Oxford Health NHS Foundation Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Wednesday 29 January 2025, 09:00-12:00

Microsoft Teams virtual meeting

AGENDA

No.	Item	Lead	Purpose	Paper	Time
Welcome					
1.	**#Hellomynameis** and apologies for absence	Chair	Welcome	N/A	09:00
Patient Story					
2.	Patient Story *(to be rearranged)*	Chief Nurse	-	-	
Opening items					
3.	Register of Directors' Interests and declarations on items on the agenda	Chair	Assurance	Enclosed	
4.	Minutes of the meeting held on 27 November 2024		Approval	Enclosed	
5.	Action log and Matters Arising from the Minutes		Assurance	Enclosed	
Strategic, Regulatory & System					
6.	Trust Chair's report	Chair	Discussion	Enclosed	09:10
7.	Chief Executive's report [Link to Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB) papers: https://www.bucksoxonberksw.icb.nhs.uk/about-us/board-meetings/board-papers/]	CEO	Discussion	Enclosed	09:20
8.	Corporate Affairs report: a. Legal, Regulatory and Policy b. Board Assurance Framework	AD Corp Affairs	Information & Assurance	Enclosed & Reading Room	09:35
9.	FY25/26 Annual Plan Update	ED of Strategy & Partnerships	Discussion	Enclosed	09:45
Performance, Sustainability & Quality					
10.	Integrated performance and sustainability reporting: a. Integrated Performance Report (IPR) b. Quality & Safety Dashboard c. Finance report	Exec Team	Information & Assurance	Enclosed	10:00
11.	Patient Safety Incidents (PSI) report	Chief Nurse	Assurance	Enclosed	10:40
10 minutes' break 10:50 – 11:00					

12.	Committee assurance reports (3As): a. Audit Committee 03 December 2024 b. Charity Committee 04 December 2024 c. Finance & Investment Committee 14 January 2025 d. People, Leadership & Culture Committee 21 January 2025	Committee Chairs	Discussion & Assurance	Enclosed & Reading Room	11:00
Governance & Reports on recommendation of committees					
13.	Health, Safety & Security annual report	Chief Finance Officer	Assurance	Enclosed	11:20
14.	Emergency Planning, Resilience & Response (EPRR) annual report	AD Corp Affairs	Assurance	Enclosed	11:30
15.	Standing Financial Instructions	Chief Finance Officer	Approval	Enclosed	11.35
16.	Committee Terms of Reference a. Audit & Risk Committee b. Finance & Investment Committee c. People, Leadership & Culture Committee	AD Corp Affairs	Assurance	Reading Room	11:40
Closing matters & Resolution to conduct private business					
17.	Any Other Business				11:45
18.	Questions from the public, governors or staff				
19.	Review of the Meeting				
20.	Confidential matters - Resolution by the Board to exclude the public, any observers and press from the remainder of the meeting and conduct its business in private for matters which may be prejudicial to the public interest if conducted in public or for other reasons				
	Close Date of next meeting – 26 March 2025				12:00

READING ROOM/APPENDIX

Supporting reports to be taken as read to prompt discussion and decisions as required

21. Appendix to the Chief Executive's report:
Link to the Buckinghamshire, Oxfordshire & Berkshire West (**BOB**) Integrated Care Board (**ICB**) Board papers: https://www.bucksoxonberksw.icb.nhs.uk/about-us/board-meetings/board-papers/

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

23. Minutes and agendas of Committees:
    a) Audit Committee 03 December 2024
    b) Charity Committee 04 December 2024
    c) Finance & Investment Committee 12 November 2024 and 14 January 2025
    d) Mental Health & Law Committee 15 October 2024
    e) People, Leadership & Culture Committee 16 October 2024 and 21 January 2025
    f) Quality Committee 07 November 2024

24. Committee Terms of Reference
    a) Audit & Risk Committee
    b) Finance & Investment Committee
    c) People, Leadership & Culture Committee

Oxford Health NHS Foundation Trust

(Agenda item: 3)

REGISTER OF DIRECTORS' INTERESTS

January 2025

PART A – CURRENT BOARD MEMBERS

PART B - FORMER BOARD MEMBERS DURING 2024/25

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	No interests to declare.
Rob Bale	Interim Chief Operating Officer for Mental Health and Learning Disability[1]	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.
Geraldine Cumberbatch	Non-Executive Director	Director of **Croydon Business Venture Ltd** – locally-based business involved in facilitating support for small local businesses. Trustee of **Start Up Croydon** - the locally-based charity/initiative of Croydon Business Venture Ltd which supports start-up businesses. Dispute Resolution and Public Law Solicitor for the **Port of London Authority (PLA)** – responsible for handling dispute and regulatory matters on behalf of the PLA, a statutory port trust, who are the custodians of the River Thames. Partner is employed by **NHS England** as a Clinical Network Senior Clinical Programme Manager for the London Clinical Networks.
Charmaine De Souza	Chief People Officer	Board member for **Hightown Housing**, a charitable housing association covering Hemel Hempstead and the surrounding area and counties of Hertfordshire, Buckinghamshire, Bedfordshire and Berkshire.
Chris Hurst	Non-Executive Director	Non-Executive Director and Audit Chair at **Coventry & Warwickshire Integrated Care Board** (remunerated) from 03 June 2024. Executive coach and mentor – past clients have included senior staff in NHS organisations, local and national government, and in the private sector. Formerly Managing Director & Owner, **Dorian3d Ltd** – a consultancy business providing support to public sector clients (including the NHS, local authorities and governments) and independent advice to the private sector. Dorian3d Ltd closed on 31 December 2022. Partner is Regional Delivery Director with the **Strategic Estates Planning team of NHS England**, Midlands region.
Britta Klinck	Chief Nurse	No interests to declare.

[1] Interim since October 2023.

Grant Macdonald	Chief Executive Officer[2]	Mental Health Member - **Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB)** from 14 January 2025 Trustee - **Oxford Academic Health Science Partnership** from 08 January 2025
Karl Marlowe	Chief Medical Officer	Educational Supervisor of **Oxford University's Medical School** Honorary member of **Oxford University's Department of Psychiatry**. Chair: **Oxford Health Biomedical Research Centre; Applied Research Collaboration Oxford & Thames Valley; Oxford HealthTech Research Centre; Oxford Health Clinical Research Facility** Board Member: **Health Innovation Network Oxford & Thames Valley; Oxford Academic Health Partnership** Chairman: **The Social Interest Group Board** (charity for marginalised populations). Includes directorships of: **Penrose Options; Equinox Care; Pathways to Independence; Safe Ground**; **SIG Investments** (unremunerated). Advisor: **UNTANGLE GRIEF**, digital peer support platform;**Tasting Colours**, digital wellbeing service (unremunerated). Wife is founder of '**Jump in puddles**' a social purpose 'UK B-Corp' consultancy working with various innovation across health companies and charities. Sibling is on the **staff bank** for the **OHFT's Oxfordshire Out of Hours GP service**.
Ben Riley	Chief Operating Officer for Community Health Services, Dentistry & Primary 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)
Mohinder (Mindy) Sawhney	Non-Executive Director	Non-Executive Director at **Hampshire and Isle of Wight Integrated Care Board** (remunerated) from 01 December 2023 and Senior Independent Director. Managing Director of **root+branch ltd** (management consultancy). Has previously undertaken engagements with related bodies including the General Medical Council, health charities and suppliers to the NHS.
Heather Smith	Chief Finance Officer	Non-Executive and unremunerated Member of the Board and Trustee of **Arts at the Old Fire Station (AOFS)**, a charity. AOFS shares the Old Fire Station building in Oxford with the homelessness charity Crisis and encourages people from all backgrounds to understand and shape the world in which we live through stories, creativity and the arts, and by connecting with others.

[2] Interim Chief Executive Officer 01 July 2023-November 2024. Formerly Executive Managing Director for Mental Health, Learning Disability & Autism Services

		Family member is General Manager at **Normec Latis Scientific Limited**, who deliver water testing services to various NHS organisations both directly and via 3rd parties. Normec Latis provide laboratory testing and technical consultancy services including advice on water systems such as management of microbiological risk. Normec Latis Scientific is a subsidiary of the **Normec group** based in the Netherlands and specialising in Testing, Inspection, Certification & Compliance.
Richard (Rick) Trainor	Non-Executive Director	**Exeter College, Oxford**: Honorary Fellow **University of Oxford**: member (unpaid) of the History Faculty **Rhodes Trust:** Interim Warden of Rhodes House and CEO of the Rhodes Trust (from January 2025 up to and including December 2025) Vice President & Trustee and Chair of the Centenary Committee of the **Economic History Society**, Fellow and Emeritus Professor of Social History at **King's College London,** Chair of the Academic Panel of the **Museum of London**, 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, to Wolfson College, Cambridge and to the Royal Society of Medicine (president elect, Royal Society of Medicine's History of Medicine Society)
David Walker	Trust Chair	Miscellaneous journalism, lecturing and writing. Partner is a member of the **NHS Assembly** - created 2019 to advise NHS England on delivery of improvements in health and care, potential to influence NHS policy affecting the Trust.
Lucy Weston	Non-Executive Director	Chair of **Red Kite Community Housing Ltd** (registered charitable housing association based in Buckinghamshire) and Director of Twenty11 (Homes) Ltd (subsidiary of Red Kite Community Housing Ltd). Formerly Chair of **Soha Housing** (stepped down in September 2023). Self-employed - **Lucy Weston Consulting.**
Andrea Young	Non-Executive Director	Board Governor at **University of West of England** (second term running July 2023 – July 2026) and member of its Audit Committee. The University is the trainer and supplier of Allied Health Professionals and Nurses in the West of England, which may be relevant to contracts/services in the Bath, Swindon and Wiltshire area.

		Member of the **Independent Reconfiguration Panel**, providing independent advice to Ministers on changes to health services (4-year appointment starting 18 March 2024). Self-employed independent coach/mentor and member of the **Critical Coaching Group**, a professional body for independent coaches and mentors. Partner owns/runs **Wantage Natural Therapy Centre** and is a practicing chiropractor with referrals from Oxfordshire GPs. Listening volunteer with the **Samaritans** (starting June 2024).

DECLARATION OF INTERESTS
PART B - FORMER BOARD MEMBERS DURING 2024/25

Name	Role	Interests Declared
Nick Broughton	Chief Executive (until 30 June 2023, on secondment from July 2023 to September 2024)	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.
David Clark	Non-Executive Director – Nominee of The University of Oxford (until end of December 2024)	**University of Oxford:** • Emeritus Professor of Experimental Psychology. • Emeritus Fellow, Magdalen College; • Member of the Board of Calleva Research Centre, Magdalen College; • Member of Project Board for the Life & Mind Building; and • Co-Director, Oxford Centre for Anxiety Disorders & Trauma **NHS England:** • National Clinical and Informatics Advisor for the NHS Talking Therapies for Anxiety Disorders & Depression programme; • Member of Mental Health Currencies for Mood & Anxiety Disorders Working Group; • Member of Community Mental Health Outcomes Task & Finish Group; and • Member of PROMS (Patient Reported Outcome Measures) for Community Mental Health Services Expert Reference Group **Co-developer of internet cognitive therapies for social anxiety disorder and PTSD** (post-traumatic stress disorder) further to research at the University of Oxford; these may become licensed and made available to the NHS, further to recommendation by NICE, for use in NHS Talking Therapy for Anxiety and Depression services. Clinical Advisor to **Anxiety UK.**

		Fellowships of the **British Academy**, **Academy of Medical Sciences**, **Academy of Social Sciences**, **Kings College London** and **London School of Economics.** Honorary Fellowships of the **British Psychological Society** and **British Association of Behavioural and Cognitive Psychotherapies.** Various International Fellowships, Memberships and Honorary Memberships of learned societies and professional organisations, and member of the editorial boards of numerous academic journals.
Kerry Rogers	Director of Corporate Affairs & Company Secretary (until May 2024)	Trustee - **Age UK Oxfordshire.** Board observer 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.
Philip Rutnam	Non-Executive Director (until 30 September 2024)	Chair, **National Institute of Economic and Social Research** which is an independent and politically impartial institution that seeks to improve economic policy through research and advice. Chair, **National Churches Trust**. This is the national charity for churches, chapels and meeting houses. It provides grants, advice and support and advocacy, including supporting the use of the buildings for community benefit which may be relevant to health care. Council Member, **University of Surrey**, and Lay Member of Governing Body of the University of Surrey. The University is a **partner in the Oxford Health Biomedical Research Centre** and has active research and teaching programmes in health care. Non-Executive Director, **Innovate Surrey Limited (ISL).** ISL is the innovation and enterprise arm of the University, supporting business development, spin outs and growth. Chair, Advisory Board, **WA Communications.** WA is a strategy and communications consultancy active in a number of sectors including energy, transport, financial services, education and health care. Senior Adviser, **Civil Service College.** CSC is a not-for-profit entity separate from Government which provides training, consultancy and development services for mainly public sector entities in the UK and abroad. Assistant Churchwarden and Parish Council Member, Parish of Barnsbury, Diocese of London.

Meeting of the Oxford Health NHS Foundation Trust Board of Directors

Minutes of a meeting held on Wednesday, 27 November 2024 at 09:00 Microsoft Teams virtual meeting

Present:[1]

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

In attendance[3]:

Attendees/observers from Oxford Health NHS FT staff

Katrina Anderson	Service Director, Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Directorate – *part meeting*
Lisa Bamseysilva	Office Manager, Marlborough House Adolescent Unit
Alison Bourne	Head of HR Policy, Reward and Projects – *part meeting*
Ben Cahill	Deputy Director of Corporate Affairs
Laura Carter	Head of Strategy – *part meeting*
Martin Crabtree	Communications Manager
Kim Davies	Senior Mental Health Practitioner, CAMHS Outreach services – *part meeting*
Rachel Garnett	Senior Project Manager – *part meeting*
Ffion Gore	CAMHS Experience and Involvement Lead, Oxfordshire Community Teams – *part meeting*
Sarah Hill	Head of Service, Adults & Older Adults Buckinghamshire – *part meeting*
Elaine Jones	Executive Officer to CEO and Chair
Tina Malhotra	Clinical Director for Buckinghamshire Mental Health Services
Sue Marriott	Executive Assistant
Lola Martos	Interim Clinical Director, Adult Community Health Team, Oxfordshire – *part meeting*
Vicky Norman	Head of Service, CAMHS Community Service Oxfordshire – *part meeting*

[1] Quorum is 2/3 of the whole number of members of the Board (including at least 1 NED and 1 Executive) i.e., where voting members of the Board are 15 (from October 2024), quorum of 2/3 with a vote is 10

[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

Vanessa Raymont	Director of Research & Development – *part meeting*
Lisa Reynolds	Associate Director for Mental Health – *part meeting*
Hannah Smith	Assistant Trust Secretary (Minutes)
Rachael Stamp	Occupational Therapy Practice Development Lead – *part meeting*
Nicola Watkins	Trainee Psychological Therapist – *part meeting*

Governor Observers

Evin Abrishami	Staff Governor representing Mental Health Services Oxfordshire, BaNES, Swindon & Wiltshire
Zahir Mohammed (Cllr)	Governor representing Buckinghamshire Council

BOD 106/24 a	**Apologies for Absence** No apologies for absence were received.	
BOD 107/24	**Patient Journey – Oxfordshire Child & Adolescent Mental Health Services (CAMHS) Community Teams (Outreach)**	
a	The Chief Nurse introduced the CAMHS Experience and Involvement Lead and the Head of Service for the CAMHS Community Service Oxfordshire. They presented their report and the presentation on behalf of the service user, who had designed the slides, and her grandmother who had been unable to attend. The service user had had an intermittent journey through CAMHS but had found the most helpful treatment to be Dialectical Behaviour Therapy (**DBT**) which they found to be significantly more effective than standard Cognitive Behavioural Therapy (**CBT**). However, they wished that they had been able to access DBT and the emotional regulation strategies which they had been taught sooner and that they been aware that they could self-refer to CAMHS. Before they had been able to access DBT they had experienced a cycle of referrals, offers of early interventions which had not materialised, CBT which had not been effective when delivered remotely and as it had felt like counselling, issues with high turnover of CAMHS staff and staff having difficulty accessing healthcare records which could have provided useful historic information. Over time, the service user had gone from being a bright 11 year old who had needed additional help in processing difficult childhood events to a 17 year old who felt unable to function; her grandmother's mental health had also suffered during this difficult time. They emphasised the importance of: (i) prevention and early help rather than crisis intervention; (ii) offering practical help to young people and families whilst they were waiting; (iii) being clear about the CAMHS offer and system and how to get help; and (iv) continuity of care.	
b	The Head of Service provided an update on how services had changed and the current improvements underway within CAMHS including: a single point of access; information for service users on what to expect; support with emotional regulation for young people and their families; support for parents to understand self-harm; and support for young people and carers/their families whilst they were waiting. In response to comments from David Clark on the importance of ensuring continuity of care and finishing a course of therapy, the Head of Service noted that she encouraged all service users to finish their treatments once started.	
c	David Clark explained that there was a difference between CBT and counselling, therefore the service user should not have experienced CBT which felt like counselling. There were also specific ways in which therapists could be trained to deliver therapy remotely as this was a very different way of providing therapy but without awareness of this, it could be too easy to slip into a video chat; some patients preferred online therapy and the outcomes could be as good as face to face therapy. The Head of Service added that online therapy was popular with some younger service users.	

d	In response to questions from Zahir Mohammed, Governor representing Buckinghamshire Council, on whether CAMHS could provide greater support in schools for them to manage mental health needs internally, the Head of Service explained that CAMHS was part of the national programme for mental health in primary schools but the national programme did not cover all schools and there may also be more coverage in Oxfordshire than Buckinghamshire. David Clark added that there was a government commitment to expand coverage to all schools by the end of this parliament and that County Councils could play a part in holding accountability to this commitment.	
e	The Board praised the presentation and thanked the service user and her grandmother. Non-Executive Directors noted the importance of early intervention and prevention but, in discussion with the Head of Service and the Chief Nurse, acknowledged the need for CAMHS to prioritise in order to meet demand and that CAMHS was one part of a wider system offer around children and young people's mental health.	
f	**The Board thanked the service user and her grandmother and noted the Patient Journey.** *The CAMHS Experience and Involvement Lead and the Head of Service for the CAMHS Community Service Oxfordshire left the meeting*.	
BOD 108/24	**Staff Story - Occupational Therapy (OT) Service**	
a	The Chief People Officer and the Head of HR Policy, Reward and Projects introduced the OT Practice Development Lead who discussed her career pathway through several OT roles before her current role working two days a week providing professional development opportunities for all Occupational Therapists working across the Trust. The OT Practice Development Lead described the OT Development Framework to help Occupational Therapists identify where they wanted to develop and the learning opportunities available, noting the relevance of this to support recruitment and retention as well as the value in encouraging in-house teaching and knowledge-sharing. The Chief Nurse added that the role also had a wider application to provide development support for the various professions under the Allied Health Professionals umbrella.	
b	In response to Board discussion, the OT Practice Development Lead emphasised the importance of professional confidence and identity in OT roles and their uniqueness compared to social work or physiotherapy roles, in order to be fully recognised by colleagues in multi-disciplinary teams. She was also working on a project to promote professional supervision, in addition to managerial and clinical supervision, to ensure that Occupational Therapists and other Allied Health Professionals who received supervision from managers or other types of clinical professional would also benefit from leadership from within their own profession.	
c	**The Board thanked the OT Practice Development Lead and noted the Staff Story.** *The Head of HR Policy, Reward and Projects and the OT Practice Development Lead left the meeting.*	
BOD 109/24	**Register of Directors' Interests**	
a	No interests were declared pertinent to matters on the agenda.	
BOD 110/24	**Minutes and Matters Arising of the meeting held on 25 September 2024**	
a	The Minutes of the meetings were approved as a true and accurate record and the actions due that meeting were noted as complete (updates in the Summary of Actions document), with remaining actions not yet due.	

BOD 111/24 a b	**Trust Chair's Report** The Trust Chair took his report as read and highlighted the value of professional network events, such as the recent Allied Health Professionals event which he had attended, and noted aspirations to bring together non-clinical staff in similar networking events. **The Board noted the report.**	
BOD 112/24 a b c d	**Chief Executive's report** The Chief Executive highlighted the Trust's commitment to system working and improving the health of the local population, noting that the Trust was working collaboratively with the Buckinghamshire, Oxfordshire and Berkshire West (**BOB**) Integrated Care Board (**ICB**) including on the Community Nursing review across the BOB system; he recommended that the Board use the link in the agenda to access the BOB ICB board papers and review the paper on the BOB ICB's approach to system planning, transformation and improvement over 2025/26. The Trust would also contribute to responses to the consultation which would inform the national 10 Year Health Plan and, alongside system partners, take steps to ensure that it was in the best position to deliver the plan. He presented his report and highlighted: the Trust's third annual Quality Improvement conference; Speak Up Month and the theme of 'listen up' recognising the power of listening with respect and compassion; activities to mark Black History Month and the positive reaction of colleagues to reclaiming narratives and names; Allied Health Professionals day; the opening of the Keystone Connect hub in Chipping Norton; the launch of the Buckinghamshire Early Engagement and Prevention service supporting people at risk of developing psychosis; and the launch of the Single Point of Access service which he explained was for community services including GPs, carers and accident and emergency. In response to a question from Rick Trainor on the areas which the Community Nursing review would focus upon, the Chief Executive replied that leadership and use of technology to improve efficiency and free up time were being considered but the challenge to meet demand was considerable. Andrea Young recommended being specific about the outcomes expected from the review. **The Board noted the report.**	
BOD 113/24 a	**Corporate Affairs report** The Associate Director of Corporate Affairs presented the report and the recent regulatory and good practice guidance relevant to the work of the Trust, with the Trust's responses and ownership through the governance framework and key meetings. She commented upon the recent introduction of the Mental Health Bill to Parliament and noted that full implementation of its proposed reforms may take approximately 10 years via a phased approach, subject to future funding. She highlighted: • NHS England's (**NHSE's**) communication to trusts and ICBs on the national Statutory and Mandatory training programme and the actions expected to improve staff experience, deliver better outcomes and reduce the time burden. The Trust's work on this would be reported through the People, Leadership & Culture (**PLC**) Committee. The Chief People Officer added that most of the actions had already been completed through the PLC Committee and the Chief Medical Officer noted that the Quality Committee was also looking to reduce areas of duplication in training;	

	• updates to NHSE's mental health dashboard to help to monitor progress against the delivery of the national five year forward view for mental health and the NHS long term plan; • NHSE's update on plans for evolving the NHS oversight and assessment framework and a new NHS performance, improvement and regulation framework; • NHSE's guidance on the insightful provider board which would inform the Board's development programme and the development of the Integrated Performance Report; • NHSE's sexual safety in the healthcare organisation charter which the Trust had signed up to and which provided a framework to support Board assurance on delivery of the principles in the charter; • review of the Care Quality Commission (**CQC**) single assessment framework; • NHS Resolution's report on prevention and reduction of workplace violence; and • the regular update on the Board Assurance Framework (**BAF**).	
b	In response to a question from Lucy Weston, the Associate Director of Corporate Affairs noted that once the Board had agreed the annual priorities for 2025/26, and further to work by the Executive on risk management, the BAF could be reviewed against these.	
c	**The Board noted the report.**	
BOD 114/24	**Intensive and Assertive Mental Health Care Response: current position and next steps**	
a	Katrina Anderson and Lola Martos (from the Oxfordshire, Bath and North East Somerset, Swindon and Wiltshire Mental Health Directorate) with Sarah Hill and Tina Malhotra (from the Buckinghamshire Mental Health Directorate) presented the report on the work undertaken to benchmark, assure and improve intensive and assertive mental health provision for psychosis in response to the CQC special review of mental health services at Nottingham Healthcare NHS FT. The teams emphasised that gap analysis had not identified any significant gaps and although they were assured of performance against a number of the recommendations, they had also identified where further work would achieve a more robust position. The teams presented on proposed next steps: (i) the Intensive Case Management model for Buckinghamshire; and (ii) the Assertive Outreach 'hub and spoke' model for Oxfordshire, with a core team based in Oxford city. The models reflected the differing needs of the populations across the geographies of Buckinghamshire and Oxfordshire, as set out in more detail in the report.	
b	The Interim Chief Operating Officer for Mental Health & Learning Disability highlighted the final slide on key areas of action and noted that the delivery of these interventions through both proposed models would help to support people who traditionally were difficult for the organisation to engage with. The key areas of action included enhanced multidisciplinary and multiagency approaches, clinical pathways wrapping around individuals and strengthening robust approaches to risk and safety planning in treatment and discharge. In response to a question from Mohinder Sawhney on whether the transaction cost of implementing two different models would be worth it for patients, the Chief Executive clarified that the proposals would not be implemented unless they were funded, although the Trust would try to deliver a version of the proposals with the resources which were available. The Interim Chief Operating Officer for Mental Health & Learning Disability noted that it could be useful to provide an update to the Board during Q1-Q2 FY26 on the progress being made even if full funding for the Intensive Case Management model and the Assertive Outreach model was not available.	**RB**
c	In response to questions from Non-Executive Directors on how the Trust would evaluate whether the models were working and the strengths and benefits of each model, the Interim Chief Operating Officer for Mental Health & Learning Disability replied that the	

	embedded outcomes already in use in adult mental health services would be used. However, some baseline data may not be available initially whilst interventions were being deployed and the Trust would need to develop local measures and metrics to evaluate delivery for those who were difficult to engage with; he acknowledged that there could be a risk of initially reporting more upon process than outcomes. He reflected upon the Trust's historic move away from an Assertive Outreach model and explained that it had not been economically viable at the time. David Clark noted that chances of funding could be improved by articulating an evaluation plan.	
d	In terms of wider context, the Interim Chief Operating Officer for Mental Health & Learning Disability explained that the Trust was responding to the same processes as other organisations and working collaboratively with neighbouring organisations on moving away from the Care Programme Approach following the publication of the Community Mental Health Framework. The Chief Medical Officer noted that this was not a knee-jerk reaction to a tragic incident but an opportunity to focus upon the needs of a group of patients with psychosis who may not have been historically invested in and to review and address areas of potential risk such as their treatment, medication and discharge. If staff could also be supported and retained, this could help to deliver interventions with a more prolonged impact and improved continuity of care. Tina Malhotra, Clinical Director for Buckinghamshire Mental Health Services, added that whichever models were pursued in a particular area, the consultants had emphasised the importance of more resources so as to reduce clinical caseloads to a level whereby clinicians could develop an ongoing and meaningful therapeutic relationship with their patients which could provide for more intensive input.	
e	The Trust Chair concluded that, subject to funding, the Board was supportive and recognised that even if the proposed new models were successful, this would remain an area and a group of patients where some risk was carried. He welcomed the Board receiving an update during Q1-Q2 FY26.	
f	**The Board: (i) noted the report and the progress and actions undertaken; (ii) confirmed it was assured with progress against the action plan; and (iii) supported the costed proposal for funding for the Assertive Outreach/Integrated Case Management Model for progression and submission to NHSE via the BOB ICB.** *Katrina Anderson, Sarah Hill and Lola Martos left the meeting.*	
BOD 115/24	**Patient Safety Incidents (PSI) report – September-October 2024**	
a	The Chief Nurse presented the report on learning identified from 8 PSIs over the reporting period and wider learning from the local incident response plan for the national Patient Safety Incident Response Framework (**PSIRF**). Recent reviews had identified learning regarding: NEWS (National Early Warning Score) recording and escalation; communicating/engaging with patients on waiting list; communicating progress on rolling out Primary Care Mental Health Hubs; and physical health provision on a mental health ward. Actions being taken were set out in the report. The implementation of PSIRF would be reviewed in coming months with a more detailed update for the private Board Workshop in early 2025, as referred to in the Summary of Actions document.	
b	**The Board noted the report and was assured by processes and structure for the identification, review and learning from PSIs.**	
BOD 116/24	**BOB Mental Health Provider Collaborative (MHPC) update**	
a	The Executive Director of Strategy & Partnerships and the Interim Chief Operating Officer for Mental Health & Learning Disability introduced the Associate Director for Mental Health and presented the update report on progress in the development of the	

	BOB MHPC over the past 16 months. System partners were working in a more integrated way through a Partnership Programme Board and had identified and agreed 4 transformation programmes (with identified priorities to lead transformation across the system) on: 1. Mental Health Crisis and Urgent Care; 2. Three Year Adult Inpatient Transformation; 3. Localising Mental Health Care; and 4. Co-Production. The BOB MHPC governance structure had been revised together with system partners to ensure effective delivery of the transformation portfolio. An action plan had been developed in partnership with the BOB Voluntary Community and Social Enterprise (**VCSE**) Health Alliance and the BOB ICB to engage and hear the voices of smaller VCSE organisations. Risks to the development of the BOB MHPC and mitigating actions were set out in the report in relation to: new operating models; data availability and sufficiency; and resourcing.	
b	The Interim Chief Operating Officer for Mental Health & Learning Disability emphasised how challenging it had been to pull together the diverse range of organisations and programmes and thanked the Associate Director for Mental Health for her work.	
c	Non-Executive Directors commented upon challenges with partnership working including ambiguous accountabilities and how to measure whether transformation programmes were effective, governance arrangements were sufficiently robust and the overall benefits of collaboration. The Chief Executive noted that although improvement may be gradual, this was an opportunity to learn with and from other organisations and the Board would be kept updated; as set out in the report, more regular quarterly updates on the development of the BOB MHPC would be presented to the Executive. The Associate Director for Mental Health added that work was taking place across organisations including the VCSE sector to clarify responsibilities and create alignment across different areas and functions so as to avoid unnecessary duplication. Further to a suggestion from Andrea Young, the Executive Director of Strategy & Partnerships agreed to review BAF risk 3.1 (shared planning and decision-making at system and place level and working collaboratively with partners) which had been consistently orange/high-risk rated.	**AB**
d	**The Board noted the report was assured by the progress which had been made.** *The Associate Director for Mental Health left the meeting. The meeting took a break for 5 minutes and resumed at 11:25.*	
BOD 117/24	**Annual Plan FY24/25 mid-year progress report**	
a	The Executive Director of Strategy & Partnerships and the Head of Strategy presented the report and highlighted that annual planning was now a fully embedded process aligned with Finance and operational directorates and the Annual Plan now included a strategic delivery element. The Strategy Delivery Plan had been reviewed by committees and was supported by: strategic principles which informed strategic programmes; aspirations and measures of success; and strategic enablers. Each of the 4 Strategic Objectives (Quality, People, Sustainability and Research & Education) was underpinned by a series of strategic ambitions and the report provided an overview of the work being undertaken on these. The Trust was achieving strategic metrics for care and for reduction in agency usage. The report provided an overview of strategic programmes, clinical priorities and finance.	
b	The Interim Chief Operating Officer for Mental Health & Learning Disability commented that although outcome measures were not yet fully being delivered against, the architecture to support this was now in place. In particular, Truecolours (the app for recording PROMs (Patient Reported Outcome Measures)) had been redeveloped and	

	was now live for pilot teams in CAMHS and Adult/Older Adult services with planned wider rollouts. Further to comments from David Clark on timelines for achieving levels of outcome monitoring in each sector and reporting on innovations being implemented in the Trust, the Interim Chief Operating Officer for Mental Health & Learning Disability acknowledged that a trajectory still needed to be agreed on using outcome measures.	
c	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care reported that staff consultations were ongoing in relation to Jordan Hill and the city hub, building development work was on track but the financial case would need to be reviewed again through the Finance & Investment Committee in light of increased costs.	
d	Lucy Weston referred to her Finance & Investment Committee 3As report (at item BOD 121/24 below) and noted that the Committee had reviewed Q2 progress against the Annual Plan and cautioned that although significant progress had been made, further clarity may be needed on specific objectives so that the Board could be clear on what it wanted to spend time focusing on and ensuring successful delivery. Mohinder Sawhney agreed and commended the informative reporting but noted that although she was assured by the progress being made on operational priorities identified by teams, the Board needed to be clearer on what the strategic priorities were which were to be pursued through the annual planning process.	
e	**The Board noted the review of mid-year progress on the FY24/25 Annual Plan.** *The Head of Strategy left the meeting.*	
BOD 118/24	**Winter 2024 system resilience - planning update for Oxfordshire**	
a	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care presented the report on winter system resilience and noted that the Trust was no longer responsible for COVID-19 vaccinations which had been passed to primary care. The winter system resilience plan was reviewed through the BOB Joint Overview and Scrutiny Committee, preparedness was stronger than a few years ago and robust processes were in place to respond to demand surges. Work in progress to bolster the Oxfordshire District Nursing service this winter, as set out in the report and including the development of a Single Point of Access, would help the duty desk to manage more efficiently and use capacity more flexibly.	
b	The Chief Nurse provided an update on staff immunisations and noted that the usual communications campaign had been running with vaccination clinics across the organisation and take-up was in line with the national average. **The Board noted the report.** *The Director of Research & Development joined the meeting.*	
BOD 119/24	**Integrated Performance, Quality and Sustainability reporting**	
a	The Executive Director of Strategy & Partnerships presented the Integrated Performance Report (**IPR**) which had been redeveloped to improve alignment with the Trust's strategic ambitions and local and national performance requirements. The Chief Executive added that at this mid-year point, further comments to improve the IPR were being considered but continuity in the reporting would help to track performance.	
b	The Executive Director of Strategy & Partnerships reported that the Trust continued to perform well against the NHS National Oversight Framework metrics with the ongoing exception of inappropriate Out of Area Placement (**OAP**) bed days; although usage of OAPs remained lower than the previous year, numbers continued to fluctuate based on clinical demand and acuity.	

c	Against the Trust's new metrics to monitor clinical performance (derived from nationally reportable metrics, national objectives and locally agreed metrics) she highlighted: • for Child & Adolescent Mental Health Services (**CAMHS**), not all targets had yet been met for four week waits or Eating Disorders services. 50% of routine waiting time breaches related to patient choice and the remaining 50% to a variety of factors but mainly first appointments being offered outside of the 7 or 28 days' timeframe; • Talking Therapies services were continuing to perform well overall but recovery rates for ethnically and culturally diverse communities were lower than the 50% target (at 49.65% in Buckinghamshire and 43.92% in Oxfordshire). David Clark added that the latest national reporting on these measures for Talking Therapies services was due to be published shortly and it would be useful for the Trust to review those areas which were performing better; • Mental Health Urgent Care Services in Oxfordshire and Buckinghamshire were generally performing above national targets, with the continuing exception of the Oxfordshire Crisis Service 4-hour response time for very urgent referrals; • acute inpatient admissions with no prior contact remained higher than the national average across both Oxfordshire and Buckinghamshire; • Community and Learning Disability services' metrics remained subject to ongoing work; • in relation to Quality metrics, there had been a slight increase in patient incidents resulting in minor harm (but no increase in incidents resulting in moderate or severe harm); and • People metrics were positive in relation to reducing agency usage but vacancy challenges remained and recruitment events had restarted over September. Supervision rates were continuing to increase but were not yet meeting targets.	
d	The Interim Chief Operating Officer for Mental Health & Learning Disability reinforced that clinical directorates down to service level were widely using this performance data in their performance meetings.	
e	**The Board noted the report.**	
BOD 120/24	**Finance and Sustainability**	
a	The Chief Finance Officer presented the Month 6 Finance Report and reminded the Board of the importance of managing finances tightly given that it had started the financial year with a deficit plan, as well as the wider context of the BOB ICS's financial position. In Month 6, the BOB ICS had received non-recurrent deficit funding from NHSE, of which the Trust's share was £2.6 million which had improved the full year plan to a deficit of £0.1 million.	
b	She highlighted that the Revenue forecast remained on plan but now included £3.4 million held for unknown risks because although the Trust had been given funding to offset some depreciation, it would need to review performance and emerging risks before committing to an improved forecast.	
c	Capital expenditure was forecast to be overspent by £1.6 million (down from £2.5 million in the last report); the position was improving but the Digital team was continuing to investigate additional funding and the Estates team was stopping or slowing down projects to bring spend back into balance.	
d	**The Board noted the report.**	

BOD 121/24	**Board Committees' update reports – matters for Alert, Advice & Assurance (3As)**	
a	The Board took as read the 3As reports from the Mental Health & Law Committee (**MH&LC**), the People, Leadership & Culture Committee, the Quality Committee and the Finance & Investment Committee. Other committees had not met since last reporting.	
b	Committee Chairs highlighted from their respective 3As reports for the: • MH&LC: (i) the impact upon the employment status of Associate Hospital Managers following a recent national case (legal advice upon the impact of the decision upon the Trust should be available by the end of November 2024); and (ii) the introduction of the Mental Health Bill to Parliament; • Quality Committee – concerns relating to high risk fire safety alerts requiring action (from reporting on Safety of the Physical Estate) and assurance provided after the meeting from the Senior Fire Safety Advisor (and made available separately to the Board) clarifying the difference between high risk and high priority items and confirming that the majority of fire risks were assessed as 'tolerable' and the only one which had been categorised as 'substantial' had already been remediated; and • FIC: i. returning £2.7 million to the BOB ICS (in effect the non-recurrent deficit funding) in order to help the overall system position but further to discussion on the importance of advocating for patient welfare, especially in the context of historic underfunding of services; ii. concerns around lack of plans to re-provide facilities for the Highfield and Meadow Unit CAMHS facilities under the Warneford Park Programme, which may need consideration as part of estates planning; iii. appetite for expenditure on Green Plan 2, when available; and iv. the Board may wish to consider where oversight of Cost Improvement Plans (**CIPs**) may sit, in light of the BOB ICB Investigation and Intervention process having highlighted CIP processes as an area for improvement.	
c	The Trust Chair noted that the Board in private session and to preserve commercial confidentiality would consider the Warneford Park Programme and the BOB ICS.	
d	**The Board noted the 3As updates from the Committees, with supporting minutes and agendas in the Reading Room.**	
BOD 122/24	**Research & Development (R&D)/Innovation report**	
a	The Chief Medical Officer introduced the Director of R&D who presented the report and highlighted: • the Trust's bid for National Institute for Health and Care Research (**NIHR**) funding to establish a Secure Data Environment for patient data generated by the NIHR Mental Health Translational Research Collaboration; • the relaunch of an updated 'Count Me In' system to increase the number of patients available to approach about participating in research studies; • the set-up of a small portfolio of interventional psychedelic studies which included post-dosing monitoring and supportive therapy for participants; and • the ongoing development of a small portfolio of research clinics including: the Oxford Prevention and Early Detection (**OPEN**) service for young adults at high risk of developing serious mental illness (discussed at the last Board meeting in public); the Baseline Biomarker Check (**BBC**) clinic for people with first episode psychosis; and Tune Up for people with psychosis who did not benefit from standard care.	

b c d e	Future reporting would provide more detail on the re-application for funding for the NIHR Oxford and Thames Valley Applied Research Collaboration. The Board discussed the impact of the OPEN service and the BBC clinic for patients with psychosis and the Director of R&D noted that these examples had already helped 30 people to avoid inpatient admission and helped 2 people to address physical causes for their psychosis. There would also have been cost savings in delivering these early interventions. The Board reflected upon potential opportunities for commercial and industrial support for R&D activities and the Chief Executive noted that the Research Strategy Group may be a useful forum to consider regional, BOB and other investment opportunities further. **The Board noted the report.**	
BOD 123/24 a	**Any Other Business/Questions** None.	
BOD 124/24 a	**Review of the meeting** Further to discussion on the Patient Journey item at BOD 107/24 and the Corporate Affairs update at BOD 113/24, the Trust Chair noted that it may be helpful for a future private Board Workshop to consider CAMHS and the implementation of NHSE's operational guidance on urgent and emergency mental health care for children and young people. He would also consider the balance of future agendas, given time spent on earlier discussion.	**RB**
BOD 125/24 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: 12:36	

Summary of Actions from the Board meeting on 27 November 2024

Relevant Item	Action	Responsibility:
BOD 114/24(b)	**Intensive and Assertive Mental Health Care update** To provide an update to the Board during Q1-Q2 FY26 on the progress being made even if full funding for the Intensive Case Management model (Buckinghamshire) and the Assertive Outreach model (Oxfordshire) was not available **Status: *not yet due***, *anticipated over April-September 2025.*	**RB**
BOD 116/24 (c)	**Partnership working and BAF risk 3.1 (shared planning and decision-making at system and place level and working collaboratively with partners)** Further to the BOB Mental Health Provider Collaborative (MHPC) update and a suggestion from Andrea Young, the Executive Director of Strategy & Partnerships agreed to review BAF risk 3.1 (shared planning and decision-making at system and place level and working collaboratively with partners) which had been consistently orange/high-risk rated. **Status: *in progress***, *over January 2025 and by the Quality Committee in February 2025*	**AB**
BOD 124/24 (a)	**CAMHS at a future Board Workshop** Further to discussion on the Patient Journey item at BOD 107/24 and the Corporate Affairs update at BOD 113/24, the Trust Chair noted that it may be helpful for a future private Board Workshop to consider CAMHS and the implementation of NHSE's operational guidance on urgent and emergency mental health care for children and young people. **Status: *not yet due***, *to be considered for Board Workshops from April 2025 onwards*	**RB**
Action held over and now due from the meeting on 27 March 2024		

BOD 31/24 (c)	**Patient Safety Incident Response Framework (PSIRF)** In Q4 FY25 or Q1 FY26 the Board should hold a workshop on the national Patient Safety Incident Response Framework once it had had a year to operate. **Status: *scheduled*** – *Progress and Challenges with implementing the PSIRF, for the private Board Workshop in February 2025.*	**BK**

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	6
Report title	Trust Chair's report
Executive lead(s)	N/A
Report author(s)	David Walker, Trust Chair
Action this paper	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board	For information/discussion
For disclosure or confidential	For disclosure

Executive summary

Peasedown St John, Chew Magna, Monkton Combe…also Ascott under Wychwood, Filkin and Broughton Poggs, Sandford St Martin and Westcot Barton. These parish names, so redolent of an older England, are reminders that Oxford Health serves some distinctly rural areas in the Cotswolds and the Mendips. On a recent visit to our new Keystone mental health and wellbeing hub in Chipping Norton, I heard that such areas are generally prosperous and social housing is sparse.

But these small country towns and attractive villages are far from problem free. In Chipping, the hub (open initially for a morning each week) is housed in a former bank that has been remade by The Branch, an impressive charity that runs a youth club, helps low-income families and – over this past Christmas – delivered meals to homes that otherwise would have gone without. Amid its rolling fields and rich ironstone cottages, people suffer, no matter their social circumstance and the new hub gives them a chance to seek help. Rural existence brings specific conditions, isolation, difficulty in accessing help and dependence on private vehicles among them. Our own staff, covering the area from Banbury to Witney and beyond inevitably spend a lot of time driving down country lanes.

An obvious point to make is that our area is diverse, generalising about need and service levels across it is hazardous. Just before Christmas I visited the children and adult mental health team for Bath and North East Somerset, based in the centre of Keynsham. The town is mid-way between Bath and Bristol. Proximity to this large city gives us access to its wide and diverse labour market, offering opportunities for recruiting and retaining staff. But the Keynsham location also means the inhabitants of Bath have to travel for consultations.

Keynsham is also a fair way from Oxford, which puts a premium on local management. The NHS is sometimes said to be top down, centrally driven when in fact it is much more like a Gruyère cheese, with lots of holes within which staff get on with their jobs in considerable autonomy. Thats particularly true of clinicians who daily make judgements quite independent of senior management structures. Of course, they are subject to all sorts of accountability through interdisciplinary teamwork, professional regulation and so on. Our colleagues in Chipping Norton, as in Keynsham, get on with the job, carrying high levels of risk, relying on their trained judgement. We need continuously to reflect on the appropriate balance between local and central, between autonomy and accountability, between far-flung and close to home.

Report history / meetings this item has been considered at and outcome
N/A

Recommendation(s)
The Board is asked to note the report.

Strategic objective this report supports	**Select**
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☐
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	~~Yes/~~No	
Legal and regulatory	~~Yes/~~No	

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	7
Report title	Chief Executive's report
Executive lead(s)	N/A
Report author(s)	Grant Macdonald, Chief Executive
Action this paper	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board	For information/discussion
For disclosure or confidential	For disclosure

Report

Forensic mental health services inspection

During November 2024 the Care Quality Commission (CQC) carried out an unannounced inspection of the Trust's forensic inpatient services. Over the course of the inspection seven inpatient low and medium secure units were inspected across three sites. The methodology used by the CQC inspection teams sought to minimise the impact of the inspection on the delivery of patient care and focused on ward environments, staff practice and interactions with patients, and patient health records and monitoring reports. High level feedback from the inspection was shared with us in mid-December while we wait for the detailed findings report. I'd like to express my thanks to colleagues across the forensic directorate for their support and assistance during the inspection.

Mental health inpatient celebration event

I was pleased to hear that we had over 150 colleagues attend the Trust's first Mental Health Inpatient Improvement event at the beginning of January at Unipart in Oxford. Staff from all professions attended the day to celebrate the work that is carried out on wards and also to learn about what changes they can make to continue to improve services for staff, carers and patients.

Community health services hub in north Oxford

The Trust is now in the final months of preparation and refurbishment of a community services hub which is Murray House at the Jordan Hill site in north Oxford. The new hub

will provide much improved facilities for both staff and patients. At the end of last year staff, patients, carers and family groups were closely involved in helping to shape the design scheme of the hub to help create a welcoming and calm environment. Staff in scope to move to Murray House were consulted during the end of last year regarding their proposed change of work location.

Lead governor

At the end of last year Anna Gardner stood down as the Trust's lead governor – at the 5th December Council of Governors meeting I and others expressed our thanks to Anna for all her work in the lead governor role, in particular I'd like to thank Anna for her support for me during my time as interim chief executive. At the December council meeting, Vicki Power was appointed our new lead governor. Vicki is a staff governor and I'm looking forward to working with her and the council over 2025.

Dr Ben Riley

At the end of February, Dr Ben Riley will be leaving the Trust to take up the role of Chief Medical Officer at the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). Ben has been at the Trust since 2020 and prior to joining Oxford Health was the Chief Clinical Officer and Chair at OxFed, the GP federation for Oxford City. I'd like to express my thanks to Ben on behalf of the board – particularly his focus on improving patient care and in developing services in the community across Oxfordshire - and wish him all the best at the ICB.

Executive colleagues

In February, Taff Gidi will be joining the Executive team as the Director of Corporate Affairs. Previously Taff was Executive Director of Governance & Risk at Portsmouth Hospitals University NHS Trust. With Taff joining, Georgia Denegri will be leaving the Trust at the end of February. On behalf of the Board I'd like to thank Georgia for her year at the Trust and wish her all the best for the future.

Grant Macdonald, Chief Executive

Report history / meetings this item has been considered at and outcome
N/A

Recommendation(s)
The Board is asked to note the report.

Strategic objective this report supports	**Select**
Quality - Deliver the best possible care and health outcomes	☑

People (Workforce) - Be a great place to work	☐
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☐**Well-led**

Links to / Implications – where applicable		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	~~Yes/~~No	
Legal and regulatory	~~Yes/~~No	

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	8
Report title	Corporate Affairs Update Report
Executive lead(s)	Georgia Denegri, Interim Associate Director of Corporate Affairs
Report author(s)	Georgia Denegri, Interim Associate Director of Corporate Affairs
Action this paper	☐ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the Board	This is a routine report with direct relevance to the Board and its committees.
For disclosure or confidential	Disclosure

Executive summary

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

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

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

The regulatory and good practice guidance, relevant to the work of the Trust, issued from 20 November 2024 to 22 January 2025, is presented in Appendix 1.

Its purpose is to inform the Board of the guidance issued and what action(s) will/are being taken by the Trust.

The regular Board Assurance Framework report is presented in Appendix 2.

Report history / meetings this item has been considered at and outcome

N/A

Recommendation(s)

The Board of Directors is asked to note the report.

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☐
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☑

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	~~Yes~~/No	
Legal and regulatory	Yes/~~No~~	

Appendix 1

Regulatory and good practice guidance (NHS England and CQC) published 20 November 2024 to 22 January 2025

	Publication, summary, and link	Publication date	Executive Lead(s) for action	Trust action(s)
	NHS England			
1.	**Research toolkit for matrons and other health and care leaders** This toolkit is in response to feedback from matrons and health and care leaders who specifically asked for guidance on: • how to recognise key components of research leadership • how to reflect on individual research leadership and create a research development action plan • how to access communities of practice and share ideas with likeminded leaders. **Link to website/document:** NHS England » Research toolkit for matrons and other health and care leaders	22/01/2025	Britta Klink, Chief Nurse	For information
2.	**Annual assessment of integrated care boards 2023/24** This report is a summary of the assessment of each ICB covering how effectively they have led their local NHS system and their contribution to each of the four core purposes of an integrated care system. It summarises an assessment of performance during the 2023/24 financial year and reflects NHS England's views relating to that period only; it does not necessarily indicate NHS England's views of performance at the time of publication. **Link to website/document:** NHS England » Annual assessment of integrated care boards 2023/24	16/01/2025		For information The summary on BOB ICB's assessment is presented at the Annex.
3.	**Enabling equitable access to clinical imaging referrals**	16/01/2025		For information

	Publication, summary, and link	Publication date	Executive Lead(s) for action	Trust action(s)
	Letter to trusts, primary care networks, GPs and integrated care boards regarding good practice guidance for ensuring more consistent and equitable access to clinical imaging requests for registered healthcare professionals working in multi-professional enhanced, advanced, or consultant practice roles. Further information, including the full guidance document and an accompanying infographic, is available on the Centre for Advancing Practice website. **Link to website/document:** NHS England » Enabling equitable access to clinical imaging referrals			
4.	**Friends and Family Test data – November 2024** **Link to website/document:** NHS England » Friends and Family Test data – November 2024	09/01/2025	Britta Klinck, Chief Nurse	For information. Regular publication of data.
5.	**Reforming elective care for patients** NHSE's new plan sets out how the NHS will reform elective care services and meet the 18 week referral to treatment standard by March 2029. Under this plan elective care will be increasingly personalised and digital, with a focus on improving experience and convenience, and empowering people with choice and control over when and where they will be treated. **Link to website/document:** NHS England » Reforming elective care for patients	06/01/2025		For information
6.	**National dental workforce collection – move to annual collection** Letter from Ali Sparke, Director for Pharmacy, Optometry, Dentistry and the NHS Standard Contract, NHS England, with details of the move to an annual data collection starting in January 2025.	20/12/2024	Charmaine De Souza, Chief People Officer / Ben Riley, COO for Community	The next workforce collection will open on 20 January 2025 and close at midnight on 17 February 2025. As this is the first

	Publication, summary, and link	Publication date	Executive Lead(s) for action	Trust action(s)
	Link to website/document: NHS England » National dental workforce collection – move to annual collection		Services, Dentistry & Primary Care	annual collection, with data already collected across January to 31 March 2024, the collection will cover April to December 2024.
7.	**Winter pressures** Joint letter with the Care Quality Commission (CQC), the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). **Link to website/document:** NHS England » Winter pressures	18/12/2024	Executive Team	For information
8.	**Preparing for a successful spring 2025 COVID-19 vaccination programme** Letter from Steve Russell, National Director for Vaccinations and Screening, NHS England, on the preparations and announcing cohorts for the spring 2025 programme. **Link to website/document:** NHS England » Preparing for a successful spring 2025 COVID-19 vaccination programme	13/12/2024	Ben Riley, COO for Community Services, Dentistry & Primary Care	Regular implementation
9.	**Provisional Never Events 2024/25 data: 1 April 2024 – 31 October 2024** **Link to website/document:** NHS England » Provisional Never Events 2024/25 data: 1 April 2024 – 31 October 2024	12/12/2024	Britta Klinck, Chief Nurse and Karl Marlowe, Chief Medical Officer	For information. Regular publication of data.
10.	**Submission to the Review Body on Doctors' and Dentists' Remuneration – evidence for the 2025/26 pay round** This is NHS England's submission to the Review Body on Doctors' and Dentists' Remuneration. The evidence covers NHSE's key responsibilities for supporting the recruitment, retention and	12/12/2024	Charmaine De Souza, Chief People Officer	For information

	Publication, summary, and link	Publication date	Executive Lead(s) for action	Trust action(s)
	motivation of NHS doctors and dentists. The submission covers each of the doctor and dentist groups within the remit of the DDRB: consultants, salaried general practitioners (GPs), the dental workforce, specialty and specialist (SAS) grade doctors, and doctors and dentists in postgraduate training. **Link to website/document:** NHS England » Submission to the Review Body on Doctors' and Dentists' Remuneration – evidence for the 2025/26 pay round			
11.	**Submission to the NHS Pay Review Body – evidence for the 2025/26 pay round** This is NHS England's submission to the NHS Pay Review Body. The evidence covers NHSE's key responsibilities for supporting the recruitment, retention and motivation of NHS staff employed on the Agenda for Change (AfC) contract. **Link to website/document:** NHS England » Submission to the NHS Pay Review Body – evidence for the 2025/26 pay round	12/12/2024	Charmaine De Souza, Chief People Officer	For information
12.	**NHS education funding guide: 2024 – 2025 financial year** The NHS education funding guide outlines NHS England's funding for learners, educational institutions, employers, and placement providers to support the education and training of professional roles within the NHS for the 2024–2025 financial year. **Link to website/document:** NHS England » NHS education funding guide: 2024 – 2025 financial year	09/12/2024	Charmaine De Souza, Chief People Officer / Heather Smith, Chief People Officer	For information
13.	**Principles for assessing and managing risks across integrated care systems**	04/12/2024	Britta Klinck, Chief Nurse / Karl	For information

	Publication, summary, and link	Publication date	Executive Lead(s) for action	Trust action(s)
	The National Quality Board provides guidance for assessing risks in complex healthcare scenarios. This document outlines principles for managing quality risks within integrated care systems, particularly in rapidly changing environments. It supports the delivery of safe, effective, and personalised care while addressing inequalities across health services. **Link to website/document:** NHS England » Principles for assessing and managing risks across integrated care systems		Marlowe, Chief Medical Officer	
14.	**Integrated operational pressures escalation levels (OPEL) framework 2024 to 2026** This Integrated operational pressures escalation levels (OPEL) framework 2024 to 2026 is for the management of operational pressures across NHS England's providers, including acute trusts, community health, mental health, and NHS 111 services and provides the core parameters that each of these types of provider must use to determine their OPEL. **Link to website/document:** NHS England » Integrated operational pressures escalation levels (OPEL) framework 2024 to 2026	02/12/2024	Executive Team	
15.	**The Innovation Ecosystem Programme – how the UK can lead the way globally in health gains and life sciences powered growth** This report summarises the Innovation Ecosystem Programme's (IEP) findings from the last 18 months and recommends a package of actions to move forward. It includes case studies. **Link to website/document:**	28/11/2024	Karl Marlowe, Chief Medical Officer / Heather Smith, Chief Finance Officer	For information

	Publication, summary, and link	Publication date	Executive Lead(s) for action	Trust action(s)
	NHS England » The Innovation Ecosystem Programme – how the UK can lead the way globally in health gains and life sciences powered growth			
16.	**Investment in general practice in England, 2018/19 to 2022/23** This report details the government's investment in general practice services and the reimbursement for drugs dispensed in general practices from 2018/19 to 2022/2023. **Link to website/document:** NHS England » Investment in general practice in England, 2018/19 to 2022/23	27/11/2024	Ben Riley, COO for Community Services, Dentistry & Primary Care / Heather Smith, Chief Finance Officer	For information
	CQC			
17.	**Terms of reference published for the second phase of the review into CQC's assessment framework and its implementation** **Link to website/document:** Terms of reference published for the second phase of the review into CQC's assessment framework and its implementation - Care Quality Commission		Britta Klinck, Chief Nurse	For information
18.	**Developing an engagement and health inequalities improvement framework for integrated care systems: Testing phase complete** **Link to website/documents:** Developing an engagement and health inequalities improvement framework for integrated care systems: Testing phase complete - Care Quality Commission	13/01/2025	Karl Marlowe, Chief Medical Officer / Executive Team	For information. Implementation in Spring 2025 at system level

Annex

NHSE Annual assessment of integrated care boards 2023/24

Buckinghamshire, Oxfordshire and Berkshire West

Oversight framework segment

3. Regionally mandated support

System leadership

Following significant senior churn within the system, the ICB must now focus on establishing stable leadership and it will be supported in this by the board development programme. Following operating model consultation, there is now significant work to do to implement the revised model to right-size the organisation at the same time as tackling significant operational and financial challenges. We welcome the early steps the ICB has taken, including resetting the mental health and acute collaboratives, and will now look to see these having the desired impact.

Improving population health and healthcare

Despite the challenging operating context and leadership fluctuations, progress has been made against key priorities such as reducing the number of elective patients waiting over 65 weeks and cancer 62-day waits, and maintaining primary care access above regional averages. However, significant challenges persist, particularly around urgent care performance and very long waits for elective care, and we will continue to provide support through tiering. The ICB is also required to support maternity service improvements in Oxford following a recent CQC inspection.

Tackling unequal access, outcomes and experience

The ICB is placing focus on key prevention priorities, in particular prevention of cardiovascular disease in the most deprived areas, and is also progressing work to improve tobacco dependence services. However, we look to the ICB to increase work to identify and treat hypertensive patients and increase referrals to the NHS Digital Weight Management Programme. The ICB should also take a wider population health management approach to explore further opportunities.

Enhancing productivity and value for money

Confidence in the ICB’s grip on this agenda is dented by the significant and unexpected financial decline in the latter part of the year. The ICB must take steps to address vacancies in its financial team, assure its board that it receives appropriate information, deliver a coherent financial

plan and work towards financial sustainability, focusing on areas like primary care prescribing. More ambitious workforce planning is also needed to address the existing temporary staffing variations and tackle the unfunded workforce growth.

Supporting social and economic development

The ICB has worked to address key prevention priorities as part of enhancing wider socioeconomic improvements, but we would expect to see wider contributions to this area as it is a fundamental purpose of an ICS. The ICB should continue to pursue opportunities for broader social and economic development alongside its key system partners and advance its sustainability agenda to meet the ambitions of its green plan. A clear strategy is needed to align these efforts with system-wide goals.

Appendix 2

Risk Management

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

Included in the Reading Room is the latest iteration of the Board Assurance Framework to ensure Board members continue to have a universal view of the Trust's strategic risk profile and its committees' assessment of the supporting control environment. This is the January 2025 edition of the BAF.

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

Since last reporting to the Board, the Executive Team meetings on 23 December 2024 and 27 January 2025 reviewed updates on the BAF, whilst the Extended Leadership Team meeting on 25 November 2024 reviewed updates on the TRR and Directorate Risk Registers. The Extended Leadership Team meeting, which is also attended by senior managers from Directorates, approves changes to TRR risks and the removal of TRR risks, as part of their oversight of operational risks.

Board Committees also received their regular updates on BAF and TRR risks and undertook deep dives into selected risks through meetings of the Audit Committee on 03 December 2024, the FIC on 14 January 2025 and the PLC Committee on 21 January 2025.

BAF extreme/red-rated risks scoring ≥15 remain:

- BAF 1.5 on *Unavailability of beds/demand and capacity (Mental Health inpatient and Learning Disability* with a Current Risk Rating of 16 (4 Impact and 4 Likelihood) – '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';

- BAF 2.6 on *Adequacy of Staffing* with a Current Risk Rating of 16 (4 Impact and 4 Likelihood) – 'Inability to plan for, attract and secure sufficient numbers of 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';

- BAF 3.4 on *Delivery of the financial plan and maintaining financial sustainability* with a Current Risk Rating of 16 (4 Impact and 4 Likelihood) – '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'; and

- BAF 3.14 on *Major Programmes* (formerly Major Projects) with a Current Risk Rating of 16 (4 Impact and 4 Likelihood) – 'Insufficient capacity and capability to deliver major programmes 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'.

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

The Executive over December 2024 and the PLC Committee at its meeting on 21 January 2025 have worked on the development of a potential new risk at BAF 2.7 (Physical Environment, Health & Safety). This risk is still a draft/work in progress and the final version and monitoring/governance arrangements are to be confirmed before it can be fully published.

No BAF risks have changed their Current Risk Ratings since last reporting although updates to descriptions, controls, assurances and mitigating actions have been made to the following risks and reviewed by their relevant committees:

- BAF 2.3 (Succession)
- BAF 2.4 (Culture)
- BAF 2.5 (Retention);
- BAF 2.6 (Adequacy of Staffing) – further to discussion at the PLC Committee meeting on 16 October 2024, BAF 2.6 has been reworked and condensed and was subject to in-depth review at the PLC Committee meeting on 21 January 2025;
- BAF 3.4 (Financial Plan and Financial Sustainability); and
- BAF 3.7 (Ineffective business planning arrangements) – further to discussion at the FIC meeting on 14 January 2025, a refocusing upon strategic rather than business planning for the risk is being considered.

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	9
Report title	**Trust Annual Planning FY25/26**
Executive lead(s)	Amélie Bages – Executive Director for Strategy & Partnerships, Heather Smith – Chief Finance Officer
Report author(s)	Laura Carter, Heads of Strategy, Peter Milliken, Director of Finance
Action this paper	☐ Decision/approval ☑ Information ☐ Assurance
Reason for submission to the Board	The Board is asked to provide feedback on the emerging priorities and associated financial plans. This paper provides an update on planning process ahead of the FY25/26 annual plan review at the Board of Directors meeting in March 2025.
For disclosure or confidential	Disclosure

Executive summary

The FY25/26 annual planning process aims to build on the progress made last year in establishing a robust planning culture within the Trust. Jointly led by the Finance and Strategy directorates, the process is now in its third year and seeks to embed our approach to planning as part of the Trust's business-as-usual way of working.

This cover note updates the Board of Directors on the progress made to date in developing the Oxford Health Foundation Trust's annual plan for FY25/26.

BACKGROUND

The FY25/26 annual planning process began with kick-off meetings for each directorate in September 2024. Building on last year's process, directorates have identified their top five priorities, focussing on improving and sustaining existing priorities. To strengthen alignment, clinical directorates outlined these priorities in workshops, attended by central and corporate leads.

Directorates were asked to engage teams in setting priorities, use co-production where possible, consider risks, address workforce constraints, and aim for a balanced financial position, including Cost Improvement Programmes (CIPs). The Chief Medical Officer and Chief Nursing Officer also outlined clinical focus areas to guide planning.

Initial directorate level priorities were presented to the Extended Leadership Team on the 2nd of December 2024. These priorities were also shared via email and feedback sought from the Council of Governors on the 5th of December 2024.

Since then, directorates have refined their plans and will continue to iterate them as funding and NHSE planning guidance (which has been delayed for FY25/26) is issued. In addition, they will coordinate joint working with ICS (Integrated Care System) partners through Place-level governance.

OXFORD HEALTH FOUNDATION TRUST DRAFT PLAN FOR FY25/26

Following the same approach as last year, the draft FY25/26 plan will comprise of a main document which aligns with our Strategy Delivery Plan contained in the first half of our Annual Plan. This will outline the Trust's key strategic priorities for FY25/26, high level system planning and a summary of clinical directorate priorities. In addition, more detailed plans from all directorates will be included. These detailed plans will contain a summary slide per directorate highlighting key priorities and risks, followed by individual slides for each priority. These will detail risks, mitigations, partnership working, KPIs, and milestones. For clinical directorates, winter plans and medium-term plans will also be included.

Strategy Delivery Plan

The Trust is in the process of refreshing its 2024/25 Strategy Delivery Plan, reviewing the portfolio of Strategic Programmes into a subset of Strategic priorities and aligning Corporate & Central Services Delivery to these priorities. These will be discussed with the Board at a later date ahead of finalisation of the Annual Plan.

Clinical Directorate Priorities:
Most directorates have focussed on sustaining and improving existing work, with many rolling over existing priorities from FY24/25.

Buckinghamshire

- Developing and improving in- patient services and the Mental Health (MH) Urgent Care Pathway for Child and Adolescent Mental Health Services (CAMHS) and Adults.
- Continuing community mental health transformation and integration with primary care.
- Advancing and embedding a directorate approach to tackling health inequalities.
- Improving the timeliness of access to assessment, diagnosis and treatment in adult services.
- Delivering sustainability and developing our infrastructure including reducing agency use by increasing bank and permanent staff, developing a Children's and Young People day service as an alternative to in-patient care, and review the estate while creating an external-facing website.

Oxfordshire, Bath and Nort East Somerset, Swindon and Wiltshire (BSW)

- Reviewing service delivery: Early identification of cost improvement programmes (CIPS) for 2026/27, repurposing existing vacancies to support priorities such as Crisis resolution and Home Treatment expansion, Acute inpatient improvement programme, implementation of Oxevision to enhance safety. Development of the Oxfordshire Mental Health Outpatient Hub.
- Partnership Integration: Review and implement services developed in partnership with the Voluntary, Community and Social Enterprise (VCSE) sector. This includes Oxfordshire CAMHS and the implementation of the BSW alliance. This also involves continuing to deliver the 10-year transformation of Mental Health services in Oxfordshire delivered in partnership with VCSE.
- Temporary workforce review: reviewing the use of medics across the directorate, working with finance and medical leads to reduce locums and optimise medic usage, and continuing to review Agenda for Change roles to reduce costs and increase substantive staffing.
- Recruitment and Retention / Health Inequalities: improving recruitment, retention, and staff wellbeing across the directorate, further updating and developing the people plan, continuing listening events, and developing leadership skills with support from Organisational Development and Learning and Development teams. In addition, developing a consistent directorate-wide approach to health inequalities, ensuring it runs as a thread through the work and the services that we deliver.

Forensic

- Integration of Pathway of Care: implementing a focused approach to planning patient care and clinical pathways based on a clear assessment of needs, and establishing a quality standard to ensure consistency and continuity across the patient pathway.
- To improve outcomes for patients through the provision of accessible services, focusing on the accessibility of services for individuals with neurodivergence, with additional cross-over benefits for those with wider neuro-accessibility needs.
- Implement a Trauma-Informed Strategy to enhance patient and staff experiences, while supporting staff affected by workplace trauma.
- Review Protected Pathways (Women's and Learning Disabilities) with the Provider Collaborative to assess how we are meeting the needs of the populations, identifying pathways to provide, and developing an implementation plan.
- Embedding CCTV across Forensic Inpatient Ward.

Learning Disabilities

- Good Lives, Good Deaths focuses on improving discharge planning; implementing health and care passports, Annual Health Checks (AHCs), and strengthening links with Primary Care; as well as enhancing proactive care planning and providing health and education training for families and carers.
- All Age Pathways is a scoping exercise to explore the current Learning Disability (LD) and autism spectrum disorder (ASD) provision within the service – this needs to encompass the whole trust pathway, not just the part within LD Services.

- Contract negotiations aim to ensure we have validated data demonstrating the work undertaken to support patients and prevent deterioration in their health, learning disabilities (LD), or autism spectrum disorder (ASD) needs, while ensuring sustainable funding for services

Community Health Services, Dentistry & Primary Care

- Our People: prioritising staff well-being, enhancing the work experience, and strengthening skills and capabilities, with a commitment to delivering the People plan
- Data Development and Analytics: establishing clear, consistent demand and capacity data across all services to enhance care quality, standardisation, and clinical decision-making, leading to improved outcomes and productivity.
- Sustainability: implementing a financially sustainable workforce model across services alongside meeting Net Zero targets outlined in the Green Plan for 2030.
- Transformation: implementing planned change programmes to deliver the Community Services and Thames Valley Dental Strategy for sustainable service and collaborating with place-based partners to build a 'neighbourhood health' approach, focusing on care closer to home and prevention as key drivers for healthier communities.
- Improvement: refining and developing Research, Innovation, and Quality Improvement capabilities to deliver against directorate priorities.

Financial planning for FY26

The Trust is at the beginning of the financial planning round for FY25/26. At the time of writing, no NHS planning guidance had been issued and there is no clear timetable on when this will be available. The Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care System (ICS) had requested informal planning submissions for 29th November and a further internal ICS planning submission has been requested for the 22nd January. The informal submissions have enabled ICS partners to work together on a consistent approach and agreed assumptions to make them more meaningful. As expected, the initial submissions showed a large ICS deficit and work to close this gap will happen over the next few weeks before the first formal submission to NHS England, which is expected to be at the end of February.

The Capital plans currently assume that each provider will get its fair share of the system capital allocation, and the Trust is working on an internal plan within this allocation.
Internally, baseline budgets have been shared with directorates to resolve any issues before the Executive team are asked to approve these in March. Once the overall financial plan is finalised final budgets will be updated to reflect investments and inflation ready for these to be approved in June.

Directorates have submitted a long list of Cost Improvement Plan (CIP) plans and will be completing more detailed plans on these by the end of February.

Report history / meetings this item has been considered at and outcome
• Extended Leadership Team (2nd December 2024) - Initial high level directorate priorities. • Council of Governors (5th December 2024) – Initial high level directorate priorities. • Executive Forum (13th January 2025) – High level view of the annual plan including refined directorate priorities (summary and detailed plans).

Recommendation(s)
The Board of Directors are asked to note the update on planning and provide any feedback ahead of the FY25/26 annual plan review at the Board of Directors meeting in March 2025.

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☑
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☑

Link to CQC domain – where applicable				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	Yes/No	
Legal and regulatory	Yes/No	

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	10(a)
Report title	Integrated Performance Report (IPR)
Executive lead(s)	Amelie Bages, Executive Director of Strategy and Partnerships
Report author(s)	Vicki Bull, Head of Business Services
Action this paper	☐ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the Board	The Integrated Performance Report (IPR) report provides the Board of Directors with an integrated view of the strategic domains of Operational Performance, Quality and People
For disclosure or confidential	Disclosure

Executive summary

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

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

The IPR underwent a six-monthly review in November 2024 and as a result, a set of improvements, where possible, to be incorporated from the following financial year were identified (e.g. expansion of Community Health Service, Primary Care & Dentistry clinical metrics, inclusion of clinical metrics for Forensics and Learning Disabilities, better visibility of Integrated Care Board performance and Place contributions to it etc.). The report will keep being updated to reflect agreed changes over its next iterations.

Report history / meetings this item has been considered at and outcome

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

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

In November 2024 locally reported total bed day usage was 267 days (156 inappropriate OAP bed days in Buckinghamshire (149 adult acute bed days and 7 older adult acute), and 111 inappropriate OAP adult acute bed days in Oxfordshire) – an increase of 53 bed days compared to October 2024. The directorates continue their focus on reducing the use of OAPs to improve the quality of patient care and improve cost control.

NHS England were reviewing the NHS Oversight and Assessment Framework with the view to publish and implement the new framework in 2024, however, to date the Framework has not yet been made available. As a result of the review, the currently reported NOF metrics to the Board may change accordingly.

(2) Clinical performance

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

Service area	Total number of indicators	Total number of indicators reported in January 2025 (Nov 24 data)	Total number of indicators with reporting mechanism in development	Comments
Child and Adolescent Mental Health Services (CAMHS)	13	12	1	• Access to mental health support for children and young people across Buckinghamshire, Oxfordshire and Bath and North-East Somerset, Swindon and Wiltshire services on a continuous upward trend. • Oxfordshire's CAMHS service continue toward achieving the national average of 61% for 4-week wait with 52.98% children and young people seen within 4 weeks (one meaningful contact within episode) in November 2024. • Buckinghamshire, Oxfordshire and Bath and North-East Somerset, Swindon and Wiltshire CYP Eating Disorders services exceeded the national target of 95% with 100% of urgent referrals seen within 7 days. • Whilst Buckinghamshire CYP Eating Disorders service met the national target of 95% of routine referrals to be seen within 28 days, Oxfordshire's and Bath and North-East Somerset, Swindon and Wiltshire services are working towards achieving the target with

				having seen 93.10% and 71.43% of routine referrals seen within the timeframe accordingly.
Talking Therapies	20	16*	0	• Talking Therapies services across both Oxfordshire and Buckinghamshire continue to perform generally well with the exception of Buckinghamshire's service reporting a decline in reliable improvement rate for those who completed a course of treatment with 62.06% patients reporting reliable improvement versus the target of 66% in November 2024. *Four metrics are reported on a quarterly basis and will be next reported in February's report.
Adult and Older Adult Community Mental Health Services	15	14	1	• Access to perinatal mental health services in Oxfordshire remains below target in November 2024. • All other Adult and Older Adult community mental health services metrics have achieved set targets or exceeded national averages in November 2024.
Mental Health Urgent Care Services	8	8	0	• Mental Health Crisis service in Buckinghamshire saw 56.92% patients within 24 hours versus the national average of 57% in November 2024. • All other measures across both Oxfordshire's and Buckinghamshire's Urgent Mental Health Services have exceeded national averages in November 2024. The Board is asked to note improvement in Oxfordshire's Mental Health Crisis service response time to very urgent referrals following a period of 12 months performing under the national average – 76% of patients were seen within the 4-hour timeframe (median wait – 3 hours) in November 2024. Such change in performance is attributed to improved data recording and wider understanding of the urgent care standards. To note: not all activity undertaken in the urgent care pathway is represented in the Mental Health Urgent Care

				waiting standards reported in the IPR due to specific national definitions.
Adult and Older Adult acute/inpatient services	30	30	0	• Acute admissions with no prior contact with community services in year prior to inpatient admissions remain higher than the national average across both Oxfordshire and Buckinghamshire inpatient services in November 2024. • More than 80% of those discharged from mental health wards were followed up within 72 hours of discharges across both Oxfordshire and Buckinghamshire in November 2024. • Rate per 100,000 population in adult acute and older acute beds with a length of stay over 60 and 90 days are lower than the set targets in both Oxfordshire and Buckinghamshire inpatient units. There is a selection of indicators that are being baselined with a view to either set a target or a trajectory after few months of monitoring within this IPR sub-section.
Community Health Service, Primary Care & Dentistry	7	5	2	• 90.95% of patients attending Minor Injury Units in November 2024 were seen within 4 hours (national target – 78%). • 74.64% of 2-hour Urgent Community Response referrals referral seen within 2 hours (target – 70%) in November 2024. • Nationally reported virtual ward occupancy level in November 2024 was 102.65%. It is possible for virtual ward occupancy to exceed 100% due to the national reporting rules (it is reported as a snapshot of capacity and caseload for the day before, so in some instances, mostly related to staff availability, capacity is low, but the caseload is high). The Trust has fed back this issue to the Integrated Care Board and flagged to the national team few months ago, but as of yet no changes to the reporting rules have been made.

(3) Delivery of Strategic Objectives

Staff turnover for Black, Asian and Minority Ethnic staff is 11.96%, which is the first time it is the same as White Staff turnover. This improvement is being supported by work from the retention team who set up workstreams to reduce turnover in identified hotspot areas. Black, Asian and Minority Ethnic staff turnover has been identified as a priority area with a particular focus on band 3 males, clerical workers, health care support workers and staff nurses.

The Trust has 40 strategic metrics to track performance against set strategic objectives and ambitions. Strategic Dashboard inclusive of all strategic metrics was be reported to the Board expected in November 2024. Next reporting – annual position – is expected to take place in May 2025 to align with the Annual plan review.

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

Strategic objective this report supports	**Select**
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☑
Sustainability - Make the best use of our resources and protect the environment	☐
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	**☑ BAF**	**☑ TRR**
Equality, diversity and inclusion	Yes	
Legal and regulatory	Yes	

Integrated Performance Report (IPR): January 2025

November 2024 data unless stated otherwise

Quality

People

Sustainability

Research

Oxford Health NHS Foundation Trust

Contents

Oxford Health NHS Foundation Trust

Guide to the Integrated Performance Report

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

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

The Key Performance Indicators included in the IPR are divided into two categories - strategic and clinical metrics.

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

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

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

Types of metrics:

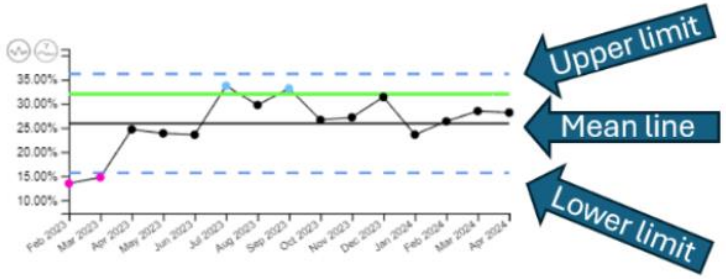
- National Measure – defined NHS Long Term plan metric with a national target or an agreed system plan
- National Objective – metric linked to NHS Long Term Plan with no agreed national target
- NOF – National Oversight Framework -NHS England's approach to oversight of Integrated Care Boards and Trusts. The metrics are under review and subject to change.

Guide to the Integrated Performance Report

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

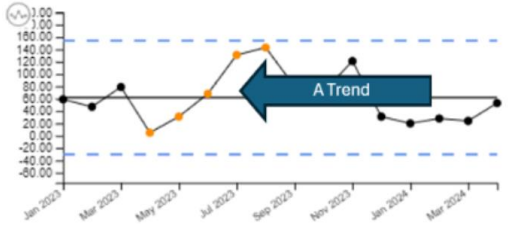
Statistical Process Charts (SPC) is an analytical technique that plots data over time. Such charts help identify variation i.e. what is 'different' and what is the 'norm'. Using these charts can help understand where focus might be needed to make a difference.

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

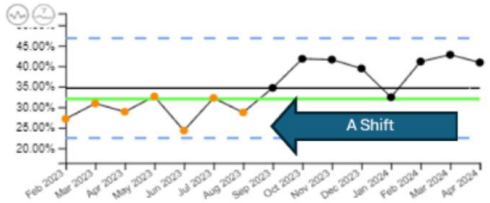


Green is the metric target line – only added to those graphs where target is applicable. Data points highlighted in pink are noted to be statistically different from the rest of the points (outside of the upper and lower control limits).

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



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



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

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

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

Section 1.1
Clinical performance (National Mental Health Standards)

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

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Child and Adolescent Mental Health Services (CAMHS)					
National measure	Improve access to mental health support for children and young people - Buckinghamshire	5878 per month	Nov-24	6140	↑	↑
National measure	Improve access to mental health support for children and young people - Oxfordshire	6794 per month	Nov-24	7700	↑	↑
National measure	Improve access to mental health support for children and young people - Bath & North East Somerset, Swindon and Wiltshire	TBC	Nov-24	6171	↑	↑
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Buckinghamshire	61% National average	Nov-24	63.35%	↓	↑
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Oxfordshire	61% National average	Nov-24	52.98%	↑	↑
National Objective Strategic Metric - Quality	Four (4) week wait (interim metric - one meaningful contact within episode) - Bath & North East Somerset, Swindon and Wiltshire	61% National average	Nov-24	72.21%	↓	↑
National Objective	Waiting time standard for a meaningful contact & outcome measure	*In development (estimated completion - FY25. Status: technical development initiated; operational action needed to record in Electronic Patient Records)*				

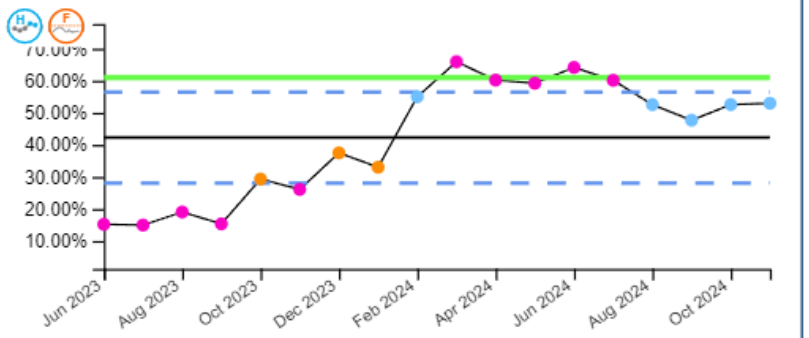
Mental Health Services – Child and Adolescent Mental Health Services – Summary dashboard (2/2)

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Child and Adolescent Mental Health Services (CAMHS)					
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position)	95%	Nov-24	95%	↑	↑
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	95%	Nov-24	93.10%	↑	↑
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Bath & North East Somerset, Swindon and Wiltshire (rolling 3 months position)	95%	Nov-24	71.43%	↓	↑
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Buckinghamshire (rolling 3 months position)	95%	Nov-24	100%	↑	↑
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire (rolling 3 months position)	95%	Nov-24	100%	→	↑
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Bath & North East Somerset, Swindon and Wiltshire (rolling 3 months position)	95%	Nov-24	100%	→	↑

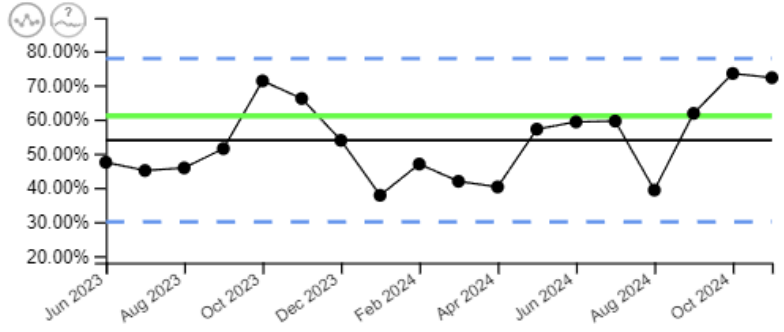
Mental Health Services – Child and Adolescent Mental Health Services

Children and Young People 4 Week Wait Pathway Interim Metric – Oxfordshire



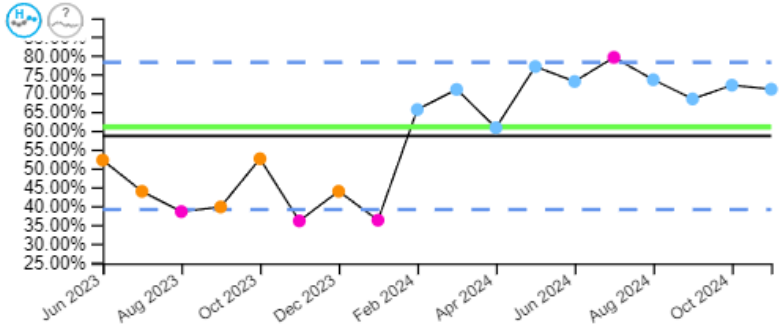
National Average: 61%	Month Year	Value	Numerator	Denominator	Median (days)
	Nov 2024	52.98 %	160	302	29

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



National Average: 61%	Month Year	Value	Numerator	Denominator	Median (days)
	Nov 2024	72.21 %	278	385	15

Children and Young People 4 Week Wait Pathway Interim Metric – Buckinghamshire



National Average: 61%	Month Year	Value	Numerator	Denominator	Median (days)
	Nov 2024	65.35 %	232	355	22

Summary

This is an interim metric, which measures one meaningful contact* within a care episode within the four (4) week period. Following on from the national 4 week wait pilots and the clinically led review of mental health standards, new non-urgent waiting time standards are being introduced for Child and Adolescent Mental Health Services (CAMHS). The Trust will be working to align existing models of care where possible to the new standards during this financial year, reporting will be updated in line with national changes to include the full metric (one contact, SNOMED** intervention or care plan, and baseline outcome measure recorded within the CAMHS pathway within the four (4) week period). There are currently no national targets set and the Trust is baselining against the national average position. Buckinghamshire CAMHS and Bath & North East Somerset, Swindon and Wiltshire CAMHS achieved national average in November 2024 whilst Oxfordshire CAMHS are working towards achieving the national average.

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

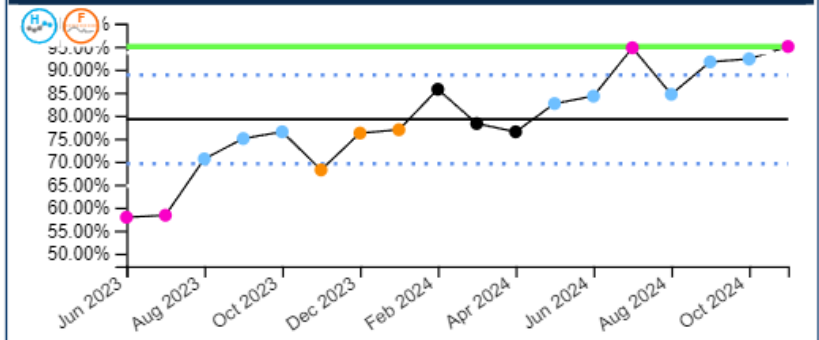
**SNOMED is a structured clinical vocabulary for use in an electronic health record.

Actions

- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Reporting will be updated in line with national full metric during this financial year.

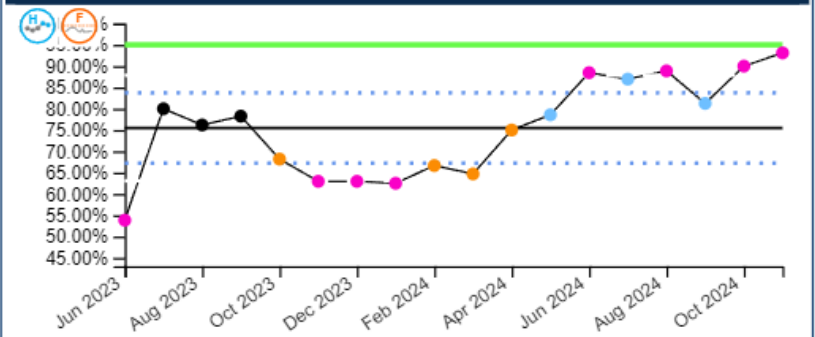
Mental Health Services – Child and Adolescent Mental Health Services

Children & Young People with suspected Eating Disorder Routine cases - Buckinghamshire (reported as rolling 3 months position in line with national approach)



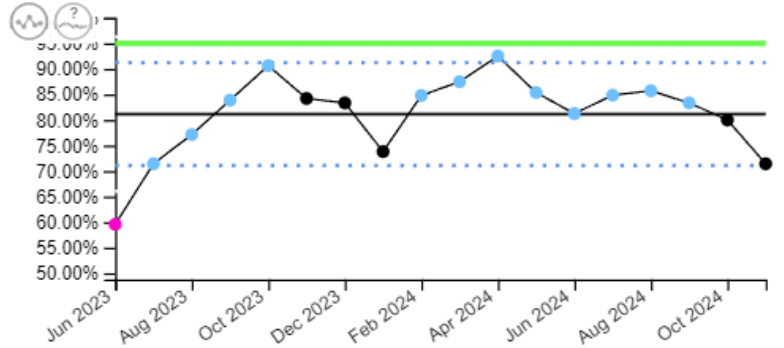
Target:	Month Year	Value	Numerator	Denominator	Median (days)
95%	Nov 2024	95.00 %	19	20	15

Children & Young People with suspected Eating Disorder Routine cases - Oxfordshire (reported as rolling 3 months position in line with national approach)



Target:	Month Year	Value	Numerator	Denominator	Median (days)
95%	Nov 2024	93.10 %	27	29	7

Children & Young People with suspected Eating Disorder Routine cases - Bath and North East Somerset, Swindon and Wiltshire (reported as rolling 3 months position in line with national approach)



Target:	Month Year	Value	Numerator	Denominator	Median (days)
95%	Nov 2024	71.43 %	15	21	19

Summary

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

The national target for routine Eating Disorders to be seen within 28 days is 95%. Buckinghamshire's CYP Eating Disorders service has achieved the national target whilst both Oxfordshire and Bath & North East Somerset, Swindon and Wiltshire CYP Eating Disorders services are working towards achieving it. Two (2) out of eight (8) breaches were attributed to patient choice – all first appointments were offered within 28 days. One (1) breach is being investigated for data quality accuracy and five (5) breaches were due to first appointment being offered outside of the 28-day timeframe.

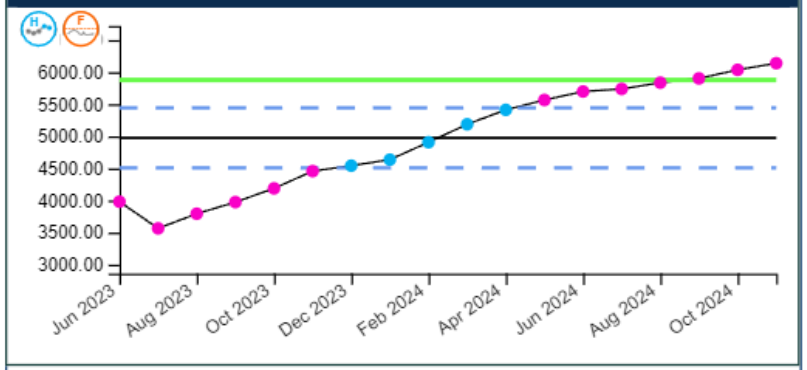
**SNOMED is a structured clinical vocabulary for use in an electronic health record.*

Actions

- Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement;
- Every patient record indicating a breach is investigated to ensure appropriate intervention has been recorded.

Metrics meeting target/target to be confirmed:

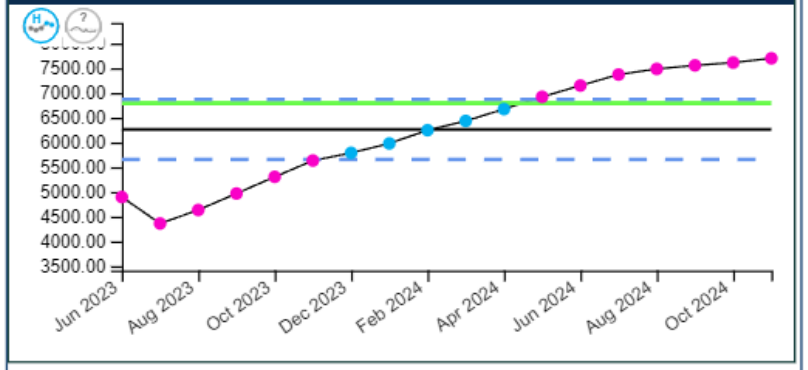
Improve access to mental health support for children and young people – Buckinghamshire



Target (Bucks sub ICB): average of **5878** a month

Month Year	Value
Nov 2024	6,140

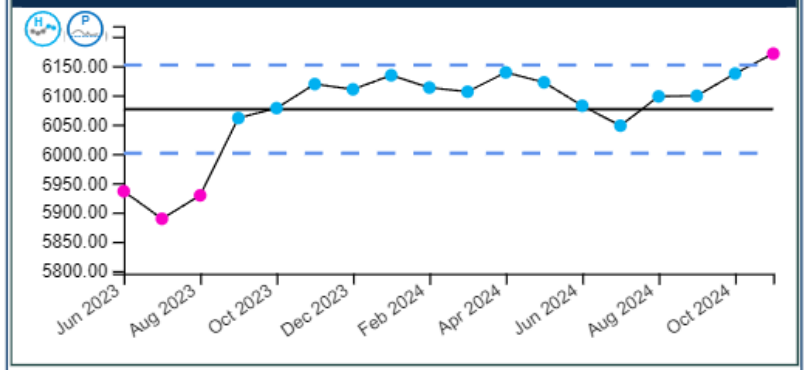
Improve access to mental health support for children and young people – Oxfordshire



Target (Oxon sub ICB): average of **6794** a month

Month Year	Value
Nov 2024	7,700

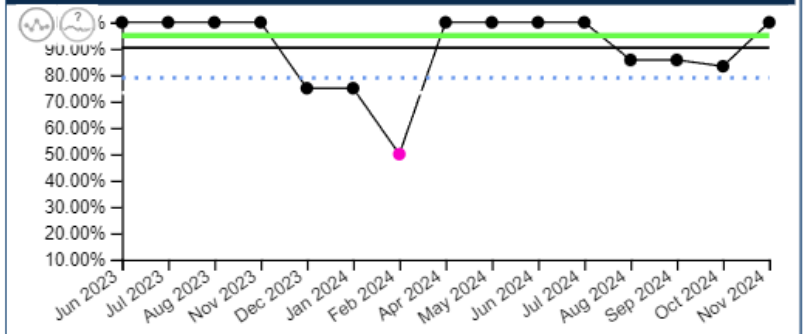
Improve access to mental health support for children and young people – Bath and North East Somerset, Swindon and Wiltshire



Target (BSW): average of **tbc** a month

Month Year	Value
Nov 2024	6,171

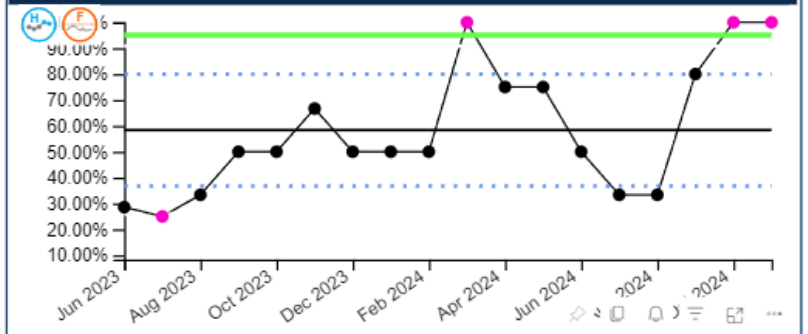
Children & Young People with suspected Eating Disorder Urgent cases – Buckinghamshire (reported as rolling 3 months position in line with national approach)



Target: 95%

Month Year	Value	Numerator	Denominator	Median (days)
Nov 2024	100.00 %	4	4	3

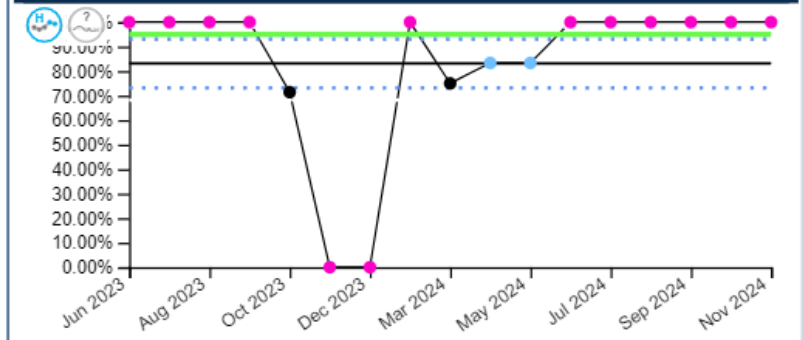
Children & Young People with suspected Eating Disorder Urgent cases – Oxfordshire (reported as rolling 3 months position in line with national approach)



Target: 95%

Month Year	Value	Numerator	Denominator	Median (days)
Nov 2024	100.00 %	7	7	3

Children & Young People with suspected Eating Disorder Urgent cases – Bath and North East Somerset, Swindon and Wiltshire (reported as rolling 3 months position in line with national approach)



Target: 95%

Month Year	Value	Numerator	Denominator	Median (days)
Nov 2024	100.00 %	5	5	5

Mental Health Services – Talking Therapies – Summary dashboard (1/2)

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

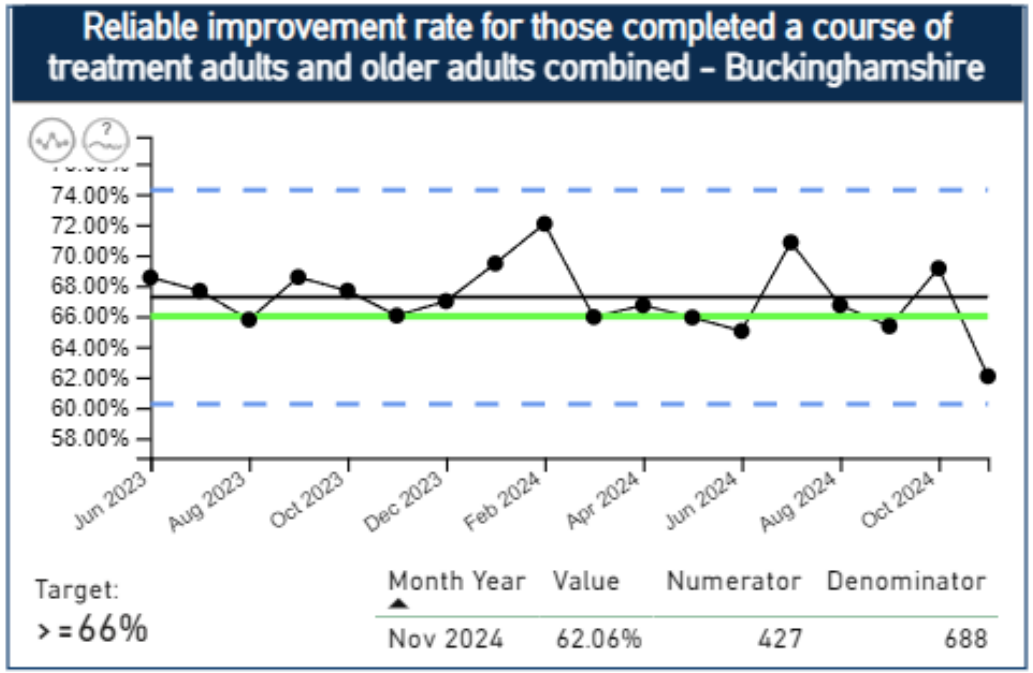
Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Talking Therapies					
National Objective	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Buckinghamshire	597	Nov-24	688	↑	↑
National Objective	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	617	Nov-24	637	↓	↑
National Objective	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire	Baselining	Nov-24	18.02%	↑	↑
National Objective	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	Baselining	Nov-24	8.63%	↑	↑
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	66%	Nov-24	62.06%	↓	↑
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	65%	Nov-24	67.975	↓	↑
National measure	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	75%	Nov-24	98.69%	↑	↑
National measure	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	75%	Nov-24	99.69%	↓	↑
National measure	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	95%	Nov-24	100%	→	↑
National measure	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	95%	Nov-24	100%	→	↑
National measure	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Buckinghamshire	10%	Nov-24	4.28%	↑	↓
National measure	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	10%	Nov-24	6.66%	↑	↓

Mental Health Services – Talking Therapies – Summary dashboard (2/2)

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Talking Therapies					
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	48%	Nov-24	48.56%	↓	↑
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	46%	Nov-24	51.39%	↑	↑
National Objective	Meet and maintain at least 50% Talking Therapies recovery rate (with improvement to 52% by end of Financial Year 24-25) - Buckinghamshire	50%	Nov-24	52.46%	↓	↑
National Objective	Meet and maintain at least 50% Talking Therapies recovery rate (with improvement to 52% by end of Financial Year 24-25) - Oxfordshire	50%	Nov-24	56.63%	↑	↑
National Objective	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Buckinghamshire (recorded monthly, reportable quarterly)	50%	*Data is recorded monthly but reported to Board on a quarterly basis. Next quarter (Q3) reporting to Board will take place in February 2025*			
National Objective	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire (recorded monthly, reportable quarterly)	50%				
National Objective	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Buckinghamshire (recorded monthly, reportable quarterly)	50%				
National Objective	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire (recorded monthly, reportable quarterly)	50%				

Mental Health Services – Talking Therapies



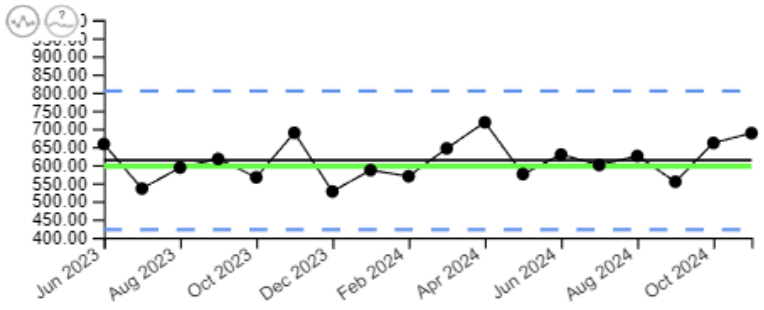
Summary & actions

Reliable improvement rate demonstrates significant improvement in patient's condition following a course of treatment, which is measured by the difference between their first and last scores on questionnaires tailored to their specific condition. Buckinghamshire's Talking Therapies service has not met the target of 66% in November 2024 with 62.06% adults and adults showing reliable improvement after completing a course of treatment. Whilst some fluctuations in performance are expected, the Service has established a focused workstream to analyse underperformance with the view of increasing reliable improvement.

Mental Health Services – Talking Therapies

Metrics meeting target or being baselined:

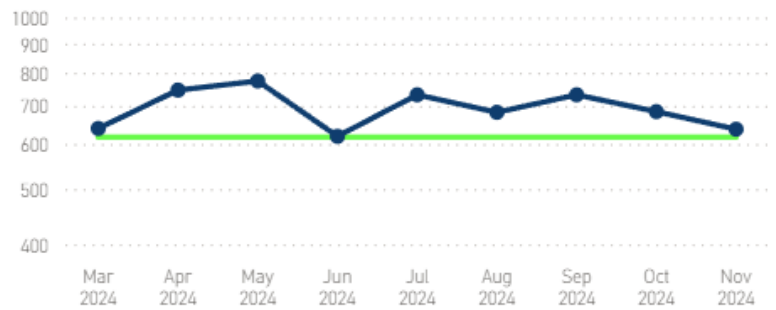
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Buckinghamshire



Target:
>=597 in month

Month Year	Value
Nov 2024	688

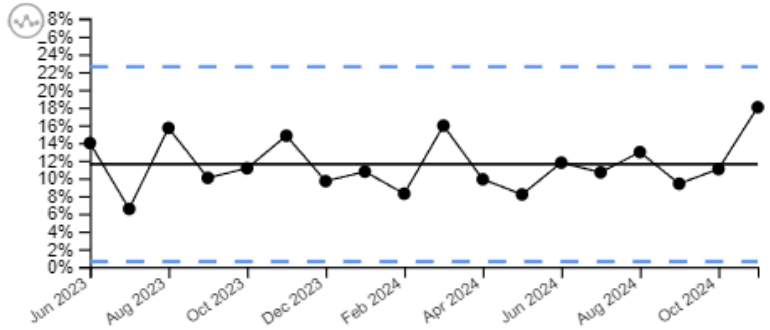
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies - Oxfordshire



Target:
>=617 in month

Month Year	Value
Nov 2024	637

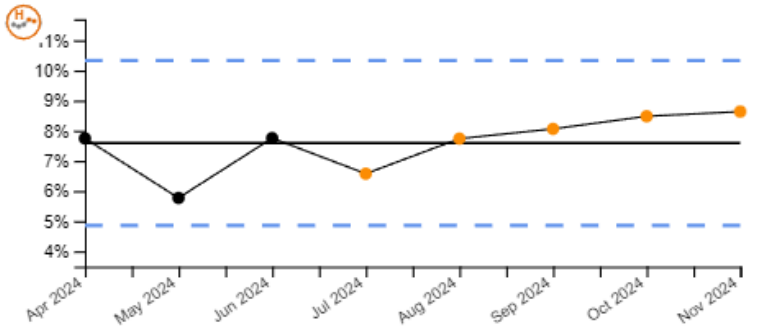
% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire



Target:
baseline

Month Year	Value
Nov 2024	18.02%

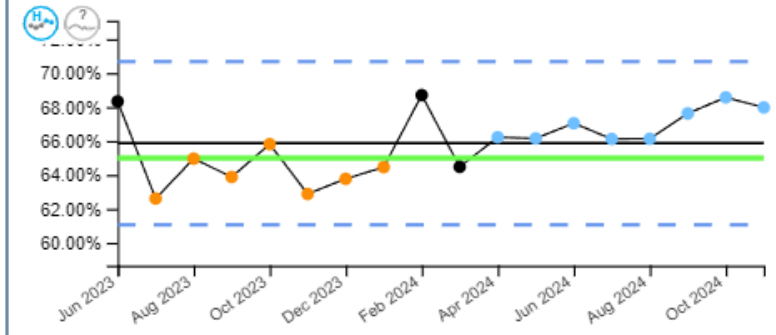
% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire



Target:
baseline

Nov 2024	8.63%

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



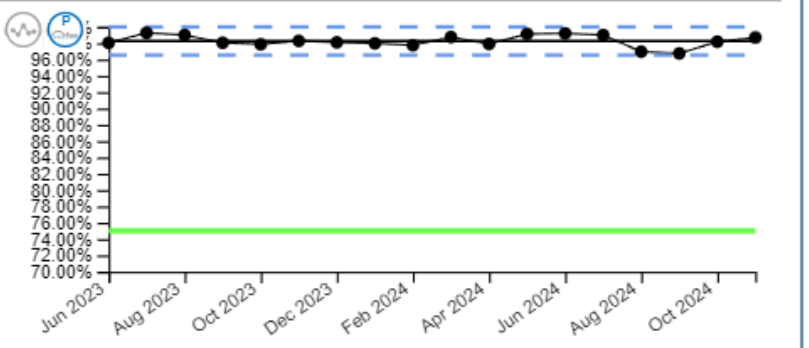
Target:
>=65%

Month Year	Value	Numerator	Denominator
Nov 2024	67.97%	433	637

Mental Health Services – Talking Therapies

Metrics meeting target or being baselined:

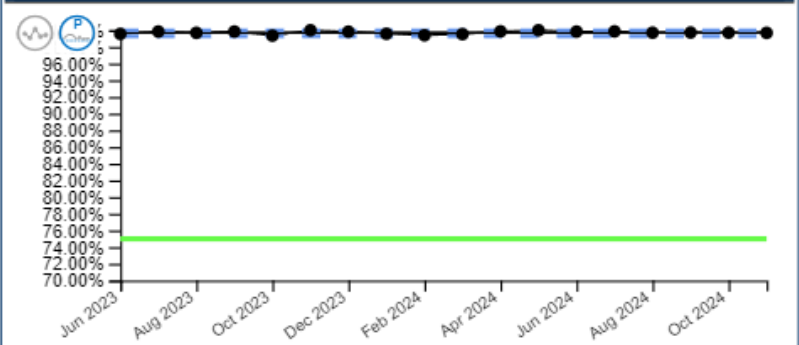
% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire



Target: >=75%

Month Year	Value	Numerator	Denominator
Nov 2024	98.69%	679	688

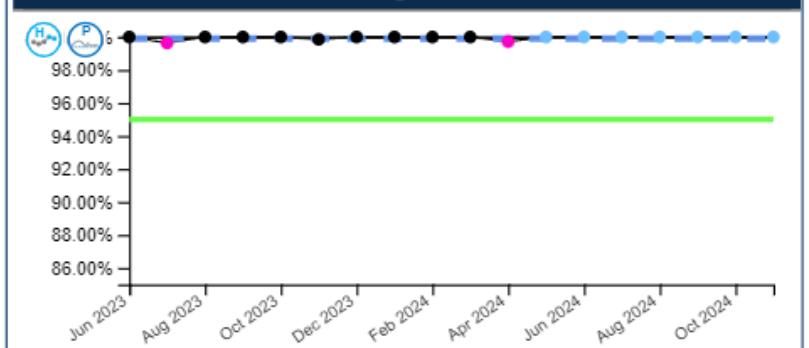
% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire



Target: >=75%

Month Year	Value	Numerator	Denominator
Nov 2024	99.69%	635	637

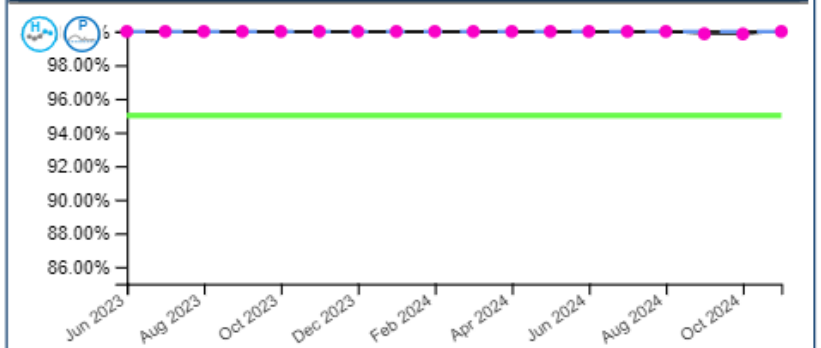
% of people receiving first appointment within 18 weeks of referral - Buckinghamshire



Target: >=95%

Month Year	Value	Numerator	Denominator
Nov 2024	100.00%	688	688

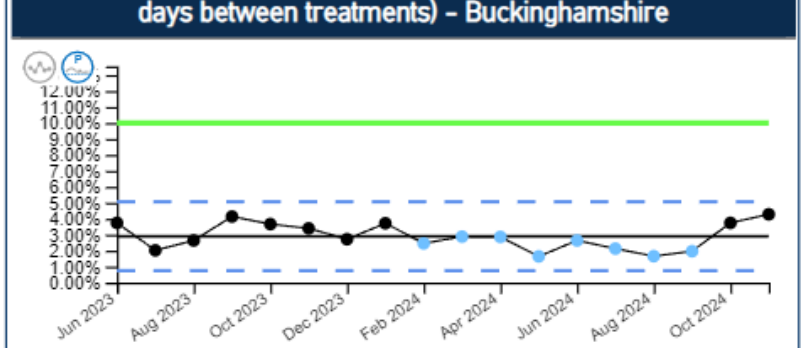
% of people receiving first appointment within 18 weeks of referral - Oxfordshire



Target: >=95%

Month Year	Value	Numerator	Denominator
Nov 2024	100.00%	637	637

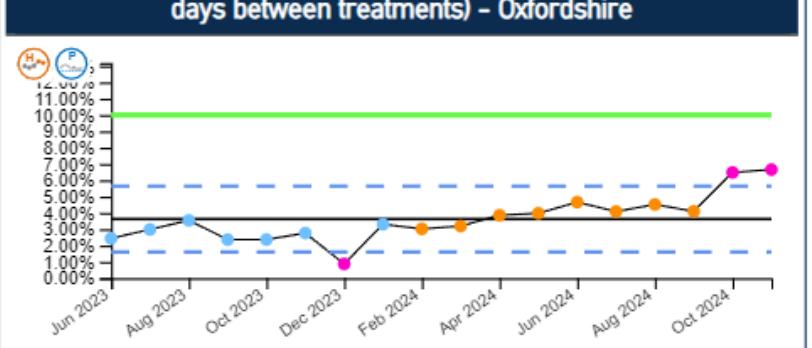
Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting no more than 90 days between treatments) - Buckinghamshire



Target: <=10%

Month Year	Value	Numerator	Denominator
Nov 2024	4.28%	31	724

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



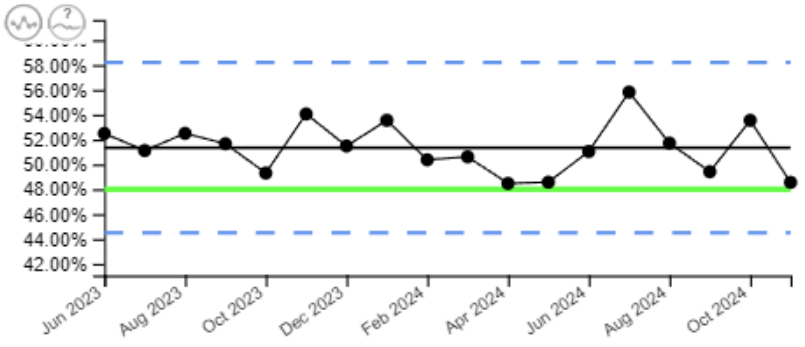
Target: <=10%

Month Year	Value	Numerator	Denominator
Nov 2024	6.66%	51	766

Mental Health Services – Talking Therapies

Metrics meeting target or being baselined:

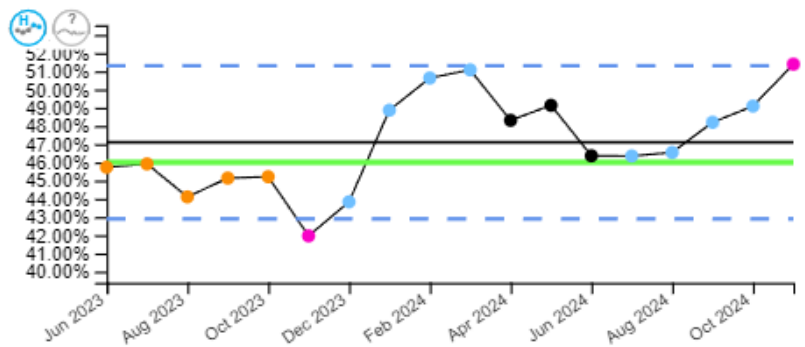
Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire



Target:
>=48%

Month Year	Value	Numerator	Denominator
Nov 2024	48.56%	286	589

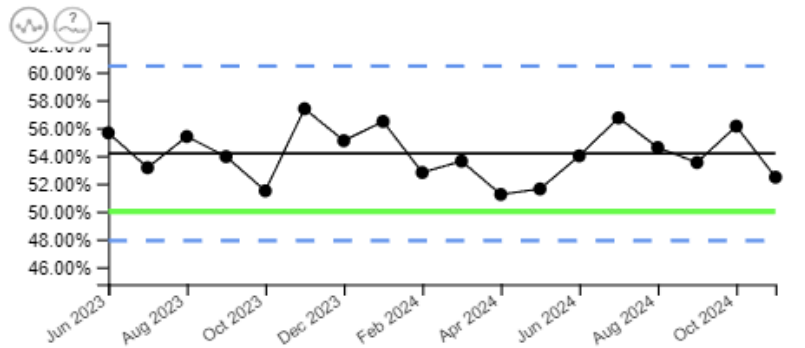
Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire



Target:
>=46%

Month Year	Value	Numerator	Denominator
Nov 2024	51.39%	314	611

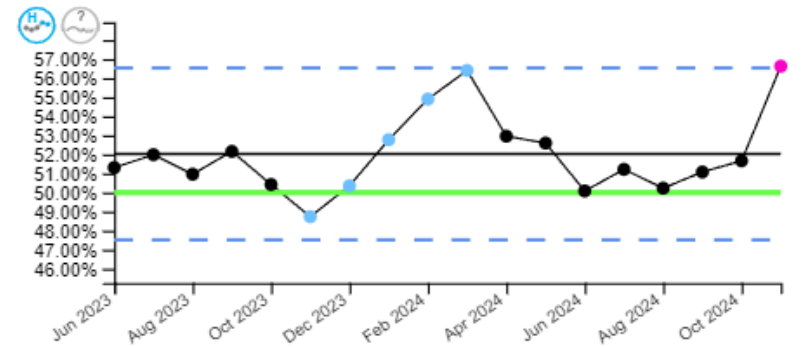
Meet and maintain Talking Therapies standards 50% Talking Thearpies recovery rate - Buckinghamshire



Target:
>=50%

Month Year	Value	Numerator	Denominator
Nov 2024	52.46%	309	589

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



Target:
>=50%

Month Year	Value	Numerator	Denominator
Nov 2024	56.63%	346	611

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

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Adult and Older Adult Community					
National measure	Improve access for Adults and Older Adults to support by community mental health services - Buckinghamshire	4568 per month	Nov-24	4631	↑	↑
National measure	Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire	6737 per month	Nov-24	7723	↑	↑
National Objective	4 week wait (28 days) standard (interim metric - two contacts within episode) - Buckinghamshire	32% National average	Nov-24	46.90%	↓	↑
National Objective	4 week wait (28 days) standard (interim metric - two contacts within episode)- Oxfordshire	32% National average	Nov-24	67.64%	↑	↑
National Objective Strategic Metric - Quality	Waiting time standard, care plan, outcome measure	*In development (estimated completion - FY25. Status: technical development initiated; waiting for national team to release code)*				
National measure	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Buckinghamshire)	60%	Q2	51%	↓	↑
National measure	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Oxfordshire)	60%	Q2	31%	→	↑

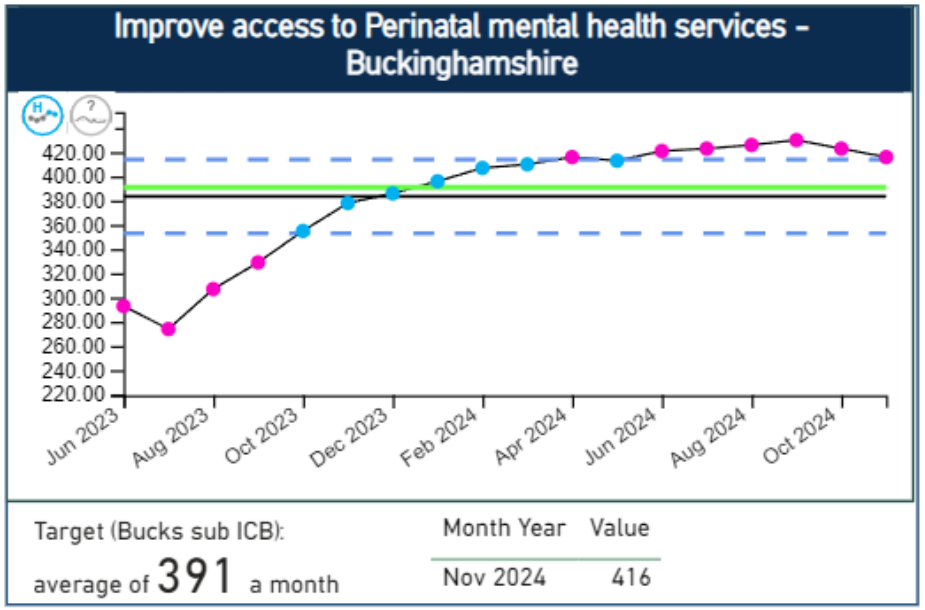
Mental Health Services – Adult and Older Adult community – Summary dashboard

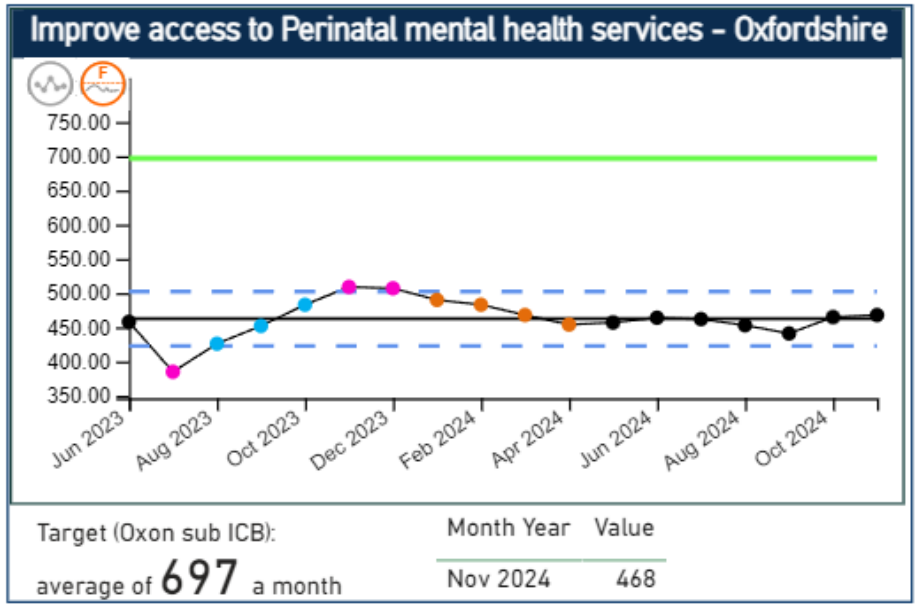
Narrative provided only for metrics under target or national average (value coloured in red below), narrative not provided for system measures:

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Adult and Older Adult Community					
National measure	Improve access to perinatal mental health services - Buckinghamshire	391 per month	Nov-24	416	↓	↑
National measure	Improve access to perinatal mental health services - Oxfordshire	697 per month	Nov-24	468	↑	↑
National measure	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire	60%	Nov-24	100%	↑	↑
National measure	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	60%	Nov-24	100%	↑	↑
National measure	Number of people accessing Individual Placement Support (IPS) - Buckinghamshire	466 year end	Nov-24	216	↑	↑
National measure	Number of people accessing Individual Placement Support (IPS) - Oxfordshire	598 year end	Nov-24	272	↑	↑
National measure	Recover dementia diagnosis rate (nationally reported system measure - Buckinghamshire)	63-64%	Oct-24	59.14%	↓	↑
National measure	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	63-64%	Oct-24	63.29%	↑	↑

Mental Health Services – Adult & Older Adult Community

Metrics not meeting target:





Summary

Above metrics measure how many women access specialist perinatal mental health services in Buckinghamshire and Oxfordshire in any given month. Perinatal mental health service provide support during pregnancy and up to one year after childbirth for women experiencing moderate to severe mental health issues. In Buckinghamshire, 416 women accessed perinatal mental health services in the month of November 2024, which is above the target of average of 391 per month. In Oxfordshire, 468 women accessed perinatal mental health services in the month of November 2024, which is below the target of average of 697 per month.

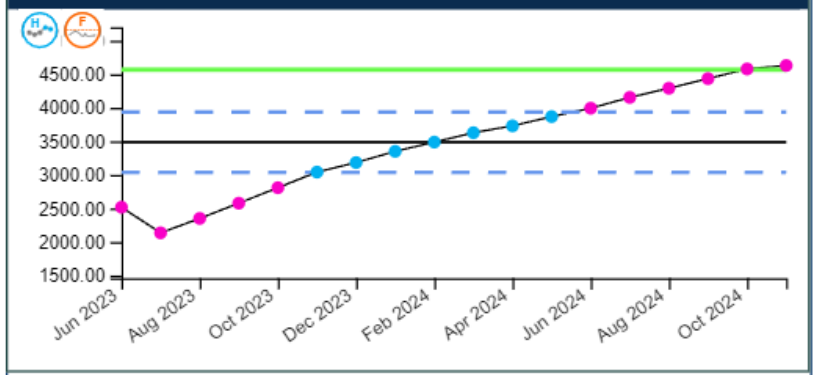
Actions

- Oxfordshire perinatal mental health service continue investigating whether this could be a positive impact of Community Mental Health Hubs meaning that people are seen earlier than a specialist intervention becomes necessary or if lower access rate is impacted by other factors.

Mental Health Services – Adult & Older Adult Community

Metrics meeting target or national average & System metrics:

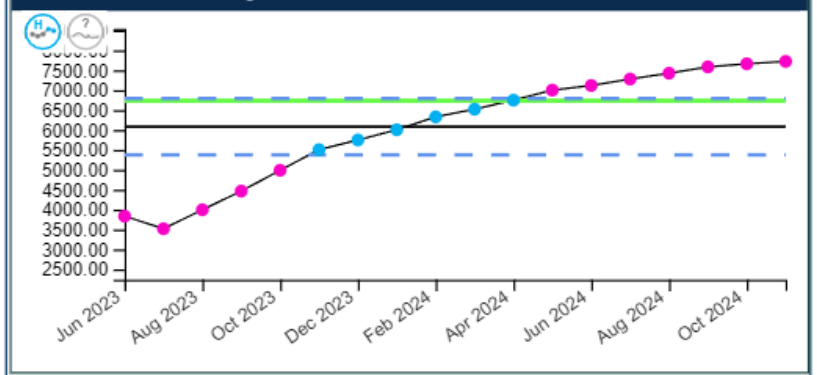
Improve access for Adults and Older Adults to support by community mental health services - Buckinghamshire



Target (Bucks sub ICB):
average of **4568** a month

Month Year	Value
Nov 2024	4,631

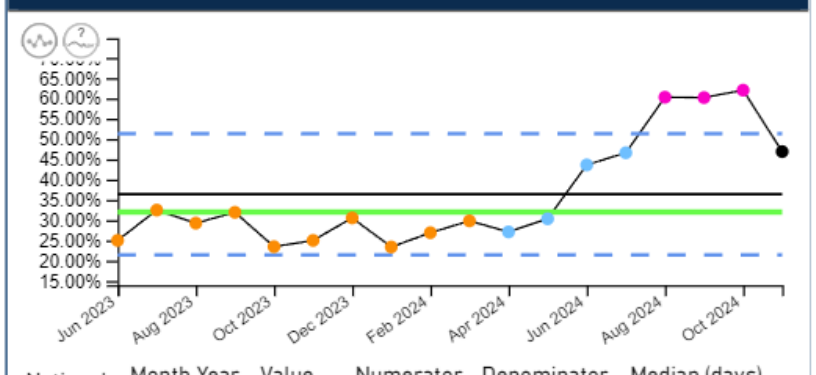
Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire



Target (Bucks sub ICB):
average of **6737** a month

Month Year	Value
Nov 2024	7,723

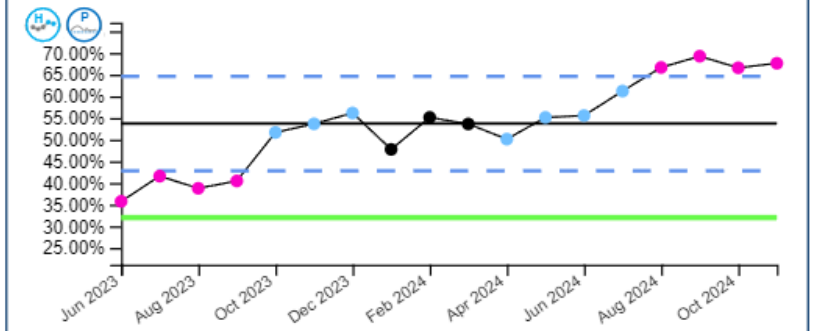
Community Mental Health 4 Week Wait Pathway interim metric - Buckinghamshire



National Average: >=32%

Month Year	Value	Numerator	Denominator	Median (days)
Nov 2024	46.90 %	106	226	36

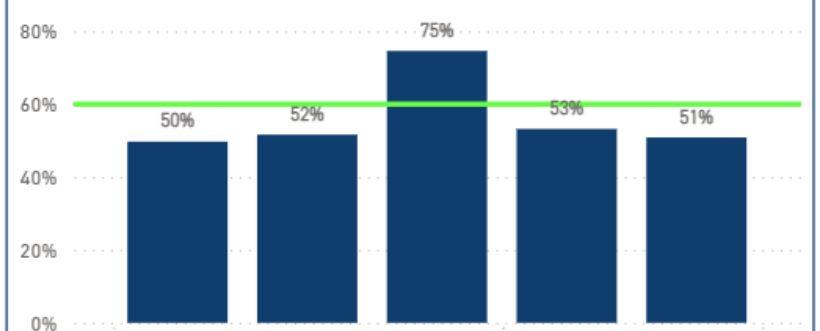
Community Mental Health 4 Week Wait Pathway interim metric - Oxfordshire



National Average: >=32%

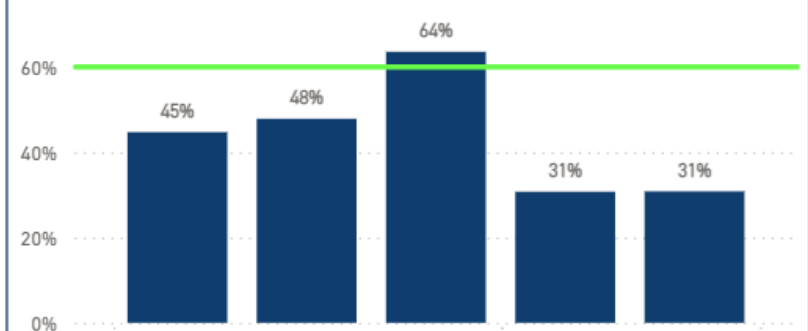
Month Year	Value	Numerator	Denominator	Median (days)
Nov 2024	67.64 %	301	445	21

Deliver annual physical healthcheck to people - Buckinghamshire (nationally reported system measure)



Target: >=60%

Deliver annual physical healthcheck to people - Oxfordshire (nationally reported system measure)

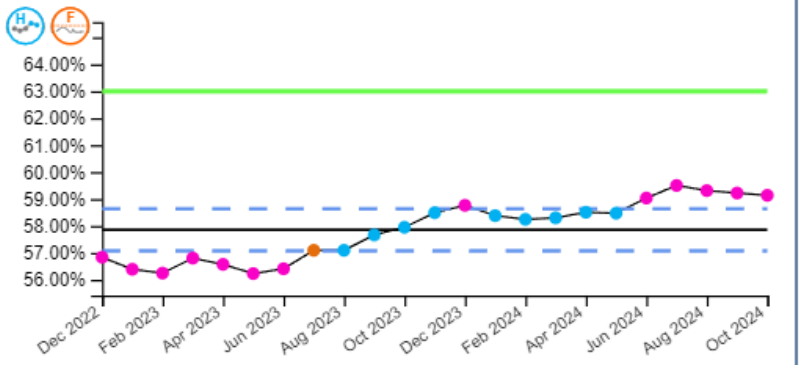


Target: >=60%

Mental Health Services – Adult & Older Adult Community

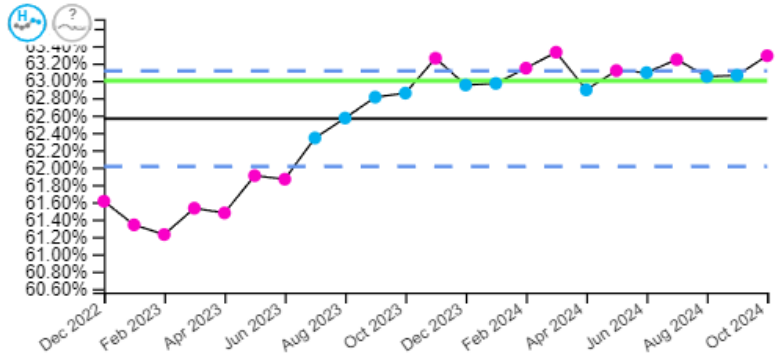
Metrics meeting target or national average & System metrics:

Recover the dementia diagnosis rate to 63-64%- Buckinghamshire (nationally reported system measure)



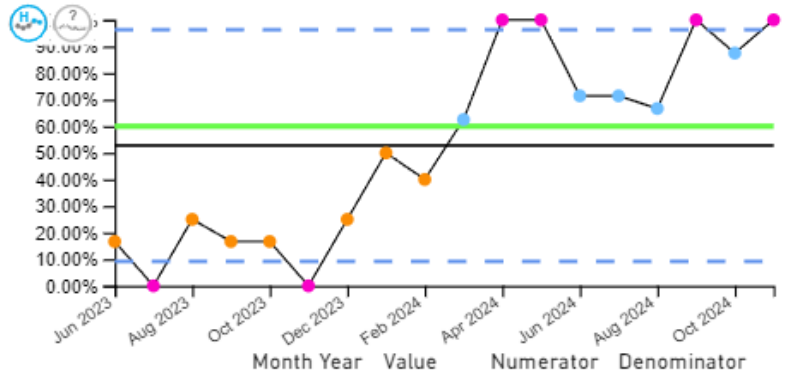
Target:
>=63%

Recover the dementia diagnosis rate to 63-64% - Oxfordshire (nationally reported system measure)



Target:
>=63%

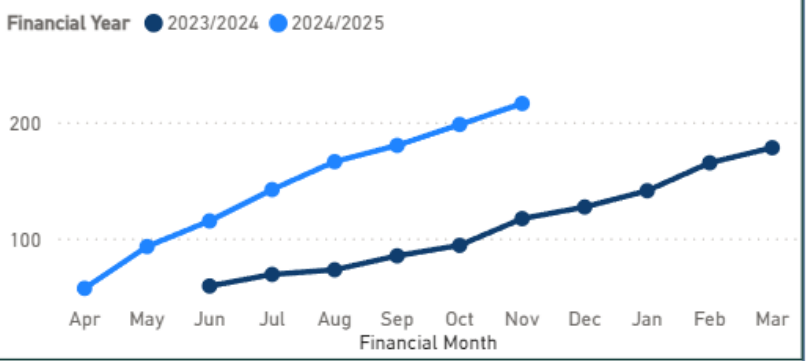
Early Intervention in Psychosis Waits (% of people with first episode of psychosis treated within 2 weeks of referral) - Buckinghamshire



Target:
>=60%

Month Year	Value	Numerator	Denominator
Nov 2024	100.00 %	3	3

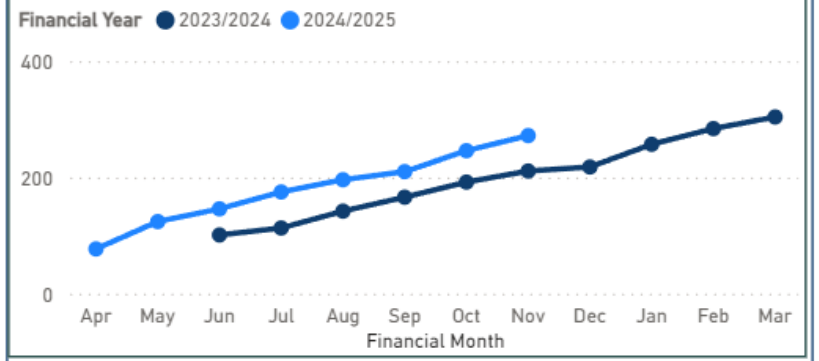
Number of people accessing Individual Placement Support (IPS) - Buckinghamshire



Target (Bucks sub ICB):
466 year end

Month Year	Value
Nov 2024	216

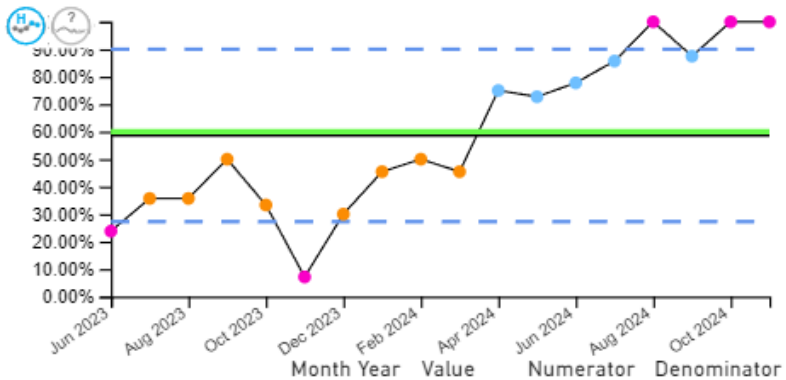
Number of people accessing Individual Placement Support (IPS) - Oxfordshire



Target (Oxon sub ICB):
598 year end

Month Year	Value
Nov 2024	272

Early Intervention in Psychosis Waits (% of people with first episode of psychosis treated within 2 weeks of referral) - Oxfordshire



>=60%

Month Year	Value	Numerator	Denominator
Nov 2024	100.00 %	16	16

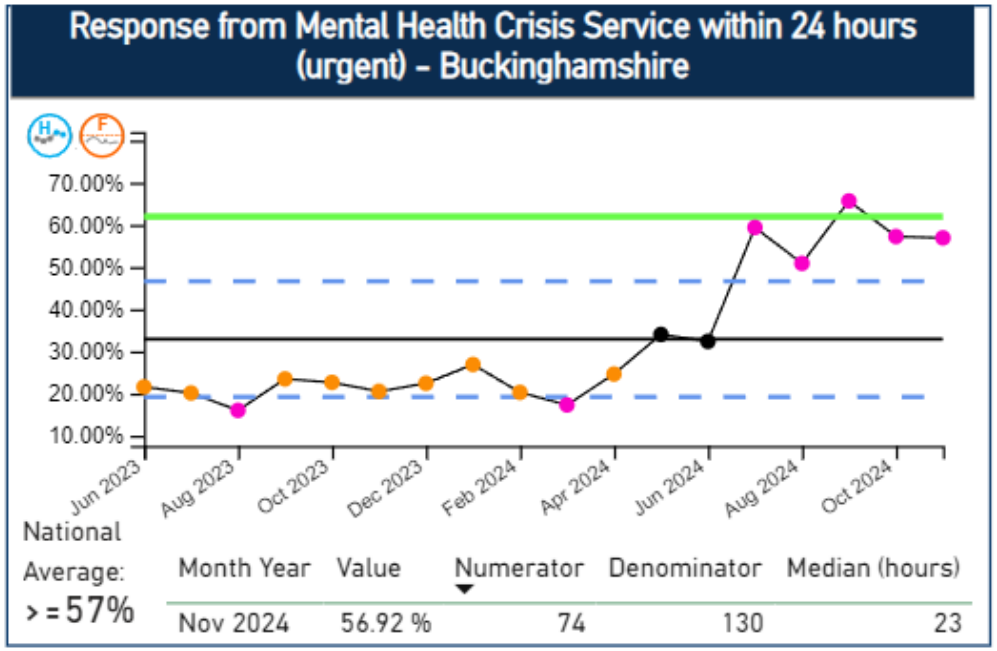
Mental Health Services – Urgent Care – Summary dashboard

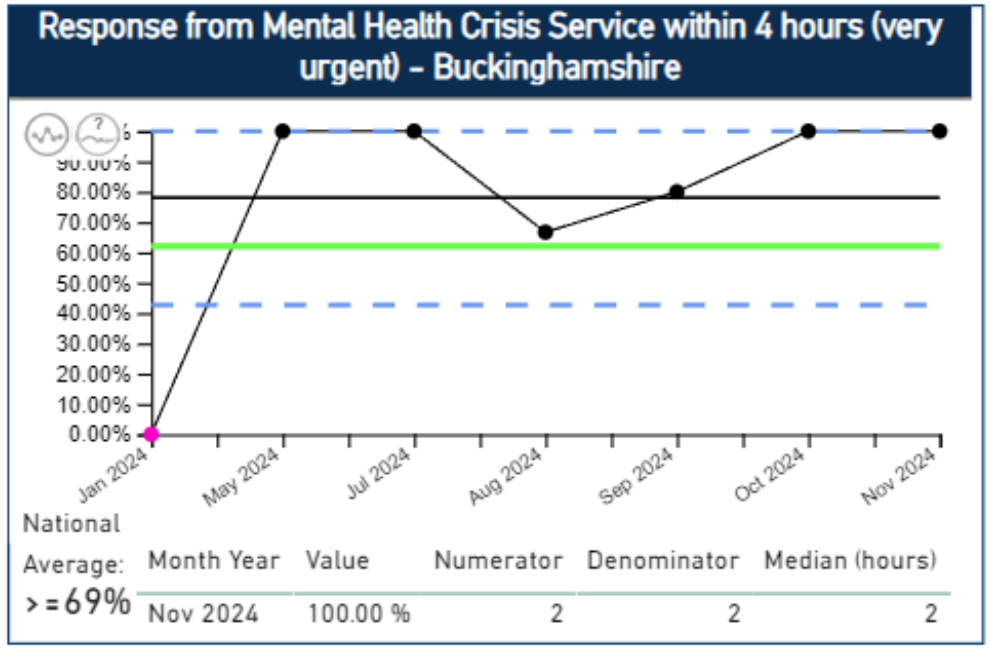
Narrative provided only for metrics under national average (value coloured in red below)

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Urgent Care					
National Objective	Response from Mental Health Psychiatric Liaison within 1 hour - Buckinghamshire	62% National average	Nov-24	93.02%	↑	↑
National Objective	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	62% National average	Nov-24	83.13%	↑	↑
National Objective	Response from Mental Health Psychiatric Liaison within 24 hours - Buckinghamshire	74% National average	Nov-24	95.83%	↑	↑
National Objective	Response from Mental Health Psychiatric Liaison within 24 hours - Oxfordshire	74% National average	Nov-24	100%	→	↑
National Objective	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	69% National average	Nov-24	100%	↑	↑
National Objective	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Oxfordshire	69% National average	Nov-24	76%	↑	↑
National Objective	Response from Mental Health Crisis Service within 24 hours (Urgent) - Buckinghamshire	57% National average	Nov-24	56.92%	↓	↑
National Objective	Response from Mental Health Crisis Service within 24 hours (Urgent) - Oxfordshire	57% National average	Nov-24	83.33%	↑	↑

* National average over April – December 2023

Mental Health Services – Urgent Care





Summary

New standards are being introduced for Mental Health Urgent Care Services. During this financial year, reporting will be updated in line with national changes. While no national targets have been set yet, the Trust will baseline its performance against the national average position. People seeking urgent mental health support should be seen by a community crisis team within 24 hours. In November 2024, Buckinghamshire's Mental Health Crisis Service saw 56.92% of people seeking urgent mental health support within 24 hours, which is slightly below the national average of 57%. Initial results of the investigation of those cases seen outside of the 24-hour timeframe suggest were mostly due to patient choice where the patient has requested a different time or date due to family or work commitments.

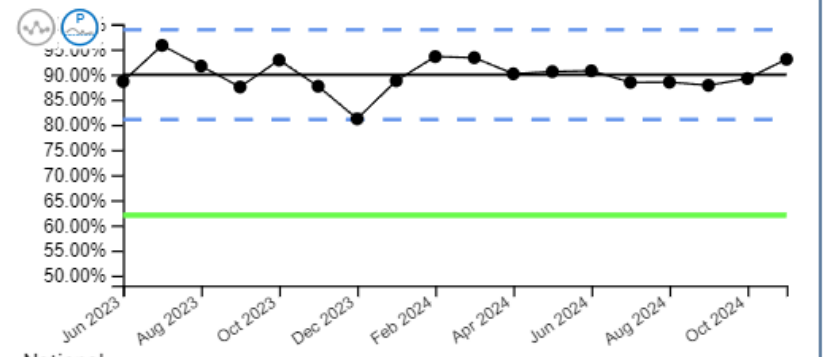
Actions

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

Mental Health Services – Urgent Care

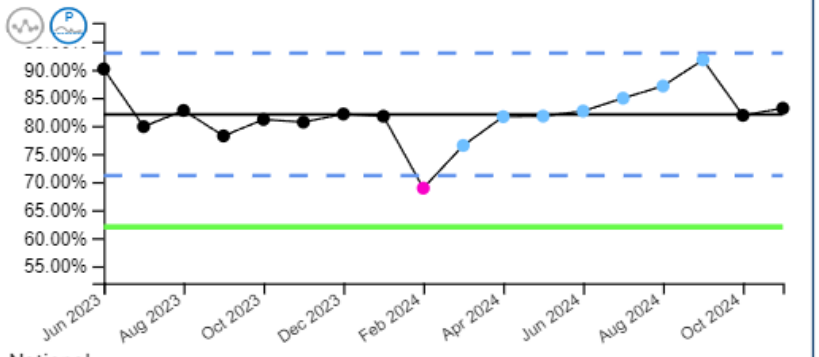
Metrics meeting national average:

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



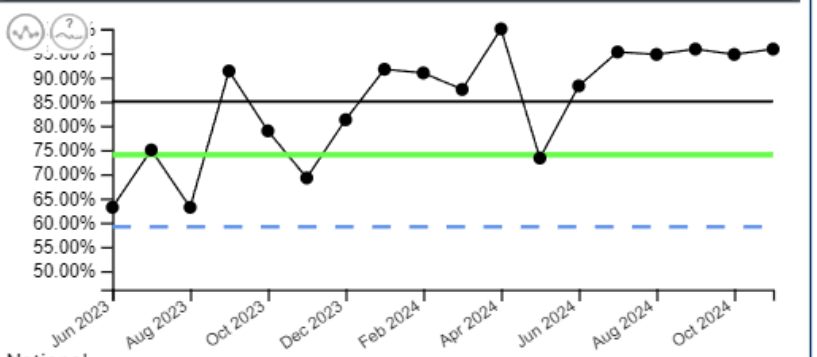
National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=62%	Nov 2024	93.02 %	80	86	1

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



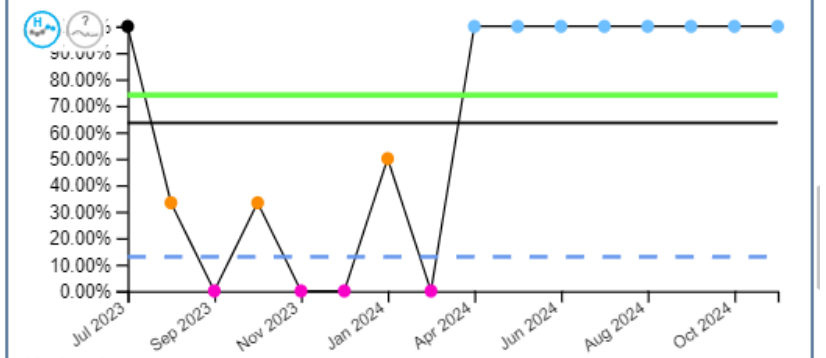
National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=62%	Nov 2024	83.13 %	138	166	0

Response from Mental Health Psychiatric Liaison Service within 24 hour - Buckinghamshire



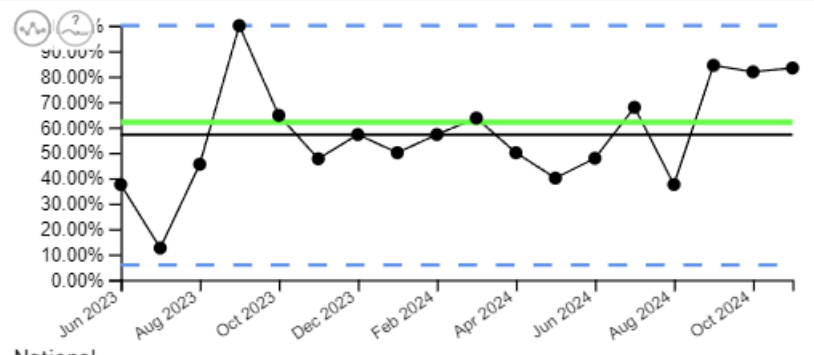
National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=74%	Nov 2024	95.83 %	23	24	1

Response from Mental Health Psychiatric Liaison Service within 24 hour - Oxfordshire



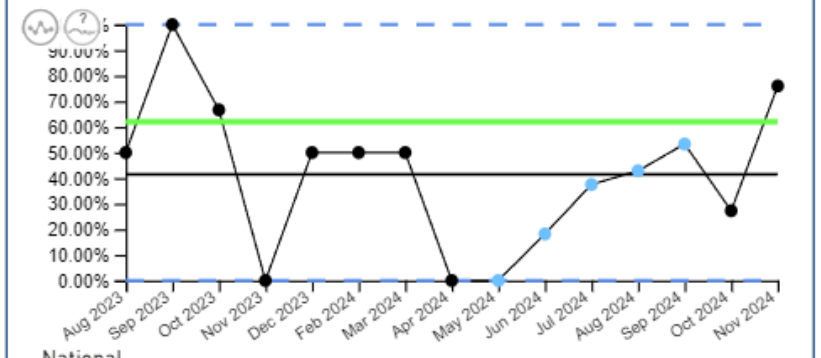
National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=74%	Nov 2024	100.00 %	1	1	21

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



National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=57%	Nov 2024	83.33 %	35	42	7

Response from Mental Health Crisis Service within 4 hours (very urgent) - Oxfordshire



National Average:	Month Year	Value	Numerator	Denominator	Median (hours)
>=69%	Nov 2024	76.00 %	19	25	3

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

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Acute / In-patients (Adults & Older Adults)					
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - rolling quarter - Adult (acute & Psychiatric Intensive Care Units) - Buckinghamshire	13% National average	Nov-24	20%	↓	↓
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - rolling quarter- Adult (acute & Psychiatric Intensive Care Units) - Oxfordshire	13% National average	Nov-24	20%	↑	↓
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - rolling quarter - Older Adult - Buckinghamshire	13% National average	Nov-24	23%	↑	↓
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - rolling quarter - Older Adult - Oxfordshire	13% National average	Nov-24	18%	↑	↓
National Objective NOF	Rate per 100,000 population in adult acute beds with a length of stay over 60 days - Buckinghamshire	8	Nov-24	3.46	↑	↓
National Objective NOF	Rate per 100,000 population in adult acute beds with a length of stay over 60 days - Oxfordshire	8	Nov-24	5.62	↓	↓
National Objective NOF	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days - Buckinghamshire	8	Nov-24	2.86	↓	↓
National Objective NOF	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days - Oxfordshire	8	Nov-24	6.3	↓	↓
National measure	72 hour follow up for those discharged from mental health wards - Adults - Buckinghamshire	80%	Nov-24	91.67%	↓	↑
National measure	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	80%	Nov-24	90.00%	↓	↑
National measure	72 hour follow up for those discharged from mental health wards - Older Adults - Buckinghamshire	80%	Nov-24	100%	→	↑
National measure	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	80%	Nov-24	91.67%	↓	↑

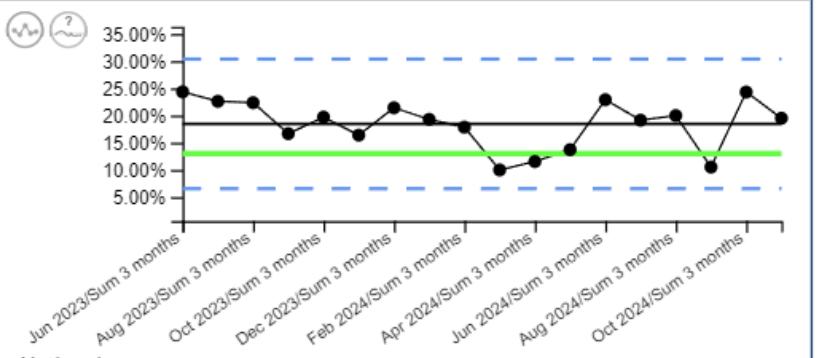
Mental Health Services – Acute / In-patients (Adults & Older Adults) – Summary dashboard (2/2)

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

Type of metric	Service Area/Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Acute / In-patients (Adults & Older Adults)					
National measure	Inappropriate adult acute mental health out of area placements - snapshot last day month - Buckinghamshire	3	Nov-24	3	↓	↓
National measure	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Buckinghamshire		Nov-24	0	→	↓
National measure	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Buckinghamshire		Nov-24	0	↓	↓
National measure	Inappropriate adult acute mental health out of area placements - snapshot last day month - Oxfordshire	5	Nov-24	2	→	↓
National measure	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire		Nov-24	0	→	↓
National measure	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire		Nov-24	0	→	↓
NOF	Inappropriate adult acute mental health out of area placements - beds days in month - Buckinghamshire	n/a	Nov-24	149	↓	↓
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Buckinghamshire	n/a	Nov-24	0	→	↓
	Inappropriate older adult acute mental health out of area placements - beds days in month - Buckinghamshire	n/a	Nov-24	7	↑	↓
NOF	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	n/a	Nov-24	111	↑	↓
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	n/a	Nov-24	0	→	↓
	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	n/a	Nov-24	0	→	↓
National Objective	% adult acute readmission within 30 days for mental health - Buckinghamshire	n/a	Nov-24	0%	→	↓
National Objective	% adult acute readmission within 30 days for mental health - Oxfordshire	n/a	Nov-24	3%	↓	↓
National Objective	% older adult readmission within 30 days for mental health - Buckinghamshire	n/a	Nov-24	0%	→	↓
National Objective	% older adult readmission within 30 days for mental health - Oxfordshire	n/a	Nov-24	0%	↓	↓
National Objective	Average number of clinically ready for discharge patients per day - Buckinghamshire	n/a	Nov-24	9	↑	↓
National Objective	Average number of clinically ready for discharge patients per day - Oxfordshire	n/a	Nov-24	7	↑	↓

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

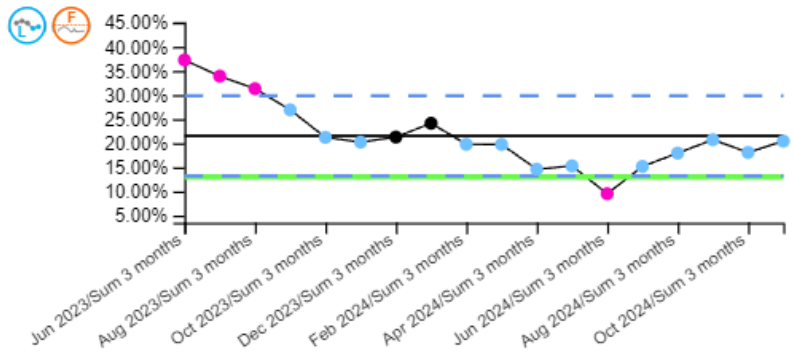
Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) – Adult (acute & PICU) Buckinghamshire (reported as rolling 3 months)



National Average: <=13%

Month Year	Value	Numerator	Denominator
Nov 2024	20 %	8	41

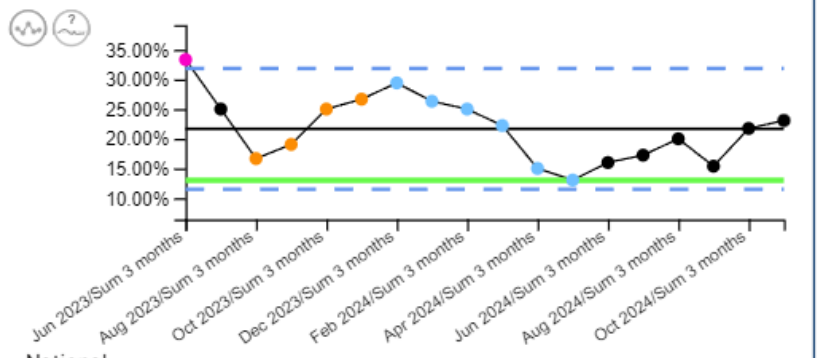
Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) – Adult (acute & PICU) Oxfordshire (reported as rolling 3 months)



National Average: <=13%

Month Year	Value	Numerator	Denominator
Nov 2024	20 %	19	93

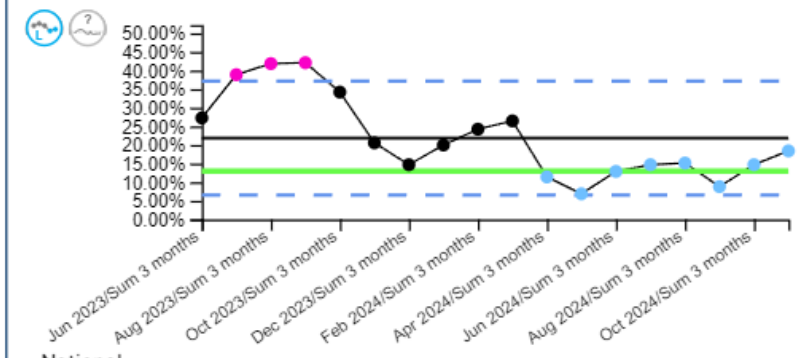
Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) – Older Adult Buckinghamshire (reported as rolling 3 months)



National Average: <=13%

Month Year	Value	Numerator	Denominator
Nov 2024	23 %	6	26

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



National Average: <=13%

Month Year	Value	Numerator	Denominator
Nov 2024	18 %	7	38

Summary

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

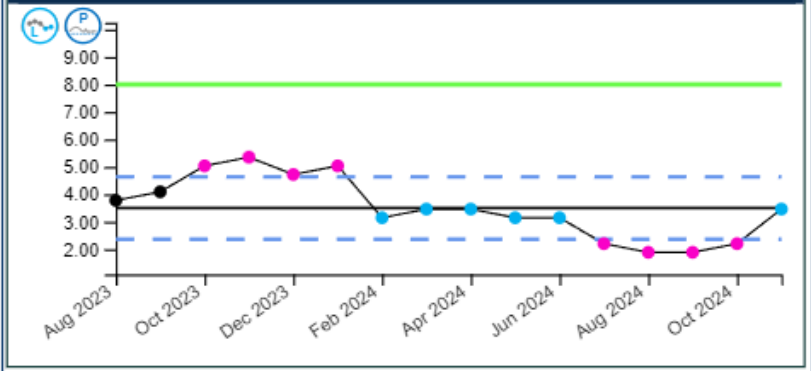
Actions

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

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

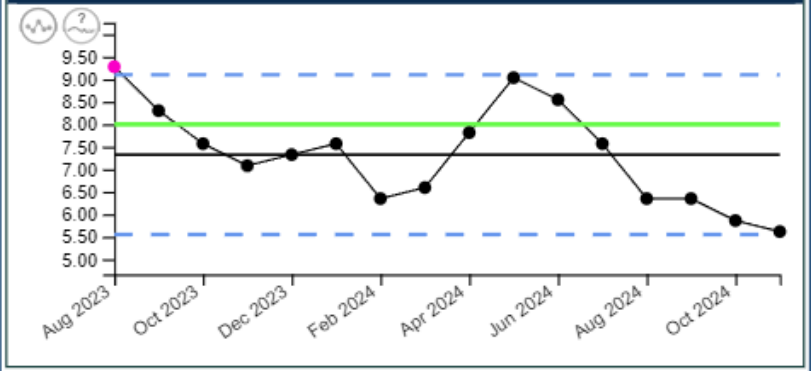
Metrics meeting target, being baselined or with target yet to be confirmed:

Rate per 100k population in adult acute beds with a length of stay over 60 days (discharged patients) – Buckinghamshire



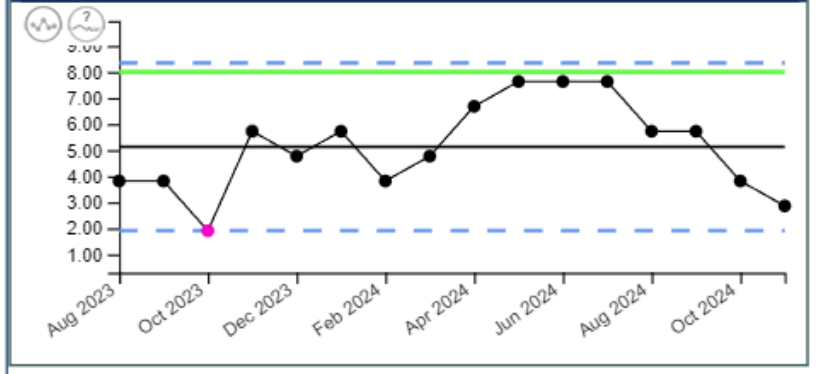
Target:	Month Year	Value (rolling 3 months)
<8	Nov 2024	3.46

Rate per 100k population in adult acute beds with a length of stay over 60 days (discharged patients) – Oxfordshire



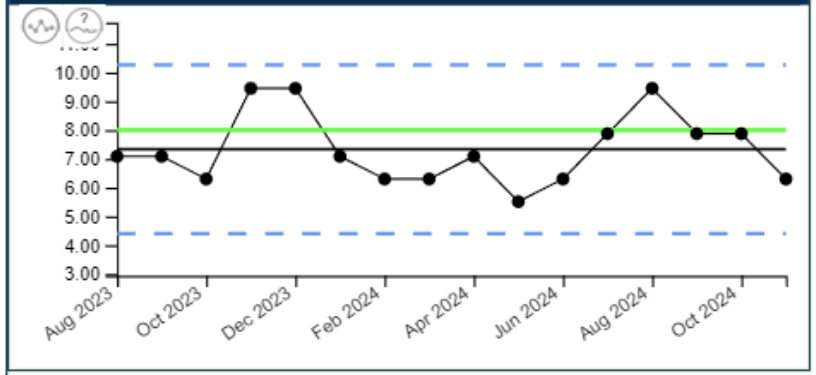
Target:	Month Year	Value (rolling 3 months)
<8	Nov 2024	5.62

Rate per 100k population in older adult acute beds with a length of stay over 90 days (discharged patients) – Buckinghamshire



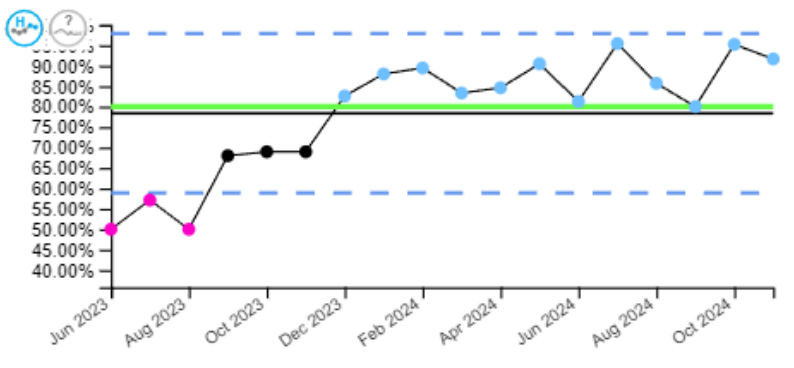
Target:	Month Year	Value (rolling 3 months)
<8	Nov 2024	2.86

Rate per 100k population in older adult acute beds with a length of stay over 90 days (discharged patients) – Oxfordshire



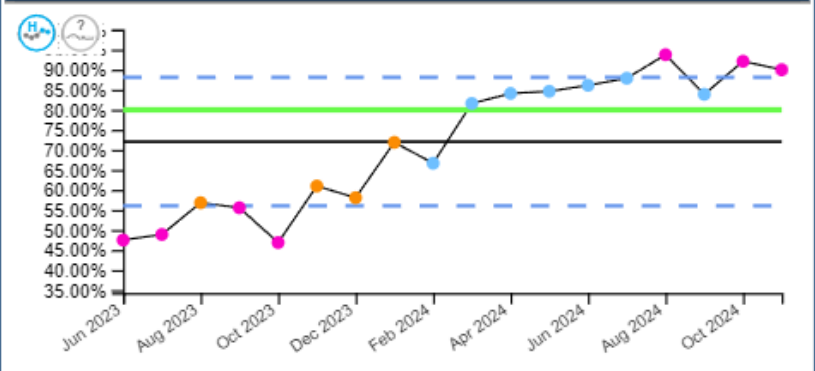
Target:	Month Year	Value (rolling 3 months)
<8	Nov 2024	6.30

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



Target:	Month Year	Value	Numerator	Denominator
>=80%	Nov 2024	91.67%	22	24

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

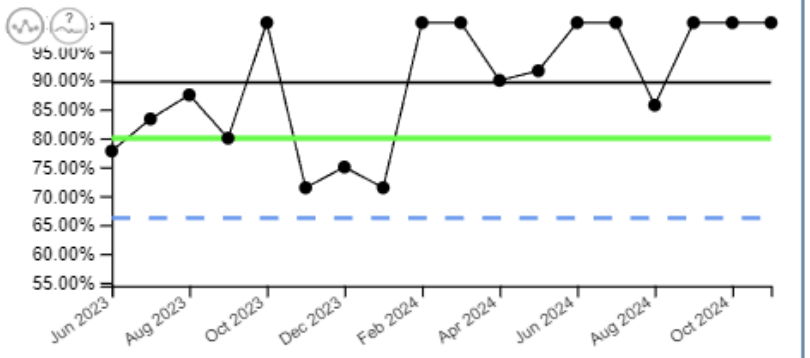


Target:	Month Year	Value	Numerator	Denominator
>=80%	Nov 2024	90.00%	27	30

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

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

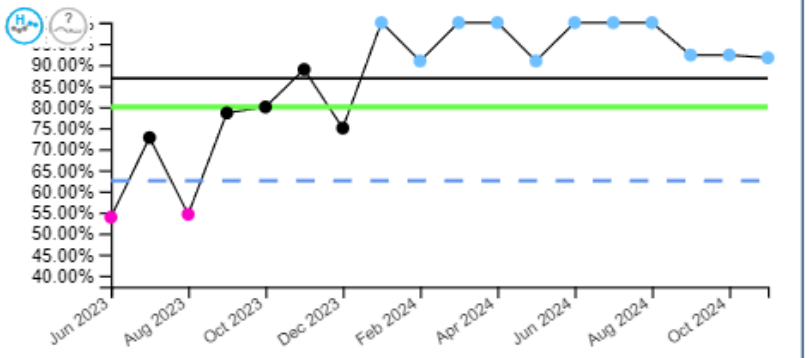
72 hour follow up for those discharged from mental health wards - Older Adult Buckinghamshire



Target:
>=80%

Month Year	Value	Numerator	Denominator
Nov 2024	100.00%	7	7

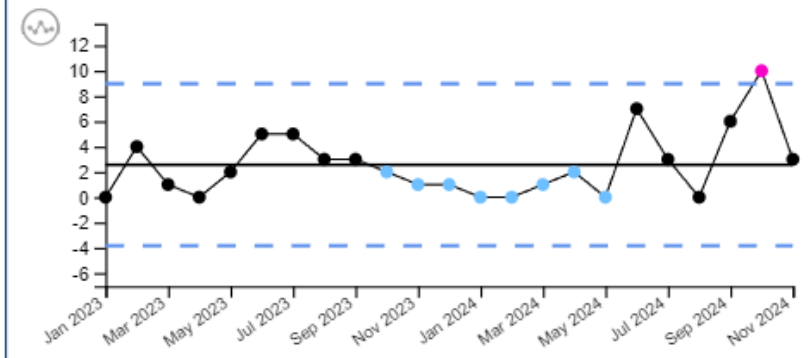
72 hour follow up for those discharged from mental health wards - Older Adult Oxfordshire



Target:
>=80%

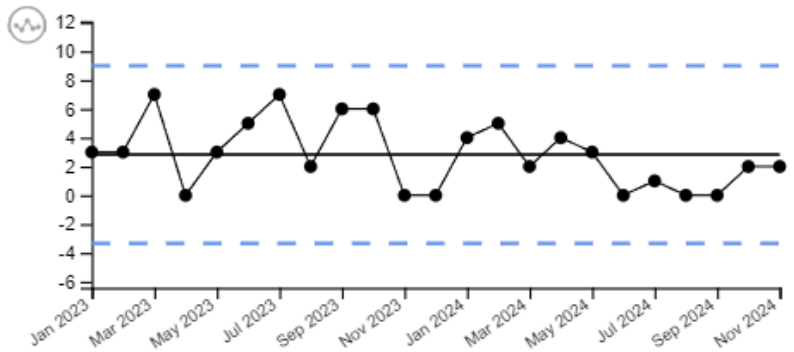
Month Year	Value	Numerator	Denominator
Nov 2024	91.67%	11	12

Inappropriate adult acute mental health out of area placements - snapshot last day of month - Buckinghamshire



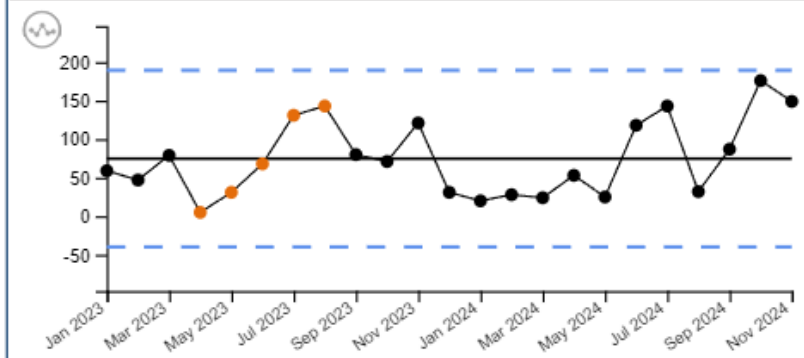
Month Year	Value
Nov 2024	3

Inappropriate adult acute mental health out of area placements - snapshot last day of month - Oxfordshire



Month Year	Value
Nov 2024	2

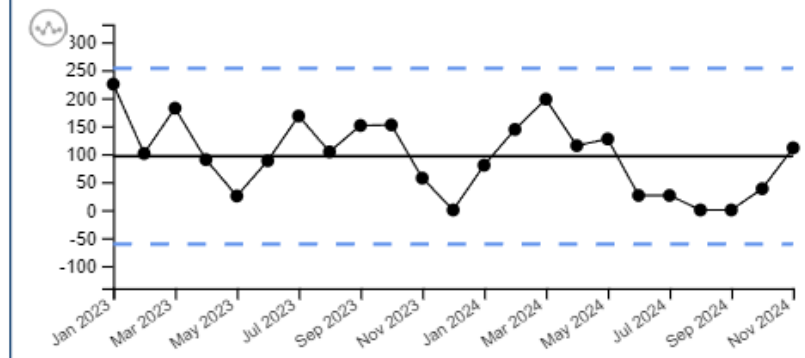
Inappropriate adult acute mental health out of area placements - bed days in month - Buckinghamshire



Month Year	Value
Nov 2024	149

NOF

Inappropriate adult acute mental health out of area placements - bed days in month - Oxfordshire



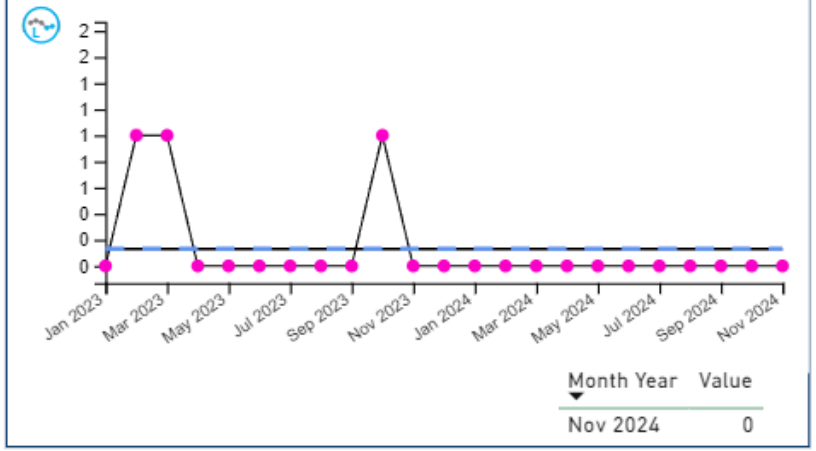
Month Year	Value
Nov 2024	111

NOF

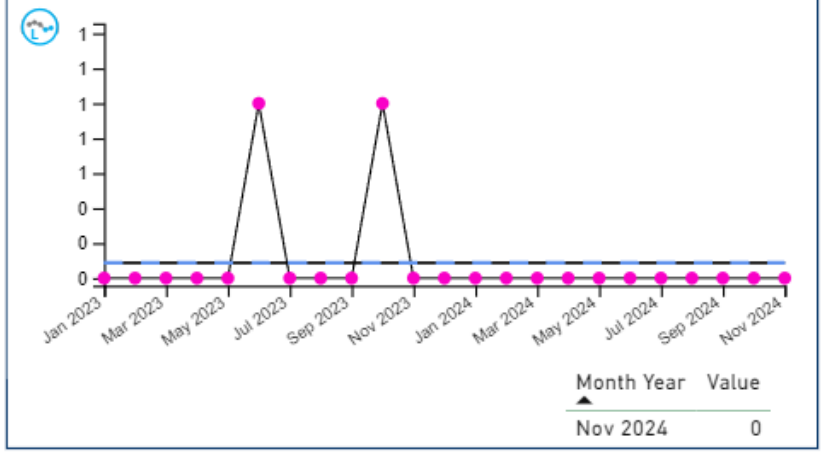
Mental Health Services – Acute / In-patients (Adults & Older Adults)

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

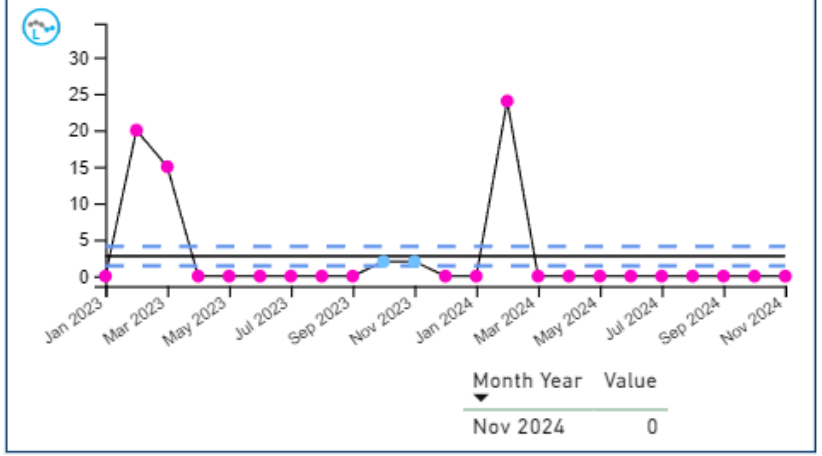
Inappropriate Psychiatric Intensive Care Unit mental health out of area placements – snapshot last day of month – Buckinghamshire



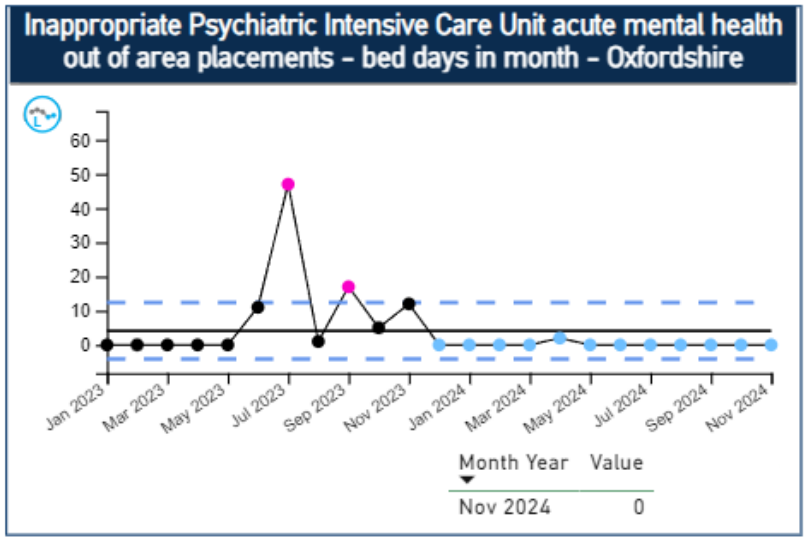
Inappropriate Psychiatric Intensive Care Unit mental health out of area placements – snapshot last day of month – Oxfordshire



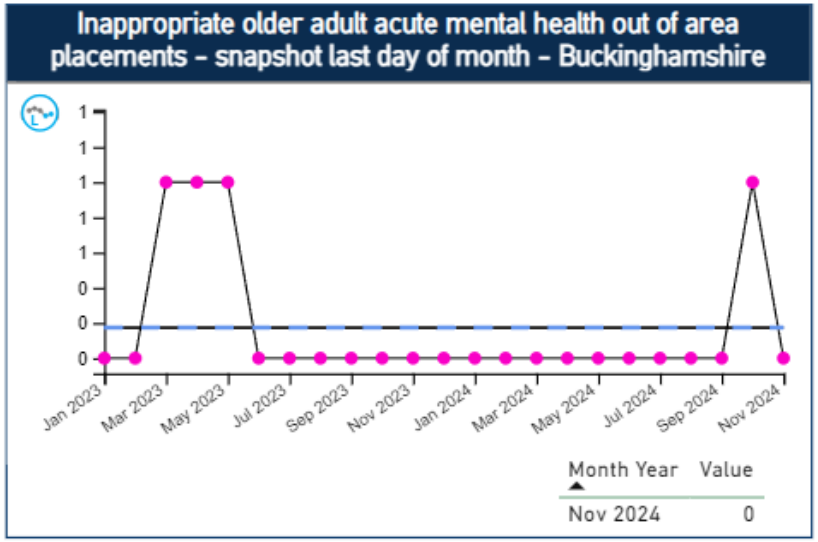
Inappropriate Psychiatric Intensive Care Unit mental health out of area placements – bed days in month – Buckinghamshire



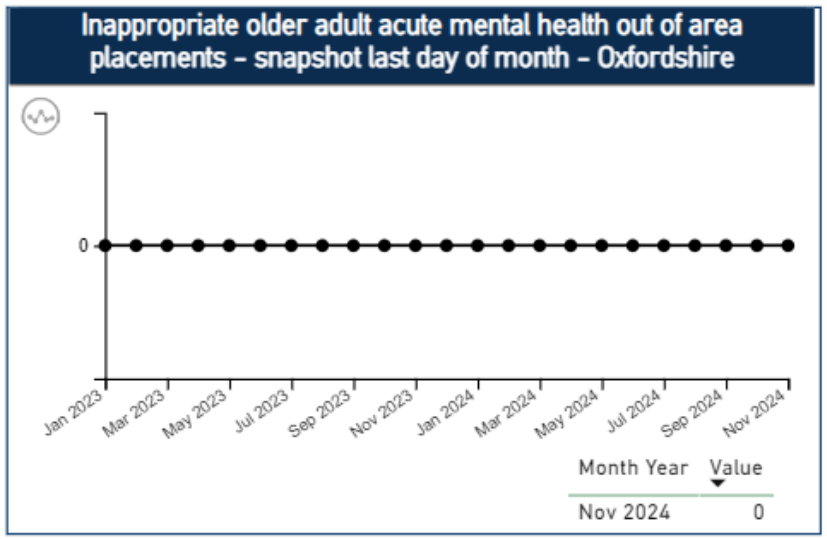
Inappropriate Psychiatric Intensive Care Unit acute mental health out of area placements – bed days in month – Oxfordshire



Inappropriate older adult acute mental health out of area placements – snapshot last day of month – Buckinghamshire



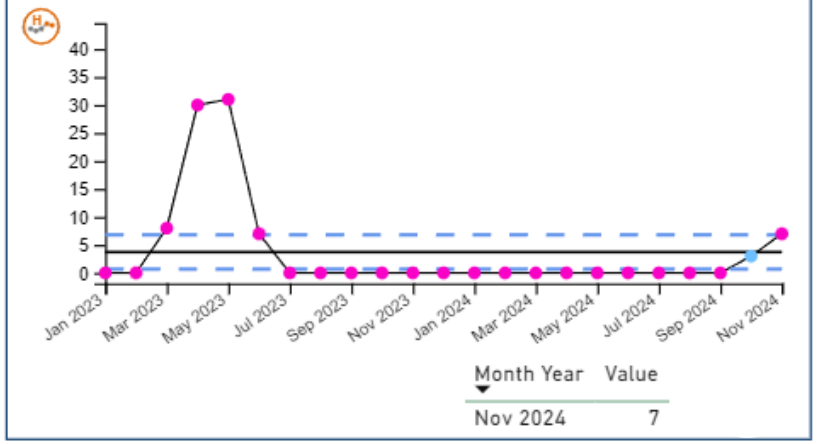
Inappropriate older adult acute mental health out of area placements – snapshot last day of month – Oxfordshire



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

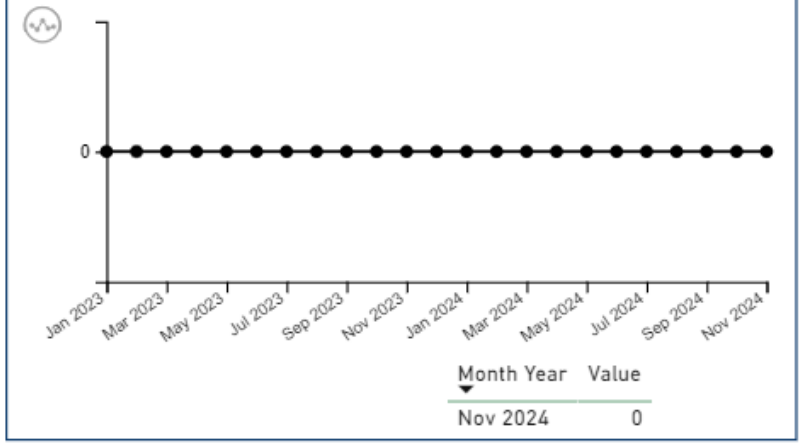
Metrics meeting target, being baselined or with target yet to be confirmed:

Inappropriate older adult acute mental health out of area placements - bed days in month - Buckinghamshire



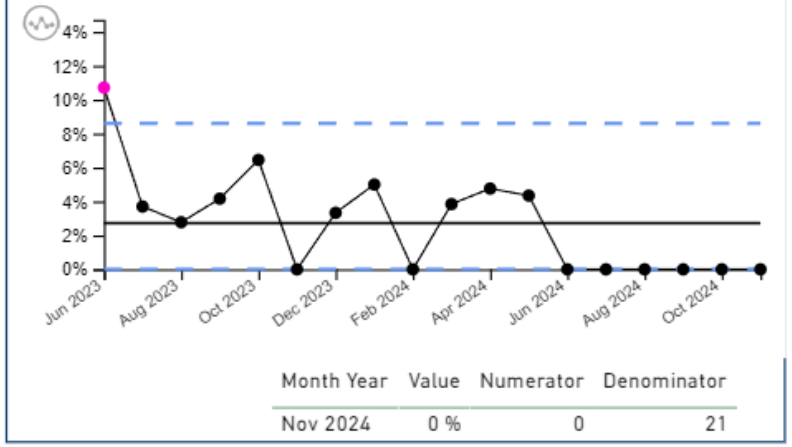
Month Year	Value
Nov 2024	7

Inappropriate older adult acute mental health out of area placements - bed days in month - Oxfordshire



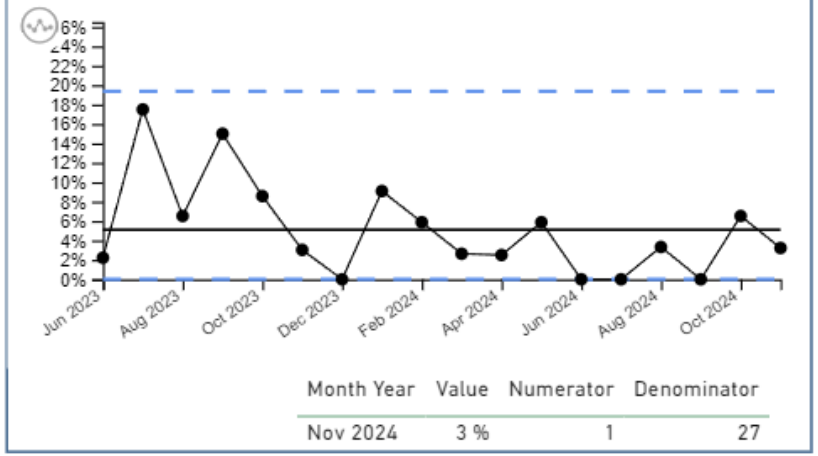
Month Year	Value
Nov 2024	0

% adult readmissions within 30 days for mental health - Buckinghamshire



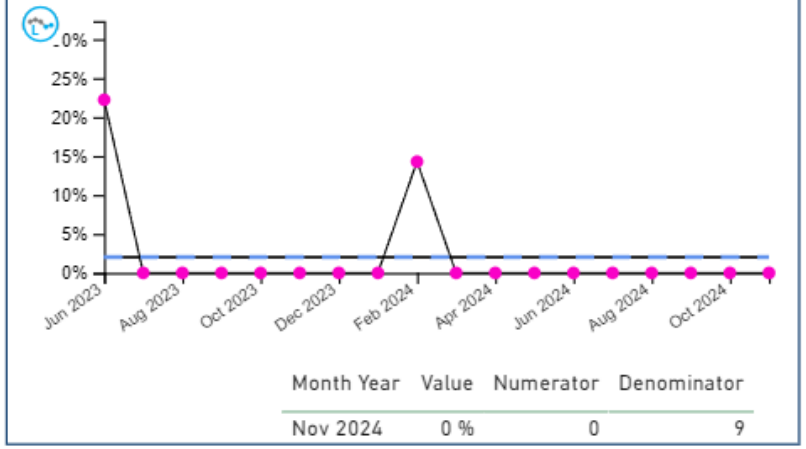
Month Year	Value	Numerator	Denominator
Nov 2024	0 %	0	21

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



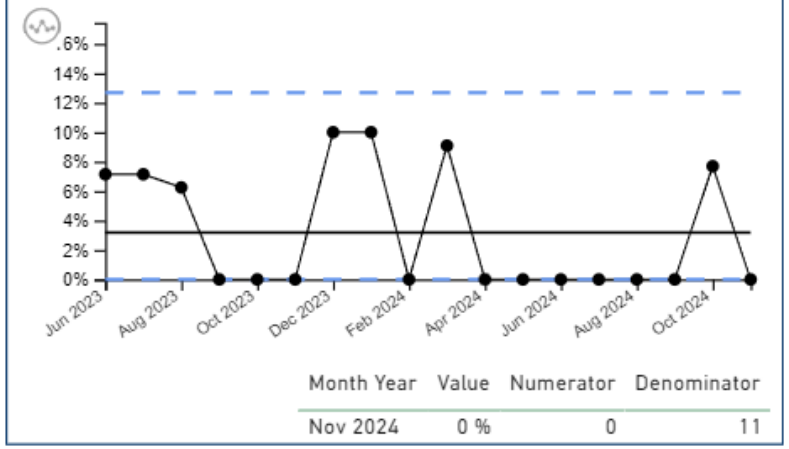
Month Year	Value	Numerator	Denominator
Nov 2024	3 %	1	27

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



Month Year	Value	Numerator	Denominator
Nov 2024	0 %	0	9

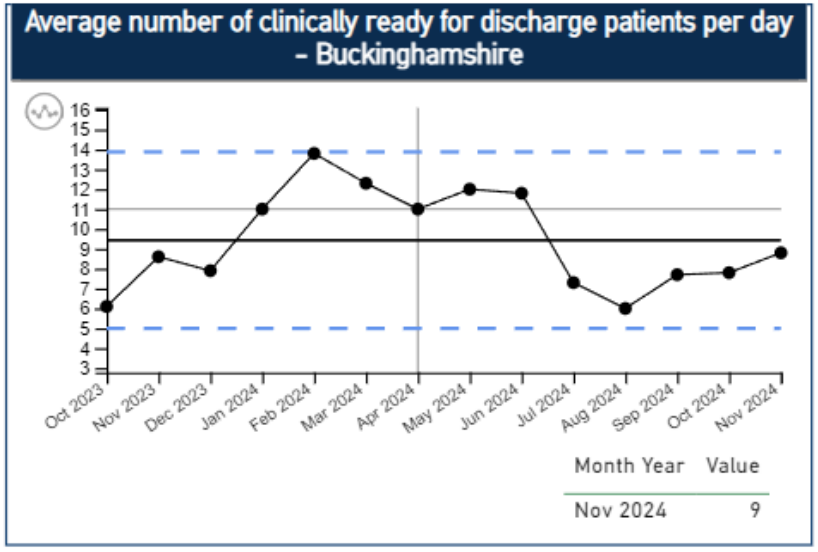
% older adult acute readmissions within 30 days for mental health services - Oxfordshire

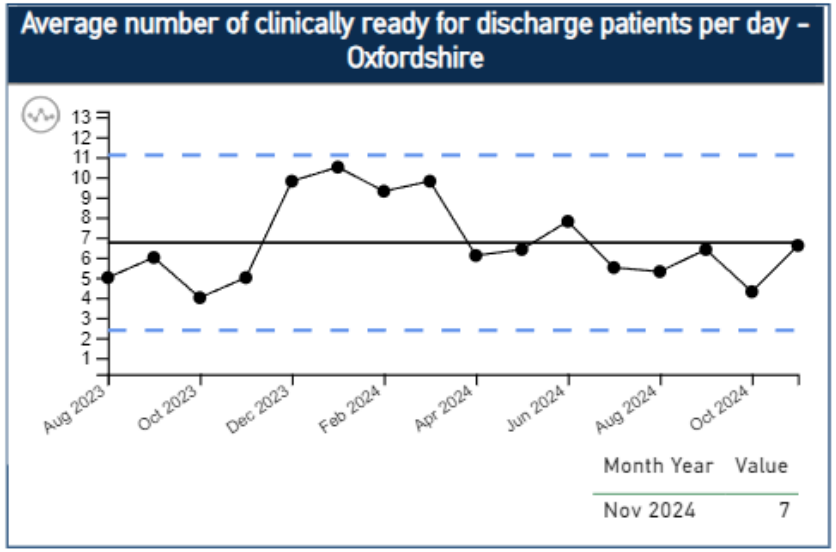


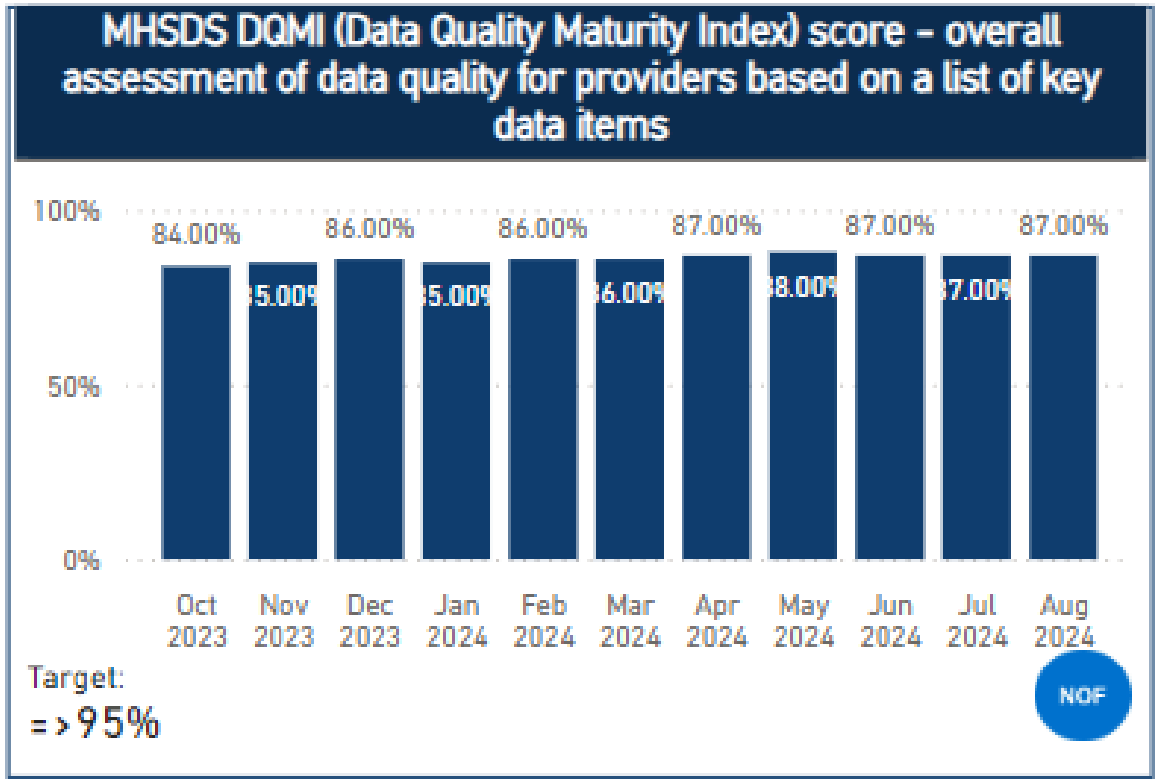
Month Year	Value	Numerator	Denominator
Nov 2024	0 %	0	11

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

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





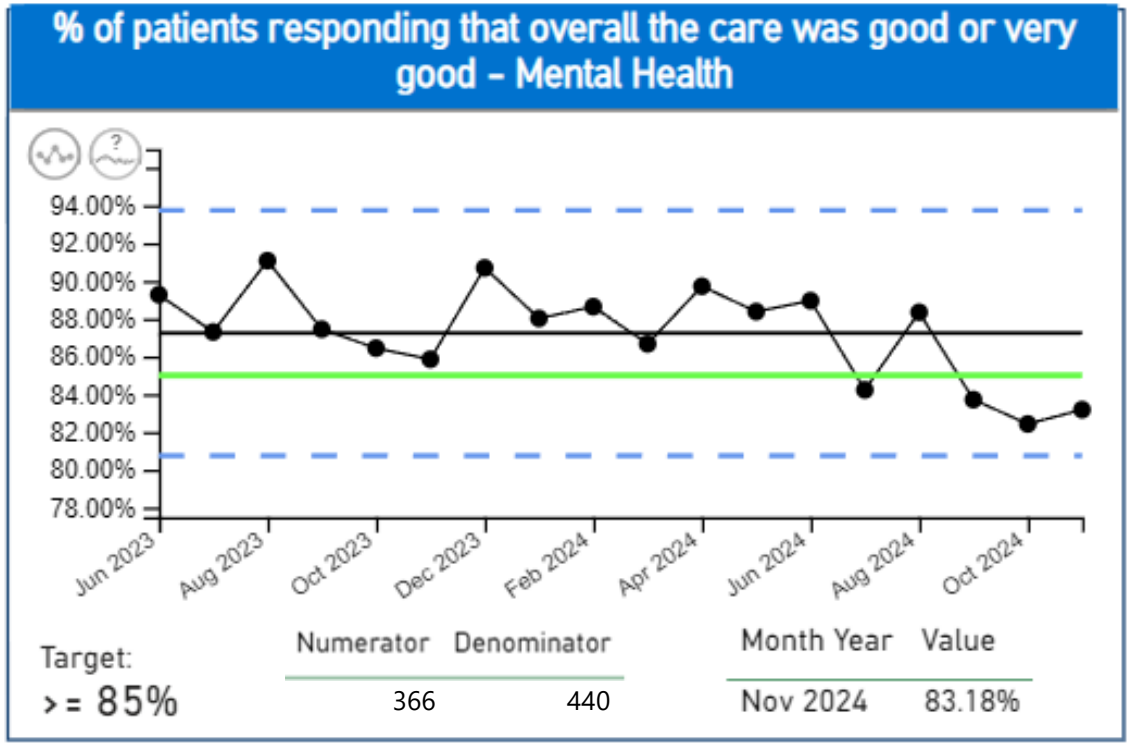


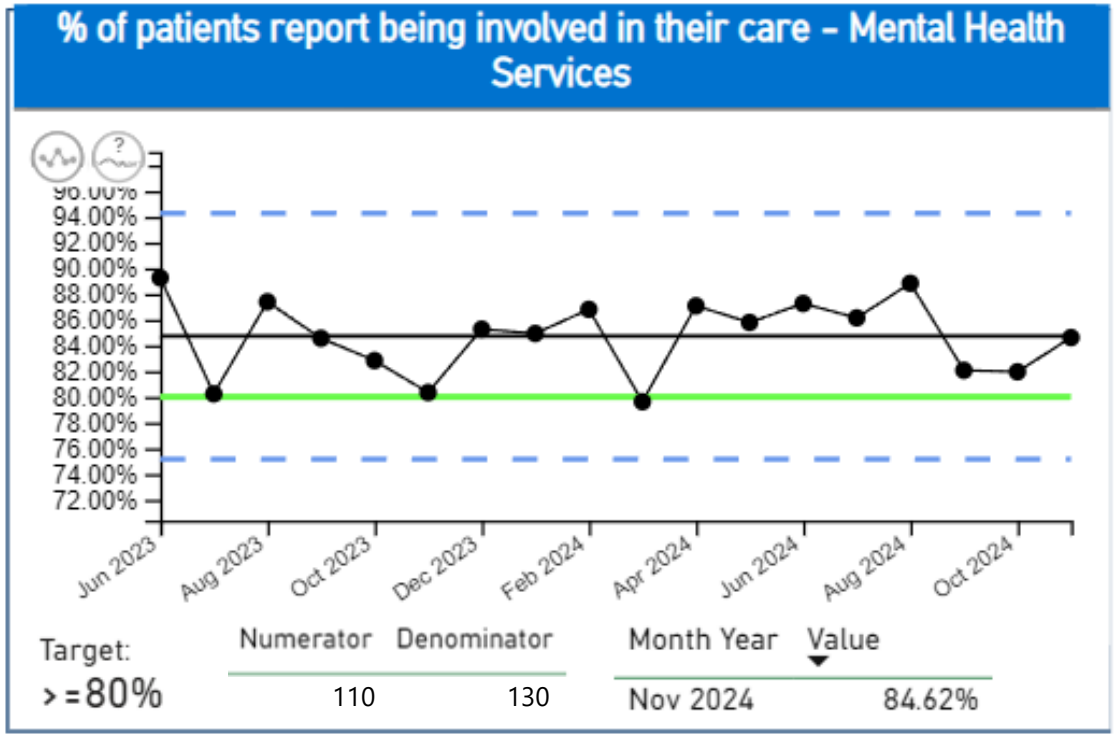
Summary & actions

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

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

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





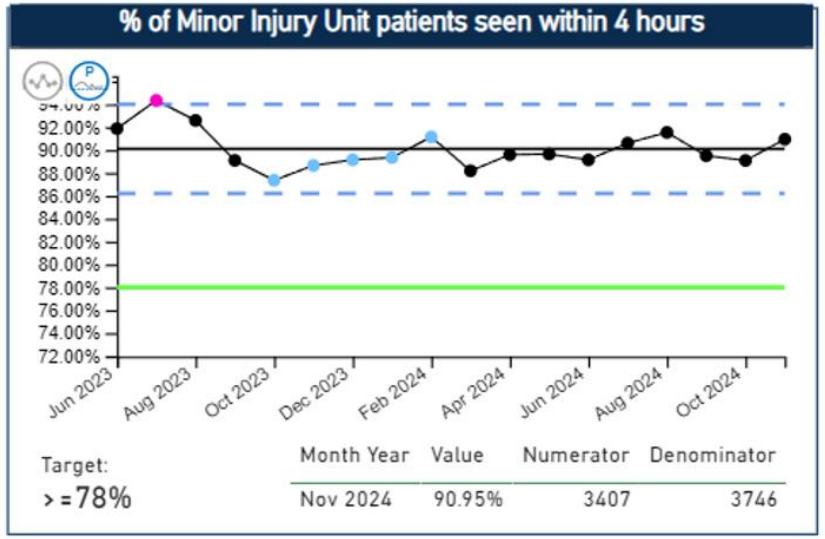
Section 1.2
Clinical performance (Community Health Service, Primary Care & Dentistry)

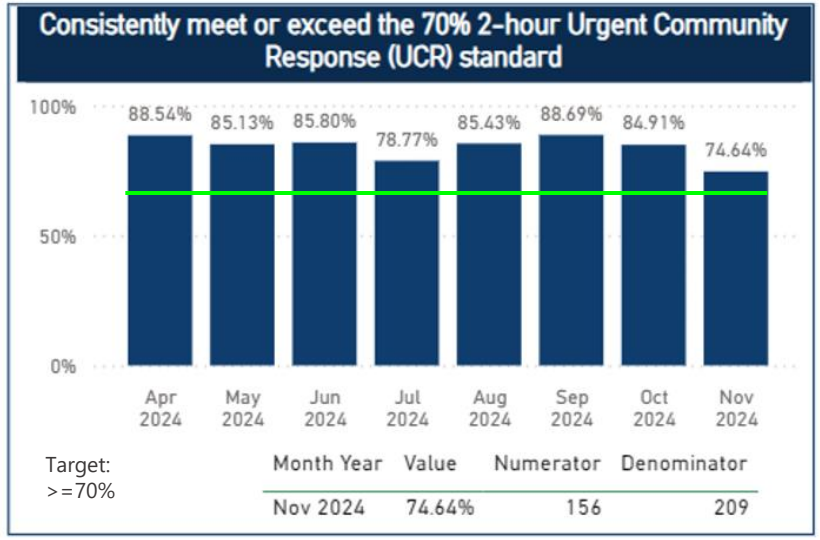
Community Health Service, Primary Care & Dentistry – Summary Dashboard

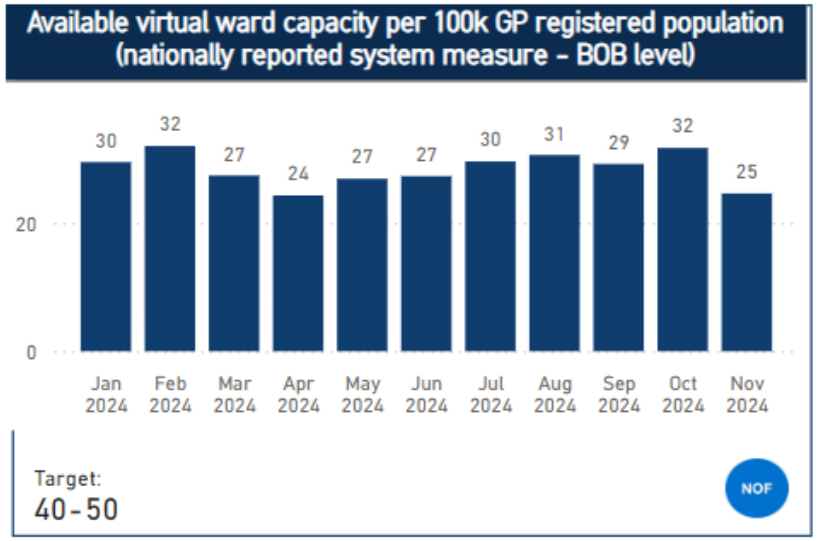
Narrative provided only for clinical metrics under target (value coloured in red) – none in November 2024. Please note that narrative for system measures will not be provided as these are monitored at Integrated Care Board (ICB) level and figures are provided to Trust Board for information only.

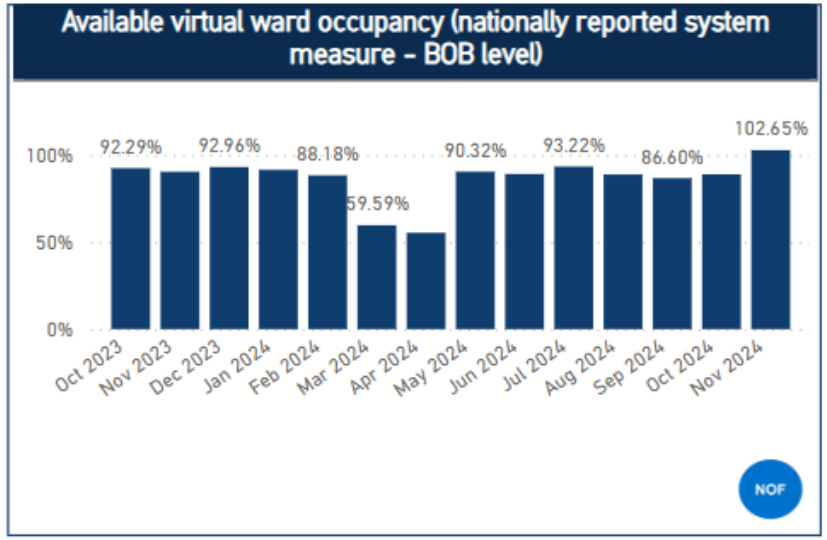
Type of metric	Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Average Length of Stay in Community Hospitals by basket of care	*In development for FY25*				
National measure	% of Minor Injury Unit patients seen within 4 hours	78%	Nov-24	90.95%	↑	↑
National measure	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	70%	Nov-24	74.64%	↑	↑
NOF National Objective	Proportion of patients discharged from hospital by pathways	*In development for FY25*				
	Average number of Medically Optimised For Discharge (MOFD) patients per night	*Under data quality investigation*				
NOF	Available virtual ward capacity per 100k head of population (nationally reported system measure - Buckinghamshire. Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level)	40-50	Nov-24	25	↓	↑
NOF National Objective	Virtual ward occupancy (nationally reported system measure - Buckinghamshire. Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level)	TBC	Nov-24	102.65%	↑	↑
Strategic Metric - Quality	% of patients responding that overall care was good or very good	85%	Nov-24	93.98%	↑	↑
Strategic Metric - Quality	% of patients report being involved in their care	85%	Nov-24	84.62%	↑	↑
Strategic Metric - Quality	% of out of hours palliative care referrals responded to within 30 minutes: the time from receipt of the call from 111 to the start of the telephone consultation was 30 minutes	Baseline	Nov-24	92.50%	↓	↑
Strategic Metric - Quality	% of out of hours palliative care referrals responded to within 60 minutes: the time from completion of that triage call to the start of the home visit consultation was within 60 minutes	Baseline	Nov-24	33.95%	↓	↑
Strategic Metric - Quality	% of Oxfordshire Stroke Rehabilitation Unit (OSRU) patients reporting improved functioning	*Reporting in development for FY26 (revised timeline) subject to operational implementation*				

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





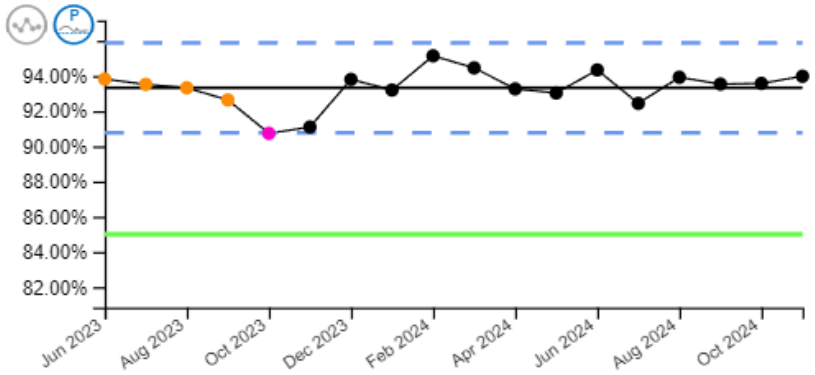




To note: it is possible for virtual ward occupancy to exceed 100% due to the national reporting rules (it is reported as a snapshot of capacity and caseload for the day before, so in some instances, mostly related to staff availability, capacity is low, but the caseload is high). The Trust has fed back this issue to the Integrated Care Board and flagged to the national team few months ago, but as of yet no changes to the reporting rules have been made.

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

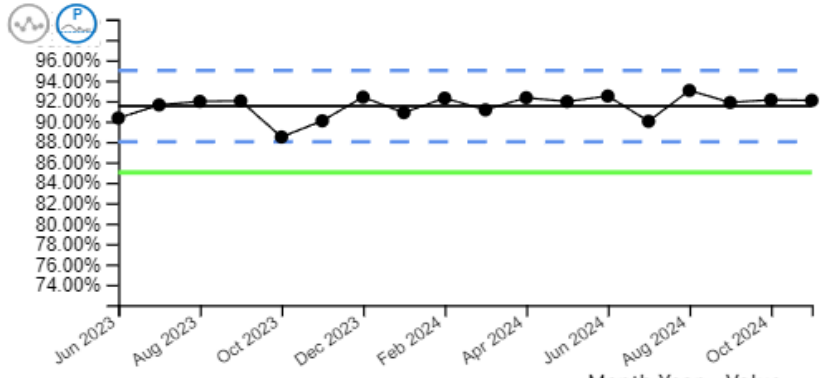
% of patients responding that overall the care was good or very good – Community Health Service, Primary Care & Dentistry



Target: >=85%

Numerator	Denominator	Month Year	Value
1593	1695	Nov 2024	93.98%

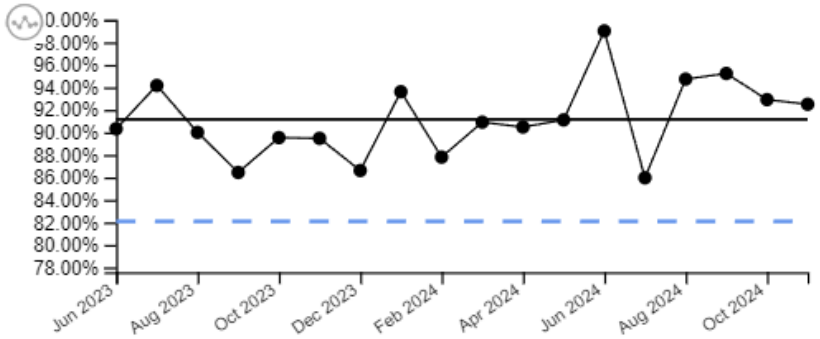
% of patients report being involved in their care – Community Health Service, Primary Care & Dentistry



Target: >=85%

Numerator	Denominator	Month Year	Value
510	554	Nov 2024	92.06%

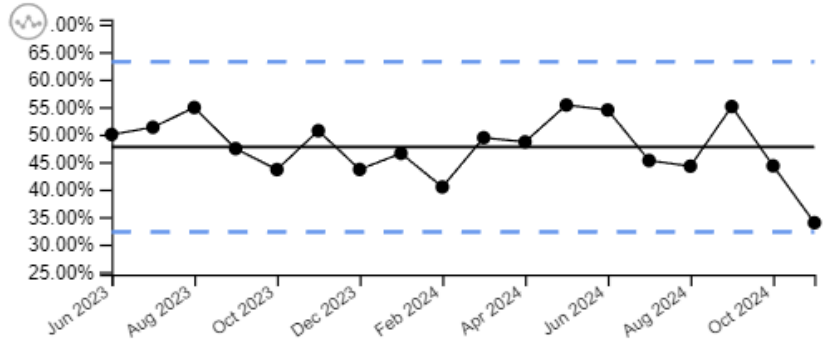
% of out of hours palliative care referrals responded to within 30 mins: the time from receipt of the call from 111 to the start of the telephone consultation was within 30 mins



Target: tbc - Baselining

Month Year	Value	Numerator	Denominator
Nov 2024	92.50%	111	120

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



Target: tbc - Baselining

Month Year	Value	Numerator	Denominator
Nov 2024	33.95%	55	162

Section 2

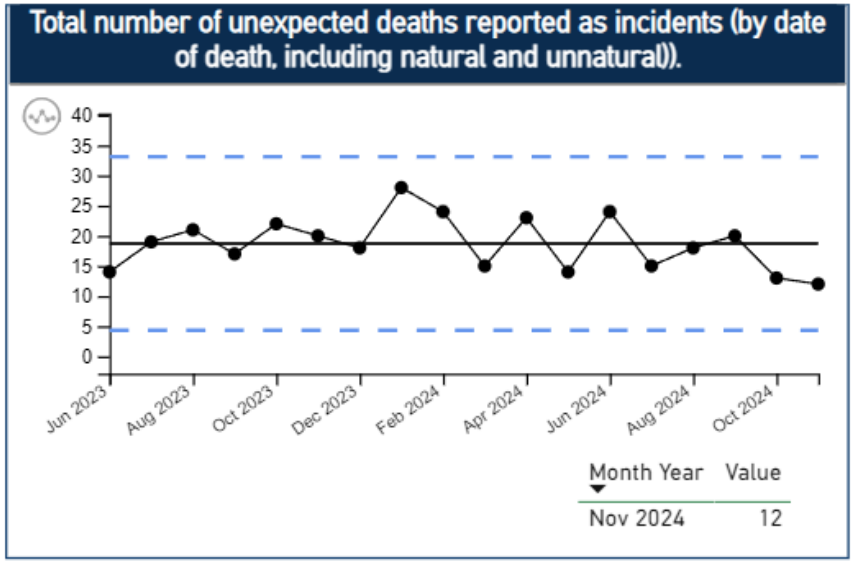
Quality

People

Quality - Deliver the best possible care and health outcomes

Quality – Summary Dashboard

Type of metric	Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
	Total number of patient incidents (all levels of harm)	TBC	Nov-24	1385	↓	n/a
	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)	TBC	Nov-24	12	↓	n/a
	Number of suspected suicides	TBC	Nov-24	1	↓	n/a
	Total number of incidents involving physical restraint	TBC	Nov-24	222	↓	n/a
	Total number of complaints and resolutions	TBC	Nov-24	68	↓	n/a
	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	TBC	Nov-24	351	↓	n/a
Strategic Metric - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint)	Less than 16 per month	Nov-24	9	↑	↓
Strategic Metric - Quality	Reduction in use of seclusion (number of incidents involving seclusion)	Less than48 per month	Nov-24	39	↑	↓
Strategic Metric - Quality	% of community mental health patients with "My Safety Plan" completed where suicide is identified as a risk within assessment	*In development for FY25. Status: Definition of reporting work in progress*				
Strategic Metric - Quality	Rate per 100,000 population of detentions on admissions to hospital of black or black British patients in relation to all other ethnic groups	*In development for FY25 (revised timeline). Status: Technical development in progress*				

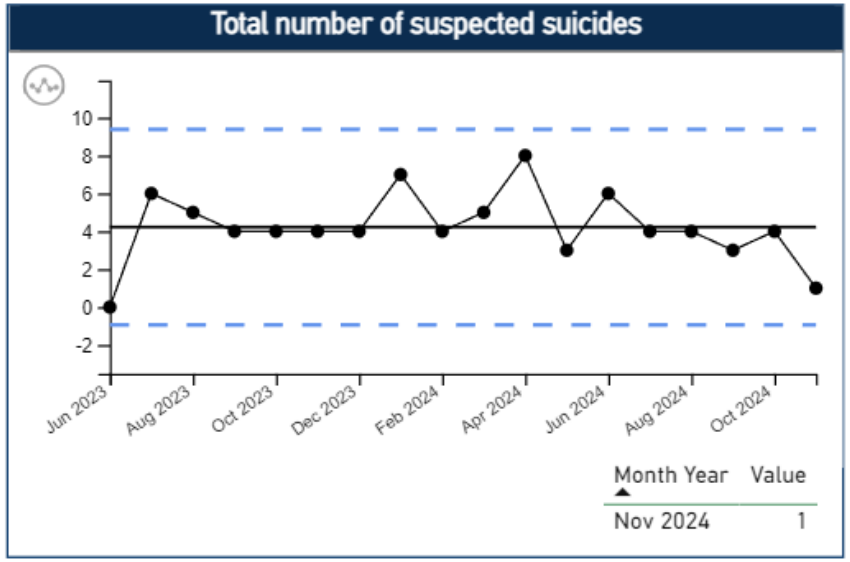


Summary, highlights, actions

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

Our internal process involves 2 senior clinicians screening every known patient death and then depending on the outcome of this initial review and/or the circumstances of the death this is then reported onto Ulysses (graph based on deaths reported onto Ulysses – both patients open and discharged at time of death). All unexpected deaths are then scrutinised by the Directorate senior management team through their weekly safety meeting, which will identify any actions and if further scrutiny is required. Alongside this we link into multi-agency reviews for all deaths of children, people who are homeless, and people with a diagnosis of autism and/or a learning disability. In addition, we provide information to Coroners and share learning through the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System learning from deaths network.

In line with the national programme, we started to roll out the medical examiner role from September 2024 to expand the independent review of cause of death for all non-coronial/ expected deaths.



Summary, highlights, actions

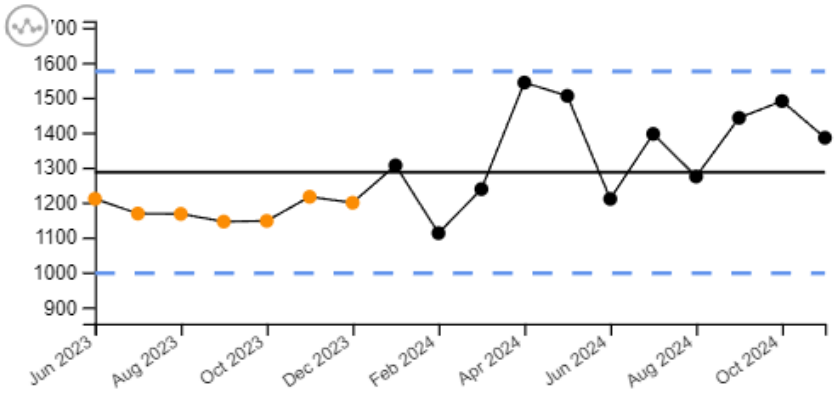
All suspected suicides are identified in near real-time daily and reviewed. Most will have an incident learning huddle completed with the clinicians involved in addition to the offer of psychological support to staff and family liaison support/Amparo to bereaved relatives.

There have been 37 suspected/confirmed suicides for open and discharged patients in the last 12 months (Oct-Sept), of which in 20 cases the patient was open to services. There were a higher number of male suspected suicides (25 males/12 females). In Q2 (July-Sept 2024) there were 7 suspected suicides. For the 1 suspected suicide in Nov 2024 the patient was not open to services at the time they died.

We have seen a lower number of deaths this year compared to last year. The Thames Valley Real Time Surveillance System shows that for about 40% of suicides in the population the person was known to OHFT services in the last 12 months.

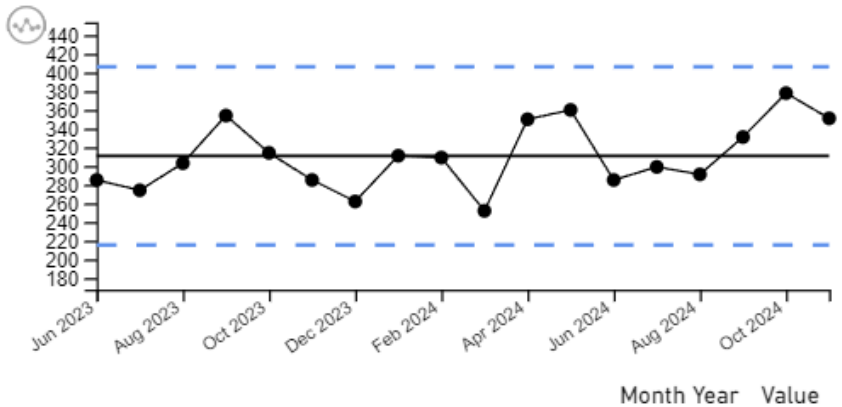
The Trust has a Suicide Prevention Group to steer improvement activity. There has been lots of work in the last year on training/education around suicide risks and prevention. The regional Suicide Prevention and Intervention Network (SPIN) continues to meet quarterly, which enables regional oversight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

Total number of patient incidents (all levels of harm)



Month Year	Value
Nov 2024	1,385

Total number of violence, physical, non-physical and property damage incidents (patients and staff)



Month Year	Value
Nov 2024	351

Summary, highlights, actions

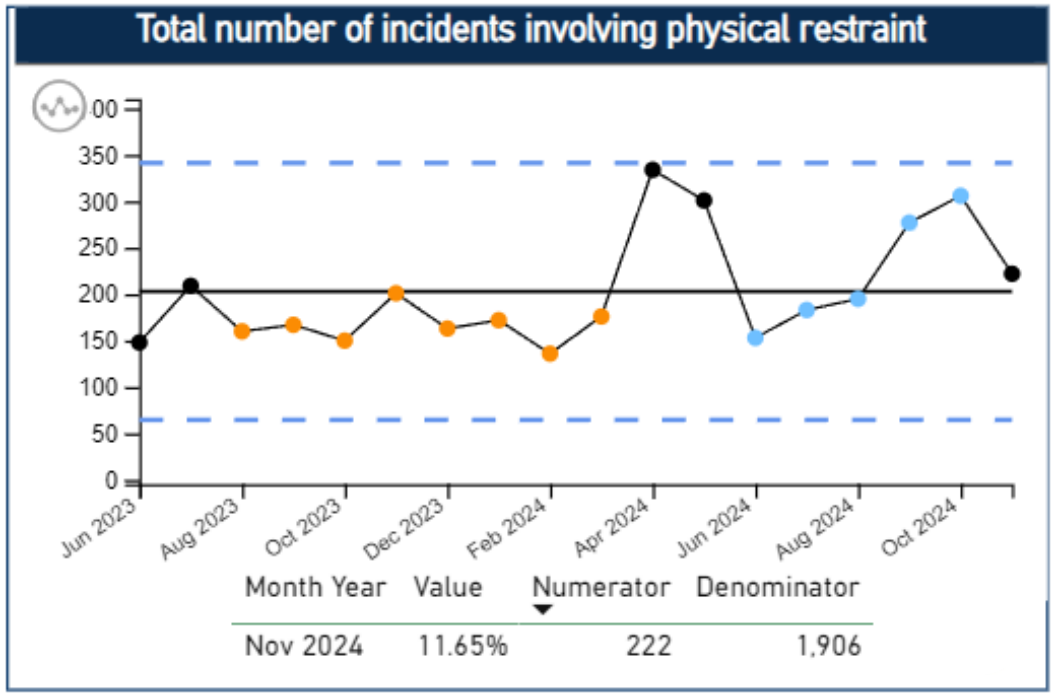
The number of incidents is higher this year than the previous year due to the opening of the new Child and Adolescent Psychiatric Intensive Care Unit. There has also been an increase in no harm/near misses and minor harm incidents. The number of moderate/severe harm incidents has remained the same or marginally reduced since April 2024. Around 91% of incidents result in no harm or minor harm, although these are good opportunities to identify and act on learning.

The most common incident categories are:
- self-harm from striking self or an object
- Self-harm by ligature without a point
- Violence patient to staff with no injury
- Verbal abuse patient to staff
- Medicines administration

Summary, highlights, actions

There has been no notable change over time in the number of violent incidents reported. The majority relate to incidents by patients towards staff. Most incidents occur on our mental health inpatient wards, particularly the forensic wards and the 2 Psychiatric Intensive care Units (adults and children/ adolescent). The type of violence is prominently verbal abuse and physical violence resulting in no injury. Of the 351 violent incidents in Nov 2024 this involved just 139 patients, with a small number of patients accounting for a high number of the incidents.. About 10% of the violence has a racial element.

There is a violence, aggression and sexual safety steering group set up to focus on reducing violence and improving how we support staff who are exposed to verbal and physically violent behaviour. Progress against the workplan is reported monthly. This is coupled with work to increase the safety and security of inpatient environments and work within the Positive and Safe Committee to continue the reduction in the use of restrictive practice.



Summary, highlights, actions

The increase in restraint seen between June 2024 – October 2024 has reduced during November 2024 from 306 restraints in October 2024 to 222 restraints in November 2024. The number of patients involved has increased from 59 the previous month to 69 patients across 22 wards in November 2024.

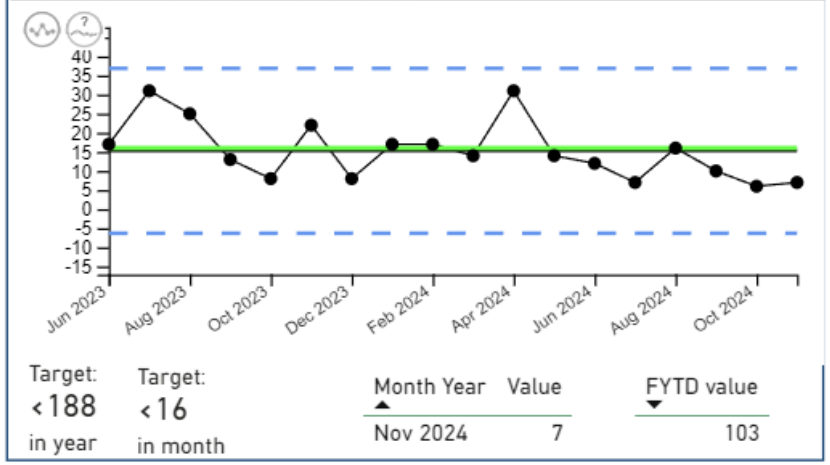
The course group for incidents involving restraint is mainly Self harm (n=65), Health (n=57) followed closely by Violence (n=84). There were 17 incidents of restraint for administration of intramuscular injection (IM) medication and 17 for nasogastric (NG) feeding.

The areas with the highest use in November 2024 continue to be across the Child & Adolescent pathway with some areas increasing and others decreasing. Meadow (Child and Adolescent Mental Health, CAMHS Intensive Care units) has decreased from 92 the previous month to 37 uses in November 2024, CAMHS Marlborough House a significant reduction to 16 from 92 in October., Highfield increased with 49 in November from 27 in October.
Sandford ward (older adults) continues to be the next highest area for restraint with 34 incidents of restraint (increase from 25 in October).

The use of physical restraint significantly increased in April and May 2024 compared to the previous 12 months, this was largely attributable to two Child and Adolescent Mental Health services, Highfield and Meadow wards. Both units saw a reduction in June, July and August 2024, followed by a two month increase which is now seeing a reduction across the pathway.

Quality

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



Target:	Target:	Month Year	Value	FYTD value
<188 in year	<16 in month	Nov 2024	7	103

Summary

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

Use of prone restraint (being held in a face or chest down position) carries increased risks for patients and should be avoided and only used for the shortest possible time. The prone position is used mostly to administer medication via intramuscular injection (IM) followed by seclusion exit procedure. In November 2024, the most common reasons were administering IM medication (4)

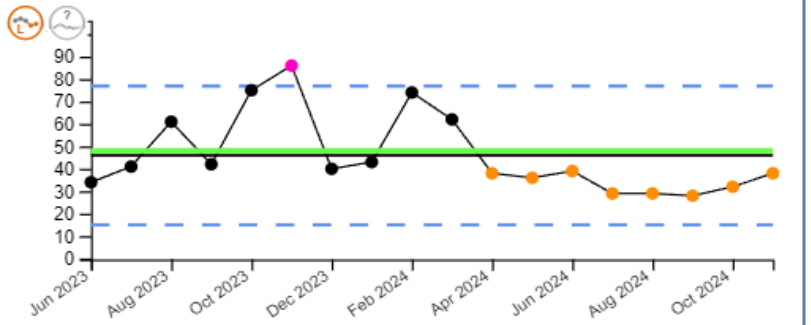
Highlights

The graph shows the use of prone by month for all wards over the last year. The Trust demonstrates a sustained reduction is use of prone restraint since 2021. However, during April 2024 this increased above the trend line with 31 uses of Prone restraints. The reduction since May has been maintained with 9 episodes of prone restraint in November.

The 7 episodes of Prone in November involved 6 patients and were spread across 6 wards. 4 episodes were to enable administration of IM medication and 1 for seclusion exit.

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

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



Target:	Target:	Month Year	Value	FYTD value
<575 in year	<48 in month	Nov 2024	39	270

Summary

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

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

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

Highlights

November 2024 saw the reduction in seclusion being maintained below threshold with 39 episodes of seclusion across 11 wards, involving 22 patients. The highest use of seclusion within the month was on Meadow (CAMHS PICU) with 10 episodes involving 2 patients, Ashurst (male intensive care) with 8 episodes involving 5 patients), and then Sapphire, Highfield and Kestrel all had 4 episodes.

The increase early in the year was largely due to one patient on Evenlode who required frequent episodes of seclusion. This has reduced in number but with longer periods of seclusion with one extended seclusion episode currently.

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

Summary, highlights

The Trust continues to value all complaints and concerns raised to use these as opportunities to make improvements. We monitor key themes identified within complaints, alongside information from other sources of feedback such as Patient Safety Incidents, Legal Claims, Inquests and HR investigations. Discussions to triangulate the information takes place on a weekly basis at the Trust-wide Clinical Weekly Review Meeting and monthly at the Trust-wide Quality and Clinical Governance Sub-Committee. The Trust introduced the new national complaints standards at the beginning of April 2024.

In November 2024 there were thirteen (13) early resolution cases, thirty-nine (39) rapid resolution complaints, fourteen (14) low level complaints and two (2) high level complaints. These for mostly for services delivered by Adult Mental Health teams in City and North-East Oxfordshire (5), GP Out of Hours service (4) and Adult Mental Health Ruby ward in Buckinghamshire (4).

During November 2024, the Trust received two-hundred and eighty-eight (288) compliments across services.

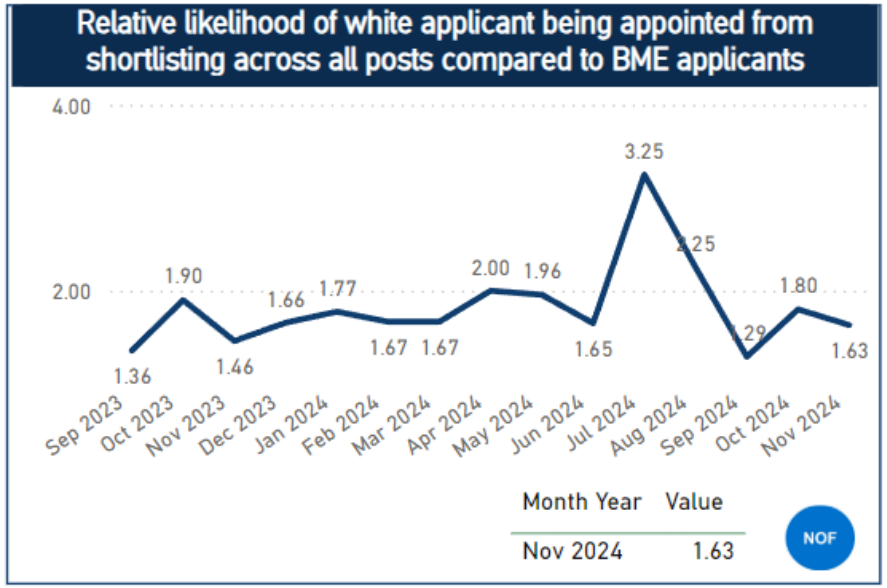
Actions :

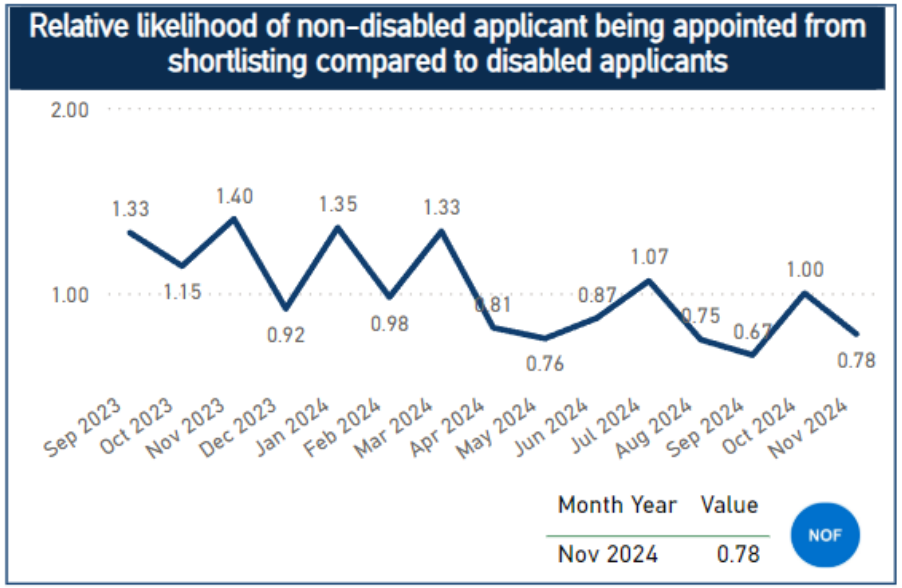
- Early resolution: work with teams to ensure service and team manager are contacting individuals within 72 hours to try to resolve issues at this stage.
- Rapid Resolution: continue to engage with services to work towards completing these cases within the 15 working day deadline and responding to complainants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

People - Be a great place to work

People metrics – Summary Dashboard

Type of metric	Metric	Target	Period	OHFT value	Change from previous reporting period	Better is
NOF	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	TBC	Nov-24	77.65%	↑	↑
NOF	Reduce staff sickness to 4.5%	4.5%	Nov-24	4.60%	↓	↓
	Personal Development Review (PDR) compliance (note: PDR season is between April – July)	N/A outside of PDR season	Nov-24	95.03%	↓	↑
	Reduction in vacancies	9%	Nov-24	12.35%	↑	↓
	% of early turnover	14%	Nov-24	14%	↓	↑
	Statutory and mandatory training compliance	95%	Nov-24	91.05%	↓	↑
	Clinical supervision completion rate	95%	Nov-24	78.76%	→	↑
	Management supervision rate	95%	Nov-24	74.39%	↓	↓
NOF	Staff leaver rate	n/a	Nov-24	7.22%	↓	↓
NOF	Relative likelihood of white applicant being appointed from shortlisting across all posts compared to Black, Asian and Minority Ethnic (BME) applicants	n/a	Nov-24	1.63	↓	↓
NOF	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	n/a	Nov-24	0.78	↓	↓
Strategic Metric - People	Reduce agency usage to meet target (% of agency used)	6.50%	Nov-24	6.4%	↑	↓
Strategic Metric - People	Reduction in % labour turnover	14%	Nov-24	11.85%	↓	↓
Strategic Metric - People	% of staff completing Quality Improvement Training Level 1	*% reporting in development for FY25. Interim measure - 914 staff completed in November 2024 (876 in October 2024)*				
Strategic Metric – People NOF	Black, Asian and Minority Ethnic (Black, Asian and Minority Ethnic) representation across all pay bands including Board level.	19%	Nov-24	24.89%	↑	↑
Strategic Metric - People NOF	Black, Asian and Minority Ethnic (Black, Asian and Minority Ethnic) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	19%	Nov-24	13.09%	↑	↑





Summary

- The relative likelihood of white applicants being appointed from shortlisting compared to Black, Asian and Minority Ethnic (Black, Asian and Minority Ethnic) applicants has decreased by -0.17 from 1.80 in October 2024, to 1.63 in November 2024. The higher the ratio, the more likely White applicants are to be appointed than Black, Asian and Minority Ethnic applicants. *A ratio under 1 indicates that Black, Asian and Minority Ethnic applicants are more likely to be appointed than White applicants and vice versa***.** A ratio of 1 indicates equal likelihood for both groups.
- The relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants has decreased by 0.22 from 1.0 in October 2024, to 0.78 in November 2024. *The higher the ratio the more likely Non-Disabled applicants are to be appointed than Disabled applicants.* A ratio of 1 would indicate equal likelihood for both groups.

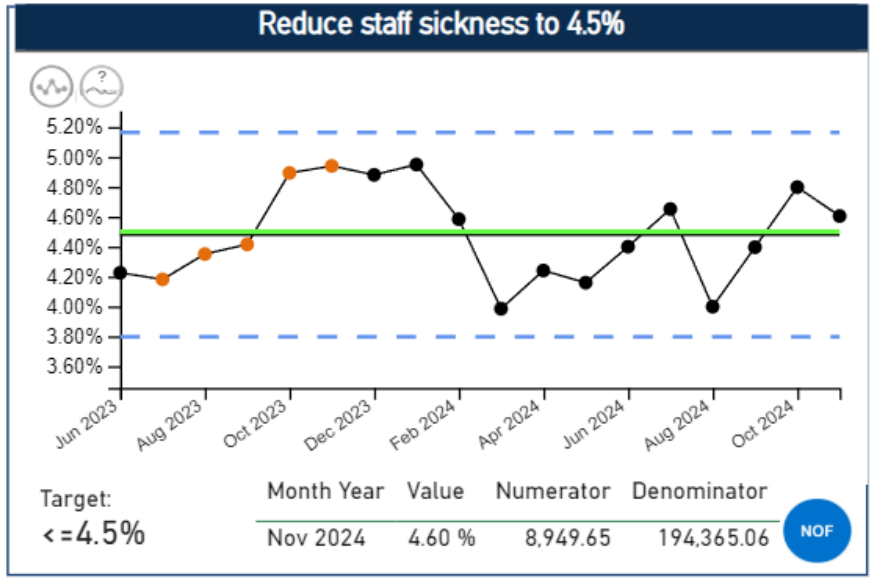
Actions

Race Equality:

- Inclusion Reps: Paper was presented and approved at EDI Steering Group meeting held on 14th November 2024. The EDI Team has completed flyer which summarises the key points to attract applications from Black, Asian and Minority Ethnic staff. The training package for staff volunteers is to be developed by L&D. The recruitment will start Q3 and training in Q4. In the meanwhile, resources have been allocated to support interviews from within the EDI Team.

Disability Equality:

- The re-accreditation of the Level 2 Disability Confident submission to the DWP was completed on 13/08/24. The Trust has been re-accredited at Level 2. Work is underway on Level 3 with the aim of submitting end of Q4.



Summary

The sickness absence decreased from 4.80% to 4.60%, 0.10% above target.

The proportion of long term versus short term cases remains broadly consistent with the previous month. The most common reasons for absence based on number of cases were Cough/Cold, Gastrointestinal, Not Specified, Anxiety/Stress non-work related and Headache/Migraine.

From 1 November absence data has been reported based on ESR calculations which are slightly different to those in Goodshape as this system is no longer used. All historical data is now reported from ESR

Actions Sickness Absence

The Human Resources (HR) Operational teams continue to regularly review the management of individual sickness absence cases where individuals have been identified as having higher levels of absence. The HR Operational Teams also focus on the areas with the highest levels of absence and work closely with line managers to support the management of short term frequent and long-term absence.

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

The Goodshape system has now been replaced by a new system which is now fully operational and there has been no significant challenges raised so far. There will be a review of the system in April, 6 months after implementation.

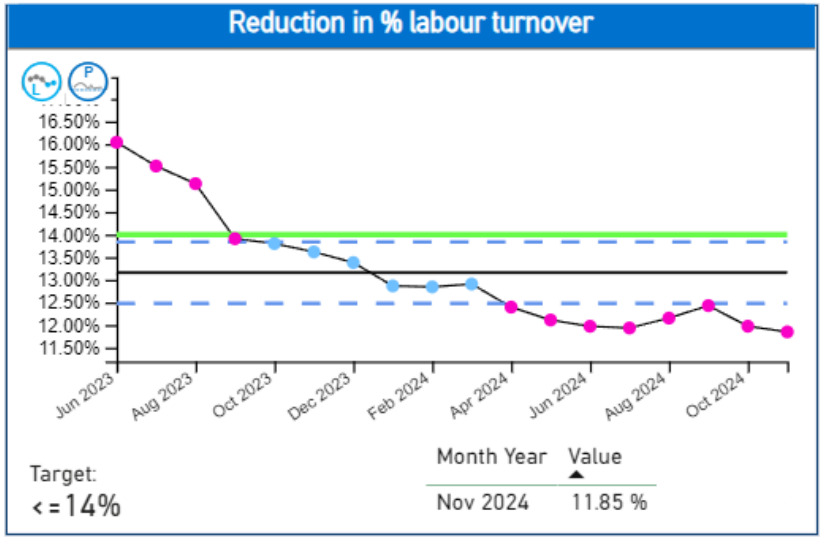
Focus on upskilling managers, including manager briefings and bespoke absence management training continues. Absence management training is being delivered in larger services where there are new line managers. We are also working on virtual e-learning sessions to make accessing training modules and materials easier for managers. Work to ensure a smooth transition from Good shape to managing absence through the E-rostering system is almost complete with training sessions for managers well underway and the transition occurring on 1 November. The transition away from Goodshape has been relatively straightforward with very few system problems.

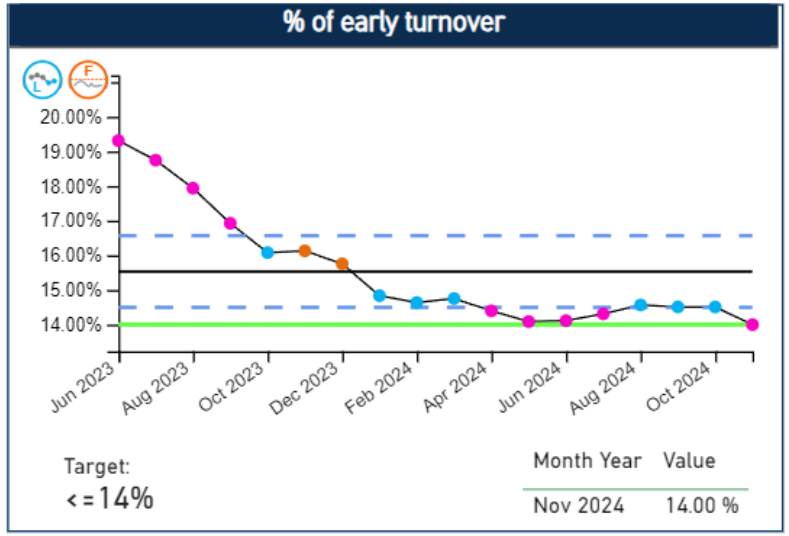
Actions Occupational Health/ Well being

The Occupational Health team undertook 190 management referrals, 8 self-referrals, no ill health retirement applications and 102 reviews during November. Of the 30 management referrals relating to Musculo-skeletal (MSK) causes, 12 were attributed to work-related issues and 5 were referred on for physiotherapy. From a stress perspective (both attributed to work and non-work-related causes) 39 referral appointments were completed (33 for perceived work stress), 8 were referred on for Staff Psychology Service assessment.

Other activities included processing 134 work health assessment questionnaires, 63 of which needed a follow-up appointment, 9 case conferences, 3 workstation specialist advice/assessment and 8 management of blood borne virus incidents. The Staff Psychology Service received 11 new referrals during November and completed 9 initial consultations plus 60 ongoing treatment sessions. Waiting times were 16 working days day on average for initial consultation. 4 Mindfulness sessions were offered.

A new Occupational Health system is being implemented between in January 2025, which has resulted in some disruption and a backlog of appointments. A risk has been added to Trust risk register and mitigations have been put in place.





Summary
Staff turnover decreased from 11.97% to 11.85% and remains below the 14% target. Early labour turnover has decreased from 14.51% to 14.00%, within target.

Staff Turnover for Black, Asian and Minority Ethnic staff is 11.96% which is the first time it is the same as White staff turnover.

The early turnover of Black, Asian and Minority Ethnic staff is still higher than early turnover of white staff with a reported 15.3% compared to early turnover of white staff 14.9% but the Trust is are moving in the right direction given the early turnover of Black, Asian and Minority Ethnic colleagues in April 2023 was 20.3%.

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

Actions

As a result of the deep dive and the hotspot areas identified the retention team have setup multiple workstreams as a direct response to reduce turnover in these areas.

The two priority areas are:

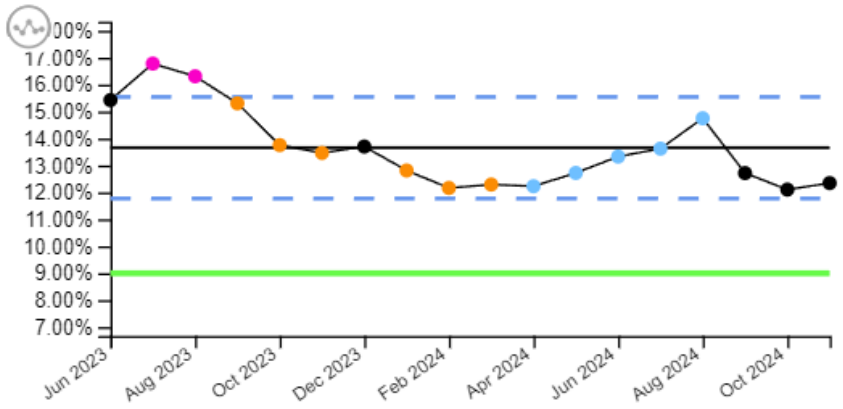
- Black, Asian and Minority Ethnic turnover – particularly band 3 males, clerical workers, health care support workers and staff nurses
- Early Turnover – Local Induction project launched, a new local induction checklist for managers is now being sent out to the manager of all new starters, this will be augmented with a planner and suggestions of activities that should be undertaken with new starters which will be launched in January.

The Retention Team presented at the People Steering Group a proposal for a Targeted Working Group aimed at progressing the Segmented approach by sharing key data and insights. The group will work together to resolve some of the challenges in hot spot areas that lead to high turnover. This was well received by PSG and the aim is to hold the first working group in January 2025.

The PDR Quality review is complete, and we are now in the design phase. One of the key themes that came from the review was that PDR's were meaningful if the manager tailored the PDR to the individual and gave enough time to complete it. The 2024 Staff Survey questions around appraisal will be reviewed when they results become available.

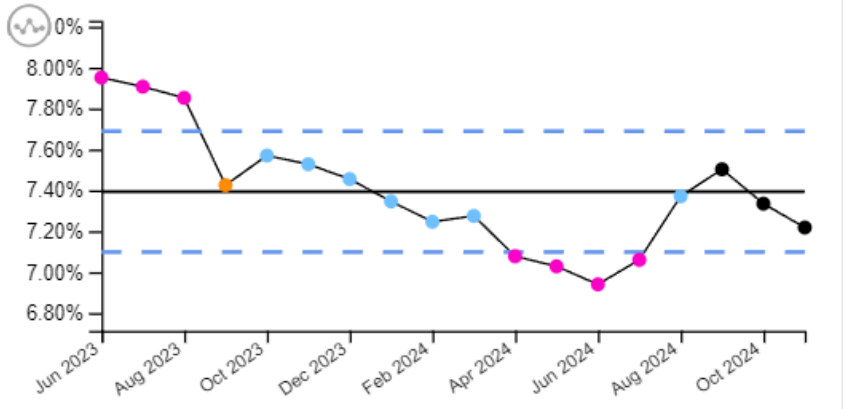
The Retention team ran several focus groups for Black and minority ethnic clerical workers and a questionnaire has been developed to understand more about their experiences of working here. This should highlight some areas of focus to make improvements going forward.

Reduction in vacancies



Target:	Month Year	Value	Numerator	Denominator
<=9%	Nov 2024	12.35 %	912.52	7,391.35

Staff leaver rate



Month Year	Value	Numerator	Denominator
Nov 2024	7.22%	450	6229

NOF

Summary

The vacancy rate has slightly increased from 12.11% to 12.35%; high vacancy rates will impact on staff wellbeing and retention, agency spend, and the quality of care provided to patients. The length of time that it is taking to hire an employee results in candidates withdrawing from recruitment process or securing roles in other organisations.

Hiring challenges remain due to low unemployment, talent market conditions, talent and skills shortages in key areas such as nursing alongside high cost-of-living and lower compensations in our geographical regions.

Actions:

A number of projects are underway to streamline our Time to Hire process. An Online ID checking platform, Trust ID, is being introduced which will result in most candidates no longer being required to attend Littlemore for an identity/right to work check. This will be rolled out in one area as a pilot by Q1 2025. Work is continuing to improve the recruitment system enabling candidates to complete and electronically sign and return onboarding documentation. These actions will speed up the time to hire, improve the efficiency of the recruitment team and improve the candidate experience.

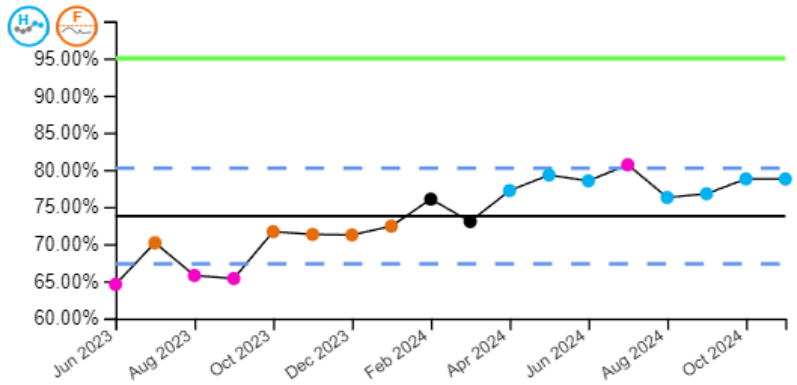
To improve the experience of staff and managers, the Recruitment team have now gone live on the HR Service Desk, progressing the HR functions strategy of one point of contact for all HR services for staff and managers. This will provide a better experience to internal customers and ensure queries are dealt in line with SLA's. The Service Desk will also enable the monitoring of responses and requests to drive improvements in the service provided.

A re-organisation of the Resourcing team has now been completed, the proposed new structure will be in place by early 2025 and will move the Trust towards a Talent Acquisition model.

Recruitment events for November and December included Universities such as Brighton and Reading, along with inhouse open days, planning is in progress for the 2nd Forensic HCA Assessment Centre to be held in January 2025 due to the success of the first event. In the longer team HCA recruitment will be centralised across the organisation with monthly assessment centres used to streamline the recruitment process, this will create efficiency, remove duplication of work and create a more positive candidate journey.

People

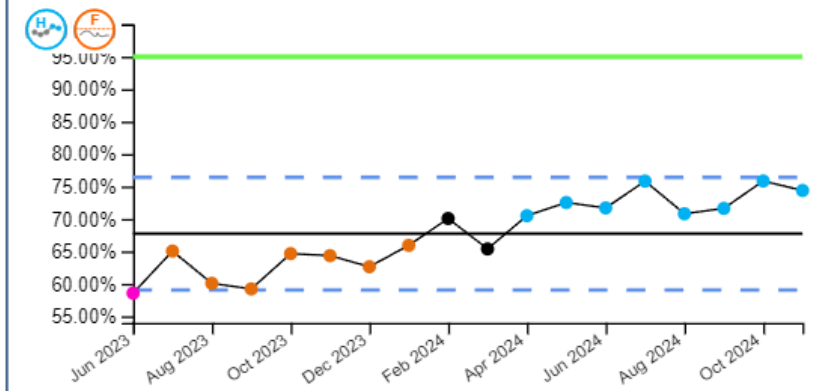
Clinical supervision completion rate



Target: >=95%

Month Year	Value	Numerator	Denominator
Nov 2024	78.76%	3496	4439

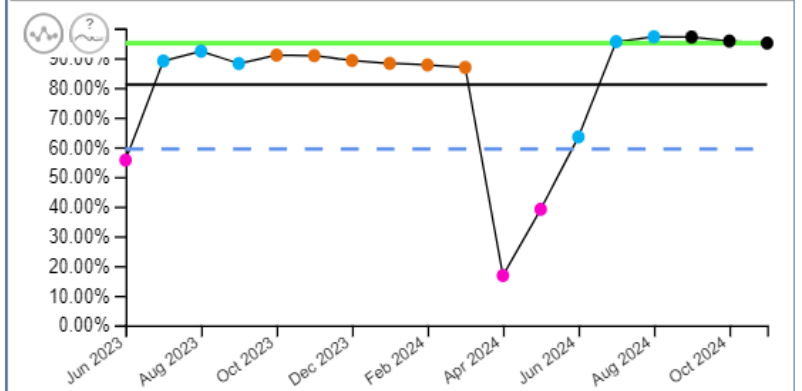
Management supervision completion rate



Target: >=95%

Month Year	Value	Numerator	Denominator
Nov 2024	74.39%	4760	6399

PDR Compliance



Month Year	Value	Numerator	Denominator
Nov 2024	95.03%	5281	5557

Summary

Good quality and regular management and clinical supervision is essential for ensuring that we provide high quality patient care and that we support staff in relation to their professional development and wellbeing. This Clinical supervision has remained the same as last month at 78.8%. Management supervision rate has decreased from 75.8% to 74.4%.

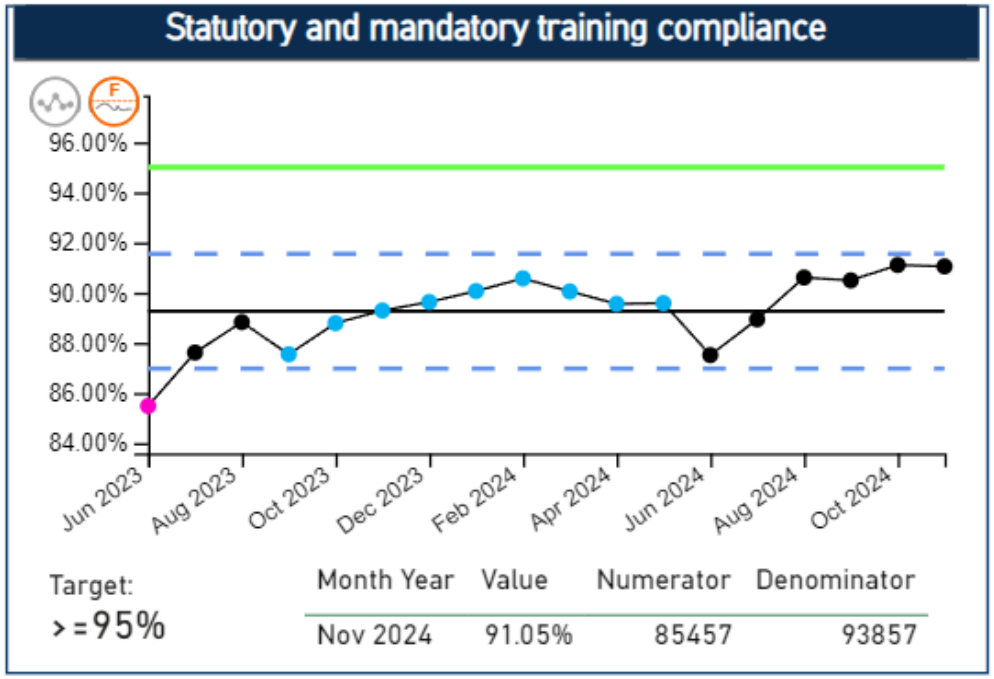
Action

The Education Strategy group is now monitoring supervision compliance – updates from the initial stages of the Quality Improvement (QI) project have been presented and the following actions are being taken forward:

- L&D systems team working with the provider to agree timeframe for changes to be made to reflect new recording of supervision.

Depending on outcome, Deputy Chief nurse and Head of L&D will:

- review of other Trust supervision policy to ensure all changes in line with CQC and professional body expectations.
- review staff survey questions relating to supervision to ensure supervision interactions are of quality and staff find them meaningful and update training/intranet/resources etc as required.



Summary

The Statutory and Mandatory rate has slightly decreased from 91.1% to 91.05%. Although monthly variation can be noted, the overall position for Statutory and Mandatory training continues to improve and all the directorates in the Trust are circa 90% and 3 above the 95% completion which demonstrates the continued commitment to supporting staff to complete this. There is currently focused work within the trust to improve the compliance for the Corporate Directorate which is the only outlier in compliance and currently sits at 85.75%.

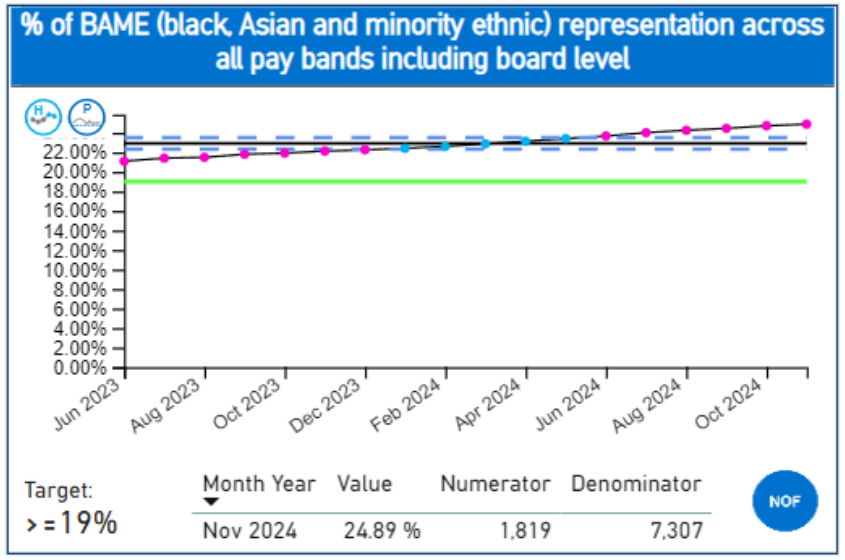
There is focused work on those pieces of training that are below 90% which includes Conflict resolution training, Fire safety training, Infection, Prevention and control training, Resus and the L1 Oliver McGowan training on autism and learning disability as well as work within the trust to improve the compliance for the Corporate Directorate.

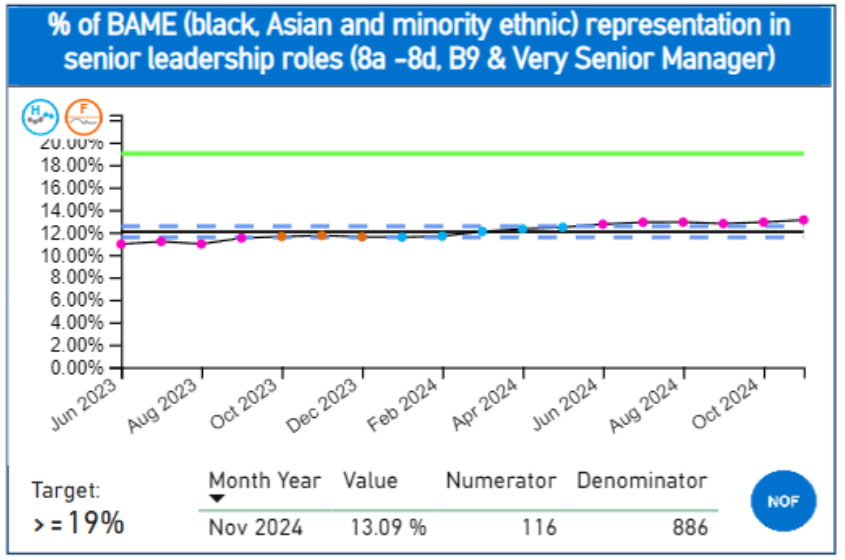
Actions

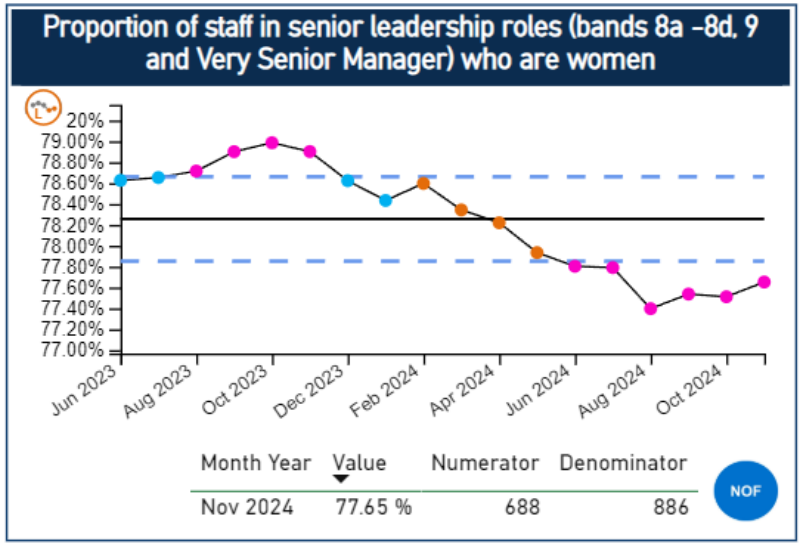
Assurances for training modules below 90%:

- Conflict Resolution – Compliance continues to improve and is currently 91.23%. Will continue to be monitored until end of FY to ensure compliance is sustained. Expected to be at 95% target by end FY.
- Fire safety (now including fire awareness 91.23% and fire response 81.7%) - Review of current training provision completed, and work is underway to create a more accurate audience for fire response training informed by the number of sites across the Trust and how these are managed. This should allow for more accurate scheduling of training.
- Infection Prevention and Control – Compliance continues to improve and is currently 89.67%. Expected to be at 95% target by end FY.
- Resus – Deep dive complete. Scheduling of additional training to address the backlog of outstanding staff complete but attendance remains a concern. Band 8a Senior resus post currently out to advert with interviews scheduled for 16th Jan 2025. Current overall compliance 78.24%.
- Level 1 Oliver McGowan – Compliance continues to improve and is currently 90.41%. Expected to be at 95% target by end FY.

People







Summary

- There has been an increase of 0.17% in the representation of Black, Asian and Minority Ethnic (Black, Asian and Minority Ethnic) staff across all pay bands in November 2024 reporting period.
- There has been an increase of 0.19% in the representation of Black, Asian and Minority Ethnic (Black, Asian and Minority Ethnic) staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in November 2024 reporting period.
- There has been an increase of 0.14% in the representation of Female staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in the November 2024 reporting period.

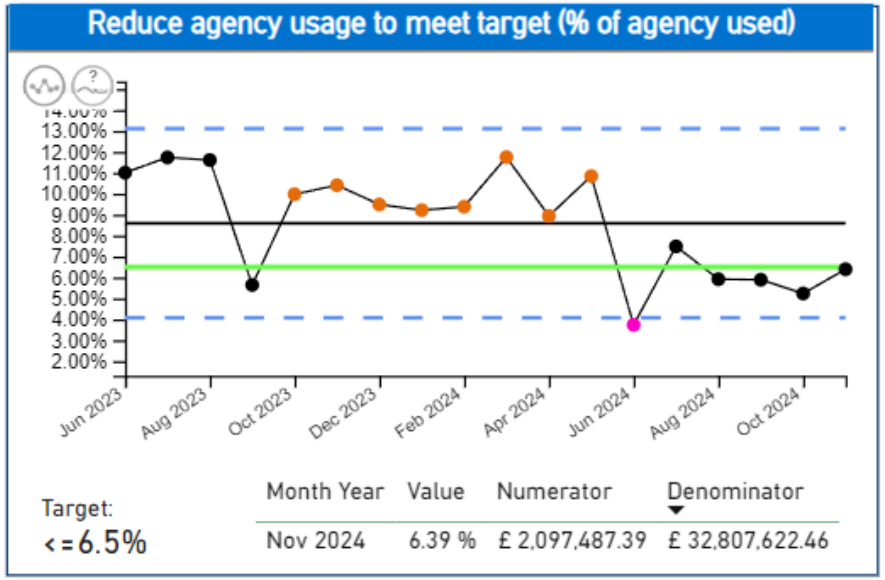
Actions

All three above metrics will be worked on under High Impact Action 2 to secure diverse and fair representation of staff in the workforce in line with inclusive recruitment and talent management principles. We will also draw on the analysis of the NHS Workforce Race Equality Standard (WRES) 2024 data and the Gender Pay Gap Report 2024 to understand how we improve representation for race and gender as this cannot be examined separately to the equality agenda.

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

Update:

- Proposal to recruit Inclusion Reps from all the directorates to sit on all interview panels for Band 8a and above is now in the implementation stage with directorates nominating staff.
- Work underway within the Human Resources and Learning & Development functions to define talent and succession planning more clearly to understand what interventions are a priority.
- Investment secured to put in place a Programme Lead, to support work to position the Trust as Anti-Racist – we will learn from others, particularly Berkshire Healthcare NHS FT.



Summary

Overall, total agency spend in November 24 was 6.4% of total pay bill The Trust is £1.1m better than plan for agency spend YTD.

Agency Spend as a % of Temporary Staffing was 39.4% (£2,097K) and Bank was 60.6% (£3,222k).

Fill rates :

NHSP shifts only (excl Medical & Dental): In November, 69.6% of our temporary staffing shifts (based on hours) were filled by bank workers, just below the 70% target. 27.9% were filled by agency workers and 2.5% were unfilled.

Medical & Dental (ID Medical, Allocate and Patchwork): In November, 42.6% of our temporary staffing shifts (based on hours) were filled by bank workers; 49.3% were filled by Agency workers and 8% were unfilled.

Highlights, updates, actions

Temporary Staffing for Agenda for Change Staff

NHS Professionals (NHSP) Will be fully staffed from January 2025, which will enable them to have a regular presence on all sites from February onwards. Analysis is being undertaken on areas where we continue to see high ad hoc agency use to target recruitment campaigns in those areas and increase Bank only headcount.

It has been agreed that NHSP will provide regular reporting to Estates to assist with the management of compliance of Bank Only workers covering Housekeeping and Portering roles, thereby reducing unavailability.

The Temporary Staffing team are continuing to support teams in migrating agency workers to the bank and substantive roles and bank workers to substantive posts. To date:

- 30 agency workers have migrated to the bank,
- 36 agency workers have moved to substantive posts
- 57 bank members have moved to substantive posts

A further 15 agency and 13 NHSP workers who are in the process of moving to substantive posts.

Agency AFC: There are currently 88 agenda for change agency workers who have ongoing temporary worker contracts with us across the Trust. The aim is to reduce this and we have made good progress with a reduction of 126 workers from a high of 214 in December 2023. Separate work is also underway to bring as many into the price cap as possible.

Retrospective shifts continue to be an issue and despite education, support and advice changes are insignificant.
6.7% of shifts filled were added retrospectively in November compared to 10.5% in November 2023. The target is 3%. The temporary staffing team will need to take to Directorate meetings and see what actions can be taken to prevent the continual utilisation.

Medical Agency use (ID Medical):

It has been identified that where rates have been increased to compensate for a medic moving from Non-Direct Engagement to Direct Engagement the overall cost to the Trust can in some instances be more due to the worker opting into the NHS Pension. Further analysis is being undertaken. We continue to be challenged by locum medics in relation to reducing their rates to come into line with the South-East rate card. Work is ongoing with ID Medical to reduce rates where every possible.

Section 3
Strategic dashboard

Strategic objectives

Strategic objectives guide the priority setting and decision-making. Each objective has a set goal and overarching ambitions, which are then linked to specific measures and targets. Full Strategic Dashboard was first reported to the Trust Board in November 2024 and is expected to be next reported in May 2025; in-year strategic metrics, where possible, are reported monthly.

Oxford Health NHS Foundation Trust

Quality	People	Sustainability	Research
Deliver the best possible care and health outcomes	Be a great place to work	Make the best use of our resources and protect the environment	Be a leader in healthcare research and education
To maintain and continually improve the quality of our mental health and community services to provide the best possible care and health outcomes. To promote healthier lifestyles, identify and intervene in ill-health earlier, address health inequalities, and support people's independence, and to collaborate with partner services in this work.	To maintain, support and develop a high-quality workforce and compassionate culture where the health, safety and wellbeing of our workforce is paramount. To actively promote and enhance our culture of equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment	To make the best use of our resources and data to maximise efficiency and financial stability and inform decision-making, focusing these on the health needs of the populations we serve, and reduce our environmental impact	To be a recognised leader in healthcare research and education by developing a strong research culture across all services and increase opportunities for staff to become involved in research, skills and professional qualifications
• Care is planned and delivered around the needs of patients • Patients are receiving effective care • We provide timely access to care and when waits occur, we will effectively monitor patients and minimise harm • We are addressing health inequalities • We consistently provide safe care, which a reduction in avoidable in-services harm • We have a safe and learning culture	• We have a sustainable workforce • We have an engaged, well led workforce • We have a skilled, learning workforce • We foster a just work environment	• We are spending and investing as efficiently as possible and sustaining our financial position over the medium term • We are on track for Net Zero Carbon emissions by 2045 as defined within the NHS Carbon Footprint plus • Our digital systems work for us, providing and asking for the right information to enable clinical care and population health management • We will have moved toward a modern, efficient estate that enables access and wellbeing for staff and patients	• We will sustain our leadership in research, strengthen our academic partnerships and embed research capability in the organisation • We will build our capacity to translate our research into services

Appendices

Latest NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Performance

Metric	Latest Target	Aug-24				Sep-24				Oct-24			
		BOB ICB	Oxon	Bucks	Berks W	**BOB ICB**	Oxon	Bucks	Berks W	**BOB ICB**	Oxon	Bucks	Berks W
72hr Follow-up	80%	**81%**	85%	75%	83%	**78%**	80%	90%	61%	**80%**	84%	76%	78%
CMH 2+ contacts (transformed)	10426	**10390**	5935	325	4150	**10810**	6280	340	4215				
CMH 2+ contacts	null	**14410**	5955	4340	4115	**15050**	6315	4505	4235	**16,155**	7105	4740	4320
CYP 1+ contacts	26531	**22600**	7390	6765	8445	**22900**	7520	6905	8500	**23352**	7695	7030	8620
CYP Paired scores (%)	null	**6%**	*	*	*	**9%**	*	*	*	**15%**	*	*	*
CYP Self-rated measurable improvement (%)	null	**39%**	*	*	*	**49%**	*	*	*	**43%**	*	*	*
CYP ED Routine	95%	**84%**	48%	77%	97%	**82%**	43%	83%	94%	**84%**	77%	86%	89%
CYP ED Urgent	95%	**62%**	*	63%	88%	**76%**	*	83%	83%	**95%**	100%	83%	100%
Dementia: 65+ Estimated Diagnosis Rate	66.70%	**62.5%**	63.0%	59.3%	65.9%	**62.5%**	63.1%	59.2%	65.8%	**62.6%**	63.3%	59.1%	65.9%
EIP 2 week waits	60%	**67%**	50%	76%	90%	**76%**	77%	71%	88%	**80%**	77%	78%	100%
Inpatient No Contact BME	null	**24%**	36%	31%	19%	**20%**	17%	*	25%	**20%**	*	36%	27%
Inpatient No Contact White British	null	**11%**	11%	21%	*	**9%**	11%	12%	*	**13%**	17%	10%	8%
Inpatient No Contact	null	**15%**	18%	22%	*	**13%**	11%	14%	10%	**16%**	16%	16%	15%
IPS	548	**590**	200	175	225	**660**	220	195	255	**760**	260	215	285
MH LoS - Adult Acute 60 days	8	**6**	8	2	8	**6**	8	2	9	**6**	8	3	7
MH LoS - Older Adults 90 days	8	**7**	9	6	6	**7**	7	6	10	**8**	9	5	11
OAPs active at the end of the period (inappropriate only)	5	*	*	*	*	*	*	*	*	5	*	*	*
Perinatal access (rolling 12 month)	1968	**1185**	310	280	595	**1285**	350	330	605	**1495**	470	415	610
SMI PH (quarterly metric)	60%					**44%**	31%	51%	58%				
Talking Therapies Completing a course of treatment	1422	**1815**	690	640	480	**1820**	735	585	500	**1970**	690	705	575
Talking Therapies Completing a course of treatment 65+(quarterly metric)	null					**500**	170	205	125				
Talking Therapies Completing a course of treatment (YTD)	8674	**9605**	3565	3300	2740	**11425**	4300	3885	3240	**13375**	4970	4590	3815
Talking Therapies Recovery	null	**52%**	49%	54%	52%	**50%**	50%	51%	50%	**50%**	46%	53%	52%
Talking Therapies Reliable Improvement	67%	**66%**	66%	66%	64%	**66%**	68%	63%	68%	**67%**	66%	65%	69%
Talking Therapies Reliable Recovery	48%	**48%**	46%	51%	48%	**47%**	47%	48%	46%	**48%**	44%	51%	49%
Talking Therapies Reliable Recovery BME (quarterly metric)	48%					**46%**	44%	48%	46%				
Talking Therapies Reliable Recovery White British (quarterly metric)	48%					**49%**	47%	52%	48%				
Talking Therapies 1st - 2nd Treatment >90 days	10%	**8%**	6%	2%	19%	**9%**	6%	2%	20%	**9%**	7%	4%	18%
Talking Therapies 6 week waits	75%	**95%**	100%	97%	86%	**96%**	100%	96%	90%	**97%**	100%	98%	93%
Talking Therapies 18 week waits	95%	**100%**	100%	100%	100%	**100%**	100%	100%	99%	**100%**	100%	100%	99%
Mental Health A&E 12hr breaches - Adult (%)	null	**13%**	12%	18%	10%	**16%**	13%	16%	18%	**17%**	15%	21%	17%
Mental Health A&E 12hr breaches - CYP (%)	null	*	*	*	*	**4%**	*	*	*	**7%**	*	*	11%
Referrals to LPS from A&E (contacts within 1hr)	null	**76%**	71%	75%	84%	**79%**	76%	84%	78%	**84%**	82%	88%	81%
Urgent referrals to CCS (contacts within 24hrs)	null	**58%**	42%	51%	83%	**64%**	52%	64%	69%	**62%**	69%	55%	74%
Very Urgent referrals to CCS (contacts within 4hrs)	null	**40%**	*	*	50%	**51%**	22%	73%	92%	**58%**	*	*	95%

* - figure too small to be reported or not reportable/monitored at Place level

Glossary of metrics (in continuous development)

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

Glossary of metrics (in continuous development)

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

Oxford Health
NHS Foundation Trust

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

29th January 2025

Quality and Safety Dashboard
For Information

Executive Summary

This paper is a summary of the quality and safety dashboard discussed monthly by the Quality and Clinical Governance Group and presented to every Quality Committee meeting. 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. The information in the Quality and Safety Dashboard is up to 30th November 2024

From reviewing a range of activity, quality and workforce indicators the below wards and community teams are highlighted by exception based on the position in November 2024 and a review of any trends from the last 3 months (September-November 2024). All of the wards/community teams were highlighted in last month's dashboard.

The report includes further details with the mitigations and actions being taken.

Highlighted wards/teams by exception:

	Enhanced Support (previously known as alert status)	**Early Warning** (previously known as to keep a watching eye)	
Inpatient Wards	• Kestrel • Kingfisher • Cotswold House Oxford • Meadow Unit CAMHS	• CAMHS Highfield • CAMHS Marlborough House • Sandford • Wintle • Allen • Ruby • Sapphire	
Community Teams	• Oxon North and West AMHT • City and NE AMHT • District Nursing	• Bullingdon mental health in-reach service • Bucks OA South CMHT • Bucks Aylesbury CMHT	• Bucks Chiltern East and West AMHT • PIRLS (Bucks) • Podiatry • Heart failure service • Special Care and Paediatric Dentistry

Governance Route/Approval Process

The Dashboard is a regular paper, developed with input from the Clinical Directorates. It is presented monthly to the Quality and Clinical Governance Group and Quarterly to the Quality Committee.

Statutory or Regulatory responsibilities

We are required to report on the inpatient staff fill rates to Trust Board members, this role has been delegated to the Quality Committee and we also on a 6-monthly basis present a safer staffing report to the Board of Directors.

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

1. Introduction

This paper is a summary of the quality and safety dashboard discussed monthly by the Quality and Clinical Governance Group and presented to every Quality Committee meeting. The information in the Quality and Safety Dashboard is up to 30th November 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. The indicators considered and the thresholds are detailed below.

Indicators reviewed

	Inpatient Wards	Community Teams
Workforce Domain	Day Reg Fill Rate (target more than 85%)	
	Day Unreg Fill Rate (target more than 85%)	
	Night Reg Fill Rate (target more than 85%)	
	Night Unreg Fill Rate (target more than 85%)	
	Nursing Associates - Day Shift Hours worked	
	Nursing Associates - Night Shift Hours worked	
	Agency % total pay (target less than 10.4%)	Agency % total pay (target less than 10.4%)
	Vacancies % (target less than 9%)	Vacancies % (target less than 9%)
	Total Turnover % (target less than 14%)	Total Turnover % (target less than 14%)
	Sickness % (target less than 3.5%)	Sickness % (target less than 3.5%)
Safe Domain	Number of staff injuries (all types of causes) with actual harm of moderate or above	Number of staff injuries (all types of causes) with actual harm of moderate or above
	Number of patient incidents with moderate or above harm (1 or less)	Number of patient incidents with moderate or above harm (1 or less)
	Most common sub-group group for reported incidents (patient and staff)	Most common sub-group group for reported incidents (patient and staff)
	Number of incidents of AWOLs (detained patients - unescorted, escroted or escape from ward) [this is Falls for Community Hospital wards)	
	Medicine Incidents resulting in harm (minor harm or above. Excludes patient refused)	Medicine Incidents resulting in harm (minor harm or above. Excludes patient refused)
	Number of pressure ulcers developed in service (categories 1-4, deep injury & unstageable. Includes where there are no lapses in care)	Number of pressure ulcers developed in service (categories 1-4, deep injury & unstageable. Includes where there are no lapses in care)
	Number of Incidents under the PSIRP from 4th Dec 2023 (note. SI criteria no longer exists)	Number of Incidents under the PSIRP from 4th Dec 2023 (note. SI criteria no longer exists)
	Unexpected deaths (natural and unnatural) incl. within 2 days of inpatient stay	Unexpected deaths (natural and unnatural)
	Number of physical restraint episodes (less than 10)	Number of suspected suicides
	Number of prone restraints (1 or less)	
	Number of seclusion episodes (less than 4)	
	Number of uses of LTS (less than 2)	
Effective Domain	Median Length of Stay YTD 23/24 incl leave (discharged patients)	Current number of patients breached waiting time target
	Number of Admissions in Month	Breached waits, Longest waiting time in days
	Bed occupancy in month excluding leave	Number of referrals received in month
	Clinical Supervision (target more than 95%)	Clinical Supervision (target more than 95%)
	Overall Mandatory Training performance (target more than 95%)	Overall Mandatory Training performance (target more than 95%)
	Fire Response Training (target more than 95%)	Fire Response Training (target more than 95%)
	Resus Training (target more than 95%)	Resus Training (target more than 95%)
	PEACE Training (target more than 95%)	
Experience Domain	Number of high/low complaints and rapid resolutions (2 or more)	Number of high/low complaints and rapid resolutions (2 or more)
	Number of informal concerns/early resolutions (2 or more)	Number of informal concerns/early resolutions (2 or more)
	Formal surveys received via IWGC in month- yes or no (no will be flagged)	Formal surveys received via IWGC in month- yes or no (no will be flagged)

We use the following threshold to identify the teams at early warning or enhanced support.

Table 1: Thresholds and expected response are detailed below, these are used as a guide.

Escalation level	When is a Team/ward Identified (Escalation Threshold)	Response
Early Warning	• 1 indicator is red rated, and 1 indicator is amber rated across at least 2 of the 4 domains. This is a guide, and a clinical Directorate might identify a team for Early Warning from soft intelligence. • A red rating of high vacancies on their own without concerns in fill rates will not identify a ward/team.	• Monitoring led by the clinical Directorate level through their clinical governance structure. • If a ward/team has been at Early Warning level for 3 consecutive months they will be moved to Enhanced Support unless there is an explanation which will be shared in the Dashboard with the Quality and Clinical Governance (QCG) sub-group. (this starts from June 2024)

Escalation level	When is a Team/ward Identified (Escalation Threshold)	Response
	• A red rating of fill rates will be considered in relation to safe staffing levels across reg/unreg staff and bed occupancy. This will not automatically lead to a ward/ team being identified. • A team/ward at Enhanced Support level can be stepped down to Early Warning if agreed by the Directorate Clinical Director/Associate Director of Nursing.	
Enhanced Support	• 2 indicators are red rated across at least 2 of the 4 domains. This is a guide, and a clinical Directorate might identify a team for Enhanced Support from soft intelligence. • A team/ward at Early Warning level for 3 consecutive months unless there is a clear reason (starting from June 2024).	• Clinical Directorate to identify actions being taken. • Actions being taken to be reported in the Dashboard and reviewed by the QCG sub-group. Additional support can be requested. • There may be a request for a more detailed presentation/deep dive at the next QCG meeting to look at the impact of the actions being taken.

This report is developed following the below process to bring together data and soft intelligence;

2. Interactive Contents Page

As the dashboard has grown the below links allow you to move around the sections in the dashboard more easily.

Contents

3. Overall summary of highlighted wards/community teams

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 November 2024 and a review of any trends from the last 3 months (September to November 2024).

Table 2.

	Enhanced Support (previously known as alert status)	**Early Warning** (previously known as to keep a watching eye)	
Inpatient Wards	• Kestrel • Kingfisher • Cotswold House Oxford • Meadow Unit CAMHS	• CAMHS Highfield • CAMHS Marlborough House • Sandford • Wintle • Allen • Ruby • Sapphire	
Community Teams	• Oxon North and West AMHT • City and NE AMHT • District Nursing	• Bullingdon mental health in-reach service • Bucks OA South CMHT • Bucks Aylesbury CMHT	• Bucks Chiltern East and West AMHT • PIRLS (Bucks) • Podiatry • Heart failure service • Special Care and Paediatric Dentistry

The rest of the report is organised by Clinical Directorate.

4. Buckinghamshire Mental Health Services

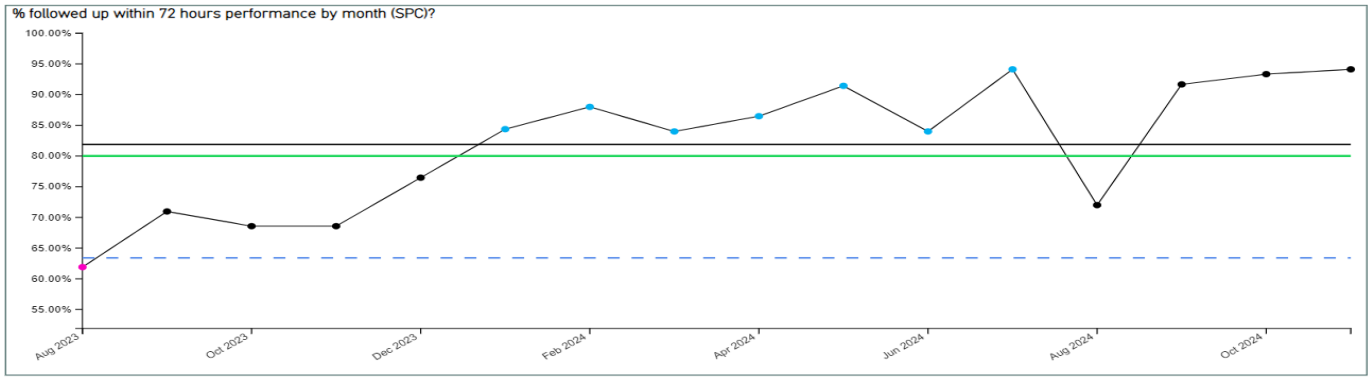
4.1 Teams with High Vacancies 30% or above (data source finance)

Inpatient Wards	Community Teams
• Ruby 32.7% (same) See TOBI inpatient quality and safety dashboard for full detail including vacancies and shift fill rates for every inpatient wards.	• Aylesbury CRHT 30.1% (same) • PIRLS 37.8% (same) • Chiltern East AMHT 35.5% (improved) (Chiltern West AMHT 26%) • Rehab team 35.8% (same) • OA South CMHT 45.8% (improved) • Adult Community Medical 34.5% (improved) • Older Adult Community Medical 57% (same) • CAMHS Neuro 36.8% (worse) • Personality Disorder Medical 48.3% (same)

4.2 Performance on inpatients followed up within 72 hours of discharge

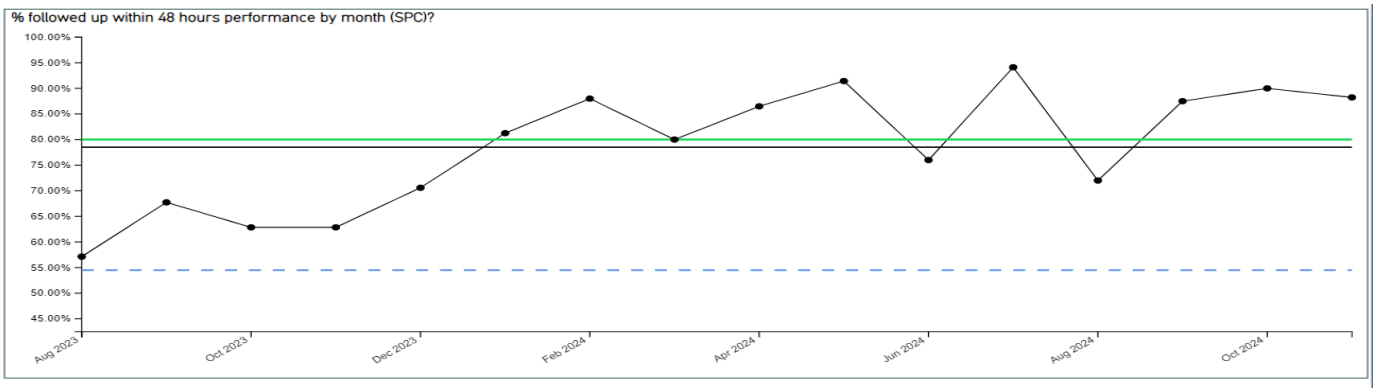
From April-November 2024 there were 244 eligible discharges with performance for 72 hour follow up at **85%.** Performance just for November 2024 was 94%.

Performance for follow up within 48 hours from April-November 2024 was 83%, graph by month below.



Eligible discharges followed up within 72hrs by ward in period selected

Ward	Eligible Discharges	Follow up 72 Hour Compliant	Follow up 72 Hour Compliant %
AMHB Ruby Ward	80	67	83.75%
AMHB Sapphire Ward	93	75	80.65%
B Older Adult Amber Ward	71	65	91.55%
Total	244	207	84.84%



4.3 Detail about wards and community teams highlighted

There are no wards/teams identified at Enhanced Support.

The following wards/teams are identified at an Early Warning level, those highlighted in yellow have been at this level for 3 consecutive months;

Wards at Early Warning

Ward	Reason for highlighting
Ruby	High vacancies 32.7%. Safe staffing maintained and no concerns about fill rates. 1 complaint and 3 early resolutions received in the month. No feedback gathered via IWGC in month.
Sapphire	High vacancies 21%. Safe staffing maintained and no concerns about fill rates. Vacancy for ward manager since Oct 2024, deputy acting up as interim. 5 seclusions in the month. Low clinical supervision rate (53% in Nov 2024, an improvement from Oct). 0 complaints/rapid resolutions and 1 early resolutions received in the month. No patient feedback gathered via IWCG in month. Tragically there was an unexpected inpatient death on the ward on 02/12/24.

Community Teams at Early Warning

Team	Reason for highlighting
Bucks OA South CMHT	High vacancies 45.8% (reducing). Also of note - 6% turnover. In last 3 months (Sept to Nov 2024): 0 high/low level complaint, 2 rapid resolution complaints and 1 early resolutions –related to feeling there is insufficient care/medication. 11 patient incidents in the last 3 months (Sept to Nov 2024) relating to patient self-harm and communication/confidentiality.
Bucks Aylesbury CMHT	Vacancies 25.5% (worse than last month). In last 3 months (Sept to Nov 2024): 0 low level complaint, 4 rapid resolution complaints and 4 early resolutions – mostly related to feeling there is insufficient care. 11 patient incidents in the last 3 months (Sept to Nov 2024) including 3 deaths (1 sepsis death, 1 expected/unnatural death and 1 suspected suicide). Most incidents relate to communication/confidentiality.
Bucks Chiltern East and West AMHT	High vacancies East AMHT 35.5% and West AMHT 26%. In last 3 months (Sept to Nov 2024): 0 low level complaint, 3 rapid resolution complaints and 2 early resolutions – mostly related to communication. 6 patient incidents in the last 3 months (Sept to Nov 2024) including 1 suspected suicide, and 1 sepsis death.
PIRLS	High vacancies 37.8% (same) and turnover 35%.

5. Community Health Services, Dentistry and Primary Care

5.1 Teams with High Vacancies 30% or above (data source finance)

Inpatient Wards	Community Teams
No wards with vacancies at 30% or higher. See TOBI inpatient quality and safety dashboard for full detail including vacancies and shift fill rates for every inpatient wards.	• Podiatry 39.6% (same)

5.2 Detail about wards and community teams highlighted

The wards/teams identified at Enhanced Support;

- District Nursing Service

See details below with the mitigations and actions being taken.

In addition, the following teams are identified at an Early Warning level, those highlighted in yellow have been at this level for 3 consecutive months;

Community Teams at Early Warning

Team	Reason for highlighting
Podiatry	High vacancies 39.6% due to local/national recruitment challenges and high demand. Turnover at 28%. There is a podiatry improvement plan with multiple workstreams that are looking to increase capacity. Waits for treatment including urgent patients waiting beyond required thresholds to be seen. 8 moderate/severe harm patient incidents reported in the last 3 months (Sept to Nov 2024), 1 serious harm relating to sepsis and 1 moderate harm to delay/failure in treatment, learning being reviewed at the moment. An annual thematic review has started to look at progress since last learning reviews, strength of mitigations and impact of actions taken. 2 low complaints, 1 rapid resolution and 2 early resolutions received in last 3 months (Sept to Nov 2024) relating to insufficient care.
Heart failure service	Waits for treatment is around 18 weeks against the NICE best practice of 2 weeks. This is due to demand exceeding the capacity of the team. No vacancies in team. None of the Community Heart Failure (HF) teams across BOB are able to see patients within 2 weeks; benchmarking demonstrates Oxon has the lowest community nurse establishment for HF despite having the largest population. The ICB rejected a Business Case submitted to increase HF capacity due to a lack of funding. Mitigations and actions are in place, including; a clear Triage SOP, a SOP to improve reporting of deaths, a patient 'waiting well' letter with safety netting has been sent to all current patients and going forward to all new patients, work underway with the EMIS team to optimise reporting from the system, improved partnership working with the OUH acute HF team and work with SDECs to support the management of HF patients. Thematic review completed by Clinical Director focusing on a review of deaths for patients on the waiting list for follow up treatment by the community HF team from Jan-Oct 2024. The review identifies the actions taken and recommendations for further actions.
Special Care & Paediatric Dentistry	Waits for treatment under GA, Children: 189 on waiting list for up to 10 months (Horton Hospital) and 4 months (JR). This is a reduction from last month. Adults: 18 on waiting list for up to 6 months, a reduction from last month. An additional 26 patients are awaiting an OUH consultant anaesthetist led pre-assessment prior to adding to GA list. Around 57% of patients are waiting over 18 weeks for treatment. 6 additional full day weekend theatre sessions have been used from Sept 2024 which has reduced the number of people waiting. Plan is to work more additional paediatric theatre lists at the weekend before 31/03/2025 to reduce this waiting list further.

Wards and Community Teams identified at Enhanced Support

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
District Nursing	Yes	• Growing demand is exceeding capacity and current available resources. The service carries a caseload of around 7,000 patients at any one time. (very low vacancies and turnover ranging	Executive team agreed additional funding at risk to increase DN staffing; the Trust secured funding for the introduction of wound care apps with PM support.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
		from 5%-29% by team, highest for North East team) • Over 8,000 visits a month are being delayed/rolled. There is a proven 28%+ gap between funded capacity and demand for the service, and referrals are increasing. • In the last 3 months (September to November 2024) the majority of incidents have related to category 2 pressure damage (developed in service) n=125 and medicines administration/supply n=70. There has been an increase in incidents between September to November, to above average levels relating to more incidents of no harm or minor harm. Most incidents are within the South West locality 149/400 relating to category 2 pressure ulcers. Out of the 54 incidents with moderate/severe harm 43 related to pressure damage developed in service. • 1 low complaint, 10 rapid resolutions and 5 early resolutions in the last 3 months (Sept to Nov 2024) mostly relating to insufficient care. With a higher number of concerns raised for the West DN team.	BOB Community Nursing Strategic Review and DN improvement plan Roll out of digital DN record underway. Urgent care services supporting essential daily visits (particularly at weekends). A clinical prioritisation framework is in place to prioritise care. Series of QI projects to maximise capacity and manage demand as much as possible.

6. Forensic Services

6.1 Teams with High Vacancies 30% or above (data source finance)

Inpatient Wards	Community Teams
• Kestrel 30.1% (same) (Kingfisher 25%, improved) See TOBI inpatient quality and safety dashboard for full detail including vacancies and shift fill rates for every inpatient wards.	• Mental health in reach service into Prisons Bullingdon (46.2%, same).

6.2 Detail about wards and community teams highlighted

The wards/teams identified at Enhanced Support;

- Kingfisher
- Kestrel

See details below with the mitigations and actions being taken.

No wards have been identified at Early Warning.

Community Teams at Early Warning

Ward	Reason for highlighting
Bullingdon mental health in-reach service	High vacancies 46% and high turnover 31% (similar to last month) impacting on treatment that can be provided.

Wards and Community Teams identified at Enhanced Support

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
Kestrel and Kingfisher (Thames House)	Yes	• Concerns raised by the Provider Collaborative following a quality visit to 5 forensic wards in July 2024. Key areas; MDT working, senior leadership, reflective practice not fully embedded, coordinated safeguarding arrangements, impact on therapeutic timetable for patients, care plans not person centred, medication administration and storage, gaps in physical healthcare. • High vacancies, 30% Kestrel (same as last month) and 25% Kingfisher (better than last month). Agency staff being used so staff fill rates fine, including Kingfisher increasing registered staff at night and having less unregistered staff working. • High use of restrictive practice on Kestrel, predominantly involving a patient.	The improvement plan was shared wat the Quality & Clinical Governance group in Nov 2024. This is monitored via governance processes and directly with commissioners weekly.

7. Learning Disability Services

7.1 Teams with High Vacancies 30% or above (data source finance)

No teams with vacancies at 30% or above.

7.2 Detail about community teams highlighted

There were no teams identified at Early Warning or Enhanced Support.

8. Oxfordshire and BSW Mental Health Services

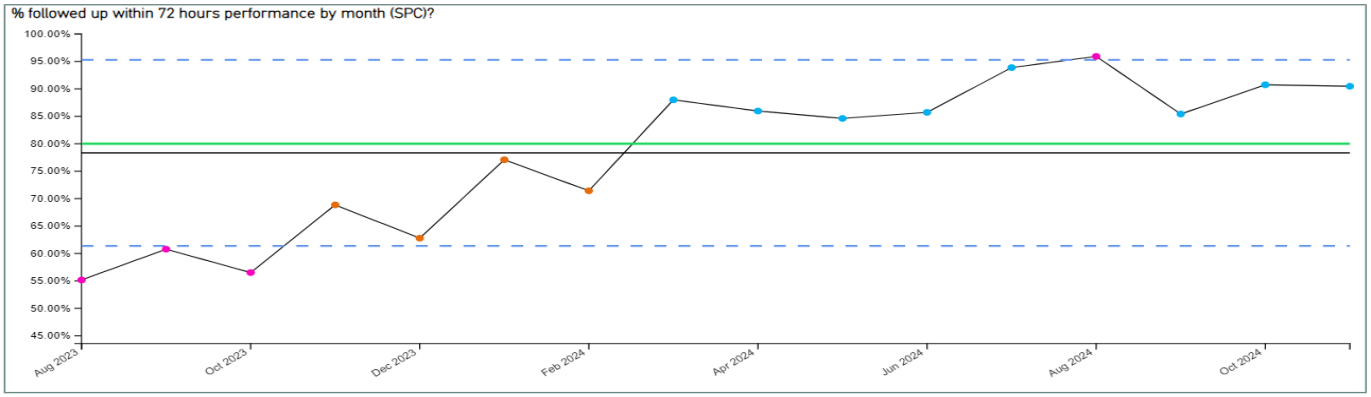
8.1 Teams with High Vacancies 30% or above (data source finance)

Inpatient Wards	Community Teams
No wards with vacancies at 30% or higher. See TOBI inpatient quality and safety dashboard for full detail including vacancies and shift fill rates for every inpatient wards.	• City and NE AMHT 30.5% (improved) • Oxon mental health hubs –Banbury 33.6% (improved) • CAMHS Neuro Psychiatry 41.2% (same) • CAMHS Crisis 34.6% (same) • Mental health support team into schools – South and City and West. • CAMHS LD/ASD Hospital@Home 44% (same) • Medical Eating Disorders 49% (same)

8.2 Performance on inpatients followed up within 72 hours of discharge

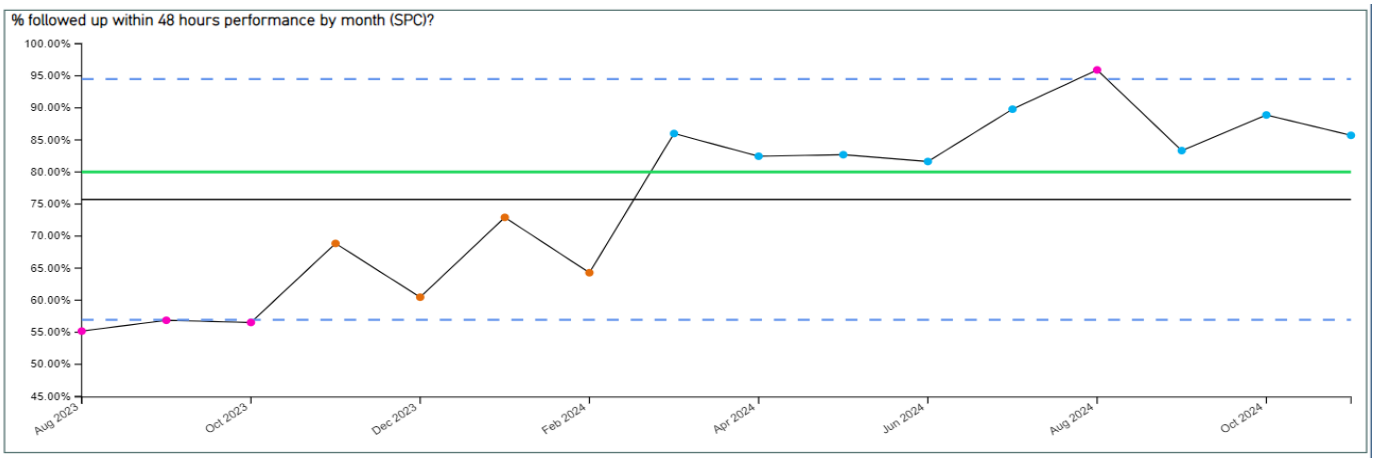
From April-November 2024 there were 400 eligible discharges with performance for 72 hour follow up at **85%.** Performance just for November 2024 was 91%.

Performance for follow up within 48 hours from April-November 2024 was 82%, graph by month below.



Eligible discharges followed up within 72hrs by ward in period selected

Ward	Eligible Discharges	Follow up 72 Hour Compliant	Follow up 72 Hour Compliant %
AMHO Allen Ward	76	65	85.53%
AMHO Ashurst PICU	11	9	81.82%
AMHO Phoenix	62	48	77.42%
AMHO Vaughan Thomas	66	58	87.88%
AMHO Wintle	83	67	80.72%
O Older Adult Cherwell	55	53	96.36%
O Older Adult Sandford	47	43	91.49%
Total	**400**	**340**	**85.00%**



8.3 Detail about wards and community teams highlighted
There are the wards/teams identified at Enhanced Support;

- Cotswold House Oxford
- Meadow Unit, CAMHS PICU
- Oxon North and West AMHT
- City and NE AMHT

See details below with the mitigations and actions being taken.

In addition, the following wards/teams are identified at an Early Warning level, those highlighted in yellow have been at this level for 3 consecutive months;

Wards at Early Warning

Ward	Reason for highlighting
CAMHS Highfield	High vacancies 19.8% although fill rates fine with the exception of skill mix change for night shifts with more unregistered and less registered staff. High use of physical restraint (n=49) and seclusion use (n=4) in month.
CAMHS Marlborough House	Number of vacancies 16% (improved) and sickness 9.9%, although fill rates met with 21.6% use of agency staff. High use of physical restraint in month (n=16). Clinical supervision levels dropped in Nov to 50% (84% in Oct 2024).
Sandford	High vacancies 25% although fill rates fine. High use of restraint (n=34) in month.
Wintle	High vacancies 24%, AWOLs for detained patients in month (n=2) and use of prone restraint in month (n=3).
Allen	High AWOLs for detained patients in month (n=5) and no patient feedback gathered via IWGC.

Community Teams at Early Warning
No community teams were highlighted.

Wards and Community Teams identified at Enhanced Support

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
Cotswold House Oxford	Yes	• Series of concerns raised by patients through PALS and complaints, VoiceAbility advocates and external commissioners over 4-month period. OCC Safeguarding and CQC informed of concerns and work underway. • Unexpected death from sepsis in March 2024 and AWOL incident with harm in Sept 2024 when patient self-harmed. • High vacancies for key leadership roles. Overall vacancy rate 11.3%. Recent high turnover, 18%. Fill rates for shifts fine and ward closed to admissions.	Ward paused for admissions from 4th October 2024. Currently 2 patients on the ward. OxBSW lead a quality review in May following some concerns and an initial action plan developed. The Provider Collaborative have since undertaken a second quality visit in Oct 2024. Improvement plan developed and being monitored weekly with input from the Provider Collaborative. Key areas: MDT working, leadership and communication, clinical competencies, patient centred care planning and risk management, engagement with families, communication with external agencies, staff conduct/communication, privacy and dignity for patients, racial abuse towards staff, staff well-being and support and management of physical health. Moved to enhanced monitoring by Provider Collaborative from 25th Oct 2024.
Meadow Unit, CAMHS PICU	Yes	• High turnover, 21%. Vacancies improving at 25.5%. Fill rates ok except for skill change for day shift with more unregistered staff. High use of agency staff. • High number of moderate patients incidents and staff injuries. • High use of physical restraint (n=36) and use of seclusion (n=10) in month. • 1 low complaint and 1 rapid resolution received in month and no patient feedback gathered via IWGC in month.	Supervision is improving, with local data indicating higher compliance. Ward have multiple group and peer supervision sessions. Recruitment on-going, skills mix review taking place to support team. Restrictive practice project in place to support staff team. Daily learning from incidents and MDT review of care. Incident learning huddle being pulled together with Senior Leadership Team and clinical team to support learning regarding multiple incidents of harm on the unit.
Oxon North and West AMHT	Yes	• Vacancies high 28% (worse than last month). Higher in the Witney team for clinical staff at about 56%. Risk with reliance on agency staff (15%) who can leave with no notice leaving patients unallocated and pressures on existing staff. Risk in relation to delays in treatment.	Substantive Consultants both off sick, and one vacancy. One WTE backfilled with Locum Consultant, other remains unfilled, seeking locum cover, 3 locums have been in team in the last 2 months, but unable to continue within the role.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
		• No substantive Consultants in team either off sick or vacancy. Half the clinical team are agency workers, resulting in some patients with no allocated worker. Team Manager on LT sick and due to leave post. • High sickness in team. • Clinical supervision in Nov 2024 67%. 80% last month. • 1 PSIRP case identified in last 3 months Sept to Nov 2024 where significant learning identified related to access to treatment. • 0 complaints, 5 rapid resolutions and 3 early resolutions in the last 3 months relating to insufficient care.	Team Manager on long term sick and due to leave post, out for recruitment, temp cover able to offer 1-2 days a week, seeking agency worker to cover post. 2 WTE further staff members due to be on long term sick following planned operations. Patients awaiting allocation have significantly reduced, 3 left and will be allocated this week. There are some breaches in patients being seen in the times frames, but contact is being had with all to review risks and mental state. Further meeting set with recruitment team on 13/12/24 to support and look at options.
City and NE AMHT	Yes	• High vacancies 30.5% (improved from last month at 32%) and turnover 20% resulting in some patients with no allocated worker. • 3 patient incidents with moderate harm or above in last 3 months (Sept to Nov 2024). Of which 2 incidents in Nov 2024. • 3 PSIRP cases identified in last 3 months, Sept-Nov 2024 2024 where significant learning identified related to access to treatment. • In last 3 months (Sept to Nov 2024): 3 low level complaint, 5 rapid resolution complaints and 4 early resolutions – medication and communication being the most common themes. Of which 4 complaints/rapid resolutions were received in Nov 2024. • 2 unexpected/unnatural deaths of which 1 was a suspected suicides in the last 3 months (Sept to Nov 2024).	Process mapping concluded and action plans being developed relating to referral and triage process. Further caseload reviews commencing again, following sickness, and increase in patient awaiting allocation in one of the teams. FACT team for recovery Campus has 3 clinical staff assigned, all three have handed in their notice, one has now left and post is advertised. Further planning regarding staffing needs to take place to ensure service is covered, considering existing staff within AMHT verses agency usage. Further meeting set with recruitment team on 13/12/24 to support and look at options.

For Information

Finance Report
November 2024 (Month 8), FY25
Report to Board of Directors

Contents

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

Executive Summary

Income & Expenditure position
- YTD £0.5m surplus – £1.7m favourable to plan
- Forecast £0.1m deficit – on plan

Capital Expenditure
- £4.7m underspend YTD
- £1.1m forecast overspend

Risks £8.5m
Opportunities £11.9m
Net £3.4m upside

Cash
- Actual £98.8m

Key messages:

1. The Revenue forecast remains on plan but includes £2.3m held for unknown risks. Taking into account the balance of opportunities, we have committed to improve our M9 forecast by £2.7m, breaking even without utilising deficit funding.
2. The revaluation of the properties using the Modern Equivalent Asset methodology is one of the opportunities likely to improve the revenue position. This opportunity has been estimated at £1.0m but is unknown until this work is completed.
3. Capital is forecasting an overspend of £1.1m, before any PFI exit payment. We are offering to exchange revenue to cover this capital overspend.

1. Income Statement

INCOME STATEMENT	Month 8				Year-to-date				Forecast			
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Forecast £m	Variance £m	Variance %
Clinical Income	45.0	47.0	2.0	4.4%	358.1	356.9	-1.2	-0.3%	537.3	533.6	-3.8	-1%
Other Operating Income	13.5	12.8	-0.7	-5.0%	84.2	93.5	9.3	11.1%	129.7	140.4	10.6	8%
Operating Income, Total	**58.5**	**59.8**	**1.3**	**2.3%**	**442.3**	**450.4**	**8.1**	**1.8%**	**667.1**	**673.9**	**6.9**	**1%**
Employee Benefit Expenses (Pay)	35.4	32.8	2.6	7.3%	270.9	260.5	10.4	3.8%	407.1	397.3	9.8	2%
Other Operating Expenses	21.9	25.2	-3.2	-14.7%	160.7	180.2	-19.5	-12.1%	243.4	260.8	-17.4	-7%
Operating Expenses, Total	**57.3**	**58.0**	**-0.7**	**-1.1%**	**431.6**	**440.6**	**-9.1**	**2.1%**	**650.5**	**658.2**	**-7.7**	**-1%**
EBITDA	**1.2**	**1.9**	**0.7**	**56.3%**	**10.7**	**9.8**	**-0.9**	**8.6%**	**16.6**	**15.8**	**-0.8**	
Financing costs	1.2	1.2	0.1	6.1%	11.6	9.0	2.7	29.8%	16.6	13.5	3.1	19%
Surplus/ (Deficit)	**-0.1**	**0.7**	**0.7**	**-1267.6%**	**-0.9**	**0.8**	**1.7**	**184.5%**	**0.0**	**2.3**	**2.3**	
Adjustments	0.0	0.0	0.0	0.0%	-0.3	-0.3	0.0	0.0%	-0.1	-0.1	0.0	0.0
Adjusted Forecast Surplus/ (Deficit)	**-0.1**	**0.6**	**0.7**	**-716.1%**	**-1.2**	**0.5**	**1.7**	**143.5%**	**-0.1**	**2.2**	**2.3**	
Amount held for unknown risks										2.3	2.3	
Forecast Surplus/ (Deficit)									**-0.1**	**-0.1**	**0.0**	

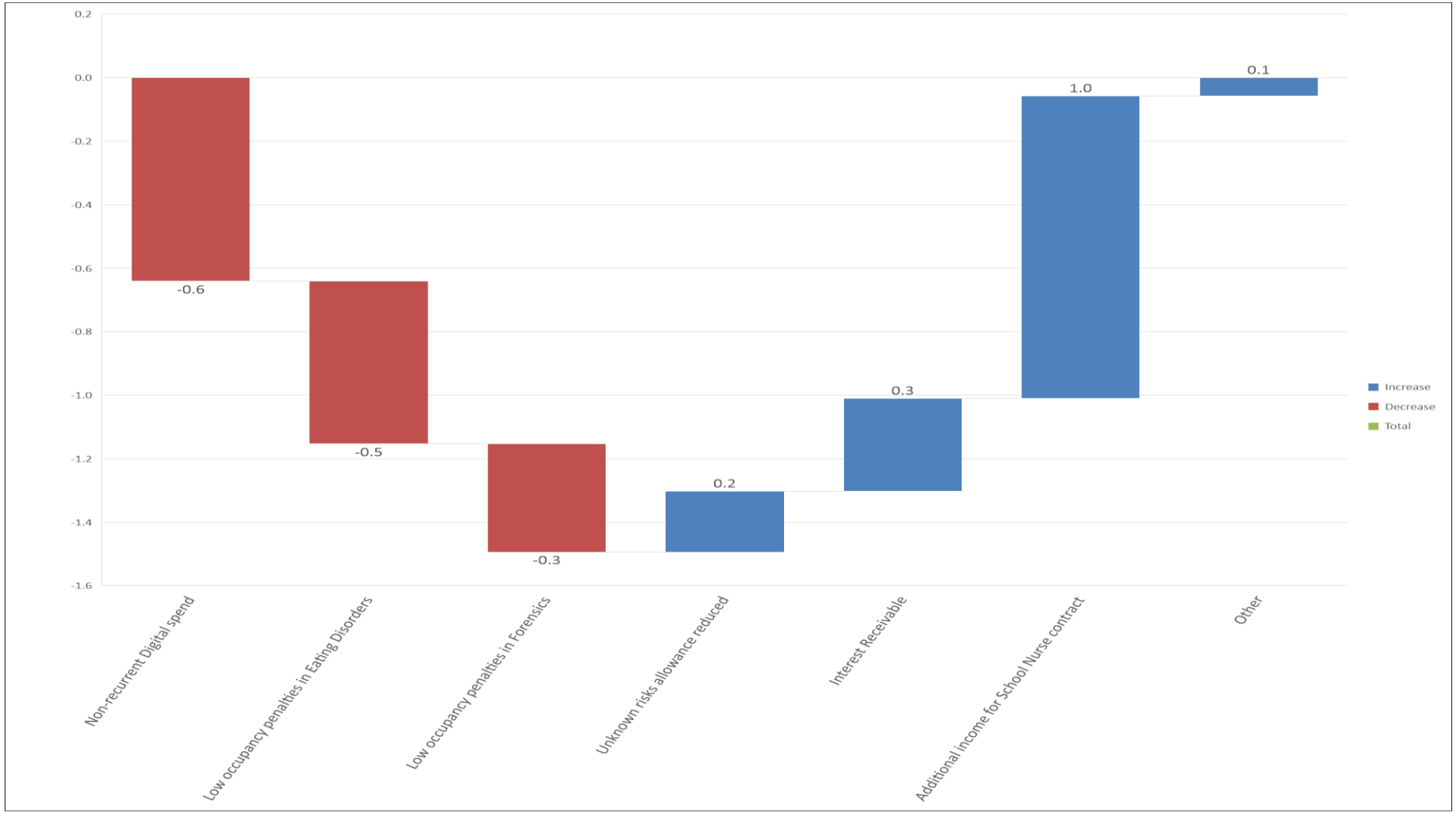
The YTD position at month 8 is a surplus of **£0.5m** which is **£1.7m** better than plan. EBITDA is **£0.9m** adverse to plan, offset with a favourable variance of **£2.7m** on Financing cost, due to higher than planned interest receivable (**£0.5m**), lower than planned PFI interest costs following the changed accounting treatment. These are offset with an adverse variance due to an expected profit on disposal in the plan but the sale of the asset has not yet happened.

The YTD favourable variance on income (**£8.1m**) is driven by **£6.3m** higher than planned sales in Oxford Pharmacy Store, **£1.2m** higher than planned Education & Training income, **£0.5m** higher than planned Research & Development income, **£0.1m** favourable variance on Provider Collaboratives where income has been matched to spend and a **£0.1m** net favourable variance across other areas.

The YTD adverse variance on expenditure (**£9.1m**) is due to higher cost of sales in Oxford Pharmacy Store (**£6.2m**), overspends on mental health out of area placements (**£2.4m**), **£0.1m** adverse variance in Research & Development (offset with higher than planned income) and a net **£0.1m** adverse variance across other areas.

The forecast is a **£0.1m** deficit which is on plan. This agrees to the submission made to NHSE and includes **£2.3m** on top of the base forecast held for unknown risks.

2. Forecast movement from previous month



3. Forecast Risks & Opportunities

Risks	£'000	Likelihood
Unavoidable non-recurrent spend	300	High
Non-payment of invoices	144	High
Audit/Balance Sheet year-end risks	3,000	Medium
Depreciation funding	1,063	Medium
Increase in agency	1,000	Medium
Mental Health OAPs	750	Medium
Unavoidable non-recurrent spend	700	Medium
Learning Disabilities OAPs	400	Medium
Education & Training income	100	Medium
Energy increase due to cold winter	100	Medium
School Nurse Contract income	953	Low
	8,510	

Opportunities	£'000	Likelihood
Modern Equivalent Asset Valuation	1,000	High
Transfer to Capital	189	High
SDF income	3,099	Medium
Audit/Balance Sheet year-end opportunities	3,000	Medium
VAT on IT licenses	1,000	Medium
Provider Collaborative underperformance gain share	750	Medium
Improved run-rate	500	Medium
Release of bad debt provision	300	Medium
Digital Income not in forecast	300	Medium
Income in Oxford Institute of Clinical Psychology Training	200	Medium
L&D income	180	Medium
Discharge of Learning Disabilities OAPs	100	Medium
Extension of Forensic EPCs	55	Medium
Release ED NHSE loan	850	Low
Discharge of Learning Disabilities OAPs	341	Low
R&D improvement	65	Low
	11,929	

Forecast range - all risks and opportunities			
£'000	Full Year	Full Year	Forecast Outturn
Upside Forecast	83	13,181	13,098
Downside Forecast	83	-8,427	-8,510

Forecast range - high likelihood risks and opportunities			
£'000	Full Year Budget	Full Year Actual	Forecast Outturn to Plan
Upside Forecast	83	1,272	1,189
Downside Forecast	83	-361	-444

The Trust's Forecast Outturn is for a **£0.1m** deficit, which is on plan. The includes **£2.3m** set aside for risks in the remainder of the year.

There are **£8.5m** of risks and **£11.9m** of opportunities to the forecast. This gives a forecast range of between **£11.9m** better than plan and **£8.5m** worse than plan. Taking into account the risks and opportunities with high likelihood only the forecast range is between **£1.2m** better than plan and **£0.4m** worse than plan.

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

4. Capital Investment Programme

Project Name	(B) Latest Budget £,000	(D) Actual Expenditure £,000	(E) System Commt's £,000	(F=D+E) Actual Plus Commt's £,000	(B-F) Variance £,000	(G) Estimated Forecast £,000	(B-G) Variance £,000	
Estates - Transformational Projects	8,967	1,221	4,126	5,347	3,620	6,756	2,210	☺
Estates - Operational	1,983	732	1,007	1,739	244	2,033	(50)	☹
Grand Total - Estates	10,950	1,953	5,133	7,086	3,864	8,789	2,160	☺
Oxford Pharmacy	117	(3)	-	(3)	121	114	3	☺
Grant Total Oxford Pharmacy	117	(3)	-	(3)	121	114	3	☺
IT Capital	277	-	365	365	(88)	315	(38)	☹
IM&T Clinical Systems	2,242	1,335	78	1,412	830	2,030	212	☺
Grand Total - IM&T	2,519	1,335	443	1,778	741	2,346	173	☺
PFI	-	-	-	-	-	-	-	
Grand Total	13,586	3,285	5,576	8,860	4,726	11,248	2,337	☺

Funding Sources	Original Funding	Changes	Latest Funding	Comments
ICS Allocation	9,459		9,459	ICS Envelope
Contribution towards CMHF Hub Wantage from Landlord		-	-	£17k received from Landlord. Removed from funding and reflected in the Wantage HUB project as income.
PDC Allocation - Estates:				
PDC Allocation - IM&T:				
-Frontline Digitalisation		469	469	
-Network Upgrade (NHSE)		50	50	24/7/24 email from A. Corfield agreeing £70k from NHSE. 19/8/24 email from H Woodley - funding reduced to £50k.
Other Funding:				
PICU VAT Recovery estimate		-	-	10/10/24 Credit Note £1,012k recieved from Kier. Removed from funding and reflected in the PICU project as income.
Sale of Shrublands		200	200	9/10/24 Exchanged on sale. Completion date set for 7/3/25.
Total Funding Available	**9,459**	**719**	**10,178**	
Funding £10,178k less Budget £13,586k			(3,408)	
Funding £10,178k less Est. Outturn £11,248k			(1,070)	

The Trust spent **£3,285k** (£1,975k M1-7) on its core capital programme to the end of November.

£1,535k of leased assets were capitalised as 'Right of Use Assets' in the first 8 months of FY25.

The capital plan is forecasting a **£2.3m** underspend against budget but a **£1.1m** overspend against all available funding.

The Estates team review of this year's capital programme and priorities has already reduced the net forecast outturn by **£2.7m** from M3.

The potential PFI exit payment also presents a risk to the capital forecast.

5. PFI Exit Settlement Risk

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

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

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

Valuation work has been completed and shared by both parties and the RICS (Royal Institute of Chartered Surveyors) has appointed an arbitrator.

Extra work has been requested by OHFT in relation to conditions surveys and due diligence as both expected to impact, and reduce, the final settlement value.

It is unlikely that the arbitration process will be concluded in this financial year. However, any exit payment could be considered a post balance sheet event that should be reflected in the accounts if material and if the process concludes before accounts are laid.

6. Directorate Financial Performance Summary

	Month 8				Year-to-date				Forecast			
	Plan	Actual	Variance	Variance	Plan	Actual	Variance	Variance	Plan	Forecast	Variance	Variance
Directorate	**£m**	**£m**	**£m**	**%**	**£m**	**£m**	**£m**	**%**	**£m**	**£m**	**£m**	**%**
Oxfordshire & BSW Mental Health	12.5	12.8	-0.2	0.0%	97.7	95.6	2.0	0.0%	147.5	147.1	0.4	0%
Buckinghamshire Mental Health	6.2	6.2	-0.1	-1.0%	47.1	44.4	2.8	5.8%	71.0	68.8	2.2	3%
Forensic Mental Health	2.8	2.8	0.0	-1.0%	22.4	22.6	-0.2	-1.0%	33.5	34.1	-0.6	-2%
Learning Disabilities	0.5	0.6	-0.1	-14.0%	4.1	4.7	-0.6	-15.7%	6.1	7.0	-1.0	-16%
Provider Collaboratives	-2.3	-2.3	0.0	0.0%	-6.6	-6.6	0.0	0.0%	-9.9	-9.9	0.0	0%
MH Directorates Total	**19.8**	**20.2**	**-0.4**	**-2.0%**	**164.6**	**160.7**	**3.9**	**2.4%**	**248.1**	**247.1**	**1.0**	**0%**
Primary Community & Dental	8.3	8.1	0.2	2.6%	67.9	66.9	1.0	1.4%	102.3	101.8	0.4	0%
Corporate	6.3	7.2	-1.0	-15.2%	48.2	48.9	-0.7	-1.5%	75.3	78.5	-3.3	-4%
Oxford Pharmacy Store	-0.1	-0.1	0.0	0.0%	-0.5	-0.7	0.2	-33.8%	-1.0	-1.2	0.2	-15%
Research & Development	0.1	0.0	0.0	38.8%	0.5	0.1	0.4	76.6%	0.7	0.5	0.2	31%
Covid-19 Costs	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0	
Reserves	-0.1	-1.5	1.4	-2117.0%	3.5	8.1	-4.6	-134.1%	0.2	-1.0	1.1	685%
Block Income	-35.4	-35.8	0.4	-1.0%	-294.8	-293.8	-1.0	0.3%	-442.1	-441.6	-0.5	0%
EBITDA	**-1.2**	**-1.9**	**0.7**		**-10.7**	**-9.8**	**-1.0**		**-16.6**	**-15.8**	**-0.8**	
Financing Costs	1.2	1.1	0.1	9.3%	11.6	9.0	2.7	22.9%	16.6	13.5	3.1	19%
Adjustments	0.0	0.0	0.0		0.3	0.3	0.0		0.1	0.1	0.0	
Adjusted (Surplus)/Deficit	**0.1**	**-0.7**	**0.8**		**1.2**	**-0.5**	**1.7**		**0.1**	**-2.2**	**2.3**	
Amounts held for unknown risks										-2.3	2.3	
Forecast (Surplus)/Deficit									**0.1**	**0.1**	**0.0**	

Block contract income is reported in a separate directorate. Clinical Directorate positions reflect the expenditure position less non-clinical income (mainly Education & Training income)

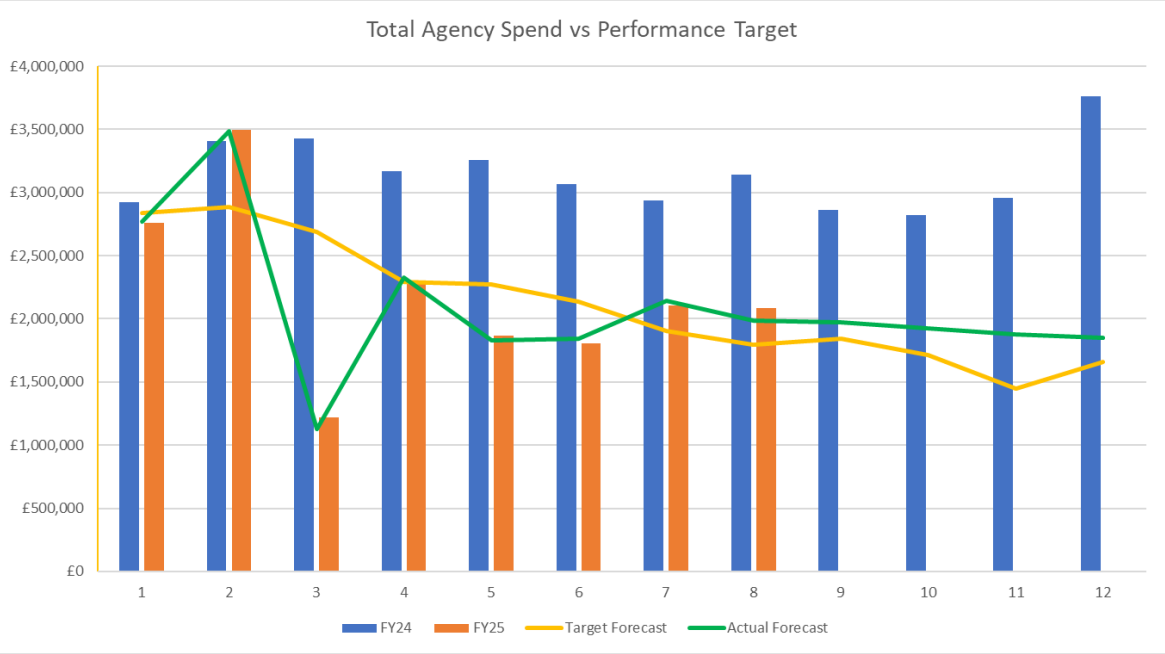
7. Provider Collaboratives Financial Performance Summary

	Month 8			Year-to-date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Secure	8.2	8.1	0.0	65.3	64.6	0.7	98.0	96.8	1.1
CAMHS	2.5	2.4	0.1	19.9	18.2	1.6	29.8	27.1	2.7
Adult AED	0.8	0.5	0.0	6.4	6.2	0.1	9.5	9.7	(0.2)
Provider Collaboratives Total	**11.4**	**11.1**	**0.1**	**91.5**	**89.0**	**2.5**	**137.3**	**133.7**	**3.6**

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

The Provider Collaboratives (PC) position is **£2.5m** favourable to plan YTD and forecast to be **£3.6m** favourable to plan. It is reported as breakeven in the Trust overall position in line with the principles of the PC to reinvest savings into services.

8. Agency Analysis



	FY24 Apr - Nov	FY25 Apr - Nov	Change from FY24
Medical	£9,890,807	£8,341,695	-£1,549,112
Nursing	£12,961,764	£7,822,741	-£5,139,023
AHP/HSS	£1,743,304	£931,545	-£811,759
Admin & Clerical	£506,768	£383,666	-£123,102
Estates	£52,857	£18,464	-£34,393
Total	**£25,155,500**	**£17,498,112**	**-£7,657,388**
FY24 VC's & FY25 Retros	£41,333	£131,979	£90,646
Prior year/Finance adjustments	-£41,333	£0	£41,333
Total Reported	**£25,155,500**	**£17,630,091**	**-£7,525,409**

YTD Target Forecast vs Actual Spend M8			
Staffing Type	**FY25 Target Apr - Nov**	**FY25 Actual Apr - Nov**	**FY25 Variance Apr - Nov**
Agenda for Change	£11,085,583	£9,288,397	£1,797,187
Medical	£7,724,817	£8,341,695	-£616,877
Total	**£18,810,401**	**£17,630,091**	**£1,180,310**

In Month 8 temporary staffing was **16%** of the Trust total pay bill with Agency at **6%** and Bank at **10%**.

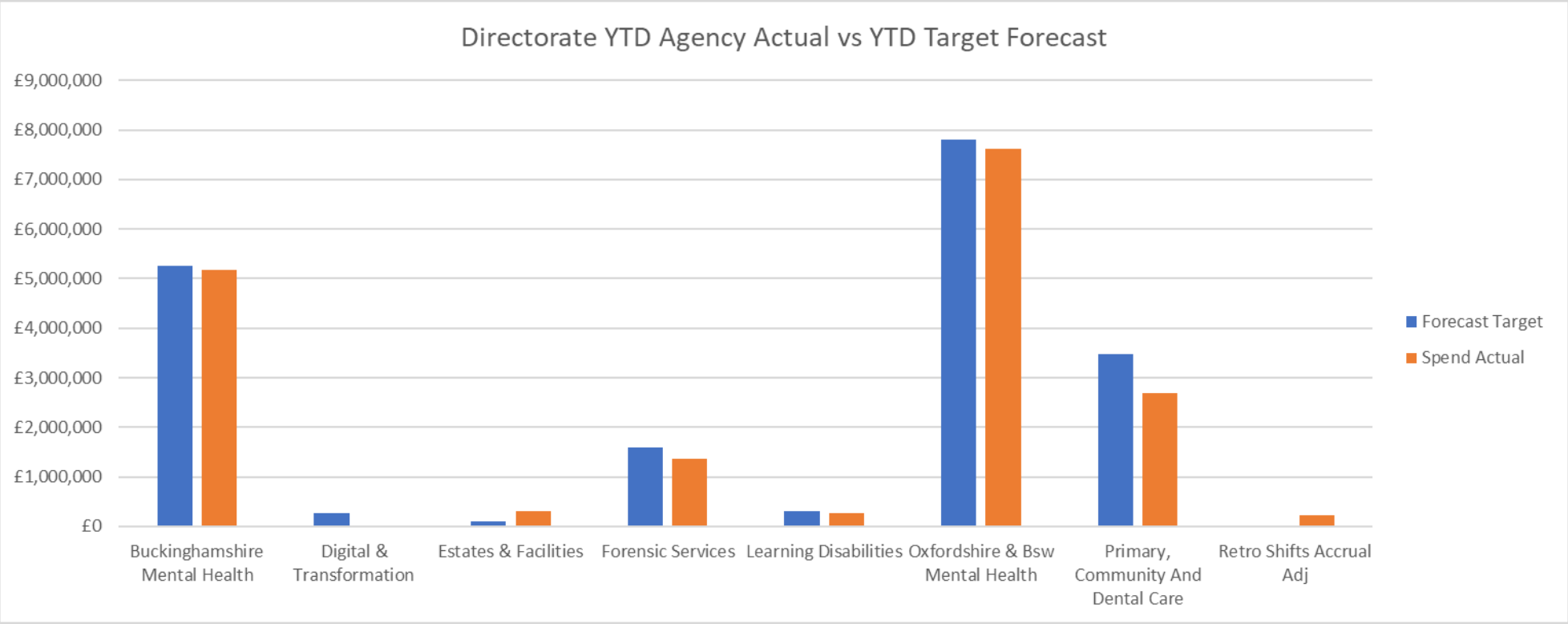
Included in the month 2 figures is **£1m** of agency cost related to FY24 which was reversed in month 3 as the FY24 accounts have been amended to reflect this.

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

Year to date agency spend, is **£1.2m** better than plan and **£7.5m** better than the same period in FY24.

The total Trust forecast spend is **£24.1m** which is **£0.3m** better than the target.

Agency Analysis Continued



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

An additional **£0.1m** was accrued in month 8 to account for any retrospective shift bookings related to this period.

All Directorates with the exception of Estates and Facilities have delivered spend levels within the target forecast year to date at month 8.

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

9. Cost Improvement Programme (CIP)

The Trust's external CIP target as reported to NHSE is **£40.2m** made up of a **£6.2m** efficiency from FY25 contract requirements (CIP) and **£34m** cost management. The Trust is reporting a full delivery of the **£40.2m** to NHS England on the assumption that any shortfall in these programmes has been mitigated by other non-recurrent benefits in the Trust's position.

Table of Planned Efficiencies							
Recurrent or Non Recurrent	**Efficiency Programme Area**	**YTD Plan M8 £000**	**YTD Actual M8 £000**	**YTD Variance M8 £000**	**Full Year Plan £000**	**Full Year Forecast £000**	**Full Year Forecast Variance £000**
Non-Recurrent	Non-Pay - Digital transformation	1,050	594	-456	1,575	891	-684
	Non-Pay - Estates and Premises transformation	0	1,232	1,232	0	1,848	1,848
	Non Pay - Other	24	24	0	36	36	0
	Pay - Agency - reduce the reliance on agency	3,359	3,359	0	5,068	5,068	0
	Non-Pay - Service re-design	6,944	6,904	-40	10,416	10,356	-60
	Pay - Establishment reviews	10,056	9,416	-640	15,084	14,124	-960
Total Non-Recurrent		**21,433**	**21,529**	**96**	**32,179**	**32,323**	**144**
Recurrent	Income - Non-Patient Care	472	472	0	708	708	0
	Non-Pay - Corporate services transformation	56	56	0	84	84	0
	Non-Pay - Digital transformation	190	646	456	285	969	684
	Non-Pay - Estates and Premises transformation	1,568	336	-1,232	2,352	504	-1,848
	Non-Pay - Fleet optimisation	8	8	0	12	12	0
	Non-Pay - Service re-design	112	152	40	168	228	60
	Pay - Establishment reviews	728	1,368	640	1,092	2,052	960
	Pay - Service re-design	2,152	2,152	0	3,372	3,372	0
Total Recurrent		**5,286**	**5,190**	**-96**	**8,073**	**7,929**	**-144**
Grand Total		**26,719**	**26,719**	**0**	**40,252**	**40,252**	**0**

Cost Improvement Programme (CIP) Cont.

Internally, as well as the **£6.2m** FY25 contract requirement, the Trust has an additional **£1.8m** CIP for FY24 CIPs that were not delivered recurrently last year, making the total internal CIP target **£7.9m**.

£6.5m of the **£7.9m** CIP target has been delivered through CIPs including upfront savings from investment, staffing establishment reviews and non-pay efficiencies. The remaining balance for the year is being met through non recurrent vacancies while recurrent plans are being developed.

	£'000				
Directorate	**CIP Target**	**Recurrent Delivery**	**Non Recurrent Mitigation**	**Total Delivery**	**Variance to Target**
Primary Community & Dental	2,548	1,240	1,308	2,548	0
Oxon & BSW MH	2,038	2,038	0	2,038	0
Bucks MH	983	983	0	983	0
Forensic MH	526	526	0	526	0
Learning Disabilities	199	199	0	199	0
Corporate	1,636	1,475	161	1,636	0
Total CIP	**7,930**	**6,461**	**1,469**	**7,930**	**0**
		81%	19%	100%	0%

10. Statement of Financial Position

Statement of Financial Position at 30 November 2024

31 Mar 24 £'000		31 Oct 24 £'000	30 Nov 24 £'000	Movement In-Month £'000	Movement YTD £'000	
	Non-current assets					
7,012	Intangible Assets	7,032	7,057	25	45	
216,329	Property, plant and equipment	213,106	213,453	347	(2,876)	
33,133	Finance Leases	31,514	31,111	(403)	(2,022)	
1,125	Investments	1,125	1,125	0	0	
412	Trade and other receivables	412	412	0	0	
651	Other Assets	654	654	0	2	
258,662	Total non-current assets	253,843	253,813	(30)	(4,849)	①
	Current Assets					
3,184	Inventories	5,190	5,718	527	2,533	②
21,722	Trade and other receivables	24,615	21,640	(2,975)	(82)	③
200	Non-current assets held for sale	200	200	0	0	
85,628	Cash and cash equivalents	99,846	98,807	(1,039)	13,179	④
110,734	Total current assets	129,852	126,365	(3,487)	15,631	
	Current Liabilities					
(77,857)	Trade and other payables	(87,102)	(87,578)	(475)	(9,721)	⑤
(2,614)	Borrowings	(2,255)	(2,297)	(42)	317	
(4,019)	Lease Liabilities	(4,067)	(4,067)	0	(48)	
(16,518)	Provisions	(16,354)	(16,365)	(11)	153	
(24,222)	Deferred income	(33,112)	(28,848)	4,264	(4,626)	⑥
(125,230)	Total Current Liabilities	(142,891)	(139,155)	3,736	(13,925)	
	Non-current Liabilities					
(12,049)	Borrowings	(11,381)	(11,381)	0	669	⑦
(21,814)	Lease Liabilities	(19,025)	(18,559)	466	3,255	⑧
(6,545)	Provisions	(6,521)	(6,521)	0	24	
(1,500)	Other Liabilities	(1,500)	(1,500)	0	0	
(41,908)	Total non-current liabilities	(38,427)	(37,961)	466	3,948	
202,258	Total assets employed	202,377	203,062	685	804	
	Financed by (taxpayers' equity)					
113,336	Public Dividend Capital	113,336	113,336	0	0	
83,359	Revaluation reserve	83,360	83,360	0	1	
1,125	Other reserves	1,125	1,125	0	0	
4,438	Income & expenditure reserve	4,556	5,241	685	803	⑨
202,258	Total taxpayers' equity	202,377	203,062	685	804	

1. Non-current assets have decreased by £4.8m YTD. Capital additions of £4.8m (including £1.5m of leased assets – mainly Unipart) have been offset by £9.6m of cumulative depreciation.
2. Inventories have increased by £2.5m YTD and by £0.5m in-month. The initial increase was due to a new infusion drug line being sold by OPS following a distribution agreement with NHSE/Sandoz as well as other aseptic drug lines. Due to increased sales, inventory levels of c£5m is expected to be steady state going forward.
3. Receivables have decreased by £3.0m in-month and by £0.1m YTD. The decrease in year is due to the combined reduction in prepayments, accrued income and VAT of £4.1m, and then offset by a net increase in outstanding debt of £1.1m
4. The cash balance has increased by £13.2m in-year and decreased by £1.0m in-month. The increase in-year is largely driven by an increase in accrued expenditure/payables of £12.5m and deferred income of £4.6m and the net outward movement/outflow of other operational, investing and financial activities of £3.9m (see cash flow statement).
5. Trade and other payables have increased by £9.7m in year and £0.5m in month. The YTD increase is driven by a net increase in trade payables and accrued expenditure of £7.5m and tax payables of £1.9m. This increase in accruals and payables is not an untypical monthly movement and often reflects the timing of the payment run. The increase in tax payables reflects the NHS pay award processed in M7.
6. Deferred income has increased by £4.6m in year and decreased by £4.3m in month. Most of the increase in-year can be attributed to the Provider Collaborative £0.3m, SDF income £0.5m, Learning Disability & Autism £2.2m, NHSPS £1.0m and other £0.6m.
7. Capital repayments of £0.7m in year have reduced the outstanding DHSC loan (that funded the Whiteleaf Centre).
8. Non-current lease liabilities have decreased in year by £3.3m and in-month by £0.5m. YTD capital repayments against existing and new leases of £4.8m have been offset by new lease liabilities of (£1.5m).
9. The £0.8m upward movement in year reflects the Trust's reported surplus in year.

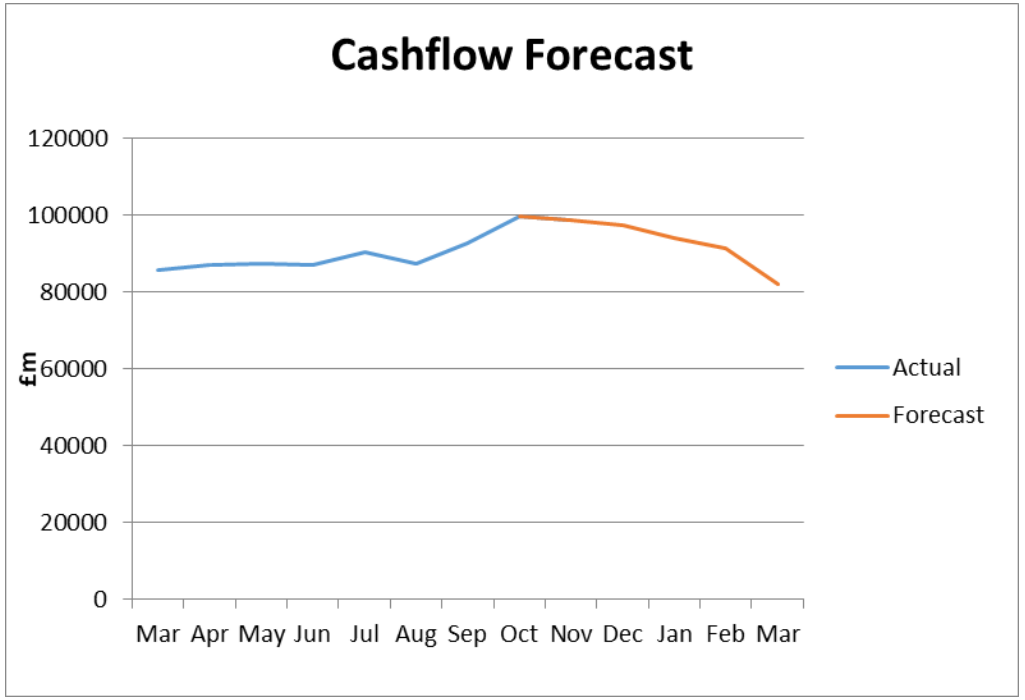
11. Cash Flow

STATEMENT OF YEAR TO DATE CASH FLOWS

31 Mar 24		31 Oct 24	30 Nov 24	Cash In/(Out) In-Month
£'000	**Cash flows from operating activities**	£'000	£'000	£'000
(13,832)	Operating surplus/(deficit) from continuing operations	(315)	198	513
(13,832)	**Operating surplus/(deficit)**	**(315)**	**198**	**513**
	Non-cash or income and expense:			
15,161	Depreciation and amortisation	8,226	9,566	1,340
13,733	(Increase)/Decrease in Trade and Other Receivables	(2,456)	262	2,718
(252)	(Increase)/Decrease in Inventories	(2,006)	(2,533)	(527)
(6,784)	Increase/(Decrease) in Trade and Other Payables	11,913	12,504	591
1,220	Increase/(Decrease) in Deferred Income	8,890	4,626	(4,264)
12,966	Increase/(Decrease) in Provisions	(199)	(188)	11
27,316	**NET CASH GENERATED FROM/(USED IN) OPERATIONS**	**24,053**	**24,435**	**382**
	Cash flows from investing activities			
5,414	Interest received	3,328	3,832	504
(13,256)	Purchase of Non Current Assets	(6,226)	(7,652)	(1,426)
(6,642)	**Net cash generated from/(used in) investing activities**	**(2,898)**	**(3,819)**	**(921)**
	Cash flows from financing activities			
(1,338)	Loans repaid	(669)	(669)	0
(6,035)	Capital element of lease rental payments	(4,159)	(4,625)	(466)
(657)	Capital element of Private Finance Initiative Obligations	(201)	(201)	(0)
(687)	Interest paid	(266)	(266)	0
(204)	Interest element on leases	(262)	(295)	(33)
(1,481)	Interest element of Private Finance Initiative obligations	(14)	(14)	0
(2,959)	PDC Dividend paid	(1,366)	(1,366)	0
(9,656)	**Net cash generated from/(used in) financing activities**	**(6,937)**	**(7,437)**	**(500)**
11,018	**Increase/(decrease) in cash and cash equivalents**	14,218	13,179	(1,039)
74,610	**Cash and Cash equivalents at 1st April 2024**	**85,628**	**85,628**	**0**
85,628	**Cash and Cash equivalents at end of period**	**99,846**	**98,807**	**(1,039)**

Summary Notes

- The actual cash flow movements are consistent with the comments made on the Statement of Financial Position.
- The closing cash position at the end of November was **£98.7.m** (£99.8m in October).
- The cash forecast is for £82.1m at the 31 March.



12. Working Capital Indicators

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	10	
Debtors % > 90 days	5.0%	9.9%	
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	85.0%	
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	92.4%	
Cash (£m) - per year-end forecast	82.1	98.8	

Summary Notes

- Debtor days ahead of target.
- Debtors % over 90 days is below target, due to unpaid invoices. These are mainly various ICB's £302k (£319k in M7), Salary overpayments £312k (£305k in M7), Central & NW London £117k (£117k in M7), NHSE £79k (£79k in M7), University of Oxford £149k (£16k in M7), NHSPS £77k and other £128k.
- NHS BPPC (Better Payments Practice Code) below target (2 Southern Health invoices for £4.4m not paid in time in August). 89.9% in-month.
- Non-NHS BPPC (Better Payments Practice Code) marginally below target. 96.3% in-month
- Cash better than year-end target.

Oxford Health NHS Foundation Trust

Report to the Meeting of the
Oxford Health NHS Foundation Trust

Board of Directors

29th January 2025

Patient Safety Reviews in November and December 2024
For: Information and Assurance

Executive Summary

It is crucial that we learn from incidents and near misses that happen 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. Further details of our progress with embedding PSIRF are detailed in the report.

The report focuses on the period November and December 2024 following on from the last report. Four reviews within our incident response plan have been identified in the period, detailed below. Overall this takes us to 54 reviews identified/completed since we transitioned to work under PSIRF.

- 1 thematic review have been identified to look at transition between CAMHS and Adult services
- 1 Unexpected unnatural death, this is a suspected suicide for a patient open to an adult community mental health team
- 1 Unexpected death of an inpatient on Sapphire Ward
- 1 significant self-harm incident in the community, possible suicide attempt. The patient was open to an adult community mental health team

An overview of two reviews completed using new methodologies under PSIRF are include; Appreciative Inquiry and Triangle of Care Self-Assessment.

Some examples of actions from recently completed reviews are shared, as well as some areas of good practice identified. The progress and closure of all actions is monitored centrally.

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 how we identify, respond and use learning from patient safety incidents to make changes.

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

Lead Executive Director: **Britta Klinck, Chief Nurse**

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

1.0 Patient Safety Incident Response Framework

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 is a significant change in how we think and behave in relation to responding, learning and improving from patient safety incidents. The Trust transitioned and started working under PSIRF from 4th December 2023, following agreement from the BOB system and Integrated Care Board (ICB). A summary of our approach and new way of working under the PSIRF as well as our 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.

The four key aims of PSIRF are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening how we learn and apply improvements

NHS England has developed standards in relation to the leadership and oversight of patient safety incident management and improvement under the PSIRF. The PSIRF programme board uses these standards to guide our work. The broad areas are listed below with the full guidance available at B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf.

- Engagement and Involvement of those affected by patient safety incident – patients, families and staff
- Safety actions and improvement – can we demonstrate we are using learning from incidents to make changes and improvements are sustained
- Policy, planning and guidance – focused on how we develop and use our incident response plan effectively
- Competence and capacity- developing and using expertise in patient safety science and engaging with those affected by an incident as well as having sufficient resources to implement our incident response plan
- Proportionate and timely responses

The PSIRF Programme Board continues to meet monthly with guidance and support from senior clinicians, the Executive sponsors and our patient safety partner. Of note;

- We celebrated a year since transition to working under PSIRF in early December 2024, this included a QI webinar about the changes and impact, staff can watch the recording available here Link to QI Webinar about changes under PSIRF Dec 2024.
- We had our third external review with the BOB ICB and NHS England to review our progress with implementing PSIRF in December 2024. The review is structured around the above NHS England PSIRF leadership and oversight Standards and is an opportunity to share the work we are doing, what's going well and our next steps. Below is a summary from the end of the review, "The Trust's continued engagement and palpable willingness to strive for improvement is highly commended. This is reflected in the progress and level of

maturity achieved. There are so many areas that others can learn from, and the team should be congratulated on their achievements thus far."

- At the last programme board meeting in January 2025 the current patient safety incident response plan was reviewed.

The key focus of the Programme Board work plan is to, i) strengthen how we share learning so it is relatable for clinical teams and ii) develop the quality of action planning to be focused on system issues so we have greater impact to keep improving the safety of care.

2.0 Recent Patient Safety Reviews

Following the last report to the Board of Directors there have been four patient safety reviews identified in November and December 2024 meeting our incident response plan and where we believe there is potential for significant learning. These are listed below;

- ❖ 1 thematic review have been identified to look at transition between CAMHS and Adult services
- ❖ 1 Unexpected unnatural death, this is a suspected suicide for a patient open to an adult community mental health team
- ❖ 1 Unexpected death of an inpatient on Sapphire Ward
- ❖ 1 significant self-harm incident in the community, possible suicide attempt. The patient was open to an adult community mental health team

Overall since we transitioned to working under PSIRF we have identified/reviewed 54 incidents under our incident response plan, covering 12 of the safety areas we prioritised for 2024 (all 7 local areas and 4 national areas). The incidents go across our different clinical directorates. The majority of cases identified have been in relation to access to care and treatment.

For the 54 cases we have used 9 different types of learning responses demonstrating a proportionate approach, effective use of resources and seen a benefit in timelier learning. We have been able to identify and start learning from incidents quicker, with 38 out of 54 reviews completed. The different learning responses we have used include; thematic reviews, incident learning huddles, observational audits, system reviews, in-depth investigations, appreciative inquiry, and work using the Triangle of Care tool developed by the Carers Trust. For each review we use a systems factor methodology (SEISP = Systems Engineering Initiative for Patient Safety) to better understand what happened ('work done') and why, against what we think or expect should happen ('work imagined') so that the learning we identify and the actions we take address the real issue.

We continue to engage and involve patients/families in every review we undertake and are using our Patient Safety Partner (with lived experience) to help gather patients/families experiences of the processes so we can keep improving our approaches.

Out of the 54 cases, 9 were identified as emergent areas, which we wanted to explore more where we thought there was potential for significant learning, these cases were;

- Medication thematic review for community hospital ward
- Cross organisational review in relation to the appropriate detention/conveyance to a health based Place of Safety.

- Males aged 35-60 identified at risk to self or others and open/recently seen by the Crisis Team. Thematic review completed.
- Suspected suicide of a female, seen by Crisis and CMHT. Physical health/pain complications. Waiting to start treatment with the Complex Needs Service.
- Death of a patient from a community hospital ward related to recognising signs/symptoms of sepsis and escalation of treatment.
- Deaths of people treated in ketamine clinic looking at communication and safety netting.
- Child/adolescent to adult mental health services transition review
- Podiatry thematic review
- Community heart failure service thematic review in relation to management of patients waiting to be seen

3.0 Learning and Changes as a result of Patient Safety Reviews

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 using the quality governance framework. The actions in response to learning are signed off by the relevant clinical directorate senior leadership team and also by Executive Directors with progress monitored centrally and evidence reviewed as part of closing.

Some examples of actions from recently completed reviews are shared below.

There were also a number of good practice elements identified from our reviews, including a number demonstrating positive engagement with and feedback from families about being involved in their loved ones care.

Type of service	Improvement area	Action(s)
Physical healthcare services	A number of reviews have highlighted learning regarding recording and calculations NEWS, escalation and soft signs.	The Oxford Health Improvement team have been asked to support work around NEWS and escalation. The City Community Hospital has been identified as the first area to pilot changes including the roll out of scenario based training.
Physical Healthcare services	Recording of baseline cognition levels as part of NEWS2	Clinical team adding baseline cognition to initial assessment forms.
Mental Health services	Decision making and communication around changes in inpatient observation levels on mental health wards	Clear plan regarding observation level to be recorded in notes for each patient. Also review how using safe and supportive observations policy, particularly how observation levels are altered/changed on the ward (policy states any lowering of observation level needs to be discussed with the Multi-Disciplinary Team)

<u>Completed Review against Triangle of Care standards</u>

The first PSIRF review to use the national Triangle of Care self-assessment was completed in November 2024. This type of review is used when there is significant learning in how we engaged and worked with family/carers. The self-assessment includes 6 standards. This review methodology allowed the team to make some immediate changes and to develop an action plan for further improvements. A key area going

forward was managing a patients confidentiality whilst still listening and engaging with a patient's family. The process was overseen and supported by the Trust Carers Lead.

Appreciate Inquiry

We have recently completed an Appreciative Inquiry into when/how a professionals meeting is triggered to support coordination of care across teams and organisations. This is a strengths-based approach to creating change (also called Safety II approach). Rather than identify a problem and look at how to solve it, Appreciative Inquiry involves exploring what is already working and how to build on that.

The Appreciative Inquiry workshops allowed the team to demonstrate how well they instigate multiple team/organisations to successfully hold professionals meetings. Allowing better coordination of care plans and cross team working. This is done by professionalism and determination. How this could be even further developed to make it easier in practice was discussed, showing continual improvement. Key themes for improvement emerged during the inquiry:

- Standardisation of Processes: There is a need for a consistent approach to scheduling and conducting professionals' meetings.
- Improved Communication: A unified IT system for updating and accessing contact information of all professionals involved in patient care is essential.
- Ownership and Leadership: Clear responsibility for organising meetings and following up on actions must be established.
- Time Management: Teams need faster access to risk panels and more time for collaborative discussions to resolve issues locally.

The above areas are being taken forward in a pilot using QI methodology, with the findings being shared widely.

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	12
Report title	Report from the Charity Committee on matters to Alert, Advise or Assure
Executive lead(s)	N/A
Report author(s)	Rick Trainor Non-Executive Director and Chair of the Charity Committee
Action this paper	☐ Decision/approval ☑ Information ☑ Assurance
Reason for submission to the Board	For Board Alert/Advice/Assurance or discussion as it sees appropriate
For disclosure or confidential	Disclosure (at Board meeting in public)

Executive summary
The Charity Committee met on 04 December 2024 and considered the attached agenda; the minutes of the meeting on 04 December 2024 are available in the Reading Room.

Report history / meetings this item has been considered at and outcome
N/A

Recommendation(s)
The Board is asked to note and discuss as it sees appropriate.

Strategic objective this report supports	**Select**
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☐
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	~~Yes/~~No	
Legal and regulatory	~~Yes/~~No	

For Alert (may require discussion)

No items discussed at the Charity Committee meeting on 4 December 2024 fall into this category.

To Advise (to monitor)

The Committee wish to advise the Board that:

- The transfer of financial investments to the approved new type of investment account, a Lloyds Bankline account, has taken place.
- Having approved, in draft form, the annual impact report and annual financial report at its meeting in September 2024, the Committee at its 4 December 2024 meeting approved the final versions (which had been scrutinised in the interim by the external auditors) of these reports and the letter of representation, recommending that they be approved by the Oxford Health Board, as corporate trustee. The latter gave these approvals at a special meeting on 11 December 2024, clearing the way for the relevant documentation to be sent to the Charity Commission (deadline: 31 January 2025).
- The Committee noted that balances were lower than a year ago, in part because the Charity has had success in remedying a previous underuse of charitable funds.
- In reviewing the Management Accounts, the Committee noted that income was lower than a year before in part because the fundraiser post was currently unfilled. The Committee noted that staffing decisions relating to fundraising in the Charity were under discussion by the Executive.
- An item has been added to the Committee's risk register due to a relatively small (£182.46) fraud because ongoing enquiries had not established how to prevent fraudulent direct debits (the device used in this particular fraud) from being set up.

- The Committee approved the Warneford 200 Project applying for grants as the Oxford Health Charity in order to meet the requirements of various funders that applications be submitted only by registered charities. The Committee was assured that there would be no financial liability for either the Charity or Oxford Health as a whole.
- The Committee noted that, despite the Charity's current lack of a full team, considerable progress was being made to fulfil the Charity's strategic objectives for 2024/25.
- The Committee was not satisfied, despite the already long delay in spending the bequest in question, with the request to spend £50,000 on a comfort cooling system in one part of Bicester Community Hospital. It was agreed that further information would be sought and that further discussions would occur before the matter was considered further at the next meeting of the Committee.
- The Committee agreed in principle to spend a bequest (which had been £93,659) on refurbishment at Wantage Community Hospital with the proviso that detailed costings be presented to the Committee at its meeting in February 2025 when final approval would be considered.

For Assurance (to note)

The Committee wish to assure the Board that the Committee continues to take seriously the need to improve financial performance.

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	13
Report title	Annual Health, Safety & Security Report
Executive lead(s)	Heather Smith
Report author(s)	Christina Foster & Rob Andrews
Action this paper	☐ Decision/approval ☐ Information ☑ Assurance
Reason for submission to the Board	Board Request / Standing Item
For disclosure or confidential	Disclosure

Executive summary

The purpose of the report is to provide the Trust Board with continued assurance that the processes and systems are in place for managing health and safety within Oxford Health NHS Foundation Trust (the Trust) remain effective.
The report covers the period from **1st October 2023 to 30th September 2024.**

- The coverage of Health & Safety Compliance Audits at Trust sites is greatly improved. Procedures have been established to optimise clear communication and monitoring of recommended actions following site audits.

- Training is being developed to ensure greater understanding of responsibilities and processes, targeting managers and other senior colleagues across all teams.

- Figures taken from the Learning and development Intranet site indicate that there are shortfalls in compliance with mandatory training in the areas of Fire Awareness, Fire Responder and Emergency First Aid. This is being addressed and will be discussed at the Fire, Safety and Security Committee.

- The Fire, Safety, and Security Team (FSS) are working with colleagues to improve physical security, particularly in CCTV where hardware and software systems are being upgraded.

- FSS are working with colleagues in Risk Management, Learning and Development and clinical teams to improve learning from incidents and near misses.

- The FSS Team are participating in a trust wide, multi-disciplinary working group seeking to reduce aggression in all its forms against staff.

- <u>Incidents reported</u>
- The number of incidents reported in Health and safety categories **last** year was **3920**.
- The number of incidents reported **this** year is **3947.**
- Incidents reported in Violence and Aggression against staff **last** year amounted to **2553**
- Incidents in V&A against staff **this** year total **2,668**. Indicating an **increase of 135**
- In other categories, the number of incident reports is similar to the previous year.

- There were **36** RIDDOR submission during the period of this report. An increase of 3 year on year.

Report history / meetings this item has been considered at and outcome
Quarterly Health, Safety & Security Committee: Approved for submission to the PLC **People Leadership and Culture Committee: Approved for submission to Trust Board**

Recommendation(s)
The Board is asked to receive the report for assurance, having been recommended by the People, Leadership & Culture Committee.

Strategic objective this report supports	**Select**
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☑
Sustainability - Make the best use of our resources and protect the environment	☐
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☑ **BAF**	☑ **TRR**
Equality, diversity and inclusion	Yes	
Legal and regulatory	Yes	

Health, Safety & Security Annual Report

October 1st, 2023, to September 30th, 2024

Contents

Introduction

Health, safety and security considerations contain legal, regulatory and moral obligations that apply across every conceivable Trust work-related activity, premises, and staff member's undertakings at Oxford NHS Trust, to ensure, as far as practicably, the best practice and safe working.

The benefits of a positive safety culture are many, the most obvious being the prevention and reduction of incidents, accidents and injuries, together with their associated direct and indirect costs to the Trust. Through effective management of H&S, reduces the likelihood of civil claims and criminal prosecutions.

FSS advise on fire safety measures, health and safety matters and any issues with security implications, and currently manage the CCTV across Trust sites. The FSS team carry out proactive risk assessments and Health and Safety compliance audits, and responding to issues arising from incidents, near misses and identified hazards.

As of September 2024, the FSS Team currently consists of 2 x Senior Fire Advisors, 1 x Health, Safety, and Security Manager, 1 x Temporary Health, Safety, and Security Manager and 1 x Interim Senior Fire, Safety, and Security Manager who has been in post since September 2024.

The FSS Team provide competent advice and support to circa 7,000 colleagues across eight community hospitals: two minor injuries units, community dental services, physical and mental health focussed community services and 26 mental health wards in a widely spread area.

Purpose

The purpose of the report is to provide the Trust Board with continued assurance that the processes and systems are in place for managing health and safety within Oxford Health NHS Foundation Trust (the Trust) remain effective.

Executive Summary

The report covers the period from 1st October 2023 to 30th September 2024.

The Fire, Safety and Security (FSS) Team works with departments across the Trust, supporting, teams and individuals on actions to remove or reduce risks from identified hazards.

The Health and Safety element of the FSS team covers several areas for staff, patients and visitors including:

- slips and trips

- manual handling
- violence and aggression
- lone working
- work-related stress
- hazardous substances (COSHH)
- management of sharps
- provision and use of work equipment including display screen equipment
- First aid
- Working conditions

The subject of fire safety is covered in a separate paper.

During the twelve months covered by this report, the FSS team has maintained and developed a positive direction throughout and has achieved improved performance despite absences, changes within the team, and team leadership.

Figures taken from the Learning and development Intranet site indicate that there are shortfalls in compliance with mandatory training in the areas of Fire Awareness, Fire Responder and Emergency First Aid. (pages 15 and 16)

Decisions around having trained first aiders available in the workplace should be based on a needs assessment carried out for each work area. Despite the clinically qualified staff in many areas who are trained in resuscitation, it is likely that there still some teams that need a nominated first aider.

Key aspects achieved through the Year

The coverage of Health & Safety Compliance Audits at Trust sites is greatly improved, with review visits scheduled to monitor progress on actions. Procedures have been established to optimise clear communication and monitoring of recommended actions following site audits.

Training is being developed to ensure greater understanding of responsibilities and processes for managers and other senior colleagues across all teams.

Communication between FSS and other risk management functions is being enhanced to improve mutual understanding of the various areas of responsibility, thereby ensuring there is no repetition of workstream and greater efficiency.

Across the trust, FSS are working closely with Estates colleagues to improve physical security, particularly in CCTV where hardware and systems are being upgraded to safeguard our people, property, service users and visitors.

Opportunities for enhancing Health & Safety systems have been highlighted and the team are working with colleagues in Risk Management, Learning and Development and clinical teams to improve learning from incidents and near misses.

By far the most frequently reported health and safety incidents where staff are harmed, physically or mentally, are those that fall into the category of violence and aggression.

The FSS Team are participating in a trust wide, multi-disciplinary working group seeking to reduce aggression against staff, decrease risks for lone workers, lessen incidents of racial abuse against staff and reduce incidents of sexual abuse, verbal or physical. This is likely to produce some changes to Zero Tolerance, Lone working and Community working policy and procedure.

In line with other NHS Trusts locally and nationally Links are being established with Thames Valley Police to commence the process of joining Operation Cavell which is a national police operation to ensure senior investigators review all crimes against NHS workers and volunteers and will use the experience of specialised and dedicated police investigators.

Other areas in which staff can become harmed fall into the categories of musculoskeletal disorder and work-related upper limb disorders, often resulting from manual handling tasks or from poor posture when using display screen equipment for extended periods. A separate working group is being established to focus on reducing work-related upper limb and musculoskeletal disorders.

Finally, the FSS have adopted the Plan-Do-Check-Act (PDCA) approach advocated by the Health and Safety Executive (HSE) for managing health and safety at work. The steps are:

Plan-Do-Check-Act (PDCA)

PDCA is an approach advocated by the Health and Safety Executive (HSE) for managing health and safety at work. The steps are:

Plan: Determine the policy/Plan for implementation.

Do: Profile risks/Organise for health and safety/Implement your plan.

Check: Measure performance (monitor before events, investigate after events)

Act: Review performance/Act on lessons learned.

This is the model used within the Trust and the following report is set out to reflect this.

PLAN

Governance and oversight

The responsibility for the Head of Health and Safety, and the FSS Team remains with the Director for Estates and Facilities, with Executive responsibility held by the Chief Finance Officer.

The Fire, Safety and Security Committee has oversight of quarterly reports and updates on current and proposed fire, health, safety, and security developments. Representatives from all directorates are able to participate with this meeting and staff-side representatives are active members. In addition to Fire, Safety and Security Committee FSS attend a variety of directorate level forums with a focus on fire, health & safety and security issues.

Health, Safety and Security Regulation and Policy

The main legislation applying to healthcare organisations are:

- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- Workplace Health and Safety standards devised by NHS Staff Council's Health, Safety and Wellbeing Partnership Group,
- Health and Safety Guidance (HSG 65) 'Managing for Health and Safety' published by the Health and Safety Executive (HSE) in 2013.

The HSE is the enforcing authority for staff, non-clinical systems of work, and premises, and the Care Quality Commission (CQC) has responsibility for ensuring patient safety standards. The Health Safety and Security workplan is set against the NHS Staff Councils Workplace Health and Safety standards.

In line with the above legislation, the Trust's Health and Safety Policy is available to all staff on the Intranet, together with related policies, documents and guidance notes. All have been reviewed; however, the Personal Safety and Lone working Policy and Zero Tolerance Policy are currently being re-written as part of the Reduction of aggression against staff work group.

During late summer and autumn, the Trust has proactively participated in an internal audit of Health and Safety. The findings of this audit and subsequent action plan will support improved efficiency of the safety structures already in place.

DO

Risk Assessment

On site audits of health and safety compliance are ongoing on a rolling schedule and provide a useful engagement opportunity with teams across the trust estate. Learning from these local audits has highlighted the need for management training in Health and Safety as set out above, with particular regard to the completion of workplace risk assessments. Face-to-face engagement at these audits allows for support to be given in this area and this gap in understanding is being reduced but can be eradicated when appropriate training is in place for relevant roles.

A centrally held library of risk assessments has now been established and the population of this is ongoing.

Understanding identified trends

The health and safety team also use the Ulysses system to understand where staff are at risk of harm, identifying trends and liaising with teams to reduce future risk. As previously noted, the most frequent and harmful hazard faced by many staff is violence and aggression from service users.

The multi-disciplinary, trust wide working group previously discussed, led by the Associate Director of Social Work and Social Care is working towards identifying methods of reducing the risk to colleagues from this hazard in all its forms.

The above working group has successfully made progress in the management of risk to staff who work in isolation from their colleagues in the community. The lone working workstream, led by the Chief Nursing Informatics Officer, has achieved agreement to provide a pilot of lone worker devices to clinical and non-clinical staff, ensuring that, should the need arise, they will easily be able to activate an alarm giving their current location and quickly get support from emergency services.

Trust wide Health and safety incidents October 1st, 2023, to September 30th, 2024

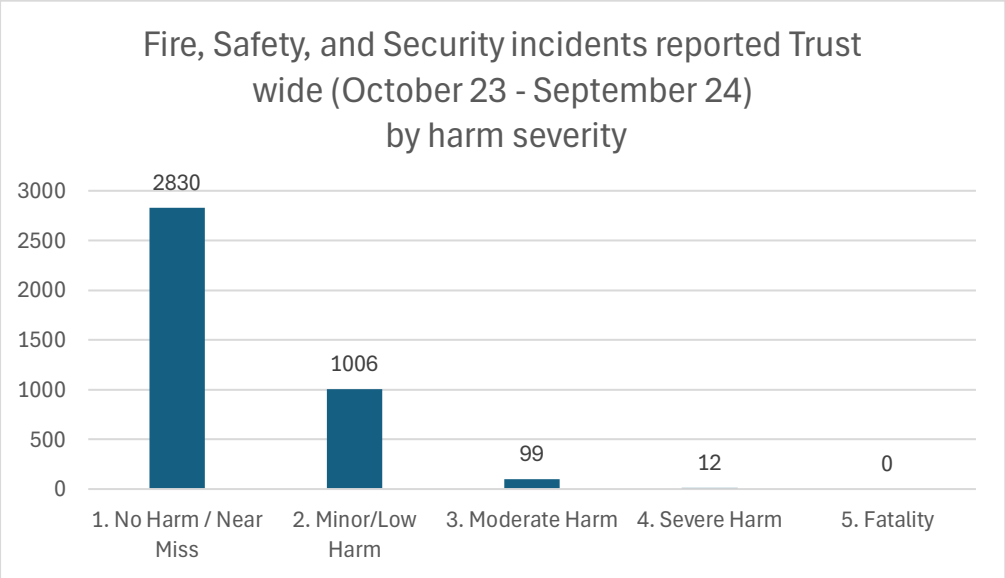
Note on comparison of the 22/23 Annual Report and the current 23/24 Annual Report.

During the period covered by the current 2023/24 report there where 3947 incident reports added under the categories covered by FSS compared to the 2022/23 figure of 5051.

This difference is due to the way the V&A and Falls were reported in the 2022/23 Annual Report which included all V&A categories.

Incidents where patients have experienced harm fall within the remit of the Patient Safety Department and therefore have not been reported within this 2023/24 Annual report. FFS report on staff related incidents only and calculations are based on this remit for this reporting period.

On a like for like basis the number last year was 3920 therefore there has been an increase this year of 27 incidents. There is a strong belief, however, that there is significant under reporting in Violence and & Aggression incidents overall, particularly for those including racial abuse. This is due to feedback from many staff when compared to incident report figures. Please see appendix 1 for a like for like comparison with previous years statistics.

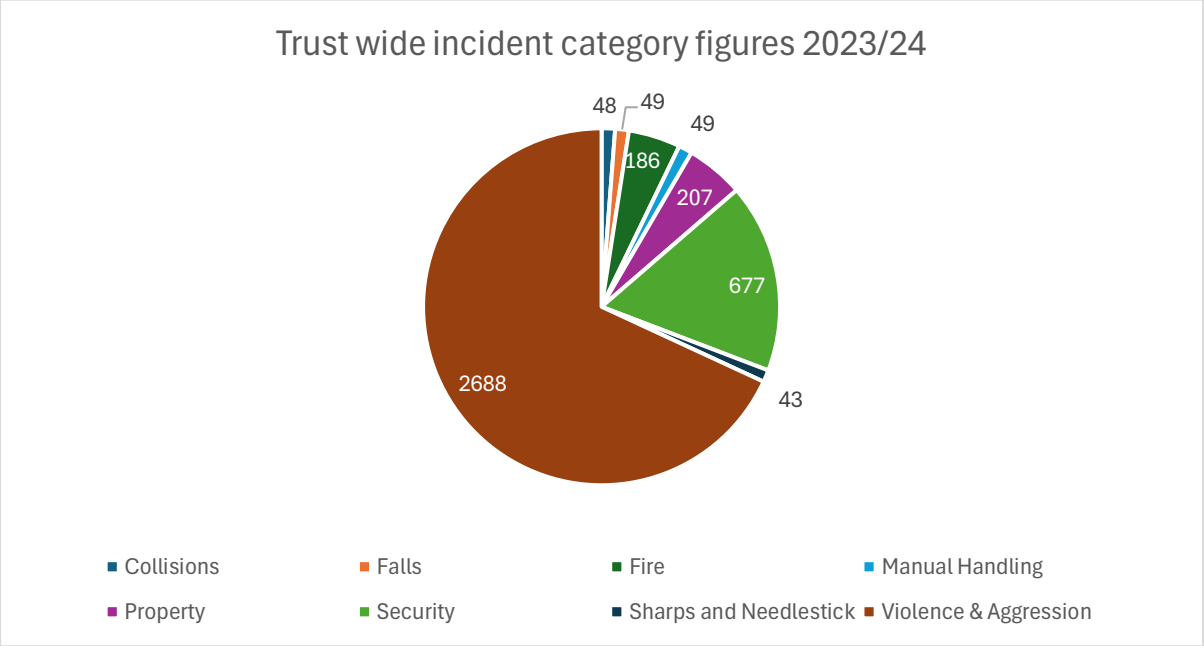


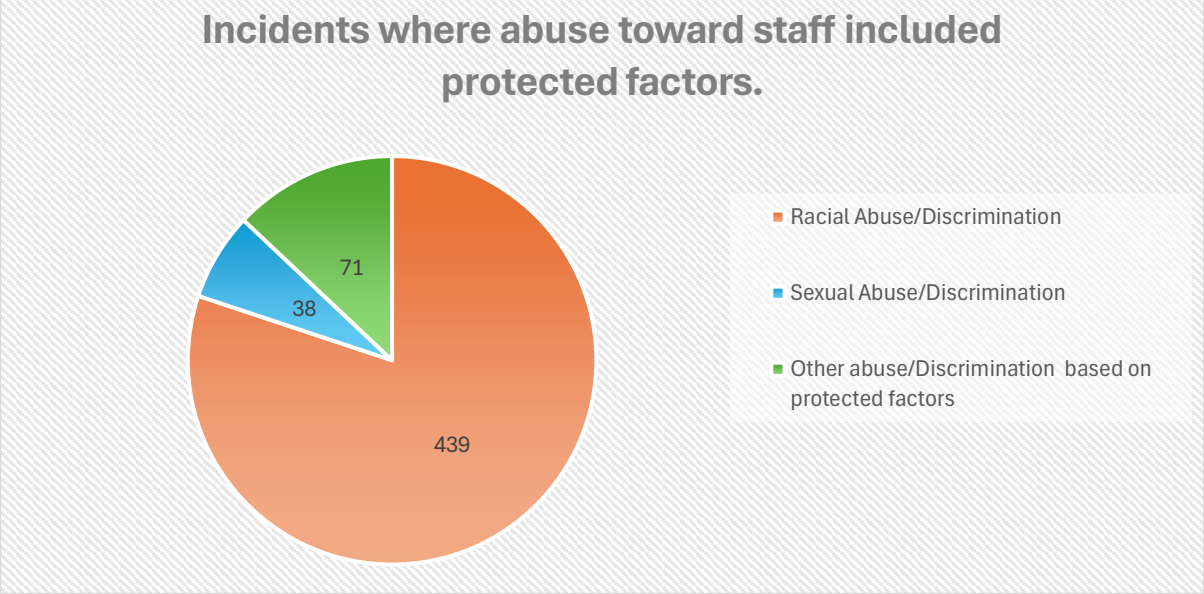
Since 2022/23, violence and aggression against staff categories have risen from 2553 to 2,668. Indicating an increase of 135 incidents trust wide for the period 23/24. It should be

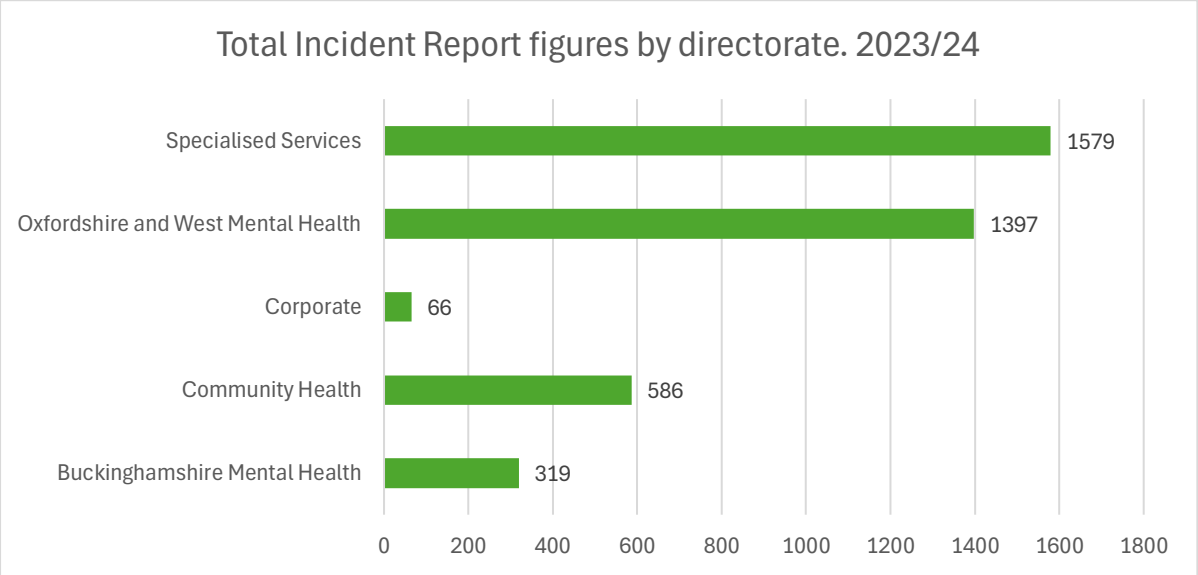
noted, however that 195 incidents of V&A against staff in 23/24 were reported from the Meadow Unit a new service, and building, serving an acute and challenging patient group.

For other categories, the number of incidents over 12 months is similar to the previous year.

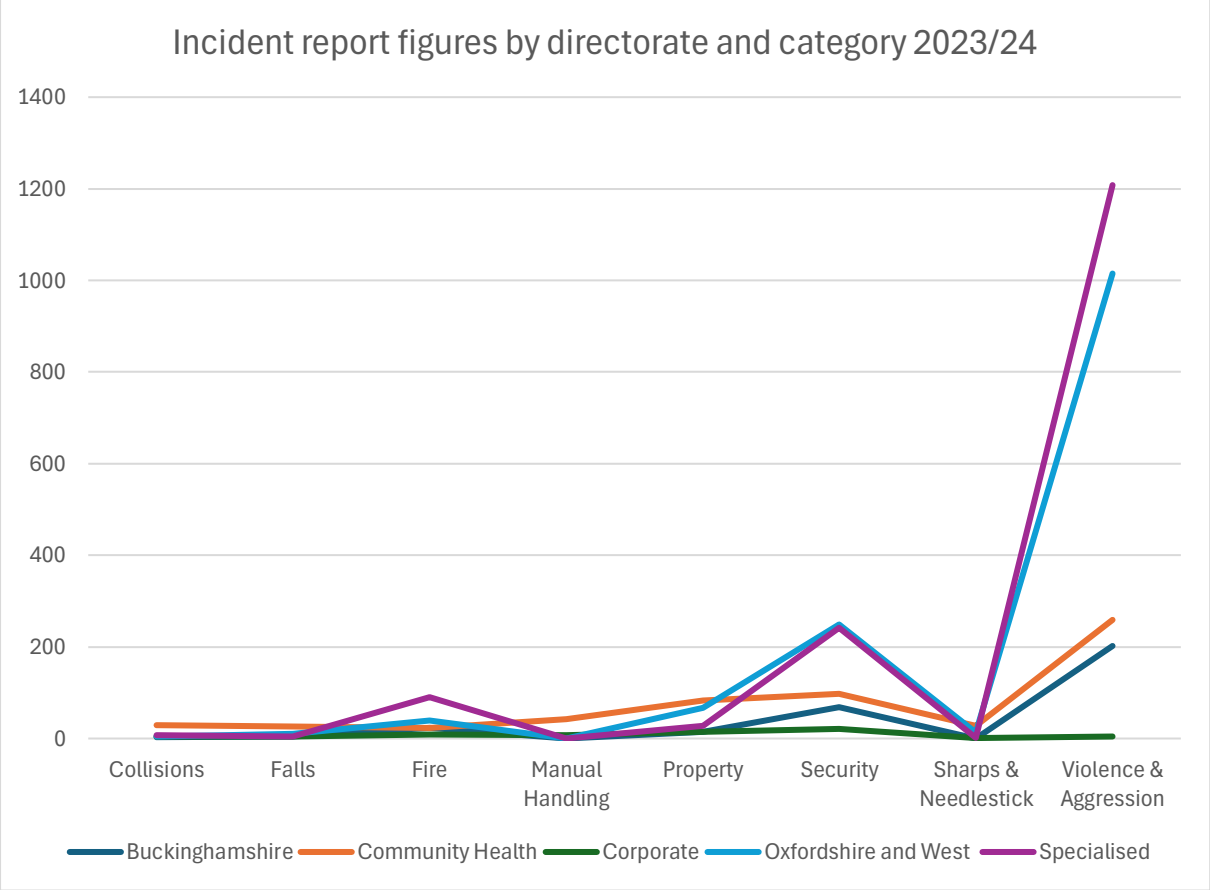
The number of incidents submitted for each category is illustrated below.





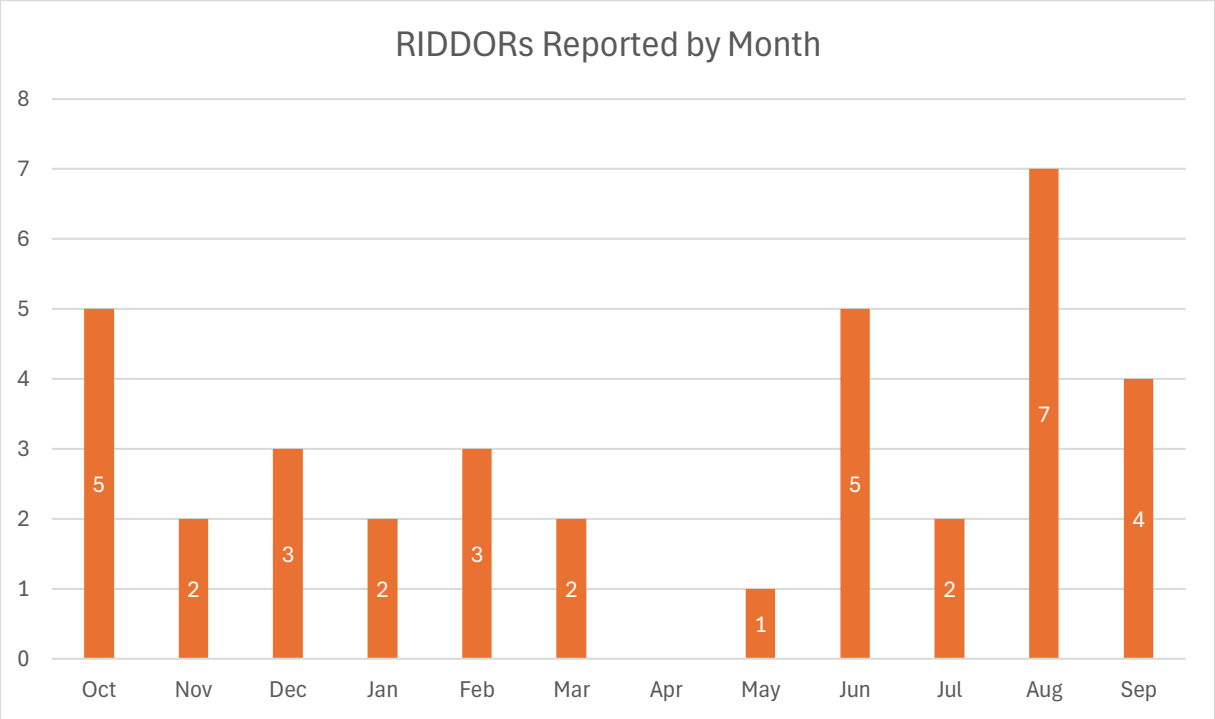


This illustrates incidents for directorates as they were during the period covered by this report. The Learning Disability and Forensic were both part of the Specialised Directorate during this time but are now stand-alone directorates.



RIDDOR

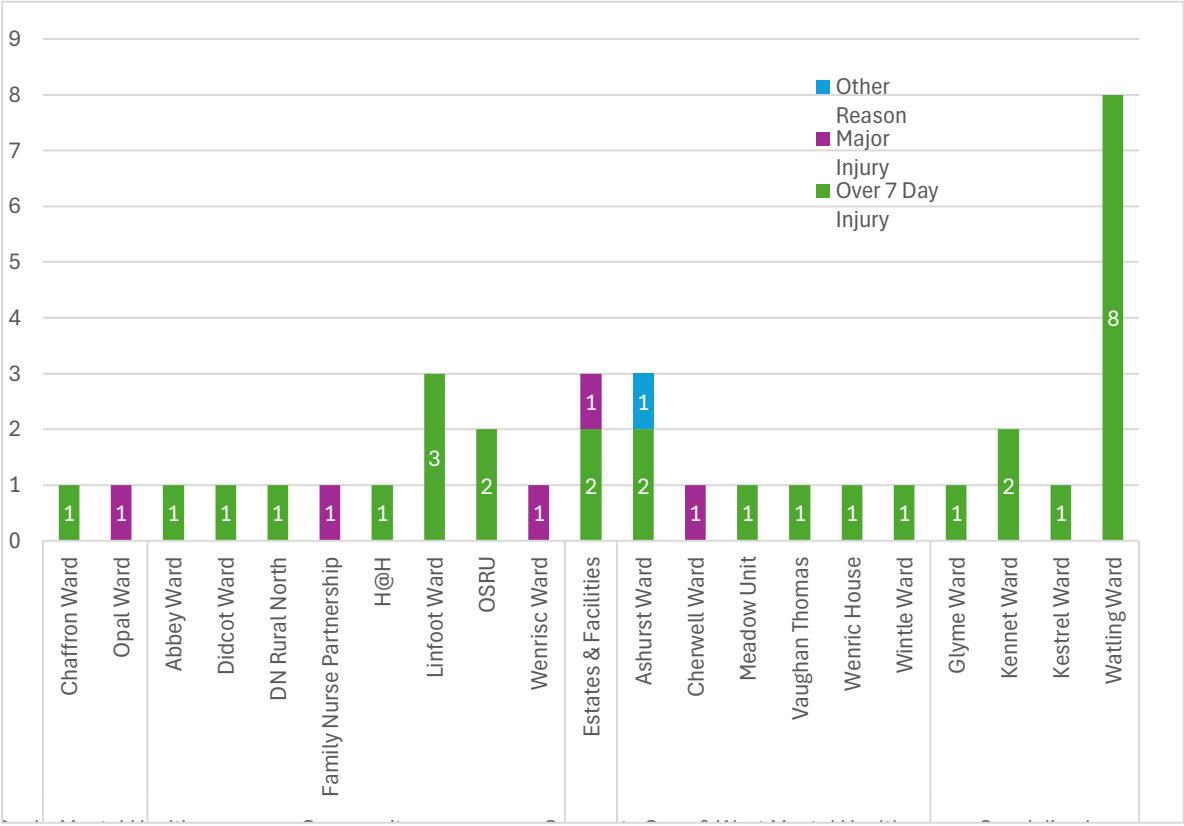
There were 36 RIDDORs reported during the period covered by this report.



30 RIDDORs were submitted due to injury resulting in 7+ days lost from work.

5 were submitted due to major injury and **1** RIDDOR was submitted because the injured party lost consciousness.

Reasons for RIDDOR submissions



Comparison with previous years

2020 – 2021 **42** RIDDOR Submissions (18 of which related to staff sickness as a result of the COVID-19 outbreak, and one of which related to a death as a result of COVID-19).

2021 – 2022 **21** RIDDOR Submissions

2022 – 2023 **33** RIDDOR Submissions

2023 – 2024 **36** RIDDOR Submissions

Of the RIDDORs submitted during 2023/24

19 were due to assault by patients on staff. **This is an increase of 8** when compared with 2022 – 2023 figures. (4 RIDDORs were reported for 1 incident on Watling (204538). 2 members of staff were involved in RIDDORs twice (on Ashurst (188465 & 192248) and Watling (189260 & 204538)).

9 were manual handling incidents. The 2022/23 figure was 11 so, **down by 3 submissions.**

4 incidents of staff fall. The 2022/23 figure was 6, **down by 2 submissions.**

3 RIDDORs were due to crush injuries reported in the Collisions category (i.e. Trapped fingers in door) The 2022/23 figure was 1. **An increase of 2.**

1 staff member was bitten by a patient's dog. There were no RIDDORs submitted due to animal attacks in 2022/23. **An increase of 1**

There have been incidents when RIDDOR reports have been submitted to the HSE outside of the required timeframe. RIDDOR is covered within the Manager's Handbook and will also be covered within proposed H&S training for managers.

We are seeking to improve the timeliness of RIDDOR reporting and have introduced weekly and monthly reviews by the FSS team. HSE raised concerns that one RIDDOR (a fall from scaffolding) that was reported several months after the incident. We have responded explaining that the injured person was working to a contractor and that we had been unable to secure information needed to submit the RIDDOR on time.

Training development

Health and Safety training will be extended to ensure that staff with greater responsibilities for managing health and safety have a complete understanding of the requirements and processes involved. Managers play a key role in health and safety and need to have the right skills to manage operational health and safety effectively including:

- Completing workplace risk assessments (a legal requirement)
- Implementing and monitoring policies and procedures
- Investigating incidents

- Providing appropriate support to staff as required

Additionally, a more formal and comprehensive response to health and safety related incident reports is being developed. This will ensure that opportunities for learning from accidents, incidents and near misses are taken and learning is used effectively and appropriately shared.

Dedicated Intranet Page

A new Intranet site, 'Fire, Safety, & Security' is now under construction and will be a valuable resource in communicating with colleagues, and improving the profile and understanding of Fire, Safety, and Security related responsibilities, processes and activities. It is hoped that we will be able to establish a means for colleagues to request advice, express concerns or opportunities and make requests relating to CCTV.

Check

Health and Safety Related Training Compliance

DSE Compliance – Total staff count 6883

Overall, **96.5%** compliance has been achieved for DSE training and compliance.

Directorate	Compliance %
Buckinghamshire Mental Health	**97.75**
Corporate (Total staff count = 1267)	**91.11 – Total non-compliant staff count = 104**
Forensic Services	**99.59**
Learning Disabilities	**98.95**
Oxford Pharmacy Store	**100**
Oxfordshire & BSW Mental Health	**97.69**
Primary Community and Dental Care	**97.35**
Provider Collaborative Commissioning	**98.75**
Research & Development (Total staff count = 86)	**93.2 Total Non-Compliant staff count = 6**

Fire Awareness Training - Total staff count 6883

Overall, 91.88%

Directorate	Compliance %
Buckinghamshire Mental Health (Total staff count = 1005)	**94.61 Total Non-Compliant staff count = 61**
Corporate (Total staff count = 1266)	**84.71 Total Non-Compliant staff count = 190**
Forensic Services	**95.49**
Learning Disabilities (Total staff count = 92)	**94.74 Total Non-Compliant staff count = 3**
Oxford Pharmacy Store	**95.83**
Oxfordshire & BSW Mental Health (Total staff count = 1947)	**92.32 Total Non-Compliant staff count = 151**
Primary Community and Dental Care (Total staff count = 1892)	**93.6 Total Non-Compliant staff count = 117**
Provider Collaborative Commissioning	**98.75**
Research & Development (Total staff count = 86)	**87.21 Total Non-Compliant staff count = 11**

Fire Responder Training Total staff count 1488 (including both inpatient staff and nominated Fire Marshalls)

Overall, 77.79% Note: There are no figures available for Learning Disorders or Provider Collaborative in the Learning and Development Reports.

Directorate	Compliance %
Buckinghamshire Mental Health (Total staff count = 137)	**72.06 (Total Non-Compliant staff count = 22**
Corporate (Total staff count = 66)	**74.63 Total Non-Compliant staff count = 6**
Forensic Services (Total staff count = 296)	**84.51 Total Non-Compliant staff count = 26**
Oxford Pharmacy Store	**100**
Oxfordshire & BSW Mental Health (Total staff count = 474)	**78.63 Now at 82.28% Total Non-Compliant staff count = 84)**
Primary Community and Dental Care (Total staff count = 482)	**76.95 Total Non-Compliant staff count = 100**
Research & Development (Total staff count = 32)	**45.16 Total Non-Compliant staff count = 15**

Emergency First Aid (This is not mandatory but is a nominated role)

Target = 95% - **51.49 % compliance achieved**

Directorate	Compliance %
Buckinghamshire Mental Health	**71.43**
Corporate	**74.29**
Forensic Services	**Not available**
Learning Disabilities	**Not available**
Oxford Pharmacy Store	**Not available**
Oxfordshire & BSW Mental Health	**30.43**
Primary Community and Dental Care	**38.89**
Provider Collaborative Commissioning	**Not available**
Research & Development	**Not available**

Health & Safety Training Level 1 Total staff count 6884

Overall, 92.66%

Directorate	Compliance %
Buckinghamshire Mental Health (Total staff count = 1005)	**94.22 Total Non-Compliant staff count = 49**
Corporate (Total staff count = 1267)	**86.2 Now at 87.37% Total Non-Compliant staff count = 160**
Forensic Services	**97.95**
Learning Disabilities	**95.79**
Oxford Pharmacy Store	**95.83**
Oxfordshire & BSW Mental Health (Total staff count = 1947)	**92.98 Total Non-Compliant staff count = 118**
Primary Community and Dental Care (Total staff count = 1892)	**94.17 Total Non-Compliant staff count = 88**
Provider Collaborative Commissioning	**98.75**
Research & Development (Total staff count = 86)	**89.53 Total Non-Compliant staff count = 7**

Moving and handling Training

Directorate	Loads	Community	Patients	Podiatry	Physios OTs	Level 1
Buckinghamshire MH	66.67		88.18		100	97.11
Corporate	78.97		85.71			89.14
Forensic Services	100		86.96		85.71	99.47
Learning Disabilities	85.71		100		90.91	100
Oxford Pharmacy Store						100
Ox & BSW Mental Health	53.85		80.75		87.5	96.56
Primary Community Dental	82.74	82.35	87.06	82.14	86.96	94.13
Provider Collaborative	100	100				95.52
Research & Development			50			92.77

ACT

Health and Safety Compliance audits

The recent internal audit of Trust wide Health and Safety systems has raised some valuable learning points.

The onsite audits carried out by Health, Safety and Security Manager, are a good measure of local Health and Safety compliance. The areas covered in the audit relate to each piece of legislative requirement that the trust must meet. This includes the Health and Safety at Work Etc. Act 1974. The Management of Health and Safety at Work Regulations 1999 and all the related regulations covering, electricity, asbestos, and lifts, the compliance audit also covers security to some degree and emergency procedures. Governance and training levels are also measured within the audits.

Learning from the previous year, each workplace is now scored against the Health and Safety Compliance audit. Moving forward, less compliant or problematic sites and teams will be highlighted and monitored at the Fire, Safety and Security Committee.

The audit requires evidence of workplace risk assessments. In the past year it has become apparent that many teams across the trust are unable to provide this evidence, to support improvement in this area specific training will be introduced for team leaders and Training will include risk identification and management, post incident report procedure and RIDDOR.

The health and safety team are keen to provide support to wards and teams around the creation of risk assessments, advice is readily available, but risk assessments must be produced by a competent person from the local workforce that is being assessed.

Risk assessments identify hazards, illustrate the likelihood of an adverse event and the potential severity of harm if the event occurs, they are a good way of understanding the

current situation and creating plans to remove or reduce the likelihood of harm, helping to establish priorities. Identified hazards that present significant risk are placed on local and directorate risk registers and if necessary, escalated to the trust wide risk register.

Directorate risk registers

The trust wide risk register is part of the Ulysses operating system, used to monitor and manage risk at a senior level. It is recommended that Directorate level risk registers be placed on the Ulysses system and that significant directorate risks are monitored by the Fire, Safety and Security Committee.

Learning

The investigation of accidents and incidents is extremely important because learning that emerges from findings can be shared, preventing the re-occurrence of similar events. The trust previously provided Root Cause Analyses training for band 7 staff, to enable the structured investigation of incidents. This has been replaced with 'System Engineering Imitative for Patient Safety' (SEIPS) training which is more focused on the investigation of patient safety incidents.

The Interim Senior FSS Manager and the Head of Patient Safety are examining the content of the new training to confirm that the methodology can be utilised for the investigation of non-clinical accidents and incidents. This may lead to certain non-clinical roles receiving the SEIPS training.

Incidents categorised with a harm severity of moderate or above do warrant investigation by the local manager and it is recommended that a formal investigation/findings section with required points for completion be added to the Ulysses Manager Response area.

The Interim Senior FSS Manager and the Risk Management Team, with the Ulysses User Group are establishing ways that this can be achieved.

Conclusion

Collaborative working with clinical colleagues and other specialists on specific areas is achieving progress in establishing a safer and more secure workplace. Making certain that straightforward and robust systems are in place, understood and utilised by colleagues helps to achieve a trustworthy, reliable and safe environment in which therapeutic care can be delivered to service users consistently, with minimal disruption.

Maintaining and building on established safe systems, the continuing mission of FSS is to ensure that teams are able to deliver excellent care, safely. The Action Plan for FSS is attached as Appendix 2

Appendix 1

Comparison of incidents reported in FSS Categories from 01/10/2020 to 30/09/2024

Previous annual reports were reporting on slightly different criteria and there have been alterations over the years to the way things are reported/recorded on Ulysses. The table below shows figures based on the current reporting criteria (where this is not possible due to a lack of data, it is noted, but this only affects certain elements of Violence and aggression reporting.

Incident Category	2020-2021	2021-2022	2022-2023	2023-2024
Overall Incident reports submitted in FSS Categories	2826	4234	3920	3948
Overall Violence & Aggression	1748	3140	2807	2688
• Trust Total **Physical** Aggression	997	1109	1173	1288
• Trust Total **Verbal** Aggression	751	2031	1634	1400
• Incidents with Racial discriminatory factor	88	200	344	439
• Incidents with Sexual Discriminatory factor	Not available	**20** Partial, from February 2022	42	38
• Incidents with other protected characteristic discrimination	Not available	**31** Partial, from February 2022	56	71
Collision	19	32	36	48
Falls	61	53	45	49
Manual Handling	31	36	37	49
Sharps and Needlestick	52	58	59	43
Property related	204	147	146	207
Security	614	670	684	677
Fire	158	151	139	186

6.Fire Safety, & Security Action Plan									
Item	Action point	Priority rating	Lead	Owner	Management response	Comments/Evidence provided	Progress monitoring		Residual rating
							Target date	Date Complete	
New	Health and Safety Policy and Health and Safety Statement to be completed, ratified, signed off by CEO and placed on the Intranet.	Major	RA	RA	Create policy and statement	Policy is in place but CEO Sign off on these documents is a requirement. Statement completed but not yet signed, with CEO	Aug 24	Aug 24	
Existing	Review existing arrangement re: H&S and Security induction. Undertake Training Needs Analysis (TNA) referencing Role and Task specific training.	Mod	RA	RA	RA will research solutions and liaise with L&D to establish training needs and develop resources.	Level 1 H&S Training is mandatory now, for all staff. Liaison between L&D and RA to introduce Level 3 H&S Training for managers	April 25		
New	Develop Health Safety and Security Training in accordance with outcomes of TNA	Mod			Develop training resources	As above Level 3 Training for managers plus reviewed Managers Handbook	April 25		
New	Training for all staff according to role to be completed	Mod			Complete all scheduled training	As above. Training to be identified, funded and commenced.	Dec 25		

6.Fire Safety, & Security Action Plan									
Item	Action point	Priority rating	Lead	Owner	Management response	Comments/Evidence provided	Progress monitoring		Residual rating
							Target date	Date Complete	
New	Create a Violence Prevention and Reduction Policy to include aspects of Zero Tolerance within.	Mod	RA	RA	Create policy	Ongoing work with the Reduction of aggression work group.	April 25		
01	Establish strategic intent to improve Health and Safety, Fire and Security (HSFS) culture Trust wide.	Mod		RA	Review to be undertaken of the trust Risk Management Strategy to ensure inclusion of Health and Safety, Security, and fire management. Seek advice and opinion from specialists within the trust.	RA is liaising with Patient Safety Lead, Emergency Planning Lead, Trust Solicitor & Risk Manager and the Risk assurance and compliance manager.	Feb 25		

6.Fire Safety, & Security Action Plan									
Item	Action point	Priority rating	Lead	Owner	Management response	Comments/Evidence provided	Progress monitoring		Residual rating
							Target date	Date Complete	
02	Expand the team to include staff for fire safety training, health and safety advisor, and security/CCTV roles.	Mod	JP	CF/RA		Ongoing, Estates review	May 25		
03	Undertake a benefits analysis of the use of on-site security staff.	Mod		DC			Feb 25		
04	HSFS policy review and update	Mod	RA	TEAM	Folder of applicable policies established	Ongoing cycle of review. Suite of policies reviewed and ratified.	Rolling schedule		
05	Review and enhance reporting lines/investigation post incident	Mod			Clear procedure needed for H&S incidents	Liaising with Head of patient safety	April 25		
06	Review of monitoring (committees)	Mod			Timing of meetings	Completed by relevant senior administrators	Jan 25		
07	Liaise with all areas of Risk Management to align, understand and support communication around Roles & Responsibilities related to managing Health and Safety across all disciplines in the Trust	Mod			Get a clear awareness of cross overs and gaps in coverage for investigating, reporting and management	RA is liaising with Patient Safety Lead, Emergency Planning Lead, Trust Solicitor & Risk Manager and the Risk assurance and compliance manager.	Sept 24	Nov 24	

6.Fire Safety, & Security Action Plan									
Item	Action point	Priority rating	Lead	Owner	Management response	Comments/Evidence provided	Progress monitoring		Residual rating
							Target date	Date Complete	
08	Schedule workplace H&S compliance audits	Mod	RA	RA DC	Schedule of audits to be established.	Schedule established and site audits are taking place	31 May 24	18.08.24	
09	Complete on-site workplace H&S compliance audits at all units and teams Trust wide. With reports and review dates established	Mod	RA	RA DC	Audits are ongoing across the Trust	Audits are ongoing and all sites should be completed by Feb 25	Feb 25		
10	Take actions to raise awareness on the essential and mandatory completion of local risk assessments.	Mod	RA	RA	To be included in training. Information and advice to be developed and placed on the Intranet within a Bulletin	Within the compliance audit. Will be covered within Level 3 Training. Intranet page being revamped to be more visible and informative	April 25		

6.Fire Safety, & Security Action Plan									
Item	Action point	Priority rating	Lead	Owner	Management response	Comments/Evidence provided	Progress monitoring		Residual rating
							Target date	Date Complete	
11	Establish Lone working management approach to mitigate LW risks to staff who are exposed whilst at work.	Mod	RA	RA	Needs analysis based on previous incidents, and risk assessment. Consider mitigation options. Establish SOP for teams in which lone working occurs.	Working group established. RA is involved in all workstreams. Arrangements in progress for trialling Lone worker devices. Matt Kent is leading on Lone worker devices. Lone worker devices – funding agreed. Lone working policy and risk assessments to be reviewed	Feb 25		
12	Develop a budget to fund Health, Safety, Security and Fire Management initiatives.	Mod	JP	CF	Ongoing – To be captured this financial year	Data for budget development to be completed.	April 25		
13	Establish a library of environmental and activity risk assessments including MSKs, V&A and Stress in the workplace.	Low	RA	RA		This work is ongoing Central library of Ras has been created	May 25	Aug 24	

6.Fire Safety, & Security Action Plan									
Item	Action point	Priority rating	Lead	Owner	Management response	Comments/Evidence provided	Progress monitoring		Residual rating
							Target date	Date Complete	
14	Action to improve individual staff commitment to risk reduction Trust wide	Low		TEAM		Increased use of intranet, training, and face to face visits on sites to raise the profile and understanding of safety, security, and fire management with all staff. FSS intranet page has been created and is being populated.	Feb 25	Dec 24	
15	Establish additional Risk Assessment documents specifically to focus on MSKs (MSDs), V&A and Stress.	Mod	AO	CF	Produce and distribute RA Templates to focus on the areas identified.	Copy of templates available on H&S Teams site and intranet page.		Oct 24	
16	Establish, monitor and manage Health and Safety focused group – H&S Champions/Persons In Control	Low	AO	DC/RA PS/CC	Plan in progress, further consultation to follow Persons in control	Using Health and Welfare Champions is not really an option. Suggest WMs and team managers nominate staff as champions who are then given level 3 H&S training	April 25		
17	Develop a budget proposal to fund FSS initiatives. To include CCTV and additional resource to support Trust needs	Low	JP	CF	Ongoing – To be captured in next financial year	Data for budget development being gathered, proposal to be ready shortly. Please remove.	April 25		

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	14
Report title	Emergency planning, resilience and response annual report 01 November 2023 – 31 October 2024
Executive lead(s)	Georgia Denegri, Associate Director of Corporate Affairs
Report author(s)	Katie Cleaver, Emergency Planning Lead Ben Cahill, Deputy Director of Corporate Affairs
Action this paper	☑ Decision/approval ☐ Information ☑ Assurance
Reason for submission to the Board	Compliance with the NHS England EPRR core standards and the NHS emergency preparedness framework (2022).
For disclosure or confidential	Disclosure

Executive summary

The emergency planning, resilience and response (EPRR) annual report provides the Board with an overview of the emergency planning and business continuity activities during the past twelve months and includes evidence of compliance with the NHS England EPRR core standards and the NHS emergency preparedness framework (2022).

The Trust received full compliance on its EPRR core standards review from the Buckinghamshire, Oxfordshire & Berkshire West (**BOB**) Integrated Care Board (**ICB**).

Report history / meetings this item has been considered at and outcome

Further to recommendation from the Audit Committee.

Recommendation(s)

Board members should each be satisfied of their individual and collective assurances that controls are in in place to deliver compliance against the Trust's obligations for EPRR.

The Associate Director of Corporate Affairs, Georgia Denegri as accountable emergency officer for EPRR, and the Audit Committee recommends that the NHS EPRR core standards self-assessment as described in the annual report be approved by the Board, having been through external audit and the scrutiny of the November Audit Committee.

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☐
Sustainability - Make the best use of our resources and protect the environment	☐
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☑ **BAF** (BAF 3.12 Business Continuity and Emergency Planning)	☐ **TRR**
Equality, diversity and inclusion	No	
Legal and regulatory	Yes	

1. Introduction

1.1. This report describes the emergency planning and business continuity activities of Oxford Health NHS Foundation Trust during 01 November 2023 - 31 October 2024 to meet the requirements of the Civil Contingencies Act 2004 and the NHS England Emergency Preparedness Framework (2022).

1.2. The Associate Director of Corporate Affairs, Georgia Denegri is the accountable emergency officer and holds executive responsibility for emergency preparedness on behalf of the organisation. The Associate Director of Corporate Affairs is supported in this role by Ben Cahill, Deputy Director of Corporate Affairs. Katie Cleaver is the designated Emergency Planning Lead and responsible for supporting the executive in the discharge of their duties. The emergency preparedness work programme for the Trust is progressed through the emergency preparedness, resilience and response (EPRR) committee chaired by the Director of Corporate Affairs with representation from service directorates, communications, information management and technology, human resources, and estates and facilities.

2. Background

2.1. The Civil Contingencies Act (2004) outlines a single framework for civil protection in the United Kingdom. Part one of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response. Oxford Health NHS Foundation Trust is subject to the following set of civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance coordination
- cooperate with other local responders to enhance coordination and efficiency

2.2. The NHS England Emergency Preparedness, Resilience and Response Framework (2022) requires all NHS organisations to plan for and respond to incidents in a manner which is relevant, necessary, and proportionate to the size and services provided.

3. Policies and plans

3.1. The EPRR and business continuity policy was updated in October 2022. All incident response plans in the EPRR response manual are reviewed on an annual basis. Services are responsible for ensuring their business continuity plans are reviewed on annual basis with support from the emergency planning lead.

4. Training, exercises and live events

4.1. A training needs analysis is undertaken on an annual basis and EPRR training is delivered accordingly. This includes training directors, senior managers and communications mangers prior to joining either the director on call rota, the communications manager on call rota or the heads of service on call rota. Individual and group annual refresher sessions are also provided. Major incident and business continuity scenarios, with prompts for discussion, are located on the intranet for team managers to independently exercise business continuity plans with their teams.

4.2. NHS organisations are required to undertake a minimum of one live exercise every three years, a table-top exercise every year and a test of the communications cascade every six months (NHS England Emergency Preparedness Framework, 2022). Lessons identified from exercises are incorporated into incident response plans, business continuity plans and shared with partner organisations.

- The following **table-top exercises** took place during 01 November 2023 - 31 October 2024:

    - **Exercise Spider - loss of pathology IT due to cyber-attack**

      Exercise Spider was attended by colleagues from the IM&T department on 14 June 2024. The scenario presented was the loss of all pathology IT services for two acute Trusts and several GP practices due to a cyber-attack. Coincidentally, the same issue occurred in reality on the same day where Synnovis - a pathology partnership between Guy's and St Thomas' NHS Foundation Trust, King's College Hospitals NHS Trust and SYNLAB - was the victim of a ransomware cyberattack, resulting in a major IT incident and a significant reduction in capacity. The exercise invigorated ongoing planning for such an incident and a clinical systems downtime plan for Adastra, EMIS and RiO was added to the Trust's EPRR response manual describing the broad steps the Trust would implement during an unplanned interruption to a clinical system.

    - **Psychosocial response**

      A table-top exercise to test the provision of psychosocial support to members of the public and staff members who had been affected by civil unrest took place on 5 September 2024. The exercise achieved the aims of ensuring staff members understood their roles and responsibilities, both

internally and externally, during an incident of this nature. Minor amendments were made to the psychosocial response plan.

- The multi-agency **communications cascade exercises** occurred in May and August 2024.

4.3. The following **live events** during 01 November 2023 - 31 October 2024 required the implementation of incident response plans and business continuity plans. Learning from live events is captured by the emergency planning lead and debrief reports are presented to the Trust's EPRR committee.

- **Hospital evacuation**

  On 9 November 2023 three inpatient wards were required to evacuate the Fulbrook Centre in Oxford. The damage to electrical components was such that services could not re-enter the building and alternative accommodation was required for all patients. In response to this incident, the Trust declared a critical incident and implemented the evacuation of hospital inpatient wards plan and set up command and control structures to manage the incident.

- **Industrial action**

  The British Medical Association (BMA) gave notice of their intention to call on all its members employed by OHFT to take part in industrial action on three occasions during the period 01 November 2023 – 31 October 2024. This required the activation of the Trust's industrial action response plan and set up of the incident coordination centre to manage the impact of the industrial action and derogation processes.

- **Clinical systems and e-roster outage**

  On 19 July 2024 OHFT experienced a disruption to the electronic patient record EMIS and the e-roster system. This impacted access to patient records and access to electronic staff rosters. In response, a critical incident was declared, command and control structures were established, and the clinical systems downtime plan was implemented to manage the incident. The incident did not require set up of the strategic level of the command structure. Tactical response was considered sufficient to ensure that the actions taken by the operational level were coordinated, coherent and integrated to achieve maximum effectiveness, efficiency and the desired outcomes.

- **Heatwave**

  The UK experienced several periods of high temperatures during 2024 which required the heatwave plan to be activated. In total, six yellow alerts were issued. Yellow alerts are issued during periods of heat which would be unlikely to impact most people, however those who are particularly vulnerable are likely to struggle to cope and therefore action is required within the health and social care sector.

5. Assurance - NHS England core standards for EPRR

5.1. The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the NHS England core standards for EPRR. These standards reflect the requirements of guidance issued by NHS England. The accountable emergency officer in each organisation is responsible for ensuring these standards are met. The EPPR core standards are reviewed every three years and will be due for review in 2025.

5.2. During quarter two, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board sought assurance regarding the Trust's preparedness in relation to the NHS England core standards for EPRR. Oxford Health NHS Foundation Trust declared full compliance with all 58 core standards and submitted a statement of compliance to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, following review of the self-assessment by the accountable emergency officer and the EPRR committee.

Core Standards domain	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
CBRN	10	10	0	0
Total	**58**	**58**	**0**	**0**
Overall assessment	**Full compliance**			

5.3. The statement of compliance and self-assessment was examined and accepted at a confirm and challenge meeting on 18 October 2024 by Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board – see appendix A.

5.4. Each year, in addition to the core standards, the annual assurance process dives into one subject area in greater detail. The outcome of the deep dive does not contribute to the organisation's assurance rating but is used to help ICBs and NHSE identify good practice and emerging themes. This year's deep dive subject was cyber security and IT related incident response and against the 11 deep dive standards OHFT declared full compliance.

6. Partnership working

6.1. The Trust works in collaboration with a range of partner agencies through formal standing meetings. The Director of Corporate Affairs and/or the Deputy Director of Corporate Affairs attends the Thames Valley local health resilience partnership. Local

health resilience partnerships (LHRPs) are strategic forums for local organisations to facilitate health sector preparedness and planning for emergencies at local resilience forum level. Members of the LHRP are executive representatives who can authorise plans and commit resources on behalf of their organisations.

6.2. The emergency planning lead attends the Thames Valley LHRP delivery group and the BSW LHRP business management group which are forums for NHS emergency planning leads. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for multi-agency emergency preparedness and response, in accordance with national policy and direction from NHS England.

6.3. Formal committees, of which the Trust is a member includes the Oxfordshire resilience group and the Buckinghamshire resilience group. These are multi-agency groups led by the county council and bring together a wide range of partner organisations.

7. Summary

7.1. Oxford Health NHS Foundation Trust has complied with the training and exercising requirements of NHS England EPRR guidance, participated in the relevant NHS and multi-agency planning forums and achieved full compliance with NHS England core standards for EPRR.

31 October 2024

Appendix A

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Georgia Denegri
Accountable Emergency Officer
Oxford Health NHS Foundation Trust

Copy: ICB AEO, OHFT EPRR Lead

Via email

BOB ICB
First Floor, Unipart House
Garsington Road
Cowley
Oxford
OX4 2PG
bobicb.eprr@nhs.net

29Th November 2024

Dear Georgia,

Emergency Preparedness, Resilience and Response (EPRR) Assurance – Confirmation of Self-Assessment and Review

In June of this year, the ICB wrote to Accountable Emergency Officers (AEOs) across the ICS to establish this year's annual assurance process of the NHS England Core Standards for Emergency Preparedness, Resilience and Response.

The ICB EPRR team subsequently completed Assurance Review Meetings with all providers, where areas of good practice as well as outstanding compliance were identified and discussed.

We reflected upon the areas of best practice and achievement over the last year, including:

- The level of work and response that your EPRR lead has managed to deliver with an acknowledgement that she is a team of one, as part of the wider discussions it was agreed to ask the region to review minimum whole time equivalence levels.
- Katie is to be complemented on her records and assurance documents provided, with a particular focus on the strategic commander assessment document and work plans.
- Delivering continued full compliance against the EPRR core standards, and the Trusts EPRR program of work, against a backdrop of incidents and emerging risks, including industrial action.

We discussed the Trust's self-assessment position, noting full compliance on all standards.

To sustain this high level of compliance requires significant effort throughout the year, so congratulations to the team and thank you for your support of them.

EPRR Assurance Statement of Compliance
As part of the national EPRR assurance process for **2024/25**, Oxford Health NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against the 58 applicable core standards, Oxford Health NHS Foundation Trust:

- is fully compliant with 58 core standards.

In line with the national NHS England Core Standards for EPRR assurance thresholds, the overall rating of the Trust for 2024/25 is:

Fully Compliant

Deep Dive

Each year the annual assurance process dives into one subject area in greater detail, referred to as the deep dive. The outcome of the deep dive is not a contributory factor to an organisation's assurance rating. It aids ICBs and NHSE in identifying good practice and emerging themes from across the NHS. This year's deep dive subject was Cyber Security.

Against the eleven deep dive standards, the Oxford Health NHS Foundation Trust self-assessment showed that all eleven standards were fully compliant.

Next Steps

Following agreement of the self-assessment with the ICB, the organisation's final overall assurance rating should be:

Fully Compliant

Yours sincerely,

Paul Jefferies
Associate Director of Emergency Preparedness, Resilience and Response
Deputy Accountable Emergency Officer

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	15
Report title	Standing Financial Instructions
Executive lead(s)	Heather Smith, Chief Finance Officer
Report author(s)	Peter Milliken, Director of Finance
Action this paper	☑ Decision/approval ☐ Information ☐ Assurance
Reason for submission to the Board	The Trust's governance framework requires any revisions to SFIs to be agreed by the Audit Committee who will recommend approval to the Board of Directors.
For disclosure or confidential	Disclosure

Executive summary

Following a review of the Trust's updated SFIs these were recommended for approval by the Audit Committee on 03 December 2024.

This paper summarises all the recommended changes and seeks their formal ratification by the Board of Directors.

Review Process

As previously reported to Audit Committee, a detailed review of SFIs has been undertaken to ensure that the Trust is operating within a robust financial control framework.

An initial review was undertaken within Finance to update the SFIs for references to statutory and other external guidance documentation, to update references to specific post holders and to provide a general update where necessary to enhance clarity. Updates and clarification were requested in relation to specific areas from relevant lead officers, including:

- Director of Estates and Facilities
- Chief People Officer
- Associate Director of Corporate Affairs
- Corporate Affairs
- Procurement
- Head of R&D
- IT & Information Governance
- OPS

Summary of key changes

Responses were received from all of the identified lead officers and the proposed changes to the SFIs are shown on the attached version of the SFIs using 'tracked changes'. The key revisions proposed are summarised below and in more detail on the 'Change Control' section on P2-3 of the updated SFIs.

- Procurement & contracts section – removal of sections no longer applicable, transfer of other sections to the procurement policy and updates to UK regulatory framework (post Brexit)
- Fraud, Bribery & Corruption section – expanded narrative
- OPS – update to align with operational processes
- R&D – update to align with operational processes
- Updated references to external organisations, NHSE guidance and national frameworks.
- Updated titles (Chief People Officer & COO for Mental Health and Primary & Community Care) and change of Executive Director lead responsibilities re: CIP's, CFO replaces Director of Strategy and Chief Information Officer.

The Financial Approval Limits on Appendix 1 to 2 on the SFIs reflects the summarised changes below:

- Tender opening panel removed from schedule as this is all electronic now.
- New limits table for authorising invoices on appendix 1
- Various other changes in limits – see 'Change Control' section on P3 of the updated SFIs

Next steps

A final proof-read of the document will be undertaken (formatting, section and page numbers etc) prior to being published on the Trust's intranet and issued to staff.

Report history / meetings this item has been considered at and outcome

Following a review of the Trust's updated SFIs these were recommended for approval by the Audit Committee on 03 December 2024.

Recommendation(s)

The Board of Directors are asked to approve the updated SFIs.

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☐
People (Workforce) - Be a great place to work	☐
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☐

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	~~Yes~~/No	
Legal and regulatory	Yes/~~No~~	

Oxford Health NHS
NHS Foundation Trust

policy title	Standing Financial Instructions
policy code	CORP 02
author(s) (name and title/role)	Peter Milliken, Director of Finance

Approval History	
Name of Committee	**Date**
Trust Board	21 March 2010
Trust Board	29 February 2012
Trust Board & Audit Committee	2012 to 2021
Audit Committee	24 February 2021
Trust Board	14 April 2021
Audit Committee	22 February 2023
Committee which approved current version Audit Committee	*Date of approval for current version* **3 December 2024**

Date of next review	Q3 FY26

Chair of Approving Committee **Chris Hurst**

Signature .....

Title .....**Audit Committee Chair**

Date .....

Change control – v 3rd Dec 2024

Number of pages (excluding appendices) – 47

summary of revisions:

The SFI's have been reviewed, with the following primary amendments:

- Foreword removed – no longer required
- P7. Legal and Policy Framework updated re: regulatory framework and compliance to guidance issued by NHSE.
- Section 1.1.1 Further reference to Standing Orders for the Board of Directors and the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.
- Section 2.1 – Audit Committee: inclusion of additional terms of reference on lines g to n re: internal and external audit.
- Section 2.4 – External Audit: new reference to the appointment & removal of the auditors in accordance with the Trust Constitution.
- Section 2.5 – addition of 'Bribery' to Fraud & Corruption section and expanded narrative.
- Section 6.4.5 – new section re: petty cash responsibilities and management.
- Section 7. Procurement and Contracts – large sections removed as no longer appliable or and other relevant sections moved to the Procurement Policy (including reverse eAuctions, Contracting and Tendering – moved to Procurement Policy)
- Section 7.2 – EU Directives replaced with relevant UK procurement regulations
- Section 7.4 - NHS England "Capital investment and property business case approval guidance for NHS trusts and foundation trusts" and strategic framework, both updated to reflect latest guidance references, and likewise for latest NHS England guidance re: "Consultancy spending approval criteria for providers"
- Section 7.5 – Tendering – rewrite based on 'Provider Selection Regime' that came into force on 1 Jan 2024 as part of regulations made under the Health and Care Act 2022.
- Section 7.10 PFI – Inclusion of additional risk assessment as part of any private financing arrangements for capital projects.
- Section 7.11 Contract Compliance Requirements – replacement of EU directives with latest UK and Public Sector procurement regulations
- Section 8 – Contracting for provision of services. New sub-section added re: OPS - new business and managing financial risk
- Section 9.4.3 – Budget manager responsibilities for payroll – updated section to include contractual changes, change forms and other changes that impact pay.
- Section 12.2.3.1 – addition of 'other third-party completion certificates' as part of validation of any capital additions.
- Section 15.1.1 – 1998 Data Protection Act updated to UK GDPR and Data Protection Act 2018
- Formerly section 10.7 – Removal of joint finance arrangements as no longer applicable.
- Formerly section 3.3.2 – Budgetary Delegation - Removal of pooled budget section as no longer relevant

- Other changes - removal of any reference to the independent regulator/Monitor replaced with NHSE/Treasury as applicable,

- Other changes to titles – Director of HR now Chief People Officer, CIP lead – CFO replaces Director of Strategy and Chief Information Officer and COO's replaced 'Managing Directors' for Mental Health/LD and Community & Primary Care.

Changes to Approval Limits – Appendix 1 to 2

Appendix 1 – Authorising of goods and services
Director Limit – increase from £150k to £500k
Exec Director – less than £1m (new limit)
CEO or CFO – increase from £200k to > £1m
Appendix 1 – Authoring of Invoices (new heading)
Change of approver **from Service Director** to **Director**
Appendix 1 – Drug Orders
Designated member of staff – increase from £1k to £25k
Ops Operations & Procurement Manager – change from £1k - £150k to £25k to £150k
All/Procurement quotations – 3 written quote limit - £25k to £50k
All/Procurement quotations – Above £25k – increased to £50k (contact procurement team)
All/Procurement single action tender waivers – remove Director and DDoF limit and replace with Head of Procurement.
All/Procurement single action tender waivers – CEO or CFO limit £500k – replaced with DoF or CFO limit £500k
All/Procurement single action tender waivers – CEO & CFO limit > £500k – replaced with CEO or CFO + NED > £500k

Appendix 2 – R&D
Limits and categories updated to reflect what was previously agreed at FIC (reducing categories from four to two).
Appendix 2 - OPS
Transactions & contracts > £2m – approval required from Executive Director

PCR (Public Contracts Regulation) table on P59, after appendix 2 – removed as no longer relevant.
R&D authorization limits table on P60 – removed and superseded by updated Appendix 2 limits.

Any change to code or merging with other policies
None

Consultation with:
Chief Finance Officer and Director of Finance
Associate Director of Corporate Affairs
Procurement and Business Services
Finance and Performance Team
Human Resources
Estates

OPS
Corporate Services
IT & Information Governance

Standing Financial Instructions Policy

Policy code – CORP 02

Version
Date of approval

CONTENTS **Page No**

1 Aim of Policy

These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

2 Legal and policy framework

Oxford Health NHS Foundation Trust (the "Trust") is a public benefit corporation which was established under the National Health Service Act 2006 (the "2006 Act") as amended by the Health and Social Care Act 2012 (the “2012 Act”).

The Trust is governed by the 2006 Act, the 2012 Act, its Constitution and Authorisation granted by NHS England and together these form the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular paragraph 7.3 of Annex 9 of the Constitution requires the Board of Directors of the Trust to adopt Standing Orders for the regulation of its proceedings and business. These Standing Financial Instructions are issued in accordance with the Standing Orders and the Regulatory Framework which requires the Trust to adopt Standing Financial Instructions for the regulation and conduct of the Board of Directors and officers (staff) in relation to all financial matters with which they are concerned. These Standing Financial Instructions shall have effect as if incorporated in the Standing Orders for the Board of Directors but, for the avoidance of doubt, these Standing Financial Instructions do not form part of the Constitution.

In addition to the Regulatory Framework, the Trust is required to comply with guidance issued by NHS England including (but not limited to) the following including all amendments, replacements or modifications made and including any other guidance issued by NHS England.

NHS Oversight Framework
NHS annual plan and operational plan guidance
NAO: Code of Audit Practice
Code of Governance for NHS Provider Trusts
Managing operating cash in NHS Foundation Trusts
NHS England and HM Treasury approval for special payments
NHS Foundation Trust Accounting Officer memorandum
Department of Health and Social Care Group accounting manual
Asset Register and Disposal of Assets: Guidance for providers of CRS
Roles and responsibilities in the approval of NHS Foundation Trust PFI schemes
Transactions guidance for Trusts undertaking transactions, including mergers and acquisitions.

3 Policy

1 INTRODUCTON

1.1 General

1.1.1 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. In conjunction with the Standing Orders for the Board of Directors and the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust, they provide a comprehensive business framework for the administration of the Trust's affairs (License condition CoS3). All directors and officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions contained within them.

1.1.2 These SFIs identify the financial responsibilities, which apply to everyone working for the Trust and its constituent organisations including any Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Chief Financial Officer (CFO) must approve all financial procedures.

1.1.3 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in the application of the Trust's disciplinary procedures, which may include dismissal and, if it is considered that bribery and/or corruption may be involved, referred to the Local Counter Fraud Specialist for investigation

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

a) "Board of Directors" or "Board" means the Chair, Non-Executive Directors and the Executive Directors of the Trust collectively as a body,
b) "Budget" means the forecast resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out any or all functions of the Trust, for a specific period,
c) "Budget Holder" means any employee with delegated responsibility for a budget, including the Chief Executive, Executive Directors, Directorate Leads, and Directorate Managers as defined in the Budgetary Control Policy,
d) "Chief Executive" means the chief officer of the Trust and NHS Foundation Trust Accounting Officer,
e) "CFO" means the chief financial officer of the Trust,
f) "Funds held on trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers

derived through the NHS & Community Care Act. Such funds may or may not be charitable,

g) "Legal Adviser" means the properly qualified person or persons appointed by the Trust to provide legal advice,

h) "Trust" means the Oxford Health NHS Foundation Trust;

1.2.2 Wherever the title Chief Executive, CFO, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "officer" is used and where the context permits, it shall be deemed to include officers of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and delegation

1.3.1 The Board is responsible for reviewing and approving an annual plan and for considering compliance with its terms of authorisation and any risks to compliance. The Board will consider and approve actions to manage risk.

1.3.2 The Board exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of resource budgets within overall income;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money, efficiency, productivity and effectiveness);

d) defining specific responsibilities placed on directors and employees as indicated in the Standing Financial Instructions, and Scheme of Delegation;

e) the monitoring of risks assessed as high;

f) reviewing monthly the performance of the Trust against plan;

1.3.3 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Scheme of Reservation and Delegation' document. All other powers have been delegated to such other committees or officers as the Trust has established.

1.3.4 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Reservation and Delegation document adopted by the Trust.

1.3.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.6 The Chief Executive and CFO will, as far as possible, delegate their detailed responsibilities but they remain accountable for their own defined areas of financial control.

1.3.7 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of and understand their

responsibilities within these SFIs.

1.3.8 The CFO is responsible for:

a) Leading the development of financial strategy with the Board of Directors;
b) Establishing financial policies to strengthen the financial governance of the Trust that supports the delivery of the Trust's objectives and key performance indicators;
c) Implementing the Trust's financial policies, establishing systems for monitoring compliance and for co-ordinating any corrective action necessary to further these policies;
d) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented, maintained and promulgated to supplement these instructions;
e) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
f) Developing the Trust's policies on fraud and corruption; developing work plans; developing and promulgating an anti fraud culture

and, without prejudice to any other functions of directors and employees to the Trust, the duties of the CFO include:

g) the provision of financial advice to the Trust and its directors and employees, and to the Joint Management Groups established under Section 75 Health Act Flexibilities;
h) the design, implementation and supervision of systems of internal financial control; and
i) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.9 <u>All directors and employees</u>, severally and collectively, are responsible for:

a) the security of the property of the Trust;
b) avoiding loss;
c) exercising economy and efficiency in the use of resources;
d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation; and
e) Reporting suspected theft or fraud to the CFO or the Local Counter Fraud Specialist and/or the Local Security Management Specialist.

1.3.10 Any <u>contractor or employee of a contractor</u> who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.11 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

2 AUDIT, FRAUD & CORRUPTION, SECURITY MANAGEMENT

2.1 Audit Committee

2.1.1 In accordance with the Constitution and the Standing Orders for the Board of Directors, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2024), which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;
b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
c) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
d) monitoring compliance with Standing Orders and Standing Financial Instructions;
e) reviewing schedules of losses and compensations and making recommendations to the Board;
f) reviewing the arrangements in place to support the assurance framework process prepared on behalf of the Board and advising the Board accordingly;
g) monitoring and reviewing the effectiveness of the Trust's internal audit function;
h) reviewing and monitoring the auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;
i) developing and implementing policy on the engagement of the auditor and/or an external consultant to supply non-audit services to the Trust, taking into account any relevant guidance or best advice issued by NHS England regarding provision of non-audit services;
j) reporting to the Council of Governors any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken
k) reviewing arrangements by which officers may raise in confidence concerns about possible improprieties in matters of:
    - financial reporting and control
    - clinical quality and patient safety
    - other matters
l) ensuring that arrangements are in place for the proportionate and independent investigation of such matters as set out in Standing Financial Instructions 2.1.1 above, and for appropriate follow-up action;
m) agreeing with the Council of Governors the criteria for appointing, reappointing and removing auditors;
n) making recommendations to the Council of Governors in relation to the appointment, reappointment and removal of the auditor and approving the remuneration and terms of engagement of the auditor;

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. The Counter Fraud guidance on reporting procedure must be followed (see Counter Fraud Policy).

2.1.3 It is the responsibility of the CFO to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed or retained.

2.1.4 The Trust will comply with the National Audit Office Code of Audit Practice.

2.2 Chief Financial Officer

2.2.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
b) Monitoring the performance of internal audit, ensuring that internal audit has the necessary staff, balance of skills and meets the NHS mandatory audit standards;
c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;
d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board.

2.2.2 The CFO or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
b) access at all reasonable times to any land, premises or members of the Board or officer of the Trust;
c) the production of any cash, stores or other property of the Trust under an officer's control; and
d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, within a programme of work approved by the Audit Committee, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies and procedures;
b) the adequacy and application of financial and other related management controls;
c) the suitability of financial and other related management data;
d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i. fraud and other offences,
ii. waste, extravagance, inefficient administration,
iii. poor value for money or other causes.

2.3.2 Internal Audit shall also independently verify on a periodic basis that the Trust complies with its assurance framework.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO and the Local Counter Fraud Specialist and/or Local Security Management Specialist must be notified immediately.

2.3.4 The Head of Internal Audit or their nominated officer will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.5 The Head of Internal Audit shall be accountable to the CFO for day-to-day operational issues, but is otherwise accountable to the Audit Committee, including for audit strategy and planning, and for the timeliness and quality of its work. The reporting system for internal audit shall be agreed between the CFO, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed annually.

2.4 External Audit

2.4.1 The auditor is to be appointed in accordance with the provisions of paragraph 13 of the Trust Constitution. This states that the Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

2.4.2 The accounting officer shall ensure that the auditor is provided with every facility and all documents and information which they may require for the purposes of carrying out their duties and functions under Schedule 10 to the 2006 Act and in accordance with any guidance or best practice advice issued by NHS England on standards, procedures and techniques to be adopted including (but not limited to) the guidance set out in the NAO Code of Audit Practice referred to under the Legal and Policy Framework paragraph above.

2.4.3 The accounting officer shall ensure that the Trust complies with the guidance set out by NHS England in the NAO: Code of Audit Practice, insofar as it applies to the Trust.

2.4.4 When the Council of Governors ends an External Auditor's appointment in disputed circumstances, the Chair should write to NHS England informing it of the reasons behind the decision.

2.4.5 Where the current provider of external audit services seeks to be considered for the provision of non-audit services they will be required to obtain the approval of the Audit Committee. They will be required to submit a letter from

their Ethics partner detailing how auditor independence would not be compromised by the work and stating that the work would be complaint with the ethical standards of the National Audit Office Code of Audit Practice. In accordance with the independence requirement the External Auditor shall not be permitted to have non-audit fees exceeding 70% of their audit fee in any year.

2.5 Fraud, Bribery and Corruption

2.5.1 It is the responsibility of the Trust to ensure that policies and procedures for all fraud and bribery related work is implemented, including findings from investigations and proactive work. In line with their responsibilities, the chief executive and chief finance officer shall monitor and ensure compliance with any relevant guidance issued by NHS England and/or NHS Counter Fraud Authority on fraud, bribery and corruption in the NHS. Further details regarding the collaborative working arrangements between NHS England and NHS Counter Fraud Authority can be found in the Memorandum of Understanding between NHS England and NHS Counter Fraud Authority.

2.5.2 A fraud offence can be committed by any person who dishonestly makes a false representation to make a gain for themselves or another or dishonestly fails to disclose to another person information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Examples of fraud (though not exhaustive) may include:

- falsely claiming to be sick or working elsewhere whilst sick
- falsifying time records, such as claiming pay for time not worked
- undertaking private work during NHS time
- unauthorised private use of NHS equipment with intent to avoid a charge or payment
- submitting altered/bogus invoices or claims for payment
- making false claims for subsistence and expenses
- falsifying any official records
- failing to declare criminal convictions to gain employment

2.5.3 A bribe is offering, promising, or giving a financial, or otherwise, advantage to another person with the intention of bringing about improper performance or reward. The Bribery Act 2010 also states that a person is guilty of an offence if they request, agree or receive, or accept a financial or other advantage intending that a relevant function or activity should be performed improperly by them or another. It further states that offering or agreeing to accept a bribe is an offence even if no money or goods have been exchanged.

2.5.4 In addition to the above, the Trust may be guilty of an offence of failing to prevent bribery if an associated person, for example someone who performs services on behalf of the organisation, bribes another person intending to obtain or return business or a business advantage. To present a defence to the charge of 'failing to prevent bribery' an organisation must have sufficient and adequate procedures in place to prevent bribery by associated persons. Full details can be found in the Trust's counter fraud and bribery policy.

2.5.5 In line with their responsibilities, the Board shall monitor to ensure compliance with the provisions of the Bribery Act 2010. Senior officers (including non-Board level managers) can be individually held criminally liable for the Trust's bribery offences.

2.5.6 The Criminal Finances Act 2017 reinforces the tax evasion rules relating to IR35 and makes relevant bodies criminally liable where they fail to prevent facilitating tax evasion. The Board of Directors shall monitor and ensure compliance with the Act.

2.5.7 The Chief Finance Officer is responsible for the promotion of counter fraud measures within the Trust, and in that capacity, they will ensure that the Trust co-operates with NHS England and NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

2.5.8 The Trust will appoint at least one person (who may be either an officer or a person whose services are supplied to the Trust by an outside organisation) as an NHS Local Counter Fraud Specialist, in accordance with any guidance issued by NHS England or the NHS Counter Fraud Authority Fraud on the suitability criteria for such appointees. The Chief Finance Officer will ensure that the Trust's local counter fraud specialist is accredited by the Counter Fraud Professional Accreditation Board. The local counter fraud specialist shall report directly to the Chief Finance Officer and shall work with NHS England and NHS Counter Fraud Authority.

2.5.9 Where the Trust appoints a Local counter fraud specialist whose services are provided to the Trust by an outside organisation, the Chief Finance Officer must be satisfied that the terms on which those services are provided are such to enable the local counter fraud specialist to carry out his functions effectively and efficiently and, in particular, that they will be able to devote sufficient time to the Trust.

2.5.10 The local counter fraud specialist and the chief finance officer will, at the beginning of each financial year, prepare a written work plan outlining the local counter fraud specialist's projected work for that financial year.

2.5.11 The local counter fraud specialist shall have the opportunity to attend Audit Committee meetings and other meetings of the Board of Directors, or its committees, as required.

2.5.12 The Chief Finance Officer will ensure that the local counter fraud specialist:

- keeps full and accurate records of any instances of fraud and suspected fraud
- reports to the Board of Directors, through the Audit Committee, any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust has all necessary support to enable them to efficiently, effectively and promptly carry out their functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of their work
- receives appropriate training and support, as recommended by NHS Counter Fraud Authority

- participates in activities which NHS England directs, or in which NHS Counter Fraud Authority is engaged, including national anti-fraud measures
- the chief finance officer must, subject to any contractual or legal constraints, require all trust staff to co-operate with the local counter fraud specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.
- the chief finance officer must also prepare a "fraud response plan" that sets out the action to be taken both by persons detecting a suspected fraud and the local counter fraud specialist, who is responsible for investigating it
- any officer discovering or suspecting a loss of any kind must either immediately inform the chief executive and the chief finance officer or the local counter fraud specialist, who will then inform the chief finance officer and/or chief executive; where a criminal offence is suspected, the chief finance officer must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the local counter fraud specialist.
- for losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Finance Director must immediately notify:
    - the Board of Directors
    - the Auditor.

2.5.13 The Local Counter Fraud Specialist will provide the Audit Committee with a written quarterly report on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health Social Care and the NHS Standard Contract on NHS security management.

2.6.2 The Chief Executive shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance and the NHS Standard Contract on security management.

2.6.3 The Trust shall nominate a Non-executive Director, who should be a member of the Quality Committee, to be responsible to the Board for NHS security management. The Chief Executive shall nominate an Executive Director to act as Security Management Director.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management

Director (SMD) and the appointed Local Security Management Specialist (LSMS).

2.6.5 The Trust shall prepare a 'Security Policy' that sets out measures to protect patients, staff, visitors, premises and assets.

The Chief Executive will ensure that:
Breaches of security and weakness in security-related systems are reported as soon as practicable to the:

- Local Security Management Specialist
- Audit Committee
- Auditor

3 BUSINESS PLANNING, BUDGETS AND BUDGETARY CONTROL

3.1 Preparation and approval of business plans and budgets

3.1.1 The Chief Executive will, on an annual basis, compile and submit to the Board an annual plan which takes into account financial targets and that meets the requirements of NHS England's planning guidance. The annual plan will contain:

a) Strategic overview – past and future
b) Review of past performance against plan
c) Changes to forecast and plans for service developments, operating resources required, investment and disposals, capital expenditure (CapEx)
d) Compliance with core healthcare targets and standards
e) Risk and performance management
f) Board of Directors' role, structure and capacity
g) Membership report
h) Compliance with the authorisation
i) Financial projections

3.1.2 Prior to the start of the financial year the CFO will, on behalf of the Chief Executive, submit an annual plan budget for approval by the Board. A medium-term plan will also be presented to cover the impact of, and give context to, the annual budget for the year. The medium-term financial plan will cover a 2-3 year period and include:

a) Income & expenditure
b) Activity
c) The Statement of Financial Position
d) Key Performance Indicators
e) Cash flow
f) Risk Assessment and mitigation plans; and
g) Any additional information required by NHS England

3.1.3 The CFO shall monitor financial performance against the financial plan and budget on a monthly basis and report to the Board.

3.1.4 All budget holders and managers will sign off their allocated budgets, in accordance with the Trust's Budgetary Control policy.

3.1.5 The CFO has a responsibility to promote the highest level of financial governance and ensure that adequate training is delivered on an ongoing basis to budget holders and managers to help them manage successfully.

3.2 Investment

3.2.1 The Board will agree a policy setting out the governance process for all major investments undertaken by the Trust, the Investment Policy, in accordance with best practice guidance issued by NHS England. The CFO will develop the policy for approval by the Finance and Investment Committee. As reflected in the scheme of delegation and its terms of reference, the Finance and Investment Committee will have delegated authority to:

a) Recommend investment and borrowing strategy and supporting policies
b) Approve investment and performance benchmarks
c) Review performance of investments with an annual report to the Board
d) Ensure proper safeguards are in place for the security of the Trust's funds
e) Monitor compliance with investment policy and procedures
f) Approve external funding arrangements within delegated authority

3.3 Budgetary delegation

3.3.1 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of any budget virements.

3.3.2 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the CFO.

3.4 Budgetary control and reporting

3.4.1 The CFO will devise and maintain systems of budgetary control. These arrangements will be set out in the Budgetary Control Policy, the purpose of which will be to assist the Board, budget holders and budget managers in understanding how the process of budgetary control operates within the Trust and their individual role within that process. The policy will set out the Trust's budgetary control framework, making explicit links to Standing Orders, Standing Financial Instructions, and the budget preparation and control procedure, which will provide details on the preparation of the budget. The Budgetary Control Policy is to have the effect as if incorporated in the Trust's Standing Orders.

3.4.2 The systems of budgetary control will include:

a) monthly financial reports to the Board in a form approved by the Board containing:
    i. income and expenditure to date showing trends and forecast year-end position;
    ii. movements in working capital;
    iii. movements in cash and capital;
    iv. capital project spend and forecast outturn against plan;
    v. explanations of any material variances from plan;

vi. details of any corrective action where necessary and the Chief Executive's and/or CFO's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
c) investigation and reporting of variances from financial and workforce budgets;
d) monitoring of management action to correct variances; and
e) arrangements for the authorisation of budget transfers.

3.4.3 Each Budget Holder is responsible for ensuring that:

a) any material overspending or reduction of income which cannot be met by a virement of budget elsewhere is not incurred without the prior consent of the Board;
b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of budget virements;
c) no permanent employees are appointed without the approval of the Chief Executive, or as delegated, other than those provided for within the available resources and staffing establishment as approved by the Board.

3.4.4 The Chief Executive is responsible to the Board for the Cost Improvement Programme which supports the financial viability and sustainability of the Trust and can demonstrate that the Trust operates as an efficient provider of health services. Responsibility for the establishment and delivery of the Cost Improvement Programme is delegated to the CFO, with accountability for individual schemes devolved to the responsible Executives.

3.5 Capital expenditure

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.6 Monitoring returns

3.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisations within designated timescales.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The CFO, on behalf of the Trust, will:

a) Keep accounts in such a form as NHS England may, with the approval of HM Treasury, direct;
b) Prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of HM Treasury direct;
c) Comply with any directions given by NHS England with the approval of HM Treasury as to:
    i. The methods and principles according to which the accounts are to be prepared
    ii. The information to be given in the accounts

4.2 The Trust's annual accounts must be subject to independent external audit. The Trust's audited annual report and accounts must be formally approved by the Board. The Trust is required to lay its annual report and accounts before Parliament in accordance with guidance and a timetable for submission set out by NHS England.

4.3 The annual report and accounts and auditor's report on the accounts must be presented to the Council of Governors after the end of the financial year but not before the annual report and accounts have been laid before Parliament.

4.4 The annual report and accounts will include:

a) Directors' report
b) Remuneration report
c) Accounting Officer's statement of responsibilities
d) Auditor's opinion and certificate
e) Annual Governance Statement
f) Foreword to the accounts
g) Primary financial statements
h) Notes to the accounts

5 TREASURY MANAGEMENT

5.1 General

5.1.1 The Board of Directors will approve a Treasury Management Policy and Scheme of Delegation. The Board will delegate to the Finance and Investment Committee approval of the Trust's treasury management and investment policy, procedures, processes and controls in accordance with policy.

5.1.2 The CFO is responsible for:

a) Proper operation of accounting systems including cash flow projections,
b) Reviewing treasury reports and preparation of reports for the Board and Finance and Investment Committee,
c) Managing the Trust's day to day banking arrangements,
d) Advising on the provision of banking services and operation of accounts, and the investment of surplus cash.

5.1.3 The Trust will maintain a risk averse stance to investing cash surplus balances. The Board of Directors shall approve the banking arrangements.

5.2 Banking Arrangements

5.2.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions issued from time to time by NHS England as well as Treasury requirements. The Board shall approve the banking arrangements.

5.2.2 The CFO is responsible for:

a) bank accounts;

b) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and
c) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
d) monitoring compliance with policy, procedures and NHSE / Treasury guidance.

5.3 **Banking procedures**

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts, which must include:

a) the conditions under which each bank account is to be operated;
b) the limit to be applied to any overdraft; and
c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 **Review**

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 **Income systems**

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 **Fees and charges**

6.2.1 The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the DH's Commercial Sponsorship: Ethical Standards in the NHS shall be followed.

6.2.2 All officers must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 **Debt recovery**

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding

debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated as soon as possible and within a month of detection. If appropriate, the services of the LCFS may be used to support recovery.

6.4 **Security of cash, cheques and other negotiable instruments**

6.4.1 The CFO is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
b) ordering and securely controlling any such stationery;
c) ensuring adequate facilities and systems are in place for employees whose duties include collecting and holding cash, including ensuring they obtain safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc, shall be banked intact within a week. Disbursements shall not be made from cash received, except under arrangements approved by the CFO.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes. Patient monies and Charitable donations are deemed to be official funds and must be managed in accordance with procedures approved by the CFO.

6.4.5 **Petty cash**

6.4.6 The budget holder will hold overall responsibility for any petty cash float issued to their department cost code and be up to date with the current petty cash procedures.

6.4.7 It is the responsibility of the new float holder to adhere to the patient finance procedures on the intranet.

7 TENDERING AND CONTRACTING PROCEDURE

7.1 **Duty to comply with Standing Orders, Standing Financial Instructions and Procurement Policy.**

7.1.1 The procedure for making or entering into all contracts by or on behalf of the Trust shall comply with the Standing Orders, Standing Financial Instructions

(except where Standing Order No. 3.13 Suspension of Standing Orders is applied) and Procurement Policy.

7.1.2 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's charitable trust funds and private resources.

7.1.3 All those involved in the tendering and contracting process should be aware that the Bribery Act 2010 replaced the fragmented and complex offences at common law and the Prevention of Corruption Acts 1889-1916. This is broadly defined in the sections below:

a) two general offences of bribery: (i) offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly and (ii) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper;
b) the new corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of the organisation;
c) bribing a foreign official.

7.1.4 All personnel involved in tendering and contracting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them into breach of the Act that could leave them open to investigation by the Local Counter Fraud Specialist, and criminal proceedings being commenced.

7.1.5 It is the responsibility of the CFO to publish and maintain rules and procedures for tendering and contracting in the Trust's Procurement Policy. The Procurement Policy is to have the effect as if incorporated in the Trust's Standing Orders.

7.2 Governing Public Procurement

7.2.1 There are three distinct procurement regulations that are running concurrently:

- Public Contracts Regulations 2015 (PCR15) for tenders or contracts started before 24th February 2025
- The Procurement Act 2023 (PA23) with effect from 24th February 2025
- Provider Selection Regime (PSR) for Healthcare services only.

7.4 Capital Investment Manual and other NHS England Guidance

7.4.1 The Trust shall comply as far as is practicable with the requirements of the NHS England "Capital investment and property business case approval guidance for NHS trusts and foundation trusts" (updated February 2023) and DHSC "Health Building Note 00-08: Strategic framework for the efficient management of healthcare estates and facilities (updated January 2024) in respect of capital investment and estate and property transactions.

In the case of management consultancy contracts the Trust shall comply with

7.4.2 NHS England guidance "Consultancy spending approval criteria for providers" , published on the NHS England website NHS England » Consultancy spending approval criteria for providers

7.5 **Formal Competitive Tendering**

7.5.1 **General Applicability -** The Trust shall ensure that competitive tenders are invited for:

a) the supply of goods, materials and manufactured articles;
b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

7.5.2 **Health Care Services -** Where the Trust elects to invite tenders for the supply of healthcare services, the PSR, Procurement Policy and these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8.

7.5.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience.

7.5.4 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.5.5 Exceptions and instances where formal tendering need not be applied are set out below.

a) Formal tendering procedures **need not be applied**:
    i. Where the estimated expenditure or income does not, or is not reasonably expected to, exceed the limits set out in the Financial Limits Approval Matrix at Appendix 1;
    ii. where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;
    iii. regarding disposals as set out in Standing Financial Instructions No. 7.14;
    iv. where the requirement is covered by an existing contract and the scope of the contract compliantly allows for additional goods or services to be procured.
    v. where NHS Supply Chain agreements are in place and have been approved by the Board;
    vi. under PSR for Healthcare services only, where there is limited or no reason to change from the existing provider because: there is only one provider in the market, patients have a choice of provider and the number is not restricted or the existing provider us satisfying the existing contract and will likely satisfy the new contract.

b) Formal tendering procedures **may be waived** in the following circumstances:

i. In times of extreme urgency where the timescale genuinely precludes competitive tendering. Note that failure to plan the work properly would not be regarded as a justification for a single tender;
ii. where specialist expertise is required and is available from only one source, that may include technical reasons and exclusive rights Note, reasonable care should be taken and sufficient pre-market research conducted to accurately determine that the specialist expertise is only available from one source;
iii. where a change of supplier from the original supplier would result in incompatibility or disproportionate technical difficulties in operation and or maintenance.
iv. There is a requirement to directly award as a tender process has not been successful.

7.5.6 **Fair and Adequate Competition** – Except where the exceptions set out in SFI Nos. 7.1.2 and 7.5.5 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, in accordance with the Trust's Procurement Policy.

7.5.7 **List of Approved Firms -** The Trust shall ensure that, where approved supplier lists have been established through a legally compliant process, the firms/individuals invited to tender (and where appropriate, quote) are among those on the appropriate approved supplier lists. Where the Trust decides to deviate from those established lists, the normal procurement policies and procedures must apply.

7.5.8 **Items which subsequently breach thresholds after original approval -** Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits should be managed in accordance with the procedure applicable in the relevant procurement regulations.

7.6 **Private Finance for capital procurement (see overlap with SFI No. 12)**

7.6.1 The Trust should normally consider private finance funding when considering large or exceptional capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector. This should include a full risk assessment of the proposal to the Trust.
b Any investment that meets NHS England's criteria as set out in the investment policy will be reported to NHS England.
c The proposal must be specifically agreed by the Board of Directors.
d Any proposed investment should be reported to the local ICS.
e The selection of a contractor/finance company must be on the basis

of competitive tendering or quotations.

7.7 **Compliance requirements for all contracts**

7.7.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a The Trust's Standing Orders, Standing Financial Instructions and Procurement Policy;

b The applicable Procurement Regulations:
Public Contracts Regulations 2015 for tenders or contracts started before 24th February 2025
The Procurement Act 2023 with effect from 24th February 2025
Provider Selection Regime (PSR) for healthcare services only.

c NHS guidance on Consultancy spending approval assessment criteria

d Cabinet Office Spending Controls

e Such of the NHS Standard Contract Conditions as are applicable.

7.7.2 Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

7.7.3 Contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

7.7.4 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.7.5 The Trust is required to comply with the UKGDPR and Data Protection Act (2018). Where procurement or acquisition of a service or system which requires the use of personal information, of staff, patients, or other identifiable people, is initiated the Trust must ensure that the person or organisation providing the system or service is subject to the obligations imposed on the Trust as data controller by the UKGDPR and Data Protection Act (2018). The provider of the system or service will be required to provide assurance about their responsibilities as a data processor, and this will include committing themselves to the obligations of the Trust by signing a data processor agreement.

7.8 **Personnel and Agency or Temporary Staff Contracts**

7.8.1 The Chief Executive shall nominate appropriately qualified officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.8.2 The use of agency staff shall be in accordance with detailed procedures approved by the Chief People Officer and in accordance with guidance issued by NHSE.

7.9 **Healthcare Services Agreements (see overlap with SFI No. 8)**

7.9.1 In accordance with the Health and Care Act 2022 and the Health Care Services (Provider Selection Regime) Regulations 2023, where the Trust is providing Healthcare Services:

a) The Chief Executive, or nominated officer (as defined at appendix 1 to these SFIs) is responsible for ensuring the Trust enters into suitable service contracts with service commissioners for the provision of NHS services. Service contracts must be signed in accordance with the approval matrix at appendix 1 to these SFIs;
b) Service agreements with NHS commissioners for the supply of healthcare services shall be drawn up as a legally binding contract based on templates (as they exist) agreed by NHS England and the Department of Health and Social Care;
c) The Chief Executive, as Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the service contracts.

7.9.2 Where the Trust is commissioning Healthcare Services

a) Contracts or service agreements with NHS providers for the supply of healthcare services shall be drawn up as a legally binding contract, unless under exceptional circumstance this would be via the NHS Standard Contract Documentation;
b) The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

7.10 **Disposals (See overlap with SFI No. 14)**

7.10.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;
b obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
c items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed at each review of the SFIs;
d items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
e land or buildings concerning which DHSC/NHSI guidance has been issued but subject to compliance with such guidance.

7.11 **In-house Services**

7.11.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.11.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a Specification group, comprising the Chief Executive or nominated officer/s and specialist.

b In-house tender group, comprising a nominee of the Chief Executive and technical support.

c Evaluation team, comprising normally a specialist officer, a procurement officer and a CFO representative. For services having a likely annual expenditure exceeding £1,000,000, a Non-Executive Director should be a member of the evaluation team.

The overall process should be led by Strategic Procurement.

7.11.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.11.4 The evaluation team shall make recommendations to the Board.

7.11.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8 CONTRACTING FOR PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Chief Executive, or nominated officer (as defined at appendix 1 to these SFIs) is responsible for ensuring the Trust enters into suitable Service Contracts with service commissioners for the provision of NHS services. Service Contracts must be signed in accordance with the delegated approval matrix at appendix 1 to these SFIs.

8.1.2 All Service Contracts should aim to implement the agreed priorities contained within the Trust's Integrated Business Plan (IBP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

a the standards of service quality expected;

b the relevant national service framework (if any);

c the provision of reliable information on cost and volume of services;

d the NHS National Performance Assessment Framework;

e that contracts build, where appropriate, on existing Joint Investment Plans;

f that contracts are based on integrated care pathways.

8.2 **Partnership arrangements and jointly managing risk -** The Chief Executive will ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. Where a formal partnership arrangement exists, this will be reflected in the appropriate legal documentation and where the Trust is the Lead Provider any sub-contracts will align quality and activity requirements with the head contract and apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial

arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 **OPS** - **New business and managing financial risk**

Risk assessment and due diligence - New business is risk assessed against set criteria including financial, operational, regulatory and reputational aspects. All new business is assessed by OPS SMT with oversight provided at the OPS Oversight Board and FIC. Mandatory compliance checks verify supplier (SOP 4.7 Qualification of supplier), products (SOP 4.10 Approval and setting up of new product line) and customer (SOP 4.8 Qualification of customer) involved. Each new supplier is independently assessed using a financial health check via Dun and Bradstreet finance analytics.

Delegated approval – Oversight of high value transactions or new business contracts with complex risk profiles >£2m per annum is provided at OPS Board and at FIC with required approvals from the Lead Executive Director.

Contractual controls - Commercial and quality technical agreements outline terms, required notice, responsibilities, payment schedules, performance metrics, penalties and breaches. All credit limits are based on an assessment of financial stability and are reviewed quarterly by OPS finance team.

Insurance - All new business is covered by OPS top-up insurance for loss, theft and damage and is managed and reviewed by OPS finance team.

Monitoring & Review – Financial accounts are reviewed monthly by central finance and performance is tracked against budget and set measures, including stock holding value, write off value and outstanding debt total. Finance performance reports are shared with the Lead Executive Director and presented at FIC. All financial risks are recorded on Ulysees, as required.

Escalation – All financial risks are reported on Ulysees and oversight is provided to the Lead Executive Director with escalation to the Trust Board, as appropriate, to determine corrective actions.

8.4 **Reports to Board on Contracts -** The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contracts. This will include information on costing arrangements. All parties should agree a common currency for application across the range of contracts.

9 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 **Remuneration and terms of service**

9.1.1 In accordance with Standing Orders 5.7.1.2 the Board shall establish a Nominations Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

a determine appropriate remuneration and terms of service for the

Chief Executive and other executive directors (and other senior officers), including:

i. all aspects of salary (including any performance-related elements/bonuses);
ii. provisions for other benefits, including pensions and cars;
iii. arrangements for termination of employment and other contractual terms;

b determine the remuneration and terms of service of executive directors (and other senior officers) to ensure they are fairly rewarded for their individual contribution to the Trust having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

c determine and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

9.1.3 The Board will need to consider and approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those officers not covered by the Committee.

9.1.4 The Trust will remunerate the Chairman and Non-executive Directors in accordance with resolution of the Council of Governors. The Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference, to undertake this responsibility.

9.2 **Funded establishment**

9.2.1 The budget will reflect the agreed workforce establishment. Changes to the establishment and the associated budget changes will be agreed as part of an establishment control procedure, as defined in the Budgetary Control Policy.

9.3 **Staff appointments**

9.3.1 No director or officer may engage, re-engage, or re-grade staff, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

a authorised to do so by the Chief Executive;
b within the limit of his/her approved budget and funded establishment;
c it is in accordance with Trust policies and procedures as approved by the Director responsible for Human Resources, in particular with respect to pre-employment checks.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for officers.

9.3.3 The Chief Executive has delegated responsibility to the Managing Director of Mental Health Services & Learning Disabilities Care to agree arrangements for the appointment of new staff under any Section 75 agreement.

9.4 **Processing of payroll**

9.4.1 The Chief People Officer is responsible for:

a specifying timetables for submission of properly authorised time records and other notifications;
b the final determination of pay;
c making payment on agreed dates;
d agreeing method of payment.
e verification and documentation of data;
f the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
g maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
h security and confidentiality of payroll information;
i checks to be applied to completed payroll before and after payment;
j authority to release payroll data under the provisions of the UKGDPR and Data Protection Act (2018);
k pay advances and their recovery;
l separation of duties of preparing records and handling cash; and recovery of overpayments for current employees.

9.4.2 The CFO is responsible for:

a procedures for payment by cheque, bank credit, or cash to officers;
b procedures for the recall of cheques and bank credits
c maintenance of regular and independent reconciliation of pay control accounts; and
d a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Budget managers have delegated responsibility for ensuring that they, other line managers and any deputies that they or their line managers may nominate within their area of budgetary responsibility:

a submit time records, contractual changes, termination forms and notifications of other changes that impact upon pay that are accurate in accordance with agreed timetables;
b complete time records and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer; and
c Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Head of HR Operations must be informed within 2 working days.

9.4.4 Regardless of the arrangements for providing the payroll service, the Chief People Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 **Contracts of Employment**

9.5.1 The Board shall delegate responsibility to a manager for:

a ensuring that all employees are issued with a Contract of

Employment in a form approved by the Board and which complies with employment legislation; and

b dealing with variations to, or termination of, contracts of employment.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis through the annual plan process, and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will directly, or through delegation, set out:

a the list of managers who are authorised to place requisitions for the supply of goods and services;

b the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Requisitioning

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. An assessment of value for money must take into account, cost, quality and whole life costs. In addition to value for money the requisitioner must also ensure that appropriate internal financial control is maintained throughout the procurement process. In so doing, the advice of the Trust's procurement lead shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.

10.2.2 Staff approving requisitions must be clear that they understand what is being requested and be able to justify the request. They should consider the benefit obtained from requisitioning the goods/services and the impact of not requiring goods/services and whether the benefit is worth the expenditure being incurred.

10.3 System of Payment and Payment Verification

The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance and Better Payments Practice Code.

10.3.1 The CFO will:

a. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and the

Procurement Policy and be reviewed at each review of the SFIs;

b. prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;
c. be responsible for the prompt payment of all properly authorised accounts and claims;
d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
    i. Segregation of duties.
    ii. A list of Trust employees authorised to certify invoices.
    iii. Certification that:

        - goods have been duly received, examined and are in accordance with specification and the prices are correct;
        - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
        - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
        - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
        - the account is arithmetically correct;
        - the account is in order for payment.

    iv. A timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

    v. Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 10.4 below.

10.4 **Prepayments**

10.4.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

1. Prepayments are only permitted where contractually obliged or the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).
2. Prepayments may be considered for Small Medium Enterprises (SME) or Volunteer, Community and Social Enterprises (VCSE)

where it can be evidenced that payment in arrears may cause financial distress to that organisation.

3. The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
4. The CFO will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
5. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.5 Official orders

10.5.1 Official Orders must:

1. be raised for all non-pay expenditure in accordance with the Trust's Procurement Policy;
2. be consecutively numbered;
3. be in a form approved by the CFO;
4. state the Trust's terms and conditions of trade;
5. only be issued to, and used by, those duly authorised by the Chief Executive.

10.6 Duties of Managers and Officers

10.6.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;
b) contracts above specified thresholds are advertised and awarded in accordance with the relevant public procurement regulations as at SFI no. 7.2;
c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS England – see note 7.4.1;
d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

   i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
   ii. conventional hospitality, such as lunches in the course of working visits;

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the Chief Executive;

f) all goods, services, or works are ordered on an official order;
g) verbal orders must only be issued very exceptionally - by an employee designated by the CFO and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
j) changes to the list of employees and officers authorised to certify invoices are notified to the CFO;
k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO within the Petty Cash Procedure Notes;
l) petty cash records are maintained in a form as determined by the CFO.

10.6.2 The Chief Executive and CFO shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within ESTATE CODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

11 EXTERNAL BORROWING AND INVESTMENTS

11.1 External borrowing

11.1.1 The CFO must prepare a Treasury Management Policy and detailed procedural instructions for applications for loans and overdrafts. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, representing value for money, and comply with the latest guidance from NHS England and best practice.

11.1.2 Any short-term borrowing must be with the authority of two members of the Finance and Investment Committee, one of which must be the Chief Executive or the CFO. The Board must be made aware of all short term borrowings at the next Board meeting.

11.1.3 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the CFO.

11.1.4 The CFO will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits as set by the Terms of Authorisation. The CFO is also responsible for reporting monthly to the Board concerning the PDC debt and all loans and overdrafts.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

11.2 Investments

11.2.1 In support of the Trust's high level objectives, the key objectives of the treasury management function are to ensure:

11.2.1.1 A competitive return on surplus cash balances within the Trust's agreed risk profile (taking account of the cost of administering this function)

11.2.1.2 That competitively priced funds appropriate to the Trust's needs are available when required and throughout the required period

11.2.2 The Trust will maintain a risk-averse stance to investing cash surplus balances and can invest surplus funds solely with certain 'permitted institutions' considered low risk by the Trust for a maximum investment period of three months,

11.2.3 The Board of Directors will approve a scheme of delegation in respect of investments and delegate to the Finance and Investment Committee:

11.2.3.1 Approval of the Trust's treasury management and investment procedures, processes and controls;

11.2.3.2 Responsibility for monitoring performance of investments, internal controls and compliance with policy and procedures.

11.2.4 The CFO shall:

11.2.4.1 Prepare a comprehensive policy and detailed procedures covering treasury management and investment for the Finance and Investment Committee's approval;

12 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital investment

12.1.1 The Chief Executive:

12.1.1.1 Shall ensure there is a comprehensive governance framework for capital investment;

12.1.1.2 Shall ensure PRINCE2 project management methodology or equivalent is followed in all capital schemes;

12.1.1.3 Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

12.1.1.4 Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

12.1.1.5 Shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support, if appropriate, and the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 The Finance and Investment Committee will approve an Investment Policy.

12.1.3 For every capital expenditure proposal the Chief Executive shall ensure:

12.1.3.1 that a business case (in line with the Trust's governance framework for capital investment and guidance contained within the Capital Accounting Manual) is produced setting out:

iii. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
iv. the involvement of appropriate Trust personnel and external agencies;
v. appropriate project management and control arrangements; and

12.1.3.2 that the CFO has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of NHS Estate Code.

12.1.5 The CFO shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

12.1.6 The CFO shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.7 The approval of the Capital Investment Programme shall not constitute approval for expenditure on any scheme; each scheme must have specific approval prior to expenditure.

12.1.8 The Chief Executive shall issue to the manager responsible for any scheme:

12.1.8.1 specific authority to commit expenditure;

12.1.8.2 authority to proceed to tender (refer to Appendix 1);

12.1.8.3 approval to accept a successful tender (refer to Appendix 1).

The CFO will issue a scheme of delegation for capital investment management in accordance with NHS Estate Code guidance and the Trust Standing Orders.

12.1.9 The CFO shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 Asset registers

12.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the CFO concerning the form of any register and the method of updating, and arranging for a physical check and valuation of land and buildings against the asset register to be conducted

once a year.

12.2.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health.

12.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

12.2.3.1 properly authorised and approved agreements, architect's certificates or other third-party completion certificates supplier's invoices and other documentary evidence in respect of purchases from third parties;

12.2.3.2 stores, requisitions and wages records for own materials and labour including appropriate overheads; and

12.2.3.3 lease agreements in respect of assets held under a finance lease and capitalised.

12.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.2.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.2.6 The value of each asset shall be maintained in accordance with methods specified in the Foundation Trust Annual Reporting Manual (ARM).

12.2.7 The value of each asset shall be depreciated using methods and rates as specified in the ARM.

12.2.8 The CFO shall calculate and pay Public Dividend Capital annual dividends (capital charges).

12.2.9 The Trust must not dispose of any protected property without the approval of NHS England. This includes the disposal of part of a property or granting an interest it.

12.3 **Security of assets**

12.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the CFO. This procedure shall make provision for:

12.3.2.1 recording managerial responsibility for each asset;

12.3.2.2 identification of additions and disposals;

12.3.2.3 identification of all repairs and maintenance expenses;

12.3.2.4 physical security of assets;

12.3.2.5 periodic verification of the existence of, condition of, and title to, assets recorded;

12.3.2.6 identification and reporting of all costs associated with the retention of an asset; and

12.3.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the CFO.

12.3.4 Whilst each officer has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and officers in accordance with the procedure for reporting losses, and reported to the Local Security Management Specialist for investigation.

12.3.6 Where practical, assets should be marked as Trust property.

13 STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

13.1.1.1 kept to a minimum whilst ensuring that there are no stock-outs throughout the supply chain, with contingency plans;

13.1.1.2 subjected to annual stock take or more frequent periods as determined by the CFO;

13.1.1.3 valued at the lower of cost or net realisable value.

13.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the CFO. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal shall be the responsibility of a designated Estates Manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated Manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4 The CFO shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the CFO and there shall be a physical check covering all items in store at least once a year.

13.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the CFO.

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the CFO any evidence of significant overstocking and of any negligence or malpractice (see also 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the CFO who shall satisfy himself that the goods have been received before accepting the recharge.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and condemnations

14.1.1 The CFO must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the CFO of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

14.1.3.1 condemned or otherwise disposed of by an officer authorised for that purpose by the CFO;

14.1.3.2 recorded by the 'Condemning Officer' in a form approved by the CFO, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the CFO.

14.1.4 The 'Condemning Officer' shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO who will take the appropriate action.

14.2 Losses and special payments

14.2.1 The CFO must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments. The Counter Fraud Specialist, with the approval of the CFO, must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the CFO or inform the Local Counter Fraud Specialist and/or Local Security Management Specialist. This officer will then appropriately inform the CFO and/or Chief Executive. Where a criminal offence is suspected, the CFO must immediately inform the police and Local Security Management Specialist if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the CFO must inform the relevant LCFS in accordance with section 24 of the NHS Standard Contract.

14.2.3 The CFO must notify the External Auditor and the chair of the Audit Committee of all material frauds.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO must immediately notify:

14.2.4.1 The Board,

14.2.4.2 The External Auditor.

14.2.4.3 The Local Security Management Specialist.

14.2.5 The Board shall agree a delegation of limits delegated for the writing-off of losses (see Appendix 1).

14.2.6 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.7 For any loss, the CFO should consider whether any insurance claim can be made.

14.2.8 The CFO shall maintain a Losses and Special Payments Register in which write-off action is recorded and report this to the Audit Committee together with any constructive losses.

15 FINANCIAL INFORMATION, COMMUNICATION, and TECHNOLOGY

15.1 The CFO, who is responsible for the accuracy and security of the computerised financial data (the data) of the Trust, shall:

15.1.1 devise and implement any necessary procedures to ensure integration of the system and adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the UKGDPR and Data Protection Act (2018), Caldicott principles and NHS Guidance;

15.1.2 ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

15.1.3 ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

15.1.4 ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

15.2 The CFO shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 Where computer systems have an impact on corporate financial systems the CFO shall satisfy him/herself that:

15.3.1 systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology and Digital Strategy;

15.3.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

15.3.3 appropriate staff have access to such data; and

15.3.4 such computer audit reviews as are considered necessary are being carried out.

15.4 In the case of computerised financial systems which are proposed General Applications (i.e. normally those applications which are commissioned-in by the Trust or which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and officers will send to the CFO:

15.4.1 details of the outline design of the system;

15.4.2 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.5 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.6 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.7 The CFO shall ensure that financial risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.8 The CFO shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16 PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Managing Director of Mental Health Services & Learning Disabilities Care must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where NHS England instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17 FUNDS HELD ON TRUST

17.1 Corporate Trustee

17.1.1 Standing Order No. 2.2 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 2.3 that states the Trust's accountability to the Charity Commission for charitable funds.

17.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

17.1.3 The CFO shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

17.2 Accountability to the Charity Commission and the Independent Regulator

17.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's accountability to the Charity Commission for charitable funds held on trust and to the Independent Regulator for non-charitable funds held on trust.

17.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All members of the Board of Directors and Trust officers must take account of that guidance before taking action.

17.3 Applicability of Standing Financial Instructions to funds held on Trust

17.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

17.3.2 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

18 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 8 and SFI No. 10.6.1

(d))

18.1 The CFO shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' (amended, in part by the Bribery Act 2010) and is also deemed to be an integral part of these Standing Financial Instructions and associated Standing Orders. Any suspected breach of policy on gifts and hospitality will be reported to, and investigated by, the Local Counter Fraud Specialist and may result in a criminal prosecution being commenced.

19 RETENTION OF DOCUMENTS

19.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in line with statutory legislation and guidance issued by the Department of Health and other regulators. The Chief Executive shall develop a policy and ensure all staff are aware of the mandatory requirements and best practice in relation to the retention of documents.

19.2 The CFO is responsible for:

19.2.1 developing policy in respect of the retention of documents in accordance with statutory requirements and best practice;

19.2.2 proactively providing the Board with assurance of compliance with policy;

19.2.3 raising awareness.

19.3 The documents held in archives shall be capable of retrieval by authorised persons.

19.4 Documents will be held and destroyed in accordance with Trust policy. A record of documents destroyed shall be maintained.

20 RISK MANAGEMENT & INSURANCE

20.1 Programme of Risk Management

20.1.1 The Board of Directors is accountable for ensuring that there is an appropriate structural control environment in place, and that all risks are identified, assessed, and properly managed. The Board of Directors has approved the Integrated Governance Framework and the Risk Management Policy & Strategy (policy code RMHS16) which clearly demonstrates how risk management processes and structures across clinical, environmental, and business areas of the organisation will be co-ordinated.

20.1.2 The programme of risk management shall include:

20.1.2.1 a process for identifying and quantifying risks and potential liabilities;

20.1.2.2 engendering among all levels of staff a positive attitude towards the control

of risk;

20.1.2.3 management processes to ensure all significant (i.e. extreme or red-rated) risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

20.1.2.4 contingency plans to offset the impact of adverse events;

20.1.2.5 audit arrangements including; internal audit, clinical audit, health and safety review;

20.1.2.6 a clear indication of which risks shall be insured; and

20.1.2.7 arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by the ARM.

20.2 **Indemnity: Risk Pooling Schemes administered by NHS Resolution (NHSR)**

20.2.1 The Trust will arrange indemnity through the risk pooling schemes administered by NHS Resolution (formerly known as NHS Litigation Authority).

20.3 **Indemnity arrangements with commercial insurers**

20.3.1 The Trust may seek additional insurance to the NHSR schemes where this is deemed necessary based on an assessment of residual risk after the application of NHSR insurance. Such commercial insurance will be obtained in line with the Trust Procurement Policy.

20.3.2 In addition, the Trust may enterinto insurance arrangements with commercial insurers in the case of:

20.3.2.1 commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

20.3.2.2 where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

20.3.2.3 where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHSR. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Independent Regulator.

20.4 **Arrangements to be followed by the Board in agreeing indemnity**

cover.

20.4.1 The Director of Corporate Affairs & Company Secretary shall ensure that the arrangements for indemnity for losses and claims entered into with NHSR are appropriate for the purpose of the activities and assets of the Trust. The Director of Corporate Affairs & Company Secretary shall ensure that documented procedures cover these arrangements.

20.4.2 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Corporate Affairs & Company Secretary should ensure documented procedures also cover the management of claims and payments below the deductible, where such cases are managed through the Inquests & Claims team (legal services); other cases may be separately managed in accordance with the Losses & Special Payments procedures managed through the Finance team and under the responsibility of the CFO.

Appendix 1

	ALL	ALL	ALL	OPS	IMT	Estates	ALL	Estates	CPSU	ALL / PROCUREMENT		
	Authorising of Goods & Services	Authorising of Invoices	Signing Income & Expenditure Contracts	Drugs Orders	Capital Orders	Capital Orders	Excess Capital Business Case Expenditure	Revenue Orders	Drugs Orders	Quotations	Opening Panel	Single Action Tender Waiver
<£150	Designated Member of Staff £500	Designated Member of Staff £500	Director limit £500k	Designated Member of Staff <£25k	Capital Development Team limit £25k	Project Manager limit £25k	Variations Up to £100k to Capital Programme Sub Committee Variations between £100k & £500k to Finance & Investment Committee Variations above £500k to Board of Directors	Operational Manager limit £10k	Designated Member of Staff £500	1 Written Quote Limit £10k	2 Direct reports to Director Limit £500k	n/a
<£500												
<£1000	Budget Manager Limit £5k	Budget Manager Limit £5k							CPSU Procurement Manager limit £50k			
<£2,500												
<£5,000												
<£10,000	Direct Report to Director Limit £25k	Direct Report to Director Limit £25k										
<£15,000								Head of Service limit £50k		3 Written Quote Limit £50k		Head of Procurement <£150k
<£25,000												
<£50,000	Director Limit £500k	Director Limit <£200k		OPS Operations & Procurement Manager limit £50k	Chief Information Officer limit £150k	Assoc Head of Capital limit £75k						
<£150,000				General Manager limit £150k				Director limit £150k	Chief Pharmacist limit £150k	>£50k Follow Procurement Policy (contact procurement team)		
<£200,000		Exec Director Limit <£500k		CEO or CFO limit £200k	CEO or CFO > £200k	Head of Estates limit £300k		CEO or CFO limit £200k	CEO or CFO limit £200k			DoF or CFO limit <£500k
<£300,000				CEO & CFO above £200k				CEO & CFO above £200k	CEO & CFO above £200k			
£500,000						Director of Estates limit £500k						
£500,000 - £1,000,000	Exec Director <£1m	CFO or CEO >£500k	Managing Director up to £1m			CEO or CFO above £500k					2 Directors Above £500k	CEO or CFO + NED above £500k
> £1,000,000	CFO or CEO >£1m		CEO or CFO > £1m									
> £2,000,000												

Appendix 2

	R&D		Provider Collaborative		Charitable Funds	Sale of Equipment	Losses & Special Payments	Petty Cash Claim reimbursement
	Financial Approval for Research Contracts, Grants, Collaboration agreements, SLA's, NDAs, PIC's, VTC's	Research Contracts, Grants, Collaboration agreements, SLA's NDAs, PIC's signatories	Commissioning Budget Expenditure (where contract in place)	Signing of Commissioning Contracts				
<£150	R&D Senior Accountant Limit £5k	R&D Manager Limit £10k	Service Director limit £500k for contract invoices	Service Director contracts < £1m CFO Contracts > £1m	Charity Finance Manager Limit £5k	1 quote <£250 Service Director limit £1k	Service Director limit £500	Budget Manager limit £150
<£500								Executive Director limit £500
<£1000								
<£2,500						Service Director 3 written quotations limit £150k	CFO limit £10k	
<£5,000								
<£10,000	R&D Finance Business Partner Limit £25k	Head of R&D Limit £150k			Charity Finance Manager & Financial Controller signatories Above £5k		2 Executive Directors Limit £25k	
<£15,000								
<£25,000								
<£50,000	DoF Limit £150k						Board Of Directors Above £25k	
<£150,000								
<£200,000	CFO Limit £500k	R&D & NIHR Infrastructure Director Limit £500k				CEO or CFO 3 written quotations limit £500k		
<£300,000								
£500,000								
£500,000 - £1,000,000	CFO & CEO > £500k	CEO or CFO above £500k	DoF limit £1m for contract invoices			CEO & CFO 3 written quotations		
> £1,000,000			CFO sign off for invoices > £1m					

Appendix 3

Definitions

Board of Directors - the Board of Directors in formal meeting
CEO - Chief Executive Officer, The Trust's accounting officer, designated post and acting
CFO - the Trust's Chief Financial Officer, designated post and acting
COO - Chief Operating Officer for Mental Health Services & Learning Disabilities Care and the Chief Operating Officer for Primary and Community Care Services
Executive Director - Executive Director of the Trust being a full member of the Trust's Board of Directors to include all post holders (substantive and acting)
Service Directors – Oxfordshire & BSW, Buckinghamshire Mental Health Services, Community Services, Specialised Services
Corporate Directors – Director of Estates & Facilities, Deputy CFO, OPS General Manager, Chief Pharmacist
Drugs General Manager and Chief Pharmacist – senior manager with overall delegated responsibility for pharmacy within OPS and CPSU
Direct Report - those posts that report directly to Executive or Service/Corporate Directors, either managerially or professionally
Budget Manager - the designated person(s) with responsibility for that budget
Designated member of staff - the named individual approved by the budget manager
Authorised signatory - the named individual on the authorised signatory list

Notes
General note: that in all cases the higher authority covers the lower levels
Signing health care contracts is only permissible following validation of financials by CFO (or CFO's nominated officer)

Investment approval limits and business case approval limits are defined in the budgetary control policy (Section 8)

Meeting	Board of Directors Meeting in Public
Date of Meeting	29 January 2025
Agenda item	16
Report title	Committee Terms of Reference
Executive lead(s)	Georgia Denegri, Interim Associate Director of Corporate Affairs
Report author(s)	Georgia Denegri, Interim Associate Director of Corporate Affairs
Action this paper	☑ Decision/approval ☐ Information ☑ Assurance
Reason for submission to the Board	Approval of the terms of reference of Board committees is a power reserved by the Board
For disclosure or confidential	Disclosure

Executive summary

This paper sets out the revised terms of reference of the Audit and Risk committee, Finance and Investment committee, and People, Leadership and Culture committee, for the Board's approval.

All committee terms of reference have been transferred in a common template for consistency. Other key changes include clarification of committee purpose, duties and responsibilities, clarification of the role between committees to avoid as much as possible duplication of reporting, addition of clauses regarding behaviours and conduct (benchmarking and guidance, conflict of interests, Trust values, equality, diversity and well-being), and non-material revisions to governance clauses in accordance with the Standing Orders. The remit of the committees has not changed and remains in accordance with the Board's Scheme of Delegation.

Following discussion at its workshop in the autumn which had reflected upon the three different types of Audit committees described in the HFMA NHS Audit Committee Handbook, the committee concluded that it operates as an Audit and Risk committee taking more active oversight of the system of risk management and is therefore recommending that it is renamed to Audit and Risk committee.

The Board is reminded that the terms of reference of the Quality committee and the Mental Health and Law committee were approved by the Board in November. The terms of reference of the Nominations, Remuneration and Terms of Service committee and the Charity committee will be brought for approval to the next meeting of the Board in March.

The terms of refence of the three committees are included in the Reading Room.

Report history / meetings this item has been considered at and outcome
The terms of reference of each committee were considered and agreed at their recent meetings as follows: Audit and Risk committee at its meeting on 5 December 2024, Finance and Investment committee at its meeting on 14 January 2025, and People, Leadership and Culture committee at its meeting on 21 January 2025.

Recommendation(s)
The Board of Directors is asked to approve the terms of reference of the Audit and Risk committee, the Finance and Investment committee, and the People, Leadership and Culture committee.

Strategic objective this report supports	Select
Quality - Deliver the best possible care and health outcomes	☑
People (Workforce) - Be a great place to work	☑
Sustainability - Make the best use of our resources and protect the environment	☑
Research & Education - Be a leader in healthcare research and education	☑

Link to CQC domain – where applicable				
☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Links to / Implications		
Links to Board Assurance Framework (BAF) risk(s) / Trust Risk Register (TRR)	☐ **BAF**	☐ **TRR**
Equality, diversity and inclusion	~~Yes~~/No	
Legal and regulatory	Yes/~~No~~	

BOARD ASSURANCE FRAMEWORK FULL VERSION JANUARY 2025

BAF SUMMARY Contents of this summary table (p.1-4) are hyperlinked to full BAF (at p.5 onwards).

REF.	LEAD EXEC. DIRECTOR (ED) / MONITORING COMMITTEE	RISK	CURRENT RATING	TARGET	MOVEMENT	REVIEW Date
1. Quality - Deliver the best possible care and outcomes						
1.1	Chief Finance Officer / Finance & Investment Committee	**Utilising digital, data and technology to drive quality, efficiency, economy, research, and innovation** A failure to utilise and engage with digital, data and technology to drive quality, efficiency, economy, research, insights, analytics and innovation, resulting in poorer patient outcomes and experience, lack of insights to support decisions, lower return on investments, lack of insights driving quality improvements, lack of innovations.	12	6	↔	29/10/24 14/01/25
1.5	Interim Chief Operating Officer for Mental Health & Learning Disability / Quality Committee	**Unavailability of beds/demand and capacity (Mental Health inpatient and Learning Disability)** Lack of local admission beds due to demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge could lead to: **(i)** increase in Out of Area Placements (**OAPs**) further from home, **(ii)** inappropriate inpatient placements; **(iii)** patients being unable to access specialist care required to support recovery; **(iv)** patients and carers/families having a poor experience; and **(v)** services falling below reasonable public expectations.	16	8	↔	29/10/24 07/11/24
1.6	Chief Operating Officer for Community Health Services, Dentistry & Primary Care / Quality Committee	**Sustainability of the Trust's primary, community & dental care services** There is a risk that the inability to progress, with key partners, the re-design and re-commissioning of primary, community and dental care services across Oxfordshire threatens the medium- and long-term sustainability of these services. In this scenario, waiting lists/delays will continue to grow, quality and safety of care will be increasingly compromised, the financial position will deteriorate, the needs of the service users will be insufficiently met and there will be poorer health outcomes and experiences. The successful mitigation of this risk requires the Trust to work effectively with a wide range of ICB partners and stakeholders to deliver a number of priority strategic actions and enablers (set out below), which in turn will enable the successful transformation of key primary and community care pathways.	12	9	↔	29/10/24 07/11/24
2. People - Be a great place to work						
2.3	Chief People Officer	**Succession planning, organisational development and leadership development**	12	4	↔	07/01/25

	People Leadership and Culture Committee	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.				21/01/25
2.4	Chief People Officer People Leadership and Culture Committee	**Developing and maintaining a Culture in line with Trust values** A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes being compassionate and inclusive, recognition and reward, having a voice that counts, **health, safety & wellbeing of staff, working flexibly**, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	9	4	↔	07/01/25 21/01/25
2.5	Chief People Officer People Leadership and Culture Committee	**Retention of staff** A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	12	9	↔	07/01/25 21/01/25
2.6	Chief People Officer People Leadership and Culture Committee	**Adequacy of Staffing** Inability to plan for, attract and secure sufficient numbers of 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 adequate levels of permanent staffing cannot be secured, dependency upon planned bank staff or agency staffing can occur which is unsustainable in the medium to long term. This can result in negative financial and quality of care implications. Success in Recruitment will remain in jeopardy if Retention fails, as retaining our existing staff remains crucial to ensure we have stable, effective and welcoming environments into which to welcome new staff. Recruitment and Retention 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: Trust culture, personal & leadership development, training, appraisals, staff support and wellbeing, and rewards and benefits.	16	9	↔	10/01/25 21/01/25

3. Sustainability - Make the best use of our resources and protect the environment						
3.1	Executive Director of Strategy & Partnerships Quality Committee	**Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level.** Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.	12	8	↔	28/10/24 07/11/24
3.4	Chief Finance Officer Finance & Investment	**Delivery of the financial plan and maintaining financial sustainability** Failure to deliver financial plan and maintain financial sustainability over the short (1-2 years) or medium-term (3-4 years), including, but not limited to: through funding reductions; non-delivery of CIP savings; budget overspends; and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England; and insufficient cash to fund future capital programmes.	16	12	↔	20/12/24 14/01/25
3.6	Director of Corporate Affairs & Co Sec Audit Committee	**Governance and decision-making arrangements** Failure to maintain and/or adhere to effective governance and decision making arrangements, and/or insufficient understanding of the complexities of a decision may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.	8	4	↔	19/03/24 23/04/24
3.7	Executive Director of Strategy & Partnerships Finance & Investment	**Ineffective business planning arrangements** Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.	12	6	↔	13/12/24 14/01/25

3.10	Chief Finance Officer Finance & Investment	**Information Governance & Cyber Security** Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions), cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; reputational damage.	12	9	↔	29/10/24 14/01/25
3.12	Director of Corporate Affairs & Co Sec Emergency preparedness, resilience, and response (EPRR) committee (sub-group to Executive Management Committee) and Audit Committee	**Business Continuity and Emergency Planning** Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.	9	9	↔	13/12/24 23/04/24
3.13	Chief Finance Officer Finance & Investment	A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties (Health & Care Act 2022), and national targets, for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2032, for the emissions we can influence (our NHS Carbon Footprint), net zero by 2045) could lead to: a failure to meet Trust and System wide objectives, reputational damage, loss of contracts with commissioners, contributing to increased air pollution within the wider community, and loss of cost saving opportunities.	9	3	↔	07/11/24 14/01/25
3.14	Chief Finance Officer Finance & Investment	**Major Programmes** Insufficient capacity and capability to deliver major programmes effectively or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised projects; inability to proceed with projects; failure of projects to complete or to deliver against preferred outcomes; non-delivery of required savings, unplanned expenses, delays and wasted resources.	16	6	↔	05/11/24 14/01/25
4. Research & Education - Become a leader in healthcare research and education						
4.1	Chief Medical Officer Quality Committee	**Not maximising the Trust's Research and Development (R&D) potential.** Not fully maximising the potential to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.	6	3	↔	29/10/24 07/11/24

Risk rating matrix and scoring guidance appears at Appendix 1

Strategic Objective 1: Deliver the best possible care outcomes

1.1: Utilising digital, data and technology to drive quality, efficiency, economy, research and innovation

Date added to BAF	10 February 2022
Monitoring Committee	Finance & Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	29/10/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**4**	**3**	**12**
Target risk rating	3	2	6
Target to be achieved by	March 2026		

Risk Description:

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

Key Controls	Assurance	Gaps	Actions
	Level 1: reassurance		
Implementation of the Trust Digital Strategy Revised improved Governance across Digital, Data and Technology within the Trust and across the ICS. Programme and project management of Frontline Digitisation strategic programme. Embedding the development and use of TOBI (Trust Online Business Intelligence) data from ward to Board level. Engagement with Data Platforms for direct care, insights, including population health insights and analytics. Collaboration with Oxford University and other health research organisations and	Digital Strategy Implementation Plan review to ensure delivery by 2026. Right governance to facilitate clinical engagement in the digital programme of works. Exec oversight of Frontline Digitisation programme. Integrated Performance Report to Board to provide assurance around Trust performance and data Utilisation of data for insights and analytics to support direct care, service improvements and population health analytics. Digital Data and Technology Governance pulling together all	GAP: Due to the cyber-attack on the clinical systems supplier and subsequent 5-month outage in 2022, clinical data was captured outside of clinical systems in an unstructured format. As the new systems were implemented, they were only basic systems initially capturing basic clinical data. Therefore, there are 2 data gaps – the data from the outage and the data which is not captured until the new system optimisations take place. GAP: Lost opportunities to develop data insight, population health analytics, system interoperability, health innovations due to the focus being on recovery from the outage.	ACTION: Optimisation of core clinical systems to ensure data captured at point of care and can be used for insights into population health, service transformation, quality improvements. Data recovery programme overseen by Trust CEO. Business Continuity Working Group to ensure any future data gaps are relevant and agreed ACTION: Ensure the Trust engages to focus on realising the benefits of the data analytics platforms with links to the optimisation programme and Truecolours.

networks to support innovation, quality improvements and commercial development. Utilisation of Oxford Healthcare Improvement (OHI) Centre skills and resources to support data insights, analytics and service improvements. Optimisation Programmes of Trusts new EPRs to ensure the right data is captured at the point of care. Data Quality Programme to ensure good quality data is captured at the point of care. Co-production and user engagement in all developments, optimisations and implementations. Horizon scanning to ensure right choices are being made.	elements into the Digital, Data and Technology Strategy Board meetings, feeding into the Executive Committee and Board. Innovation Pipeline to facilitate oversight, prioritisation and resources for Trust digital innovations. Digital Clinical Safety Group supported by CCIO to provide assurance re clinical data. Digital Leadership Team now including CNIO to facilitate clinical engagement and oversight. Artificial Intelligence (AI) Strategic Group to facilitate innovative AI projects leveraging efficiencies. Digital, Data and Technology Skills and Workforce Group within the Trust, ICS and Regional to focus on upskilling the digital data and technology champions and wider digital skills. Data, Analytics and Research Group within the Trust and ICS to facilitate use of data platforms. **Level 2: internal** **Digital programme highlight reports for Digital Data and Technology Board.**	Outcome measure data lacking. GAP / OPPORTUNITY: Interdependency on other NHS organisations for data platforms such as Federated Data Platform, Shared Care Record, Secure Data Environment. GAP: Potential funding shortfalls to realise benefits of available digital capabilities. GAP: Digital skills and capabilities of the Trust workforce to realise the benefits of the digital tools available. GAP: Outcome data not collected in a structured way from the clinical services. GAP: Research opportunities lost due to data not being available for the research team. GAP: Digital innovations within the Trust need more oversight and support. GAP: Target architecture not set out, to identify any Technology and Infrastructure gaps. GAP: Transparency over support, service and availability and relationship management.	ACTION: Ensure resources are applied to engage with the programmes around external data platforms. ACTION: Working with NHSE to ensure all relevant funding opportunities are realised. ACTION: Digital, Data and Technology Group to facilitate and have oversight of improving the workforces' digital skills and capabilities alongside the ICS and regional groups. ACTION: Focus on facilitating the digital recording of patient outcome measures across the Trust. ACTION: Engage with patients and research team around "Count me in". ACTION: Engage with BRC Data Science Theme team ACTION: Support digital innovations from idea to implementation using agile methodology. ACTION: Enabler 2 work on corporate services transparency and responsiveness, to include digital and technology.

	Data Quality Group focussing on key data quality issues. Information Management Group Digital Update. Finance and Investment Committee oversight of Frontline Digitisation Programme. Integrated Performance Report to Board. Quality Committee Oversight. Internal Trust Digital Assurances – Cyber Security, Infrastructure Assessment, Clinical Safety, Information Governance. **Level 3: independent** NHSE Mandatory Clinical Data Reporting. CQC Inspections. Patient/carer feedback, incl. 'I Want Great Care' results. Use of NHSE Digital Maturity Framework "What Good Looks Like" to measure Trusts Digital Maturity improvement aligned to the Digital Programme of works. Internal audit reviews KPMG assurance of Frontline Digitisation programme governance. Knowledge sharing with Berkshire Healthcare digital teams as part of Mental Health Provider Collaborative and with ICS counterparts.	GAP: Lack of strategic approach to ensure the value of the Trust's data is being realised and to drive data insights.	

	NHSE digital assurance framework DTAC [for assessing products]. Performance against national NHS Oversight Framework indicators [for services].		

Strategic Objective 1: Deliver the best possible care outcomes

1.5: Unavailability of beds/demand and capacity (Mental Health inpatient and LD)

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Interim Chief Operating Officer for Mental Health & Learning Disability
Date of last review	29/10/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**4**	**4**	16
Target risk rating	4	2	8
Target to be achieved by	July 2025		

Risk Description:

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

Key Controls	Assurance	Gaps	Actions
1) Lead organisation for CAMHS single point of access for provider collaborative network beds. Roll out of Hospital at home to prevent admission and support earlier discharge.	**Level 1: reassurance** - Staffing reports performance reports via oversight with collaborative IPR as well Clinical oversight via Directorate monthly Senior Management Team (SMT) meetings and Exec, daily monitoring SITREP reviews. **Level 2: internal**	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).

2) Adult eating disorder collaborative. 3 Timely access to beds for patients with Learning Disabilities - 4) Adults and older Adults: Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors; - Proactive management of flow and OAPs; - Care Planning; - System partner calls to improve discharge; - Roll out of Crisis Resolution, Home Treatment, Early Intervention, Intensive Support and Hospital at Home teams to prevent admission and support earlier discharge; National review and roll of MH Operational Pressures Escalation Level (OPEL) framework	- 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. 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. 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,	Ongoing Development of hospital at home CAMHS. 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. Routine monitoring of OAPS by LD team which has dedicated case manager role who has oversight of all admissions 4. Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate SMT. Operational risks also monitored through the Trust Risk Register at 1068 (mental health waiting times) Directorate Harm Minimisation Groups well established and will report findings to Directorate SMTs to inform Transformation Programme Demand and Capacity projects, 1024 (reporting on waits) Work with operational services has been undertaken to identify and document clinical waiting time standards re emergency, urgent and routine referrals to develop waits reporting to 'red flag' patients waiting longer than

which has clear set of escalation to support access to local beds MH provider collaborative working across Buckinghamshire, Oxfordshire and West Berkshire to support and transform services, 3 key work programs: 1: Mental Health Crisis & Urgent Care – Community 2.3 Year Adult Inpatient Transformation 3. Localising Mental Health Services		shortage of staff and the aftermath of COVID-19. Some mental health community teams are also managing high numbers of patients unallocated to a care coordinator due to demand being higher than capacity. This impacts inpatient areas and creates the need to use Out of Area Placements (OAPs).	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 Vacancies continue to be high. Details reported in the Quality and Safety Dashboard provided to the Quality Committee (and to the Board), as well as in highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. Mitigations via Retention and Recruitment workstreams and the Improving Quality Reducing Agency programme (monitored through the People, Leadership & Culture Committee). Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate SMT. Operational risks also monitored through the Trust Risk Register at 1068 (mental health waiting times) Directorate Harm Minimisation Groups well established and will report findings to Directorate SMTs to inform Transformation Programme Demand and Capacity projects, 1024 (reporting on waits) work with operational services has been

			undertaken to identify and document clinical waiting time standards re emergency, urgent and routine referrals to develop waits reporting to 'red flag' patients waiting longer than agreed standard. 1001 (OAPs). Monitoring also through highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control. Review of OEPL framework undertaken, once finalised nationally to be implemented across services Directorate SLTS engaged with Provider collaborative programme. Work commenced on all programmes, monitored by PC board

Strategic Objective 1: Deliver the best possible care outcomes

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Chief Operating Officer for Community Health Services, Dentistry & Primary Care
Date of last review	29/10/24
Risk movement	↔
Date of next review	February 2025

	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	July 2025		

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

In this scenario, waiting lists/delays will continue to grow, quality and safety of care will be increasingly compromised, the financial position will deteriorate, the needs of the service users will be insufficiently met and there will be poorer health outcomes and experiences.
The successful mitigation of this risk requires the Trust to work effectively with a wide range of ICB partners and stakeholders to deliver a number of priority strategic actions and enablers (set out below), which in turn will enable the successful transformation of key primary and community care pathways.

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

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	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).	contract and finance re-negotiation – many service contracts contain irrelevant KPIs, commissioning gaps or duplications, and some have seen no income uplift for over 10 years, despite significant expansions in provision due to legislative and population changes. Other core services, such as the Urgent Community Response, have continued to operate as extended national pilots since the pandemic, without a secured service contract, which limits long-term planning. • Lack of suitable premises to collocate the staff and deliver sustainable service models. There have been unexpected delays to the FY24 Estates work programme delaying on our ability to increase the capacity and sustainability of services in the UEC	Care team to facilitate more effective and timely hospital discharges and best use of community bed resources. The performance data for this Hub, and the other services in the acute admission and discharge pathway, is reviewed regularly at Oxfordshire UEC Board. A second programme of work has started. This is focusing on improving the sustainability of the UEC pathway to be delivered during 2024. *Longer-term:* A community service transformation programme is underway with system partners at Oxfordshire Place to improve patient outcomes and service sustainability~~.~~, supported by external programme management team. This will align closely to the Frontline Digitisation Programme which will also improve sustainability. Resources have been identified by the Trust to establish a community services transformation team to deliver this work, and support its implementation in services, led by the Transformation Director role within the Directorate Leadership. An Oxford City estates plan and business case to develop a new North and South city hub was approved by Trust Board in autumn 2023. The Estates and Operational Directorate Teams are reviewing the sites and services affected by the delays to the works programme at The Fiennes and Witney CH to agree a mitigation plan. This will manage any short-term service delivery risks until the works can be completed next financial year. The financial impacts of the City Hubs project and timeline changes largely fall on the Trust's capital programme and have been considered within this programme and reviewed at CPSC and FIC. There will be a modest impact on

		pathway into FY25. This has impacted particularly on: The Oxford City Community Services Hub project – a rescheduling of the expected Jordan Hill development completion date to March 2024 has in turn delayed the service transformation timeline to bring together multiple children's and adult's service teams into a single North Hub The works to expand the Minor Injuries Unit at Witney Community Hospital have been delayed until FY26 due to insufficient capital funding in FY25 to complete the works. A review is underway to identify and manage immediate pressures on the MIU clinical space and patient waiting areas, to mitigate the increased patient attendances. NB. This issue impacts on the ability of the service to meet the national 4-hour ED performance target reported to Board. The works to develop a single expanded reception, waiting area and improved patient flow for the Urgent Care Centre and GP OOH clinics at The Fiennes Centre, Banbury, have been postponed until FY26 due to insufficient capital funding	revenue which will be managed through usual financial monitoring and planning processes. A more sustainable delivery model for the Oxfordshire 0-19 healthy child services, which have been reprocured by Oxfordshire County Council, went live on the 1st of April 2024; performance data should be available in the next few months. At Place level, regular meetings are held with the ICB Oxfordshire Place Director to progress work on local stakeholder engagement for transformation work (focusing on Wantage CH services initially) and at a county level with system Exec leads at the Oxfordshire Integrated Leadership Board. This issue impacts on the ability of the service to meet the national 4-hour ED performance target. Performance against the 4-hour ED targets and the implementation of agreed mitigations plans will be reported to Board This will be monitored and managed through the usual financial and planning processes May 2022, the Trust and OUH signed a Memorandum of Understanding (**MoU**) to support closer working for Oxfordshire residents, with a focus on community urgent and planned care. This has facilitated the delivery of a joint OH-OUH Hospital at Home service, launched in winter 2023 The 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

		in FY25 (the Trust's UEC capital funding bid to NHSE for this site was declined). This will in turn delay proposals to operationally integrate these services to reduce duplicated existing costs and improve patient experience and service sustainability.	written to the partnership expressing their intention to extend the contract until 2026.

Strategic Objective 2: Be a great place to work

2.3: Succession planning, organisational development and leadership development

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer
Date of last review	07/01/25
Risk movement	↔
Date of next review	July 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**3**	**4**	**12**
Target risk rating	2	2	4
Target to be achieved by	July 2025		

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

Key Controls	Assurance	Gaps	Actions
- Service model review and modifications of pathways across Operations (cross-reference to 1.2 and the risk against failure to deliver integrated care); -Investment in the Affina Team journey – an all-in-one assessment and development tool for team leaders - multi-disciplinary leadership trios within	**Level 1: reassurance** -6 weekly Compliance reporting board within L&D monitoring all training compliance. - Monthly report to Executive Leadership Team on key workforce metrics – currently focuses on Stat and Man training but opportunity to include other metrics - Education Strategy Group (ESG) **Level 2: internal**	a. Staff do not have access to the correct Statutory and mandatory training due to ESR errors. b. The priority for 2024 is to ensure mandatory training figures achieved to date remain consistently strong. Aggregated compliance reporting of statutory	a. Focus work on remaining statutory and mandatory training complete and progress to be monitored until end of FY. L&D have implemented new statutory and mandatory training auditing process with the first report submitted to ESG in Jan '25. b. Trust to write Statutory and mandatory training policy once National alignment is complete to ensure maintenance of recorded success in approach to delivery of training. **Alignment**

clinical directorates to support and develop clinical leadership; - the Organisational and Leadership Development Strategy Framework (approved by the Board, October 2014) – aims to maximise effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery. - Clearly defined development pathways for all professional groups including clinical and non-clinical staff. - Delivery of a Masters' framework offering relevant development opportunities for all staff including both registered and unregistered professionals. - Inspire Network (replaced Linking Leaders conferences) event focused on Organisational Development on 10 March 2022 and considered Staff Survey results; and - Implementation of a Trust wide approach to Leadership development under the NHS Leadership Academy 'Our Leadership way' framework	- People, Leadership & Culture Committee; - Analysis and use of annual staff survey to measure progress and perception of leadership development; - Yearly staff appraisals; PDR compliance rate was 97.06% in September 2024. - Monitoring of Clinical supervision rate was 76.76% in September 2024 compared 80.39% in July 2024. - Monitoring of Mandatory training compliance rate was 90.49% in September 2024. -Monitoring of Resus and PEACE training compliance at Quality and clinical governance sub-committee **Level 3: independent** -Internal audit completed by PWC in May 2023 identifying 5 key areas for improvement. With agreed action plan to deliver improvement. Trust have completed all actions and created internal quality assurance processes to ensure changes upheld. -National NHSE Statutory and Mandatory training alignment to the Core skills training framework underway enabling centralised oversight. -National Retention Self-assessment tool against the seven elements of the NHS people Promise.	and mandatory training mask success and risk areas. c. The Trust have responded to the need to ensure all staff have access to a PDR by implementing a new 'PDR Season' delivery style. There is a need to measure its continued success as well as measure the effectiveness of the PDR process in providing staff with the appropriate development opportunities. d. Unclear response to staff development for areas of high risk in relation to staffing levels. e. Unclear progression routes for non-clinical progression pathways f. There is a need for a clear segmented retention plan created in response to People Promise self-assessment – this has now been completed g. There is a need for clear representation of	due to be completed by end of FY 2024/25 but subject to change dependent on progress. c. The second PDR season had a 97% compliance rate in September 2024. OD teams to analyse staff survey response results relating to 'we are always learning' elements. L&D team to analyse the uptake of CPD and developmental opportunities following PDR to measure effectiveness of appraisal process. d. Podiatry service highlighted as an area of high risk in relation to current short-term staffing levels and longer-term succession planning. L&D have been awarded £70K from BOB ICB for a 12month project post to complete work on local podiatry apprenticeship delivery model. e. L&D have introduced Data & Digital Academy in partnership with Multiverse training provider; data and AI programmes, focused on the foundational skills to make better decisions with data to start in March '25. f. Trust has successfully appointed People Promise manager and complete the national retention self-assessment tool which identified 'We work flexibly' as area most important to staff to focus retention plan.

		Leadership development training for all staff including opportunities to develop skills and access Coaching and mentoring. Initial analysis of current offer identified gaps in New/Aspiring Leader programme. h. Equality and Diversity. The WRES and WDES are monitored against national benchmarks and areas variation are reviewed and action plans developed.	g. L&D Leadership team introduced L7 Anderson apprenticeship programme in response to widening overall leadership offer. First cohort to start in April '25. Scoping of content for 'New/Aspiring leader' programme underway. h. work of the Equality & Diversity Lead. NHS Workforce Race Equality Standard reporting. Focus at Board level. Ongoing work with HR to develop routine statistical analysis to identify key areas for actions and follow-up. Development of Quality Improvement Race Equality programme. The EDI team have adopted the QI approach to deliver organisational change and have 3 QI Race Equality programmes and 3 QI Disability programmes ongoing, these are evidenced based programmes based on the needs identified in the WRES and WDES. The QI programmes for Race have all delivered outcomes and considerations are now being given to what future QI race programmes will look like in light of the March 2024 WDES and WRES data. The outputs of the 3 QI Race Equality programmes and the outputs of the WRES and WDES 20204 have been included in the EDI work programme which also includes the delivery of the 6 High Impact Actions to deliver the NHS EDI Improvement Plan OWNER: Head of OD

		i, No formal succession planning/talent process in the Trust for clinical and non-clinical staff j, Leadership	i, Phase one of a QI project was completed in Feb 2024 and was sent back to 'Design' following review of People Steering Group The Trust is adopting the national 'Scope for Growth' model with target completion December 2024. NHSE support for Scope for Growth has fallen away and so the People Dept are scoping another approach, a workshop was held in November 2024, and it will become an area of focus for the Retention Team in 2025/6. OWNER: Head of OD Phase one of a QI project was completed in Feb 2024 and was sent back to 'Design' following review of People Steering Group j, The Trust is adopting the national 'Scope for Growth' model with target completion December 2024. National support for this model has been removed and instead NHSE are encouraging Trusts to design a model that works for them. The HR SLT had an in depth round table on Talent on the 24 Sept ember 2024 and Head of OD doing some scoping with regional and national teams on the core requirements which will impact on the model that will be developed. Talent and succession planning will form a key area of focus for the Retention Team in 2025/6

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	07/01/25
Risk movement	↔
Date of next review	July 2025

	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	August 2025		

Risk Description:
A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes being compassionate and inclusive, recognition and reward, having a voice that counts, **health, safety & wellbeing of staff, working flexibly,** supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture.
The absence of this could result in: harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

Key Controls	Assurance	Gaps	Actions
- HR Policies & strategies, include Workplace Stress Prevention & Response, Equal Opportunities, Dignity at Work, Flexible Working, Grievance and Sickness policies; - Freedom to Speak Up Guardian; - Health & Wellbeing Strategy, groups, services and Intranet site & resources;	**Level 1: reassurance** - Learning Advisory Group (LAG) Group (now called Education Strategy Group (ESG)); - Equality & Diversity Steering Group; (all reporting to People Steering Group – which has oversight from the People Leadership and Culture Committee); - H&S group SEQOSH accredited -Analysis of completed H&W Framework.	Need to improve staff experience and respond to issues identified in the **Enabler 3 Programme – Supporting our People and Teams.** The broad issues identified include: - Disconnect between leadership and those on the "shop floor". - Lack of autonomy. - Poor communication. The quarterly People Pulse consistently	**Enabler 3 Programme – Supporting our People and Teams** Two reference groups have taken place. The project is in the design phase. Plan is to consult on the project design at the November 2024 reference group with view to move to delivery stage early 2025. Expected to be a 2–3-year programme of work.

- Employee Assistance Programme; - Occupational Health Service; - Signed Sexual Safety Charter and EIDA Charter - Equality, Diversity and Inclusion team, plans, training and groups, Staff Equality Networks; - Delivery of the NHS equality, diversity and inclusion (EDI) improvement plan by delivering all 6 of the High Impact Actions (HIA) - 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.	-Completed analysis of Sexual Safety 10 principles. **Level 2: internal** - People, Leadership & Culture Committee (quarterly); - Quarterly People Pulse checks (measures of staff engagement) **Level 3: external** - National Staff Survey results; - External endorsement of the Trust's wellbeing work via take-up of Trust's model through BOB ICS.	identifies gaps in communication as well. - Leadership / Managers not demonstrating values of 'caring, safe and excellent'. Need to improve staff experience and respond to issues identified by both the Staff Survey and quarterly People Pulse. The Staff Survey identifies a gap in **flexible working** with the Trust score for this People Promise element being below the national median. (This will be reviewed with 2024 Staff Survey when it becomes available) The score for **'we are safe and healthy'** is in line with the national median.	**Flexible working** The Trust is taking part in Cohort 2 of the national NHSE Retention Exemplar Programme. In addition, a dedicated People Promise Manager has been appointed for 12 months from June 2024 to review and develop a project to support flexible working (and remove the barriers to it) across the Trust. **Health & Wellbeing** Ongoing promotion of a Wellness culture taking a proactive and preventative approach. Five working groups are in place to embed Civility & Respect, including Restorative Just & learning Culture as part of cultural change. Kindness into action modules have been purchased – these will enable the Trust to develop "The OHFT Way" through training. Commenced process to make Kindness into Action Essential training with the aim to have it in place in September 2024. This was not supported by Education Strategy Group due to the burden of training on staff so

		Sexual Safety Charter 10 principles analysed, and gaps identified. EDI Recurring work to embed EDI following the Quality Improvement 'Plan Do Study Act' Cycle – priorities for the Race Disability and Gender to be identified through analysis of WRES and WDES and pay gap data.	will be promoted through other forums Policy work will include implementation of a new **Respect, Civility & Resolution Policy (Disciplinary Process). Publication in July 2024.** Collaborative working with EDI QI project 2 is exploring this Policy through a race lens. Annual Stress Survey took place in May 2024. Analysis of results has taken place and results are broadly positive. The results have been shared with the executive. REACT training is promoted to support uptake of wellbeing conversations. Violence & Aggression Working Group includes Sexual Safety/Domestic Abuse and Sexual Violence as a specific pathway. Mental Health First Aid training for managers. Enabling safe spaces and confidential support to all staff. EDI The Race Equality Work Programme's three Quality Improvement (QI) Projects concluded their first PDSA cycle in April 2024. Following the submission of the Workforce Race Equality Standard (WRES) 2024 in May 2024, engagement and consultation is underway with relevant stakeholders, such as the Race Equality Staff Network to co-produce and develop the Race Equality Action plan for

			2024/25 which will reflect the Trust WRES priorities and align with the BOB ICB Equality Objectives and the 6 High Impact Actions. The draft Race Equality Action Plan was to be presented for approval to the EDI Steering Group on 2nd July 2024 and was approved and is now being worked through. Considerations and thinking are also being given to how we could potentially learn from other Trusts such as Berkshire who have committed to being "anti-racist" organisations. The Deputy CEO from Berkshire attended the Executive in December 2024 to share their learning Project Approach to delivery of the High Impact Actions which are monitored by the EDI Steering Group. On the 5th of September meeting the latest results are: 18 High Impact Actions are due to be completed, and the current status is: • 14 are complete • 4 are pending • All HIAs have owners and estimated delivery dates

Strategic Objective 2: Be a great place to work

2.5: Retention of staff

Date added to BAF	May 2021
Monitoring Committee	People Leadership and Culture Committee

	Impact	Likelihood	Rating

Executive Lead	Chief People Officer
Date of last review	07/01/25
Risk movement	↔
Date of next review	December 2024

Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**3**	**12**
Target risk rating	3	3	9
Target to be achieved by	July 2025		

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
Establishment of a substantive Retention Team. Trust signing up to be part of the National Retention Exemplar Programme and hosting a 12-month post for a People Promise Manager - delivering career development pathway for HCAs; - Learning from Exit Questionnaires / Interviews; - Health & Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives; - Freedom to Speak Up Guardians to support identifying factors driving staff leaving and sharing these with Executives and Board - Training, supervision and Performance and Development Review (PDR) processes to provide a process for line manager	**Level 1: reassurance** - Quarterly review of leavers exit interview data by HR SMT. **Level 2: internal** - Reports to Executive Management Team (monthly); - Reports to People Leadership and Culture Committee (quarterly); - Performance data reports to Board: - Turnover was 12.34% September 2024 (target <14%); - Vacancy rate was 12.72 % in September 2024 (target < 9%); - Quarterly People Pulse checks (measures of staff engagement) **Level 3: independent** - National Staff Survey results (annual process) - National – BOB ICS recognition for R&R with Enhanced Occupational Health & Wellbeing Pilot Regionally - H&W key group member of R&R	Not currently reporting on areas flagging as hotspot areas to senior management or Exec. Work now planned to take a more segmented view in relation to retention. Not currently able to target leavers that are of interest due to leaver forms not recording ethnicity or length of service	– The early turnover rate remains just over the ~~14~~ 14.35% target. We will continue to monitor and highlight hot spot areas within reports to senior management and Executive teams. Early Turnover QI The Retention team have launched the discovery phase of a QI project with the aim of gathering intel from multiple sources to start to understand why staff are leaving in their first 12 months. There is a particular focus on BAME staff and staff in Admin and Clerical roles. BAME male clerical workers are of particular concern Local Induction Project The local induction project group membership has been agreed and the kick of meeting has been scheduled for 1st October. The aim of this project is to support managers with the first 6 months of a new starter joining to improve

and staff interaction on career aspirations; - Monthly multi-disciplinary meeting; review community and mental health hotspots	planning and new national resource.		staff experience and reduce early turnover Analysis of leavers' data has highlighted some pressure points that we will look to address. The Retention team is focusing activity in hot spot areas, community nursing, clerical workers and health care support workers. In future, hotspot areas brought to the MDT meeting will be reported on and shared with Senior management or the Executive team to highlight areas of high turnover. Onboarding QI project identified issues with Managers signing off training completed externally, Induction booking confirmations not being received by new starters, and no telephone line for recruitment. These are just some of the issues that have been identified and resolved as part of this project. There are a number of other improvements that are being worked on such as additional support for new starters who cannot access systems or need training. The Career Conversations QI project, 1:1 coaching has been dropped in favour of L&D sessions. These have been poorly attended so a decision was made not to run them anymore. L&D is working on a Comms strategy to make information about

			learning opportunities more accessible. A review of the staff survey around the quality of PDRs will take place to see if this is still an issue. The Talent Management project has been paused whilst a decision is made by the executive team about how they would like to proceed. This will be a focus for the retention team in 2025/6 The compliance at the end of the PDR season was 97%. The focus has now moved to 'how meaningful' staff find the PDR. A survey was sent out in August receiving 129 responses were received. A series of focus groups have been setup throughout October to gain further feedback from staff and managers. The feedback will be collated, and areas of improvement identified for implementation in time for the 2025 PDR season. QI project – Leaver Process A QI project has been launched to review the current leaver process with a view to making improvements to help the retention team better understand the reasons why staff are leaving and allow for BAME staff and staff leaving early to be identified from the leaver form so that supportive stay conversations can be had. Staff Survey 2024

			32 site visits were undertaken. Teams were prioritised due to low response rates in the 2022 Staff Survey and a further 2 teams where a visit was linked to their 'one action'. In addition to the site visits, colleagues from EDI, Wellbeing, Retention and Core OD Team organised and held 4 Roadshows with one of the objectives to promote the staff survey engagement.

Strategic Objective 2: Be a great place to work

2.6: Adequacy of Staffing

Date added to BAF	17/01/24
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer (& potentially Chief Nurse)
Date of last review	10/01/2025
Risk movement	↔
Date of next review	July 2025

	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	December 2026		

Risk Description:

Inability to plan for, attract and secure enough 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 adequate levels of permanent staffing cannot be secured, dependency upon planned bank staff or agency staffing can occur which is unsustainable in the medium to long term. This can result in negative financial and quality of care implications. Success in Recruitment will remain in jeopardy if Retention fails, as retaining our existing staff remains crucial to ensure we have stable, effective and welcoming environments into which to welcome new staff. Recruitment and Retention 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: Trust culture, personal & leadership development, training, appraisals, staff support and wellbeing, and rewards and benefits.

Controls	Assurance	Gaps	Actions
Implementation of the OHFT People	**Level 1: reassurance** Consistent quarterly updates to staff via	**Train Theme Gaps**	L&D deep dives (DD) into poorest compliance training areas - findings to be reported Board & its sub-

Plan priorities and actions to mitigate the impact of this risk. The People Plan links to the NHS wide Workforce plan with three themes of a. **TRAIN;** b. **RETAIN;** c. **REFORM**. Assurance routes are consistent across each element, to support consolidation and effectiveness. **Train Theme**: The NHS LTWP includes of apprenticeships, the Trust being an anchor institution to drive recruitment and supply, alongside leveraging the impact of volunteers Using the NHS Workforce Plan to focus on increasing the supply of domestic education / training and reduce reliance on international staff. **Retain Theme:** The NHS LTWP incorporates the seven elements of the NHS People Promise improving	organisational whole communications, supporting to managers to deliver key messages, alongside easily accessible intranet resources. **Level 2: internal** Bi-annual updates on Trust People plan Progress to PLC and, including Learning Advisory Group, EDI Steering Group, HR Policy Group etc. **Level 3: independent** Report inspection findings by external commentators to Board (e.g. CQC, Ofsted, external auditors) to provide assurance and validation of reported outcomes.	There is not enough delivery capacity for training places; via both internal and external provision Staff do not all have access to the correct Statutory and mandatory training due to ESR data quality issues. Vacancy rates impede clinical teams releasing staff to education / training events. This short-term difficulty exacerbates the issue in the medium and longer term. Centrally held data on learning needs and career development requires a review to ensure it remains fit for purpose. **Retain Theme Gaps** Lack of assurance that OHFT leavers in critical roles felt adequately supported during their	committees. Directorate leads to identify training concerns and use the DD data to form response action plan. DD areas are currently CPR, Fire awareness and Conflict Resolution. L&D team continually analyse the uptake of CPD and developmental opportunities post PDR, measuring appraisal process effectiveness. Ongoing development of further non-clinical career pathways Establishment of other clinical apprenticeship offers including pathways in dental, pharmacy and social work, and Podiatry assistant apprenticeship to help address vacancies within these particular services which have significant shortages. Encourage Nursing Associate apprenticeship uptake to support consistent pipeline to Nurse degree as well as respond to NHSE workforce plan to increase staff numbers. Use NHSE incentive payments to enable 12-month fixed term AHP apprenticeships. The PDR season had a 97% compliance rate (Sept 24). OD teams will analyse staff survey results relating to the '*We are always learning'* elements. Complete Training Needs Analysis based on PDRs, individual feedback, discussions with leaders and managers data. Hold Workshops to promote L&D activities annually prior to PDR season. Refresh Study Leave Policy Review effectiveness / impact of educational experience programme.

retention and reducing the leaver rate regarding staff leaving the NHS (opposed to moving within the NHS sector). Delivery of the NHS People Promise		employment, and therefore that leavers could be avoidable. 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.	Improve engagement with school/colleges Develop Trust work experience policy, focusing on offer to those wishing to join the Trust as being an anchor institution. Development Education career pathways L3 to L7 qualifications responding to the new-Educator workforce strategy. Development of IT Functional skills offer. Review pathways for professions it is hard to recruit to. Establishment of Peer support worker apprenticeship offer including agreement for PSW role within establishment teams and budgets in line with NHS workforce plan. Dedicated support for staff in first 6-12 months of employment reducing early turnover. Development of a *Just & Restorative* culture helping staff feel supported and enabled – including revised employee relations process (e.g. disciplinary, grievance) Launch 'Braver than before' Leadership programme Launch of 'Our Leadership way' Leadership behavioural framework and development of Leadership training offer. Use of the externally funded NHS People Promise exemplar programme cohort 2 to embed the People Promise, utilising the best practice support and examples A segmented Retention plan was created for 2024 focused on profession; location; and protected characteristics. Expansion of Psychological professionals including EMHPs.

Reform Theme: working and training differently.		**Reform Theme Gaps** Ongoing work to explore full extent of technology benefits e.g. AI capability to support routine transactional tasks within the HR team	Enhanced health and wellbeing promoting new resource in Occupational health to support psychological wellbeing. Targeted support to deliver annual staff survey actions focusing on year-on-year improvement. Refreshed annual awards approach from 23/24 will be continued for 24/25 Ensuring best possible start improving local induction and new starter experience to. Embed Flex working into 'Delivering the People Promise' Training for managers. Review TRiM business case prior to Trust wide roll out. Investing in marketing and branding being an employer of choice. Refresh design of job descriptions reducing duplication / delays in recruitment. Work with clinical leaders to identify and define options to initiate different workforce models (e.g., ACPs, PAs etc). Create a proactive, Talent Acquisition and Compliance team. Deliver the 6 High Impact Actions in the NHSE EDI improvement plan as part of wider programme of EDI work. Invest and grow membership of equality networks to support employee voice. Maximise Executive Director sponsorship offers and identify training for Execs in relation to Sponsorship roles. Continue to invest in Employee Assistance Programmes. Enabling Workstream will focus on "Supporting Our People and Teams" and interventions that shape a

			positive culture and behaviours based on civility, respect and fairness. Improved access to HR services via an HR Service Desk, rebuild of HR & L&D Intranet, employ new Document Management system and transfer of data Increase workforce efficiency through implementation of E-Rostering systems for inpatient, and medics Closer links to TOBI and SQL improving visibility of workforce data via a dashboard, supporting managers and leaders making informed decisions Continued system optimisation and efficiency via, expenses system review, implementing new Occupational Health system, transition of absence management from Goodshape to E-Rostering system, and roll out of ESR developments, e.g. manager self service Continue the work on reforming our HR policies and guidance (including development of employee handbook) in line with national policy templates and frameworks, and our restorative, just and learning culture principles. Continue to work with ICB on Scaling People Services to understand if automation and process redesign at system level can generate efficiencies across provider boundaries.
		Resource to undertake Trust wide Workforce Planning - work has been done on a medium-term plan for inpatient nursing but a wider view is required to understand our workforce needs.	Develop Trust wide approach to workforce planning that considers supply and demand and current workforce model. Managed Service Providers – Continue to work closely with our MSP. Deliver NHSP Improvement plan as set out in the Internal Audit of NHSP bookings processes.

			Review OHFT Temp Staffing arrangements making recommendations to CNO and CPO. L&D review of pastoral care and support given to international new joiners **Further detail to be added once objectives for 24/25 are confirmed.**

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

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

Date added to BAF	Pre-Jan 2021 Refocused and revised in July 2022
Monitoring Committee	Quality Committee
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	28/10/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**3**	**12**
Target risk rating	4	2	8
Target to be achieved by	Q1 2024/25		

Risk Description:
Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.

Key Controls	Assurance	Gaps	Actions
Governance and joint-decision-making: - Active participation in shaping emerging BOB and place-levels governance; - Development of Provider Collaborative arrangement in	**Level 1: reassurance** - Reporting through Directorate SLTs and BOB MH Provider Collaborative Executive Oversight Meeting Executive steering group in place for Community Dental Partnership	**Performance and planning:** Absence of system-wide data sets and aligned reporting.	**Performance and planning:** Work progressing to agree performance reporting at System, Place and Trust levels, aligned with Internal Planning process. Owner: Executive Director of Strategy and Partnerships

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. Partnership Group in place for community Dental Services including membership from BHFT, CNWL. **Resourcing:** - Role of Associate Director to lead work on the BOB Mental Health Provider Collaborative on behalf of the Trust has been appointed to and role commenced; - Service development lead for each Mental Health directorate now in post. Director of Transformation for Community Services	**Level 2: internal** - Reporting through: Executive Management Committee; Strategic Delivery Group and Trust Board. **Level 3: independent** - ICS-level and Place-level emerging governance for Mental Health, Learning Disability and Autism (MH, LD&A) and Community - Partnership and Alliance arrangements with other organisations, including the voluntary sector; - Provider Collaborative Governance - Oxfordshire's Place Based Partnership board (CEO attendance) - Oxfordshire's Urgent and Emergency Care (UEC) Board for the cross-system Oxfordshire Improvement Programme - Southeast Planning Group for Community Dental Services in place to oversee overall commissioning process	**ICS and Place-level governance** BOB Mental Health Partnership Governance has been reviewed and updated to reflect agreed transformation priorities this will need to be fully embedded and operationalised to enable collaborative working and joint decision making. No additional resourcing agreed at system-level to support this work. Lack of oversight and governance for Community services at ICS and Place-level. Unclear decision-making impeding collaborative working with partners. Learning Disability governance being developed by ICS. **Investment** Financial pressure on ICSs, County Councils and Social Care impacting adversely on required MH & LD investment. Arrangements outside of urgent care funding that is managed at Place level lack a clear forward planning engagement mechanism. No growth	**ICS and Place-level governance** Working with Place-based and local partners to ensure place and system governance. Resourcing requests for BOB Mental Health Provider Collaborative sent to ICB. Oxon MH LD&A place-based board is currently being reviewed alongside the Outcomes Based Contract. Strategic partnership approach for Community Services still to be developed as part of new Community Services Transformation Programme. Collaborative arrangements for community services in Oxfordshire the most developed through urgent care pathways through the systemwide Oxfordshire Improvement Programme. Special Education Needs and Disabilities (SEND) emerging partnership working but still embryonic. Other areas of focus with the ICS to be developed including. OWNER: Executive Managing Directors, Executive Director of Strategy & Partnerships and Chief Executive **Investment** Continued engagement in funding dialogue with ICSs for system clinical and financial planning. For Mental Health, enable this via Provider Collaborative arrangements. Finance (OH Director of Finance) is represented at the BOB Mental Health Partnership Board. Continued development of Provider Collaborative transformation programmes with ongoing discussions with ICB regarding resourcing.

leads on OHFT Community input into Oxfordshire's Improvement Programme (urgent care) and partnership working with Oxford University Hospital's Trust (OUH) joint working arrangements. - new Executive Director role of Executive Director of Strategy & Partnerships from April 2022. - Head of Strategy in post from Oct 2023 to support coherent response and process in place national planning from ICB to Trust to Place level. - Senior Programme Manager in place to manage Thames Valley Dental Partnership		funding awarded to community services in 24/25. **Approach to system working.** No systematic approach to support partnership working in Place.	CEO representation and engagement at the ICB led System Recovery Transformation Board. To raise and influence through Place Based Partnership Board OWNER: Chief Finance Officer, Executive Director of Strategy & Partnerships and Executive Managing Directors **Approach to system working.** Embedded resources now in place within operational Directorates, and role of Associate Director of Mental Health leading on the BOB Mental Health Provider Collaborative has been recruited to and commenced. Ways of working and internal governance for this work are being established. NHSE supported and funded workshops being held with VCSE partners to develop an action plan to strengthen partnership working between BOB Mental Health Provider Collaborative and VCSE sector. OWNER: Executive Managing Directors, Executive Director of Strategy & Partnerships Strategy development work ongoing and will help clarify the ambition for partnership working in the organisation. Assessment and mapping of our key Principle 'We work in partnership and are an active player in our ICS' underway for all Strategic Programmes. This will show (and give assurance on) to what extent our programmes align to this principle and what the gaps to address are. OWNER: Executive Director of Strategy & Partnership.

			Engagement with the BOB ICS led system review of 24/25 planning round. This will inform the 2025/26 planning being clear on the principles, processes, and ways of working the system will sign up to. OWNER: Executive Director of Strategy & Partnership & Chief Finance Officer

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

3.4: Delivery of the financial plan and maintaining financial sustainability

Date added to BAF	11/01/21
Monitoring Committee	Finance and Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	20/12/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**4**	**16**
Target risk rating	4	3	12
Target to be achieved by	2027		

Risk Description:

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

Controls	Assurance	Gaps	Actions
- Financial culture, meaning the skills and ownership, systems and incentives to manage budgets over the medium term across the Trust; - Annual Financial Plan and Budget produced, and approved by FIC and the Board; - Medium-Term Financial Plan produced annually and reviewed by FIC and the Board. - Monthly cash-flow and Balance Sheet reports; - Established Finance and Business Services teams and recently deepened Procurement team capability;	**Level 1: reassurance** - Monthly finance review meetings within Finance team and with directorates; - Monthly analysis of forecast, run rates, risks and opportunities; - Reconciliations of ledger accounts; - Monthly Capital Programme Sub-Committee review. **Level 2: internal** - Monthly Exec scrutiny of overall financial position with Quarterly Deep Dives; - Quarterly Exec scrutiny as part of Service Directorate performance reviews.	a) Funding pressures – BOB system faces significant shortfalls and financial capability challenges and Oxfordshire community services contract is known to be under-funded. Although there appears to be commitment to the Mental Health Investment Standard, there is uncertainty on the level of new funding for mental health going forward. b) Agency spend – the Trust's workforce challenges have led to excess agency usage and spend which puts pressure on ability to	a) Financial challenges escalated to the ICS and NHSE. Offer support to ICB financial capability building and improved cross system-working. Handed back loss-making contracts (CHC and s117). FY25 plans currently remain a deficit. Owner: Chief Finance Officer b) Deliver plans to reduce agency spend further in FY25. Improve workforce planning capability.

- Standing Financial Instructions and Financial Policies; - regular reporting on Financial position and impact of wider financial system risks to FIC and Board; - temporary-staffing programme; - active management of Capital Programme.	- Finance and Investment Committee (every 2 months); - Monthly Finance reporting to the Board to provide assurance on progress and recovery actions. -Monthly Directorate agency review panels **Level 3: independent** - Internal Audit reviews including annual review of financial controls; - External Audit review pf financial statements; - Monthly reporting to, and monitoring by, NHSE and the Integrated Care Board (ICB).	remain within budget. Workforce planning is not universally well-supported across the Trust. c) Cost Improvement Plans process does not yet capture all efficiencies or look ahead to future years. More use of costing data, benchmarking and challenge of underlying cost base is required. Better linkage of costs to activity, and in due course to outcomes, is needed as is improved analysis of gross over and underspends and intentionality of resource allocation decisions.	Owner: Chief People Officer c) Use Community Transformation programme, Mental Health Improvement programme and the Corporate Services and Central Teams enabler work to determine medium-term CIP programmes informed by regularly reported costing analysis. Embed and develop CIP reporting process begun in FY24. Better link workforce, activity and resources in Annual Plan FY26 and factor in time for early analysis of resource analysis. Assess value for money implications of outcome measures as they become available. Owner: Chief Finance Officer Due to system moving into investigation & Intervention (NHSE's I&I process) the Trust is engaged in various external reviews undertaken by PWC on behalf of the ICB. This involves reviewing potential improvement suggestions and reviewing the Trusts grip and control which may also strengthen the Trusts finances.

			Owner – Chief Finance Officer

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

3.6: Governance and decision-making arrangements

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

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

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

Controls	Assurance	Gaps	Actions
In accordance with the NHS Code of Governance, the delivery of good governance is controlled through an effective Board of directors, with an appropriate balance of skills and experience to enable them to discharge their respective duties and responsibilities effectively. The purpose of the organisation and the vision set by the Board are the starting point for the system of governance which is set out in the Integrated Governance Framework (IGF).	**Level 1: reassurance** The Nominations, Remuneration and Terms of Service Committee (NEDs) and Nominations and Remuneration Committee (Governors) review the composition, balance, skills and experience annually as per minutes of meetings and Board refresh. Jan 2024 reshuffle of Committee Chairs / members to protect independence of judgement. Board self-assesses (and CoG) against various statements and	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-	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.

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 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)	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 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	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 national reporting and local intelligence	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 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

- 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; - 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.	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; - 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.	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 Appetite considered with Board and Audit Committee (last in March 21). Latest version shared with ExELT Feb 2024 and Feb 2024 Board workshop. OWNER: Director of Corporate Affairs & Co Sec/Board of Directors TARGET DATE: approval to Board in Q1/Q2 FY25. COG working groups reinstated and now reestablished. *Gap & Action Closed*. Invitations to observe Board Committees will continue with ongoing

- 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		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.	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 strategic planning arrangements

Date added to BAF	Risk description revised July and September 2022
Monitoring Committee	Finance and Investment Committee
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	13/12/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**3**	**12**
Target risk rating	3	2	6
Target to be achieved by	July 2025		

Risk Description:
Ineffective strategic 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 Annual plan for the organisation and 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	**Level 1: reassurance** 1 year cycle of strategy development completed with Trust Board resulting in first iteration	a) Strategic Plan to be fully embedded in clinical	a) Board and Executive team identifying Strategic Priorities for 2025/26 and 2026/27. These will also feed into

Health and Care Strategy 2021-26; First iteration of Strategy Delivery Plan finalised for use by Trust Leadership Team to guide delivery of current strategy and as basis for engagement process with staff, patients, carers and partners to develop next Trust's strategy. Strategy team structure established and currently recruiting to key vacancies, notably the Head of Planning role. **The team is implementing and embedding the strategic delivery approach for the Trust.** Annual Plan 24/25 published on intranet et website and including both Strategic Delivery Plan and Clinical Directorates Plan. Mid-Year update against 2024/25 Plan presented at Board.	of Strategy Delivery Plan **now finalised. Trust Strategy Governance to oversee the progress of the Strategy Delivery Plan.** **Level 2: internal** Integrated Performance Report to the Board in public revised with focus on delivery against the strategic objectives via the strategic dashboard and performance against 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. Executive level and Board level workshops in train to identify Strategic Priorities for 2025/26 and 2026/27. **Level 3: independent**	directorates plans as part of business planning b) Annual Planning does not include a robust and systematic trajectory-setting process for all directorates ~~and~~	development of new Strategy to be implemented in 2026. Strategy team supporting development of these strategic priorities to refresh the currently identified 17 Strategic Programmes. Priority for 2026/2027 Planning round will be to fully embed the work on Strategic Priorities as part of the Planning Process. Strategy Delivery Group to be redeveloped to better support this approach. Change Management Group continues to develop a central model to change identification and management. Project and Programme best practice frameworks reviewed for Trust wide approach. **OWNER: Exec Director of Strategy & Partnerships and relevant Executive Leads for each delivery area.** b) Now that a Performance function has been developed and resourced in the Trust, ambition to make the plan more quantitative needs to be revised for 2026/27 Planning to identify where trajectory and target setting as part of the annual planning would be beneficial. Overall process is in place to track delivery of Annual Plan and report to Board. Integrated Performance Report has been refreshed and covers most major performance indicators with a performance management

			infrastructure now in place in most directorates of the Trust. OWNER: Exec Director of Strategy & Partnerships and Chief Finance Officer. **Track delivery of 2024/25 Annual Plan and report to the Board (bi-annually). Progress against trajectories will be included in the IPR. Board to be updated on the progress of the 24/25 Annual Plan in November 24.**
		c) ICS Planning process evolving in the context of the new national and local operating models and yet to be confirmed	c) Support development of an ICS Planning process. Actively engaging and supporting ICB Planning process in the context of the new operating framework of the ICB and expected new operating framework nationally. In particular, engaging via BOB MH Provider Collaborative to develop approach for Mental Health Planning. OWNER: Exec Director of Strategy & Partnerships and the Chief Finance Officer.
		d) Workforce Planning function and leadership is a gap. e) Trust could benefit from medium term (3 year) plan to tie together finance and service improvement /sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an	d) Workforce Planning approach and leadership to be identified. OWNER: Executive Team e) Strategic Dashboard developed to show strategic ambition and outcome measure for each strategic objective as well as performance against key performance measures and reported twice a year in Integrated Performance

		implementation for the Trust strategy.	Report. Starting to move to two years planning cycle for Strategic Priorities being identified. Guidance for current 2025/26 Plan being developed has been to aim to continue current priorities where appropriate. Ambition is that, in alignment with new Strategy to be implemented in 2026, Annual Planning will move to a 3-year plan being refreshed on an annual basis.

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

3.10: Information Governance & Cyber Security

Date added to BAF	12/01/21
Monitoring Committee	Finance & Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	29/10/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
Current risk rating	**4**	**3**	**12**
Target risk rating	3	3	9
Target to be achieved by			

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

Controls	Assurance	Gaps	Actions
- Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing; - Information assets and systems are risked assessed using standard Data Protection Impact Assessment (DPIA) tool; - 'Third Party Cyber Security Assessment' (checklist & questionnaire) developed, to provide a	**Level 1: reassurance** - Information Management Group (IMG); - Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group **Level 2: internal** Finance & Investment Committee receives reports from IMG - Monitoring of IG training attendance;	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.	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 achieved 95% attendance of mandatory IG training (Aug 2024). Mandatory training is supplemented by specialist training for subject matter experts such as DPO and cyber consultants.

systems requirement specification and to ensure any new Information Systems being procured adhere to DSPT Cyber Security standards; Systems access control and audit managed by way of: programme of penetration testing (annually from 2020); cyber security assessed and tested prior to 3rd party contracts being awarded; Implementation of new Security information and event management system (SIEM) has taken place. Event logs are now being automatically monitored for suspicious activity. Microsoft Defender for mobile has been applied to mobile devices managed by InTune. Those devices now have malware and web filtering applied. Privileged Access Management (PAM) has been implemented which controls and constrains access to elevated administrative accounts on the network. USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender	- Incident management and response process (enhanced to meet DSPT requirements) - NHS Digital Data Security and Protection Toolkit (DSPT) annual self-assessment. - Programme of Phishing simulation/testing of all staff and subsequent report (annual from 2023 **Level 3: independent** - Improved NHS Digital's BitSight cyber rating, which exceeds peers in benchmarking and is in top 30% of organisations globally. - VMS Vulnerability Scanning, and NCSC WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated; -Independent, annual penetration test planned for Q1 annually; Independent DSPT annual audit for external assurance; -Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. - Secure messaging accreditation achieved/maintained (NHS Digital DCB1596);	The clinical system outage, which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting mandatory data-set information and contractual information to commissioners, which could lead to contractual and reputational consequences. R&D Trials are also facing delays due to gaps in data. Penetration testing undertaken in Feb 2024 identified several risks which are being remediated as a priority by the operational IT teams involved. With the rise of AI, there is an increasing reliance on staff proficiently handling suspicious Web, Teams, and Email content, Staff awareness of such threats is only partially mitigated via existing guidance. The Trust needs a dedicated mandatory customisable targeted Cyber Security Awareness Training solution, providing audited participation, knowledge validation and success metrics and reporting, to significantly mitigate the risks from	The Trust has initiated a project working with a third party to support the recovery of reporting (project runs May 2023 - January 2024); the priority is to enable prompt recovery of reporting whilst ensuring that robust processes are in place when restarting automated data reporting. The recovery work will report on the data available but some gaps in data will continue because: **(i)** whilst mitigations have been put in place to ensure that the data that was captured during the outage is accessible to clinicians, it will not be possible to use this data for external reporting; and **(ii)** reduced functionality of the new systems RIO and EMIS, due to the pace at which these needed to be implemented, means that some data will not be available for reporting and analysis purposes until the full functionality is implemented. **OWNER: Head of Clinical Systems** Funding and approval to recruit to enhance the cyber security team has been secured and recruitment is ongoing. A cyber security team consisting of 4 members of staff has been created enhancing the Trust's ability to prevent, manage and respond to cyber threats. The Trust achieved Standards met in the 2023/24 Data Security & Protection Toolkit cycle. The Trust achieved Significant Assurance status in the June 2024 KPMG audit assessment. A few remediations of findings in Q2's cyber assurance (pen test) continued into Q3 but are progressing well, with hardened password recommendations for legacy accounts being implemented via service delivery team in association with cyber team due in September. Consideration for lengthier

Advanced Threat Protection); - Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit the flow of phishing emails, malware and/or unsafe URLs. - Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises. - Cyber Security Awareness and Cyber Security SharePoint sites		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.	passwords for all to be enforced are being discussed in Q3 2024 and could be implemented via the same methods as the legacy account hardening, making use of any operational lessons learnt. Cyber Team awareness of the adoption of National Cyber Security Centre's Cyber Assessment Framework (CAF) based DSPT is being achieved via attendance of several NHSE webinars through summer 2024 to ensure they understand the content, approach and expectations of the CAF-aligned DSPT ready for its start in September 2024. Review of the likely significant changes related to this are due from September onwards, in association with IG and operational IMT teams and are likely to consume resource in late Q3 into Q4. Lack of Cyber Security specific awareness training has been raised at ICS level to explore the potential for a joint approach and will be a subject covered by the ICS collaborative working group. Direction and guidance are being sought from the SIRO before any work begins on an awareness training solution, which would likely need to be a collaborative effort between L&D and Cyber. Phishing Simulation Report (Aug 2023) produced for the SIRO and next steps being discussed for IMG, Execs and Audit Committee awareness. A further Phishing exercise planned for Q3 into Q4 2024 to retest staff who were phished by the last exercise and presented with a static awareness training page. To measure improved awareness. Phishing exercise (different to the Aug 2023 exercise) is planned for Q4 2024/Q1 2025 for all staff to raise and measure awareness of phishing emails and feed into wider awareness training needs analysis.

			OWNER: Head of IT User account deletion process is being strengthened to ensure timely disablement and deletion of leavers accounts. A new process ensuring NHSP provided resources are known and all have end dates supplied at the beginning of their assignments has been created. Further analysis and actions to ensure all leavers are identified and removed is taking place. A robust process is in place, working closely with HR to ensure leavers are identified and processed in a timely manner. The introduction of a 'tell us once' form designed to notify all interested parties is in operation for ESR based Staff. OWNER: Head of IT All Trust managers ensure mandatory Training completed. OWNER: Head of IG

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

3.12: Business continuity and emergency planning

Date added to BAF	19/01/21
Monitoring Committee	Emergency preparedness, resilience, and response (EPRR) committee (sub-group to Executive Management Committee) and Audit Committee
Executive Lead	Director of Corporate Affairs & Company Secretary
Date of last review	13/02/2024
Risk movement	↔
Date of next review	August 2024

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	3	15
Current risk rating	3	3	9
Target risk rating	3	3	9
Target to be achieved by	July 2025		

Risk Description:

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

Key Controls	Assurance	Gaps	Actions
- Accountable Emergency Officer (currently Director of Corporate Affairs & Company Sec), supported by a clinical director; - Designated Emergency Planning Lead, supporting the executive in the discharge of their duties; - EPRR committee 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates & facilities. - Psychosocial Response Group (subgroup reporting to EPRR committee. - Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic; - EPRR Response Manual incident	**Level 1: reassurance** - Emergency Preparedness Resilience and Response (EPRR) Committee (chaired by AEO) 3 x per year; - Psychosocial response group (sub-group of EPRR committee); - Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee. **Level 2: internal** - Annual EPRR report (most recently to the Audit Committee and the Board in Nov 2023); - EPRR Committee ensures that learning from EPRR Exercises, and live incidents, are incorporated into policy / procedure / practice. This is in addition to learning being incorporated into major incident plans, business continuity plans and shared with partners; - Self-assessment against NHS EPRR Core Standards. 2023 Full compliance		

response plan - (updated February 2024) provides emergency response framework; - On call system; director. - Directorate/service specific Business Continuity Plans (BCPs) in place for services, in respect of: Reduced staffing levels (for any reason e.g., pandemic); evacuation; technology failure; interruption to utility supplies (gas & electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown; infection control; food supply; pharmacy supply; - Completion and updating of (BCPs) supported and monitored by Emergency Planning Lead, with register of BCPs held centrally. - BCPs are reviewed annually or following an incident; - Training for directors on call (strategic and tactical), heads of service (tactical), key staff with operational responsibility for hazmat/CBRN response - Undertaking of exercises (live exercise	Based on the quality of response to the following, reputation and resilience have been safeguarded through 'no surprises' No serious harms from Major Incident of IT clinical systems outage; from Industrial Action; from COVID response, from OOH business continuity incident, from locality floods etc **Level 3: independent** - 2023 Self-assessment (as set out in annual report to the Audit Committee and the Board in November 2023) examined and accepted ~~by BOB ICB on behalf of NHSE~~ - There is no formal mechanism in place to obtain assurance from any independent third parties that take place in EPRR exercises. If the Trust participates in a multi-agency exercise, then other participants can make comment during any verbal or written debrief process. In June 2023, KPMG governance risk and compliance services inspected a total of 13 assertions from a total of 33 mandatory assertions in the data security and protection toolkit. All four assertions relating to		

every three years, tabletop exercise every year, and a test of communications cascades every six months (NHS England emergency preparedness framework, 2022)). Lessons incorporated into incident response plans, business continuity plans and shared with partner organisations; - Training scenarios on intranet for services to use to exercise business continuity plans; - Engagement with Local Health Resilience partnerships, and Membership of Oxon & Bucks Resilience Groups; - Horizon scanning and review of National and Community Risk registers by Emergency Planning lead.	EPRR were rated as substantial.		

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

3.13: The Trust's impact on the environment

Date added to BAF	09/02/21
Monitoring Committee	Finance & Investment
Executive Lead	Chief Finance Officer
Date of last review	07/11/24
Risk movement	↔
Date of next review	March 2025

	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), and national targets, for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2032, for the emissions we can influence (our NHS Carbon Footprint), net zero by 2045) could lead to: a failure to meet Trust and System wide objectives, reputational damage, loss of contracts with commissioners, contributing to increased air pollution within the wider community, and loss of cost saving opportunities.

Key Controls	Assurance	Gaps	Actions
Trust Green Plan/Strategy 2022-25; (Green Plan 2 2025-28 to be developed for sign off Jan 25) Executive Lead for Sustainability Chief Finance Officer; Commitment by Board to Zero Carbon Oxford Charter (Jan 2021); Full time Sustainability Manager post within Estates & Facilities Team; Green Task Force Benchmarking and annual Green Plan reporting; Procurement Policy – sets out sustainability commitments required by suppliers; Green Energy Supplier for electricity via CCS, New Developments in accordance with NHS Net Zero Buildings Guidance	**Level 1: reassurance** Monitoring deliverables by Sustainability Manager- **Level 2: internal** Green Task Force Group to deliver Green Plans ~~2~~ chaired by Chief Finance Officer, attended by Estates, Pharmacy, Procurement, Communications Team and some Services; meets Quarterly. Estates Buildings & Transport Sustainability Group meets quarterly; Travel & Transport Strategy Group now in place and chaired by CFO **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 and the Estates Group. The Trust is also part of ZCOP sprint group with Oxford University to review how to adapt our building estate to climate	GAP1: Trust direct carbon emissions in FY 24 were 17% below the F10 baseline year but here was a 2.5% increase in consumption in year, primarily driven by increased business mileage. GAP2: current resource may be insufficient to implement Green Plan 2 in particular a Heat Decarbonisation plan for the estate GAP3: Green Plan Capital & Revenue Budget to achieve Net Zero targets	1). Review Annual Business Mileage and consider long term plan to transfer mileage into more sustainable modes of travel. QI Project OWNER Sustainability Manager 2). Complete analysis of resource requirements to implement Green Plan 2 Action Plan OWNER Sustainability Manager 3). Development of Green Plan 2 which will set out the Trusts approach to achieving Net Zero carbon by 2040. OWNER: Director of Estates and Facilities / Sustainability Manager.

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

3.14 Major Programmes

Date added to BAF	20/09/22
Monitoring Committee	Finance and Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	05/11/24
Risk movement	↔
Date of next review	February 2025

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

Risk Description:

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

Key Controls	Assurance	Gaps	Actions
Programme Boards in place for most strategic programmes and ~~for~~ key projects. Standing Financial Instructions and Scheme of Delegation. Senior teams' leadership of change and focus on ensuring delivery. - Improved internal programme leadership capability within service directorates complemented where	**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 for Execs (bi-monthly), FIC and Board (bi-annually);	a) Portfolio oversight now in place but this will take time to become embedded. b) User engagement in change and change load management not always well-managed. c) Patient voice and experience are not yet routinely embedded in programmes.	a) Board, Committee and Exec to continue to feedback on and help develop new portfolio management approach. b) The Trust is engaging staff across the Trust on our approach to change management. In addition, the newly established change management group has representation across the Trust. c) Patient Experience and Involvement strategic programme to be implemented.

needed by external resource. Strategic PMO manager providing a strategic portfolio management process and project and programme framework to support delivery. Project and Programme Management Reference Group established with representation across the Trust to co-design and implement the programme and programme framework. Templates and methodology for major capital programmes investment appraisal published in Summer 2024. Change management group established to review how change is managed and to set up clear and consistent process to manage change across the Trust.	Strategy Delivery Group introduced to support delivery of the portfolio and to consider impact of changes in the round. Capital Programme sub-committee (reviews capital project progress, attended by Services, IM&T and Estates leaders) and reports to FIC; and FIC receives specific updates on Major Projects including the Warneford programme. Non-Exec Digital Champion appointed. Executive Sponsors in place for all strategic programmes across the Trust. **Level 3: Independent** Internal audit reviews. KPMG assurance over Frontline Digitisation programme. CB representation at Digital and Data Strategy Board.	d) Specific challenges in Estates resourcing and model. e) Capacity and skills in the Financial Management team to support major projects	d) First draft of Estates model has been prepared. To be completed, communicated and implemented. e) Development of the Finance Business Partner roles to be able to provide financial support to major projects

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

4.1: Not Maximising the Trust's Research and Development (R&D) potential

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Chief Medical Officer
Date of last review	29/10/24
Risk movement	↔
Date of next review	February 2025

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	3	3	9
Current risk rating	**3**	**2**	**6**
Target risk rating	3	1	3
Target to be achieved by			

Risk Description:

Not fully maximising the potential to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.

Controls	Assurance	Gaps	Actions
- Director of R&D; - NIHR Infrastructure Managers meetings provides an opportunity for managers of the OH hosted NIHR awards and the R&D Director to meet regularly to ensure alignment and discussion future opportunities. On a quarterly basis these meeting will be augmented by the OUH BRC and CRF Managers. - Clinical Research Facility (CRF) steering committee - Biomedical Research Centre (BRC) Steering 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	Level 1: reassurance Level 2: internal - Research updates and R&D reporting into the Quality Committee; - R&D reports to Board (at least twice a year), - BRC reports to Board on a regular basis Toronto - Oxford Psychiatry Collaboration also provided to the Board Level 3: independent - The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR); - Annual Statement of Expenditure Reports are submitted to DH for the BRC, CRF, ARC and Med-tech & In vitro diagnostics Co-operatives (MICs) have been replaced by Health-Tech Research Centres (HRCs) - 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. As of the 01 October 2024, R&D will be audited by the South-Central Regional Research Delivery Network; RRDN) annually.	GAP:-Following the clinical system outage in August 2022 the issues with migration and recording of diagnosis within RIO have now resolved and RI now have the ability to produce accurate recruitment lists. are also resolved. GAP: The Trust 'Count me in (CMI)' programme paused following the CareNotes outage. Recruitment reverted to a consent model and direct clinician referrals. This remains on hold as a Trust research recruitment strategy, awaiting new research forms in RIO and the ability for appointment letters with CMI leaflet attached, to be sent direct from RIO. When ~~If~~ CMI service resumes, it will require a relaunch to staff and patients. We have no date for this to be resolved. CMI is being led by a Hon Consultant Psychiatrist • Research and Development and an Academic Clinical Fellow - Forensic Inpatient Ward via the BRC Data Science Theme. This project is ongoing. R&D are considering an additional senior project management role to support the delivery of this project. GAP: CMI forms have been built and are now being	RIO 'Research contact preference' form and 'Research approaches and participation' form are in the final stages of development and testing, expected to go live by September 2024. A new team is being added to RIO teams pick list named 'Research team'. The addition of the 'Research team' to the RIO teams pick list will facilitate the documentation of clinical trial activities for participants who do not have an existing RIO record. This enhancement allows for the inclusion of a progress note, the uploading of essential documents such as consent forms and participant information sheets, and the recording of activities in the newly created 'research contact preference' and 'research approaches and participation' forms. Monitoring through reporting into the Finance & Investment Committee (FIC) and the Board. FIC also monitoring BAF risk 3.14 on delivery of Major Projects, such as the Warneford.

Hospitals NHS Foundation Trust OUH), and Oxford Brookes University (OBU). It brings together the teams responsible for supporting clinical research across both NHS Foundation Trusts and both Universities in Oxford, as part of an initiative supported at the highest level in all organisations and by the Board of the Oxford Academic Health Partners The JRO reports into the JRDC. OH have recently been in conversation with the BOB ICS to discuss how research with the 5 NHS Trusts OH has links with OBU in relation to the development of the research element of NMAPS.		tested. These will allow patients research contact preference details and approaches and participation in research to be recorded in RIO. This will also support 'Count me in' (CMI) when relaunched. GAP (Controls): Warneford redevelopment – to progress. Complicated capital project and is being carefully monitored by the Finance & Investment Committee and with regular updates to the Board in private session. GAP (Controls): R&D Strategy in development. Includes Monitor and Improve study set-up times, support early adoption of innovation to reduce waiting lists and increase productivity, Review / re-launch "Count me in". Develop a future proof strategy to sustain, grow and support the development of Research Focused Clinics. Facilitated by clinical academic posts, this work will feed into the wider growth of such post throughout the Trust. A scoping report of Research Focused Clinics' opportunities has been conducted and disseminated. For example, the ARMS (OPEN) clinic provides a unique opportunity to	The R&D operational plan will be developed as part of the OH Planning process. Further work is being conducted to establish the clinics' ongoing needs in relation to both clinical and research databases. This work is being carried out with the CIO to support clinics in ensuring they are meeting national and internal Information Governance guidelines. The clinics present a unique opportunity to develop new patient pathways, facilitate translational research and support the Trust's strategy. R&D have established communication routes to update relevant stakeholders of progress. R&D are assisting with developing a business case to secure ongoing funding for a vital service.

		provide early intervention, treatment and route into research for a large group of patients, with potential cost saving benefits to the Trust. There is a gap in funding provisions for this service.	

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

Table 1a: Risk Matrix

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

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

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

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

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

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

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

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

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

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

Oxford Health NHS Foundation Trust

Meeting of the Audit Committee

Tuesday, 03 December 2024
09:30-12:00[1]
Microsoft Teams virtual meeting (live video streaming – invitation only)

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

AGENDA

			Start time	Allocated (mins)
1.	Welcome and Apologies for Absence[2]	CMH	09:30	10
2.	Confirmation of items for Any Other Business	CMH		
3.	Minutes of the Audit Committee Meeting on 03 September 2024 and Matters Arising (paper 03/AC)	CMH		
4.	Committee workplan (see overview plan at the end of this agenda)	CMH		
External Audit				
5.	Accounts closure process and External Audit progress report (paper 05/AC)	EY/HeS	09:40	15
Internal Audit				
6.	Internal Audit updates (paper 06/AC) including:	KPMG/ PM/HeS	09:55	20
	a. progress report and approach to Internal Audit Plan FY26;			
	b. Core Financial Controls (significant assurance with minor improvement opportunities);			
	c. Patient Experience review (significant assurance with minor improvement opportunities); and	AF		
	d. Health & Safety: risk management review (partial assurance with improvements required).	RA		

[1] 09:00-09:15 Non-Executive Directors only pre-meeting;
09:15-09:30 Auditors and Counter Fraud pre-meeting; and
09:30 main meeting starts.

[2] Apologies from Committee members from Mindy Sawhney. From regular attendees: Jack Stapleton (Internal Audit)

Counter Fraud

7. Counter Fraud progress report and approach to Counter Fraud Plan FY26 (paper 07/AC)	KPMG/ HeS	10:15	15

Risk

8. Board Assurance Framework and Trust Risk Register report with update on BAF 1.6 (Primary and Community Sustainability) (paper 08/AC)	BR/ GD	10:30[3]	15

Governance & Assurance

9. Cyber Security report (paper 09/AC)	WH/DR HeS	10:45	15
10 minutes' break (if required)		11:00	10
10. Clinical Audit update report (paper 10/AC)	CF/KM	11:10	15
11. Standing Financial Instructions (paper 11/AC)	PM/HeS	11:25	10
12. Emergency Planning, Resilience & Response annual report (paper 12/AC)	GD	11:35	10
13. Audit Committee Terms of Reference (paper 13/AC)	GD	11:45	10

Any Other Business

14. Any Other Business (oral discussion)	CMH	11:55	10
15. Questions from observing Governors (oral discussion)			
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; b. any points to raise from the private pre-meetings; and c. content and behaviours.			

Meeting Close 12:00

Date of next meeting: 12 February 2025 09:00-12:30

[3] Timing to support attendance by Ben Riley, Chief Operating Officer for Community Health Services, Dentistry & Primary Care.

Audit Committee – overview plan for 2024/25[4]

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	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									

[4] Summarises the Committee's more detailed Work Plan

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
Timetable for Annual Report & Accounts	Finance / Heather Smith	x					x		
Financial Statements and Accounts	Finance / Heather Smith		x	x				x	x
Going Concern Statement	Finance / Heather Smith		x	x				x	x
Annual Report and Annual Governance Statement	Corporate Governance / Georgia Denegri		x	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.	Brian Aveyard/ Neil McLaughlin / Hannah Smith / Georgia Denegri	x	x	x	x	x	x	x	
OTHER ASSURANCE FUNCTIONS AND MANAGEMENT REPORTING									
Assurance from Committee Chairs on themes previously identified in audits	NED Committee Chairs	x	x		x	x	x	x	
Clinical Audit update report	Claire Forrest/Angela Ward/Karl Marlowe					x			
Clinical Audit annual report	Claire Forrest/Angela Ward/Karl Marlowe		x					x	
Cyber Security (*Encrypt'Send Secure')*	IT/Heather Smith	x			[x]	x		x	
Whistleblowing arrangements (invite Whistleblowing Champion NED)	HR (Jill Castle/Zoe Moorhouse)/ Heather Smith			[x]	~~x~~	~~[x]~~			x
Emergency Planning, Resilience & Response annual report – for approval and recommendation to Board	Emergency Planning/ Georgia Denegri				[x]	x			

Item	Owner(s) or function	Q4 Feb 2024	Q1 April 2024	Q1 June 2024	Q2 Sept 2024	Q3 Dec 2024	Q4 Feb 2025	Q1 April 2025	Q1 June 2025
POLICIES & STRATEGIES									
Standing Financial Instructions (on a 2 years cycle, last done 2023 – next due 2025 *but check what is brought in Dec 2024*)						x			
Scheme of Delegation	Corporate Governance / Georgia Denegri						x		
Risk Management Policy	Neil McLaughlin / Hannah Smith / Georgia Denegri		~~x~~		~~x~~	~~x~~	x		
Counter Fraud Policy	Finance & KPMG								
GOVERNANCE									
Minutes	Corporate Governance	x	x	x	x	x	x	x	x
Audit Committee annual report	Corporate Governance		x	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									

Audit Committee
[DRAFT] Minutes of the meeting held on 03 December 2024 at 09:30 via MS Teams

Present[1]**:**

Chris Hurst	Non-Executive Director (the **Chair/CMH**)
David Clark	Non-Executive Director (**DC**)
Rick Trainor	Non-Executive Director (**RT**)

In attendance:

External Audit - Ernst & Young LLP (EY)	
Claire Mellons	External Audit - Partner, Ernst & Young (**CM**)
Michael Mason	External Audit, Ernst & Young (**MM**) – *part meeting*
Internal Audit and Counter Fraud – KPMG	
Neil Thomas	Internal Audit – Partner, KPMG (**NT**)
Gareth Hall	Internal Audit – KPMG (**GH**)
Adam Makda	Counter Fraud – KPMG (**AM**)
Oxford Health NHS FT	
Attending Board members	
Georgia Denegri	Associate Director of Corporate Affairs (**GD**)
Grant Macdonald	Chief Executive (the **CEO/GM**)
Ben Riley	Chief Operating Officer for Community Health Services, Dentistry & Primary Care (**BR**) – *part meeting*
Heather Smith	Chief Finance Officer (the **CFO/HeS**)
Other Trust staff in attendance	
Brian Aveyard	Risk, Assurance & Compliance Manager (**BA**) – *part meeting*
Ben Cahill	Deputy Director of Corporate Affairs (**BC**)
Angie Fletcher	Deputy Chief Nurse (**AF**) – *part meeting*
Claire Forrest	Head of Clinical Standards (**CF**) – *part meeting*
Will Harper	Head of IT (**WH**) – *part meeting*
Peter Milliken	Director of Finance (the **DoF/PM**)
Jeremy Philpot	Interim Director of Estates & Facilities (**JP**) – *part meeting*
Darren Rodgers	IT Infrastructure Manager (**DR**) – *part meeting*
Hannah Smith	Assistant Trust Secretary (**HaS**) (Minutes)

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

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

1.	**Welcome and Apologies for Absence**	
a	The Chair welcomed attendees to the meeting.	
b	Apologies for absence were received from Mohinder Sawhney, Non-Executive Director.	
c	Apologies from non-Committee members were received from: Jack Stapleton, Internal Audit, KPMG.	
2.	**Minutes of the Meeting on 03 September 2024 and Matters Arising**	
a	The minutes of the Audit Committee meeting on 03 September 2024 were approved as a true and accurate record.	
	Matters Arising	
b	The following actions were noted as complete (with supporting detail in the Summary of Actions document) or on the agenda: • item 10(c) Timetable for procurement of Internal and External Audit contracts; *19 June 2024* • item 9(d) Accounts closure process – on the agenda; and *23 April 2024* • item 12(c) Clinical Audit update report – on the agenda.	
c	The following actions were noted as in progress for the next meeting: • item 6(d)&(e) PLC Committee ongoing monitoring of temporary staffing themes - underway; • item 8(b) Canteen food losses – Catering Manager now appointed; and *16 June 2023* • item 6(a) Risk Management policy. The Associate Director of Corporate Affairs noted that comments and recommendations had been implemented but the policy document was still with her.	
3.	**Committee workplan**	
a	No comments.	
EXTERNAL AUDIT, INTERNAL AUDIT AND COUNTER FRAUD		
4.	**Accounts closure process and External Audit progress report**	
a	The Chief Finance Officer presented the report from the lessons learned review of the FY24 External Audit process. Further to the detail in the report, there had been a fundamentally good process between Finance and External Audit and improvements noted were mainly refinements arising from a continuous improvement mindset; some learning opportunities had been taken and acted upon between the interim and final audit. Claire Mellons concurred and added that External Audit had also recognised the impact of staff turnover and resourced appropriately for the FY25 audit. The Finance and External Audit teams would also meet in person in January 2025 to agree planning and schedule site visits.	
b	**The Committee noted the report and the Chair commented positively upon a relationship with External Audit which was constructive and maximised learning.**	

5.	**Internal Audit progress report and review reports**	
a	Neil Thomas presented the progress report and noted that the Internal Audit Plan FY25 was on track for completion by year end, subject to national guidance on the timescales for the Data Security & Protection Toolkit review. The Cyber Security review was underway and the Access and Activity Data (Waits Management) review had been removed from this year's plan to take place next year and been replaced with the Provider Collaboratives review. The Chair noted that the management action tracker in the report was useful to outline the status of actions and he noted that there were no significant overdue actions.	
	Core Financial Controls (significant assurance with minor improvement opportunities)	
b	Neil Thomas presented the review on Core Financial Controls and noted that this was positive assurance and the recommendation to include an annual control to confirm that depreciated assets had been fully removed from the fixed asset register was fairly common. Areas of good practice had been identified and the report also included comparative areas of learning from other mental health trusts. In response to a question from David Clark, it was confirmed that the RAG-ratings related to the priority of the recommendation rather than the status of the mitigating actions.	
c	The Chair commented upon the importance of the Trust appropriately safeguarding assets as a public benefit corporation and the useful assurance which this report provided. He clarified with Neil Thomas that the target dates for: (i) evidence of the fixed asset verifications and the updated debtors ledger and credit management procedure should be this coming March 2025; and (ii) detailed review of petty cash floats was August 2025. The Chief Finance Officer added that discussions needed to take place first before potentially reducing the number of petty cash floats and to inform users in a timely way.	
	Patient Experience (significant assurance with minor improvement opportunities)	
d	The Deputy Chief Nurse joined the meeting and Neil Thomas presented the review on Patient Experience which had focused upon the governance structure in place, implementation of the Experience and Involvement Strategy and walkthroughs of a sample of patient transitions/discharges from Children's to Adult services and from Inpatient to Community services. This was another positive assurance review, with areas of good practice identified and the Trust's processes had benchmarked well against other mental health trusts. Discharge from services generally had the potential to be risky and for gaps to emerge as patients moved on therefore more discipline in planning and documenting discharge planning meetings had been recommended. The Deputy Chief Nurse provided assurance that: actions were well on track to meet their target dates early in the new year; responsibility for monitoring delivery of the Experience and Involvement Strategy had now transferred to the Director of Psychological Professions; and a Core Clinical Standards audit would help to provide assurance against quality of care and key worker arrangements.	
e	The Chair noted the Committee's role in assessing the effectiveness of evidence and assurance to ensure that there were no significant gaps or inconsistencies; the inclusion of learning from other mental health trusts, in response to the Committee's previous request, was useful to provide a comparative benchmark to support this. He emphasised that: (i) where data was held in more than one place, it should be congruent and consistent; and (ii) same day discharge planning would lead to risks of insufficient time to line up care or implement adjustments. He was satisfied that actions had been progressed promptly and were nearing completion.	

	Health & Safety: risk management (partial assurance with improvements required)	
f	The Interim Director of Estates & Facilities joined the meeting and Neil Thomas presented the near final review and highlighted improvements required on how Health & Safety: risk assessments were completed; training was managed; incidents were investigated and learned from; and the Health & Safety policy was monitored. Actions related to controls and control design had also been recommended, with target dates which provided time for system design, implementation and operation. It was noted that there had been changes in the team responsible for Health & Safety and that the team size was smaller than in another comparable trust, although that organisation's team also had responsibility for fire safety and emergency planning.	
g	The Chief Finance Officer reported that Health & Safety was a high priority for compliance and explained that the review was at near final stage whilst the draft underwent further and final checks to ensure alignment around the recommendations including those relating to training, lessons learned and reporting.	
h	The Interim Director of Estates & Facilities confirmed that he and the Senior Fire, Health, Safety & Security Manager had reviewed and supported the recommendations, some of which had already been completed whilst others were underway. For context he summarised the status of the team, noting recent departures and sickness absence; the team was not yet fully resourced and he cautioned that this may impact upon the final target timeframes for actions.	
i	The Chair led the meeting in a discussion on the importance of safety as a baseline (for patients, staff and visitors) and statutory obligations. In response to questions on any areas where immediate action was possible, consideration of interim resourcing to accelerate progress and Executive confidence in escalation arrangements, the Chief Executive noted that the Interim Director of Estates & Facilities was making good progress on improvements with the Senior Fire, Health, Safety & Security Manager and a new Head of Estates. However, given the conditions that he had taken on, compounded by short-term sickness absence, this would take 3-6 months. The need for additional resource had been recognised and was being supported by the Chief Finance Officer, with appropriate alerts and escalations from the Interim Director of Estates & Facilities through the Trust Risk Register to the Executive. The situation was being monitored by the Executive and also through the work of the People, Leadership & Culture Committee and the Quality Committee. The Chair emphasised the importance of being alert to potential risks and their crystallisation, especially in the interim. The Committee would keep a close eye on the follow-up to recommendations and completion of actions from the review but was reassured that progress was already being made.	
j	**The Committee noted the progress report and received the review reports. The Committee was assured by the review reports into Core Financial Controls and Patient Experience. The Committee would keep a close eye on the completion of recommendations/actions from the Health & Safety: risk management review which had been presented in near final form.** *The Deputy Chief Nurse and the Interim Director of Estates & Facilities left the meeting.*	
6.	**Counter Fraud progress report**	
a	Adam Makda presented the report and highlighted: (i) recent activity including visits to the Trust, fraud alerts and proactive work on the completion of the joint review with Internal Audit on Core Financial Controls referred to above; and (ii) progress against the FY25	

	Counter Fraud Plan, including completion of fieldwork for the Reporting Culture review, ongoing fieldwork for the joint review on Cyber Security and scoping on the Secondary Working review. As set out in more detail in the report, three new referrals had been received, of which one remained open and related to secondary working.	
b	The Committee discussed the referral which had related to a job applicant with an alleged history of fraudulent activity, according to references. The referee, another trust, had been unwilling to provide further information formally and in writing to the Trust. The Chair expressed his disappointment if there had been lack of cooperation.	
c	**The Committee noted the report.** *The Risk, Assurance & Compliance Manager joined the meeting.*	
7.	**Internal Audit and Counter Fraud approach to FY26 Planning**	
a	The meeting discussed the approach to Internal Audit and Counter Fraud Planning for FY26 and agreed to follow a similar but wider process to last year through presentation to the Extended Leadership team (not just the Executive team), discussion with individual Executives and a workshop with the Committee. Neil Thomas noted that a wider approach may be helpful to ensure that senior managers were familiar with the scope of reviews.	
b	**The Committee supported the wider approach to Internal Audit and Counter Fraud Planning FY26.**	
RISK, GOVERNANCE & ASSURANCE		
8.	**Board Assurance Framework (BAF) and Trust Risk Register report with update on BAF 1.6 (Primary and Community Sustainability)**	
a	The Chair introduced the report and welcomed the Chief Operating Officer for Community Health Services, Dentistry & Primary Care to the meeting in order to present a deep dive into BAF risk 1.6 on the sustainability of Primary, Community & Dental Care services, especially in light of the delivery of the Oxfordshire Community Services Transformation programme and the need to manage and mitigate risks associated with delivery of this strategic change. The Chair recommended that the Committee be mindful of the impact of delays in capital investments when examining the actions which had been taken.	
b	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care presented the high/orange-rated risk and noted that the situation around general resilience and sustainability of the services had improved but some services remained subject to high demand and ongoing pressure, such as district nursing and podiatry. There was a national shortage of podiatrists and reduction of agency usage in this area could compromise patient safety, which therefore informed workforce and skill mix planning. Digital tools were also being explored to reduce pressure and increase efficiency in district nursing. He took the Committee through the short and longer term actions to mitigate the risk, especially further to the unexpected delays to the Estates work programme for the Fiennes and Witney community hospital. Although the delays had not created patient risks, the environments were crowded.	
c	The Chair commented upon the improvement in partnership working over recent years, especially in relation to winter resilience preparedness and system Emergency Planning. The Chief Operating Officer for Community Health Services, Dentistry & Primary Care agreed and noted that this had been maintained after the response to the pandemic.	

d	In response to questions from the Chair on recovery from the clinical systems outage (which had resulted from a failure with third party supplier-hosted patient record systems) and any remaining data gaps or issues around data reliability, the Chief Operating Officer for Community Health Services, Dentistry & Primary Care reported that functionality of the current patient record system was better than before but the Trust would continue to have gaps in its data where the outage had resulted in data not being recorded in systems. However, the EMIS system had been deployed successfully to district nurses which had helped them to move away from paper-based records, although there was more which could be done on interoperability with medicines management systems and the Trust was exploring the capability of EMIS to improve productivity, reporting and interoperability. The Chief Executive added that the Executive had yesterday received a presentation on productivity improvements through e-prescribing, whilst the digital agenda generally looked promising for future developments.	
e	The Chair referred to the second part of the report and reminded the Committee of its role to review the adequacy and effectiveness of the system of integrated governance, risk management and internal control and to assure itself on the adequacy and effectiveness of the management of strategic risks. The Committee reflected upon the information with which it had been provided and the discussion above in relation to the specific risk subject to the deep dive and the wider discussion on the Internal Audit review reports. The Chair invited the Committee to raise any concerns or further observations of risk management arrangements; no concerns or further observations were made.	
f	The Chair also reminded the Committee of regular upcoming reporting, at its next meeting, of risks which were assigned to the Committee for its monitoring and oversight at BAF 3.6 (Governance and decision-making arrangements) and BAF 3.12 (Business Continuity and Emergency Planning), noting that the Emergency Planning, Resilience & Response annual report was on the agenda at item 12 below.	
g	**The Committee noted the report and was assured by the management of BAF risk 1.6 (Primary and Community Sustainability) and key strategic and operational risks.** *The Chief Operating Officer for Community Health Services, Dentistry & Primary Care and the Risk, Assurance & Compliance Manager left the meeting*.	
9.	**Cyber Security report**	
a	The Head of IT and the IT Infrastructure Manager joined the meeting and presented the report highlighting that the Trust's global security position had further improved during the year and, as set out in the report, several of the risks had been downgraded as significant progress had been made during FY25 in implementing technologies to harden cyber defences. Cyber awareness training was planned and another phishing exercise was scheduled to re-test a targeted sample of users, prior to a wider campaign next year. Further to a question from David Clark, the meeting considered the common and ongoing risk of phishing and the importance of keeping awareness high; the Head of IT confirmed that the re-test of the targeted sample was focused upon users who had previously been caught out, to ensure learning, but testing would be rolled out to the rest of staff next year. Cyber Security was also the subject of a current joint Internal Audit and Counter Fraud review which would be reported into this Committee. The Trust was also participating in the development of a wider system Cyber Security strategy and agreement of a common set of standards for organisations to work to.	

b	The Chair thanked the Head of IT and the IT Infrastructure Manager for the detail in their report and presentation and the assurance on progress which the Trust was continuing to make. Going forwards, he noted that Cyber Security reporting would go initially through the Finance & Investment Committee (**FIC**) and then the Audit Committee would reflect upon this work and take assurance from the initial scrutiny through the FIC. The Audit Committee would continue to receive the Data Security & Protection Toolkit review from Internal Audit which would provide assurance in relation to risks such as phishing and areas such as Counter Fraud.	
c	**The Committee noted the report and was assured.** *The meeting took a break for 10 minutes and resumed at 11:10. The Head of IT, the IT Infrastructure Manager and Michael Mason left the meeting.*	
10.	**Clinical Audit update report**	
a	The Head of Clinical Standards joined the meeting and presented the report on Clinical Audit and NICE (National Institute for Health and Care Excellence) activity and progress against the Clinical Audit Plan FY25. More detail was also included in the report on: • clinical audits that had not met compliance levels, along with their mitigations or improvement plans; and • reporting structure and the governance and assurance framework for Clinical Audit and NICE, including directorate local governance/quality teams, the Improving Care Group and the Clinical Effectiveness Decision Group. Clinical Audit was also monitored through quarterly updates to the Quality Committee.	
b	Further to a question from David Clark on the Core Clinical Standards (Inpatient) audit which had not met compliance levels and had action themes related to patient experience, the Head of Clinical Standards explained that the action themes related to: (i) 1:1 time offered to patients and expectations around how this would be conducted; and (ii) reviews of documentation such as care plans reflecting patient needs, goals and carer views. 1:1 time and reviews may have actually taken place but in different ways which may not have been captured by the language used in the clinical audit.	
c	The Chair thanked the Head of Clinical Standards for the additional detail in the report and he and Rick Trainor commented upon the volume of clinical audits (169) and the complexity of the governance arrangements. The Chair noted the importance of resourcing to support this and maintain the Clinical Audit Plan, with recruitment currently underway for a Clinical Audit and NICE Team Manager. He clarified that the Quality Committee was the prime vehicle of governance for Clinical Audit reporting; the Audit Committee should consider the work of internal assurance functions such as Clinical Audit but this could be achieved through assurance that oversight was provided by the Quality Committee. The Audit Committee should also consider whether value was being maximised for the Trust from the development and implementation of the Clinical Audit Plan; the links to innovation and transformation in the report had been helpful for this. The Chief Executive agreed that the value-added consideration was relevant, especially as Clinical Audit continued to operate alongside Quality Improvement rather than being replaced by it. It may be for the Quality Committee however to separately consider the volume and quality of clinical audits.	
d	**The Committee noted the report.** *The Head of Clinical Standards left the meeting*.	

11.	**Standing Financial Instructions (SFIs)**	
a	The Director of Finance presented the SFIs and explained that they had been brought up-to-date with recent statutory and external guidance, references to specific roles and generally to enhance clarity and align with operational processes. Revisions were summarised in the covering report and set out in the section on change control in the policy. He highlighted that: (i) the procurement and contracts section would be transferred to an updated version of the Procurement Policy which would be provided to the next meeting; and (ii) the Financial Approvals Limits at Appendices 1-2 had been updated.	**PM/ HES**
b	The Chair noted that the changes were sensible and asked what had motivated the proposed changes to the Financial Approval Limits. The Director of Finance replied that the revised Financial Approval Limits were a better fit for the growth and current size of the Trust as well as increased Research & Development grants and funding.	
c	**The Committee RECOMMENDED the updated SFIs for final approval by the Board.**	
12.	**Emergency Planning, Resilience & Response (EPRR) annual report**	
a	The Associate Director of Corporate Affairs and the Deputy Director of Corporate Affairs presented the EPRR annual report which provided an overview of EPRR and business continuity activities over 01 November 2023 to 31 October 2024 to meet the requirements of the Civil Contingencies Act 2004 and the NHS England Emergency Preparedness Framework 2022. The annual report included a summary of live events during the reporting period which had required the implementation of incident response and business continuity plans; these had been well managed. The Committee was invited to consider and approve the NHS EPRR core standards self-assessment contained within the annual report and individual Committee members should each be satisfied that controls were in place to comply with the Trust's EPRR obligations. The self-assessment had been reviewed by the EPRR committee and the Buckinghamshire, Oxfordshire & Berkshire West (**BOB**) Integrated Care System (**ICS**) had also confirmed the self-assessment and that the Trust was compliant with the 58 core standards. The BOB ICS confirmation of EPPR self-assessment and review would be circulated after the meeting.	**GD**
b	The Chair led the Committee in reflection upon the Trust's EPRR preparedness in the face of live events, the adequacy and effectiveness of controls as demonstrated by the Trust's response and the commitment and behaviours shown. The Committee also considered and took assurance from the discussion at item 8 above on BAF risk 1.6 (Primary and Community Sustainability) on improved partnership working, especially in relation to winter resilience preparedness and system Emergency Planning.	
c	**The Committee APPROVED the EPPR annual report, including the NHS EPRR core standards self-assessment, and recommended it to the Board for receipt.**	
13.	**Audit & Risk Committee Terms of Reference (ToR)**	
a	The Chair and the Associate Director of Corporate Affairs presented the ToR of the Audit & Risk Committee, further to discussion at the Committee's Workshop on 03 September 2024 which had reflected upon the three different types of committee described in the HFMA NHS Audit Committee Handbook and agreed that the Committee operated as an Audit & Risk Committee taking more active oversight of the system of risk management.	

b	The Associate Director of Corporate Affairs explained that the ToR had been updated, rather than significantly changed, from the Committee's existing ToR as could be evidenced from the marked-up version provided which showed new proposed text in blue font whilst the majority black font showed the original text or text copied from other Trust committees' ToR and inserted across all committees for consistency. She highlighted that the Committee's role in Cyber Security, Clinical Audit and in relation to other committees had been further clarified. The Chair confirmed that he had been involved in developing the ToR and was content that the updated ToR more fairly reflected and provided improved clarity on the Committee's role and responsibilities.	
c	The meeting reviewed the ToR and suggested: • 'whistleblowing' references should be replaced by 'Freedom to Speak Up', in the context of the Committee's role in assuring itself on these arrangements and processes. Whistleblowing was a dimension of Freedom to Speak Up; and • remove paragraph 4.1.10 and reinstate the strike-through version of 4.1.12 which was clearer and less ambiguous in relation to the Committee's role in relation to Cyber Security.	**GD**
d	**Further to the discussion above and suggested final amendments to be considered, the Committee APPROVED the adoption of the Audit & Risk Committee Terms of Reference and RECOMMENDED these to the Board for final approval, together with the change of name of the Committee to 'Audit & Risk'.**	
Any Other Business		
14.	**Any Other Business and Questions**	
a	None.	
15.	**Review of the meeting**	
a	The Committee noted that the updated SFIs, EPRR annual report and Audit & Risk Committee ToR would be recommended to the Board.	
	Meeting Close: 11:50	
	Date of next meeting: 12 February 2025	

Meeting of the Oxford Health Charity Committee – Governance

Wednesday 4th December 2024 1.30pm – 2.30pm via. Microsoft Teams

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

AGENDA

	Agenda Item	Lead	Indicative Time
1	**Welcome and apologies for absence**	RT	1.30pm
2	**Declarations of interest/related party transactions**	RT	1.35pm
3	**Minutes of the Meeting on 4th September 2024** (1) **and Action Updates** (2)	RT *CCG 003i_24 &* *CCG 003ii_24*	1.40pm
4	**Annual Impact Report (final) and Annual Financial Report (final)** Please note these are subject to final sign off after making changes as requested by the auditor. This will be confirmed verbally at the committee meeting.	ME/PM *CCG 004i_24,* *CCG 004ii_24 &* *CCG 004iii_24*	1.45pm
5	**Financial Management Accounts** **- Including update on Investment Closure**	PM *CCG 005i_24 &* *CCG 005ii_24*	1.55pm
6	**Legacies and Inactive Funds**	ME *CCG 006_24*	2.05pm
7	**Risk Register**	ME/BC *CCG 007_24*	2.10pm
8	**Warneford 200**	RT/JF *CCG 008_24*	2.15pm
9	**Any Other Business/Close** **- ROSY Update**	RT/ME *CCG 009i_24 &*	2.25pm

	- **Update on the Charity Commission Review of The Captain Tom Foundation**	*CCG 009ii_24*	

Charity Committee 2025 Dates

Tuesday, 25 February	10:00-12:30	Microsoft Teams
Thursday, 22 May	10:00-12:30	Microsoft Teams
Tuesday, 23 September	10:00-12:30	Microsoft Teams
Tuesday, 9 December	10:00-12:30	Microsoft Teams

Attendance – Governance Sub-group

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

Meeting of the Oxford Health Charity Committee – Development

Wednesday 4th December 2024 2.30pm – 4pm via. Microsoft Teams

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

AGENDA

	Agenda Item	Lead	Indicative Time
1	**Welcome and apologies for absence**	RT	2.30pm
2	**Declarations of interest/related party transactions**	RT	2.35pm
3	**Minutes of the Meeting on 4th September 2024** (1) **and Action Updates** (2)	RT *CCD 003i_24 & CCD 003ii_24*	2.40pm
4	**Charity Strategy Update**	ME *CCD 004i_24 & CCD 004ii_24*	2.50pm
5	**Requests £10k+** - **Bicester Air-Conditioning** - **Wantage Legacy Options**	AL/SR *CCD 005i_24* DO/SB *CCD 005ii_24*	3.00pm
6	**Impact Reporting**	ME *CCD 006_24*	3.30pm
7	**Fundraising Update**	ME *CCD 007_24*	3.40pm
8	**Any Other Business/Close**	RT	3.50pm

There is also attached a copy of the presentation provided to charity panel members, to give the Committee a flavour of the requests from this quarter (CCD_009_24_Autumn Requests 2024).

Charity Committee 2025 Dates

Tuesday, 25 February	10:00-12:30	Microsoft Teams
Thursday, 22 May	10:00-12:30	Microsoft Teams
Tuesday, 23 September	10:00-12:30	Microsoft Teams
Tuesday, 9 December	10:00-12:30	Microsoft Teams

Attendance – Development Sub-group

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

Minutes of the

Oxford Health Charity Committee – Governance Meeting

Wednesday 4th December 2024 01.30-02.30pm, held via Microsoft Teams

PLEASE NOTE, THESE MINUTES ARE A DRAFT COPY AND HAVE NOT BEEN FINALISED/APPROVED BY THE COMMITTEE

Present:

Rick Trainor (RT)	Non-Executive Director (Chair)
Charlotte Evans (CE)	Executive Assistant (Minutes)
Ben Cahill (BC)	Deputy Director of Corporate Affairs
Angela Conlan (AC)	Interim Development Manager – Oxford Health Charity
Martin Crabtree (MC)	Acting Head of Communications
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Charmaine Desouza (CD)	Chief People Officer
Michelle Evans (ME)	Interim Head of Charity
Chris Hurst (CH)	Non-Executive Director
Britta Klinck (BK)	Chief Nurse
Chris Langridge (CL)	Oxford Health Charity Administrator
Peter Milliken (PM)	Director of Finance
David Walker (DW)	Chair - Oxford Health NHS FT

Guests – present for relevant agenda item:

Jane Freebody (JF)	Project Lead, Warneford 200
Karl Marlowe (KM)	Chief Medical Officer

Apologies:

Amelie Bages (AB)	Executive Director of Strategy & Partnerships
Grant Macdonald (GM)	Chief Executive
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care
Michael Williams (MW)	Financial Controller, Finance

1	**Introductions and Apologies**	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. Peter Milliken (PM) was attending due to apologies from Michael Williams. There have been recent changes to the charity team after Julie Pink left in November. Michelle Evans (ME) is now Interim Head of Charity, and Angela Conlan (AC) is Interim Development Manager. 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 4th September 2024 and Action Updates**	
	The minutes for the Governance Charity Committee Meeting on 4th September 2024 were accepted as an accurate record of the meeting. In regard to matters arising, please see separate action tracker. There are currently the following outstanding actions: • Investment Portfolio Proposal - Financial investments being transferred to a new type of investment account. PM to get an update from MW to see if this has been completed or not. **ACTION OPEN.** • Independent Members - Action is currently paused due to staff changes and to remain as an outstanding action. **ACTION OPEN.** • Draft Financial Report – Trust has now invoiced charity re: ROSY for 6 months of 24/25 and the whole of 23/24. **ACTION CLOSED.** • Financial Management Accounts – Misreport in Q1 has now been corrected in the latest management accounts. **ACTION CLOSED.** • More Partnership Report – this has been circulated to executives. **ACTION CLOSED.**	
4	**Annual Impact Report (Final) and Annual Financial Report (Final)**	
	ME and PM presented the annual impact report and annual financial report which were seen in draft format at the meeting on 4th September. The reports now contain the full accounts, and following circulation of the papers these have now been approved by the independent review/auditors. The formal sign off will be added to the document. PM summarised that the balances in the management accounts have gone down year on year, leading to a gradual erosion on the financial position of the Charity. Chris Hurst (CH) noted the trends of income down and expenditure down. A discussion was had that previously there has been an underuse of charitable funds, deployment of funds and focus. The charity team have done lots of work to change that by raising awareness of the Charity and aligning appropriate flexibility around use of funds to have the greatest impact. So, whilst the financial income was	

	growing for a while, the successful use of funds has improved and increased, leadingto the overall position going down. Thanks were given to Danielle Manning for working really hard with collating information and navigating the review process. For next steps, once the committee have approved the reports and letter of representation, they will go to the corporate trustees at the board meeting scheduled for 11th December. Clarification was given that the board of directors act as the corporate trustee. These documents will then be submitted to the Charity Commission in January (deadline is 31st January). ME has advised that, as the website is not the most stable, she would prefer to submit the documents earlier rather than waiting until the deadline. The committee were happy to approve the annual impact report, annual financial report and letter of representation. They were happy to recommend to the board as corporate trustees the approval of the reports and letter of representation.	
5	**Financial Management Accounts**	
	PM presented the financial management accounts in the absence of MW. In summary, income and expenditure are down by around a third compared to last year. The previous year's financial statements were up compared to this year. The net movement has been decreased due to investing rather than building. There has been a net decrease in terms of net assets of £3,000 at the end of September (end of quarter 2). If this continues there will be more of a change in comparison to the previous full year. It was noted that assets/the portfolio is not decreasing because of a conscious effort. ME highlighted that the charity team are currently without a full-time fundraiser post (the previous incumbent left in August), and they are now seeing the impact of this in the accounts. Georgia Denegri (GD) advised that the post was vacant until the appointment of a permanent CEO was finalised. The role is still on a list regarding corporate investments and will be reviewed. There was discussion around the increase innational insurance contributions and if this will have an internal impact on charity expenditure. It was noted that these changes will have an impact due to the staff cost element as the Charity are not exempt from national insurance changes. The negative impact will be the reduction in the amount of money that can be spent elsewhere. The changes to national insurance contributions are from April 2025 (the next financial year).	

	Investment Closure In regard to financial investments being transferred to a new type of investment account, investments have been sold and transferred to a Lloyds Account. A BankLine Account is being set up. This bank account is in line with the Trust policy as BankLine offers a competitive interest rate and unlimited protection in the event of the bank failing. It was asked if the investment return being below 2% for the first 6 months of the year was affected by the transition (the investment closure), although the transition is still incomplete. PM advised that this has not been affected as the transfer/closure happened after these accounts were published. The investment return is down and has been problematic over the last few years, hence the plan to move to a bank account rather than an investment portfolio approach. PM will check how long the transition will affect returns once we have the new account. **ACTION PM.** The Committee is asked to note this information provided in the papers and discussion.	**PM**
6	**Legacies and Inactive Funds**	
	ME presented the paper on legacies and inactive funds. There has been a conscious effort to try and progress some of the active funds and spend some of the money. Some of the legacies are very specific but the team are continuing to work through them. It was discussed that some cases are difficult to handle, and the team are doing well in the circumstances. The team encourage people to think about ideas about how to spend the money with particular reference to the value they can get and how to spend the money appropriately. There are guidance documents which outlines what the money can and cannot support, which can trigger conversations and examples. It was noted that flexibility in donations gives the Charity more flexibility to adjust resources as the needs develop, and the importance of general appeals. CD asked about recommendations, and whether the team present statements to fund advisors and have active discussions on the amount of money left and how would they like to spend it. The answer was that Fund advisors are usually those from an Executive or service director level, and all funding decisions need to be signed off by 2 fund advisors. The names of lead fund advisors are to be added to either this paper or the management accounts as an appendix. **ACTION ME/MW.** KM and BK discussed their recent meeting with colleagues in Canada and how research activities can attract legacy funding as people feel they are contributing to something that will make progress in a specific area. KM	**ME /MW**

	suggested there may be specific restricted funds that could be promoted for areas of research, such as for children, mental health, dementia and epilepsy. BK advised the new Head of Spiritual and Pastoral Care has been appointed (Andrew Williams). There was an error noted in the paper in the last paragraph, it should say issue of 2nd quarter (not 3rd quarter) statements are being delayed (not 3rd quarter). There will be a new legacy added to the paper for the next meeting. The Committee is asked to note this information provided in the papers and discussion.	
7	**Risk Register**	
	BC and ME presented the risk register. It had been previously agreed to bring the risk register to a charity committee only if there had been an update/new risk/significant change. ME advised there are risks currently not meeting target and a new risk around direct debit. A new risk has been added following fraudulent Bank activity on the Lloyds ROSY Account, of Direct Debit payments totalling £182.46 (£60.81 refunded). This was identified following non-authorised direct debits to the 'DVLA' identified through fund statement reviews undertaken by Head of Charity and Development Manager. Action has been taken in that the finance manager reported to Lloyds as fraudulent activity and details of how a direct debit can be set up without signatory approval sought. Contact made with the DVLA by the finance manager to identify who set up the direct debit and what it was for, DVLA confirmed it was not coming into their accounts, and the referenced registration number did not relate to an active vehicle. Head of Finance Accounts followed up with Lloyds and was able to confirm with them that an individual had set up the direct debit but could not facilitate any refunds. This was escalated to the financial controller (as signatory for the account). The response from Lloyds is that Direct Debits can be set up electronically by anyone with the bank details and no signatory approval is required and that a reference can be added, like DVLA, but it does not necessarily mean that the referenced organisation is taking the funds. They can confirm refunds once the transactions have been confirmed as fraudulent. The finance manager has followed up to Lloyds to ask that no direct debits are permitted on any of our accounts without signatory approval moving	

	forward. Refunds outstanding of £121.65. Thankfully it is felt this has been an isolated incident but there is an ongoing risk as there is no way of blocking direct debits being set up. The team will need to closely scrutinise the bank statements. There is a risk around misalignment of trustee structure of the Charity that requires mitigations around recruitment of new non-executives on departure of previous members, with roles and responsibilities of Committee Members included in the 2023 Terms of Reference review. There was discussion around whether this risk is correct, as both Non-Executives and Executives are paid by the Trust and not by the Charity, which does not employ anyone).There is not a requirement for non-executives to be within the corporate trustee. ME will look into this risk and bring it back to next meeting. **ACTION ME.** It was agreed that there need to be some new independent members appointed. BC commented on the format of the risk register and a discussion was had that it useful to know the latest risk update, with a date, date for formal review and any residual risks after mitigations. BC will look at reworking the format of the risk register. **ACTION BC.** The Committee is asked to note this information provided in the papers and discussion.	**ME** **BC**
8	**Warneford 200**	
	Jane Freebody (JF) and Karl Marlowe (KM) attended to discuss Warneford 200. Warneford 200 is a series of events at the Warneford Hospital site in 2026. The events are designed to attract a wide range of audiences including users of mental health services, families, professionals, trainees, academics, students, schools, colleges and universities. The programme of events includes a touring exhibition, creative workshops, a play, a re-created 19th century asylum garden, a walk/trial around the grounds, online resources for local school,s and working with Oxford Brookes. The aim of the events is to generate discussion about mental health with stories of the Warneford Hospital over the last 200 years. This will include looking at mental wellbeing and associated activities, supported therapeutic environments, awareness and development of new approaches. The project is being guided by a steering group with KM being the lead executive. As well as the steering group, services users are being involved at every stage. The cost of the series of events is between £160,000 - £200,000. To raise the money, JF is planning on applying for funds from various	

	organisations such as the National Heritage Lottery Fund, The Arts Council and the Paul Hamlyn Foundation. It is important that approaches to these organisations are made from a registered charity. It is therefore the intention, with the agreement of this committee, to approach organisations as the Oxford Health Charity. It was clarified the Charity will not incur any costs. It was highlighted the benefits to the Charity including raising the profile and expanding the supporter base. ME pointed out thatOxford Health Charity's purpose is to enhance patient care, and so funding applications to do need link back to this. ME also advised JF to read the terms and conditions when applying, as some organisations do not accept a corporate trustee model. BK asked if we were involving our staff and JF advised that Tom Cox, Artscape Project Manager, and Laura McCarthy, Green Spaces Coordinator, are involved. DW has been thinking about the Trust providing a contribution to the Warneford 200 project to help generate more enthusiasm and generate local interest. The committee were happy to approve JF planning on applying and approaching organisations as the Oxford Health Charity. JF to send all draft funding applications to ME for review and recording. ME/JF will keep the committee updated on the progress of the Warneford 200 project.	
9	**Any Other Business/Close**	
	ROSY Update ME advised that since the paper had been submitted, the founders of ROSY have written to Grant Macdonald (GM) and Ben Riley (BR) to raise concerns of fundraising and the possibility of the Trust picking up the service. The Oxford Health Charity does have potential to enhance and support ROSY, but the conversation with GM and BR will need to look at core delivery of ROSY. It was advised this will be pursued offline. **Update on the Charity Commission Review of the Captain Tom Foundation** Circulated for information. Clarification that Captain Tom raised millions of pounds for NHS Charities Together, which is separate to the Captain Tom Foundation set up by the family.	
10	**Date of Next Meeting(s)**	
	• Tuesday 25th February 2025 10am – 12.30pm • Thursday 22nd May 2025 10am – 12.30pm • Tuesday 23rd September 2025 10am – 12.30pm • Tuesday 9th December 2025 10am – 12.30pm *All to be held via. Microsoft Teams.*	

Attendance – Governance Sub-Group

	Feb 2024	May 2024	Sept 2024	Dec 2024
Rick Trainor	✓	✓	✓	✓
Non-Executive Director (Chris Hurst)	✓	✓	✓	✓
Amelie Bages				
Britta Klinck	*Deputy*	✓	*Deputy*	✓
Kerry Rogers/Georgia Denegri from May 2024	✓	✓	*Deputy*	✓
Ben Riley				
David Walker	✓	✓		✓
Julie Pink	✓	✓	✓	
Michelle Evans	✓	✓	✓	✓
Michael Williams	✓	✓	✓	*Deputy*
Olga Senior	✓	✓		
Donna Clarke				
Donna Mackenzie/ Beth Morphy				
Zoe Moorhouse				
Learning & Development				
Jane Appleton/Comms		✓		*Martin Crabtree*
Mark Waring/Ellyn Carnall				

Minutes of the

Oxford Health Charity Committee – Development Meeting

Wednesday 4th December 2024 02.30pm-04.00pm, held via Microsoft Teams

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Present:

Rick Trainor (RT)	Non-Executive Director (Chair)
Charlotte Evans (CE)	Executive Assistant (Minutes)
Ben Cahill (BC)	Deputy Director of Corporate Affairs
Angela Conlan (AC)	Interim Development Manager – Oxford Health Charity
Martin Crabtree (MC)	Acting Head of Communications
Georgia Denegri (GD)	Associate Director of Corporate Affairs
Charmaine Desouza (CD)	Chief People Officer
Michelle Evans (ME)	Interim Head of Charity
Chris Hurst (CH)	Non-Executive Director
Britta Klinck (BK)	Chief Nurse
Chris Langridge (CL)	Oxford Health Charity Administrator
Jeremy Philpot (JPh)	Interim Director of Estates & Facilities
David Walker (DW)	Chair - Oxford Health NHS FT

Guests – present for relevant agenda item:

Susannah Butt (SB)	Transformation Director, Older People SMT
Jane Hudson (JH)	Bicester Hospital League of Friends
Alice Lockhart (AL)	Operations Manager – Abingdon, Older People SMT
Dorothy O'Dell (DD)	Transformation Lead, Performance Team
Steven Rutter (SR)	Operational Support Manager, Community Hospitals

Apologies:

Amelie Bages (AB)	Executive Director of Strategy & Partnerships
Ellyn Carnall (EC)	Operational Support Officer
Donna Clarke (DC)	Service Director, Bucks Leadership Team
Grant Macdonald (GM)	Chief Executive
Ben Riley (BR)	Executive Director, Primary, Community & Dental Care

1	**Introductions and Apologies**	
	Rick Trainor (RT) welcomed the group and acknowledged apologies for absence received as above. 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 4th September 2024 and Action Updates**	
	The minutes for the Development Charity Committee Meeting on 4th September 2024 were accepted as an accurate record of the meeting. There were no comments or amendments to be made, and they were formally approved. In regard to matters arising, please see separate action tracker. There are currently the following outstanding actions: • Oxfordshire Health Services Research Grant - Action is currently paused during this interim phase ME will connect with Kate Saunders to review in the Spring. **ACTION OPEN.** • Bicester Air Conditioning – On the agenda for today. • Grant Applications Oxfordshire Community Foundation – ME and GD to discuss offline. **ACTION OPEN.** • Project and Impact Reporting – On the agenda for today. **ACTION CLOSED.**	
4	**Charity Strategy Update**	
	Michelle Evans (ME) presented the updated strategy documents which had been circulated ahead of the meeting. We are broadly on track with a good number of key performance indicators (KPIs) showing as green/completed or on track. One KPI is related to communication strategy and a style guide. This has been written and circulated to committee members as an additional paper. ME highlighted that the strategy and KPIs were written when the Charity had a full team. The team are now at reduced capacity and working with interim arrangements following the departure of the Head of Charity and Involvement. The team are also currently without a full-time fundraiser. This will affect the team's ability to turn all the benchmarks to green/completed over the next few months. ME is in discussion with Ben Cahill (BC) around limited resources and	

	there will be a further update at the next committee meeting in February 2025. The Committee is asked to note this information provided in the papers and discussion.	
5	**Requests £10k+**	
	Bicester Air-Conditioning Alice Lockhart (AL) and Jane Hudson (JH) attended to ask the committee for approval for their request for Bicester air-conditioning. The request is for the Community Health Services, Dentistry and Primary Care directorate to use £50,000 to install a comfort cooling system into a side room at Bicester Community Hospital. This request was due to come to the Charity Committee earlier in the year, but the correct escalation proves did not happen. There was a sum of money (£50,000) left by a patient in their Will to the League of Friends at Bicester Community Hospital. The ask was that the money was used to provide an enhanced environment in the hospital. It was thought this was specifically related to temperature, but JH clarified this was not the case, but it was to be spent in a lump sum on a substantial item that would enhance patient care within the ward. It was identified by the Ward that a cooling system enhancement would help to improve the environment and patient experience. Other options had been reviewed, such as awnings, but as Bicester Community Hospital is not owned by the Trust, changes could not be made to the outside of the building. It has been confirmed with the family that if the Trust vacate the building, the cooling system enhancements can be left in that building. JH advised it had been difficult to find something that would be of a significant cost that the NHS would not provide. Chris Hurst (CH) asked about the set-up at Bicester Community Hospital and was advised that if the cooling system enhancement was only in one side room, that would leave 11 patient areas/rooms without the cooling system. There was discussion around maximising value for money and maximising benefit. Jeremy Philpot (JPh) raised concerns about the quote and where it had been obtained from. JPh also had concerns around the VRV system power supply and if there is a suitable	

	power supply, and also the ongoing maintenance going forward. JPh felt work needed to be done to ensure due diligence has been done by the estates team. It was also raised whether we had spoken to the landlord and got agreement/approval, and whether any planning applications were needed. There were concerns that the paper for the request as it mentions the donor being specific about what the money is to be used for (temperature) and there was a concern that the ideas the service have then come up with may have been based on a misunderstanding. Britta Klinck (BK) also asked for the paper to be reviewed as it seems to say we have already got the cooling system enhancement in other areas and Bicester was not included. It was raised that the family feel this has been taking quite a long time to resolve, approximately 3 years. From the outside it may look like the NHS is slow and inefficient. Charmaine Desouza (CD) wanted to ensure that someone is actively liaising with the family and help them to understand we want to spend the money wisely. We also need to apologise for the extended delay. JH advises that someone on the committee of the League of Friends should hve conversations with the relatives. ME advised that as the money is not with the Charity at this stage (and with the Bicester League of Friends) the Charity do not have any contact with the family. The committee were not happy to approve the request as they felt more work needed to be done in terms of the paper and estates work. The issues are not something the Committee can resolve in today's meeting. There needs to be a viable proposition, of a cooling system enhancement or otherwise, so that the money and be spent without any further significant delay. AL to review request/paper around Bicester air-conditioning. JPh will follow up with estates regarding quote etc for Bicester air-conditioning. Susannah Butt (SB) will speak to relevant heads of service about the issues and help to find an appropriate resolution for the gift to be utilised whilst managing issues around cooling/temperature, estates and facilities requirements and carbon footprint. SB will also link in with ME during these conversations. **ACTION SB/AL/JPh.** **Wantage Legacy Options**	

	Dorothy O'Dell (DD) presented the Wantage Legacy Options. For background, Wantage Community Hospital was a high-profile community hospital. In 2016 the decision was made to temporarily close the inpatient ward on the ground floor. It was felt there was a significant gap in terms of agreement from health services and the system, and the local community, around what the longer-term plan should be. After undertaking a significant engagement piece with members of the local community around what would be the best use of the space, as well as liaising with stakeholders and targeted public engagement, the decision was made by the Trust to permanently close the inpatient ward and have a commitment to a refurbishment programme for the ground floor to provide a range of clinic based services to meet patient need for the Wantage and Grove areas. The refurbishment programme will look at ensuring the greatest reach of services for local community needs. The programme includes some enhancements that have been identified from charity funding: • A changing places room • A digital suite • Art inspired by a wayfinding design around the hospital • Garden development. There has been a legacy left to the hospital pending the long-term plan and future. The Committee is asked to approve the report to allocate funding from the Robey legacy donation of £93,659 to the identified projects. Costs included in the report are the highest provisional value and will be ratified during detailed design and tender stage. The finalized amount can be shared at the next charity committee meeting in February, but support for the projects is required to enable tenders to take place. BK raised that the estimated £5,000 for the art did not sound enough, and it was suggested if the building costs are covered then any surplus money can be used to make a larger fund for artwork.. It was also advised that the Wantage Hospital League of Friends are match-funding the garden. The committee were happy to support the request, based on worst case financial scenarios, but with costing and specific	**SB /AL /JPh**

	financial approval coming to the charity committee in February. ME/CE to add to agenda for February 2025. **ACTION ME/CE.**	**ME /CE**
6	**Impact Reporting**	
	ME provided a summary of project and impact reporting. There were approximately 61 requests during the autumn period, which is the highest number yet, totalling nearly £100,000. ME advised she was not able to present the full outcome of the autumn application window as the fund advisors had not seen all the requests before the impact report paper was submitted. Whilst the majority of the requests were with the fund advisors for approval, ME shared that 11 have been approved and 5 have been declined. The requests were declined because they were outside of the usual process, outside of the charity's remit or declined by fund advisors. Ahead of today's meeting, the copy of the presentation provided to charity panel member was circulated, to give the Committee a flavour of the requests from this quarter. A summary of the requests include: • Gym renovation on Ashurst and Phoenix Wards • A Christmas Tree at Saffron House • Wreath making workshop for patients • Furniture and music equipment for Lucy's Room • Sensory support for waiting room areas • Create at Home art packs • A carers trip to Waddesdon Manor The next charity window, for spring, will be open from 13th January – 14th February 2025. Recent projects include: • A bespoke mural for Paediatric Assessment Area, Townlands Hospital MIU, Henley • Afternoon tea on St Leonard's Ward, Wallingford • African drumming workshops in Wiltshire • Attendance at Stroke Ed Training Course • A baby changing unit at Wallingford Community Hospital • Festival of Flowers at City Community Hospital Looking at social media presence, the Oxford Health Charity currently has 334 followers on X, 380 on Facebook and 452 on	

	LinkedIn. A number of NHS organisations have changed their use of X, as they feel it falls short of the values under which a platform like that should operate. Currently, Oxford Health's position is to continue using this platform. However, we are liaising closely with the communications team should anything change. It was also noted that the Oxford Health Charity are now on Instagram with 32 followers. The Committee is asked to note this information provided in the papers and discussion.	
7	**Fundraising Update**	
	ME provided a summary of fundraising and income generation. The Oxford Health Charity have been successful with grant applications from The Gardens Trust and Charlbury Beer Festival. They are under consideration for a grant from the Veterans Foundation. ME highlighted the work Chris Langridge had done in liaising with fundraisers for support to carry out challenges and create communication/promotion. Brush Party in September 2024 generated £336. Carol's Crafts and Concert for ROSY generated £2360. Oxford Half in October generated £10,000 with 30 runners. The Inflatable 5k Obstacle Course in Newbury generated £470. MV Kelly Ltd has fundraised £15,700 for ROSY as a corporate fundraiser. They have also pledged further support over the next couple of years. There is the opportunity to purchase Oxford Health Charity Christmas cards and hessian bags. Oxford Health Charity Christmas Cards (10 pack) | Oxford Health Charity Oxford Health Charity hessian bag | Oxford Health Charity The Lucy's Room appeal has made some progress. The official opening for Lucy's Room was held on 5th October 2024. The front area has now been finished and outdoor furniture safely secured. Inside has been partitioned, providing a larger room and smaller room. Sound proofing panelling, as well as an air conditioning unit, have been installed. Next steps for Lucy's Room include the installation of PIT alarms, furniture being purchased with charity funding, acquiring more musical instruments, a commemorative plaque	

	is to be created, and a proposal is being put together to hand the Lucy's Room over to the service. DW highlighted the delay between the official opening of Lucy's Room, and it is not yet handed over to the service. ME acknowledged this and a proposal to the AHP service was written by Julie Pink prior to her leaving, and the charity are awaiting a response. **ACTION ME** JPh will follow up with estates regarding the installation of PIT alarms. **ACTION JPh.** There is also the continued opportunity to use Easy Fundraising. Easy Fundraising partners with over 7,000 brands who 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. https://www.easyfundraising.org.uk/causes/oxfordhealthcharity The Committee is asked to note this information provided in the papers and discussion.	**ME** **JPh**
8	**Any Other Business/Close**	
	None discussed at today's meeting.	
9	**Date of Next Meeting(s)**	
	• Tuesday 25th February 2025 10am – 12.30pm • Thursday 22nd May 2025 10am – 12.30pm • Tuesday 23rd September 2025 10am – 12.30pm • Tuesday 9th December 2025 10am – 12.30pm *All to be held via. Microsoft Teams.*	

Attendance – Development Sub-Group

	Feb 2024	May 2024	Sept 2024	Dec 2024
Rick Trainor	✓	✓	✓	✓
Non-Executive Director (Chris Hurst)	✓	✓	✓	✓
Amelie Bages				
Britta Klinck	*Deputy*	✓	*Deputy*	✓
Kerry Rogers/Georgia Denegri from May 2024	✓	✓	*Deputy*	✓
Ben Riley				
David Walker	✓	✓		✓
Julie Pink	✓	✓	✓	
Michelle Evans	✓	✓	✓	✓
Michael Williams			✓	
Olga Senior	✓	✓		
Donna Clarke				
Donna Mackenzie/ Beth Morphy				
Zoe Moorhouse				
Learning & Development				
Jane Appleton/Comms		✓		*Martin Crabtree*
Mark Waring/Ellyn Carnall				*Jeremy Philpot*

Meeting of the Oxford Health NHS Foundation Trust
Finance and Investment Committee

Minutes of a meeting held on
Tuesday 12 November 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	Interim Chief Operating Officer for Mental Health and Learning Disability (**RB**)
Georgia Denegri	Associate Director of Corporate Affairs (**GD**)
Dr Ben Riley	Chief Operating Officer for Community Health Services, Dentistry & Primary Care (**BR**)
Heather Smith	Chief Finance Officer (**HeS**)
David Walker	Trust Chair (**DW**)

In attendance:

Grant Macdonald	Chief Executive (**GM**)
Brian Aveyard	Risk, Assurance and Compliance Manager (**BA**) – *part meeting*
Sue Butt	Transformation Director (**SB**) – *part meeting*
Mark Byrne	General Manager, Oxford Pharmacy Store (**MB**) – *part meeting*
Lindsay Fenn	Senior Programme Manager, Warneford Park Programme (**LF**) – *part meeting*
Nicola Gill	Corporate Governance Officer (**NG**) (minutes)
Alison Gordon	Head of Financial Management (**AG**) – *part meeting*
Jane Little	Head of Procurement (**JL**) – *part meeting*
Peter Milliken	Director of Finance (**PM**)
Jeremy Philpot	Interim Director of Estates and Facilities (**JP**) – *part meeting*
John Upham	Sustainability Manager (**JU**) – *part meeting*
Mark Underwood	Head of Information Governance (**MU**) – *part meeting*

Governor Observers:

Vicki Power	Staff Governor – *part meeting*

1.	**Apologies for Absence**	
a	Apologies were received from members and attending Board members: Amelie Bages, Executive Director of Strategy & Partnerships.	
b	The Chair welcomed all to the meeting and confirmed it would be quorate once David Walker, Trust Chair joined the meeting.	

2.	**Annual Planning & Budget setting** ***Annual Plan and oversight arrangements***	
a	The Chief Finance Officer presented the paper at FIC 64/2024 noting that Oxford Health had introduced a planning process, have improved it and are seeking to maintain a degree of stability for the team so they know what to expect and that they feel a sense of continuity and progress. It has been streamlined and kept simple. The paper shared about the annual planning process runs through key parameters of our approach this year and sets out the timeline and elements being considered. The clinical principles have been discussed at the Extended Leadership Team (ELT) meeting, so they are understood and known by all the different leaderships teams. She noted that this committee had not updated the Terms of Reference regarding the role in respect of planning and whilst it was agreed the Board were lead for planning this committee needs to have a high-level view to inform the financial planning work, we do otherwise it would be done in isolation from delivery.	
b	The Chair commented that she liked the key considerations and the clinical principles being used to guide it, her own reflection would be that it would be good to see how we can incorporate some of the learning from the ICB/cross organisation in this planning period. She also reflected that she did not see these priorities played out in the document we ended up with last year, so some thought about how at Board level we ensure we have sufficient clarity of oversight over strategic priorities as it so dense and would like this to be reviewed and revised in the in the next iteration. The Chief Finance Officer responded that conversations were taking place at exec around how we streamline the 14 strategic programmes and the 3 enablers for next year. The Chair commented that as a Board what is so strategically important, we need to ensure we have our eye on delivering and say what are the 3 or 5 things we want to make sure happen next year and how do we simplify Board oversight to ensure they are delivered. The Chief Finance Officer thanked the Chair for her feedback.	
c	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care spoke about the wound care App that the directorate were rolling out for the district nurses and community nursing which was a large priority for them, and this needed including in the plan.	
d	The Chief Finance Officer noted that the Mid-year review was an opportunity for the committee to challenge the progress made to date. The mid-year review has been presented in draft form to the ELT on 4 November and the document was in the process of being updated with comments received at ELT. There will be a final review by the Executive Team on 18 November in advance of the final version being submitted to Board on 27 November.	
e	The Chair noted her reflection would be that there was lots of good information, but it was very hard to look at our original plan and work out how successful we had been against those individual specific qualitative measures due to the density of the commentary. The Chief Finance Officer noted it needed overall assessment of how successful the trust had been, and this might be added by the Chief Executive. The Chair felt it needed to be line by line on each of the things we said we would deliver, how successful have we been.	
f	The Chief Finance Officer asked if the information on slides 15/16 worked better on the strategic programmes. The Chair felt those pages were helpful but there was insufficient detail for her to tie it back to individual objectives in the plan. The Chief Finance Officer noted that slide 35 onwards was the more detailed version of the document. The Chair felt the rag rating was helpful personally as it allows at a glance to see where the issues are but was surprised some were not red. The Chief Finance	

	Officer commented that they were not applying the standard of completely delivered in every aspect by year end which is what red would mean so this would be worth reviewing.	
g	The Chief Finance Officer agreed to feedback the comment that it was quite difficult to take from this are we delivering what we need to or not. In general, her view was that we were, and it might be helpful to note what key things are at risk.	
h	The Chair commented that if we had put something in the plan that was not going to be met then it should be red rated albeit with a mitigation that there were extremely good reasons why but if we agree a one-year plan up front she would have thought we were clear on delivery against that.	
i	David Walker commented that for the sake of running the organisation and knowledge of ourselves, more of a sharp edge honesty about what we are not doing, not able to do would make the document more useful.	
j	The Chief Finance Officer will feedback to the Executive Director of Strategy & Partnerships and discuss it further with her.	
	Annual Budget setting approach	
a	The Director of Finance took the paper at FIC 65/2025 as read noting that the budget setting approach had been changed significantly the previous year in terms of timetable and have followed a similar track for this year. The thing that drives us following this process is the nature in which our money comes in. More of an unknown going into next year in the investment side due to what might happen with Mental Health Investment Standard (MHIS) and System Development Funding (SDF) which have been stable and known in advance in previous years. Initial direction is this will continue in a similar form, but we do not know what will happen yet and may not until the full national guidance is issued. He spoke about efficiencies and noted the process was not hugely different to last year, we have set clearer steps of where it will go and how it will be approved. The system has been in an Investigation & Intervention (I&I) process with NHS England and one of the areas that has come out of this that we can strengthen is our CIP documentation and sign off processes, which we are aiming to do along with writing a formal CIP and Efficiencies Policy.	
b	The other area to flag in terms of our financial planning is where the system is and the potential impacts that will have on our planning. We are in the Tier 3 and a half I&I process and everything else with NHS England, our working assumption is the system will expect to get back to break even this year from a deficit and we will need to play our part in this so we need to prepare that the plan will become harder to achieve next year some of this will made managed through the efficiency programme. It is not a huge amount of change but what is going on in the background and the involvement of the System into our trust planning and budget setting will be different to in previous years.	
c	Discussion ensued regarding whether we were still in a regime of being commissioned even though we were led to believe this would cease with the introduction of the ICS. The Director of Finance felt although there was still work to be done in terms of the joint commissioning approach in the different sectors and was not operating in the traditional ICS way, but it was in a better place and was going in the right direction.	
d	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care spoke about Section 5 and the Cost Improvement Programme parts which describes the pro-rotaring out and where all that falls in the context of the shift into the Community and that strategic shift. It is a challenging scenario for community services when we	

	have not had any growth money for some time, there are opportunities to save money next year in terms of ward staffing, GP out of hours staffing model and the non-pay costs identified but would be stretching it to hit that target of £3m. Those areas highlighted are not budgeted spends, they are all overspends that are balanced out by other underspends elsewhere. The challenge is the big areas of savings may not be CIPS.	
e	The Chair noted the interventions recommended by the ICB in their PwC review make a lot of proposals around CIP management and radical change to how we manage CIPS and also more intentional how we look at them, if we know some contracts are underfunded compared to others is there the latitude for us to make more strategic decisions about how we allocate money that might address the CIP point.	
f	The Chief Finance Officer clarified that they had asked for everyone to illustrate 2% CIPS but no decisions had been made yet what they are for we are trying to make sure we have some room to make decisions and understand the consequences of that level of savings so that we can work through our negotiations in respect of it.	
g	The Chief Executive felt clear that we need to be the people responsible for the mental health money in the ICB. He had clarified with PwC that the areas in the I&I report suggested we would look at as good practice and consider some but a lot of them we will not do as they were off the shelf ideas and not trust specific.	
h	Discussion ensued regarding how we get the space in the budget setting programme to make intention decisions about resource allocation. The Chief Finance Officer responded they were thinking about ways of doing this.	
i	A**ction: The Chair requested a deep dive into CIPS take place at a future meeting.**	**PM/AG**
j	**The Committee noted the reports.**	
3.	**Financial Management** ***M6 Financial Report (incl CPSC 3As)***	
a	The Head of Financial Management took the paper at FIC 66/2024 as read and highlighted the key messages: • In M6 the ICS received non-recurrent deficit funding from NHS England, of which £2.6m has been allocated to the trust meaning our planned deficit is now £0.1m; • The significant change on the revenue position is that we are potentially forecasting £3.4m better than plan and have put this in as a balancing figure for unknown risks; • Still the risk of the PFI exit payment but it will likely hit capital and is unlikely to hit revenue; and • Capital is £1.2m underspend YTD but still forecasting a £1.6m overspend.	
b	The Chief Finance Officer noted that being given the additional funding does make it confusing, and set out some of the decisions made around M6. We are trying to make sure that we consider the pressing needs of our services and make sure any flexibility in our plans supports those, these are decisions already made and taken into account in saying that we can improve our plan by up to £4m if we wish to. We are making a head start on some of that community nursing recruitment, obviously that takes a while in year to build up pay spend so the financial impact this year will not be huge, but we are taking the risk that we get some funding next year but if we do not this will need to be reconsidered.	

	Small amounts have been made available for TRIM, the HR operational teams and anti-racism. Digital projects have needed a reasonable amount of expenditure in addition to progress various projects which we think will be beneficial and lone working devices is something that is a real concern to our staff so to spend money on getting devices set up would be useful. We are still looking at waiting lists in particular as something we might spend some more money on and also talking to directorates about ensuring they are not generating underspends unnecessarily.	
c	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care spoke about Southern Hub and that fact we were originally going to repurpose the Blackbird Leys building but having looked at the services that need to go in it is tight on space along with changes the Council are making to parking. Work has been undertaken with the estates team and directorate to look at alternatives with 9 different options nearby and a couple are favoured which will be presented to CPSC. There is also a GP surgery health centre that has become available nearby and might be a better option, so it is currently being worked up.	
d	The Chair spoke about the suggestion we hand money back to the ICB to help their underlying deficit position, principally being the £2.6m that we have been given as deficit funding to hand back to them and potentially a further swap from revenue to capital so to offer up another £1.3m of revenue saving in return for an additional £1.3m of capital which she felt we could be comfortable with. The Chair would have concerns as partly it undermines our messaging that we are significantly underfunded both in community and mental health sectors, we are putting in bids to ICS for separate funding to address known pressures which have been rejected yet with the other hand we are giving them money back. She would find that kind of narrative hard to explain.	
e	The Chief Executive noted the need to get to break-even and primarily doing that felt important and acknowledging the system was in a more difficult place. He commented that the Executive team were aligned with the Chair's comments and would not give any money back that could be spent usefully on our staff or the patients we serve and their families. We are in a slightly different place that says it is better to highlight that now than at the end of the year.	
f	The Interim Chief Operating Officer for Mental Health and Learning Disability felt the challenge for the directorate is to manage the message of CIP versus you have got extra money and something about how we get this message clear for the directorate so they know what they are doing and how they can spend money. He felt our planning and control allowed us to be a lot clearer earlier on in terms of what we can spend. His biggest challenge was how this get spent appropriately around the patients but without setting up expectations of things we are not able to sustain.	
g	The Chair felt the point around CIPS, and the messaging was spot on and there was a way to describe it which is about CIPS being about improving efficiency and effectiveness in order that we have money to create better outcomes for more people but the mechanism by which we drive this must support that ultimate aim.	
h	The Chief Finance Officer noted that due to PwC's work it was transparent to the ICB that we have money available in our forecast. She felt it would be difficult to walk away from a commitment to move towards break-even.	
i	The Chief Executive commented that we should agree this and use a small amount of money to get us to break even. We will do everything we can to have money to make next year as good as it can be for the patients we serve but we need to do this small initial part now and did not feel it could be deferred.	

j	The Chair was not comfortable with this but agreed it was the pragmatic decision and choice at this point but some kind of narrative around how we are making those decisions with the patient in mind needed to build around this.	
k	**Action: The Chief Executive requested that a list was put together of opportunities of outsourcing/insourcing for future conversation.**	**RB/BR**
l	**The Committee noted the report.**	
4.	**Financial culture and capability** ***Enabler: Our Central Teams and Corporate Services PID***	
a	The Chief Finance Officer presented the paper at FIC 67/2024 noting that the Annual Plan for FY25 includes as Enabler 2 a programme of work described as Our Central Support and Corporate Services. The PID for this was reviewed by Executives and updates at the initial programme board on 26 September. Initiation of this programme was paused until after the summer due to the Senior Responsible Officer's commitments to the BOB planning round. In the interim, teams have begun work on reviewing and reforming the three prioritised cross-cutting processes: i) hiring and onboarding; ii) temporary staffing and iii) buying things. These processes are deliberately described in terms not linked to specific corporate functions. Digital systems improvements are also underway in HR and Finance teams, the Estates & Facilities team are revisiting their model as a whole, IT improvements are being rolled out as part of Frontline Digitisation and the Digital team are improving the governance of the way they work with services.	
b	The Chair noted that there were no costs attached to the PID currently and how we resource this happening would be an important part of it. The Chief Finance officer responded that internal resource would be used to produce the dashboard in the first placed around surface quality and then will work with this to show improvements over time which is what we did with IPR. On costs she felt the support to go and spend money as she needs to but agreed it would be helpful to have an overview of costs.	
c	The Chief Executive commented that for him there was one indicator that was more important than any other, if a staff member goes on the staff intranet, they can see straight away how to navigate through it. We need to be aware of culture as we are asking our staff services to serve more and making people's lives simpler.	
d	The Chair commented that it was a very compelling message for people in support service to make it is a simplistic as possible as they are contributing to patient outcome, they are freeing up clinician time to spend with patients.	
e	The Chair asked what the proposal was for the PID. The Chief Finance officer responded that it was a work in progress, the governance for which was the Executive Forum who had not yet had the final version. After the next Corporate Services workshop, it should be taken back to the Executive Forum for final sign off. This programme is reported to Board every six months and the Chief Finance Officer asked when FIC might like to see it. The Chair commented it would be helpful to see it every six months prior to Board. Once there was clarity around the deliverables it could be brought to a FIC meeting.	
f	David Walker, having recently attended professional assemblies within the trust, commented that the energy had been excellent and asked suggested this for the corporate entity. The Chief Finance Officer acknowledged this was part of the	

	engagement workstream noting that firstly they had to get the leaders working together, then the team below that and then an all-staff type event.	
g	**The Committee noted the reports.**	
5.	**Programmes & Projects**	
	Warneford Park Programme update before articulation of value	
a	The Programme Manager took the report at paper FIC 70/2024 as read commenting they were still on track for the application on 31 March noting there was pressure on this timeframe. They were seeking from the committee if there was any other assurance they wanted to see and were they comfortable the right areas were being looked at in terms of requirements. The second public consultation is taking place the first week in December and the final design review panel with the council and architects is this week. They are reasonably confident that all items in their assurance plan will be green by the time they submit the planning application in March.	
b	The Chief Finance Officer noted the one significant issue arising out of the consultation is the question of whether we have our strategy with respect to the Highfield and Meadow Unit correct. We have had written confirmation from our partners this week that they are prepared to drop that area from the planning application, so the December planning consultation will not include an application for the southwest corner. This does not alter the COA, but it does provide more time to consider and validate the current assumptions regarding the future of CAMHS provision.	
c	The Chair commented that there was an option about legal brinkmanship about whether we can adjust the terms of the COA nearer the time. The alternative is we think about re-provision and asked if we were in parallel working up either re-provision as part of a broader estates strategy or thinking about whether the planning application needs changing to re-provide more space in the hospital etc. She felt there was some urgent decision making to be done on what the contingency position might be.	
d	David Walker commented that it was urgent to get the planning permission for what we currently had and would be an accomplishment.	
e	The Chair asked if one planning permission was secured did this activate the COA. The Chief Finance Officer responded it did not.	
f	The Chief Finance Officer acknowledged the need for a contingency plan. She noted that the earliest, if we had funding and planning consent achieved to make a decision about the COA was March 2026.	
g	The Chair commented that Rick Trainor, Non-Executive Director and lead for the Warneford Park Programme should take recommendations to the Board rather than FIC.	
h	**The Committee noted the report.**	
Break 10:55-11:05 (10 minutes)		

6.	***Update on articulation of value and costings analysis***	
a	The Chief Finance Officer took the paper at FIC 68/2024 as read noting this was an update to show the committee how it was evolving. She highlighted there was information within the report about a demonstration on the new costing tool that would be useful to undertake.	
b	The Chair commented that she found the attached appendix helpful and noted that translating this into something meaningful to people would be crucial to its success.	
c	**The Committee noted the report.**	
7.	**Programmes & Projects**	
	Projects oversight summary	
a	The Chief Finance Officer took the paper at FIC 69/2024 as read.	
b	The Chair commented that it did not include any figures. The Chief Finance Officer acknowledged this and commented that she wanted to check the approach was right for this paper before adding the figures. She noted that including Enabler 2 would make sense.	
c	The Chair noted it was striking that the document was not about major projects but major capital project and were it about project management oversight the list would look very different. She spoke about a point in the PwC ICS review about the likes of PIDS for CIPS and perhaps transformation more widely and where they are captured and asked what the proposal was to resolve that? Would it be taken offline to discuss at Executive and come back with a proposal for January.	
d	**Action: The Chief Finance Officer agreed to bring this back in January following Executive review aligned with the Terms of Reference Review.**	**HeS/ GD**
	Cotswold House Marlborough business case	
a	The Interim Chief Operating Officer for Mental Health and Learning Disability took the paper at FIC 72/2024 as read highlighting it covered the improvement works required at Cotswold House, some of the challenges of working in the PFI and outlines the risks we have with the Unit.	
b	The Chair sought clarification what it was that was driving this being an exceptional business case that was not included in the capital plan, was it ligature prevention work or refurbishment, especially when our capital position is already severely tested.	
c	The Interim Chief Operating Officer for Mental Health and Learning Disability responded that it was the ligature risk presented on the Unit and the need to complete the ligature work, inevitably some of this work will require some refurbishment but the primary focus is around reducing risk.	
d	The Chair commented that from the data the ligature risk seemed low and we have three rooms that accommodate where we think the risk is prevalent, and whilst it is important to do this across the site when compared with risk elsewhere in the trust how can we demonstrate that this risk is at the top of the list and requires funding outside what is already an overspent capital position.	
e	The Interim Chief Operating Officer for Mental Health and Learning Disability noted that whilst we did have the three rooms it was beholden on staff making the right decision	

	at the right time which puts a burden and challenge onto staff which is probably unachievable due to the nature of the work. Whilst it is an improvement having the three rooms in order to serve that patient population effectively and the increased challenge from this patient group the works are required.	
f	The Chief Executive commented this was a basic duty in this type of inpatient unit to eliminate these obvious in room ligature risks which was agreed a few years ago. When he joined the trust, it was one of his main concerns. This is a standout issue; they are a high-risk group who tend to self-strangulate and therefore only a small movement from that to a fixed ligature point we need to eliminate.	
g	Discussions ensued regarding whether this was a priority listing on risks and whether it needed to be undertaken this year and the reasonings behind this. It was noted that they appeared on the risk registers, were highly rated and reviewed at a high level of frequency. It was seen as urgent and the fact the decision was made over two years ago meant it should be carried out this year.	
h	**The Committee APPROVED the recommendation.**	
	OPS Banbury Warehouse post project evaluation	
a	The General Manager, Oxford Pharmacy Store presented the paper at FIC 72/2024 noting it included a post project evaluation for their relocation to Banbury and a case study outlining how they are collaborating with Royal Berks with their aseptic delivery service. He shared his presentation with the committee noting there was a six-month delay to the project and a 13% overspend, despite that the main benefits of the project were realised. Several learnings resulted from this both positive and negative.	
b	The Chief Finance Officer noted there was an outstanding action on this committee about learning more about our licence responsibilities and if content she will flag to Board members and offer the training in the regulatory requirements to any Non-Executive or Executive who would like to take this up.	
c	The Chief Finance Officer noted that a discussion had taken place at OPS Board about procurement and what could have been done differently and having a wider supplier base for the trust would have helped. The long-term answer is to have a strategic procurement approach. On benefits realisation we are seeking to realise the benefits and this report is stage one of that.	
d	The Chief Finance Officer acknowledged that the new templates did not currently cover benefits realisation, and they should do.	
e	**Action: To finalise templates, SFIs and CIPS to include benefits realisation.**	**HeS**
f	**The Committee noted the reports.**	
8.	**Information Governance put before Green Plan**	
	Information Management Group 3As report	
a	The Head of Information Governance took the report at paper FIC 75/2024 as read and highlighted the Toolkit changes which had shifted the focus to decision making and evidencing that. To have the risk owner chairing, fully aware of the risks that are brought to the IMG would be a good thing in terms of the toolkit and cyber assessment elements that go with it. This will happen once the substantive Director of Corporate Affairs is in post and acknowledged that in the meantime this had been well chaired by the Deputy	

  b c a b c	Director of Corporate Affairs and well supported by the Associate Director of Corporate Affairs. The Chair acknowledged this was a good point in relation to best practice and ensure the risk of not having a substantive chair be mitigated offline. **The Committee noted the report.** ***Integrated Information Governance Policy*** The Head of Information Governance presented the policy at paper FIC 76/2024) noting that cosmetic work had been undertaken and a paragraph had been added regarding the new arrangements of using Microsoft 365 on personal devices. The Chief Finance Officer noted that on page 7 there was information on sending emails, 'send secure' and thought it was implied if they include personal data for example, secure data but the policy states every email to outside email addresses should be sent secure which would need amending. The Head of Information Governance confirmed this would be amended. **The Committee APPROVED the policy.**	
9. a b c d	***Green Plan 1 FY24 update*** The Sustainability Manager presented the report at paper FIC 73/2024 noting in terms of overall position we have reduced carbon emissions to a certain extent but not met the southeast region target by a short amount. Primarily our carbon emissions have reduced by 3% over the last 5-year period, primarily due to energy reduction. Our carbon emissions associated to our business mileage has reduced from pre-covid period of 6million miles is now down to 4million miles. Energy consumption has stayed the same. The new Green Plan will set out the strategic approach over a 3-year period to reduce our overall carbon footprint and air pollution and ultimately improve healthcare outcomes. The new forward Green Plan 2 will set out the strategic commitments over the next 3 years 2025-2028 is how we will achieve and as an organisation get to net zero by 2040. The Green Plan will then feed into a BOB ICS Green Plan by the end of March 2025. The Chair requested that offline how we capture our progress against 2022 and to understand where we were against any SMART targets set and perhaps a rag rating of those areas met and those we might potentially miss. **The Committee noted the report.**	**JU**
10. a b	**Operational & Strategic Risks** ***BAF risk update: Sustainability*** The Chief Finance Officer took the paper at FIC 74/2024 as read noting the risk ratings had been kept at the same level and it had been updated but the substance of the risk was the same. The Sustainability Manager noted the next 3 years would be identifying hot spots across the estate in terms of energy consumption and building consumption along with our fleet, business mileage and staff commute. **Action: The Chair requested this risk be re-visited when the next Green Plan 2 was available.** ***BAF risk update: Major projects***	**JU/ HeS**

c	The Chief Finance Officer took the paper at FIC 74/2024 as read. The Chair queried whether the risk rating was correct, as currently rated at 16 and her sense was major projects now had much better control and oversight.	
d	The Chief Finance Officer explained the reason it had not been reduced it as there was still quite a lot in the pipeline to be decided.	
e	The Chair agreed it leave it unchanged for now.	
f	The Risk, Assurance and Compliance Manager highlighted that both the target dates needed to be considered going forwards.	
g	**The Committee noted the report.**	
11.	**Financial Governance**	
	Procurement Report incl Single Action Tender Waiver	
a	The Head of Procurement took the paper at FIC 77/2024 as read.	
b	**Action: The Chair spoke about the PwC ICS report mentioning procurement and strengthening this and requested whether in the next report there might be some reflection on these and where the opportunity might lie.**	**JL**
c	**The Committee noted the report.**	
12.	**Minutes of the Meeting held on 17 September 2024 and Matters Arising**	
a	The minutes at FIC 78/2024 of the Finance and Investment Committee meeting held on 17 September 2024 were approved as a true and accurate record.	
	Matters Arising	
b	The Committee noted several actions were completed along with the following matters arising:	
	Impact of FY25 capital plan revision	
a	The Interim Director of Estates and Facilities took the report at paper FIC 79/2024 as read.	
b	The Chair commented that it was helpful to be able to document that we had oversight on impact.	
c	The Interim Chief Operating Officer for Mental Health and Learning Disability had no specific concerns and hopefully going forwards we will be in a better position.	
d	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care noted the original problems still apply and wanted to flag that nothing had changed, and the case still stands.	
e	The Chair asked if these were all rolling into the next financial year. The Interim Director of Estates confirmed this was the case. He thanked Kelly Bark for her work on the report.	
	Operational analysis of reference cost variances	
a	The Interim Chief Operating Officer for Mental Health and Learning Disability noted that he had been working with both the finance and operational teams to understand this, there were some areas such as our talking therapy service where we do not think we	

	have counted the activity properly, there are some issues as some of activity is estimated because of our issue around data which will improve going forwards. Then there are issues where we have moved staff from other providers to us which has created anomalies. There are several issues that need to be worked on and as our data recording improves this should assist. He felt it was about how we support frontline services to understand and make sense of this and if it could be linked to a value conversation it would add for more.	
b	The Chief Operating Officer for Community Health Services, Dentistry & Primary Care noted the issue for them was they have a group of staff who work shifts across both the GP Out of Hours and Minor Injuries Units and our current systems do not yet have the functionality to automatically allocate the costs in the right place. The finance and HR team have been working on this and currently would have to be done manually, hopefully a solution will be found by December.	
c	The Chair commented this was first about the process before we can unpick what the data might tell us and asked the Chief Finance Officer if it was being picked up by her team which it was.	
	Jordan Hill – financial case review	
a	The Transformation Director took the report at paper FIC 80/2024 as read noting that they had promised to bring back the financial position to today's meeting which they had done and was articulated within the report. The headlines are they are working within the revised financial plan and so there are no additional issues to raise. This committee will have the proposed recommendations for South City Hub option to consider at its meeting in January.	
b	**The Committee noted the reports.**	
	Revised Terms of Reference	
a	This item was deferred until the meeting in January 2025.	
10.	**Any Other Business (AOB)**	
a	None.	
11.	**Brief reflections on today's meeting**	
a	The Chair requested any reflections on the meeting to be sent to her.	

Meeting close: 12:00
Date of next meeting: 14 January 2025 09:00 -12:00 via Microsoft Teams

Oxford Health NHS Foundation Trust

Finance and Investment Committee

Microsoft Teams virtual meeting

09:00-12:00 on Tuesday, 14 January 2025

AGENDA

Apologies to: nicola.gill@oxfordhealth.nhs.uk

No.	Item	Lead	Task	Paper	Time
Standing items / Opening business					
1.	Apologies for Absence, and quoracy check	LW		N/A	09:00
Annual Planning					
2.	Budget setting and Financial Planning approach for FY26	HeS	For discussion	Enclosed	09:05
3.	Emerging priorities (verbal update, paper to be circulated after the meeting)	AB	For information	Verbal update	
Financial Management					
4.	M8 Financial Report (incl CPSC 3As)	HeS/PM	For Information, Discussion & Decision	Enclosed	09:45
Financial culture and capability					
5.	FIC Terms of Reference	GD	For approval	Enclosed	10:20
Break 10:30 – 10:40 (10 minutes)					
Strategies					
6.	Frontline Digitisation/Digital Strategy update	AC/HeS	For information	Enclosed	10:40
7.	Estates Strategy update	JP/HeS	For information	Enclosed	
Programmes & Projects					
8.	Summary of programmes and project approvals	HeS	For assurance	Enclosed	
9.	Warneford Park Programme update	SC/HeS	For assurance	Enclosed	
10.	Community Services Transformation Programme: Oxford City Hubs (South Hub Blackbird Leys area)	BR/SB	For assurance	Verbal update	
Operational & Strategic Risks					
11.	Trust Risk Register (TRR) and Board Assurance Framework (BAF)	BA/HS	For assurance	Enclosed	11:15
12.	BAF 3.4 deep dive: Financial Sustainability	PM/AG	For assurance	Enclosed	

13.	BAF 3.7 deep dive: Ineffective business planning	LC/AB	For assurance	Enclosed	
Financial Governance					
14.	Procurement Report (incl Performance against the Procurement improvement plan, I&I recommendations and Single Action Tender Waiver)	JL	For assurance	Enclosed	11:35
15.	Trust Indemnity & Insurance arrangements	BC	For information	Enclosed	
Governance					
16.	Minutes of Meeting held on 12 November	LW	For approval	Enclosed	11:45
17.	Actions and Matters Arising	LW	For information	Enclosed	
18.	Any other business	LW			
19.	Brief reflections on today's meeting	All			
20.	Date of next meeting – 18 March 2025, in person, venue TBC				
Reading Room/Appendix (supporting reports to be taken as read and noted)					
21.	Capital Programme Sub-Committee minutes and agenda: September and October 2024		To note		
22.	Warneford Park Internal Programme Board minutes and agenda: October and November 2024		To note		
23.	Information Management Group agenda: January 2025		To note		
24.	Standing Financial Instructions updated and approved by Audit Committee on 03 December 2024		To note		

Meeting of the Mental Health & Law Committee

Tuesday, 15 October 2024
14:00-16:00 hours

Microsoft Teams Virtual meeting (invitation only)

Apologies to Leanne Dunkley, Leanne.dunkley@oxfordhealth.nhs.uk and Nicola Gill, Nicola.Gill@oxfordhealth.nhs.uk

AGENDA

1.	Welcome, apologies for absence and quoracy check *(defined as 4 of the membership to include at least one Non-Executive Director and at least one Executive)*	Chair	14:00
2.	Minutes of the Previous meeting (paper MH&LC 18/2024)	Chair	14:00
3.	Trends in Mental Health Act (paper MH&LC 19/2024) *To include updates on:* • *Mental Health Act Managers* • *CQC Activity/Compliance* • *Adequacy of guidance/training on MHA legislation*	MU	14:05
4.	Trust Risk Register update	KM/BA	14:30
5.	Patient Participation Group & Pals update	DM	14:50
6.	Mental Capacity Act & DOLS update (paper MH&LC 21/2024)	Amy Allen	15.00
7.	Mental Health Managers Story (oral update)	MU	15:10
8.	Recent adjudication affecting AHM's (oral update)	MU/KM	15:30

Any Other Business

11.	Any Other Business (oral discussion)	All	15:45
Meeting close			16:00

Date of next meeting: to be confirmed

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	✓			

MINUTES of the Mental Health & Law Committee meeting held on Tuesday 15 October 2024 at 1400 hrs via Microsoft Teams

Present:	
Geraldine Cumberbatch (**GC**)	The Chair
David Walker (**DW**)	Trust Chair
Karl Marlowe (**KM**)	Chief Medical Officer
Georgia Denegri (**GD**)	Associate Director of Corporate Affairs
Mark Underwood (**MU**)	Head of Information Governance

In attendance:	
Daniel Mercier (**DM**)	Associate Director of Social Work and Social Care
Mike Bellamy (**MB**)	Associate Hospital Manager
Charmine De Souza (**CDS**)	Chief People Officer (observer)
Leanne Dunkley (**LD**)	Corporate Governance Officer (*minutes)*
Nyarai Humba (**NH**)	Governor Observer

Item	**Discussion**	**Action**
1.	**Welcome and Apologies for Absence (GC)**	
a	The Chair welcomed members of the Committee and confirmed the meeting was quorate.	
b	Apologies were received from Amy Allen, Mental Capacity Act/Liberty Protection Safeguards Lead and Grant Macdonald, Chief Executive.	
2.	**Minutes of previous meeting held on 16 July 2024 and Matters Arising (DW)**	
a	The minutes of the meeting held on 16 July 2024 were approved as a true and accurate record.	
b	**Matters Arising:** **The Committee noted that the following actions have been completed:** • Correspondence to CQC regarding the capacity to consent to treatment. The Chief Medical Officer noted that the CQC is currently undergoing reconfiguration. The Chair noted that it is important that there is a paper trail with CQC as to where the burden lies in terms of the legislation; • The Mental health managers story is on the agenda today; and	

c	• Add the Mental Capacity Act and Liberty Protection Lead as a member of the Committee to the Terms of Reference. **Therefore, these actions could be closed**. The following actions remain: • Committee Chair to discuss offline with Deputy Director for Quality and Head of Information Governance to consider reports - to stay open. The Deputy Director of Quality has now left the Trust, and the Deputy Director of Social Work and Social Care will be producing these reports moving forward. GC and DM to discuss offline; • Ethnicity data on POHWER and VoiceAbility - reports today on the Independent Mental Health Mangers and moving forward this report will include an interrogation of the ethnicity data. The Associate Director of Social Work and Social Care added that the ethnicity data will improve over the next quarter with support from the Advocacy partners; • The inpatient mental health survey will be brought back to the Committee once completed by the Chief Medical Officer.	**DM/GC** **DM** **KM**
3.	**Trends in Mental Health Act (MU)**	
a	The Head of Information Governance took the Committee through the presentation, Trends in Mental Health Act report at paper MH&LC 19/2024, noting any key highlights and escalations to the Committee.	
b	The Chief People Officer asked for clarification as to what 'nearest relative discharge' is. The Head of Information Governance explained that this is unique to the Mental Health Act which follows a strict hierarchy, and relates to an individual's spouse, civil partner or blood relative, including grandparents, siblings and children, there is only ever one and it is the role of the approved mental health clinician who makes applications to detain people under a section 2 or 3 and occasionally a section 4 to determine who that person is.	
c	The Associate Director of Social Work and Social care added that the increase in nearest relative discharges could be following the recommission of the IMHA services, whose role includes informing patients of the rights of the nearest relative including the right to apply for discharge. The Chief Medical Officer added that sometimes patients' relatives experience difficulty in not agreeing to appeal the nearest relative discharge decision. This is despite the relative feeing strongly that the individual should stay in hospital, so often conversations are facilitated to allow the family member to voice their concerns, and the consultant is the	

	one who stops the discharge, rather than the relative, as often these will be the family members that the patient will return to which makes it a complex and challenging situation.	
d	The Chair asked whether the increase in nearest relative discharge is considered problematic or preferable, noting that it allows for the clinical team to be the "bad guy" rather than the relative and brings objectivity to the decision. The Head of Information Governance agreed that this does allow for objectivity, and it is an important check in the Mental Health Act and an important right for the patient and relative to have access to, overall, it is a good thing to see an increase and shows that patients are being made aware of their rights.	
e	The Head of Information Governance in response to a question posed by the Trust Chair noted that an increase in detention or duration of detention has not been identified following the recent national debate regarding the duties of Mental Health Trusts in public protection. An increase in public risk in individuals risk assessments has also not been identified. The legal interest test is with a view to the protection of other persons, when you get into the forensic elements where restriction orders are considered, as they require mental health services rather than going to prison, the judge will consider the crime committed and the character of the offender. Where a restriction order is issued, there is a slightly different judgement, whereby the risk of the person committing the same act again (and whether the public require protection from that individual), therefore those forensic orders have strong public protection through them, rather than the protection of others as the criteria and there has been no change in the Trusts figures. An increase in the number of people subject to forensic orders and admission to forensic services has not been identified.	
f	The Trust Chair noted that in day-to-day clinical practice, consultant psychiatrists may have shifted their thinking due to the potential consequences should something bad happen after discharge. The Chief Medical Officer added that Community Treatment Orders (CTOs) were not reducing in number, there has been a marginal increase in these, which are used for individuals who are considered a high risk to themselves or others, so there is the potential that there may be a decrease in these due to the reluctance of the clinician to issue them. This may also have an impact on tribunals and mental health managers hearings, as they may not want to take the potential risk of violence, based on weighing the evidence, so will need to monitor these along with detentions to observe any patterns. The Chair agreed and noted the need to monitor to look for any patterns or trends.	
g	The Chair asked if, in relation to the Mental Health Act managers meetings (some of which have been cancelled), it would be useful to have	

	insight into the reasons for the hearings not going ahead to consider avoidable common themes, as the number is increasing. The Head of Information Governance noted that no significant patterns have been identified and will include further detail to the Committee for the next report.	MU
h	The Chief Medical Officer noted that oversight of the CQC visits is important to monitor, as there are some outstanding overdue actions, which are likely estate issues. The other components of the visits are around empowerment, which will include the rights being read to the patient. The most recent CQC visit encapsulates Phoenix ward, Ruby and some of the other wards that are closely monitored. The Head of Information Governance noted that there are some estate issues due to the fabric of the buildings. The Empowerment issues tend to be around the difficulty of evidencing the provision of information rather than it not being provided, very often it is related to the section in RIO not being completed and occasionally that the information regarding the IMHA service.	
i	The Chief Medical Officer, in relation to a question posed by the Trust Chair, noted that the use of Oxevision is monitored in the Positive and Safe Committee and that it would be interesting to ask the committee how many patients do not consent to its use. The Head of Information Governance added that more people tend to opt in than out and it is used and maintains the process of doing this with consent, as opposed to other trusts who treat it as a medical device. This does generate freedom of information requests on its use, how we gain consent, and the materials used to support and explain its use to patients.	
j	The Chief Medical Officer noted there is a focus on inpatient mental health settings, as a provider of mental health services, should a patient manage to self-harm the Trust is responsible. It may be that the national picture is different to the Trusts as we have a different process for consent to have the Oxevision switched on. There is a national QI project that is being led locally by the Executive Managing Director of Mental Health and Learning Disabilities, which will consider changing our monitoring process as at present the timings of observations are not accurate which leads to legals issues for staff as they could be seen as falsifying records, due to not having an accurate monitoring system. It may be something that this Committee needs to take a position on. The Head of Information Governance commented that this was discussed in the Trust's Information Management Group. **The Committee noted the update**	
4.	**Trust Risk Register update (KM)**	

a	The Head of Information Governance noted that the mandatory training figures continue to improve and the first face to face specialist medical training, which was mostly focused on the Mental Capacity Act, was well attended and would support the removal of risk 1033 - Rollout of Liberty Protection Safeguards Training (as although this has been delayed indefinitely, the mandatory training for all staff is increasing).	
b	The Chair noted that, from the figures, the Trust is in a much better position than where it began with these training rates, increasing from 54% to 95% and thanked all staff that have been involved in achieving this. There was committee support for the removal of this risk from the register but need to continue to be vigilant.	
c	The Chief Medical Officer noted that the Mental Capacity Act and liberty protection safeguards lead has had a significant impact on achieving the training figure. The Chair agreed and commented that this needs to become systems based and embedded so that things do not deteriorate should an individual leave the Trust.	
d	The Associate Director of Social Work and Social Care added that supporting the Mental Capacity Act and Liberty Protection Safeguards Lead is part of the Safeguarding team's workplan. **The Committee supported the removal of risk 1033 from the Trust Risk Register.**	
5.	**Update on Independent Mental Health Advocate Service**	
a	The Associate Director of Social Work and Social Care took the reports at MH&L 20/2024 as read, noting any key escalations and highlights to the Committee.	
b	In response to a question from the Trust chair on the Trust's relationships with the voluntary and social enterprise sector, the Associate Director of Social Work and Social Care responded, noting it can at times be complicated by a slightly adversarial relationship. There have been complaints and safeguarding concerns raised from the IMHA service, so part of the work is to support those better relationships and mutual accountability. The IMHA have an important human rights role but need to ensure that they are using established processes to escalate concerns, which can be dealt with at unit level and escalated up as needed. The IMHA services have been invited to consider Patient Carer Race Equality Framework, as some of the standards talk about access to culturally appropriate advocacy. All partners are being asked what they are doing around this and there is a lot happening in relation to race equity. The providers have been very interested and have committed to exploring this	

	with us to progress this journey together, which will help to continue to improve relationships.	
c	The Chief Medical Officer added that the IMHA do not have full access to notes and noted that the Caldicott principles require confidential notes to be kept as such. Legislation says that IMHA should have access to the assessment, treatment plans and care plans so curios as to how this is being resolved.	
d	The Associate Director of Social Work and Social care noted that this is a complicated area, which could add to mutual mistrust with the IMHA services requesting access to notes and overlaps with the IMHA's need to gain access for service users. Following a recent meeting further work is ongoing to clarify what the law and to separate out the issue of subject access request and section 130b purposes access and how this will work practice regarding access and staff safety. The Associate Director of Social Work will be happy to bring the outcome of this work back to the Committee.	**DM**
	The Committee noted the update	
6.	**Mental Capacity Act and DOLS Update**	
a	The Mental Capacity Act and Liberty Protection Safeguards Lead was unable to attend the meeting, the paper was taken as read and no questions were raised.	
7	**Mental Health Managers Story**	
a	The Head of Information Governance introduced Mike Bellamy, who is a mental health act manager in the Trust.	
b	MB noted that following the tragic events that took place in Nottingham, which have generated significant public discussion, there have been a few cases that he has been involved in where it was marginal whether to discharge the person or not and that the Nottingham murders have impacted on staff decision-making. The next committee meeting will be considering some case studies for situations where the decision to discharge would be appropriate to see if there is a reluctance to discharge. This will be used as a development opportunity to consider sample reports to see which are good quality and which could be improved.	

c	MB gave a brief history of his journey with the Trust, which included being a non-executive member of the Board of Directors. After leaving the Board of Directors he continued as a Mental Health Manager as felt that there was more work to do to improve practice.	
d	He then went on to explain about what the panels do, noting that staff put significant time into writing these reports. He said that managers want to ensure that they are doing a thorough and professional job, along with patient's and relatives feeling that their concerns are being listened to, understood, and examined.	
e	Panels are there to review the evidence, probe for missing information and to hear from staff, patients, and their families before going into recess before coming back with the decision. There is a noticeable difference between the discharge rate for tribunals and Mental Health Act managers, which is something that is trying to be understood and to better achieve consistency of practice. Excellent support is given by the Mental Health Act Office who help in liaising with staff, organising the panels, and support with the write-ups. One of the biggest challenges is to get higher quality reports and discussions to support decision making.	
f	The Trust Chair asked whether it was essential that Managers are not employed by the Trust to have the distance to maintain assurance. MB responded that he did not feel it would undermine the ability to give a fair hearing or be a barrier if a manager were employed by the Trust but did not that a salaried Trust employee could have their independence questioned.	
g	The Associate Director of Social Work and Social Care added that the Mental Health Act office and Mental Health Managers do fantastic work. Considering the quality of reports, it is important from a patient's rights and accountability point of view that the report is clear in why the clinicians are arguing for the continuation of the detention, which can make the judgement complicated if the report is less transparent and clear. There is an interesting dynamic when considering the difference in discharge rates between tribunals and hospital managers as hospital managers have a scrutiny function, so have different rhythm making direct comparison difficult.	
h	MB noted that when a panel does make the decision to end a detention a different form is completed to the one completed to confirm the section should continue. It has been suggested that the form is reviewed to make it more explicit the grounds considered and where the panel sits on those different criteria, to show how the different parameters were addressed. The Head of Information Governance added one issue has been the length of some of the reports, particularly the psychiatrist reports that the	

	managers have to consider. There have been cases whereby tribunal doctors, who are considered independent, are employed by the Trust. If the word employee is used, then the legislation would need to be changed to reflect this in the wording. The rhythm of when managers meet to discuss discharge is an important consideration as it is driven by renewals and continuation of CTOs, so there are less appeals made to the managers than to the tribunal's. The Mental Health Act does not set any criteria by which mental health act managers make their decision, whereas the Tribunals have a large amount of legislation regarding how they make decisions which can be a good thing as it enables managers not to discharge in certain situations. MB responded that, as managers, the evidence is considered to reach a verdict that balances DOL against safeguarding the patient and others, within a well-defined framework.	
i	The Chair thanked MB for the enlightening discussion and asked, regarding the training that managers receive, whether there are areas that should be covered that aren't at present and whether there is any benefit for dual training for managers and tribunal's to be clear on the similarities and differences between the services.	
j	MB responded that they receive annual training, which covers the different Mental Health Act sections and the difference between them, including when as Managers they do not have the right to discharge. The consistency of report writing is something that needs to keep being monitored and discussed. The conduct of the hearings is discussed regularly, along with reviewing previous reports to identify what made it a good report helps to raise the standard and improve consistency. The Mental Health Act office does let managers know if they feel the report is lacking clarity or something has been missed. The Head of Information Governance commented that managers are valued in the mental health community. There are four business meetings a year with the managers which invariably all have a training content to them along with the legislative aspect, based on the managers' feedback.	
k	The Chief Medical Officer commented that Mental Health Act Managers and tribunals were set up not to be in an adversarial setting, especially with the context, which is not always apparent in the tribunals, but is much clearer in the managers hearings. He went on to ask whether it has been a common occurrence for Non-Executive Directors to become Mental Health Managers. MB responded that it used to be more common and at one stage there were 3 Non-Executive Directors who were Managers, however that pattern has fallen away due to the time constraints that Non-Executive Directors face. MB has liaised with the Trust Chair to lobby for Non-Executive Directors to become managers as it was helpful. The Trust Chair attends the meetings and updates the managers on Trust issues,	

	which is helpful and appreciated. The Head of Information Governance noted that the second longest servicing manager was a Non-Executive Director in 1994.	
l	The Chair added that the appeal to Non-Executive Directors should go out again and should be taken to Board to encourage Non-Executive Directors to attend these meetings. The Associate Director of Corporate Affairs added that she has only worked in one Trust where Non-Executive Directors perform the role as associate Mental Health Act Managers.	
m	MB added that if Non-Executive Directors do not feel able to make the commitment to be a manager, sitting in on hearings would be beneficial for them to improve understanding.	
n	The Chair thanked MB for time and agreed that sitting in on these hearings are highly beneficial in understanding what happens. **The Committee noted the update**.	
8.	**Adjudication affecting Associate Hospital Managers**	
a	The Head of Information Governance commented that a panel of solicitors is going to be consulted as it does change the perception of managers. If legal opinion regards managers as employees, the Mental Health Act will need rewording as at present it is explicitly written that they cannot be employees of the Trust for section 23 of the Act.	
b	The Chair clarified that this was a first instance decision, which could well be challenged and asked in relation to the timescale for getting advice regarding this issue. The Head of Information Governance responded that by the end of November advice should have been received.	
c	The Chief People Officer clarified that at present managers are not employed by the Trust, however they are paid by the Trust, similar to Non-Executive Directors and receive a number of resources such as a Trust laptop, training and indemnity. The Chief people Officer noted that this is model other regulators commonly use. **The Chair summarised that this will be something to watch and to share with the Committee once the advice is available, to consider the Trust's position.**	
OTHER BUSINESS		
9.	**Any other business**	

a	The Chief Medical Officer summarised the current position of the CQC for the Committee including the withdrawal of ICS inspections and review of the CQC structure, leadership and inspection approach. . The Chair noted this update and looked forward to further updates on the CQC.	
10.	**Meeting Review (ALL)** None	
11. a	**Meeting Close** There being no other business the meeting closed at 15:35 hrs.	

The next meeting is scheduled to be held on Tuesday 04 March 2025 at 09:00 hrs via Microsoft Teams

People Leadership and Culture Committee
Minutes of a meeting held on
Wednesday 16 October 2024 at 13:30
in Therapy Room 5, The Whiteleaf Centre, Bierton Road, Aylesbury, HP20 1EG

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**)
Emma Leaver	Service Director Community **(EL)**
In attendance:	
Joe Smart	Head of Organisational Development (**JS**) – *part meeting*
Brian Aveyard	Risk Assurance and Compliance Manager **(BA)**
Alison Bourne	Head of HR Policy, Reward and Projects **(ABo)** – *part meeting*
Jane Blacklock	Programme Improvement Manager - Temporary Staffing **(JB)** – *part meeting*
Sue Butt	Transformation Director (**SBu**) – *part meeting*
Rita Bundhoo-Swift	Freedom to Speak Up Guardian (**RBS**) – *part meeting*
Lianne Bowes	Freedom to Speak Up Guardian (**LB**) – *part meeting*
Jill Castle	Head of HR - Community & Corporate (**JC**) – *part meeting*
Vicky Drew	Deputy Head of Learning and Development (**VD**) – *part meeting*
Zoe Moorhouse	Head of HR (**ZM**) – *part meeting*
Alison Williamson	Deputy Head of Learning and Development (**AW**) – *part meeting*
Apologies:	
Andrea Young	Non-Executive Director (**AY**)
Grant Macdonald	Chief Executive Officer (**GM**)
Georgia Denegri	Interim Associate Director of Corporate Affairs **(GD)**
Heather Smith	Chief Finance Officer (**HS**)
Amelie Bages	Executive Director of Strategy & Partnerships (**AB**)
Becky Elsworth	Head of Learning & Development (**BE**)

1.	**Introductions and apologies** The Chair welcomed the Committee members. Apologies were received from Andrea Young, Non-Executive Director.	**Action**
2.	**Declarations of Interest** No interests were declared.	
3. **a.**	**Minutes of the meeting 10 July 2024** The Chair proposed the minutes of the previous meeting were noted as an accurate record.	
4. **a.**	**Action tracker and matters arising from the minutes** The Chair handed over to the Chief People Officer (CPO) to update on the open actions on the log:	

b.	**13e Workforce report.** This has been left open as the People Insights report will include analysis of data at a high level and Workforce data packs will be in the Reading Room for Reference.	**Closed**
c.	**14c EDI actions.** EDI work is ongoing.	**CDS/MP/JS**
d.	**4.f/8k Risk Workshop on Culture and deep dive on culture risk.** CDS to discuss with GD. As a holding position there in an update on the agenda on Enabler 3 so will be able to consider risks in relation to this. At the Executive Away Day recently Enabler 3 was discussed at length.	**CDS/GD**
e.	**1A 2.4 Retrospective Shift Management.** There is a substantive item on temporary staffing on the agenda as well as the independent report on Temporary Staffing arrangements including recommendations which will be reviewed.	**JB**
f.	**AC 53/2022 Mandatory training.** There is a substantive item on mandatory training on the agenda.	**BE**
g.	**11.0 & 12.i.** Both items to be kept open until updates have been brought on Mandatory Training and Supervision and Food Strategy. The Chair noted that the Food Strategy was an action inherited and the update was needed at the next meeting.	**BE/AB MS/CDS**
h.	The Chair commented that she felt there were actions to be done when actions are received from internal audit and which committee monitors these and would be useful for the committee to see what was coming out of internal audit. Who is monitoring to be resolved offline but requested a) PLS-related IA reports be made available in the reading room for Committee members and; b) a single list of all internal audit actions for the committee's information. The CPO noted that all internal audit actions in relation to temporary staffing had been completed. **Action: Noted for future.**	**All**
5.	**Managers & People budget (HS)**	
a.	Purpose – To seek assurance that managers are clear about the Trust's expectations and have appropriate support in place – defer this item to January's meeting.	
b.	This item was deferred to the January 2025 meeting.	
6.	**Update on the Enabler 3 programme of work related to Supporting our People and Teams (JS)**	
a.	Purpose – To assure the committee of target state the programme aims to bring about is identified and work programme is adequately resourced.	
b.	The Head of Organisational Development (HOD) took the report as read and highlighted the spider diagram in the report which allowed them to see quickly the elements of strength and weaknesses, with the elements around the 'Leadership model', 'Measuring and monitoring culture' and 'Visibility, Support, Engagement and Communications' scoring among the lowest. Twenty-six people provided input, but it resonated with what was being seen elsewhere around engagement and leadership. This data has been used to produce the agenda for the November meeting. The HOD also spoke about resources.	
c.	The Chair reminded the committee as an assurance committee they were not being asked to make a bid for resources but would leave it Exec colleagues in the room to take forward.	
d.	The CPO noted that the Executive were aware and had spoken about the resources required for this programme of work. The Chief Nurse (CN) noted that the challenge	

	would be making this meaningful for everyone in the organisation, it needs to make sense to people.	
e.	The Service Director Community (SDC) commented that for her it was about unpicking some of the staff experience, particularly where it might not have gone well and feed into this work in a meaningful way, making it tangible. The SDC acknowledged the need to be purposeful in how such information was gathered from staff.	
f.	The Interim Managing Director for MH and LD Services (MDMH) spoke about the need to keep this process simple in an un simple world, the simple thing is we all work in teams, and they must operate as a unit. There are many teams who may have different cultures, but they need to be questioning the framework and how they work. The team need to be expected and empowered to ask those questions about how they are working.	
g.	Discussions ensued regarding resources and the need to support teams along with the leadership programme and the need to look at how we support our junior leaders and teach them how to lead and focus on staff experience.	
h.	The Chair noted it was useful to see where we had got to and acknowledged that the challenge around resourcing has meant this had not moved at the speed we would have liked. She echoed that the complexity was at the wrong end and from lack of resource had not had the time to do the complex thinking which would allow delivery to the front line to be simple and this needed reversing. The Chair commented that she had picked up from the description so far that there had been some bottom-up work which was important. From her experience of culture work that is where one foot needs to be, the other foot absolutely must be in strategy – what is it we are trying to achieve as an organisation and what are the specific cultural assets that will allow us to achieve it. The Chair felt there needed to be an articulation of 'why is it kindness really matters.' As a moral value she agreed with it but what, from a corporate perspective, what value is it serving in achievement of strategic aims.	
i.	The HOD noted they were currently trying to frame this work on the People Promise which would give the framework that ties into the leadership framework and would welcome the opportunity to work with the Strategy team.	
j.	The Chair noted the next step in this work had been identified as a staff workshop in November and requested the Committee had sight of the roadmap showing the timeframe for actual completion of work.	
7.	**Deep dive into the People implications of the Community Transformation Programme (SBu)**	
a.	Purpose – • How does the Trust identify priority areas for transformation/what design principles are selected; and • What are we learning about our capability and capacity to bring about change.	
b.	The Chair welcomed the Transformation Director (TD) explaining that the committee had invited her along to give her experience of bringing about change during the Community Transformation Programme.	
c.	The TD shared her presentation which was a deep dive into the People implications of the Community Transformation programme with the committee. This programme commenced from Autumn 2023 when the Transformation Team formally came together (including x3 matrix posts of x2 HR and x1 Comms and Engagement). As well as aligning the direction of the programme within the directorate there was a large	

amount of work undertaken to ensure alignment to Place/BOB strategic programmes e.g. urgent and emergency care, SEND and community nursing.

d.

The TD spoke about how the design principles had been selected and explained that the Community Services Strategy work developed an agreed eleven principles in partnership with staff, teams, local stakeholders, and system partners that help to guide the programme. Draft transformation principles developed collaboratively across community and mental health programmes to foster alignment in the Trust. Close involvement in the Trust wide approach to improvement that is currently being developed in exploratory phase currently. A framework (design principles) for change and improvement is likely develop from this work.

e.

The TD highlighted the following points around what we were learning about our capability and capacity to bring about change:

- **Upskilling in large scale** cross service changes. Require significant external partner interface and/ or local community, public and political dimensions.
- Remaining **agile** around the **human aspects of change across the different workstreams** to lead, engage and support colleagues from individual to team level with delivery whilst ensuring the pace and technical aspects of strong programme management approaches or techniques remain.
- **Balancing** the financial position of the Directorate with the medium to long term strategic goals of the community services strategy
- **Prioritising programme resource** through collective review has enabled all to acknowledge the whole programme requirements. Flexibility in deployment to meet evolving needs and acknowledgement when capacity can 'come online' to support future workstreams.
- The importance of alignment with **Trust wide programmes** e.g. digital, capital; patient and carer experience and involvement; quality improvement; workforce plan to name a few!

f.

The SDC alluded to the challenge of engaging staff and the approaches that had been taken to assist this process.

g.

The TD set out the following points on how well we support our change agents:

- Senior Responsible Officer (**SROs**) for most workstreams are a clinical or ops lead with a **Transformation Lead** assigned to support
- **Dedicated HR posts** guide our organisational change and development of new workforce models
- **Communications and engagement** plan for each workstream:

- targeted engagement and leadership visibility with staff and teams
listening, responding, and working through change particularly with those who are more anxious
- involving staff to shape and inform the 'how' e.g. themed working groups, staff experience focus
- Some of our workstreams have 'change champions' to facilitate and promote the 'why'

- Regular sessions with the **FTSUGs** – forward plans and feedback shared to inform change approaches
- It is an allotment! Requires constant nurturing and attention

Development areas

- Just concluded an **NHS Elect bespoke Change Management training programme** - Transformation Team and Directorate's Heads of Service. Taking into practice including a possible OD approach to transformation
- Further alignment across **QI and transformation**

h.

GC asked about engagement and the interlink was to PDRs and how closely that was interwoven to allow tangible goals for staff. The SCD commented that she did not feel a good enough job had been done on highlighting the PDR season and the cascade of

	objectives. This had been discussed through the planning process and the need to be explicit on what was required. She mentioned it might be worth having an exploratory conversation around an organisational development approach, where we then might have competency stands within that which would dovetail into PDR objectives next year around a broad understanding/appreciation of transformation through to levels and behaviours that a member of staff should be working towards to become a responsible officer for a project.	
i.	The MDMH spoke about staff engagement and asked what clinical voices they were hearing and engaging as there was a risk of it becoming a lean methodology approach, how do we just make everything efficient versus the evidence and science behind it. The TD responded that broadly speaking the clinical leaders had been championing the change and it was more the middle-layer of clinical leadership that had the most anxiety around ways of working.	
j.	The CPO asked what the main barrier had been to drive the change and pace of the plan. She commented on Corporate Services noting the model for HR was good which had served the programme well. The TD responded that it was confidence, both in terms of execution and then cascading this confidence down to all in staff.	
k.	The Chair reflected the following: • The start well, live well, age well route which was BOB level and the way this can be used to combat the refuge staff can take in service fragmentation/silos as a way of managing their feelings of 'overwhelm'; inviting people to contribute to these overarching themes can be a way of overcoming this; • The need for common methodology, language and architecture and how are we building this into PDRs as she was not sure this had been achieved yet; • Corporate services question which was identified in an internal audit a few years ago through the Bucks services and is still there – would be good to think about this at some point as it looks like the transformation programme in CS has in part been successful by duplicating corporate structures; and • Systemic perspective – how do we build this into the training and development we are providing for staff and to consider the implications of this.	
8.	**Leadership development (BE)**	
a.	Purpose – progress update to include a timeline for anticipated review of work.	
b.	VD took the paper as read noting it was a work in progress with scoping taking place currently to develop the programme ready to launch in April 2025.	
c.	The Chair noted that the committee had discussed the adoption of the NHS Leadership Way framework recently and that the quality of leadership point was a recurring one. We know the quality of leadership is key to service delivery, quality improvement and staff engagement and retention. Research outside the NHS shows that at least 65% of people leave their job because of their immediate line manager so the more we support and improve that experience the better.	
d.	The CN noted that a crucial area of work was the leadership of the middle layer offering direct support and guidance. Historically we have focussed on teaching people how to be leaders and then assuming we have taught them how to do this so they can do it forever more, but the world is constantly changing, and we have not grasped the ongoing development and support for these managers. VD commented that they see it with the students and how they support the apprentices and how they use peer	

	support and how they embed the coaching skills between each other. We could learn a lot from the work we are doing with the universities and embed that with our staff.	
e.	AW noted that some of the CPD funding had been invested into more staff within the L&D department that are trained in coaching techniques so we will be able to open up the coaching offer which will support with some of the leadership programmes. Discussions took place around how we set up peer support and mentoring and the potential to use the group of experienced leaders to set up peer groups who could support staff. How do we draw on the experience of those staff who have undertaken the roles and can support staff.	
f.	The CPO noted the need to align this work with the sense of leadership in teams as in the Enabler 3 work we want teams to be able to lead together and show leadership qualities with each other. With the Enabler work going on in parallel she highlighted the April deadline might be delayed enabling them to run together.	
g.	The MDMH cautioned against an over-reliance on the delivery of skills through training programmes which require colleagues to be away from work and then struggle to implement the skills back to the job. We need to think about how to create learning opportunities that are embedded within day to day work and resource this properly.	
h.	The Chair reflected on the following points: • Challenge to the delivery mechanism made and thought needs to be given to this. An observation is we conflate the offer of something with the delivery of the actual thing. If we were able to wrap in a reflective learning process around the actual job rather than the delivery of an input, we may create greater uptake from people who feel they are too busy to be developed but would also allow us to target our resources differently. There is a serious challenge in the delivery mechanism and needs reflection; and • There is a lot of temptation to parallel process within directorates because corporate services feel a bit slow – something to be attentive too.	
i.	The Chair spoke about trying to move to a multi-disciplinary model noting she was not assured this was pointing us into true MDT, her challenge being: • The speed to which corporate are able to respond; • The delivery mechanism from L&D; and • The integration between medics and the MDT model. In particular, it would be useful to seek assurance that the leadership work being developed for medics and the wider leaderships work is aligned. **Action: Assurance the points made by the Chair be brought back to a future PLC.**	**BE**
9. **a.**	**Staff Safety – quarterly update (HS)** The Chair requested that Rob Andrews or a member of team be invited to the next PLC meeting to present the update with a focus on sexual violence aa well as violence and aggression against staff.	**NG**
10. **a.**	**Workforce transformation & pipeline (RB/EL)** Purpose – to determine: • What roles/services do we anticipate needed transformation either because of recruitment challenges, demand etc; • What is our timeline for developing some options; • How do we continue to identify such targets; and	

	• What are the design criteria.	
b.	The Chair commented that the committee is seeking assurance about work to look at the fundamental causes of workforce supply issues, and the levers within the control of the Trust e.g. can we look at the design of the work, the conditions of the work, or the role type that is undertaking the work. Such an approach is necessary because every quarter we look at the same picture in some services on vacancy rates and we know these are difficult to recruit to posts. We are shifting our performance around recruitment and retention, and we are doing some innovative work around our pipeline and hopefully as BOB finds it feet more firmly, we will work together with partners to amplify supply routes. In the meantime, we have posts we cannot recruit to so we need to look at what is within our gift to impact on this issue.	
c.	The MDMH presented slides based on work being undertaken already. He noted this was a huge and ongoing challenge and found it difficult to find one place to capture it and present it. He spoke about the work that happened in Community hospitals around developing overseas staff which had an enormous impact on their vacancy rate. The biggest change in mental health was how they look at agency and they are now seeing people coming over substantively. In Bucks he is asking medics to look at their skill mix as this was the area with the largest long line agenda for change agency. They were doing this work but not in a way that just talks about transforming the workforce, they were doing it by service line in a way that tries to identify services where these changes can be made. Alongside this there are ways we need to challenge ourselves around some of the digital agenda issues, how we spend less time in front of a computer or writing things to provide us with the data and information and spend more time facing patents. There is work happening in both community and mental health with our electronics systems around making them make sense from a clinical perspective as well as from an IT perspective and trying to get this balance right.	
d.	The Chair requested that a further conversation take place in January using the Mental Health slides from the data packs from this meeting to inform the discussion. To also discuss and make explicit our process.	**MS/CDS/ RB**
e.	The CPO concurred with the MDMH that the staffing issues were being looked at through different lenses. She noted that regards temporary staffing we were better than plan at M6 and if recommendations were implemented the whole lens of temporary staffing would be more stable and will come into HR. By that point longline agency will have been reviewed also.	
11.	**Deep dive: Training & Development. How is budget allocated. How is it aligned to Trust Strategy (BE/AW)**	
a.	Purpose – to include corporate staff training – the inappropriate matrices issue has been identified and we need to allow time for staff training and to put our staff in the position of mandating an activity but then not making it possible for them to comply. It was also agreed that the original ask for this paper was to understand how we spend the totality of our Training and Development budgets and not just CPD element. The Chair noted that this paper provided a good start and that we would still need to look at the total picture in a future meeting.	
b.	AW took the paper as read noting that over the last year they had changed the way they looked at CPD funding. The paper covered funding from NHSE for CPD for nurses and AHPs only. Summary data is presented on the themes for funding requests and the agreed top-slicing of funding to support more cost-effective approaches and strategic priorities for multiple professional groups. The next steps to continue to improve the internal processes include establishing an education/training forum in each Directorate, guides for managers on scoping CPD needs and the consideration of how CPD needs for other professions can be supported.	

c.	The Chair commented that between this paper and the annual educational report we had a good overview of how the process was working. She noted that as a committee what they needed to see was what the total training and development budget was and how it was aligning with the achievement of the trust strategy and its annual plan which could be brought to a future meeting.	
d.	The MDMH found it a helpful and transparent report and asked how the split between community and mental health services was decided. AW responded that it was decided on percentage head count for nurses and AHPs only. **Action: Add to forward agenda**	**NG**
12.	**FTSU. Detriment and Impact update (RBS/LB)**	
a.	The FTSUG took the report as read noting the paper was brought to the committee for information and provide clear guidance on detriment staff may suffer as a result of speaking up. RBS noted that Guardians from across various regions collaborated to develop a guidance document to support staff. This guidance was further adapted and finalised to align with Oxford Health values with a clear process. The guidance was endorsed by Trust Executives and has now been uploaded to the intranet.	
b.	AY, the Lead NED in her written comments on Committee papers shared that she had recently had the experience of someone bringing a case where they felt they had suffered detriment during which the new guidance was used. Her feedback was that the guidance triggered the appropriate response. AY commented that it was strange that some referrals to FTSUG came directly from HR and wondered why that was. Separately discussions had taken place at the Executive meeting this week to accelerate work to have a single policy for whistleblowing and speaking up.	
c.	The CPO highlighted that the Government had announced a review of Patient Safety and within this review the National Guardians Office is included through the lens of Patient Safety.	
d.	The Chair spoke about the triangulation of data with the employment report and wondered from a staff perspective if it was clear where to begin a process as there are so many access points. Was there a way of testing this.	
e.	RBS responded that when the pulse survey was undertaken in the previous quarter they specifically asked if people understood what the different routes were for speaking up and where to go. The survey highlighted within our trust there was a good understanding of the different routes and how to navigate through them. What they see	
f.	and becomes confusing sometimes is when people have been to different avenues and either their expectation has not been met or the outcome not as expected the fallback is they come to the FTSUG to look at it and their role is to listen. It is important to highlight the different routes for staff.	
g.	The Chair thanked the FTSUG for their work.	
h.	RBS reminded the committee that it was Freedom to Speak up month and all activities relating to this were on the website.	
13.	**Deep dive: Stat and Man training – Outliers specific updates (BE)**	
a.	Purpose – specific area of cous – directorates and types of training still not at 95%.	
b.	The Chair noted that the committee had taken a keen interest in Statutory and Mandatory training over the last couple of years and stated it was a credit to all the teams that the trust had moved from about 60% to well over 90% in most areas, a remarkable achievement. She went on to congratulate the thoroughness to it and were supporting what the Healthcare Financial Management Association (HMFA) describes	

c.	as a culture of compliance. The committees ask for the report was information on the outliers. The Chair asked if there was a report going to Board for resus training. The CPO commented that work had been carried out on resus training over the last month. This was two-fold, the CEO has asked service directors to propose a plan of how they will reach 90% resus by the end of the financial year. Separately the Executive reviewed a paper this week looking at the barriers which have been identified for resus training. There was no plan to bring to Board and there was now a significant grip on this training. The Chair asked if the target delivery date of 90% was the end of the financial year and CPO confirmed this. The Chair commented that if this was the case then PLC should review this at the meeting in January to check progress and the likelihood of reaching that target. **Action: to bring an update to the meeting in January to review progress on the target.**	**BE**
14. a. **b.** **c.** **d.** **e.** **f.** **g.**	**Education Quality Report (BE)** Purpose – to provide annual assurance OFSTED statutory requirements as OHFT is a provider of education. The Chair noted this report provided a good insight into the process and evidenced the excellent work being undertaken. The Chair asked when course numbers were provided it also includes the number of staff, so we are less provider focussed and more customer focussed. At some point a sense check of when we are training for new competences, what is the process to make sure that there are jobs and functions that are going to be acceptable to clinical colleagues as we are spending money on the input but then not able to benefit. AW responded that was behind the decision this year to pause any more advanced clinical practice provision until this had been resolved and was currently reviewed. The CN spoke about the future development of the simulation training and would be good at some point to see the strategy around this. VD responded that they had 2 SIM fellows who had just started with the team. The Chair acknowledged that there had been conversations about the requirement for a workforce strategy and the difficulty of being able to create headspace here. She spoke about a clinical transformation strategy from which you would derive the workforce transformation strategy from which you would derive the L&D strategy. What we have are the last two and not the first one. She understood that when the new plan was delivered next year, we would have our own clinical strategy at which point we can have a sensible workforce strategy, but it was worth acknowledging that this was a risk. The CPO noted that workforce planning will be a function of HR but have no resource attached to it and it will take some time to identify the resource required to undertake both workforce planning and look at the strategy we need around delivering this. **Action: An update to be brought to the next meeting on when we will have a workforce plan in place and what can be achieved in the meantime.** GC questioned the learner cohort rates on the EDI front were low and was there any particular reason why or anything we needed to be concerned about. VD in terms of staff they were getting through on the cohorts they had no control over who was being suggested. They want to do a piece of work to understand how services are allocating places. The CPO noted we did not have a disproportion on our WRES data for accessing training there is equal access to all.	**CDS**

15.	**People Insights report (AB)**	
a.	Purpose – to provide assurance on key people performance activities, and to be assure the Trust is able to identify and respond to emerging and current issues.	
b.	The Chair congratulated the Head of HR, Policy, Rewards and Projects (HHRPRP) on how the report was developed and noted that it made sure the committee was aware of our national and regional developments and understood that application to the trust and that we were looking at the data we produced and attempting to triangulate it and identify any key issues.	
c.	The HHRPRP highlighted that we talk about removing our Probation Policy in this paper, which is a positive, however some things they did not anticipate coming out of the Employment Rights Bill and from the government might change this. There had been helpful guidance released today around Sexual Safety at Work. This was the second iteration of the report which is designed to draw together priorities which are set nationally, regionally, or locally and show them against the insights we are able to draw from our own data. The HHRPRP noted that she was trying to show both the performance against target and the trend in performance. This report was still a work in progress and would welcome feedback.	
d.	The Chair requested any comments on the structure to be sent to herself and the CPO offline.	
e.	The CPO commented about the need to be realistic about the volume of change which will come down from the top as we were only at the start of a new government and what does this mean for us as a trust and the agenda setting for this committee. The MDMH suggested this be picked up in an agile way, perhaps on a similar line to the report that goes to Board on the latest Legal, Regulatory and Policy information.	
f.	The Chair asked about the removal of probation and sought assurance that related processes had been managed in some way. For example, the completion of the care certificate is tied to passing probation. Have we identified the interdependencies and mapped them out. The HHRPRP confirmed it was a work in progress and nothing would be done until those issues had been sorted along with contracts being compliant. There would be a clear plan in place within the next four weeks. The Chair asked if this would be going through the People Steering Group (PSG) then to Board. The HHRPRP confirmed it had been through the correct governance process.	
g.	The Chair spoke about the disparity in the pay offers being stark and was that playing out in the staff group. The CN felt there was more playing out around the political messaging currently which was affecting morale. At CNO they have been driving positive messaging. Many nurses were not happy with the pay deal, and it was interesting that UNISON drove the acceptance rather than the RCN. The HHRPRP noted that the disparity was not something that was being talked about in her regular meetings with UNISON.	
h.	The CN asked about the use of BAME through the report as she understood we were using the term Global Majority now. The CPO responded that a terminology guide was being brought to the EDI Steering Group and a decision had not yet been taken on this.	
i.	The Chair asked the SCD and MDMH if the report was alerting them to emergent areas of risk, was it doing something useful. Both felt the report was useful and gave clear information in an objective and transparent way.	
Break (10 mins)		
16.	**Employee Relations Annual report (JC/ZM)**	

a.	Purpose – to provide annual assurance on actions and interventions in relation to HR casework.	
b.	The report was taken as read.	
c.	The CPO shared AY's comments that it was a good snapshot and transparent to share with the wider audience and focussed in on what HR support was required to have a flowchart or appropriate training for managers to de-escalate issues before they become a formal grievance.	
d.	The Head of HR (HHR) spoke about the new policy which was now called the Civility, Respect and Resolution Policy which would encompass the disciplinary process. The expectation is that there is much more thought at the beginning of a process going into what somebody has done, what other people were involved, what impact did it have and a much broader view of the situation before any decision are being made including a focus on learning and is it more about someone needing training or more learning for the team. This will hopefully reduce the number of cases.	
e.	The Chair noted that during a site visit that morning a manager had spoken highly of using the new policy and how positively it had been received. The HHR noted it also reduced the harm to people.	
f.	GC spoke about the title from a legal perspective and felt that having disciplinary in there was important because in terms of following through process whether it is to suspension or dismissal it is important. She also asked whether the informal process included mediation. The HHR responded that it can do, and that mediation was more often used as an alternative to a grievance.	
g.	GC observed that there was still a disproportionate number of BAME staff in terms of suspensions and dismissals. The HHR responded there was a constant focus on this. **Action: The Chair requested that for the next report the total number of disciplinaries and the percentage total number of disciplinaries for that directorate to understand if we are seeing the proportionate number of disciplinaries for the size of the workforce per directorate.** **Future Analysis with FTSU colleagues.**	**JC/ZM**
17.	**Wellbeing Guardian Responsibilities Report (JS)**	
a.	Purpose – to provide annual assurance to the Guardian and to the Board that the organisation understands its Wellbeing obligations.	
b.	The Chair noted she was the Health and Wellbeing Guardian and thanked the HOD for the report commenting that it was helpful to see all the information in one place.	
c.	The HOD noted that it was a two-part report, one giving an update on guidance and the other benchmarking using the hospital framework data. He flagged that the Health and Wellbeing team had asked for more of a link with the Chair and CPO if that would be helpful for them.	
d.	The CPO commented that it was a difficult area to keep on top of in terms of the national picture as they have switched their emphasis on what the want trusts to deliver but nonetheless if you all at all of the efforts being taken to make it a better, safer place to work is a good one compared to our BOB neighbours.	
e.	The MDMH felt there were good things happening, but his challenge would be if he were a staff member in team X would be how does he navigate through all of this on our systems. How do we make it simple for staff to access and see what is happening. We need to challenge ourselves about the accessibility and navigability.	

f.	The HOD acknowledged this point and responded that there was a wellbeing wheel with a QR code that can be scanned from any phone. This can be taken from the poster. Although this is one element of making it accessible but the engagement and reaching all is high on his radar and something that requires work 'as if you don't know you don't know.' The MDMH felt that as a frontline manager he needed to know just enough about everything to be able to signpost staff correctly and it was a challenge. The SCD noted the challenge of engaging with their staff that work in the out of hours, how do we engage our whole workforce tangibly. The HOD commented that this is where they need to work hand in hand with Communications.	
g.	The Chair commented that the committee can take assurance that there is a wide range of activity taking place across the nine domains. Where there was less assurance was around the take up on these things and would like to see this included in the next report. In addition, the report cites the triangulation of data as a way of understanding and assessing risk and planning activity but there is no evidence of the triangulation within the report, and this should be added.	**JS**
18.	**Strategic and Operational Risks (HSm/BA)**	
a.	Purpose: to provide a summary paper of changes to risks.	
b.	The CPO highlighted the volume of work currently being undertaken on the Trust Risk Register and the high-level risks. The Chair made the following comments: • **BAF 2.3: *Succession planning:*** The Chair noted there were aspects of this risk that would be better expressed in **BAF 2.6 *Adequacy of Staffing***; *i.e.* ***a)*** L&D to focus work on training with areas of the poorest compliance and **b)** PDR (these are most likely as they relate to Adequacy of staffing rather than Succession). • **BAF 2.6 *Adequacy of Staffing*** is too focused on HR and as such is not adequately identifying the risk. It needs to be broadened out to encompass more of the NHS / Trust Workforce Plan, particularly the Reform elements to support the 'left shift', MDT and whole pathway working.	
c.	The Chair requested that both **BAF 2.3** and **2.6** were updated accordingly. **Action: The Chair requested a more in-depth review of BAF 2.6 Adequacy of Staffing at the next meeting drawing towards the new government stance on both NHS broader reform and employment legislation changes.**	**BA**
19.	**Temporary Staffing update (CDS/DW/JB)**	
a.	Purpose – to ensure the committee is assured that: • Confirmation of the ceiling target set by NHSEI and the directorate agency targets that have been set to comply with the ceiling target • underlying dynamics of Agency use increasingly understood and improving strategies to address • Performance against plan being managed and course corrected • Interdependence with other Trust initiatives identified • Focus on reduction of long lines of Agency and related actions • Overview of NHSP Improvement plan	
b.	The CPO presented the paper noting the Trust is £1.4m better than plan year to date and at M6 this will be £1.7m. Work has continued to migrate agency workers to bank and/or to substantive roles. The number of long lines of agency continue to decrease and Directorate Agency Control Panels provide oversight and control. Agency line of work have reduced from 250 in January 2024 to 97 as of 23 September 2024. Bank fill	

	rate is about 70% but she felt this could be 75% by the end of the financial year. In terms of NHS Professionals, we are resetting what we are doing with them, bank fill rates have gone up and there are still problems with their quality of service, but they are still yet to fill all their positions which has taken longer than anticipated. ID Medical have two contracts with us medical and Agenda for Change agency. On Agenda for Change rates are being brought down to the southeast ceiling and reducing the overall usage. She highlighted that in the reading room there was the report from the temporary staffing collaborative, the focus now will be on delivering the recommendations from that report.	
c.	The MDMH highlighted embedding the processes within the directorates for agenda for change which has had a massive impact. They own it now and they understand what they are driving where previously they felt quite challenged by this. It would be fair to say that medical is a few steps behind for a whole host of reasons. They were addressing the issues with medical, and work needed to be done on retaining their workforce.	
d.	The Chair noted the progress over this period was significant, and the external review offered significant additional assurance. She noted that engagement with the Southeast temporary staffing collaborative was positive and welcomed the openness with which the team had engaged. **Action: The Chair would like to have a comparative view of our BOB colleagues within the report.**	**CDS**
e.	The Chair commented that our engagement with the Southeast temporary staffing collaborative could have started sooner which would have resulted in quicker progress and an earlier realisation of the benefits. She felt there were things to reflect on as a trust and what lessons had been learnt. The CPO responded that these conversations had started, and assurances could be given at executive level they were putting in place conversations and time to have more frank discussions about areas that are jointly owned, and cross cutting and we would learn why this had not been done previously.	
20.	**Vaccinations update (FLU/COVID) (BK)**	
a.	Purpose – to provide annual assurance of arrangements that are in place.	
b.	The CN took the report as read noting one of the challenges was getting enough vaccinators. They were challenged on a number of areas and had decided to try and push hard to say it is now or never as there will be no clinics after Christmas. They were also using incentives and freebies at clinics. She also spoke about vaccine fatigue and people's mistrust of authority and conspiracy theories being spread which did not help.	
c.	The Chair acknowledged the uphill struggle and asked colleagues to be curious about what happens in other context and see if there is any learning that can be added to the already good practice.	
21.	**PLC Workplan**	
a.	This paper was available in the reading room.	
22.	**Highlight/Escalation Reports**	
a.	Nothing to escalate on these reports.	
23.	**ER Casework review Report**	
a.	This paper was available in the reading room.	
24.	**Workforce Report – Data packs**	
a.	Nothing to escalate on these reports.	

25. **a.**	**AOB** None.	

NHS
Oxford Health
NHS Foundation Trust

People, Leadership and Culture Committee
Tuesday 21 January, 13:30-17:00, virtual via MS Teams

Agenda

Item no:	Item:	Action: (for approval/ information/ assurance)	Paper / Reading Room/ verbal	Presenter:	Time:
1	**Welcome, introductions, apologies and quoracy** Apologies: None received Observers: None		Verbal	**MS**	**13:30**
2	**Declaration of Interests**	For assurance	Verbal	**MS**	
3	**Minutes of previous meeting on 16 October 2024**	For approval	PLC 03/2025	**MS**	**13:35**
4	**Action tracker and matters arising from the minutes**	For assurance	PLC 04/2025	**CDS**	
	Matters arising - actions/updates from previous meeting				
5	**OD Strategy – first steps to identifying what needs to be included** Update on workshop [to follow update on approach and timetable]	For assurance	*RR/App 21(i)-21(iii)/2025*	**CDS**	**13:40** 5m
6	**Leadership development** - How can we be assured there is alignment between the leadership programme for AfC and the leadership programme for medics - Delivery mechanisms	For assurance	*RR/App 21(iv)/2025*	**BE**	**13:45** 5m
	Improvement and transformation				
7	**How do we support MDT leadership trios in directorates** - Understanding of what they are and how we support them	For assurance	*RR/App 21(v)/2025*	**KL/BK**	**13:50** 10m
8	**Managers & People budget (Assurance of Managers discharging their budgetary responsibilities)** • Financial culture • Integration with Enabler 3 • How managers operate within their delegations	For assurance	PLC 08/2025	**HS**	**14:00** 10m
9	**Health & Safety** - Annual report - H&S Internal audit	For assurance	PLC 09(i)/2025 PLC 09(ii)/2025	**HS/JP**	**14:10** 10m
10	**Staff Survey Results**	For assurance	Verbal	**BM**	**14:20** 10m

11	**Equalities update** - Gender Pay Gap - Ethnicity Pay Gap ***EDI update*** - Update NHS England EDI improvement plan - Update on 3 QI race equality projects	For assurance	PLC 11/2025	**MP**	**14:30** 10m
12	**Workforce transformation & pipeline:** To seek assurance: - What roles/services do we anticipate needing transformation either because of recruitment challenges, demand, etc - What's our timeline for developing some options - How do we continue to identify such targets - What are the design criteria	For assurance	Verbal	**BK/RB/EL**	**14:40** 15m
13	**AHP Strategy** - Trajectory of delivery of strategy and progress report on the trajectory	For assurance	PLC 13/2025	**BK**	**14:55** 15m
14	**Deep Dive: Social Workers** - an overview of the profession within OXH - how many, in which services etc - Strengths, Weakness, Opportunities and Challenges/Threats - The key things they want to work on over the next 12-18 months with indicative timetable - Anything else they want to raise to the Committee		Presentation	**BK**	**15:10** 15m
15	**Training budget and strategy alignment** - An understanding of whole Trust view of budget	For assurance	PLC 15/2025	**CDS/BE**	**15:25** 10m
16	**Deep dive priorities - top rated area/team on early warnings dashboard**	For assurance	Discussion	**CDS**	**15:35** 10m
	People insights				
17	**People Insights Report** Associated risks: -Succession planning, organisational development & leadership development (BAF 2.3) -Workforce planning (BAF2.1 / TRR1020) • To provide assurance on key people performance activities, and to be assured the Trust is able to identify and respond to emerging and current issues.	For assurance	PLC 17/2025	**AB**	**15:45** 10m
	BREAK				15:55 (10m)
	Assurance				
18	**Strategic and Operational Risks** • BAF 2.6 Reform element – review of controls	For assurance	PLC 18/2025	**HSm/BA/ CDS**	**16:05** 15m
19	**Bank & Agency staff** - assurance on the controls we rely on from suppliers re fit and proper, training; how we seek their feedback as not captured in staff survey	For assurance	PLC 19/2025	**CDS/JB**	**16:20** 10m

20	**Temporary Staffing update** Associated risks: -Retention of Staff (BAF 2.5 / TRR 1146) -Recruitment (BAF 2.2/TRR 1019) To ensure the Committee is assured that: • Confirmation of the ceiling target set by NHSEI and the directorate agency targets that have been set to comply with the ceiling target • underlying dynamics of Agency use increasingly understood and improving strategies to address • Performance against plan being managed and course corrected • Interdependence with other Trust initiatives identified • Focus on reduction of long lines of Agency and related actions • Overview of NHSP Improvement plan	For assurance	PLC 20/2025	**CDS/ JB**	**16:30** 15m
	For information only – Papers in Reading room				
21	**Matters Arising Information** • OD Strategy – first steps to identifying what needs to be included • Leadership development	For information For information	*RR/App 21(i)-21(iii)/2025* *RR/App 21(iv)/2025*		
22	**Principles of Team Leadership OHFT**	For information	*RR/App 21(v)/2025*		
23	**Highlight / Escalation Reports** a. People Steering Group (ZM) b. Education Strategy Group (prev. LAG) (BE) c. EDI Steering Group* (MP) d. People Systems Programme Board (SB) **EDI H&E Report to include full HIA update*	For information	*RR/App 22(i)/2025* *22(ii)/2025* *22(iii)/2025* *22(iv)/2025*		
24	**ER Casework review Report** Associated risk: -Staff Wellbeing (TRR 1018) • To ensure that PLC has sight of numbers of staff currently suspended; and that their wellbeing is being supported	For assurance	*RR/App 23/2025*	***JC/ZM***	
25	**Workforce Report –** Data packs - Cover sheet - Summary data - HR KPI review - HR & L&D - Whole Trust - Mental Health - Community Services	For assurance	*RR/App* *24(i)/2025* *24(ii)/2025* *24(iii)/2025* *24(iv)/2025* *24(v)/2025* *24(vi)/2025* *24(vii)/2025*	 ***SB*** ***SB*** ***SB*** ***SB*** ***SB*** ***RB*** ***EL***	
26	**PLC Workplan**	For assurance	*RR/App 25/2025*	***CDS***	
27	**PLC Terms of Reference**		*RR/App 26/2025*	***GD***	
	Closing				
28	**AOB**		Verbal		**16:45** 10m
29	**New risks identified and actions for other Committees and the Board**	For assurance	Verbal		**16:55**
30	**Date of next meeting** 29 April 2025, 13:30-17:00				

	Meeting close				**17:00**

Oxford Health NHS Foundation Trust

Meeting of the Quality Committee

Thursday, 07 November 2024
09:30 - 12:30
In Person POWIC room, Warneford

(live video streaming – invitation only)

Apologies to leanne.dunkley@oxordhealth.nhs.uk

AGENDA

			Indicative Time
1. Apologies for Absence and quoracy check[1]		AY	09:30
Minutes and Matters Arising			
2. Minutes of the meeting of the Quality Committee on 28 August 2024 and Matters Arising (paper – QC 64/2024)	*To confirm & report matters arising*	AY	09:35
Safety			
3. Quality and Clinical Governance Sub-Group (QCG-SG) escalation reporting including: a. Quality and Safety Dashboard (paper – QC 65/2024) b. Patient Safety Incident report including mortality and homicide reviews (paper – QC 66/2024) c. Quality Account (paper-QC 67/2024)	*For assurance*	JK/BK	09:40
4. Service Deep Dive a. Update on Strategy (2022-2027) and service development in Learning Disability service (oral update) b. Learning Disabilities and Autism Services-access to healthcare annual report (2023-2024) (paper-QC 68/2024)	*For assurance*	BK/RB	10:00
5. Quality Compliance & Regulation update a. CQC Compliance & Regulation-well led guidance.(paper-QC 69/2024)	*To note*	CF/BK	10:30
6. Safety of the Physical estate (paper-QC 70/2024)	*To Approve*	JP/HS	10:40
7. Oxford pharmacy store (paper-QC 71/2024)	*For assurance* *For assurance*	MB/HS BR	10:50

[1] Apologies received from Committee members: No apologies received.

Apologies received from regular attendees: Amèlie Bages, Director of Strategy and Partnerships,.

The quorum for the committee is five members to include the Chair of the Committee (or the vice chair of the Committee in their absence), one Non-Executive Director and one Executive Director.

8. Winter Preparedness/resilience (oral update)			11:10
Break -10 minutes			11:20
Effective			
9. Clinical Effectiveness updates:			11:30
a. Clinical Effectiveness Group (CEG) report (paper – QC 72/2024)	*For assurance*	KM/RM	
b. Clinical Audit update Report (paper – QC 73/2024)			
c. Medicines Management report (paper – QC 74/2024)	*To Approve*	AF/CF	
• *For supporting detail: CEG minutes & action log in the **Reading Room/Appendix (papers – RR/App 10/2024)***		MM/KM	
Caring & Responsive			
10. PCREF (paper-QC 75/2024)	*For Assurance*	DM	11:50
Annual Plan Strategic Programmes			
11. Provider Collaboratives (paper-QC 76/2024)	*For Assurance*	BK	12:00
Strategies and Policies			
12. Learning from Patients, Family and Carers (oral update on strategy)		BK	12:05
13. Policies to approve -Epilepsy Policy (paper-QC 77/2024)	To Approve	JK	12:10
Governance and Risk Management			
14. Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) (paper – QC 78/2024)-BAF 1.5 review	*To discuss & for assurance*	BA/GD	12:15
15. Operating Framework (clinical Governance structures) (paper-QC 79/2024)		GD/BC	12:25
Any Other Business			
16. 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	12:30
17. Review of the meeting		AY	
Meeting Close		AY	12:30

Date of next meeting:
TBC February 2025

READING ROOM/APPENDIX

- supporting reports to be taken as read and noted –

Attendance 2023/24

QC - Core membership (Quorum)	May-23	Jul-23	Sep-23	Nov-23	Feb-24
Andrea Young	✓	✓	✓	✓	✓
Rob Bale	*N/A*	*N/A*	*x*	✓	✓
Marie Crofts	✓	*Britta Klinck deputised*	*x (Britta Klink deputised)*	✓	*Britta Klink*
Geraldine Cumberbatch	✓	✓	✓	*x*	✓
Grant MacDonald	✓	✓	*x*	✓	✓
Karl Marlowe	✓	✓	✓	✓	✓
Ben Riley	✓	✓	*x*	✓	✓
Heather Smith	✓	✓	✓	✓	✓
Kerry Rogers*	✓	✓	✓	✓	✓
Attending Board members (voting & non-voting included in quorum)					
Amelie Bages*		✓	*x*	*x*	✓
Charmaine DeSouza	*x*	*x*	*x*	*x*	*x*
David Walker	✓	✓	*x*	✓	✓

QC - Core membership (Quorum)	May-24	Jul-24	Sept-24	Nov-24	Feb-25
Andrea Young	✓				
Rob Bale	✓				
Britta Klink	✓				
Geraldine Cumberbatch	*x*				
Grant MacDonald	✓				
Karl Marlowe	✓				
Ben Riley	✓				
Heather Smith	✓				
Georgia Dengei	✓				
Attending Board members (voting & non-voting included in quorum)					

Amelie Bages*	*Mat*				
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 *(to include positive and safe each month and May meeting to include ToR and work plan)*	Jane Kershaw/Britta Klinck	*X (ToR & workplan included)* ✓	*x*	*x*	*x*	*x*	
Directorate/Service area 'deep dive' *(Presentation)*	Britta Klinck/Grant Macdonald/Ben Riley	*X 0-19 service* ✓	*X Learning Disabilities*	*X*	*X*	*X*	
Quality Account (quality priorities) *(May meeting includes annual report)*	Rose Hombo	*X* ✓			*X*		
Patient Safety Incident Report (PSIs) *(Learning from Deaths Report, to include mortality and homicide reviews)*	Jane Kershaw/Britta Klinck	*X* ✓	*X*	*x*	*X*	*X*	
Safe Staffing	Britta Klinck		*X*			*X*	
Quality Compliance and Regulation update *(CQC, NHSE/I etc - report as and when required)*	Britta Klinck	*X* ✓	*X Well led guidance*	*X*	*X*	*X*	
Director of Infection Prevention & Control (IPC) – IPC annual report	Helen Bosley/Britta Klinck	*X* ✓					
Safety of the physical estate – annual report *Ligature update (BK/MC)*	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) *(quality assurance report around the governance and quality of medicines regulation in OPS)*	Natasha Arif/Nicola Mayes/Mark Byrne/Heather Smith/Karl Marlowe	*X (review of programme)* ✓			X		
EFFECTIVENESS							
Clinical Effectiveness Decision Group (CEDG) *(RR minutes from CEDG group, new NICE guidance)*	Ros Mitchell/Karl Marlowe	*X* ✓	X	*X*	*X*	*X*	
Clinical Audit updates	Angie Fletcher/Karl Marlowe	*X* ✓	X	*X*	*X*	*X*	
Clinical Audit annual plan and annual report	Angie Fletcher/Karl Marlowe	*X* ✓					
Medicines Management	Michael Marven/Karl Marlowe	*X* ✓	*X*	*X*	*X*	*X*	
Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) *review each one at each meeting*	Ben Cahill/Brian Aveyard/Hannah Smith/Neil McLaughlin	*X* ✓	*X*	*X*	*X*	*X*	
Health Inequalities-Quality Improvement (smoking cessation/SMI Health checks/ dashboarding waiting list for Index of Multiple deprivation/ethnicity data)	Karl Marlowe		*X*				
QUALITY IMPROVEMENT							
QI Spotlight presentation (developing capability and the impact on staff and patients)	Angie Fletcher/Britta Klinck		*X Plan for the year*		*X (projects)*	*X (projects)*	

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 *(Experience and involvement) update on strategy*	Donna Mackenzie-Brown/Rose Hombo/Britta Klinck	X ✓			X		
Experience and Involvement report *(update on strategy)*	Donna Mackenzie-Brown/ Rose Hombo / Britta Klinck				X		
PCREF Framework *(update on strategy)*	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 *(as and when – new policies for approval and certain policies for review)*							
Legal Proceedings Policy	Neil McLaughlin/Georgia 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

Meeting of the Oxford Health NHS Foundation Trust
Quality Committee

[DRAFT] Minutes of a meeting held on
Thursday, 07 November 2024 at 09:30

In Person Warneford Hospital

Present[1]:	
Andrea Young Britta Klinck	Non-Executive Director (Committee Chair) (**AY**) Chief Nurse (**BK**)
Karl Marlowe	Chief Medical Officer (**KM**)
David Walker	Trust Chair (**DW**)
Rob Bale	Interim Chief Operating Officer for Mental Health and Learning Disabilities (**RB**)
Georgia Denegri	Associate Director for Corporate Affairs (**GD**)
Lucy Weston	Non-Executive Director (**LW**)
In attendance[2]:	
Leanne Dunkley	Corporate Governance Officer (**LCD**) (minutes)
Angie Fletcher	Deputy Chief Nurse (**AF**)
Michael Marven Pete McGrane	Chief Pharmacist and Clinical Director for Medicines Management (**MM**) Clinical Director of Primary, Community Services (**PM**)
Tina Malhotra Daniel Mercier Rosalind Mitchell Rami El-Shirbiny Bill Tiplady Claire Forrest Jane Kershaw Kirsten Prance Steven Smith	Clinical Director, Buckinghamshire Mental Health Services (**TM**) Associate Director of Social Work and Social Care (**DM)** Deputy Chief Medical Officer and Clinical Director for Dental (**RM**) Consultant and Clinical Director Forensic Services (**RS**) Director of Psychological Professions (**BT**) Head of Clinical Standards (**CF**) Head of Patient Safety (**JK**) Clinical and Service Director for Learning Disabilities (**KP**) Head of Operations Estates and Facilities (**SS**)

1.	**Apologies for Absence**	**Action**
a	Apologies for absence were received from Ben Riley, Chief Operating Officer for Community, Primary Care and Dental Care and David Clarke, Non-Executive Director.	

[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.

b	Apologies for absence were noted from the following regular attendees: Grant Macdonald, Chief Executive, Lola Martos, Interim Clinical Director Ox and BSW Mental Health services Hannah Smith, Assistant Trust Secretary, Brian Aveyard, Risk Assurance and Compliance Manager, Vanessa Raymont, Director of Research and Development, Matthew Edwards, Director of Clinical Workforce Transformation, Bill Tiplady, Director of Psychological Professions and Ben Riley, Chief Operating Officer for Community Health Services, Dentistry and Primary Care	
c	**The Chair confirmed the meeting was quorate.**	
2.	**Minutes of the Quality Committee on 28 August 2024 and Matters Arising**	
a	The Chair welcomed all to the meeting.	
b	The minutes at QC (i)/2024 Minutes of the Quality Committee (**QC) on the 28 August 2024** were confirmed as a true and accurate record, it was noted that Kestrel was spelt incorrectly and Vanessa Raymont and Lola Martos job titles needed amending, which was amended after the meeting.	
c	***Matters Arising***	
d	The Action Log was reviewed and updated, the Committee agreed that the following actions could be closed and removed from the action log: 11(b) BAF R&D risk score review-This is on today's agenda. 3(c) Restrictive Practice/Rapid Tranquilisation and Prescribing: this will be monitored through the positive and safe group and will feed back to the Committee through the QCG-SG escalation report. 15(e) Quality Governance system: this is on today's agenda. 9(f) BAF 1.1-It has been agreed that this will be monitored by the Finance and Investment Committee. 6(c) Patient and Carer Race Equality Framework: update on today's agenda.	
SAFETY		
3.	**Quality and Clinical Governance Sub-Group (QCG) escalation report**	
a	The Chief Nurse took the report at QC 65(i)/2024 as read, noting the key highlights and escalations.	
b	The Chief Medical Officer noted that it is good to see the significant improvement in the Mental Health discharge 72-hour follow up, however further progress is required to achieve follow up within 48hours, which is the Trusts standard. He commented that following national directions to set up new services, for example the newly established Community Mental Health Hubs, which have ongoing high vacancy rates, there needs to be a push within directorates to increase partnership working, including working with the third sector organisations to fill those vacancies and deliver the services.	
c	The Associate Director of Social Work and Social Care responded to a question posed by Lucy Weston, that within the Reducing Violence and Aggression group, best practice will be developed though the working group, which is	

	looking at learning, development and education, acknowledging that the Trust covers a wide range of settings and so what is best practice in the forensic department may not be the same as a community primary care team. Managers are being asked to develop risk assessments based on the 2020 standards to consider quantifiable predictable risks, which will allow for more coherent reporting moving forward and will encourage staff to be more proactive. A lot of this is around building relationships with patients and managing acceptable behaviours and challenging unacceptable behaviour rather than zero tolerance. The Chief Nurse, the Clinical Director for Community Services and the Clinical Director for Forensic services added that this covers all abuse, which is increasing across the NHS, and can be damaging. It is important to move away from the Zero Tolerance Policy, as this cannot be practiced and move towards managing unacceptable behaviour which the group is currently reviewing. There is work to do with staff to help them understand the language and to better equip them to challenge the unacceptable behaviour that has led to the current situation and how it could have been handled differently, which is going to require a cultural shift. Patients need to understand what is acceptable and what is not and what the expectation is as this is a two-way relationship with shared responsibility. **The committee noted the report.**	
d	**a) Quality and Safety Dashboard**	
e	The Head of Patient Safety took the report at QC 65(ii)(iii)/2024 as read, highlighting key points and escalations.	
f	The Trust Chair challenged whether it would be meaningful to map some of these teams and services in terms of partners, as some of these services rely on boundaries with another organisation. The Chief Nurse and Head of Patient Safety noted that these discussions are held in the sub-group each month as to what is within the Trusts gift to do something about and where it is not, which could be made clearer in the report. The aim of the dashboard is to collate together the information that may alert us to a risk to quality, however it is also about the local knowledge and concerns that directorates escalate that does not trigger on the dashboard. The vacancy rates are concerning; however, this is considered alongside the safe staffing report which provides good assurance that fill rates are achieved through patient care hours per day, through the use of agency staff, but which can impact on quality.	
g	The Chair requested, in terms of vacancies, it would be useful to see the number of vacancies, rather than just the percentage, as the impact of this will vary depending on the size of the team, especially those with 30% or more vacancy rate. She asked whether in relation to the issues in Cotswold House and Thames House raised by the Provider Collaborative (PC as requiring intervention and investigation, would our current system have alerted these issues to us? The Chief Nurse and Head of Patient Safety noted that Cotswold House was in early warning due to supervision and culture issues. Thames House had flagged due to vacancies, however, fill rates were being achieved. This is where the local intelligence comes in as not everything will trigger a warning. It is about knowing what is happening at service level, which for these wards was around a few	

	complex patients and a change in leadership team, which sometimes can have an impact and should be considered as part of the review and discussions. The Interim Chief Operating Officer for Mental Health and Learning Disability added that it would be good to link in with the PC, as to how they identified these issues, so that we can work better as a system. The Chair commented that the Trust needs to continue to refresh the triggers and learn from incidents and investigations, she noted although we are part of the provider collaborative, and host it, it operates independently.	
h	The Chief Medical Officer commented that we need to work in collaboration and partnership to address vacancies to consider how to fill those gaps. It would be good to see the occupancy rates to consider alongside the staffing levels and acuity level of patients, as if bed occupancy is 65% then the staffing should not be exceeding 100%. The Chief Nurse agreed and added that further work on the use of agency staff in community services is also required as this can impact on quality.	
i	The Trust Chair noted low clinical supervision rates and questioned whether this was uniform across specialities and the impact of this on staff retention and patient safety. The Chief Nurse commented that it can have an impact, however this is mostly due to recording of supervision as management and clinical supervision are recorded separately within a clunky system. Supervision should be about good clinical practice and support to do the job. The Chair added that PLC have been asked to review these templates and practice, which the Chief Nurse supported, as this is not a national requirement to have them recorded separately. The clinical Director for Forensic Services commented it would be helpful in the future to use AI to record supervision. The Deputy Chief Nurse noted that a piece of work to review supervision and refresh the policy to make it simpler and align with professional bodies requirements and to ensure that the right components are covered is under way. The Chair asked the Chief Nurse to flag with PLC.	
j	The Clinical Director for Forensic Services commented that with the increasing complexity and acuity of patients on the wards along with changes in leadership the burden on units is increasing, which can lead to other process having to give, so need to consider the nature of the unit and what is happening at that time, which could be used as an indicator that the unit or team requires more support.	
k	LW commented that the dashboard is improving, and challenged how intelligence and patients voice/experience are reflected and tied into this, as the issues raised by the PC was around patient concerns and complaints. The Head of Patient Safety noted that complaints and concerns are now included within the dashboard and are looking at how patient feedback is collected and what it tells us. The Interim Managing Director for Mental Health and Learning Disability noted that this is being asked in the Mental Health Transformation Programme, in terms of collating the patients and carers voice. There are ongoing developments within the Advocacy services to become more proactive in collecting feedback. Currently understanding what is happening on the wards, with regular meetings so that these are picked up and addressed.	

l	The Chief Nurse commented that the Advocacy Service could be utilised more effectively, which the Deputy Director of Social Work and Social Care supported. **The Chair thanked the team for the report, including the explanation of the thresholds. It was noted that the dashboard is becoming more sophisticated, however further development is underway.** **The Committee noted the report.**	
	b) Patient Safety Incident Report (PSI):	
m	The Head of Patient Safety took the report at QC 66/2024 as read, noting any key highlights and escalations to the group.	
n	The Chief Nurse noted that there is good oversight in the subgroup of all the ways the learning is shared and disseminated which will be brought to this Committee. There is real push to do improvements that will transform services and make them safe, rather than investigations.	
o	The Head of Patient Safety In response to a question from the Trust Chair regarding the recent report from Health Service Safety Investigation Board, noted that the OHFT team led the national training for staff involved in patient safety, and agreed, that the national reports are helpful , and are reviewed for prompts and recommendations. There has not been a direct impact on her role since the publication of the report. The Chair noted that the number of regulators is wide ranging, which is being considered in the second part of the Dash Review.	
p	The Chief Medical Officer noted that the team have done great work to get ahead of the national average with this programme of work, which should be celebrated. The Trust should continue to use the national terminology around learning and improvement and consider this from a patient and family's perspective.	
q	The Chair noted that the death and mortality trends sound concerning, however many are community age related deaths, so would be helpful to see the number of those seen in primary care, which The Head of Patient safety will include noting that around two thirds of the deaths are in the community. The Chief Medical Officer noted that it would be good to see the numbers for assurance, which is reviewed externally. The Head of Patient safety commented that most of the deaths were expected and nothing concerning raised. There has been a sustained reduction in local suicides as well, which is positive to see. **The committee noted the report.**	
r	**C) Quality Account**	
s	The Head of Patient Safety took the report at QC 67/2024 as read. **The Committee noted the update**	

4	**Service Deep Dive, Update on Strategy (2022-2027) and service developments in Learning Disability service and Learning Disabilities & Autism Services-access to healthcare Annual Report 2023-2024**	
a	The Clinical and Service Director for Learning Disabilities gave an oral update on the strategy noting that the quality improvements standards have ceased so it is difficult to compare with previous years. t. There is a gap analysis underway in terms of what we think will be reportable data and as a Trust will need to consider the audit process. Should hopefully be able to bring an update in May.	
b	She then updated the Committee regarding the Learning Disability Service as part of the deep dive, taking them through the report at QC 68/2024, noting that waiting times remain static, compared to pre-covid levels, as there was a reduction in activity during Covid. The service is currently going back through NHS benchmarking and our standards to complete a comparison across acuity which has increased. As expected from the LD strategy, we will likely see a reduction in the number of patients but an increase in tier 2 work, which is engaging with other services to support and adjust, and we are looking at ways to triangulate data. There are a small number of waiting time breaches due to circumstances outside of our control such as patient being unavailable or awaiting a specialist assessment.	
c	There is further caseload management work to do as there are 42 patients who have not been seen for a year, as they are only on psychiatrist only caseloads for a yearly review. This has dropped off as only one full time consultant, additional support is being brought in to help catch up and discussions are under way as how to manage this going forward including discharging them back to GP rather than staying on a caseload. There has been a history of patients and families decompensating when they do not have that support, which may in part be due to a lack of understanding of the system. There is now a targeted approach to review these patients and determine if they can be safely discharged with a plan. A piece of work has been started with care providers regarding patients not brought to clinic, as they need to be aware that patients are not attending essential health appointments, which will be a quality issue in their contract. There may be safeguarding concerns in this regard. A deep dive will take place as the service cancelled appointments during the summer to identify why these were cancelled.	
d	The Interim Chief Operating Officer for Mental Health and Learning Disability commented that there are patients taking certain medications that cannot be discharged. There is also a reluctance from primary care for us to discharge, at present caseloads are being reviewed and cleansed where possible to ensure that people are not being missed. He noted that there have been challenges over the past year with changes to the service and its group of patients with huge inequalities of 90 staff and 800 patients. It should be celebrated that the service is good at not admitting people to hospital, which increases pressure on the community teams and carries a financial burden for the Trust. The Clinical and Service Director for Learning Disabilities noted that there are currently 2 patients in hospital beds who are awaiting discharge from Oxford. There are	

	patients placed outside of Oxford who we have responsibility for who have decompensated before preventative work could take place, which is a risk and clinical concern. There are currently no commissioning agreements for us to maintain clinical oversight and joint reviews of these patients, we do not know where they are placed, so need to have some further commissioning discussions.	
e	In response to a question posed by LW regarding advocacy and team structure for the patient group the Interim Chief Operating Officer for Mental Health and Learning Disability noted that developing this advocacy culture is about supporting teams at a local level to increase understanding and to give them a sense of autonomy to make changes within the national frameworks, it is also about looking at the wider system as well.	
f	The Chair thanked the team for the report and endorsed the emphasis on physical health. The Clinical and Service Director for Learning Disabilities noted that the work undertaken is a testament to the Trust who have been supportive of this Directorate. **The Committee noted the Report and updates.**	
5	**Quality Compliance and Regulation Update**	
a	The Head of Clinical Standards took the report at QC 69/2024 as read, noting any key escalation or highlights.	
b	The Chair commented that it feels like the Trust is in better shape to deal with the potential changes in the regulatory framework and sought confirmation that the outcome of Mental Health Act Inspections (MHA) inspections goes to the Mental Health and Law Committee (MH&LC). The Chief Medical Officer commented that he endorsed the CQC recommendations especially around inspectors being experienced in the area they are inspecting and confirmed that the MH&LC receive reports each meeting on MHA inspections and resulting actions. **The Committee noted the update**	
6	**Safety of the Physical Estate 2023/2024**	
a	The Head of Operations for Estates and Facilities took the Committee through the key highlights and escalations from the paper QC 70/2024. The Chair noted that this is in an important paper due to recent national issues related to estates in Mental Health causing safety risks for patients.	
b	The Head of Operations for Estates and Facilities noted that the Maintenance team are currently running with vacancies, which has affected the percentage of Planned Preventative Maintenance only achieving 69%. A restructure of the Estates and Facilities team is under way to ensure the team can meet the Statutory and Mandatory requirements and appoint authorising engineers and responsible persons.	

c	LW noted that Estates is discussed in Finace and Investment Committee (FIC), who undertook a deep dive, which identified that as the team are getting up to speed with routine checks a lot of work was being uncovered. She then asked what is causing the most anxiety. The Head of Operations for Estates and Facilities noted that fire safety is causing the most anxiety as there are also 4000 remedial works outstanding 1045 of which are high risk according to the Fire Safety Officers, scoring over 16, which has been escalated to the Chief Finance Officer and reported through Ulyssess.	
d	The Chief Medical Officer noted that this was raised at Executives on Monday in terms of the Trust Risk Register. The Chair asked for this to be taken back to the Executive meetings to gain a response to this from the Lead Director regarding the actions and mitigations in place to the fire safety actions that can be shared at the November Board meeting.	
e	The Associate Director of Corporate Affairs noted the Chief Executive was asking for updates regarding this issue, noting that Health and Safety is discussed at PLC. The Chair responded that this is a separate paper to the Health and Safety and one which the Quality Committee receives annually (Safety of the Physical Estate)	
f	The Chair summarised that the team is in the process of transitioning to be in a better place to manage the volume of work, noting that the key areas of safety assessment are satisfactory, and the Trust Risk Register has now been updated to reflect all those issues. The executive lead director will be asked to give an update to this Committee on the fire safety issues raised as a matter of urgency. **The Committee noted the report.**	
7	**Oxford Pharmacy Store**	
a	The Chief Pharmacist and Clinical Director for Medicines Management took the report at QC 71/2024 as read, noting any key highlights or escalations.	
b	The Chair asked what the nature of the distribution complaints was. The Chief Pharmacist and Clinical Director for Medicines Management noted that these relate to small numbers where products are lost, damaged or misdirected during transport.	
c	The Chair summarised that it is excellent to see the improved governance and oversight. **The Committee noted the update.**	
8	**Winter Preparedness/Resilience**	
a	The Clinical Director for Community Services provided an oral update to the Committee, noting that this year there is no additional winter funding available as there have been in previous years. System wide discussions are taking place and plans to manage have been developed. This includes the use of Single point of Access (SPA) for all referrals to ensure that the breadth of community resources is utilised including advanced care planning and the use of the	

	emergency community response, to prevent where possible hospital admission. These referrals will be accepted directly from SCAS and Primary Care. GP's and OCG colleagues will also be based in SPA which allows for greater collaboration.	
b	The offering in relation to beds has also been strengthened, we are not able to open more beds, however if the ambulatory services and admission avoidance are better utilised it will ease the demand on beds.	
c	Working on the system flow with a greater focus on discharge coordination and ensuring that patients are receiving the right care in the right place at the right time.	
d	The core elements of community services are under pressure, so the Trust has gone at risk financially with the District Nursing Service to create additional capacity for the weekends, with the hope that there will be some additional investment money in the new year. However, we will need to consider what happens if the additional funding is not available.	
e	In the GP out of Hours, there has been a shift in general practice, which makes the GP out of hours more attractive and so the Christmas rota is almost complete without having to offer incentives. This may change if colleagues realise a neighbouring Trust is paying incentives to cover the Christmas period.	
f	The Trust Chair asked for an update on the staff Flu and Covid vaccination programme, which protects staff, patients and their communities. The Chief Nurse highlighted that the campaigns have now been running for three weeks and have just received the first set of data, which shows we are currently at 17%. Last year the Trust achieved 54%, so not where we want to be. Struggling with vaccine fatigue and directorates are being asked to encourage staff to have their vaccines and there will be further communications out to staff, including videos. She noted that the idea of making vaccinations mandatory for health care workers did a lot of damage, there are multiple reasons why staff may not want the vaccination, and some may be having them outside of the Trust. Last year the national average amongst frontline staff was around 49%. The Clinical Director for Community Services noted that staff seem more reluctant to have their Covid Vaccinations this year, so suspect we will achieve better figures in relation to Flu vaccinations compared with Covid vaccinations. The Clinical and Service Director for Learning Disabilities commented that it must be about the message that we are here to care for people which we can only do if we are well and not being a carrier. There is a lot of fear within our society and people experienced negative side effect, so it also about understanding and counteracting those stories. It may be worthwhile targeting the Flu vaccination rates above all.	
g	The Chief Nurse noted that there are still cases of Covid across the Trust and people are still dying from it, so it is a patent safety issue, although no one is talking about the fatality numbers as has been reported in previous years. LW noted that need to consider the mechanisms of delivery and how clinics are set up, along with the persuasive message to ensure that it is easy for staff to get	

	vaccinated such as vaccinators attending team meetings, as staff feedback is that they must go somewhere to get vaccinated, so it does not feel easy. The Chief Nurse noted that there are clinics across the organisation, along with peer vaccinators who can visit teams and services, to make it as convenient as possible.	
h	The Chair noted that as a Board there is a need to decide what is acceptable and what we are prepared to tolerate. It may be that the performance data by directorates need to be reviewed. There is assurance that if you want to have the vaccines you can get them. This needs to be monitored at Board level monthly and challenge why it is difficult to get back to the take up we used to have. **The Committee noted the Update**	
	Effective	
9	**a) Clinical Effectiveness Group (CEG) report**	
a	The Deputy Chief Medical Officer took the report at QC 72/2024, as read noting any key highlights and escalations.	
b	The Chair noted the group is doing great work and seeing positive improvements. She asked if the dual diagnosis policy is being implemented and checked? The Chief Medical Officer noted that the current policy states that each team should have a dual diagnosis lead, which is probably unnecessary and not achievable. The Chief Nurse noted that this was discussed at the sub-Group and that the policy needed to be amended. The Interim Chief Operating Officer for Mental Health and Learning Disabilities noted that some teams will require a dual diagnosis lead, such as the ALT teams. The Chair asked for an update in 6 months' time through the CEG report.	
c	The Chief Medical Officer noted that with the SNOWMED codes a detailed cost review is under way as to how much services cost. **The Committee noted the update.**	
d	**b) Clinical Audit Update**	
e	The Head of Clinical Standards took the paper at QC 73/2024 as read noting any key highlights and escalations to the Committee.	
f	The Clinical and Service Director for Learning Disabilities noted that the clinical standards audit is proving difficult in Learning Disabilities, they are working closely with colleagues to review the audit as sections of it do not align with the processes, so will improve.	
g	The Chair asked regarding the issue with respiratory equipment for children. The Head of Clinical Standards noted that there were no overdue actions found, will discuss with the directorate and update at the next meeting. **The Committee noted the report**	

h	**c) Medicines Management Report** The Chief Pharmacist and Clinical Director for Medicines Management took the report at QC 74/2024 as read noting any key highlights and escalations to the Committee. **The Committee noted the update.**	
CARING & RESPONSIVE		
10	**Patient Carer Race Equality Framework (PCREF)**	
a	The Associate Director of Social Work and Social Care took the report at QC 75/2024 as read noting any key highlights and escalations to the Committee.	
b	The Chair noted that it was a good report that identifies the direction of travel and asked for a timeline for when the reports would be generated. The Associate Director for Social Work and Social Care noted that reporting will start from the next financial year with national reporting to NHS England. The Chief Nurse added that this will take time to keep embedding and weave into our way of doing things across the Trust, as these measures are best practice. The new Mental Health Bill is PCREF focused, which is a good foundation. **The Committee noted the update**	
Annual Plan Strategic Programmes		
11	**Provider Collaboratives (PC)**	
a	The Chief Nurse took the paper at QC 76/2024 as read, noting any key highlights and escalations to the Committee.	
b	The interim Chief Operating Officer for Mental Health and Learning Disabilities noted that the adolescent CAMHS PICU is different to an adult PICU, with a range of complex needs and therefore a very different dynamic of patients.	
c	In Response to question from LW, the Chief Nurse noted that the concerns regarding Cotswold House were raised by patients around day-to-day practices. There has been new leadership going into the unit and they have restricted admissions at present. There was one out of area placement (OAP's) from Gloucestershire who we are working with. There were concerns regarding consistency, but no direct concerns regarding the treatment of the patients, when requiring high levels of seclusion. The interim Chief Operating Officer for Mental Health and Learning Disabilities added that there has been a big change in the team since the summer with some staff new to the NHS and managing eating disorders and so they are being supported to develop those skills. The team have identified themselves the need to work better with patients.	
d	LW asked if the Trust make complaints regarding patients that are out of area. The Interim Chief Operating Officer for Mental Health and Learning Disabilities noted that this is done in several ways, so that there is system level oversight. There is not a systematic way to report and capture as it is done through block contacts. The Clinical Director for Forensic Services noted that the PC have their own quality oversight, so that all Providers are doing the same. As a Trust we do	

	not have the authority to go in and tell them what to do. The Clinical and Service Director for Learning Disabilities added that this is captured at system level as we link in with and provide data for the national data set, there is also ICB oversight. The PC have their own quality governance, reporting into weekly safety review meetings. Ideally, we would not want to send a patient out of area.	
e	The Chief Medical Officer added that Provider Collaboratives are still in the early stages within the Mental Health system and urgent and emergency care with OUH and so need to consider how to build the quality lens on that. The Clinical Director for Forensic Services added that there needs to be sensitivity in how concerns get triggered as nationally the memory of Edenfield and Reading is still fresh. Further developments are needed as the system is struggling as it produces a large volume of admin to investigate.	
f	The Chair summarised that we now have increased visibility of services in our collaborative, including the independent sector, which is maturing. The closure of units is having an impact and proving problematic, but the collaborative has better systems to deal with this. **The Committee noted the Update**	
Strategies and Policies		
12	**Learning From Patients, Families and Carers**	
a	The Deputy Chief Nurse provided an oral update to the Committee, noting that the strategy launched in 2021 and is coming to the end of the 3-year tenure. She noted that involvement is now overseen by Bill Tiplady, who has recently recruited a recovery and lived experience lead to provide some leadership, and PALS and complaints is overseen by the deputy Chief Nurse, so a slightly different approach than previously. The strategy is being reviewed as to how we take the future ambitions forward. The Trust was ambitious with the strategy and have made good progress with those ambitions, however there is more to do including how best to resource the work. At present on track to pass strategy, however, need to review the measures going forward. There is an internal audit taking place to review the governance arrangements, reporting lines and embedding of the strategy which will hopefully be available in the new few weeks, and be used as the baseline going forwards. A fuller report will be brought to the May Quality Committee meeting. **The Committee noted the updates**	
13	**Policies to approve.** **Epilepsy and Seizure Management Policy**.	
a	The policy weas taken as read, noting that it was approved at Quality and Clinical Governance Subgroup. **The Committee Approved the Policy**	
	Governance and Risk Management	

14	**Operational and Strategic Risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF)**	
a	The Chair took the reports as read at QC 78/2024, noting that no changes had been made to the ratings.	
b	The Associate Director of Corporate affairs noted that the Trust Risk Register had been updated in terms of the Fire and Health and Safety Risks, which the Chair commented requires further investigation. The ratings for the BAF 1.5-Unavailblity of beds/demand and Capacity (Mental Health and Learning Disability) and 4.1-Not maximising the Trust's research and Development potential ratings are remaining the same.	
c	The Chief Medical Officer noted that the BAF 4.1 is well mitigated and will update the risk for the next meeting.	
	The Committee noted the report	
15	**Operating Framework 25/26**	
a	The Associate Director of Corporate Affairs took the papers at QC 79/2024 as read, noting that it was not within the scope to have standardisation across the directorates at present, however this will be developed over time.	
b	The Chair said the slides are very helpful and that the variation between directorates had been noted before and challenged whether there is any evidence that one approach is better than the others? And are the local directorates being allowed autonomy to decide that. She noted that at high level this demonstrates Ward to board clinical governance and planning, however it does not show how it operates ward to service and then to division, which still requires setting out. Is the lack of consistency acceptable or does a way to improve it need to be considered? How does the directorate receive the upward report of the actions and quality issues in their divisions as there are a lot of service lines. The committee were assured this activity takes place but is different across directorates.	
c	The Consultant Psychiatrist and Clinical Director for Buckinghamshire Leadership noted that in Buckinghamshire each service line feeds into the Ops and Governance meetings and that then feeds into the directorate's quality meetings, which she will share.	
d	The Chief Nurse noted that there is still work to do and it would be good to have a central dashboard that goes down to team level. The Chair added that if there is Board oversight, it should be possible to recognise variation, where appropriate, in services. The Associate Director for Corporate affairs will reflect on how to capture the quality aspect.	
	The Committee noted the update	
15.	**AOB**	
a	The Chair noted that in the PC report, it does not demonstrate that it reports to the Quality Committee, so needs to be amended.	

16.	**Review of the meeting**	
	Meeting closed at 12:44 **Date of next meeting: Thursday, 06 February 2025 09:00-12:00 hours via MS Teams**	

Oxford Health
NHS Foundation Trust

Audit and Risk Committee
Terms of Reference

Contents

1. Purpose

1.1 The Audit and Risk Committee (the Committee) is established as a committee of the Board of Directors (the Board) of Oxford Health NHS Foundation Trust (the Trust) to contribute to the overall delivery of the Trust objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the Trust and its delegated components.

2. Constitution

2.1 The Board has established a committee known as the Audit and Risk Committee as a standing assurance committee of the Board.

2.2 The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation of Powers and may be amended from time to time. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2.3 The Committee is a non-executive chaired committee of the Board and its membership comprises of non-executive directors only. Its members, including those who are not members of the Board, are bound by the Standing Orders of the Board and other policies of the Trust.

2.4 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.

2.5 These Terms of Reference, which will be published on the Trust's website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

3. Authority

3.1 The Committee is authorised by the Board to:

3.1.1 Investigate any activity within its Terms of Reference.

3.1.2 Seek any information it requires within its remit, from any employee or member of the Board (who are directed to co-operate with any request made by the committee) within its remit as outlined in these Terms of Reference.

3.1.3 Commission any reports it deems necessary to help fulfil its obligations.

3.1.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the Board for obtaining legal or professional advice.

3.1.5 All procedural matters in respect of conduct of meetings shall follow the Board's Standing Orders, Scheme of Delegation and Reservation and/or Trust Constitution as required.

<u>Limitations of Authority</u>

3.2 The Committee shall be delegated the power of the Board of Directors to require the attendance of any member of the Trust staff.

3.3 Save as is expressly provided in the terms of reference, the Committee shall have no further power or authority to exercise, on behalf of the Board of Directors, any of its functions or duties.

3.4 For the avoidance of doubt, the Committee shall not itself be responsible for undertaking any operational involvement in the Trust's governance (internal control) or risk management systems but require directors and managers of the Trust to undertake certain work, receive their reports (both verbal and written), and consider them before reporting to the Board of Directors thereafter.

4. Duties and responsibilities

Governance, Risk Management and Internal Control

4.1 The duties of the Committee are:

4.1.1 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

4.1.2 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

4.1.3 To ensure that the Trust acts consistently with the principles and guidance established in HMT's Managing Public Money.

4.1.4 To assure itself on the adequacy of the process for the development and evidencing of all risk and control related disclosure statements (in particular the Annual Governance Statement), and review any Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

4.1.5 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of strategic risks and the appropriateness of the above disclosure statements.

4.1.6 To assure itself on the adequacy of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and related reporting and self-certification.

4.1.7 To assure itself on the adequacy of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud Service.

4.1.8 To assure itself on the adequacy of the effectiveness of the Trust's arrangements and processes to support whistleblowing (the arrangements by which staff may raise concerns in confidence about possible improprieties

relating to financial, clinical or organisational matters). Assurance in relation to whistleblowing arrangements will also help to support the Annual Governance Statement.

4.1.9 To assure itself on the adequacy of the governance and procedures relating to the Charity.

4.1.10 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.1.11 To seek specialist external assurance, when appropriate, for example in relation to Cyber Security.

4.1.12 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions.

Internal Audit

4.2 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

4.2.1 Considering the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

4.2.2 Reviewing and approving the Internal Audit strategy and ~~operational~~ plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Board Assurance Framework.

4.2.3 Considering the major findings of Internal Audit work (and management's response), including the Head of Internal Audit Opinion, and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

4.2.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

4.2.5 Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit

4.3 The Committee shall review the work and findings of the External Auditor appointed by the Trust's Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

4.3.1 Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.

4.3.2 Discussion and agreement with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy.

4.3.3 Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

4.3.4 Review all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board of Directors and Council of Governors and any work carried on outside the annual audit plan, together with the appropriateness of management responses.

4.3.5 Overseeing the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

Other Assurance Functions

4.4 The Audit and Risk Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. NHS England, Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

4.5 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. This will particularly include the:

- Quality Committee in relation to clinical audit, clinical risk and assurance
- Charity Committee in relation to charity risk and assurance
- Finance & Investment Committee in relation to financial, digital including cyber security, Estates, Green Plan, Information Governance, and data quality risk and assurance
- People, Leadership & Culture Committee in relation to workforce, Freedom to Speak Up, and Health & Safety risk and assurance.

4.6 In reviewing the work of committees relating to clinical risk management, the Committee members will wish to satisfy themselves on the assurance that can be gained from the Clinical Audit function.

Counter Fraud

4.7 To assure itself that the Trust has adequate arrangements in place for counter fraud, bribery, and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

4.8 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access

and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

4.9 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

4.10 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Fraud, Bribery and Corruption.

4.11 To report concerns of suspected fraud, bribery, and corruption to the NHSCFA.

Freedom to Speak Up

4.12 To review the adequacy and security of the Trust's arrangements for its employees, contractors, and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Emergency Preparedness, Resilience and Response (EPRR)

4.13 To receive and review the annual Emergency Preparedness, Resilience and Response assurance report before being submitted to the Board.

Financial Reporting

4.14 To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

4.15 To review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

- 4.15.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- 4.15.2 changes in, and compliance with, accounting policies and practices;
- 4.15.3 unadjusted misstatements in the financial statements;
- 4.15.4 significant judgements in preparation of the financial statements;
- 4.15.5 significant adjustments resulting from the audit;
- 4.15.6 letter of representation; and
- 4.15.7 qualitative aspects of financial reporting.

4.16 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

5. Other functions

5.1 The Committee will consider matters referred to it by the Board or any other Board committee.

5.2 The Committee will ensure effective interface with the other Board committees to assure itself of the effective co-ordination of risk management processes across the Trust, both clinical and non-clinical.

5.3 The Committee will refer relevant risks or other matters to appropriate Committees for information or mitigation and will oversee appropriate risks delegated to it from the Board.

6. Specific responsibilities

6.1 The Committee can request a report on any subject or issue relevant to its Terms of Reference.

6.2 The Committee will consider the following reports before being submitted to the Board:

- Annual Report and Accounts, including the Annual Governance Statement
- Annual emergency preparedness, resilience and response (EPRR) assurance report
- Annual DSPT audit

6.3 The Committee will be responsible for reviewing the following strategies and policies:

- Risk Management Strategy and Policy
- Board of Directors Scheme of Reservation and Delegation of Powers
- Standing Financial Instructions

7. Membership and attendance

7.1 The Committee membership will be appointed by the Board and consist of:

- At least three Non-Executive Directors, one of whom with recent financial experience and skills will be the Chair of the Committee.

7.2 The Chair of the Committee may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

7.3 The Chair of the Trust shall not be a member of the Committee and should they attend by invitation, they will not count against the quorum.

7.4 In the absence of the Chair and Deputy Chair, or if the Chair and Deputy Chair have a conflict of interest, the remaining members present shall elect one of their number to Chair the meeting.

7.5 The Chief Finance Officer, the Chief Executive, the Director of Corporate Affairs and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the External and Internal Auditors.

7.6 Other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Chief Executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement. A member of the office of the Director of Corporate Affairs shall be Secretary to the

Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

7.7 Other Non-Executive Directors and up to two governors at each meeting have standing invitations to attend any meeting.

7.8 The Non-Executive Director members of the Committee may nominate any other Non-Executive Director of the Trust as their deputy to attend meetings in their absence.

7.9 The Board will review the membership of the Committee annually to ensure that it meets the evolving needs of the Trust. The Committee membership 2024/25 is presented at the Appendix.

7.10 The Committee may invite non-members to attend, in a non-voting capacity, all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair of the Committee.

7.11 Attendance at the meeting may be by videoconferencing at the discretion of the Committee Chair.

7.12 Committee members are required to:

- Attend at least 75% of meetings, having read all papers beforehand.
- Act as 'champions', disseminating information and good practice as appropriate.
- If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

8. Frequency of meetings

8.1 Meetings shall be held not less than four times per financial year (and a fifth meeting may be required in May or June of each year as part of the process of reviewing the Annual Report and Financial Statements before submission to the Board of Directors). The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

8.2 The frequency of meetings can be varied at the discretion of the Chair of the Committee.

8.3 An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

8.4 At least once a year, the Committee Chair will consider meeting with the Chairs of other committees or consider having a joint meeting between the Audit Committee and the Quality Committee. The Committee will be able to review the work of other committees throughout the year through their reporting to the Board. Together with the option to discuss matters of joint interest at joint meetings with the Chairs of other committees, this will assist the Committee to discharge its function, under these Terms of Reference, to review the work of other committees whose work can provide relevant assurance to the Committee's own scope of work.

9. Calling meetings

9.1 Meetings will be called and conducted in accordance with the Trust's Standing Orders. The notice period will be a minimum of ten days. Written reports are to be sent to members at least five clear days before the meeting.

9.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.

9.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

10. Quoracy

10.1 The quorum for the committee is a minimum of two members to include the Chair of the Committee (or the deputy chair of the committee in their absence).

10.2 Attendance will be monitored as part of the committee's annual report to the Board and will be reported in the Trust's Annual Report.

10.3 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

10.4 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

11. Decision making and voting

11.1 The Committee must have regard to guidance issued by NHS England, the Care Quality Commission, and will also have regard to NHS policy and best practice.

11.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

11.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

11.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

11.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

11.6 Where committee members unable to attend a meeting have nominated a deputy to attend in their place, the name(s) of the nominated deputy(ies) will be recorded in the minutes of the Committee and deputies will exercise full voting rights at meetings and be included in the quorum. Where more than one individual attends to deputise for a committee member, they may between them only exercise the one vote of that member; the vote may not be divided between the deputies and if agreement upon exercise of the one vote cannot be reached then this will be recorded as the vote not being able to be cast.

12. Behaviours and Conduct

Benchmarking and guidance

12.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example guidance issued by the Government, the Department of Health and Social Care, NHS England, Care Quality Commission, and the wider NHS in reaching their determinations.

Conflicts of interest

12.2 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the Trust's policies and procedures. This will be recorded in the minutes.

12.3 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

Trust values

12.4 Members will be expected to conduct business in line with the Trust values and objectives and the principles set out by the Board.

12.5 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Code of Conduct.

12.6 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

12.7 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

12.8 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

Equality and diversity

12.9 Members must demonstrably consider the equality and diversity implications of decisions they make.

13. Accountability and reporting arrangements

13.1 Meetings of the Audit & Risk Committee will be formally recorded and once approved, submitted to the Board at the next opportunity.

13.2 After each meeting of the Committee, the Chair of the Committee will make a report (in the form of 3As – Alert/Advise/Assurance) to the next meeting of the Trust Board and draw to its attention any issues that require its particular attention or require it to take

action. Where the Chair of the Committee considers appropriate, they will escalate immediately any significant issue to the Chief Executive or Chair.

13.3 The representative Non-Executive member of the Quality Committee appointed to the Audit Committee shall draw specific attention to any issues that require notification to the Audit Committee.

13.4 The Chair of the Committee will submit an annual report of the work of the Committee to the Board to include reports on frequency of meetings, members' attendance, any recommendations to address non-attendance or changes to membership, and business conducted by the Committee (cross referenced to its remit). The purpose of the Annual Report is to ensure that the Committee is working to its terms of reference and has appropriate membership.

14. Administrative support

14.1 The Committee will be supported administratively by the Director of Corporate Affairs or their nominated member of their team, whose duties in this respect will include:

14.1.1 Agreement of the agenda with the Committee Chair and lead Executive Director, collation and distribution of papers at least one week before each meeting.

14.1.2 Good quality minutes are taken in accordance with the Standing Orders, produced within ten working days of a meeting and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

14.1.3 Action points are taken forward between meetings.

14.1.4 An annual work programme summarising those items to be considered during the year is provided to the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

14.1.5 Providing support to the Committee Chair and members as required.

15. Review of committee effectiveness and terms of reference

15.1 The Committee will undertake an annual self-assessment of its performance against its annual work programme, membership, and compliance with its Terms of Reference. This self-assessment will form the basis of its annual report to the Board.

15.2 The Committee's annual report will include details of its governance cycle, meeting dates, a summary of the business conducted, membership attendance, and whether meetings were held in quorum.

15.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

Date approved by Committee:	03 December 2024
Date approved by the Board:	29 January 2025
Next review date:	April 2026

Document management and revision history

Version	Date	Summary of changes
1.0	31 January 2018	Approved by the Board of Directors
1.1	February 2020	Received by the Audit Committee
1.2	April 2020	Received by the Audit Committee
1.3	May 2022	Received by the Audit Committee
1.4	16 June 2023	Received by the Audit Committee
1.5	19 July 2023	Approved by the Board of Directors
1.6	03 December 2024	Revisions presented in new committee terms of reference template; change of name to Audit & Risk committee; review and clarification of committee purpose, duties and responsibilities; addition of clauses regarding behaviours and conduct (benchmarking and guidance, conflict of interests, Trust values, equality and diversity) and non-material revisions to governance clauses in accordance to Standing Orders.
1.7	30 December 2024	Audit committee's comments re FTSU and cyber security incorporated.
1.7	29 January 2025	Approved by the Board of Directors

Appendix

Audit committee membership

Chris Hurst	Non-Executive Director (Committee Chair)
Mohinder Sawhney	Non-Executive Director
David Clark	Non-Executive Director
Rick Trainor	Non-Executive Director

Oxford Health
NHS Foundation Trust

Finance & Investment Committee
Terms of Reference

Contents

1. Purpose

1.1 The Finance and Investment Committee is established to provide scrutiny and an objective view of the financial performance and financial strategy of the Trust, including the capital programme, together with an understanding of the risks and assumptions within the financial plans and projections, to provide assurance to the board about the integrity and deliverability of the Trust financial and efficiency plans. The committee oversees the development and delivery of the estates strategy, digital strategy, arrangements for procurement, value for money, productivity and efficiency, including plans to deliver savings and transformation. For capital expenditure, it reviews and approves business cases and disposals £500k+ to £2m, PIDs for schemes £2m+, forecast variation £100k to £500k and monitors major capital projects during delivery. It also monitors compliance with Information Governance, including Data Quality and Cyber Security.

2. Constitution

2.1 The Board has established a committee known as the Finance and Investment Committee as a standing assurance committee of the Board, operating in line with unitary board principles.

2.2 The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation of Powers and may be amended from time to time. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2.3 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders of the Board and other policies of the Trust.

2.4 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.

2.5 These Terms of Reference set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

3. Authority

3.1 The Committee is authorised by the Board to:

3.1.1 Investigate any activity within its Terms of Reference.

3.1.2 Seek any information it requires within its remit, from any employee or member of the Board (who are directed to co-operate with any request made by the committee) within its remit as outlined in these Terms of Reference.

3.1.3 Commission any reports it deems necessary to help fulfil its obligations.

3.1.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary

to fulfil its functions. In doing so the committee must follow any procedures put in place by the Board for obtaining legal or professional advice.

3.2 All procedural matters in respect of conduct of meetings shall follow the Board's Standing Orders, Scheme of Reservation and Delegation and/or Trust Constitution as appropriate.

Limitations of Authority

3.3 The Committee shall be delegated the power of the Board of Directors to require the attendance of any member of the Trust staff.

3.4 Save as is expressly provided in the terms of reference, the Committee shall have no further power or authority to exercise, on behalf of the Board of Directors, any of its functions or duties.

4. Duties and responsibilities

Financial strategy and culture

4.1 Critically review the Financial Strategy (the Long-Term Financial Approach), including the financial culture and capability of the Trust.
4.2 Receive progress reports and review recommendations on variations to strategy.
4.3 Approve any relevant supporting strategies.
4.4 Make recommendations to the Board of Directors on approval of key financial strategies.

Estates, Digital and Environmental Sustainability strategies

4.5 Critically review the Estates strategy.
4.6 Critically review the Digital strategy.
4.7 Critically review the Green Plan and equivalent environmental strategies.
4.8 Receive progress reports and review recommendations on variations to strategies.
4.9 Approve any relevant supporting strategies.
4.10 Make recommendations to the Board of Directors on approval of key strategies.

Annual and Financial planning

4.11 Review the *process* by which the Trust sets out annually its objectives, priorities and plans, noting that decisions around priorities and content of the Annual Plan are reserved to the Board.

4.12 Review the Trust annual and medium-term financial plans, assess the assumptions therein and the alignment with overall Trust objectives before submission to the Board and external bodies.

Financial performance management

4.13 Review in-year performance against financial plan and forecast outturn, including key assumptions, risks and mitigations.

4.14 Review levels of contingency within the Trust financial plans and the phasing of key developments and efficiency schemes (including the full impact of depreciation).

4.15 Monitor in-year income and associated risk, including any income disputes.

4.16 Oversee and monitor the delivery of any annual plan priorities and programmes assigned to it by the Board.

Capital Projects

4.17 Consider and approve all capital expenditure proposals, acquisitions, and disposals within the authorities delegated to the Committee by the Board of Directors, under the Trust's Scheme of Delegation:

- critically scrutinise all business cases over £500k;
- approve business cases (over £500 less than £2m); and
- make recommendations to the Board of Directors on approval over £2m

4.18 Approve all PIDs for schemes over £2m.

4.19 Approve of any forecast variation of £100-£500k of the approved budget for a capital development in line with the Budgetary Control policy.

4.20 Annually review the Capital Programme and make a recommendation to the Board of Directors.

4.21 Monitor delivery of the capital investment programme through 3As reports from the Capital Programme Sub Committee (CPSC).

4.22 Receive and consider evaluation reports for capital schemes over £2m.

Efficiency and value for money

4.23 Consider Value for Money in all aspects of the Committee's work.

4.24 Scrutinise the Trust's proposals to continuously improve the value obtained from our resources and review delivery against those plans.

4.25 Monitor the delivery of annual cost and performance improvement plans, ensuring that action is identified and taken to deal with any slippage in the plan, wherever possible.

4.26 Receive and scrutinise an analysis of the Trust's audited annual Reference Costs.

Procurement and commercial

4.27 Monitor the procurement and commercial operations of the Trust including compliance with procurement regulation.

Cash management and investment funds

4.28 Approve any financing or use of financial instruments within its delegation.

4.29 Be empowered to delegate its authority to the Chairman or the Chief Executive within the limits contained in the Trust's Scheme of Delegation.

4.30 Review compliance with financing agreements and covenants and the operation of treasury management policies.

Information Governance

4.31 Monitor compliance with Information Governance, including Data Quality and Cyber Security.

4.32 Receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

4.33 Receive reports on audits to assess information and information technology security arrangements, including the annual Data Security & Protection Toolkit audit.

4.34 Provide assurance to the Audit and Risk Committee and the Board that there is an effective framework in place for the management of risks associated with information governance, including data quality and cyber security.

Accounts and Accounting Policies

4.35 Consider any changes to accounting policies before the Audit and Risk Committee scrutinises the statutory accounts.

4.36 Review Special Payments and Losses before scrutiny by the Audit and Risk Committee where possible.

4.37 The Draft Annual Accounts are provided to FIC as an opportunity to identify any learning from the accounts or to identify any discrepancies with FIC's understanding.

Other policies

4.38 The Finance and Investment Committee will oversee the following policies:

- Budgetary control policy
- Treasury Management policy
- Investment policy
- Procurement policy
- Acquisition and disposal policy for land and property
- Integrated Information Governance policy
- Sustainability policy

5. Other functions

5.1 The Committee will consider matters referred to it by the Board, the Audit and Risk Committee or any other Board committee.

5.2 The Committee has no sub-committees but will receive a variety of reports to allow it to carry out its stated duties. The Committee will ensure effective interface with the Audit and Risk Committee, and with the Executive-led Capital Programme Sub-Committee and Information Management Group, to receive information, assurances and escalations and assure itself of the co-ordination of relevant risks. The Committee will work to minimise overlap with the Audit and Risk Committee.

5.3 The Committee will refer relevant risks or other matters to appropriate Committees for information or mitigation and will oversee appropriate risks delegated to it from the Board.

6. Membership and attendance

6.1 The Finance and Investment Committee membership will be appointed by the Board and consist of:

- At least three Non-Executive Directors (one from a financial and/or commercial background who will be its Chair)
- Chief Finance Officer (Executive lead)
- Chief Operating Officer for Mental Health and Learning Disability
- Chief Operating Officer for Community Health Services, Dentistry & Primary Care
- Executive Director of Strategy and Partnerships
- Director of Corporate Affairs

6.2 The Chief Executive, other Non-Executive and Executive Directors and up to three governors at each meeting have standing invitations to attend any meeting.

6.3 The Board will review the membership of the Committee annually to ensure that it meets the evolving needs of the Trust. The Committee membership at time of writing is presented at the Appendix.

6.4 An Executive or Non-Executive member of the Committee may nominate a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. In the case of an Executive member that deputy could either be another Executive Director of the Trust or some other deputy as appropriate. The Non-Executive Director members of the Committee may nominate any other Non-Executive Director of the Trust as their deputy to attend meetings in their absence. A deputy should be nominated only in exceptional circumstances for a particular meeting, and in such circumstances would count towards the quorum for the meeting.

6.5 The Committee may invite non-members to attend, in a non-voting capacity, all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair of the Committee.

6.6 Regular attendees, who are not voting members unless formally deputising and exercising the vote of their principal, and who will attend at their discretion, include: Director of Finance, Head of Financial Management, Chief Digital & Information Officer, Director of Estates & Facilities and members of the Corporate Governance team.

6.7 The Committee shall appoint one member to be the vice chair of the committee who shall exercise the powers and functions of the Chair of the Committee in their absence.

6.8 Attendance at the meeting may be by videoconferencing at the discretion of the Committee Chair.

6.9 Committee members are required to:

- Attend at least 75% of meetings, having read all papers beforehand.
- Act as 'champions', disseminating information and good practice as appropriate.
- If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

7. Frequency of meetings

7.1 Meetings shall be held not less than five times per financial year.

7.2 The frequency of meetings can be varied at the discretion of the Chair of the Committee.

7.3 An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

8. Calling meetings

8.1 Meetings will be called and conducted in accordance with the Standing Orders for the Board of Directors. The notice period will be a minimum of ten days. Written reports are to be sent to members at least five clear days before the meeting.

8.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.

8.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Quoracy

9.1 The quorum for the committee is three members to include at least two Non-Executive Directors (one of who to be the Chair of the Committee or the vice chair of the committee in their absence), and at least one Executive Director to be the Chief Finance Officer or nominated Deputy. Deputies and other attending Board members will count towards the quorum and attendance rates.

9.2 Attendance will be monitored as part of the committee's annual report to the Board and will be reported in the Trust's Annual Report.

9.3 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflict of interest, then that individual shall no longer count towards the quorum.

9.4 If the Committee is not quorate, then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

10. Decision making and voting

10.1 The Committee must have regard to guidance issued by NHS England, the Care Quality Commission, the Integrated Care Board(s), and will also have regard to NHS policy and best practice.

10.2 Decisions will be taken in accordance with the Board of Directors' Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

10.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

10.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

10.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

10.6 Where committee members unable to attend a meeting have nominated a deputy to attend in their place, the name(s) of the nominated deputy(ies) will be recorded in the minutes of the Committee and deputies will exercise full voting rights at meetings and be included in the quorum. Where more than one individual attend to deputise for a committee member, they may between them only exercise the one vote of that member; the vote may not be divided between the deputies and if agreement upon exercise of the one vote cannot be reached then this will be recorded as the vote not being able to be cast.

11. Behaviours and Conduct

Benchmarking and guidance

11.1 The Committee will take proper account of national guidance and appropriate benchmarking, for example guidance issued by the Government, the Department of Health and Social Care, NHS England, Care Quality Commission, and the wider NHS in reaching their determinations.

Conflicts of interest

11.2 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the Trust's policies and procedures. This will be recorded in the minutes.

11.3 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

Trust values

11.4 Members will be expected to conduct business in line with the Trust values and objectives and the principles set out by the Board.

11.5 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Code of Conduct.

11.6 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

11.7 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

11.8 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

Equality and diversity and well-being

11.9 Members must demonstrably consider the wellbeing, equality and diversity implications of decisions they make.

12. Accountability and reporting arrangements

12.1 Meetings of the Finance and Investment Committee will be formally recorded and once approved, minutes will be submitted to the Board at the next opportunity.

12.2 After each meeting of the Committee, the Chair of the Committee will make a report (in the form of 3As – Alert/Advise/Assurance) to the next meeting of the Trust Board and draw to its attention any issues that require its particular attention or require it to take action. Where the Chair of the Committee considers appropriate, s/he will escalate immediately any significant issue to the Chief Executive or Chair.

12.3 The Finance and Investment Committee may work with the Audit and Risk Committee specifically when issues arise in relation to the Audit and Risk Committee's role in maintaining effective systems of governance, risk management and internal control within the Trust.

13. Administrative support

13.1 The Committee will be supported administratively by the Director of Corporate Affairs or their nominated member of their team, whose duties in this respect will include:

- Agreement of the agenda with the Committee Chair and lead Executive Director, collation and distribution of papers at least five days before each meeting.
- Production of good quality minutes in accordance with the Standing Orders, within ten working days of a meeting and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- Action points are taken forward between meetings.
- An annual work programme summarising those items to be considered during the year is provided to the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.
- Providing support to the Committee Chair and members as required.

14. Review of committee effectiveness and terms of reference

14.1 The Committee will undertake an annual self-assessment of its performance against its annual work programme, membership, and compliance with its Terms of Reference. This self-assessment will form the basis of its annual report to the Board.

14.2 The Committee's annual report will include details of its governance cycle, meeting dates, a summary of the business conducted, membership attendance, and whether meetings were held in quorum.

14.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval**.**

Date approved by Committee: 09 January 2025
Date approved by the Board: xx
Next review date: May 2025

Document management and revision history

Version	Date	Summary of changes
1.0	29 November 2017	Approved by the Board of Directors.
1.1	11 March 2020	Reviewed and approved by FIC.
1.2	12 July 2022	Reviewed and approved by FIC.
1.3	04 July 2023	Reviewed and approved by FIC.
1.4	19 September 2023	Reviewed and approved by FIC.
1.5	November 2024	Revisions presented in new committee terms of reference template; clarification of committee purpose, duties and responsibilities; addition of clauses regarding behaviours and conduct (benchmarking and guidance, conflict of interests, Trust values, equality and diversity) and non-material revisions to governance clauses in accordance to Standing Orders.
1.6	14 January 2025	Approved by the committee subject to minor amendments
1.7	[date/month] 2025	Approved by the Board of Directors.

Appendix

Finance and Investment committee membership

Lucy Weston	Non-Executive Director (Committee Chair)
David Walker	Non-Executive Director
	Non-Executive Director
Heather Smith	Chief Finance Officer (Lead Executive Director)
Rob Bale	Chief Operating Officer for Mental Health & Learning Disability
Ben Riley	Chief Operating Officer for Community Health Services, Dentistry and Primary Care
Amelie Bages	Executive Director of Strategy and Partnerships
	Director of Corporate Affairs

Oxford Health
NHS Foundation Trust

People, Leadership and Culture Committee
Terms of Reference

Contents

1. Purpose

1.1 The People, Leadership and Culture Committee (the Committee) is responsible for monitoring the development and delivery of the Trust's People plan and Organisational Development strategy consistent with the NHS People Plan. It will provide scrutiny and constructive challenge to ensure the Trust can deliver its People plan and be sustainable in the long term, including responsibility for the leadership, health and wellbeing of staff. The Committee will make recommendations to the Board and provide assurance against regulatory requirements relating to workforce.

1.2 The Committee is established to maintain a strategic overview of the workforce, educational and organisational development arrangements to ensure a positive culture and working environment for staff, to enable the provision of high-quality care and good clinical outcomes for patients. The Committee will seek assurance on behalf of the Board that the organisation has an aligned and joined up culture across all directorates and services in which all staff thrive and contribute to the delivery of outstanding care for patients.

1.3 The Committee will promote equality, diversity and inclusion across the Trust, ensuring appropriate assurance on behalf of the Board.

2. Constitution

2.1 The Board has established a committee known as the People, Leadership and Culture Committee as a standing assurance committee of the Board, operating in line with unitary board principles.

2.2 The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation of Powers and may be amended from time to time. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2.3 The Committee is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders of the Board and other policies of the Trust.

2.4 The Terms of Reference for the Committee outlined below are defined by the Board and may be amended by the Board at any time.

2.5 These Terms of Reference, which will be published on the Trust's website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

3. Authority

3.1 The Committee is authorised by the Board to:

3.1.1 Investigate any activity within its Terms of Reference.

3.1.2 Seek any information it requires within its remit, from any employee or member of the Board (who are directed to co-operate with any request made by the committee) within its remit as outlined in these Terms of Reference.

3.1.3 Commission any reports it deems necessary to help fulfil its obligations.

3.1.4 Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the Board for obtaining legal or professional advice.

3.1.5 All procedural matters in respect of conduct of meetings shall follow the Board's Standing Orders, Scheme of Delegation and Reservation and/or Trust Constitution as required.

Limitations of Authority

3.2 The Committee shall be delegated the power of the Board of Directors to require the attendance of any member of the Trust staff.

3.3 Save as is expressly provided in the terms of reference, the Committee shall have no further power or authority to exercise, on behalf of the Board of Directors, any of its functions or duties.

3.4 For the avoidance of doubt, the Committee shall not itself be responsible for undertaking any operational involvement in the Trust's governance (internal control) or risk management systems.

4. Duties and responsibilities

4.1 The People, Leadership and Culture Committee will:

Leadership and workforce governance assurance

4.2 Oversee and scrutinise the development and implementation of the Trust's People Plan and Organisational Development Strategy (including component plans) and priorities and receive exception and mitigation reports on any significant risks to delivery.

4.3 Ensure the Trust has sufficient and appropriately educated and professionally developed staff to provide high quality care and services.

4.4 Seek assurance that the following processes are working effectively:

- leadership development
- talent management and succession planning
    - recruitment and retention
    - appraisal
    - performance management

4.5 Seek assurance that the Trust complies with the Equality Act, including the requirement to undertake Equality Impact Assessments and to monitor the outcomes of the Equality Delivery System (EDS2) Action Plan.

4.6 Seek assurance that arrangements for raising concerns, including the functions of the Freedom to Speak Up Guardian, meet national expectations and have the confidence of staff.

4.7 Seek assurance that an effective process is in place to ensure employee relations matters are resolved quickly and effectively.

4.8 Seek assurance that the Trust is compliant with regulatory requirements in relation to workforce matters, that immediate and effective action is taken where there is variation, and that the health and wellbeing of staff is being effectively promoted and supported.

4.9 Receive reports and action plans on the requirements of new and emerging guidance from regulators and external agencies that relate to workforce and provide assurance that the Trust has in place processes, guidance and support to ensure that all staff are treated fairly.

4.10 Seek assurance that staff establishments are up to date and processes in place to ensure a full complement of staff, thereby minimising reliance on temporary staffing.

4.11 Receive internal audit reports relating to workforce matters.

4.12 Provide assurance to the Board and relevant Committees on compliance with relevant workforce legislation and best practice, including medical and nursing revalidation.

4.13 Provide assurance to the Audit & Risk Committee and the Board on the required workforce assurances included in the Annual Governance Statement; i.e. that the 'description of the key ways in which the trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective' [alongside] 'a description how the trust complies with the '*Developing Workforce Safeguards'* recommendations' [about safer staffing].

<u>Resourcing</u>

4.14 Ensure there is an effective workforce planning process in place and review and monitor implementation of annual workforce plans.

4.15 Oversee the development and implementation of recruitment and retention, talent development and well-being strategies/plans.

4.16 Review key workforce performance indicators and ensure action plans to deliver improvements are robust and delivering the required performance.

4.17 Seek assurance that systems are in place to ensure staff are well-led and effectively deployed.

<u>Operational performance</u>

4.18 Oversee and seek assurance in relation to key performance indicators aligned to the objectives established in the Trust's People Plan.

<u>Education and learning & development</u>

4.19 Monitor the effective delivery of the Trust's strategy and plans for staff education and professional development and provide assurance to the Board that these approaches are effective and targets will be met.

4.20 Ensure the Trust is delivering its responsibilities in terms of provision of education and learning and development.

4.21 Ensure quality education is delivered as a provider of education for trainees and student placements.

4.22 Scrutinise action plans arising from reports relevant to the remit of the Committee, including those produced relating to:

- Junior doctors' surveys
- Guardian of Safe Working Junior Doctors Working Hours

4.23 Receive exception reports and assurance regarding progress with required actions from the Executive Team and Education Strategy Group.

4.24 Review assessment reports from external education and professional regulators, e.g. Health Education England and the General Medical Council, alongside postgraduate and undergraduate education satisfaction surveys and specialty reviews; and receive assurance regarding progress with any required actions.

4.25 Seek assurance regarding the sufficiency and/or quality of clinical supervision and mentorship and alert the Board to any reported unmitigated risks.

Culture - Equality, Diversity and Inclusion

4.26 Seek assurance that diversity and inclusion are embedded in Trust policies and procedures by scrutinising the annual WRES and WDES data and that areas of concern are being addressed.

4.27 Monitor the development of the Trust's culture (safety, collective leadership, celebrating difference, co-production and continuous improvement) and the embedding of behaviours and staff experience consistent with Trust values.

4.28 Consider staff feedback and response rates gained through engagement events, the annual staff survey and pulse survey in order to gain assurance that satisfaction levels are improving through monitoring activity at a central and local level.

4.29 Review themes arising from exit interviews and receive assurance of the effectiveness of actions taken to address these.

4.30 Scrutinise and assess the effectiveness of the organisation's arrangements for complying with the NHS Constitution in relation to staff rights and pledges.

4.31 Scrutinise action plans relating to People and Culture arising from Care Quality Commission (CQC) inspections and receive assurance that effective improvement measures are taking place.

4.32 Support the regular reporting to the Board to ensure that the Trust is supporting and promoting a culture of 'Freedom to Speak Up' across the organisation, undertaking specific reviews on areas of concern on behalf of the Board as directed.

Culture - Organisational Development

4.33 Review the Organisational Development plan to ensure it aligns with the values and delivers the Trust Strategy.

4.34 Review the Organisational Development plan to ensure it considers the core components necessary to organisational development including culture, behaviours, ways of working, structures, systems and processes.

4.35 Seek assurance that the culture across the Trust aligns and is one that supports a just, fair, inclusive and compassionate culture.

4.36 Review and monitor implementation of the Trust's strategy for improving staff engagement, talent management, leadership development and other emerging strategies.

4.37 Ensure the Trust invests in putting in place effective systems and processes for learning and development to promote and grow talent from within the Trust.

4.38 Ensure the Trust adopts and embeds a mindset and approach of quality improvement and continuous learning and development in all that it does.

4.39 Ensure the Trust adopts and embeds a culture of collective leadership.

Health and Safety

4.40 Monitor compliance with health and safety legislation and regulatory requirements.

4.41 Work closely with the Quality committee regarding reports on violence and aggression against staff and improvement plans.

Risk Management

4.42 Ensure the Trust has robust workforce and health and safety related risk management systems and processes in place.

4.43 Review all risks in the Board Assurance Framework that have been assigned to the Committee to monitor.

4.44 Review all risks on the Trust-wide Risk Register (15+) relating to workforce and health and safety and note and comment on the changes proposed by the executive.

4.45 Refer relevant risks or other matters to appropriate committees for information or mitigation and oversee risks referred to it from the Audit & Risk Committee, the Quality Committee or any other committee or the Board.

4.46 Provide assurance to the Audit and Risk Committee and the Board in relation to workforce, Freedom to Speak Up, and Health & Safety risk. Work closely with the Quality Committee and the Finance & Investment Committee to ensure that staffing issues, workforce planning, and promotion of safe and just culture are effectively triangulated and fully integrated into the board governance framework.

Specific responsibilities

4.47 The People, Leadership and Culture Committee can request a report on any subject or issue relevant to its Terms of Reference.

4.48 The People, Leadership and Culture Committee will consider the following annual reports before being submitted to the Board:

- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender pay gap
- Health and Safety (including fire, security and welfare) annual report (statutory)
- Medical revalidation
- Nursing revalidation

4.49 The People, Leadership and Culture Committee will be responsible for overseeing the following strategies:

- People Plan
- Organisational Development strategy
- Equality Diversity System
- Nursing strategy
- Allied Health Professionals (AHP) strategy

4.50 The People, Leadership and Culture Committee will be responsible for approving prior to submission to the Board the following policies:

- Disciplinary policy
- Freedom to Speak Up and Whistleblowing
- Equality, Diversity & Inclusion

4.51 The People, Leadership and Culture Committee will receive assurance through an escalation report that the Trust workforce related policies are up to date.

5. Membership and attendance

5.1 The People, Leadership and Culture Committee membership will be appointed by the Board and consist of the following voting members:

- At least three Non-Executive Directors, one of whom will be the Chair of the Committee
- Chief People Officer (executive lead)
- Chief Nurse
- Chief Operating Officer for Mental Health and Learning Disability
- Chief Operating Officer for Community Health Services, Dentistry and Primary Care (or deputy)
- Executive Director of Strategy and Partnerships
- Director of Corporate Affairs

5.2 The Trust Chair, Chief Executive, other Non-Executive Directors and up to three governors at each meeting have standing invitations to attend any meeting.

5.3 The Board will review the membership of the Committee annually to ensure that it meets the evolving needs of the Trust. The Committee membership at the time of writing is presented at the Appendix.

5.4 An Executive or Non-Executive member of the Committee may nominate a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. In the case of an Executive member that deputy could either be another Executive

Director of the Trust or some other deputy as appropriate. The Non-Executive Director members of the Committee may nominate any other Non-Executive Director of the Trust as their deputy to attend meetings in their absence. A deputy should be nominated only in exceptional circumstances for a particular meeting, and in such circumstances would count towards the quorum for the meeting.

5.5 The Committee may invite non-members to attend, in a non-voting capacity, all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair of the Committee.

5.6 Regular attendees, who are not voting members unless formally deputising and exercising the vote of their principal, include: the Head of Resourcing, Head of HR Policy, Reward & Projects, Head of Organisational Development, Head of Equality, Diversity & Inclusion.

5.7 The Committee shall appoint one member to be the vice chair of the committee who shall exercise the powers and functions of the Chair of the Committee in their absence.

5.8 Attendance at the meeting may be by videoconferencing at the discretion of the Committee Chair.

5.9 Committee members are required to:

- Attend at least 75% of meetings, having read and considered all papers beforehand.
- Act as 'champions', disseminating information and good practice as appropriate.
- If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf.

6. Frequency of meetings

6.1 Meetings shall be held not less than four times per financial year.

6.2 The frequency of meetings can be varied at the discretion of the Chair of the Committee.

6.3 An annual programme of business will be received by the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

7. Calling meetings

7.1 Meetings will be called and conducted in accordance with the Trust's Standing Orders. The notice period will be a minimum of ten days. Written reports are to be sent to members at least five clear days before the meeting.

7.2 Extraordinary meetings may be held at the discretion of the Chair. A minimum of two working days' notice should be given when calling an extraordinary meeting.

7.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

8. Quoracy

8.1 The quorum for the committee is five members to include the Chair of the Committee (or the vice chair of the committee in their absence), one Non-Executive Director and at least one Executive Director to be the Chief People Officer or nominated Deputy. Deputies and other attending Board members will count towards the quorum and attendance rates.

8.2 Attendance will be monitored as part of the committee's annual report to the Board and will be reported in the Trust's Annual Report.

8.3 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

8.4 If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

9. Decision making and voting

9.1 The Committee must have regard to guidance issued by NHS England, the Care Quality Commission, and will also have regard to NHS policy and best practice.

9.2 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

9.3 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

9.4 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

9.5 If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication.

9.6 Where committee members unable to attend a meeting have nominated a deputy to attend in their place, the name(s) of the nominated deputy(ies) will be recorded in the minutes of the Committee and deputies will exercise full voting rights at meetings and be included in the quorum. Where more than one individual attends to deputise for a committee member, they may between them only exercise the one vote of that member; the vote may not be divided between the deputies and if agreement upon exercise of the one vote cannot be reached then this will be recorded as the vote not being able to be cast.

10. Behaviours and Conduct

Benchmarking and guidance

10.1 The Committee will take proper account of National Agreements and appropriate benchmarking, for example guidance issued by the Government, the Department of Health and Social Care, NHS England, Care Quality Commission, and the wider NHS in reaching their determinations.

Conflicts of interest

10.2 All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) in accordance with the Trust's policies and procedures. This will be recorded in the minutes.

10.3 Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

Trust values

10.4 Members will be expected to conduct business in line with the Trust values and objectives and the principles set out by the Board.

10.5 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Code of Conduct.

10.6 Members of the Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

10.7 The Committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

10.8 All members of the Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Committee.

Equality and diversity and wellbeing

10.9 Members must demonstrably consider the wellbeing, equality and diversity implications of decisions they make.

11. Accountability and reporting arrangements

11.1 Meetings of the People, Leadership and Culture Committee will be formally recorded and once approved, submitted to the Board at the next opportunity.

11.2 After each meeting of the Committee, the Chair of the Committee will make a report (in the form of 3As – Alert/Advise/Assurance) to the next meeting of the Trust Board and draw to its attention any issues that require its particular attention or require it to take action. Where the Chair of the Committee considers appropriate, s/he will escalate immediately any significant issue to the Chief Executive or Chair.

11.3 The People, Leadership and Culture Committee will work with the Audit & Risk Committee specifically when issues arise in relation to the Audit & Risk Committee's role in maintaining effective systems of governance, risk management and internal control within the Trust.

11.4 The Chair of the Committee will submit an annual report of the work of the Committee to the ~~Audit Committee~~ Board to include reports on frequency of meetings, members' attendance, and any recommendations to address non-attendance or changes to membership, and business conducted by the Committee (cross referenced to its remit). The purpose of the Annual Report is to ensure that the Committee is working to its terms of reference and has appropriate membership.

12. Administrative support

12.1 The Committee will be supported administratively by the Director of Corporate Affairs or their nominated member of his/her team, whose duties in this respect will include:

12.1.1 Agreement of the agenda with the Committee Chair and lead Executive Director, collation and distribution of papers at least one week before each meeting.

12.1.2 Good quality minutes are taken in accordance with the Standing Orders, produced within ten working days of a meeting and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

12.1.3 Action points are taken forward between meetings.

12.1.4 An annual work programme summarising those items to be considered during the year is provided to the Committee for assurance at the beginning of the financial year; however, this will be flexible to new and emerging priorities and risks.

12.1.5 Providing support to the Committee Chair and members as required.

13. Review of committee effectiveness and terms of reference

13.1 The Committee will undertake an annual self-assessment of its performance against its annual work programme, membership, and compliance with its Terms of Reference. This self-assessment will form the basis of its annual report to the Board.

13.2 The Committee's annual report will include details of its governance cycle, meeting dates, a summary of the business conducted, membership attendance, and whether meetings were held in quorum.

13.3 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval**.**

Date approved:	xx January 2025
Approved by:	Board of Directors
Next review date:	May 2025

Document management and revision history

Version	Date	Summary of changes
1.0	July 2023	Approved by the Board of Directors.
2.0	xx January 2025	Revisions presented in new committee terms of reference template; clarification of committee purpose, duties and responsibilities; addition of clauses regarding behaviours and conduct (benchmarking and guidance, conflict of interests, Trust values, equality and diversity) and non-material revisions to governance clauses in accordance to Standing Orders.

Appendix

People, Leadership and Culture committee membership

Mindy Sawhney	Non-Executive Director (Committee Chair)
Andrea Young	Non-Executive Director
Geraldine Cumberbatch	Non-Executive Director
Charmaine De Souza	Chief People Officer (executive lead)
Britta Klinck	Chief Nurse
Rob Bale	Chief Operating Officer for Mental Health & Learning Disability
Ben Riley	Chief Operating Officer for Community Health Services, Dentistry and Primary Care
Amelie Bages	Executive Director of Strategy & Partnerships
	Director of Corporate Affairs