quality research
- Reviewing and agreeing R&D risks and ensuring appropriate mitigation is in place
- Ensuring systems and processes are in place to manage and protect Data, including ensuring staff are aware of their responsibilities
- The strategic direction of research within the Trust

Specific/expert roles

Principal Investigator (PI) / Chief Investigator (CI)

The PI is the person designated to take responsibility for the conduct of the research study at a particular site in which the study is being conducted.

The CI is the person designated to take overall responsibility for the design, conduct and reporting of the research study where the study involves more than one site.

They have the responsibility to:

- Develop research proposals that are ethical and scientifically sound
- Coordination of the study set up, including finances, regulatory approvals, capability and capacity to conduct the study and contracts

- Conduct research in accordance with the protocol and regulatory guidelines
- Ensure the safety of study participants
- Record and report any adverse events during the conduct of the study to the appropriate external agencies and the Trust
- Disseminate study results
- Provide leadership for the research team

Researchers

Researchers are those individuals directly involved in the development and conduct of the study, analysis of data and report writing. They may or may not have direct contact with study participants. They have the responsibility to aid the PI/CI in conducting their responsibilities.

It is the responsibility of researchers, including PIs/CIs, not to commence their intended project unless full approval from a relevant national body and OHFT R&D confirmation of capacity and capability have both been received.

They must ensure that all necessary documentation is held in a manner compliant with relevant GDPR legislation (<https://ico.org.uk/for-organisations/data-protection-and-the-eu/data-protection-and-the-eu-in-detail/the-uk-gdpr/>) and that all information held by OHFT concerning their project is kept up to date. This includes, but is not limited to:

- any amendments that are made to the approved research protocol or funding for the project
- any adverse incidents/near misses or complaints concerning the research

Researchers must make themselves aware of and abide by all OHFT policies and procedures whilst conducting research in or on behalf of the Trust.

Funder(s)

The funder is the organisation providing financial support to conduct the study either through contracts, grants or donations to an authorized member of the study team. They are responsible for ensuring that there are sufficient funds to conduct the study from the start through to completion.

Sponsor

The sponsor is the organisation taking primary responsibility for securing the arrangements to initiate, manage and finance a study. The sponsor is usually, but not always, the main funder of the research study.

They have the responsibility to:

- Ensure the scientific quality of the study.
- Ensure HRA approval has been granted, and NHS REC, Medicine and Healthcare product Regulatory Agency (MHRA), Administration of Radioactive Substances Advisory Committee (ARSAC) and Confidentiality Advisory Group (CAG) approvals have been granted where necessary.
- Ensure arrangements for the management and monitoring of the study are in place.

Team/unit managers

Team/unit managers are responsible for establishing systems to comply with the Trust's R&D approval process and research government functions.

Front line staff

Front line research staff described in the UK Policy for Health and Social Care Research as the group of people involved in the conduct of a research project. This group may include care professionals, academics, patients and service users, members of the public, research professionals, students and/or scientists. Research team members' accountability should be clearly agreed between them and their employer(s) (Or directly with the sponsor, where this accountability does not arise in the context of their employment, e.g. in the case of research team members who are patients, service users or the public). Research teams are responsible for:

- demonstrating to chief investigators and sponsors their suitability to conduct the research;
- acquiring any particular knowledge and skills in order to conduct the research;
- conducting the research according to the approved research proposal or protocol and any complementary information (such as the research ethics committee application form), in compliance with any applicable regulatory standards and guidance;
- providing information in a suitable format for potential participants that is clear and relevant to their participation in the research and, where consent is required, to their decision-making about taking part in the research; and
- ensuring participants' safety and well-being in relation to their participation in the research (e.g. by asking questions about the patient's experience with the research intervention) and reporting adverse events where expected or required.

7. Risk

OHFT is responsible for ensuring that its research activities are conducted in accordance with applicable legal obligations. A key risk to the safe and managed delivery of research is activity that happens outside of regulatory frameworks, without the review of appropriate authorities. OHFT will take appropriate action towards any individual(s) who do not follow relevant R&D procedures.

The Developing and maintaining Team Risk Registers SOP within Research and Development QA02 V1.0 sets out the process for identifying, controlling, monitoring, and escalating risks within the R&D, OHFT. The purpose for undertaking these procedures, is to enable the department and each of its teams to adequately assess, record, and reduce risk. Additionally, the SOP aims to provide specific guidance to staff on channels for escalating risks through R&D and the Trust. The purpose of standardising these processes is to ensure that adequate precautions are in place to protect the health, safety and wellbeing of individuals participating in and conducting clinical research within OHFT. Each team and each research study have its own unique set of risks and these risks need to be managed in different ways depending on their context. A risk register is the way in which we record, monitor and review risks. In OHFT each Team, Service, Directorate, are required to have a risk register. R&D also require risk registers for each study delivered within OHFT.

8. Training required to implement policy

It is important that everyone involved in research is trained or appropriately experienced to perform the specific tasks they are being asked to undertake. Good Clinical Practice (GCP) is the international ethical, scientific and practical standard to which all clinical research is conducted. GCP training is a

requirement set out in the UK Policy Framework for Health and Social Care Research developed by the Health Research Authority for researchers conducting clinical trials of investigational medicinal products (CTIMPs).

Different types of research may require different training, and some researchers are already well trained and competent in their area of expertise. Some researchers doing other types of clinical trials may also benefit from undertaking GCP training, but other training may be more relevant.

9. Appendices and relevant procedures

All up to date relevant R&D policies can be found on the OHFT Intranet.

1. Standing Financial Instructions Corp02 (1)
2. Developing and maintaining Team Risk Registers within Research and Development QA02 V1.0
3. QA01 Auditing Research Studies V4.0

10. Monitoring and evaluation

Criteria	Measurable	Lead person/group	Frequency	Reported to	Monitored by	Frequency
Number of studies	OKR - Number of portfolio studies running within the Trust	R&D Director	Monthly	Board		
Participant Recruitment	OKR - Number of participants recruited to portfolio studies running within the Trust	R&D Director	Monthly	Board		
NIHR Infrastructure reporting and updates	Reports from CRF, BRC, ARC, /MIC	Head of R&D chairs NIHR Infrastructure Group	Monthly		Each Infrastructure award has its own Steering committees chaired by an OHFT Executive	Varies depending on award
Research Finances	R&D Financial Performance		Monthly	OHFT Financial Board Report		

		Reported by R&D Business Partner				
		Responsibility Director of R&D				

Equality impact assessment

This form is an Equality Impact Assessment Form. It is used to review services and policies to ensure fair and consistent services for staff, service users and carers. It is a legal duty to prevent discrimination.

The form consists of two parts. Part 1 is screening to see if the Procedural Document or service requires a full assessment. It is through this screening process that you can find out whether the Procedural Document or service requires a Part 2.

Part 1

Equality Impact Assessment	
Service Area Research and Development (R&D)	Date: 16.02.2024
Policy title: R&D Policy	

Purpose of policy: This policy is required to protect the interests of our patients, staff and facilities involved in research. The aim of this policy is to articulate Oxford Health NHS Foundation Trust's (OHFT's) expectations in relation to the proportionate and effective development and management of research activity within the Trust.

What is the likely positive or negative impact on people in the following groups?

Older or younger people - none

People with disabilities - ensuring procedural documents are in an accessible format – none

People from different ethnic/cultural backgrounds (including those who do not speak English as a first language) - Ensuring procedural documents are clear and easy to use

Men, women or transgender people - none

People with different religious beliefs or no religious beliefs - none

Gay, lesbian, bisexual or heterosexual people - none

People from a different socio-economic background – none

Evidence

What is the evidence for your answers above? Our policy has been framed with a view to the principles of good practice in the management and conduct of social care research as articulated in the UK Policy for Health and Social Care Research (2017)
What does available research say? N/A
What further research would be needed to fill the gaps in understanding the potential difficulties or known effects of the Procedural Document? None
Have you thought about consulting/researching this gap? What would you need? N/A
Does the Procedural Document need a Full Equality Impact Assessment? No

Part 2

Evidence – please give evidence on how the Procedural Document is likely to have a significant impact (either or positive or negative) on the below.
Race & ethnicity – neither positive or negative
Gender – neither positive or negative
Age – neither positive or negative
Disability – neither positive or negative
Sexual orientation – neither positive or negative
Religion or belief – neither positive or negative
Other – this policy is aimed to ensure that no one group is advantaged or disadvantaged, we formulate our guidance to be inclusive to all individuals and groups

Consult Formally
Who needs to be consulted? OHFT Quality Sub Committee: Effectiveness
Has there been a consultation which would give the information needed? N/A
Which types of evidence have been gained (qualitative/quantitative) Our policy has been framed with a view to the principles of good practice in the management and conduct of social care research as articulated in the UK Policy for Health and Social Care Research (2017)

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

Board of Directors

22 May 2024

Guardian of Safe Working

For: Information

RR/App 25(i)/2024 (Agenda item: 11(b) and 24)

Executive Summary

This report summarises key information relating to junior doctor working patterns over the last six months, and the future focus of the Guardian of Safe Working in three main sections, including:

- Exception report data
- Analysis of relevant data
- Looking forward

The focus of the Guardian has been to target junior doctor posts which consistently lead to breaches of working hours or where service provision impacts upon training quality. We have made steady but tortoise-like progress towards compliance with the BMA fatigue and facilities charter – most recently implementing a new on-call rest at the Warneford Hospital - but I still feel confident that the trust will achieve compliance with continued diligence and perseverance by the Junior Doctors Forum. In the next quarter I will continue this work and endeavour to establish 'Exception Reporting Champions' in key areas around the trust.

Governance Route/Escalation Process

This paper was previously considered at People, Leadership and Culture (PLC) committee during its meeting on 30th April 2024. PLC requested some additional

assurance regarding the routes through which issues are escalated and actioned, and a further report will be brought to the next meeting of PLC discussing those issues in greater detail.

Statutory or Regulatory responsibilities

In appointing a Guardian of Safe Working, and reporting annually to PLC and Board, Oxford Health meets its statutory responsibilities in accordance with the junior doctor contract agreed nationally in 2016.

Recommendation

The Board is asked to note this report, and be assured of the processes in place to safeguard the wellbeing of our junior doctors, led by the Guardian of Safe Working.

Author and Title: Dr Rebecca McKnight, Consultant Psychiatrist & Guardian of Safe Working

Lead Executive Director: Dr Karl Marlowe, Chief Medical Officer

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **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/Priorities of the Trust:*
 - 1) *Quality - Deliver the best possible care and health outcomes*
 - 2) *People - Be a great place to work*
 - 4) *Research and Education – Become a leader in healthcare research and education*

1 Exception report data

OHFT has received 103 exception reports during the past two quarters; a breakdown of which is shown below. This report covers a 6 month period due to the absence from work of the Guardian of Safe Working during the previous quarter.

Exception Reports (ER)		
Reference period of report	01/09/23 - 31/03/24	
Total number of exception reports received	103	
Number relating to immediate patient safety issues	2	<i>All raised appropriately at the time of the exception report</i>
Number relating to hours of working	87	<i>FY2/ST1-3 = 62 FY1 = 17 ST4-7=8</i>
Number relating to pattern of work	6	
Number relating to educational opportunities	8	
Number relating to service support available to the doctor	0	

Note: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.

2 Analysis of data

The number of exception reports has continued to be lower overall than expected, especially given verbal reports presented by trainees at relevant meetings. There is a pattern of increased reporting around the time of rotation changes – soon after induction or changing clinical post – which then drops off towards the latter part of the rotation. This is especially the case in non-psychiatric trainees, i.e. FYs and GPVTS. I speculate that this relates to feeling they are about to change trust and feel less motivated to submit reports but have yet to gather empirical evidence of this rationale.

The majority of reports relate to doctors at training levels FY1-ST/CT3, both in working hours and during out of hours commitments. Geographical hotspots are evident and have not changed significantly.

There have been no further fines made secondary to exception reports, the last fineable exception was in 2022.

3 Active Areas of Work

Improving safe working in areas highlighted by exception reporting

- Vaughan-Thomas Ward at the Warneford Hospital, Oxford City AMHT and out of hours work at the Emergency Department Psychiatric Service are consistently the geographical services producing the highest number of exception reports amongst FY1-CT3 doctors.
- CAMHS ST4-7 rota remains the least compliant higher trainee rota. I have just met with the CAMHS trainees as a group and remain concerned the on-calls are not always promoting safe working. I will be taking this forward with HR and medical education shortly. There is a particular issue with the CAMHS trainees accessing the allocate reporting system which I can sort out.
- The JDF committee and GOSW are meeting with relevant clinical leads and clinical supervisors to understand why this pattern occurs and see if the areas can be supported to ensure safe working conditions for juniors. A comparison with similar clinical services with better working hours compliance may be helpful (e.g. another inpatient ward in the same location or AMHT).

Pushing forward implementation of the BMA Fatigue & Facilities Charter

OHFT committed to the BMA Fatigue & Facilities Charter in 2019 – a series of conditions to promote safe working and high quality work/rest environments for junior doctors across the trust – but has yet to become fully compliant. Restrictions during Covid-19 was a significant factor in the delays, alongside logistical challenges in working with the estates department. We have gradually improved in our compliance levels and in coming weeks this will further increase. Recent developments include:

- **Rest Spaces:** An on call rest room at the Warneford has been allocated (in the Neill Unit corridor) and is currently being refurbished. When complete this will be set up as a bedroom for use by out of hours working doctors, especially those requiring rest at the end of a shift prior to driving home. An issue with the sewerage system causing a malodorous aroma in the doctors' mess at the Warneford is in the process of being sorted out. Rest spaces in Littlemore and Aylesbury remain a challenge but are being actively worked on.
- **Hot Food provision:** A hot food vending machine for the Warneford was purchased and fitted but unfortunately rapidly malfunctioned. I believe a replacement will be forthcoming in due course. We are compliant with hot food vending options in Aylesbury and Littlemore.
- **Finances:** The allocated funding to support compliance has to be agreed annually to be rolled over and if not will be withdrawn from the trust. This has been achieved to for the 2024/2025 year but only with the helpful intervention of Grant McDonald at the last moment as we met considerable resistance from finance. It is a challenge to spend all the capital when many rest related items are consumables or have limited lifespan and require replacement. Examples include food in the mess, laundry services for on call spaces, kitting out new rest

spaces when these are identified. We were also unable to make progress during 2020-2021 due to the pandemic.

4 Looking forward

Dr Katherine Reid and Dr Tom Costelloe have been sharing the role of JDF Chair until Dr Reid commenced her maternity leave at the end of 2023. Dr Heidi Cooper has kindly taken on JDF Co-Chair for the duration of Dr Reid's absence.

The JDF will aim in the coming months to focus on the following areas:

- **Focus work on geographical hot spots for exception reporting.** This will involve meeting with the relevant consultants in clinical areas and seeing how they can be supported to ensure fewer breaches of safe working conditions. *E.g. Is a lack of admin support in that area leading to juniors spending excessive time on administrative duties? Are the juniors in those posts very early on in training and struggling to articulate their training and safety needs to senior colleagues?*
- **Pushing forward implementation of the BMA Fatigue & Facilities Charter** – as described in section 3. We will be completing the rest areas, looking to provide further secure bicycle racks/lockers at various trust sites and working on the security of our financial pot.
- **Continuing to attempt to understand & reduce barriers to exception reporting,** e.g. focus meetings with groups of trainees, trying to appoint 'Exception Reporting Champions', making myself more available to trainees who want to discuss issues. I am considering some MS teams based Guardian of Safe Working drop in sessions where I will be available to discuss anything trainees might like to bring.

We will continue to work on:

- Close relationships with the medical education team to ensure that the balance between training, service provision and safe working conditions remains optimal. I try to attend METC, JLNC and any other meetings I am invited too.
- Annual auditing of rotas at all levels, focusing specifically on those with greatest clinical pressures. This provides significant insight into the efficacy of the exception reporting system.
- Challenges for less than full time trainees, especially relating to the flexibility of essential educational activities and compensatory rest days.

- Clarifying and improving the mechanisms through which issues raised are registered, assessed and actions identified, linking more closely with Clinical Leaders and Medical Managers in order to provide greater assurance that appropriate actions are taken as a result of issues being raised. PLC, when considering this paper, asked for a further update at their next meeting, setting out these processes, in order to feel more fully assured.

4 Appendix: Role of the Guardian of Safe Working

1. Introduction

The Guardian of Safe Working (GoSW) was implemented following junior doctor contract negotiations in 2016. The GoSW must have no management role within the organisation. It is expected that the GoSW serves for 3 years; I started in Nov 2022.

2. The Role

The GoSW, having no part in the management structure of the Trust, is able to act independently in response to concerns raised by trainee doctors. The work of the GoSW is subject to external scrutiny by the Care Quality Commission (CQC) and by Health Education England (HEE). The aim is to ensure the safety of doctors and therefore of patients.

The GoSW reports directly to the Board and has two broad aims:

- To promote a culture where trainee doctors feel comfortable about raising concerns with respect to their working hours and do not fear adverse repercussions if they raise these, either in person by talking to the GoSW, or by generating an exception report (see appendix for definitions).
- To report to the Board and Directorates, on the numbers and patterns of exception reports that are being generated by trainee doctors.

3. Features of the new Junior Doctors' Contract

a) Exception reports:

Whenever the work schedule (see below for definition of work schedule) does not reflect the work that was agreed (e.g. the junior doctor is working too many hours on call), or when the safety aspects of the contract are breached, the trainee is expected to raise an 'exception report' using a computerised system (DRS4). The aim of this system is to ensure that a work schedule remains fit for purpose. The exception report provides real-time information and identifies problems as they arise. It benefits both employers and training doctors, as whenever safe working is compromised (e.g. a trainee works too many hours) or an educational opportunity is missed, these problems can be raised and addressed early on in a placement, resulting in safer working and a better educational experience. The role of the GoSWH is to oversee exception reporting and compliance with the 2016 contract, but only with respect to working hours. The Director of Medical Education oversees missed training opportunities.

b) Work schedule:

This is similar to a consultant's job plan. Supervising consultants (called Clinical or Educational Supervisors) and employers will be required to devise work schedules for each post. This will be a generic schedule setting out the hours of work, the work pattern, the service commitments and the training opportunities available during the post.

During their first meeting with a Clinical or Educational Supervisor, a trainee doctor and their supervisor will identify the experiences the trainee could gain from that post, and that they require in order to achieve certain desired competencies during their training. The work schedule will be agreed with their supervisor. The work schedule can be altered at any time – within contract rules - to more accurately reflect the job, should it become apparent this is necessary. E.g. Changing work hours from 9am-5pm to 8.30-4.30pm.

c) The Junior Doctors' Forum (JDF):

This advises the GoSW of issues relating to safe working and will also advise the Director of Medical Education of concerns about missed educational opportunities for trainees.

d) Sanctions for the Trust:

If certain contractual rules are broken with respect to trainee doctors' working hours the GoSW is to **fine the Trust**. This money is to be distributed for the benefit of all junior doctors and the GoSW will be guided by the JDF as to how they might want to spend the money.

Trainee doctors are expected to take **time off in lieu (TOIL)** (preferred as we are trying to limit their working hours) for the occasions they work extra and unexpected hours, or to receive **extra payment**.

e) Additional GoSW Powers:

The GoSW can:

- Require a review of a work schedule to be undertaken where necessary
- Intervene where issues are not being resolved satisfactorily.
- Give assurance to the board that trainee doctors are rostered safely and are working safe hours.
- Identify for the board any areas where there are current difficulties maintaining safe working hours.
- Outline for the board any plans already in place to address these difficulties.

- Highlight for the board any areas of persistent concern which may require a wider, system solution.

f) The national and regional picture:

National and Regional GoSW meetings are held. In the Thames Valley we have a quarterly GoSW meeting. I have actively liaised with the OUH & Berkshire GOSW since starting my role.

We have consistently received below the expected level of exception reports, based on the number of trainees working in our Trust, as compared to our colleagues in Oxford University Hospitals Trust, Buckinghamshire, Milton Keynes and Berkshire. This may relate to the out of hours rota intensity being less in mental health than some acute specialties but also reflects underreporting.

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

Board of Directors

22 May 2024

Medical Education

For: Information

RR/App 25(ii)/2024 (Agenda item: 11(b) and 24)

Executive Summary

This report summarises key information relating the Trust's programme of Medical Education, including:

- Undergraduate provision
- Postgraduate provision
- Feedback from recent surveys
- Areas of concern/risks
- Strategic aims and priorities

Governance Route/Escalation Process

This paper was previously considered at People, Leadership and Culture (PLC) committee during its meeting on 30th April 2024.

Statutory or Regulatory responsibilities

Oxford Health meets its statutory responsibilities in relation to the delivery of Medical Education.

Recommendation

The Board is asked to note this report.

Author and Title: Dr Alastair Reid, Director of Medical Education

Lead Executive Director: Dr Karl Marlowe, Chief Medical Officer

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. **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/Priorities of the Trust:*
 - 1) *Quality - Deliver the best possible care and health outcomes*
 - 2) *People - Be a great place to work*
 - 4) *Research and Education – Become a leader in healthcare research and education*

Background

The Trust provides medical education at both Undergraduate and Postgraduate levels. We are the biggest placement provider of Mental Health placements for doctors within the BOB ICS. A breakdown of our doctors and dentists in training, alongside the structure in place to support medical education within the Trust is shown at appendix one.

Medical Undergraduate Provision

Ongoing:

- We currently host 26 placements overall (24 x 3-week placements + equivalent of 2 placements for students made up of CAMHS + OA one day offering).
- We provide 2 clinical placements at any one time for Medical Undergraduates from Oxford University. Placements are distributed mostly in Oxfordshire but a cohort is now also established in Bucks. Students are present for 3 weeks per block, with 4 students per block, 3 blocks per year.
- We provide one day placements in CAMHS and neuro-CAMHS as part of the placement experience.
- 2 Fellowships in Medical Education are provided to support the simulation-based learning program to supplement clinical placements.
- Administrative support is in place and working well. Funding to teams is well-received and acknowledges the multi-disciplinary roles.

Feedback:

On the whole feedback is very positive: 75% of feedback responses are good or very good. Overall scores have dropped slightly from 2023. There are no specific themes arising. There are only 2 years to compare data, however, and the feedback process had been suspended due to the COVID pandemic.

We plan to develop guidance for student placements based on best practice. This will be a QI project for the Undergraduate QI lead role.

Developments since February 2023:

1. The National mandate for increase in student numbers will not affect Oxford University student numbers for at least the next 2 years. After this point, we may need more placements.

We are re-distributing some placements:

- 2 new placements to be offered in Swindon from July 2024 – to support development of SWB as location for teaching and training.
 - 1 additional placement in Aylesbury (increased from 5 to 6), to reflect generally very good feedback from these placements and change in Consultant distribution giving new opportunities.
2. A formula is being developed for ensuring Consultant teaching time is acknowledged financially to clinical directorates and can be recognized in job-planning. In line with other Trusts in the region
 3. In longer term, future plan: FMEs are developing a teaching clinic for medical students, to be piloted in the Oxford Early Intervention Service. This provides opportunities for students to spend more 1:1 time with patients, and running a clinic.
 4. Multi-disciplinary project – positive feedback
 5. Hosting education fellow from Brighton Medical School. Continuation of funding for nurse education fellow, with L&D funding extra time for her.

Financial

6. Annual Accountability Report continues for 2023, to be signed off by the Chief Finance Officer to ensure that the Medical Undergraduate Tariff (MUT) is spent on Undergraduate training – in keeping with the Tariff guidance document – within the Trust.
7. HEE has now been subsumed into NHS England. Therefore tripartite agreement is now between NHSE, the University, and the Trust, with regard to the provision of Medical Education. This is in conjunction with the Tariff Guidance document (i.e. funding from NHSE) which indicates how it should be spent with regard to both Undergraduate and Postgraduate Education.

8. No changes proposed in Medical Undergraduate Tariff, following reduction in national rates from 1st September 2022

Postgraduate Medical and Dental Training

Alongside our doctors in training, we also host Academic Clinical Fellow (ACF) posts and Academic Clinical Lecturer (ACL) posts, both fully funded by NIHR and locally funded. Currently there are 7 ACF trainees within the Trust, and 6 ACL trainees. This is an increase from 2022/3, and is significantly more than the Trust has hosted in recent years. We will continue to explore opportunities to use similar routes to encourage doctors to join us as part of our overarching recruitment and retention strategy.

The total number of placements provided is approximately 120 per annum, rising to 130 from August 2024. FY1 and FY2 trainees rotate every 4 months, CT and GPVTS trainees rotate every 6 months. This gives an approximate total number of doctors and dentists in training passing through the Trust per 12 months as 215.

All doctors and dentists in training require an appropriately trained and approved Clinical Supervisor who is substantively appointed Consultant, GP, or Dentist.

Developments since February 2023:

1. The national program of geographical re-distribution of training posts has combined with an expansion program.
2. An increase in training posts will increase the number of locally trained doctors which will help Consultant recruitment in time to come, since we know that trainees are likely to stay close to where they train and take up Consultant posts locally. The Trust has agreed to support an increase in training posts, offered via the National programs.
3. New placement numbers:
 - 3 x new CT (including 1 in SWB CAMHS)
 - 4 x new ST (including 2 in CAMHS)
4. Appointment of a Psychotherapy Tutor – this is a statutory requirement for the Core Psychiatry Training scheme.

5. Interim arrangement for Addictions Tutor (also a statutory requirement for Core Psychiatry Training)

Awards:

A number of colleagues have received awards for their work in medical education over the last year, which we should celebrate:

Dr Shah Tarfarosh: Trainee Peer of the Year: SE Division Awards 2024;
Dr Monty Lyman: Trainee Innovator of the Year: SE Division Awards 2024
Dr Chris Kowalaski: shortlisted for Psychiatry Educator of the Year at the National 2023 Royal College of Psychiatry awards

Medical Education accommodation

The POWIC Building provides a hub for Medical Education and specific space to meet the training requirements in Oxfordshire. The Whiteleaf Centre is also used for trainees in Bucks. There are some issues with access for Medical Students owing to lack of front-door security.

Simulation-based learning

This is led by Dr Chris Kowalski, who is supervising 2 Fellows in Medical Education (FME)s and 1 nurse (funded by NHSE and L&D department), plus 1 Junior Doctor fellow from Brighton Medical School as well as 1 local project on Inclusion, Dr Pamina Mitter.

Projects:

1. Undergraduate projects – 5th year undergraduate simulation – *“Building skills for psychiatric practice simulation programme”*
2. 6th year undergraduate simulation – *“Preparing for Practice in Mental Healthcare: An Interprofessional Undergraduate Simulation Workshop”*. In 2023: 300 students over 18 half-days, (155 medical students) – student nurses from paediatrics, physical health, mental health; OTs; physiotherapists. Feedback is very positive.
3. Structural and Institutional Racism in Mental Healthcare Workshop:
 - a. Examining unconscious bias as enacted on psychiatric wards

- b. Considering barriers to access to healthcare that are perpetuated by institutional and structural racism
 - c. Enhancing self-awareness to differing cultural values and beliefs around mental healthcare delivery
- 4. CPD activities – paediatrics – delivered by HEE Fellow; Ambulance service
- 5. In development:
 - a. Supporting development of postgraduate (Oxford Postgraduate Psychiatry Course) simulation sessions
 - b. Research project evaluation the 6th year sim programme
 - c. 360° video simulated scenarios project:
 - Scenarios of acute inpatient ward delivered via VR headsets, with a facilitated debrief exploring interprofessional collaboration and methods of enabling the delivery of patient-centred care

GMC Annual Survey 2023

NHSE Regional Summary – Trainee Survey for Oxford Health NHS FT:

Areas of concern highlighted included:

- General Psychiatry at the Warneford. Some negative feedback and negative outliers- including rudeness and incivility.
- CAMHS at the Warneford (based on feedback from multiple locations). Some negative feedback and negative outliers.

NHSE Regional Quality Committee Meeting (held on 27th March 2024):

Our self assessment report was accepted, and we received particularly positive feedback for having an International Medical Graduate (IMG) Tutor.

Areas of concern included on the Risk Register:

1. General Psychiatry at the Warneford – RAG rated as minor risk (lowest level).
 Action plan: Noted that Oxford City AMHT has high levels of exception reports. DME has met with Consultants as a group and some 1:1. DME has regular meetings with AMD for this team. Changes to the way the team works may

improve working situation. Overall feedback from trainees and students is positive and it is considered a valuable and suitable training environment.

2. CAMHS at the Warneford – RAG rated as minor risk (lowest level).
Some of the feedback relates to the regional training program.

Action plan: There have been multiple meetings with Training Program Director (TPD) and DME and Head of School of Psychiatry. GoSW has met with trainees. DME and TPD has met with trainees. Specific issues include workload, especially out-of-hours; the regional educational program; changes in the curriculum; application of new guidance from the RCPsych around research requirements and use of special interest time. Work is being done in each of these areas to acknowledge the situation. The Head of School of Psychiatry, DME and TPD will be meeting trainees again in April 2024 to review progress and hear of ongoing concerns.

3. Academic trainees had raised concerns that they were not being released from clinical work to be able to utilize their academic time (as funded by NIHR). OUCAGS had raised a concern. The issue is on the risk register, RAG rated green (lowest level).

Action Plan: The issue was initially raised in December 2022. There have been no ongoing concerns raised by trainees. We have focused on ensuring trainers fully appreciate the academic needs of this trainee group. DME will discuss with OUCAGS to ascertain whether they consider this as an ongoing issue.

Overall, aim for DME to meet with trainees as a group 6 monthly to increase direct contact with trainees and hear of concerns directly.
Also to introduce monthly 1 hour open-door session for trainees, doctors or others to contact DME.

Strategic Aims for Medical Education

Medical Education strategy has been incorporated within the Trust's annual planning programme. Our key priorities are:

1. Re-structuring of Medical Education Budgets

- a. There is significant income for Medical Education but budgets need to be set to acknowledge current spending and future needs.
2. Development of Enhanced Roles within Medical Education
 - a. There are statutory roles to be set up and appointed to. There are also important roles to enable continued delivery of educational programs and to maintain quality.
3. Leadership Program for Consultants
 - a. A program has been set up – to be jointly offered to Consultants and to Band 8b non-medical staff, offering a practical strategic leadership program embedded in clinical service delivery. The program will be delivered by Green Templeton College. We are in the final stages of preparation, looking to recruit in May and to start the program in June.
4. Increasing Patient Participation in Medical Education
 - a. Scoping of this project is currently underway.
5. Increasing Simulation Based and Technology Enhanced Learning (STEL) – Allocation of Dedicated Space]
 - a. Space in the POWIC Building is identified and available. Finance to be agreed for lease and small amount of building work

Current and Developmental projects:

Leaders in training – eLiT. A regional program initiated by Oxford University Hospital and Royal Berkshire Hospital Trusts, for all Trusts in the region. The program provides leadership skills for new educators, with the aim to develop Medical Education leadership across the region. This is the 2nd year of running the program. We have one ST6 trainee participating in this program this year

Trainee led:

- Bucks Movie Club – enhancing psychiatry learning through film
- Enhancing Cultural Awareness and Reflection Through Art (Oxon)
- Clinically Relevant Interview Skills in Psychiatry (CRISP)
- Trainee Medical Education lead (planned)

Technology working group (trainee and educator led) to:

- explore technology requirements of trainees are met;
- to help early detection of problems with current software and/or equipment and enable interface with IT team;

- to explore new developments, e.g. commissioning online learning platform.

Other Educational Offerings:

Motivational Interviewing course: 2 x ½ day workshops per year

Coroners Report Writing course

Areas of Concern

1. Maintaining an adequate supply of substantively appointed Consultant supervisors (Trainers). There is a continual movement of placements to ensure that there are enough appointed and trained supervisors. However there has been improvement in this area over the past year, and, for example, there are good numbers of substantive in-patient Consultants now, and we can offer many in-patient posts now.
2. Finance structures – the Medical Education budgets remain poorly structured. However this has been accepted as a top 5 strategic aim for Medical Education and the finance team are aware.
3. Negative feedback from GMC Survey 2023. Plans in place, as above. The 2024 Survey is currently underway (March-May 2024 – results released July 2024).

Appendix One

Number of Doctors & Dentists in Training

Psychiatry placements:

FY1	Bucks 7	Oxon 7				
FY2	Bucks 1	Oxon 7				
GPVTS	Bucks 6	Oxon 4		Banbury 2		
CT	Bucks 10	Oxon 25	(SWB)Severn Deanery 4			
ST4-6	GA/OA 18	MPT 2		CAMHS 6	Forensic 6	LD 2

FY1 = Foundation Year 1;

FY2 = Foundation Year 2;

GPVTS = GP Vocational Training Scheme;

CT = Core Trainee;

ST4-6 = Specialist Trainee

Medical Placements:

2 x GPVTS at Emergency Medical Units (EMU)

Dentists:

1 x CT; 1 x Joint Dental Foundation CT; 1 x ST Special Care Dentistry

