

# Integrated Performance Report (IPR) Report: November 2022

October 2022 data unless stated  
otherwise

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



Section 1:

# Introduction to the Trust strategy 2021-2026

# Introduction to the Trust Strategy 2021-2026

**Executive Summary:** Martyn Ward, Director of Strategy and CIO

## 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:

## Trust Headlines;

Key risks, issues and highlights from  
Executive Managing Directors

This section is updated bi-monthly in line  
with Trust Board Meetings. The latest  
update is for the period ending October  
2022.

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

**Executive Director commentary:** Grant MacDonald, Executive Managing Director, Mental Health, Learning Disabilities and Autism

**Narrative updated:** 22 November 2022

**For reporting period ending:** 31 October

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
Workforce challenges	Issue	The central recruitment team have recovered to support the services in ensuring there are a rolling campaign to fill vacancies alongside exploring creative approaches to attraction. Alongside this there are several 'new role' initiatives being pursued as well as opportunities for appropriate oversees recruitment; together with a range of organizational development activities to support retention. In particular, 32 training places have been secured for Psychological Wellbeing Practitioners. Finally temporary staff are used to maintain service levels and the agency management work programme is aiming to reduce reliance on, and cost of temporary workers sourced in this way.
CIP programme	Risk	Initial progress has been made in identifying cost improvements in the directorates with limited success. However, the primary focus this year is cost control and identifying agreed costs and associated budgets as part of H2 work and planning into FY24
Cost Control	Risk	Alongside the agency reduction programme and work to reduce out of area placements the key cost reduction work is aimed right sizing the requirements for additional staff to manage fluctuations in acuity.
Waiting times to assessment and treatment	Issue	The trust is taking part in a southeast region collaboration to benchmark waiting times and share learning on management strategies. The first draft of information is being used to improve and clarify definition of outputs. Alongside this the trust is engaging clinical colleagues in developing measures where no national measures exist to aid understanding of the issue and support decision making on resource allocation to address.
Acute Out of Area Placements (OAPs)	Risk	The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control. There has been minimal use of inappropriate OAPs which is in part due to operational pressures but is mainly as a result of the planned transition from/reduction in contracted appropriate OAPs from 21 to 4 during this financial year

## 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:** 22 November 2022

**For reporting period ending** 31 October 2022

Headline	Risk, Issue or Highlight?	Description (including action plan where applicable and please quote performance/data where applicable)
National Advanced IT Outage and Critical Incident Response	Issue and Risk	<p>The Advanced IT outage has continued to impacted significantly on the majority of our urgent care, primary care and community services, resulting in a Trust-wide critical incident being continued.</p> <p>Emergency business continuity measures and processes remain in place to actively monitor and respond to any risks and incidents. The team has worked hard to develop a plan to rapidly roll-out EMIS Web in an accelerated timescale and this is due to be implemented from end of November/early December. A plan is also underway with OUH partners to implement Cerner EPR into ward-based services, such as Community Hospitals and H@H. It is hoped this will roll-out shortly after EMIS.</p>
First Contact Care Innovation Week	Highlight	<p>During October, we held a successful week of focused work with colleagues across the Trust to redesign the out-of-hours GP and minor injuries services, as part of the wider community services transformation plan. By the end of the week, the team developed detailed proposals for the service that set out:</p> <ul style="list-style-type: none"> <li>• A sustainable and more resilient winter delivery model and future operational plan</li> <li>• Workforce/recruitment and staff engagement plan including a new approach to operational and clinical delivery</li> <li>• Financial sustainability model</li> <li>• IT and Estates proposals</li> <li>• A QIA / risk assessment</li> </ul> <p>These outline plans are now being worked up into an engagement plan for service users and staff and an implementation roadmap.</p>
Staffing and financial pressures	Risk	<p>Due to ongoing staffing and financial pressures we continue to face ongoing capacity issues in our preventive and planned care, children's services and first contact care pathways. We also continue to experience financial and patient flow challenges in community rehabilitation services.</p>

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	Latest Trust Position	Trend
(N1) A&E maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	69.3% (Oct)	88.8% (July)	↓
(N2) People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (MHSDS) (quarterly)	56%	67.7% (June)	88.2% (June)	↑
(N3) Data Quality Maturity Index (DQMI) MHSDS dataset score - reported quarterly	95%	54.2% (June)	94.3% (June)	↓
(N4) IAPT - Percentage of people completing a course of IAPT treatment moving to recovery (quarterly)	50%	46.5% (June)	48.5% (June)	↑
(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%	88.7% (Aug)	99% (Aug)	→
(N6) IAPT - 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	98.4% (Aug)	100% (Aug)	→
(N7a) Inappropriate out-of-area placements (OAPs) for adult mental health services - OAP bed days used (Bucks) – local figures	0	n/a	0 (Oct)	↓
(N7b) Inappropriate out-of-area placements (OAPs) for adult mental health services – OAP bed days used (Oxon) – local figures	0	n/a	29 (Oct)	↑

**Executive Summary:** Martyn Ward, Director of Digital and Transformation

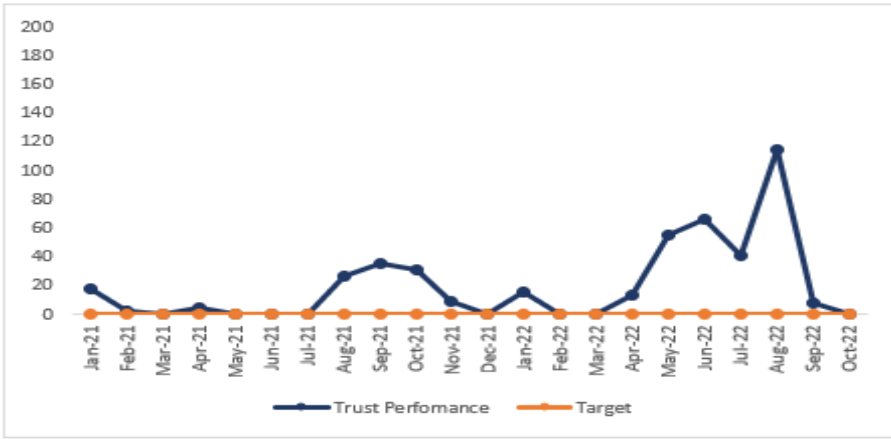
**Narrative updated:** 14 November 2022 for reporting period ending: **31 October 2022**

**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 and NHS Improvement, CCGs, providers and sustainability and transformation partnerships, and integrated care systems. The table above shows the Trust's performance against the **targeted** indicators in the framework. Areas of non-compliance are explained overleaf. The Oversight metrics have changed for FY22/23, work is underway to report these in future board IPRs.

**Performance:** Overall performance is good, with the exception of the number of inappropriate out of area placements. Please see overleaf for more information on OAPs. MIU 4 hour performance, DQMI and IAPT are slightly below. MIU performance is due to increased activity levels this year, increased appointment times due to patient complexity and staffing issues. The position is being monitored and action taken as appropriate. IAPT & DQMI performance is being monitored but is not currently a cause for concern.

# National Objective: areas of underperformance

NHS Oversight Framework Metric	Target	Actual	NHS Oversight Framework Metric	Target	Actual
<b>(N7a) Inappropriate</b> out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP <b>bed days used</b> (Bucks)	0	0	<b>(N7b) Inappropriate</b> out-of-area placements (OAPs) for adult mental health services – aim to reduce OAP <b>bed days used</b> (Oxon)	0	29



**Executive Director commentary:** Martyn Ward, Director of Strategy and CIO  
**Narrative updated:** 14 November 2022  
**For reporting period ending:** 31 October 2022

## The issue and cause

The use of Out of Area Placements has reduced in September, placements remaining are due to demand outstripping capacity for inpatient beds.

## The plan or mitigation

Following recent NHSE/I 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 trend. **October 2022 locally reported total bed day usage was 29 days (0 inappropriate OAP bed days in Bucks, and 29 inappropriate OAP bed days in Oxon).** In April, changes to IPC guidance have allowed patients who have completed their 14-day period of isolation and are COVID negative to be repatriated to vacant Oxford Health beds. Therefore, maximising bed capacity and reducing the need to purchase further OAP capacity. The Trust has an agreed trajectory to reduce the number of block purchased beds, with the aim to be down to 4 beds from 9 December 2022.

Section 4a:

# Comparative/Benchmarking Data

\*Please note that due to the clinical systems outage, this section is not able to be updated

Section 4b:

# South East Regional Performance including Provider Collaborative Performance

**Commentary by:** Claire Page, Head of Performance and Information

**Narrative updated:** 15 November 2022

**For reporting period ending:** 11 November 2022

### **Weekly data 29 weeks to 10 November 2022:**

**Bed occupancy** comparison not included as OHFT data not available due to system outage.

### **Mental Health - No. of people awaiting admission:**

The number of people awaiting admission to Oxford Health is low in the region, averaging 6 people over the past 29 weeks. Across 8 providers the total number of people awaiting admission is 73 on average.

**Inappropriate Out of Area Placements (OAPs):** not included as OHFT data not available due to system outage.

### **Availability of 136 suite:**

136 suite availability in Oxford Health is above the regional average of 41%, at 60% availability over 29 weeks as at the weekly snapshot position.

**Commentary by:** Gillian Combe, Clinical Director, Thames Valley CAMHS Provider Collaborative

**Narrative updated:** 17 November 2022

**For reporting period ending:** 31 October 2022

### **Demand:**

- Referrals have increased again but several discharges mean there are beds in the Network
- Inappropriate out of area bed use hit a low of 3 children and young people (CYP)
- Down to 1 delayed discharge

### **Initiatives:**

- Hospital@Home for Eating Disorders confirmed as being made substantive
- Hospital@Home for moderate to severe learning disabilities and autism will launch soon. Adverts are out for members of the team
- ALPINE guidelines for eating disorders continue to be rolled out across the Paediatric wards. Results of analysis show an additional impact of reduced admission to Paediatric wards as staff confidence in treating in the assessment unit has improved

### **Current pressures:**

- Quality improvement work at Taplow Manor (formerly Huntercombe Maidenhead). CQC recently rated Requires Improvement
- Taplow media coverage has led to increased stakeholder scrutiny
- Lack of social care provision impacting on Tier 4 referrals and discharges
- Workforce pressure due to lack of trained staff across most disciplines but some improvements in recruitment

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: October 2022** 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%	34%	55%	63%	57% (Specialised Dir)			46%	→
(1b) Staff trained in restorative just culture	TBC	-	-	-	-	-	-	26	→
(1c) BAME representation across all pay bands including board level	19%	14.5%	18.9%	30%	37.7% (Specialised Dir)			20.2% (Aug)	↑
(1d) Cases of preventable hospital acquired infections - YTD	<3	-	-	-	-	-	-	0 YTD	→
(1e) Reduction in use of prone restraint	TBC	-	14	1	-	95	-	110 uses	↓
(1f) Patient safety partners employed	2	-	-	-	-	-	-	0 JDs banded	n/a
(1fa) Improved completion of the Lester Tool for people with enduring SMI (EIP)	90%	-	88%	70%	-	-	-	81% (July*)	
(1fb) Improved completion of the Lester Tool for people with enduring SMI-AMHT	75%	-	66%	61%	-	-	-	64% (July*)	
(1g) Evidence patients have been involved in their care (clinical audits) reported bi-monthly	95%	No clinical audits completed since August 2022						See narrative	n/a
(1h) Clinical staff in non-learning disability services have completed internal eLearning on autism	TBC	-	-	-	-	-	-	See narrative	→

\* Latest available data due to Carenotes outage.

The arrows indicate the trend against the last reported position

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

**Governance: Executive Director:** Chief Nurse | **Responsible Committee:** Quality Committee  
**Reported period:** October 2022 unless otherwise indicated in brackets in the penultimate column

**These are the new indicators introduced which need further development and targets to be agreed.**

This year, our Objective Key Results (OKRs) are;	Target	Comm Services	Oxon & BSW	Bucks	LD	Forensic	Trust	Trust Trend
(1i) Numbers of Pressure Ulcers developed in service category 3 and grade 4	TBC	8	0	0	0	0	10	-
(1j) 48 hour follow up for those discharged from mental health wards	TBC	-	-	-	-	-	-	-
(1k) 72 hour follow up for those discharged from mental health wards	80% (national)	-	66% (27/41)	92% (12/13)	-	-	72% (June*)	-
(1l) Inpatient Length of Stay (LOS) excl delay/leave – Mental Health Adult Acute	TBC		58 days	76 days			66 days (July*)	↑
(1m) Inpatient Length of Stay (LOS) – EMU	TBC	9 days	-	-	-	-	9 days (July*)	↓
(1n) Inpatient Length of Stay – Stroke	TBC	31 days	-	-	-	-	31 days (July*)	↑
(1o) Inpatient Length of Stay – Rehab	TBC	27 days	-	-	-	-	27 days (July*)	↓
(1p) Medically fit for discharge (MFFD) – Community	TBC	79	-	-	-	-	79 (July*)	↓

\* Latest available data due to Carenotes outage.

The arrows indicate the trend against the last reported position.

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

## Governance

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

**Executive Summary:** Marie Crofts, Chief Nurse

**Narrative updated:** November 2022

**For reporting period ending:** 31 October 2022

Three OKRs which are underperforming:

- Clinical supervision
- Completion of the Lester physical health tool for relevant patients on the AMHT caseloads
- Staff training on Autism awareness and reasonable adjustments

Please see overleaf for more information by measure on the cause of the underperformance and the plans to mitigate and improve performance. We are also reporting on the position on the use of prone restraint and patients are being involved in their care.

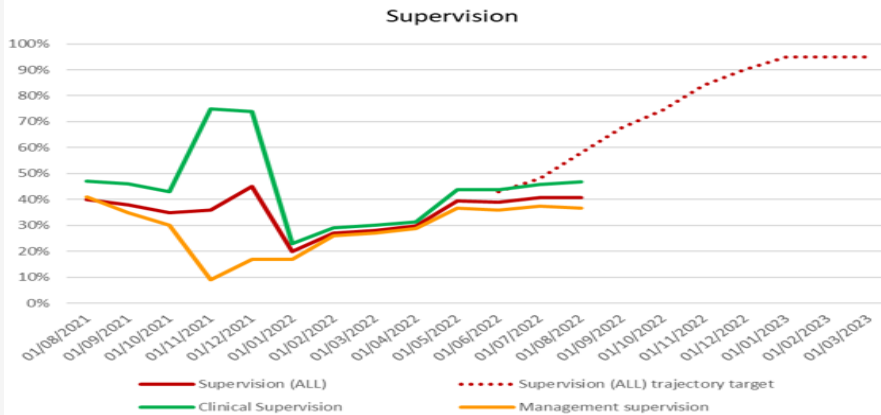
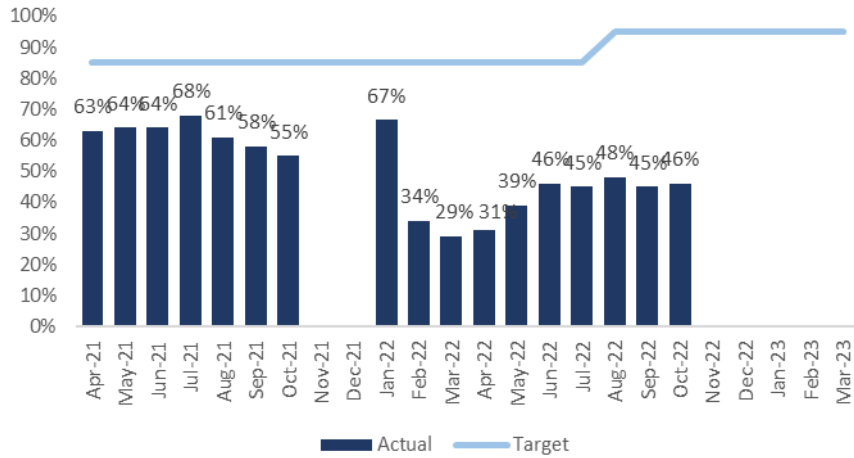
The review of the current Quality OKRs has been paused due to the attention needed to support the efforts around the IT outage which happened from early August 2022. This task is still needed so that the key indicators are monitored and reported here.

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

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

# Objective 1: Quality; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1a) Clinical supervision completion rate	95%	46% (Oct)



**Executive Director commentary:** Marie Crofts, Chief Nurse

### 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 and issues with accuracy of reporting from OTR.

### What is the plan or mitigation?

Current position in October 2022 46% for clinical supervision, this is a 1% improvement from last month. The directorate with the highest compliance is Buckinghamshire mental health services at 63%. We are behind the trajectory to achieve 90% by end of December 2022.

A Supervision Steering Group meets monthly to lead on the recovery plan. The group has developed a QI driver diagram setting out the actions planned.

Review of OTR system to start in Nov 2022, this has been slightly delayed in starting due to a focus on mandatory training up to now.

Recovery plan in place, actions include:

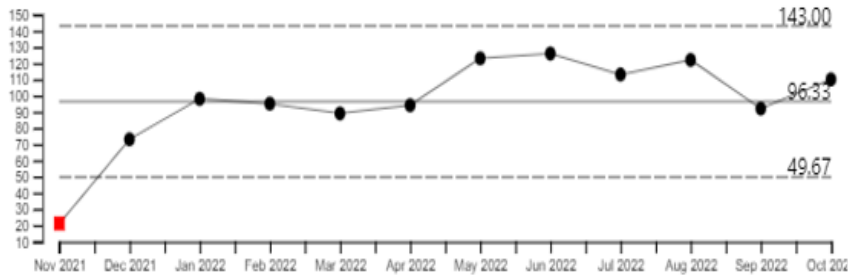
- Accuracy of supervision requirement attached to each staff member for example corporate service staff have the lowest clinical supervision rate.
- Targeting services with the poorest rates
- Addressing recording issues
- Continue to deliver and evaluate staff training, this is available monthly
- Spot checks by Heads of Nursing to ensure supervision is taking place

# Objective 1: Quality; areas of underperformance

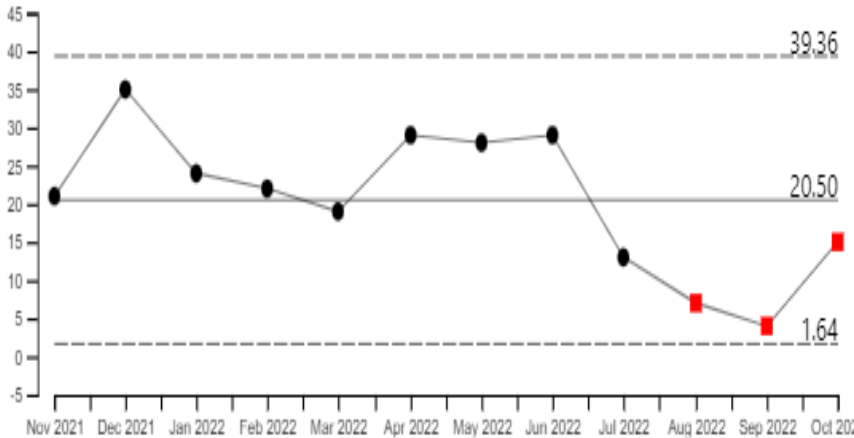
Objective Key Result (OKR)	Target	Actual
(1e) Reduction in use of prone restraint	Less than 20 uses per month	110 (Oct)

Number of uses of Prone Restraint all wards

Graph 1.



Graph 2.



**Executive Director commentary:** Marie Crofts, Chief Nurse

**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 as part of a seclusion procedure, planned care or to administer immediate IM.

**What is the plan or mitigation?**

Graph 1. shows the use by month for all wards. Since December 2021 the use of prone has increased. The increase relates to a particular patient on a forensic ward who is very unwell and waiting placement in a higher secure environment, the use of prone is part of an individualised care plan.

Graph 2. shows the information excluding this one patient to give a better view of the position.

A large-scale QI programme is underway to reduce the use of restrictive interventions, including prone restraint. This is part of the national mental health patient safety programme of which we are part of.

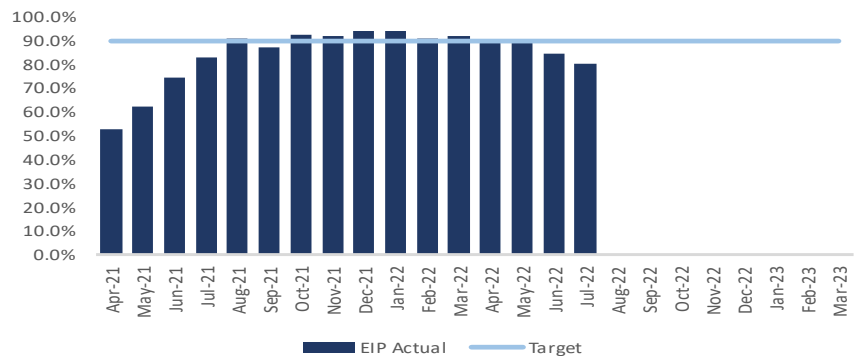
From the **2020 baseline, in 2022 we have seen a 21% reduction** in use of prone, excluding the 1 patient mentioned above. There has been a significant drop in use from June 2022 which should continue based on the actions in place.

# Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1fb) Improved completion of the Lester Tool for people with enduring serious mental illness (AMHTs for patients on CPA)	75%	64% (July)



Objective Key Result (OKR)	Target	Actual
(1fa) Improved completion of the Lester Tool for people with enduring serious mental illness (EIP teams for patients on CPA)	90%	81% (July)



**Executive Director commentary:** Marie Crofts, Chief Nurse

## Context

The indicator is based on the completion of the comprehensive 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

Completion rate for the Lester screening tool is below target at the moment. However data from August 2022 is unavailable due to the IT outage.

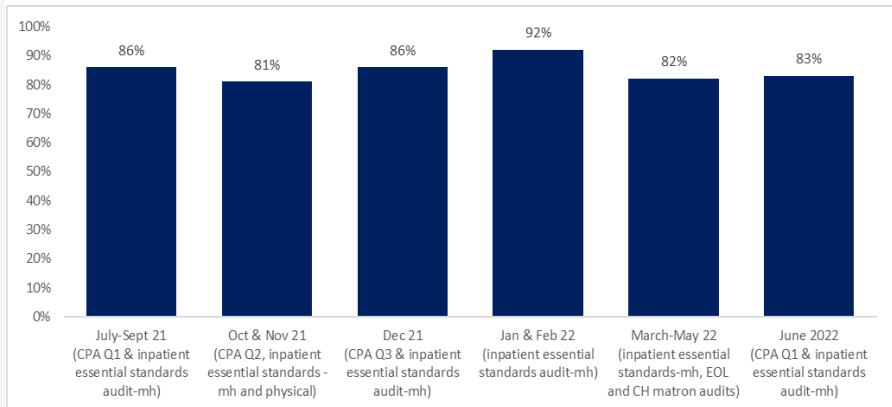
There is an improvement plan in place with 3 workstreams.

The focus in 2022/23 is:

- Make changes to the physical health forms on the patient record
- Expand smoking cessation work
- Education and training for staff – physical health skills for wider team
- Develop patient information
- Enable patients to access own digital records e.g. health locker
- Increase the role of peer support workers and introduce community volunteer roles to promote screening
- Improve flexibility and mobility of testing to reduce DNA through mobile clinics and individual kits by nurse.

# Objective 1: Quality; areas of underperformance

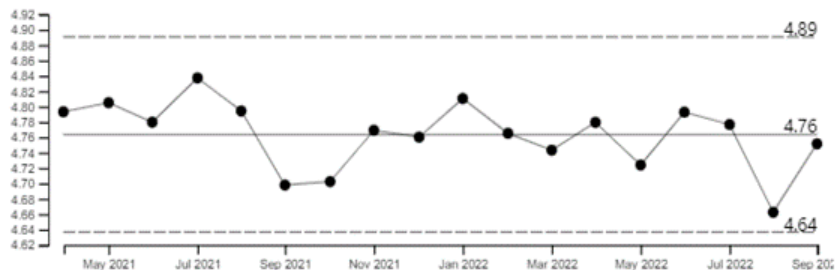
Objective Key Result (OKR)	Target	Actual
(1g) Evidence patients have been involved in their care (bi-monthly clinical audit)	95%	83% (June)



## Based on local patient and carer survey results:

The below graph shows the average score for the survey question- **were you involved as much as you wanted to be in your care and treatment?**

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



## Executive Director commentary: Marie Crofts, Chief Nurse

### The context

The feedback we receive and the clinical audit information, detailed below, tells us patients are not always and consistently being involved in their care or care planning. This affects a patient's experience, the outcomes they can achieve and their safety.

Our local survey data (IWGC) shows no substantial change in response to the question 'was someone involved as much as they wanted to be in their care'. Last 12 months ave. 4.76 out of 5, n=10,295.

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

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

No clinical audits have been completed since early August 2022 due to the IT outage.

### The plan or mitigation

#### QI work

A number of quality improvements projects are underway with a focus on person centred care and care planning. Examples below;

- Improving co-production in care planning – South community mental health services (90% of patients have a person centred coproduced care plan)
- Patient involvement in care planning and discharge planning – Sandford ward (improve by 50% by end of 2022)
- Community hospital personalised care planning project – what matters to me board completed for within 3 days of admission.
- Learning Disability services rolling out care planning app to improve co-production.

### Strategy

A co-produced Patient Experience and Involvement Strategy is in development, a central part of this is to improve personalised care.

# Objective 1: Quality – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(1h) Clinical staff in non-learning disability services have completed internal eLearning on autism	TBC	See narrative

## Executive Director commentary: Marie Crofts, Chief Nurse

### The Context and plan

#### Local training

New internal training was developed by the Trust in 2021 and is available to staff to complete via the Trust's learning and development portal. The roll out of the training to make it mandatory for all staff was put on hold as pilots for the new national (Oliver McGowan) training started.

#### National training

The Trust was involved in the pilot of the new national training (Oliver McGowan) in 2021, which 125 staff attended.

The **new national eLearning package for tier 1 (all staff) and 2 went live on 1<sup>st</sup> Nov 2022**. Staff only need to complete tier 1 or tier 2. However the Trust needs to set up the link via OTR to be able to record staff that have completed the elearning package. This will become mandatory training. **The second part of both tier 1 and 2 of the training is being implemented at BOB ICS level** as we need to have a cohort of train the trainers to facilitate the 1 hour interactive session (for tier 1) and the 1 day session (for tier 2) both completed after the elearning package. The train the trainers national package will not be available until early 2023.

Tier 3 training is already in place.

#### Support and services

Below are some of the other activities we are doing to improve how we work with and support people with autism:

- The Reasonable Adjustment Service at the Trust is supporting mental health clinicians to better understand and support the needs of autistic individuals with reasonable adjustments and adaptations. The service is being expanded with additional funding and recruitment is underway. A Buckinghamshire lead has recently been employed.
- Bespoke training sessions are being delivered to mental health wards and community teams, as well as regular support sessions for inpatient staff to discuss specific patients.
- Working with our autistic patients/ experts by experience we are developing an autism reasonable adjustment passport to support access to mental health services. This is being piloted.
- Resources have been developed to support clinical teams with making communication more autistic inclusive.
- We are also providing consultation and support from an adjustment perspective to individuals who do not meet the criteria for Learning Disability services but our mental health services are inaccessible.
- There has also been work from an employee perspective, for example setting up an employee dyslexia support group and autism support group.
- A new BOB wide ASD patient forum has been developed. The focus of the group will be on how to improve the experiences of autistic service users and their carers.

# Objective 2: People – be a great place to work – updated October 2022

**Governance: Executive Director:** Chief People Officer | **Responsible Committee:** People, Leadership and Culture Committee  
 Reported period: **October 2022** unless otherwise indicated in brackets in the penultimate column

This year, our Objective Key Results are;	Target	Bucks	Comm Services	Corporate Services	Estates & Facilities	R&D	Oxon & BSW	LD	Forensic	Pharmacy	Trust	National comparator	Trust Trend
(2a) People Pulse Staff Engagement score Q2(2022)	>/?	6.33↓	6.84↑	6.87↑	-	-	6.69↓	Only available at directorate level 6.81%↑ for Specialised Services			6.74	n/a	
(2b) Reduce agency usage to NHSE/I target (excl. COVID spend)	</ 8.5%	17.8%↓	3.5%↓	2.2%↑	29.3%	0.0%	13.9%↓	15.7%↑	3.8%↓	1.1%↑	9.5%	ModHos 8.7%/ Peer 7.9%	↓
(2c) Reducing staff sickness to 3.5% over 2021/22	</=3.5%	5.9%↓	6.7%↓	3.6%↓	8.0%	2.3%	5.0%↑	4.3%↓	8.0%↑	3.4%↑	5.7%	ModHos 5.2%/ Peer 4.4%	↓
(2e) Reduction in % labour turnover	</=10%	18.4%↑	15.6%↑	11.8%↓	14.8%	17.5%	16.0%↓	19.3%↓	20.2%↓	10.9%↑	15.9%	ModHos 19.1% Peer 21.3%	↑
(2f) Reduction in % <b>Early</b> labour turnover	</=10%	22.0%↑	17.3%↑	13.9%↑	12.2%	17.2%	19.2%↑	0.0%→	32.6%↓	23.3%↑	18.7%	None	↑
(2g) Reduction in % vacancies	</=9%	18.1%↑	2.8%↓	-1.9%↓	19.2%	40.0%	20.2%↓	16.9%↑	18.4%↓	3.0%↑	12.2%	ModHos 10.5%/Peer 11.2%	↓
(2h) PDR compliance	>=95%	33.4%↓	28.0%↓	23.9%↓	31.7%	18.5%	26.7%↓	33.3%↑	43.2%↓	17.3%↑	28.9%	None	↓
(2i) S&MT (Stat and Mandatory training)	>=95%	80.4%	83.1%	81.4%↓	83.6%	75.3%	80.4%↑	79.2%↓	82.9%↓	71.9%↓	81.6%	None	↓
(2j) Number of Apprentices as % substantive employees	>=2.3%	9.2%↓	6.2%↓	3.7%↑	0.0%	0.0%	6.2%↑	7.4%↑	3.0%↓	0.0%↓	5.8%	None	↑

## Objective 2: People – be a great place to work

### Governance

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

**Executive Summary:** Charmaine De Souza, Chief People Officer,

**Narrative updated:** November 2022

**For reporting period ending:** October 2022

Key headlines for this period:

### Improving Quality and Reducing Agency:

- Focus now is on the 12 week plans in relation to delivery for each of the workstreams
- Executives signed off a decision to move the management of bank staff from an in house model to NHS Professionals – thus bringing us in line with the BOB partner Trusts. We expect this transition to complete in early January.
- The focus of recruitment campaigns is aligned with the services with high numbers of vacancies and agency spend.

### Personal Development Reviews:

- The QI project is now complete and communications have gone out to staff in relation to the changes that have made to make the recording of PDRs much easier.
- The expectation is that all staff now complete a PDR if they have not had one in the last 12 months and all staff use the new streamlined approach to recording completion
- Phase 2 of the QI project will commence in the new year when we start to prepare for a “PDR” season when all PDRs will be expected to be completed between April and July.

### Statutory and Mandatory Training:

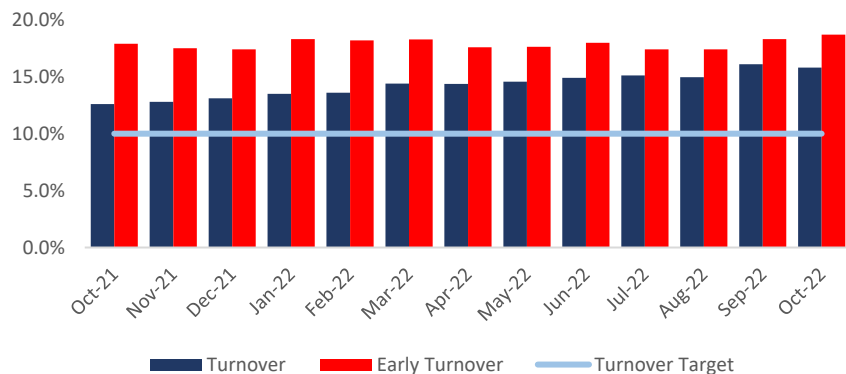
- All the system changes have now been completed in relation to the new definition of S&M Training. Currently we are behind trajectory by 4% but hope to make this up over the coming months to hit the target of 95% by the end of the financial year
- The new face to face corporate induction launched this month and day 2 of the programme requires new starters to complete their e-learning which is a new approach to driving up compliance

### Supervision:

- A review of supervision using QI principles began a number of months ago and the outputs /recommendations are set to come to EMC on the 21 November. The key recommendations are to fix the issues in the system (as we have done for Stat and Man training and PDRs) including adding additional functionality as to who can record a supervision; and a second phase of the project in the new year will focus on the quality elements of supervision.

## Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2e/f) Reduction in % labour turnover	<10%	15.8%



### Executive Director commentary:

Charmaine De Souza, Chief People Officer

### The risk or issue

Staff turnover has decreased from 16.1% to 15.8%. High levels of turnover will impact on vacancies, agency spend, quality of patient care and staff experience.

### The cause

The turnover rate continues to climb as 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.

### Executive Director commentary:

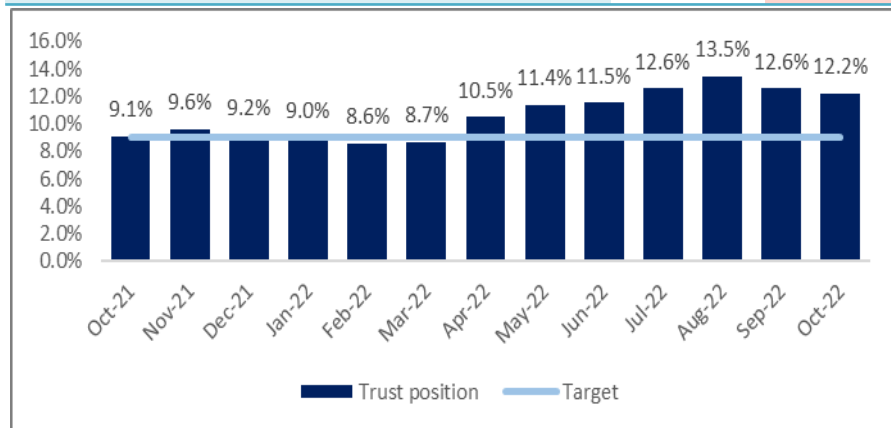
Charmaine De Souza, Chief People Officer

### The plan or mitigation

- IQRA SRO has reviewed the Retention work programme and for the next 12 weeks the programme is focussed on:
  - 1 - A Retire and Return -(QI Stage – Discovery phase)
  - Retire and return questionnaires completed with initial data being reviewed with follow up interviews being arranged.
  - 2 – PDR project. • (QI stage - Delivery Phase)
  - New PDR form launched as planned on the 1st November. Key messages going forward will be staff have completed a PDR in the last 12 months then they need to record it, if they have not had a PDR then they need to get one done.
  - 3 – Onboarding project. (QI Stage – end of scoping phase)
  - The questionnaires have been finalised and a reporting dashboard to capture the results has been completed. The 1 month, 3 month and 6-month questionnaire has been sent to 487 people on the 7 November, with the data reviewed at the meetings that take place every 2 weeks.
  - 4 – Career Conversations. (QI Stage – end of Discovery phase)
  - Initial scoping meeting has taken place with the first meeting taking place with the PNE's on the 8th November. Scoping has taken place with a review of all the current offers and options for delivery with PNE to trial 48 hour stay conversation across 6 wards
  - Work is also underway to ensure we are utilising the national high impact recommendations for the Nursing and Midwifery Retention Plan and this has been submitted to the BOB system lead.

## Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2g) Reduction in % vacancies	<=9%	12.2%



### Executive Director commentary:

Charmaine De Souza, Chief People Officer

### The risk or issue

The vacancy rate has decreased from 12.6% to 12.2%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients.

### The cause

Whilst the number of vacancies remains high and over target, there has been a decrease in vacancy rate again in October, the recruitment team are in the main, fully staffed and trained, meaning they can clear employment checks in a shorter time-frame.

### The plan or mitigation

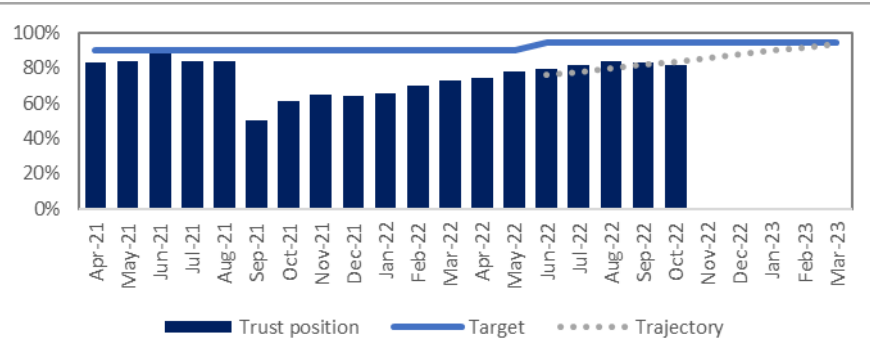
The Recruitment team continue to look at streamlining processes to speed up the employment check process whilst maintaining quality of service.

The Recruitment campaigns team continue to manage proactive recruitment campaigns for areas of high vacancy and agency spend. Trust wide campaigns include Return to Practice for Nurses and AHP's, They are working with the Princes Trust Partnership on a campaign around recruiting for AHP's.

They have developed a University/Student recruitment strategy to focus on increasing the number of student nurses that join the Trust, they continue to attend career and engagement events.

## Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2i) Statutory and Mandatory training	>/=95%	82%



**Executive Director commentary:** Charmaine De Souza - Chief People Officer

### The risk or issue

The percentage of Statutory and Mandatory training reported at the end of Oct has dipped slightly to 82%, falling 4% below the trajectory target of 86% for this month. Individuals who have not completed their training may not have the skills and knowledge to carry out their role safely

### The cause

Reporting from the Learning & Development System now reflects the new agreed statutory & mandatory training categories. There continue to be staff who cancel or do not attend training, but the Trust can be confident that the scheduling of training now reflects the needs of the staff. Final stages of work on the L&D system has highlighted an error in job role assigned at the point of recruitment for some staff resulting in the wrong training being allocated by the system affecting overall compliance rates.

### Executive Director commentary:

Charmaine De Souza - Chief People Officer

### The plan or mitigation

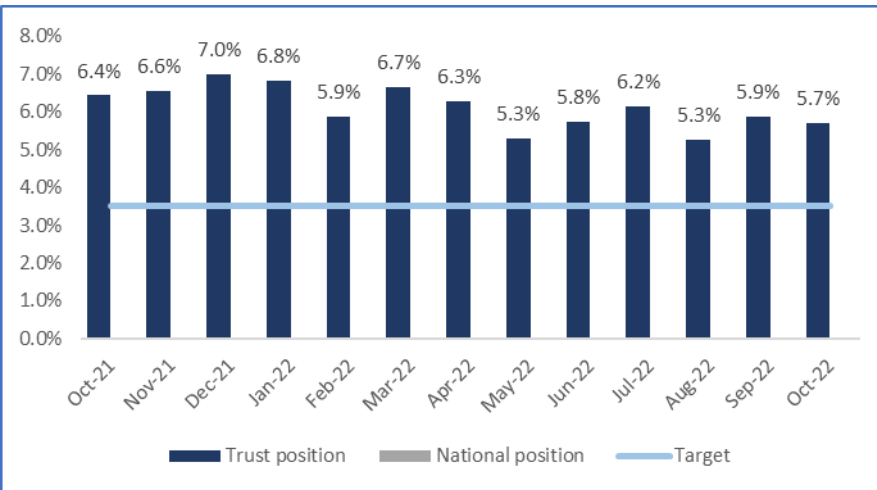
- Queries regarding errors in the L&D system to now be reported by all staff through the HR Service desk.
- Due to poor compliance rates and the clinical risks associated with these, there is focused attention on Resus (60.9%) and PEACE (64.6%) training. Detailed reports for these are sent out to team leads weekly including DNA reporting.
- L&D to offer sessions with Team managers to support how to address training concerns. Areas with poorest training compliance to be targeted first
- Comms campaign to raise profile of S&M training to be agreed. (Meeting 21st Nov)
- New corporate induction launched earlier this month (Nov) – day 2 will focus on new recruits completing their e-learning.
- Joint work to be undertaken between L&D and recruitment teams to address job role errors

## Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2c) Reducing staff sickness to 3.5%	</=3.5%	5.7%

### Executive Director commentary:

Charmaine De Souza, Chief People Officer



### Executive Director commentary:

Charmaine De Souza, Chief People Officer

### The risk or issue

The sickness absence rate has decreased from 5.9% to 5.7%. Excluding Covid absences the rate was 4.7% (4.9% last month)

### The Cause

Sickness absence remains above target, despite a small decrease in month on month absence levels in October. Despite this, the number of long-term sickness cases has decreased significantly along with work-related absences. The top five reported causes of absence were Covid Confirmed, Cough/Cold, Flu, Gastrointestinal and Headache/Migraine

### The plan or mitigation

Work is ongoing to ensure that return to work and wellbeing conversations are taking place after every absence event between line managers and employees, including additional guidance and support for managers on using the full capability of the GoodShape system. This will ensure appropriate referrals are made and signposting to the various support/assistance programmes that are available is consistently in place.

Further work is underway to understand the drivers for high volumes of absence in particular services and to ensure that there is consistent application of policy across the Trust. This will initially focus on service areas with the highest levels of absence, with bespoke interventions where necessary.

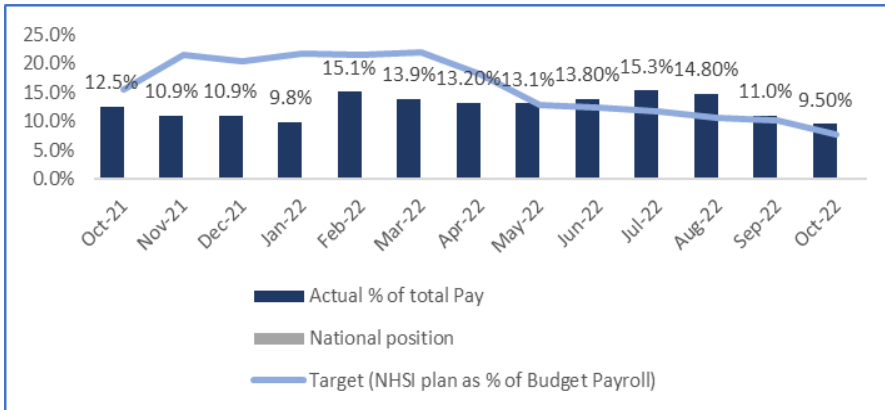
We are currently reviewing the sickness absence target in view of a different method of absence calculation (aligned to our GoodShape contract), alongside benchmarking against targets for comparator Trusts within our ICS, the SE region and nationally.

In Mental Health & Specialised directorates we are about to launch a short developmental session focused on managing absence which will be targeted toward managers of areas where we know there is high absence. We also now have a HR Advisor in post who will support first level absence management as part of their role.

For Community Services we have a specific focus on top 10 teams with the highest absence, the Senior HR Advisors are working closely with the Managers in those areas to agree appropriate actions to address absences.

## Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2b) Reduce Agency Usage to Target	<=8.5%	9.5%



**Executive Director commentary:**  
Charmaine De Souza, Chief People Officer

### The risk or issue

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

### The cause

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

### The plan or mitigation

The Improving Quality and Reducing Agency Programme has several workstreams which aim to improve the quality of our services whilst reducing agency spend.

The retention workstream obtained agreement from the EMC on the 17 September for the proposed changes to the PDR process which will go live on 1 November.

**Executive Director commentary:**  
Charmaine De Souza, Chief People Officer

### The plan or mitigation contd...

The Improving Quality and Reducing Agency Programme has a number of workstreams which aim to improve the quality of our services whilst reducing agency spend. The retention workstream has sent out the first batch of 1, 3 and 6 month new starter questionnaires to 487 recruits, the data received from these will be presented to the IQRA Programme Board in December. The recruitment workstream is developing a specific project around student nurse recruitment, this will be led by the Deputy Director of Quality and will report into the IQRA programme board.

The e-rostering workstream has been reset and the chair is currently in contact with Service Directors to provide nominations of senior staff to form part of the project group. The agency management workstream has sent out the specifications for the Guaranteed Volume Contract to agencies and the PID for the Agency Master Vendor contract (excluding Medics) has been completed.

The international recruitment workstream has had 14 nurses (8 RMNs and 6 RNs) commence employment with the Trust, there are 3 RNs with start dates confirmed for November. There are 3 RNs with confirmed start dates for December and a further 31 nurses going through the pre-employment check process. There have been 4 international OTs appointed to roles within mental health services.

The medical staffing workstream is reviewing the use of long line agency medics and recruitment activity over the last 12 months to inform the ongoing prioritisation of approach review for medical workforce recruitment activity.

An update on the staff bank options appraisal was presented to the EMC on the 24th October, the decision was made for the Trust to move to the NHS Professionals outsourced model for the staff bank provision. The target start date for the contract is the 1st January 2023, this is dependent upon the milestones in the implementation plan being achieved. A transition board has been set up and will be meeting weekly to oversee the effective move of the Bank team to NHSP

## Objective 2: People; areas of underperformance

Objective Key Result (OKR)	Target	Actual
(2h) PDR compliance	>/=95%	29%



**Executive Director commentary:**  
Charmaine De Souza - Chief People Officer

### The risk or Issue

The percentage of staff receiving a PDR in the past 12 months has remained static at a very low percentage. Individuals who do not receive a PDR may not be supported to access professional and personal development opportunities which maybe a risk to retention. There is no reliable way to corroborate the report that PDRs are occurring but not being recorded.

### The cause

Several factors are contributing to this including Learning & Development system issues, a lack of trust in and knowledge of using the L&D system which may have led to individuals not recording PDR's centrally and the PDR form being time consuming to complete.

**Executive Director commentary:**  
Charmaine De Souza - Chief People Officer

### The plan or mitigation

New PDR process launched on the 1 November with a 'drive to compliance to meet the intended trajectory by March 2023. New 'PDR season' will start on the 1<sup>st</sup> April 2023.

Currently the performance is 28% behind trajectory. The mitigation includes:

- Promotion through HR BPs at service meetings on the key message of ' If you have had a PDR within 12 months, Record it. If you have not had a PDR in the last 12 months, Book it'
- This message has been added to the intranet and the weekly bulletin
- This message has been shared by the OD team at numerus site visits across the Trust as part of the promotion of the Staff Survey
- Detailed dashboard showing compliance has been shared with Executives for cascade to their Teams and direct reports
- Head of OD due to attend monthly OMT to present the new form, share the key message and present data.

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

This year, our Objective Key Results (OKRs) are;	Comm Services	Oxon & BSW	Bucks	LD	Forensics	Pharm	Corporate & Trading	Trust	Trust Trend
(3a) <b>Favourable</b> performance against financial plan (YTD)	£4.9m adv ↑	£1.0m fav ↑	£1.2m adv ↑	£0.2m fav →	£0.3m adv ↑	£0.1m adv →	£6.0m Fav ↓	£0.7m fav →	→
(3b) Cost Improvement Plan (CIP) delivery (YTD)								£1.2m adv ↑	↓
(3c) <b>95%</b> of estate to achieve condition B rating by 2025 (75% in 2021)								75%	→
3d) Delivery of estates related NHS Carbon Footprint reduction target of 3,393. tonnes by 2028 ,Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-2038. (25,550 C02t)	Work is now underway to carry out a six-facet survey to understand the current building condition ratings. This indicator will be updated once that work is complete.							10,862 tonnes	→
(3e) <b>Achievement of all 8 targeted measures</b> in the NHS Oversight Framework (see section 2 of this report)	-	-	-	-	-	-	-	5 achieved	

**Executive Director:** Heather Smith/Martyn Ward | **Responsible Committee:** Finance and Investment Committee | **Responsible reporters:** Alison Gordon/ Christina Foster | All data relates to the position as at **end of September** unless indicated in the penultimate column

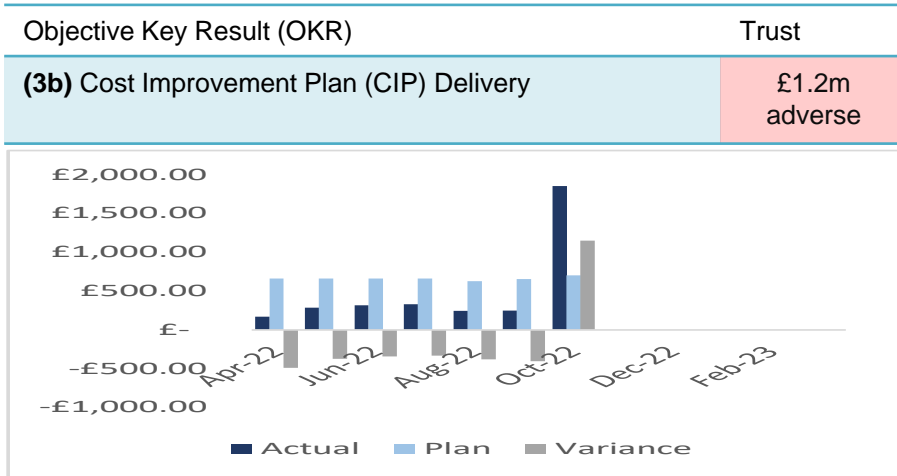
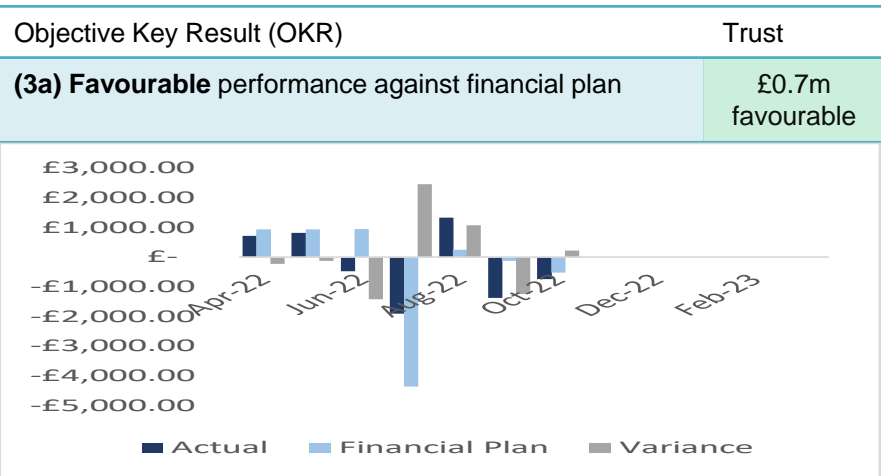
**Executive Summary:** Heather Smith, Chief Finance Officer

**Narrative updated:** November 2022

**For reporting period ending:** 31<sup>st</sup> October 2022

I&E £1.4m deficit, £0.7m favourable to plan. Financial pressures are under delivery of CIP, continuation of high level of agency and contracted OAPS both reported as Covid spend in FY22 mitigated by release of covid funding in expectation of the tapering down of these expenditure items and release of reserves and deferred income. The CIP plan for the year is £7.9m with delivery profiled evenly over 12 months. £3.4m has been delivered at month 7 this is £1.2m adverse to plan due to lack of engagement in developing CIP schemes. This CIP delivery includes £2.8m (£1.6m YTD) of Reserves budgets used to reduce this year's CIP target.

## Objective 3: Sustainability – areas of underperformance



**Executive Director commentary:**  
Heather Smith, Director of Finance

### The risk or issue

Financial performance against plan is £0.7m favourable at month 7. However this includes non-recurrent Covid funding.

### The cause

This is made up of overspends against clinical directorate budgets, notably Community £4.9m, offset with unallocated Covid-19 funding (£4.4m) and contingency reserves.

### The plan or mitigation

Planning and budget setting for FY24 needs to include detailed CIP plans and plans to get services back into budget, particularly in the Community Directorate. Finance have appointed two new Finance Business Partners and are implementing a new team structure in the Financial Management team to strengthen the financial support offered to services to help deliver on these plans.

**Executive Director commentary:**  
Heather Smith, Director of Finance

### The risk or issue

CIP Performance against plan is £1.2m adverse at month 7

### The cause

Lack of engagement with the CIP programme resulting in no significant schemes for this financial year.

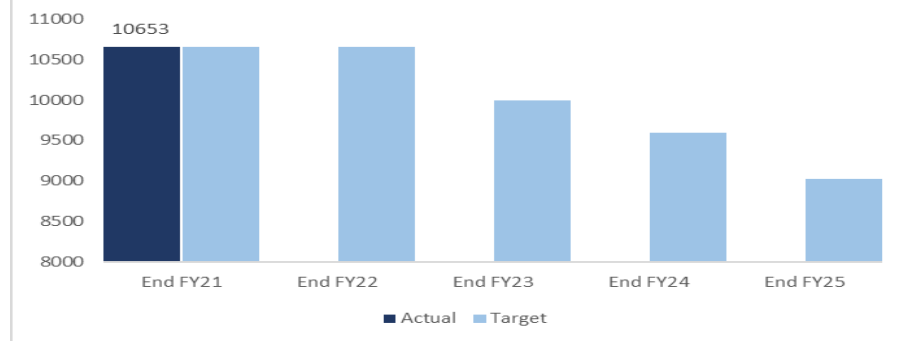
### The plan or mitigation

CIP targets have been devolved to Directorates to facilitate engagement and accountability. The Executive Team have agreed to use available reserves budget to offset some of this year's CIP targets (£2.8m) and this has been actioned in month 7 (this is the reason for high actuals in month 7). Budget setting will include developing CIP plans for FY24 to include delivery of the remaining FY23 target recurrently.

## Objective 3: Sustainability – areas of underperformance

Objective Key Result (OKR)	Target	Actual
(3d) 100% of estate to achieve condition B rating by 2025	75%	TBC

Objective Key Result (OKR)	Target	Actual
(3e) Delivery of estates related Co2 reduction target of 3,393 tonnes by 2028	3,393	6,272



### Executive Director commentary:

Martyn Ward – Executive Director: Digital & Transformation

### The risk or issue

It has now been several years since the Trust completed a condition rating survey. Although work to maintain a safe estate has been regularly carried out, there is a risk that some buildings may now be classified as condition rating C or D.

### The cause

Limited investment, shortages in skilled workforce and competing priorities. This, along with difficulties maintaining sites during COVID has resulted in a backlog/shortfall of maintenance and repair.

### What is the plan or mitigation?

Work is now underway to carry out a six-facet survey to understand the current building condition ratings. This indicator will be updated once that work is complete.

### Executive Director commentary:

Martyn Ward – Executive Director: Digital & Transformation

### The risk or issue

In FY21, the Trust consumed 4,952 tonnes of Co2 (NHS Carbon Footprint only). The aim is to reduce consumption to 3393 by 2028. The improvement trajectory is shown on the graph above. Total Carbon Emissions consumed (Supply Chain/Medicines) is 54,836

### The cause

The Trust has an obligation under Statute and the NHS Contract to reduce carbon emissions generally, becoming a net carbon organisation by 2045. This objective relates only to plans to reduce carbon emissions linked to the estate

### What is the plan or mitigation?

The estates department has an action plan describing potential schemes and a new 'Green Plan' has been produced for the Trust.

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

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

This year, our Objective Key Results are;	Previous FY	Community Services	Oxon & BSW	Bucks	Corporate Inc R&D	Trust	National comparator
Participants recruited to CRN Portfolio studies	2934 4 <sup>th</sup> Nationally	47	44	19	970	1080 3 <sup>rd</sup> Nationally	No.1 ranked Trust 4574
CRN Portfolio studies running as at month end	62 2 <sup>nd</sup> Nationally	2	5	3	26	36 4 <sup>th</sup> Nationally	No. 1 ranked Trust 98

**Executive Summary:** Karl Marlowe, Chief Medical Officer

**Data cut:** 15 November 2022

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

Note: 1270 recruits for previous FY and 669 recruits for current FY came from one study led by Prof Keith Hawton the "Oxford Monitoring System for attempted Suicide".

### CARENOTE OUTAGE IMPACT

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

Section 6:

## Patient activity and demand - **Areas of concern**

\*Please note that due to the clinical systems outage, data in this section is up to end of July 2022\*

## 6. Patient Activity and Demand – areas of concern as at end of July 2022

### 2. Section content

**Referral levels, appointment activity, number of admissions and length of stay** are routinely monitored by the Performance and Information Team using statistic process control (SPC) charts which indicate whether activity is outside of 'usual/expected' levels (or 'norms').

This section reports on **areas of concern**. Areas of concern are determined by (1) the Performance and Information Team highlighting activity outside of normal levels to services which is then (2) investigated by the services who confirm if it is a genuine area of concern.



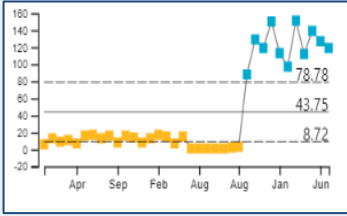

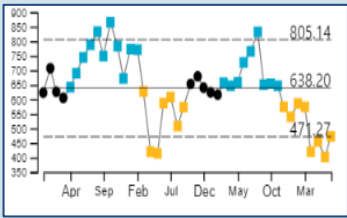

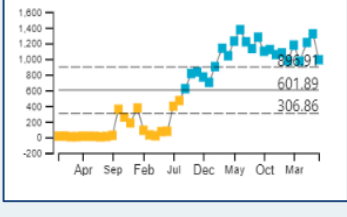

#### Headlines

- There are currently 12 areas of concern – see table below
- 5 are experiencing higher levels of demand or activity and 7 are experiencing lower levels
- Further information is provided overleaf for each area

Directorate	No. areas of concern	Areas of concern	Currency of concern	Is activity higher or lower than usual
Community	5	Care Home Support Service Tissue Viability Speech and Language Therapy	Referrals and appointments Emergency referrals and appointments Appointments	Higher Higher Lower
Oxon & BSW Mental Health	5	Memory Assessment Service CAMHS BSW In-reach Oxon CAMHS Forensic (CABS, Forensic & Specialist Housing) Oxon CAMHS Perinatal BSW CAMHS Swindon Community	Referrals Appointments Appointments  Appointments Appointments	Higher Lower Lower  Lower Lower
Bucks Mental Health	2	ADHD and Autism Memory Service	Appointments Appointments	Higher Higher

Please refer to the IPR supporting report for further information relating to demand and activity that is **not of concern**.

# Patient Activity and Demand: Community Services Noteworthy exceptions

Specialty / Directorate	Currency / Service Line	Trend over time	Activity in month	SPC Analysis Variation	Commentary
Community Services Care Home Support Service	Referrals: Care Home Support Service		343	 Service concern	<p><b>Is performance within usual levels?</b> No. Since Sept 2020 referral numbers have been increasing to above average and on or near the UCL.</p> <p><b>Is it expected?</b> Yes, during COVID there was limited access to Care Homes. The service now receiving far higher volumes of referrals than pre pandemic levels. Development of new care homes has also placed additional pressures on the service.</p> <p><b>Is it a problem?</b> Yes, the staffing levels have not increased in line with this increased demand.</p> <p><b>Is any action required?</b> Yes, the service is seeking to develop a business case to reflect this increased demand.</p>
Community Services Tissue Viability	Emergency Referrals: Tissue Viability		119	 Service concern	<p><b>Is performance within usual levels?</b> No referral numbers for Emergency referrals for the last 11 months above the UCL. Urgent referrals have been above average for last 10 months. Routine referral volumes have decreased and have been below average for the last 11 months.</p> <p><b>Is it expected?</b> Yes, the service has been responding to higher levels of activity to support the DN service which is currently on Red Level 1 escalation due to capacity concerns vs demand/complexity.</p> <p><b>Is it a problem?</b> Yes, across all DN and community nursing service lines a review of contacts/service specifications and negotiation with CCG is required.</p> <p><b>Is any action required?</b> Yes, review as above has commenced. A wound care recovery plan is being agreed for the DN service.</p>
Community Services, Adult Speech & Language	Appointments		472	 Service concern	<p><b>Is performance within usual levels?</b> No appointment numbers since December 21 have been below average and at times below the LCL.</p> <p><b>Is it expected?</b> Yes, the reduction in activity is partly driven by sickness and vacancies. In addition to recruitment a review is underway of the triage process and allocation to help maximise clinical capacity.</p> <p><b>Is it a problem?</b> Yes</p> <p><b>Any action required?</b> As outlined above</p>
Community Services Care Home Support Service	Appointments : Care Home Support Service		990	 Service concern	<p><b>Is performance within usual levels?</b> No appointment numbers have been above average since September 20 and since March 21 have been above the UCL.</p> <p><b>Is it expected?</b> Yes, during COVID there was limited access to Care Homes. The service is now returning to business as usual. Additionally since Sept 2020 the service has been more accurately capturing all activity volumes</p> <p><b>Is it a problem?</b> Yes, the staffing levels have not increased in line with this increased demand.</p> <p><b>Is any action required?</b> Yes, the service is seeking to develop a business case to reflect this increased demand.</p>

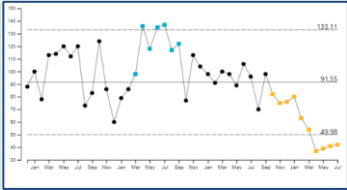

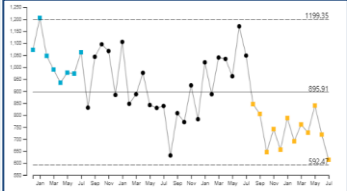

# Patient Activity and Demand: Community Services Noteworthy exceptions

Specialty / Directorate	Currency / Service Line	Trend over time	Activity in month	SPC Analysis Variation	Commentary
Community Services, Tissue Viability	Appointments: Tissue Viability		429	 Service concern	<p><b>Is performance within usual levels?</b> No appointment numbers since September 21 have been above average.</p> <p><b>Is it expected?</b> Yes, the service has been responding to higher levels of activity to support the DN service which is currently on Red Level 1 escalation due to capacity concerns vs demand/complexity.</p> <p><b>Is it a problem?</b> Yes, across all DN and community nursing service lines a review of contacts/service specifications and negotiation with CCG is required.</p> <p><b>Any action required?</b> Yes, review as above has commenced. A wound care recovery plan is being agreed for the DN service.</p>
Oxon & BSW Older Adults	Referrals (All): Memory Assessment Services		154	 Service concern	<p><b>Is performance within usual levels?</b> No, since March 2020 referral volumes have been above average.</p> <p><b>Is it expected?</b> Yes, during the first wave of Covid there was a reduction in referrals made for memory assessments.</p> <p><b>Is it a problem?</b> Yes capacity issues within CMHTs to meet the demand. This is a capacity gap since removal of S75 and lack of investment in service over a significant time frame.</p> <p><b>Is any action required?</b> SBARD completed to increase resources across the CMHTs unfortunately no additional funding is available</p>
Bucks Community ADHD & Autism service	Appointments: ADHD & Autism		90	 Service concern	<p><b>Is performance within usual levels?</b> No since October 2021 appointment numbers have been above average</p> <p><b>Is it expected?</b> Yes, activity is higher than in the previous years due to the ASD/ADHD waiting list initiative</p> <p><b>Is it a problem?</b> Yes Referrals to the service are much higher than the commissioned resource which leads to a large number of patients with long waits.</p> <p><b>Is any action required?</b> Ongoing monitoring</p>

# Patient Activity and Demand: Community Services Noteworthy exceptions

Specialty / Directorate	Currency / Service Line	Trend over time	Activity in month	SPC Analysis Variation	Commentary
Bucks Older Adult MH Memory Services	Appointments: Memory Services		418	 Service concern	<p><b>Is performance within usual levels?</b> No appointment numbers for the last 13 months have been above average with some months above or on UCL.</p> <p><b>Is it expected?</b> Yes, the south teams have been delivery activity above commissioned levels to support reducing the wait for memory assessments. The service delivery model has changed to increase telephone and digital consultations resulting in delivery of higher volume of appointments.</p> <p><b>It is a problem?</b> Yes, there is a potential impact on the quality of appointments via telephone consultations. Additionally, patients have chosen to wait longer as they did not want to have a digital consultation.</p> <p><b>Is any action required?</b> The service are encouraging more face to face and digital appointments so the position may reduce in coming months. The service are exploring the model of delivery for memory services to support assessments in a timely manner and speed up provision of treatment</p>
Oxon & BSW CAMHS BSW In-Reach	Appointments: CAMHS BSW In-Reach		33	 Service concern	<p><b>Is performance within usual levels?</b> No appointment numbers for the last 12 months have been below average.</p> <p><b>Is it expected?</b> Yes, there is an increase in demand coming both internally and from children's social care. There is also increased demand that is not reported on Carenotes due to limitations of the care record system.</p> <p><b>It is a problem?</b> Yes, it has come at a time of vacancies within the team. This will need to be monitored carefully. The vacancies are impacting on the volume of appointments delivered despite the increase in demand.</p> <p><b>Is any action required?</b> Ongoing monitoring</p>
Oxon & BSW CAMHS O Forensic	Appointments: CAMHs O Forensic (CABS, Forensic & Specialist Housing)		46	 Service concern	<p><b>Is performance within usual levels?</b> No appointment numbers for the last 2 months have been below the LCL</p> <p><b>Is it expected?</b> Yes, these are small teams with low numbers of staff. There have been significant vacancies and long term sickness within all the teams leading to an impact of a reduction in activity.</p> <p><b>It is a problem?</b> Yes, long term sickness staff have now returned at end of June but there are ongoing recruitment needs</p> <p><b>Is any action required?</b> Yes, recruited plans in place for all vacancies.</p>

# Patient Activity and Demand: Community Services Noteworthy exceptions

Specialty / Directorate	Currency / Service Line	Trend over time	Activity in month	SPC Analysis Variation	Commentary
Oxon & BSW CAMHS O Perinatal	Appointments: Oxon CAMHS O Perinatal		42	 Service concern	<p><b>Is performance within usual levels?</b> No since October 2021 appointment numbers have been below average, with last 4 below LCL.</p> <p><b>Is it expected?</b> Yes - Some sickness in team and some vacancy / Data quality issues; clinicians not recording all appts – mainly indirect / Ineffective processes within service pathway – now reviewed clarified and improved.</p> <p><b>Is it a problem?</b> Yes</p> <p><b>Is any action required?</b> Yes – see below</p> <ul style="list-style-type: none"> <li>• Consistent standardised case management</li> <li>• Office manager supporting admin to improve</li> <li>• Deep dive into care notes to ensure accurate and up to date</li> <li>• Improved focus on wait and throughput</li> </ul>
Oxon & BSW CAMHS Swindon Community	Appointments: BSW CAMHS Swindon Community		614	 Service concern	<p><b>Is performance within usual levels?</b> No since August 2021 appointment numbers have been below average.</p> <p><b>Is it expected?</b> It reflects national trends in eating disorders since the pandemic</p> <p><b>Is it a problem?</b> Yes</p> <p><b>Is any action required?</b> The Swindon service is subject to business recovery measures</p>