

BOARD OF DIRECTORS' MEETING IN PUBLIC

Wednesday, 28 January 2026, 09:00-12:30

Microsoft Teams virtual meeting

AGENDA

No.	Item	Lead	Purpose	Paper	Time
Welcome					
1.	#Hellomynameis and apologies for absence ¹	Chair	Welcome	N/A	09:00
Patient and Staff Stories					
2.	Staff Story – Inpatient Mental Health Recruitment, Buckinghamshire	Chief People Officer	Discussion	Enclosed	09:05
3.	Patient Story – Learning Disability Physical Health Strategy Governors Group	Chief Nurse	Discussion	Enclosed	09:15
Opening Items					
4.	Register of Directors' Interests and declarations on items on the agenda	Chair	Assurance	Enclosed	09:35
5.	Minutes of the meeting held on 26 November 2025		Approval	Enclosed	
6.	Action log and Matters Arising from the Minutes		Assurance	Enclosed	
Strategic, Regulatory & System					
7.	Trust Chair's report	Chair	Discussion	Enclosed	09:40
8.	Chief Executive's report	CEO	Discussion	Enclosed	09:50
[Link to Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Board (ICB) papers: https://www.bucksoxonberks.west.icb.nhs.uk/about-us/board-meetings/board-papers/]					
9.	Corporate Affairs report: - Legal, Regulatory and Policy; and - Horizon Scanning	ED of Corp Affairs	Information & Assurance	Enclosed	10:05
10.	Board Assurance Framework	ED of Corp Affairs	Information & Assurance	Enclosed	
11.	Draft Annual Plan/Medium Term Plan – update ahead of submission in February 2026	Chief Finance Officer / ED of Strategy & Partnerships	Decision, Information & Assurance	Enclosed	10:20

¹ Apologies: None

Performance, Sustainability, Quality and People

12.	Integrated performance and sustainability reporting: a. Integrated Performance Report (IPR) b. Quality & Safety Dashboard c. Finance report	Exec Team	Information & Assurance	Enclosed	10:35

10 minutes' break 11:05 – 11:15

13.	Patient Safety Incidents (PSI) report	Chief Nurse	Assurance	Enclosed	11:15
14.	Update on Mental Health Act 2025 reforms	Chief Medical Officer	Information & Assurance	Enclosed	11:25

Governance & Reports on recommendation of committees

15.	Committee assurance reports (3As) ² : a. Audit & Risk Committee 02 December 2025 b. Charity Committee 09 December 2025 c. Finance & Investment Committee 20 January 2026 d. People, Leadership & Culture (PLC) Committee 21 January 2026	Committee Chairs	Discussion & Assurance	Enclosed, Verbal & Reading Room	11:35
16.	PLC Committee recommendation: Pay Gap reports: gender, ethnicity and disability	Chief People Officer	Assurance	Enclosed	11:55
17.	Audit & Risk Committee recommendation: Emergency Preparedness, Resilience and Response (EPRR) annual report	ED of Corp Affairs	Receipt & Approval	Enclosed	12:10

Closing matters & Resolution to conduct private business

18.	Any Other Business				12:20
19.	Questions from the public, governors or staff				
20.	Review of the Meeting				
21.	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				12:30
	Date of next meeting – 25 March 2026				

² No 3As report expected from the Quality Committee or the Mental Health & Law Committee which have not met since last reporting to the November 2025 Board. The next Quality Committee meeting will be on 12 February 2026 and the next Mental Health & Law Committee meeting will be on 03 March 2026.

READING ROOM/APPENDIX

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

22. Appendices 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/>
23. Committee minutes and agendas:
 - a) Audit & Risk Committee 09 September and 02 December 2025
 - b) Charity Committee 09 December 2025 (agendas only from the start of 2026, see Charity Committee 3As report at item 15(b) above for a summary of the meeting)
 - c) Finance & Investment Committee 18 November 2025 and agenda from 20 January 2026
 - d) Mental Health & Law Committee (not expected until March 2026)
 - e) People, Leadership & Culture Committee agenda from 21 January 2026
 - f) Quality Committee 13 November 2025

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	2
Report title:	Our Staff Story
Executive sponsor(s):	Charmaine De Souza, Chief People Officer
Report author(s):	Zoe Moorhouse, Head of OD Information provided by; Joseph Goodwin, Talent Acquisition Partner, Resourcing Team.
Action this paper is for:	☐ Decision/approval ☒ Information ☐ Assurance
Reason for submission to the Board:	Regular sharing of Staff Stories for the Board.
Public or confidential	Public

Summary of the story

Today's staff story comes from H, who is a ward manager for Sapphire Ward, an adult male ward. H has been the ward manager since May 2025, and has worked for Oxford Health for nearly three years since qualifying as a Mental Health nurse.

When H became Ward Manager on Sapphire Ward, the inpatients services in Bucks had a vacancy rate of 17.46% overall, with Sapphire ward at 18.21%.

H continued to recruit as would normally be the case, by advertising, shortlisting, interviewing and selecting candidates, but at the same time joined a working group to organise an event focused on recruiting newly qualified nurses to vacancies across Buckinghamshire, including all four inpatient wards. The event focused on selecting candidates via carefully constructed skills testing alongside the usual interview process. The event also provided candidates with an opportunity to meet the team and ask questions so that we improved the candidate experience which is an important part of creating future talent pools.

The event took place on 23 July 2025 at the Whiteleaf centre with a programme including:

- Group assessment, observed by 3 assessors (including 1 Expert by Experience).
- Skills Labs x2 assessing practical, real-world challenges
- Written Task reflecting typical responsibilities
- structured interview

This was the first time H had been involved in an event like this and noticed it was a really helpful way to see strengths in candidates, particularly as many of them were newly qualified. This helped H and the other recruiting managers to make better informed decisions at selection.

The event resulted in 100% of the nursing vacancies (four) being recruited into our inpatients services in Buckinghamshire many of whom have now begun their employment with Oxford Health.

In Sapphire specifically, the event was a helpful springboard to recruitment and has now led to a 5.68% overall vacancy rate with 10.92% vacancy rate overall within inpatient services.

The event brought some challenges with the group sizes and was a busy programme which has now been honed to ensure all of those involved have been able to learn from this first experience and make subsequent events easier both for those organising and also for those involved in assessing and selecting candidates.

There has been 2 subsequent organisation wide events in September and October 2025 focused on the recruitment of Healthcare Assistants which resulted in five HCA appointments being made for inpatient services in Bucks.

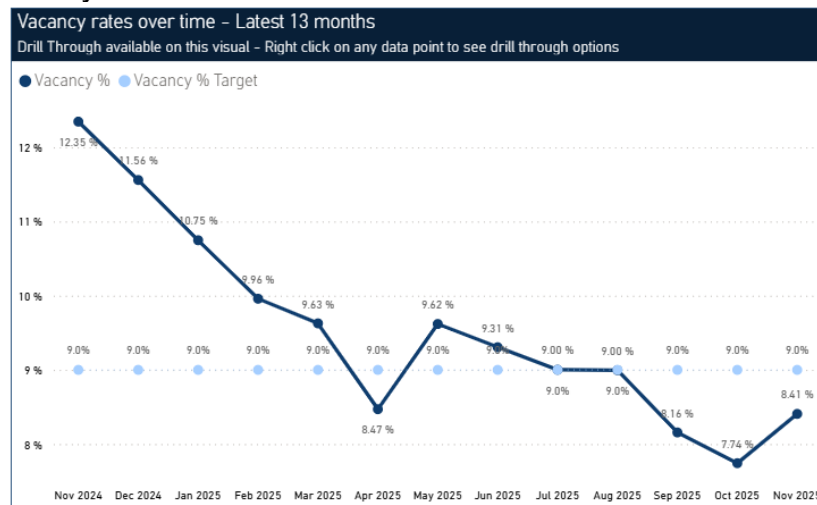
Working closely with appointing managers like H during these recruitment events has enabled our talent acquisition team to identify vacancies earlier and significantly reduce the number of adverts that attract no applicants. This collaborative approach has also strengthened decision-making by giving inpatient teams a more holistic view of candidates beyond the traditional interview. Through skills-based assessments and practical tasks, we've been able to uncover strengths that interviews alone might miss. In some cases, candidates who excelled in interviews struggled with real-world challenges, while others demonstrated exceptional practical ability. This process has allowed us to appoint well-rounded, capable individuals who are better equipped to deliver high-quality care and identify future development needs for those who are successful.

We are planning another event in May 2026 in Bucks, focused on Newly Qualified Nurses.

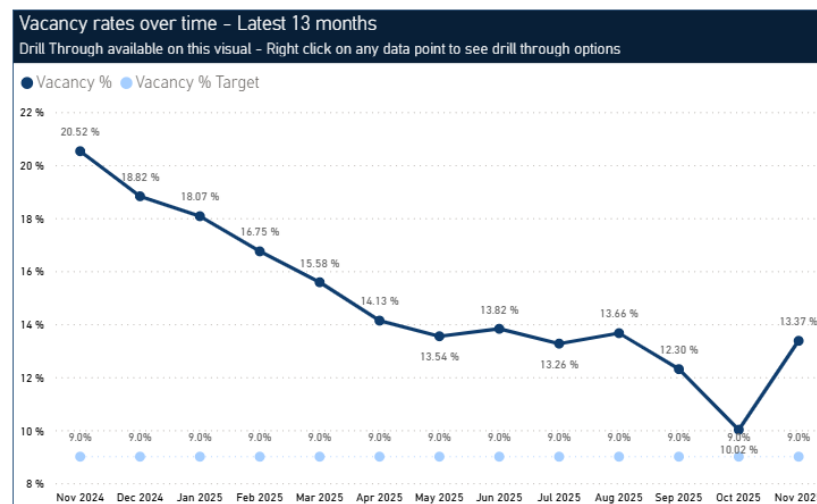
H has told us about her experiences of the event which have been crucial learning for future events. She has also been keen to support her colleagues since the event was not focused solely on recruiting to vacancies on her own ward, but was recruiting to the inpatient services as a whole. We are keen to develop this approach with other services in Oxford Health.

Background information

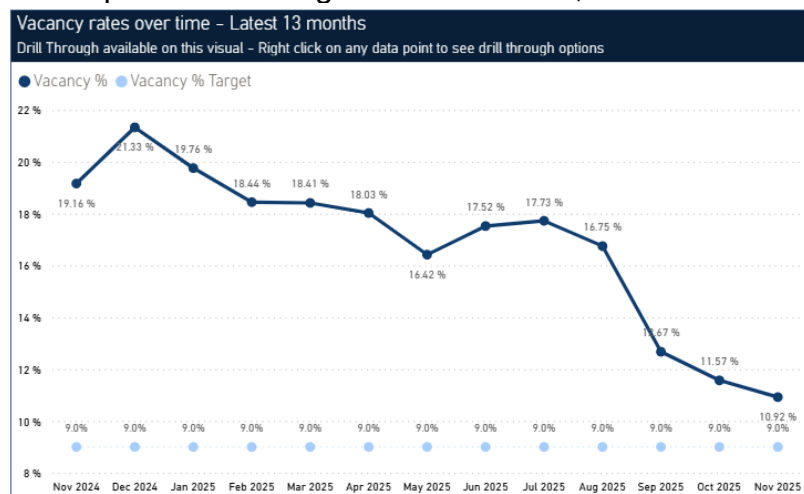
Trust overall vacancy rate:



Vacancy position in Bucks Directorate overall:



Vacancy position for inpatients and urgent care services, in Bucks:



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

Our Staff Story has been prepared solely for the Board.

Recommendation(s)

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

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	
	If yes, include brief description, e.g. CQC essential standards; Provider license etc	

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	3
Report title:	Patient Story - Learning Disability Physical Health Strategy Governors Group
Executive sponsor(s):	Britta Klink, Chief Nurse
Report author(s):	Physical Health Strategy Governors Group, supported by Emma Short (Consultant Nurse) and Rachel Miller (Patient Experience and Involvement Lead for Learning Disabilities)
Action this paper is for:	☐ Decision/approval ☒ Information ☐ Assurance
Reason for submission to the Board:	Regular Patient Story agenda item
Public or confidential	Public

Executive summary

This patient story highlights the work of the Learning Disability Physical Health Strategy Governors group, which was formed at the request of Emma Short, Consultant Nurse, Learning Disabilities to ensure that the actions the Learning Disability Physical Health Strategy, have active involvement from people with lived experience.

People with a learning disability, experience poorer health outcomes than the general population, for a variety of reasons. We believe that a keyway to work differently to address this inequality is through co-production and involvement of people with a learning disability in the work. We have knowledge of healthcare, but we need the expertise of those with lived experience of learning disability to ensure that we find and implement improvements that will make a real difference.

The presentation will provide brief information on some of the work undertaken by the group since it was established in April 2024. The groups work and preparations for this presentation have highlighted the following.

- The importance of easy read appointment letters and patient information for people with a learning disability who may only have a few hours of support time per week.

- The difficulties with online meetings, none of the group were confident about joining a Teams meeting and the group have been clear that face to face appointments work better for them.(Not all of the group have access to a computer or smart phone, some are able to use Zoom after training from My Life My Choice (Self advocacy charity)

-The need to consider accessibility to appointments with the group highlighting issues such as not being able to use their bus passes before 9am to attend appointments, which many of us do not consider but can create a barrier for some people.

-The skills of social care staff to support people in relation to healthcare and living a healthy lifestyle, has also been highlighted with, for example the group feeling that their support staff would struggle to support them to fill out the Emergency grab sheet you will hear about in the presentation. A member of support staff was supporting a member of the group at that meeting, and she acknowledged that she found some of the medical “Jargon” used difficult to fully understand.

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

This presentation has to date only been shared with the group and managers of the Patient experience Team and with Trust Board on the 28th January 2026.

Recommendation(s)

This presentation hopefully highlights the valuable contribution involving people with a learning disability in our work to hopefully ensure we use our resources in the most effective ways to improve people with a learning disabilities health and wellbeing.

The recommendation would therefore be that, the Trust board continue to develop this type of involvement and co-production work within learning disability services.

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/No If yes, include brief description, e.g. CQC essential standards; Provider license etc	



(Agenda item: 4)

REGISTER OF DIRECTORS’ INTERESTS

January 2026

PART A – CURRENT BOARD MEMBERS

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	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. Formally 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. Director of Legal Services at the University of Hertfordshire, from 04 August 2025. Husband is employed by NHS England as the Mental Health Specialist Advisor, Midlands Region (formerly was NHS England Clinical Network Senior Clinical Programme Manager for the London Clinical Networks).
Charmaine De Souza	Chief People Officer	Board member and Chair of the Remuneration & Nomination Committee for Hightown Housing (remunerated), a charitable housing association covering Hemel Hempstead and the surrounding area and counties of Hertfordshire, Buckinghamshire, Bedfordshire and Berkshire. Member of the Remuneration & Nominations Committee of Green Templeton College, University of Oxford (unremunerated) from 01 December 2025. Green Templeton College provides a leadership programme for medical and other senior leaders in Oxford Health NHS FT.
Taff Gidi	Executive Director of Corporate Affairs	Co-owner of hi-5 Coaching LLP - executive coaching partnering with individuals, teams and organisations including the NHS but no previous business with Oxford Health NHS FT. No business with the NHS but also Director of Gidi & Associates Limited, Director of A-List Accounting Ltd and Non-Executive Director of the Youth United Foundation (network of the nation's leading uniformed youth organisations including various cadets).

¹ Interim October 2023 – November 2025.

Chris Hurst	Non-Executive Director	From 1 January 2026, Non-Executive Director and Audit Chair (in common) for the new Coventry & Warwickshire and Hereford & Worcestershire ICB cluster. 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.
Emma Leaver	Chief Operating Officer for Community Health Services, Dentistry & Primary Care ²	Trustee of the Oxfordshire Play Association (OPA) – a charity with a mission to champion and support the rights of all children and young people to have access to high quality, inclusive play opportunities to improve their physical, mental and spiritual wellbeing. The charity is based in Oxfordshire and works exclusively in the county. The charity offers a blend of open community play days and targeted work for more vulnerable communities.
Grant Macdonald	Chief Executive Officer ³	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
Kamal Mahtani	Non-Executive Director – Nominee of the University of Oxford	Affiliated with the University of Oxford and including but not limited to: Director, MSc Global Healthcare Leadership Director, MSc EBHC (Systematic Reviews) Director, Oxford Primary Care Research Leadership Programme Fellow, Kellogg College Fellow, Royal College of General Practitioners
Karl Marlowe	Chief Medical Officer	Educational Supervisor of Oxford University's Clinical 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

² Interim since 01 March 2025 to December 2025. Substantive since January 2026.

³ Interim Chief Executive Officer 01 July 2023-November 2024. Formerly Executive Managing Director for Mental Health, Learning Disability & Autism Services

		Board Member: Health Innovation Network Oxford & Thames Valley Chairman: 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 social purpose companies and charities. Sibling is on the staff bank for OHFT's Oxfordshire Out of Hours GP service.
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 Joint Finance and Performance Committee of NHS Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care Board (ICB) and NHS Frimley ICB. Integrated Care Boards (ICBs) can establish and maintain joint working arrangements to jointly exercise their functions and the Thames Valley Cluster have set up these joint arrangements on an interim basis, pending more permanent arrangements when the ICBs are merged. The Committee will review the financial and non-financial targets of the Partner ICBs during the cluster period to ensure that appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance that the arrangements are working effectively. Non-Executive and unremunerated Member of the Board and Trustee of Arts at the Old Fire Station (AOFS), a charity. AOFS shares the Old Fire Station building in Oxford with the homelessness charity Crisis and encourages people from all backgrounds to understand and shape the world in which we live through stories, creativity and the arts, and by connecting with others. Family member is General Manager at 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 June 2026)

		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 Trustees at Response (appointed 10 July 2025) – a charity providing housing and support across Oxfordshire, Buckinghamshire, Berkshire, and the South West of England for people with mental health and complex needs. Collaborative working partnerships with the Oxfordshire Mental Health Partnership (includes Oxford Health NHS FT), Oxford Health NHS FT's Child & Adolescent Mental Health Service (CAMHS) and the Young People's Supported Accommodation Service (YPSA) (commissioned by Oxfordshire County Council in partnership with district councils). Other stakeholders include Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. 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). Member of the Audit, Risk & Assurance Committee and the Finance Committee of A2Dominion Housing Group – a housing association (since November 2025). Formerly Chair of Soha Housing (stepped down in September 2023). Self-employed - Lucy Weston Consulting.
Andrea Young	Non-Executive Director and Trust Chair Designate pending 01 April 2026	Member of the Independent Reconfiguration Panel, providing independent advice to Ministers on changes to health services (4-year appointment starting 18 March 2024). 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).

Meeting of the Oxford Health NHS Foundation Trust Board of Directors

[DRAFT] Minutes of a meeting held on Wednesday, 26 November 2025 at 09:00 Microsoft Teams virtual meeting

Present:¹

David Walker (DW)	Trust Chair (the Chair)
Grant Macdonald (GM)	Chief Executive Officer
Amélie Bages (AB)	Executive Director of Strategy & Partnerships* ²
Rob Bale (RB)	Interim Chief Operating Officer for Mental Health & Learning Disability
Geraldine Cumberbatch (GC)	Non-Executive Director
Charmaine De Souza (CDS)	Chief People Officer
Taff Gidi (TG)	Executive Director of Corporate Affairs*
Chris Hurst (CMH)	Non-Executive Director – <i>part meeting</i>
Britta Klinck (BK)	Chief Nurse
Emma Leaver (EL)	Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care
Kamal Mahtani (KMa)	Non-Executive Director appointee of the University of Oxford
Mohinder Sawhney (MS)	Non-Executive Director
Heather Smith (HS)	Chief Finance Officer
Lucy Weston (LW)	Non-Executive Director
Andrea Young (AY)	Non-Executive Director

In attendance³:

Attendee from Oxfordshire County Council

Ansaf Azhar	Oxfordshire County Council Director of Public Health & Communities – <i>part meeting</i>

Attendees/observers from Oxford Health NHS FT staff

Charlotte Adamson	Senior Programme Manager, Planning – <i>part meeting</i>
Ben Cahill	Deputy Director of Corporate Affairs – <i>part meeting</i>
Laura Carter	Head of Strategy – <i>part meeting</i>
Mariona Casals	Business Relationship Manager
Simon Cook	Warneford Park Programme Director (Cherwell Consulting) - <i>part meeting</i>
Kezia Lange	Deputy Chief Medical Officer, Professional Standards – attending for the Chief Medical Officer
Sue Marriott	Executive Assistant
Zoe Moorhouse	Interim Head of Organisational Development (OD) – <i>part meeting</i>
Deimante Pelakauskaite - Freimoniene	Commercial & Contracts Manager
Rachel Pirie	Head of Planning

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 April 2025), 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 – <i>part meeting</i>
Mireia RuizSoley	Restorative Just & Learning Culture Programme Manager – <i>part meeting</i>
Sam Shepherd	Deputy Director of Strategy & Planning
Hannah Smith	Assistant Trust Secretary (Minutes)
Bill Tiplady	Director of Psychological Professions – <i>part meeting</i>
Helen Wain	Experience & Involvement Lead (Buckinghamshire) – <i>part meeting</i>
Beverley White	Corporate Governance Officer – <i>part meeting</i>

Attendees/observers from Oxford Health NHS FT governors

Juliet Hunter	Public governor, Oxfordshire
Colleen Jones	Public governor, Buckinghamshire
Graham Shelton	Appointed governor, Oxford University Hospitals NHS FT
Marc Smith	Public governor, Buckinghamshire

External/Public observers

Andrew Herbert
Sophia Jaques

BOD 103/25	Welcome and Apologies for Absence	
a	The Trust Chair welcomed Board members and attendees to the meeting.	
b	Apologies for absence were received from: Karl Marlowe, Chief Medical Officer; and Rick Trainor, Non-Executive Director.	
BOD 104/25	Patient Story - Buckinghamshire Mental Health Service	
a	The Chief Nurse welcomed to the meeting: the Expert by Experience; the Experience & Involvement Lead; and the Director of Psychological Professions. The Director of Psychological Professions invited the Expert by Experience to share their experience of the interplay between physical and mental health services.	
b	The Expert by Experience gave a presentation on the challenges they had experienced as a mental health service user in having their physical health symptoms taken seriously and how they had felt invisible, with their physical pain unresolved and dismissed as 'all in the mind', when engaging with various healthcare providers. They summarised their core dilemma as: (i) where do I fit in between mental health and physical health services; (ii) can anybody meet my needs; and (iii) can anyone change my experience of rejection and disbelief. As set out in more detail in their presentation, they suggested that their experience could have been improved through: being under the care of the correct team (mental or physical health); being listened to and taken seriously; being treated for the symptoms presented; being offered a physical examination and other tests to explore alternative diagnoses; looking beyond a mental health presentation to see the whole person, not just a person with a mental health history; and services communicating with each other and including the patient in their discussions in order to develop a treatment plan. They thanked their fellow Experts by Experience for having helped them to find their voice and explained how, as an Expert by Experience, they had been involved in a wide variety of projects, including interview panels and peer reviews, and been one of the founding members of the Bucks Voice service user and carer forum.	
c	In response to questions from Board members on advice for recognising people with mental and physical health issues and providing earlier assistance or navigation into services, the Expert by Experience highlighted: • difficulties they had experienced in being able to access the specialist gastroenterology assessment which they had requested; and • primary and secondary services being uncertain as to ownership of the case.	

d	The Chief Nurse and members of the Board thanked the Expert by Experience for having shared their experience and reflected upon: • risks with categorising and making assumptions about patient needs without viewing patients holistically in order to identify and address comorbidities; • the importance of integrated healthcare and the potential to support this through Integrated Care Systems; and • potential opportunities to support patients to navigate local services and to advocate for them rather than focus upon the more transactional aspects of healthcare.	
e	The Trust Chair thanked the Expert by Experience for reminding the meeting that the patient was an expert in their own right and of the opportunities to improve the provision of healthcare through recognising that.	
f	The Board thanked the Expert by Experience and the Experience & Involvement Team and noted the Patient Story. <i>The Expert by Experience, the Experience & Involvement Lead and the Director of Psychological Professions left the meeting. Chris Hurst joined the meeting.</i>	
BOD 105/25	Staff Story – Restorative, Just & Learning Culture (RJLC)	
a	The Chief People Officer welcomed to the meeting: the staff member and qualified mental health nurse who would be sharing their experience; and the Interim Head of OD.	
b	The staff member reflected upon their past experience of a capability process, as set out in the report, and explored with the Board how the introduction of the RJLC programme since 2023 might have made a positive difference for them if it had been available then. They commented upon how these processes had now changed for the better and were more supportive and could include the involvement of the Occupational Health team. RJLC focused upon what, instead of who, may be responsible and aimed to create an environment to better support staff and encourage learning from incidents.	
c	In response to a question from Geraldine Cumberbatch on what could have helped at the time, the staff member highlighted continuity in the ownership and management of the process. They noted that a succession of managers had been involved and each new manager had led to an extension of the process, which negatively impacted continuity, therefore a 6-month process had lasted for over 18 months.	
d	The Board reflected upon: • the utility of maintaining an open and curious mindset when assessing what else might have changed for staff or led to them becoming involved in a capability process. If an underlying issue was not recognised and addressed then moving staff to another area would not necessarily lead to improvement or be supportive; and • the negative impact of the drawn-out nature of grievance or disciplinary processes and the work taking place to address this through the introduction of RJLC and also use of informal resolution of cases (cases were also monitored through the People, Leadership & Culture Committee).	
e	The Trust Chair thanked the staff member for sharing their experience and wished them well in their ongoing career at the Trust. Board members expressed that they would not want staff to undergo the type of experience described and noted the positive impact of the introduction of RJLC.	
f	The Board noted the Staff Story. <i>The staff member and the Interim Head of OD left the meeting.</i>	

BOD 106/25 a	Register of Directors' Interests No interests were declared pertinent to matters on the agenda.	
BOD 107/25 a	Minutes and Matters Arising of the meeting held on 24 September 2025 The Minutes of the meeting were approved as a true and accurate record. Actions were noted as in progress or completed: • item BOD 85/25(h) and 94/25(d) – future discussion on GP Out-Of-Hours (OOH) service being considered by the Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care for Spring 2026; and • item BOD 85/25(j) – to circulate the Expert by Experience's presentation from the previous meeting - completed.	
BOD 108/25 a	Trust Chair's Report The Trust Chair took his report as read and highlighted that when funding was tight and the NHS was contemplating shifts (from hospital to community care or from care to prevention), it was important to engage patients and the public in dialogue and enhance capacity to support this.	
b	The Board noted the report.	
BOD 109/25 a	Chief Executive's report The Chief Executive took his report as read and highlighted: • winter planning underway including participation in system wide and place-based discussions on patient flow across mental health and community in-patient beds. In response to a question from Andrea Young, the Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care confirmed that winter planning was constantly being considered and was a boosted version of daily activity to manage patient flow. She reported that there had been strong engagement with the GP OOH service to support increased activity over the seasonal period. The Chief Nurse added that the flu vaccination campaign for staff was still ongoing and, as at last week, the Trust had achieved five times the uptake compared to this time last year and was seventh best in the South of England; • recognition by NHS England's Thames Valley Deanery for excellent results on the Trust's Forensic Psychiatry Programme and being ranked first for overall satisfaction when compared to other Forensic Psychiatry Programmes across the UK. He noted that this was a strong example of excellence and a positive indicator of consultant engagement; and • recognition of the Finance Team by the Healthcare Financial Management Association's South Central conference, with the team winning the Finance Team of the year award for quality improvement work on customer satisfaction and reporting and team members also being runners-up in the rising star category.	
b	Andrea Young referred to the Warneford 200 commemoration projects and commended the planning and activities to date, including the Warneford Play which had also highlighted that although historic mental health care may have been well intentioned, it was worth challenging whether it was in the best interests of patients. She reflected on the Patient Story at item BOD 104/25 above and noted that this had demonstrated the continuing relevance of that challenge.	
c	The Board noted the report and the winter planning activity taking place.	

BOD 110/25	Corporate Affairs report - Legal, Regulatory and Policy; and horizon scanning	
a	The Executive Director of Corporate Affairs presented the report which provided: (i) insights from horizon scanning; and (ii) legal and regulatory updates together with any specific actions being taken by the Trust in response.	
b	He highlighted: - the Board's 'Listen & Learn Visits' programme to provide opportunities for Board members to: (i) visit clinical and corporate support services; and (ii) triangulate insights from visits and discussion with staff and service users with information from Board and Committee reports; - the recruitment process for the next Trust Chair, following the final term in office of the current Trust Chair, pending the decision of the Council of Governors on 04 December 2025; - the Well Led self-assessment process including upcoming review and challenge of draft findings at the Board Workshop in February 2026 and commissioning of an independent external Well Led review; and - the Trust's ambition to apply for Advanced Foundation Trust status early and to align Well Led work with this. The Trust Chair noted that the future of governor roles would also need to be considered as these had not yet been announced in relation to Advanced Foundation Trusts.	
c	The Chief People Officer referred to the update on resident doctors' industrial action in November 2025 and confirmed that emergency planning arrangements would be followed, with Executive oversight, and that the Chief Executive and the Chief Medical Officer had already been in direct contact with local leads, in accordance with guidance.	
d	Kamal Mahtani referred to the 150-day national target on set-up of clinical trials by March 2026 (from guidance on requirements for future research funding); he offered his support and emphasised the opportunity for the Trust, in collaboration with the University of Oxford, to maximise its participation in research and access to funding. The Executive Director of Corporate Affairs confirmed he would discuss with the Chief Medical Officer to progress work with the Research & Development Team to agree a plan for implementation, reporting and monitoring of the national target on set-up of clinical trials. He added that he and the Chief Medical Officer were also engaged in work to support the phasing in of changes from the Data (Use and Access) Act 2025, which updated digital information laws to promote innovation and ease organisational processes; the focus was around intellectual property, cyber security and reducing delays to support more rapid set-up of research studies to make turnaround time more competitive.	TG/ KM
e	In response to a question from Andrea Young on the national Board member appraisal framework (covering both Executive and Non-Executive Directors), the Chief People Officer and the Chief Executive confirmed that this would be used for the 2025/26 process and it was sensible to use the same tool consistently across the Board.	
f	The Board noted the report.	
BOD 111/25	Board Assurance Framework (BAF)	
a	The Executive Director of Corporate Affairs presented the report which provided an update on the revised BAF. He noted that it was still developing and feedback was being considered by relevant Executive leads on specificity of actions to address risks and ensure that the right actions had been identified to deliver the intended results to move the risk scores. The Chief People Officer noted progress which had been made to reduce the rating of risk A4 on Recruitment and Retention (from high to medium rated) but noted that time was still required to embed new ways of working.	

b	Lucy Weston added that the Finance & Investment Committee had focused on strengthening actions and assessing risk ratings. She highlighted that: • risk A3 on Financial Sustainability may be rated as too high for the way in which the risk was currently described but there may be a more nuanced risk around ability to evidence and deliver Value For Money; and • reflection may be required upon how target risk was described and distinguished from risk appetite and what kind of risk the organisation was willing to accept.	
c	The Board noted and supported the revised BAF. <i>The Deputy Director of Corporate Affairs left the meeting.</i>	
BOD 112/25	Planning - Draft Annual Plan/Medium-Term Plan and Mid-Year review of Annual Plan a The Executive Director of Strategy & Partnerships introduced the reports on: (i) the approach taken for the development of the Medium-Term Plan, ahead of first submission on 17 December 2025 and final submission on 12 February 2026; and (ii) the Mid-Year review of the Annual Plan 2025/26. She noted that the Board was being given an update further to more detailed discussion in private in December, ahead of the first submission. <i>Medium-Term Plan</i> b She presented the report on the approach for the development of the Medium-Term Plan and explained that: • a robust approach had been taken, involving coordinating planning across performance, workforce and strategy. Clinical and corporate directorates had developed their planning priorities, which had been tested and shared at the joint Board and Executive session on 03 November 2025; • the Medium-Term Plan would be developed into a delivery plan to be published alongside the Trust's new Strategy in Summer 2026; and • both the December 2025 and February 2026 Medium-Term Plan submissions would be accompanied by Board Assurance statements confirming that the key planning activities had been undertaken and that appropriate governance and decision-making processes were in place. Draft versions of the maturity assessments of the processes undertaken, which boards would be required to submit, were included as appendices to the report and would be brought back to the Board for its further discussion in private in December. These were well progressed as they had been aligned to the Well Led self-assessment process. c The Chief Finance Officer took the Board through the presentation on Annual Planning, including assessment of the Trust's position and risks. Further to Lucy Weston's point at item BOD 111/25(b) above, she explained that it was not yet possible to say whether risk A3 on Financial Sustainability was rated too high or low, in the absence of multi-year financial allocations or agreements with commissioners. Contingency planning had started with the Finance & Investment Committee to understand and manage down the Trust's cost base. Work was also underway across all directorates to identify Cost Improvement Programme (CIP) schemes across the 3-year plan period. The scale of CIP required would need service and pathway transformation but this could also provide opportunities to improve productivity and Value For Money of services; service would consider how redesigns could maximise outcomes for patients. Closer working with the Integrated Care Board (ICB) provider collaborative and specialised commissioning provider collaboratives may also offer opportunities for wider pathway investment or efficiencies. She reported positive cultural change with improvement in directorates managing within budgets and transparency around risks and choices. The Executive Director of Strategy & Partnerships added that work was also taking place with system partners at ICB and place level to consider areas subject to cost pressures.	

d	Andrea Young acknowledged the challenge in the absence of multi-year financial allocations or agreements with commissioners and suggested that clarity in: - quantifying how much the Trust could increase capacity and improve waiting lists would be useful in discussion with the ICB; and - identifying what guiding principles the Trust would protect and invest in, and what it may need to withdraw from, would help directorates. Mohinder Sawhney and Lucy Weston also supported this so that the Board could reach a collective opinion on its strategic priorities and build on the cultural shift to being able to describe evidence-based value and outcomes for patients and multi-year CIPs.	
e	The Chief Executive agreed and noted that community services already had a granular understanding of what investment would be required to improve waiting times but that investment had not been forthcoming. The choice of which activities to withdraw from was also important and he reminded the Board that commissioners had already reduced funding for Child & Adolescent Mental Health Services, in response to which the Trust was still engaged in advocating for this to be taken through a decommissioning framework process. He emphasised the importance of working in partnership with the ICB and other system partners in order to manage expectations.	
f	In response to a question from Geraldine Cumberbatch on the likelihood of eliminating Out of Area Placements (OAPs), the Executive Director of Strategy & Partnerships and the Chief Executive agreed that this was difficult, as demonstrated through the most recent Integrated Performance Report, but this was a national requirement and the Trust would submit realistic trajectories to minimise OAPs. The Chief Executive noted that the reasons for the recent increase in inappropriate OAPs were known and being addressed, with patient safety at the forefront of considerations. The Interim Chief Operating Officer for Mental Health & Learning Disability added that management of OAPs was a daily consideration but appropriate community support was key to be able to discharge OAPs appropriately.	
g	<i>Mid-Year review of the Annual Plan</i> The Executive Director of Strategy & Partnerships presented the report on the Mid-Year review of the Annual Plan 2025/26, highlighting that there were no anomalies to bring to the Board's attention and that progress against the six priorities was tracked by clinical directorates.	
h	The Board supported the approach to Medium-Term Planning and noted mid-year progress on the 2025/26 Annual Plan, ahead of the opportunity to review in more detail in private at its meeting on 10 December 2025.	
BOD 113/25	Integrated Performance, Quality and Sustainability reporting	
a	The Executive Director of Strategy & Partnerships presented the Integrated Performance Report (IPR) and, further to discussion at the previous meeting, confirmed that a NHS National Oversight Framework (NOF) dashboard had now been included which set out the Trust's position against NOF metrics. Although it was positive that the Trust was currently in NOF segment 1, she cautioned that this was relative to the performance of other trusts.	
b	She presented the IPR on the strategic domains of Operational Performance, Quality and People. Against the Trust's metrics to monitor clinical performance (derived from nationally reportable metrics and locally agreed metrics) she highlighted: Children and Young People's (CYP) Mental Health Services in Oxfordshire, Bath, North East Somerset, Swindon and Wiltshire (OBSW) continued to perform at lower than the national average for children receiving meaningful contact within 4 weeks of referral. Focused work to reduce waiting lists was taking place across directorates and the data capture process was being improved;	

	ii. the CYP Eating Disorders service in Bath and North East Somerset, Swindon and Wiltshire (BaNES, S&W) had not met urgent 7 days or routine 4 weeks targets (patient choice had been a factor); iii. Adult & Older Adult Community Mental Health Services in Oxfordshire and Buckinghamshire were generally performing well although perinatal access was currently unreportable due to technical reporting issues; iv. there were still a high number of inappropriate OAPs in Adult & Older Adult acute/inpatient services in Oxfordshire and Buckinghamshire. However, delays of Clinical Ready For Discharge patients were typically short, as social care teams acted promptly once a patient was declared delayed; v. expanded service metrics for Community Health Services, Dentistry and Primary Care (as digitisation improved data capture). Most recently a metric had been introduced to the IPR on average number of Medically Optimised for Discharge patients per night. However, there was no significant change in the underperformance against targets for: (i) Looked After Children to be receiving an initial health assessment within 20 working days; (ii) Healthy Child Programme metrics; and (iii) percentage of patients waiting over 52 weeks for community services; and vi. a full strategic dashboard, at section 4 of the IPR, setting out the 6-month position against the 4 strategic objectives and their goals and overarching ambitions, linked to measures and targets.	
c	'Quality' Strategic Objective In relation to delivery of the 'Quality' Strategic Objective and Quality metrics, there remained elevated use of restrictive practice mainly related to a group of fewer than five patients on the CAMHS Psychiatric Intensive Care Unit (PICU) and prevention of self-harm. This was a reflection of caring for patients with high acuity and complex needs. The Quality & Safety Dashboard (which helped to identify wards/teams which may need support and provide an early warning system) continued to highlight the same four teams in enhanced support but the Quality and Clinical Governance Group meeting on 23 October 2025 had agreed to downgrade one community team from enhanced monitoring to early warning after this month and following a deep dive review.	
d	'People' Strategic Objective In relation to delivery of the 'People' Strategic Objective, performance continued to improve. Agency usage remained better than target. However, sickness absence had increased and the absence data was being reviewed monthly, with managers being proactively contacted.	
e	In response to queries from Mohinder Sawhney and Lucy Weston, the Executive Director of Strategy & Partnerships clarified that the IPR and its data was supported by a ward to board process, with the Board receiving a final aggregation of data which had been already been reviewed by directorates and the Executive. The Interim Chief Operating Officer for Mental Health & Learning Disability confirmed that directorates used this data regularly in their performance meetings and there had been a significant improvement in this over the past 2-3 years. The Chief Executive noted that the Board Workshop in December 2025 was already scheduled to receive a session on the Board's role on Quality Improvement which would provide another opportunity to consider use of data.	
f	The Board noted the report and the inclusion of the NOF dashboard.	

BOD 114/25 a b	Finance and Sustainability The Chief Finance Officer presented the Month 6 Finance Report and highlighted that: - the year-to-date and forecast surplus positions were on plan; - capital expenditure was still running slower than expected but the Estates capital plan was being reviewed to produce a revised and more realistic plan for this year; and - the arbitration process for the Private Finance Initiative settlement was still ongoing and subject to independent experts completing their review. The Board noted the report and that the Month 6 position was on plan. <i>The meeting took a break for 15 minutes and resumed at 11:15.</i> <i>The Director of Research & Development joined the meeting.</i>	
BOD 115/25 a b c d	Patient Safety Incidents (PSI) report – September-October 2025 The Chief Nurse presented the report on learning identified from 8 patient safety reviews over the reporting period and wider learning from the local incident response plan for the national Patient Safety Incident Response Framework (PSIRF). A range of learning response approaches were in use and the Chief Nurse reported that 47 Incident Learning Huddles had taken place over the period. Key areas for learning identified from reviews and Incident Learning Huddles were set out in Table 2 of the report across physical and mental health services. The report also included learning from a Coroner's Prevention of Future Death notice relating to improving communication of clinical information and decisions to GPs; further investigation since the inquest had revealed that although there had been sharing of communication between the service and the GP, there was still room for improvement. The Chief Nurse highlighted the introduction of Safety Action Review Visits to enhance the current process to monitor: (i) completion of actions after a safety review; and (ii) whether the change had been sustained. Patient Safety Team members conducted supportive follow-up visits to clinical teams to review and observe implemented actions in practice and to allow clinical teams to reflect on the improvement work undertaken and identify further support needs. She reported that these had been positively received by staff. In response to a question from the Trust Chair, she added that they also operated as a mechanism to track effective and sustained improvement over time. The Board noted the report and was assured by processes and structure for the identification, review and learning from PSIs.	
BOD 116/25 a b c	Medical Appraisal and Revalidation report The Deputy Chief Medical Officer presented the report which provided assurance that the statutory functions of the Responsible Officer (to oversee processes including medical annual appraisal) were being appropriately fulfilled. She summarised that processes were much better in place, good progress against the 2024/25 action plan and drew the Board's attention to the proposed action plan for 2025/26 and progress already made since 31 March 2025, as set out in more detail in the report. The Board noted that the report had already been reviewed and recommended by the People, Leadership & Culture Committee at its meeting on 15 October 2025. The Board APPROVED the report, including the Statement of Compliance at Appendix 1, and supported the 2025/26 actions suggested.	

BOD 117/25 a	Research & Development (R&D) report The Director of R&D presented the report and highlighted the updates on the: • Biomedical Research Centre (BRC) which focused on translational research in brain health including workstreams on: (i) sleep (insomnia) which had developed a behavioural intervention now being implemented in the NHS; and (ii) molecular targets – the Antidepressants for the Prevention of Depression in First Episode Psychosis (ADEPP) trial had completed its recruitment and outcomes would be available in 2026 (if positive they would impact Early Intervention in Psychosis services); • award of £16.3 million to host the new National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) Thames Valley beginning in April 2026. This was a substantial increase on the award for the previous ARC and highlighted the standing of the Trust's research infrastructure; • NIHR Mental Health Translational Research Collaboration (MH-TRC) where a staff member had devised and implemented a uniform template to facilitate and speed up the signing of Confidential Disclosure Agreements, informing national practice; • 'Count Me In' initiative to support patient participation in research, which went live in November 2025 and would help to improve speed and diversity of recruitment to clinical trials and research studies; and • Health Services Journal (HSJ) Partnership of the Year Award 2025 for the work of the Clinical Research Facility, working with Eli Lilly & Company UK and Ireland in recognition of their biomarker pilot project which aimed to improve early diagnosis of Alzheimer's disease. Further to a question from Andrea Young, the Director of R&D confirmed that the Trust did not routinely conduct lumbar punctures in its memory clinics to collect cerebrospinal fluid for biomarker testing, although this was practised more routinely in other countries. b In response to a question from Lucy Weston on translational research which could be integrated into clinical work, the Director of R&D emphasised the importance of this if research could be proven to benefit patients but noted that there were still funding gaps to transition research from pilots into commissioned services. She reported that she met quarterly with the Chief Executive and the Trust Chair to discuss how to align R&D with the Trust's goals and clinical needs but securing funding from commissioners was a challenge. c Kamal Mahtani congratulated the R&D team on the awards and recent activity; he asked about opportunities to develop more community-based research. The Director of R&D reported that she and the Chief Medical Officer had recently attended a meeting on this with the Community directorate and there was enthusiasm to develop this but it needed to be led by clinical need and matched by appropriate funding. d The Board noted the report and congratulated the R&D team on the NIHR ARC funding award and the HSJ Partnership of the Year Award 2025.	
BOD 118/25 a	Board Committees' update reports – matters for Alert, Advice & Assurance (3As) The Board took as read the 3As reports from the: Charity Committee; People, Leadership & Culture (PLC) Committee; Mental Health & Law Committee (MH&LC); and the Quality Committee.	

b	Committee Chairs highlighted for the: - Finance & Investment Committee (verbal update - matters for advice or assurance) review of: the Month 6 position on underspent capital expenditure; progress on CIP delivery; BAF risks; progress with Frontline Digitisation delivery (with some delays due to funding pressures); the Acquisition & Disposal Policy for Land & Property; and the Use of Artificial Intelligence Policy; - PLC Committee: recommendation of the Medical Appraisal and Revalidation report (referred to at item BOD 116/25 above) and the WRES and WDES submissions (to be considered at item BOD 119/25 below). The PLC Committee had also reviewed the progress being made with Employee Relations work and correlations between different employee characteristics; - MH&LC: review of duplication between the Mental Capacity Act (MCA) training for medics and the MCA training for the Trust; approval of the updated Mental Health Act Policy; support for revised remuneration for Associate Health Managers; and improvement in the certificates of Second Opinion Appointed Doctors; and - Quality Committee: support for the new policy framework for violence prevention and reduction; and assurance on the activities and achievements of the Learning Disabilities Directorate over the last 12 months.	
c	The Board noted the 3As updates from the Committees, with supporting minutes and agendas in the Reading Room.	
BOD 119/25 a b	Warneford Park Hospital Project update The Chief Finance Officer welcomed the Warneford Park Programme Director to the meeting to present the report. The Warneford Park Programme Director took the meeting through the proposal, the partnership, the planning application and the process to secure funding including current review by NHS England. NHS capital funding allocation was anticipated to complete in Spring 2026 whilst February 2026 was the earliest that the Oxford City Council Planning Committee was likely to consider the planning application. The Board noted the update and progress to date with funding and planning applications.	
BOD 120/25 a b c	PLC Committee recommendation: Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) The Chief People Officer took the reports on the WRES and WDES as read and explained that they had been reviewed and recommended by the PLC Committee and were now provided to the Board for assurance. The Chief Executive reflected on the review and discussion of the WRES and WDES reports at the Race Equality Network, the Equality, Diversity & Inclusion (EDI) Steering Group and the Extended Leadership Team. He noted the challenge but continuing importance of identifying effective actions and the Trust's commitment to anti-racism, the Patient and Carer Equality Framework and the production of a single plan to articulate the Trust's EDI ambitions and focused areas of work. Mohinder Sawhney noted the importance of understanding where discrepancies may be arising from and testing assumptions and hypotheses so as to better identify the right actions to deliver meaningful change.	

d	The Executive Director of Corporate Affairs emphasised the importance of developing a better understanding of disciplinary inequalities and engaging with uncomfortable or challenging data.	
e	The Board noted the reports and actions on the WRES and WDES.	
BOD 121/25	Oxfordshire County Council (OCC) - Director of Public Health annual report on Children & Young People's Mental Health	
a	The Trust Chair welcomed the OCC Director of Public Health to the meeting. The OCC Director of Public Health took the Board through the report and presentation on Children & Young People's Mental Health and Wellbeing in Oxfordshire and highlighted: - the intersection between climate and health agendas and between mental health ill health and economic inactivity; - the post pandemic challenges for people living with comorbidities and long-term conditions; - rewarding employment as a protective factor for mental health and wellbeing; - various factors, including childhood poverty, contributing towards an increasing proportion of children and young people reporting poor mental health at the same time as a growing demand for special educational needs and disabilities support, with greater awareness of mental health and neurodiversity; and - the potential importance of schools and employers being able to provide support and also opportunities/apprenticeships for young people with mental health and/or neurodiversity challenges, as well as people accessing self-help.	
b	He asked the Trust to consider: - how it provided/could provide inclusive employment opportunities; and - as a provider of specialist mental health support, how it could support the local community to look after their own mental wellbeing.	
c	The Board discussed the annual report and presentation with the OCC Director of Public Health and considered: - where responsibility for prevention may lie between specialist healthcare providers and the local authority; - the role of the Oxfordshire Joint Health Overview & Scrutiny Committee; - the challenge for the local system in generating change and moving from reliance on healthcare providers to a wider range of anchor institutions having the confidence to understand and work with mental wellbeing; - support for apprenticeships but recognition that the competition to apply for limited opportunities may be a barrier to entry for those who were recovering or vulnerable; - the importance of societal interaction, lifestyle choices and the challenge of almost living a virtual life; and - the role of GPs and primary care in promoting self-help measures and providing interventions.	
d	The Board thanked the OCC Director of Public Health for the thought-provoking and engaging discussion.	
BOD 122/25	Corporate Registers: (i) application of Trust seal; and (ii) receipt of gifts and hospitality	
a	The Executive Director of Corporate Affairs took the reports as read and confirmed that there were no questions from the Board.	
b	The Board noted and received the Corporate Registers.	

BOD 123/25 a	Any Other Business/Questions/Review of the meeting In response to a question from Geraldine Cumberbatch, the Chief Nurse confirmed that there was a workstream which was part of violence prevention and reduction work which considered potential racist incidents.	
BOD 124/25 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: 12:50	

Summary of Actions from the Board meeting on 26 November 2025

Relevant Item	Action	Responsibility:
BOD 110/25(d)	150-day national target on set-up of clinical trials by March 2026 The Executive Director of Corporate Affairs and the Chief Medical Officer to progress work with the Research & Development Team to agree a plan for implementation, reporting and monitoring of the national target on set-up of clinical trials. <i>Status: in progress - the Trust has established workstreams to focus on meeting the new requirements. A paper will be presented to Quality Committee describing the work being undertaken to deliver this., alongside regular R&D reports to the Board meetings in public on the usual March, July, September and November 2026 reporting pattern.</i>	TG/KM
Actions from 24 September 2025		
BOD 85/25(h), 94/25(d)	GP Out-Of-Hours (OOH) service – future discussion To arrange a future discussion on GP OOH provision including: quantity and how stretched the service may be (including palliative care response times). <i>Status: in progress – the Interim Chief Operating Officer considering for Spring 2026.</i>	EL

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	07
Report title:	Trust Chair's report
Executive sponsor(s):	N/A
Report author(s):	David Walker, Trust Chair
Action this paper is for:	☐ Decision/approval ☒ Information ☐ Assurance
Reason for submission to the Board:	For information/discussion
Public or confidential	Public

Executive summary

Once a month, Grant and I kick off the sessions we hold to welcome people newly joining the trust. They are always instructive, not least about the variety of jobs we recruit to ...dietitians, administrators, ward assistants, researchers, psychologists and so on, and, matching that, their diverse backgrounds and incentives.

We say, and it's right, that the trust is a sort of moral community. Its principal aim is helping people, and not charging them for it. Often we'll go on from the induction event to our 'exceptional people' awards ceremony, in which colleagues are recognised for contributing to their teams and to healthcare in some special way, above and beyond what it says in their contract and terms of service. The awards, which are based on peer judgement, are a reminder that the NHS is an ethical enterprise based on compassion, selflessness and care.

But it's also big business. Many at the induction meeting have joined the trust because it's a job they need to pay the rent, sometimes to get by while they wait for another opportunity; for some it's a job they could do in the private or voluntary sectors, in which that ethical dimension can be distant. Their relationship with the Trust can be short-term – staff turnover is around 10 per cent annually.

There is one of the challenges of NHS management – how to combine altruism, vocation, human values with the details of salary, performance measurement, discipline and all the other day to day requirements of an organisation/business. At the board we talk about productivity – output per measure of input – aware of how such language grates with clinicians whose focus is patient, her state of mind, her recovery and all her individuality

as a person on life's journey. Nurses, healthy professionals, doctors may resist the effort to score recovery as output and find offensive some grading of their care and compassion as input. But parameters have to be set; staff deployed; some coherent relationship established between the resources we deploy in healthcare and our patients' lives. Therein lies the challenge and fascination of healthcare. Managers and open-minded clinicians can in principle agree on measures and methods – but getting there will take a lot of patience and goodwill.

Grant's decision to retire later this year is regrettable – we will miss him, acknowledging his work as the trust's top manager in recent years. Finding a successor will force us to confront the question I've posed: how best to combine care and organisation, a frontier made all the more frictional when resources are constrained and cries for productivity improvement are loud. Grant is a clinician turned manager. Trusts are well run by managers who have specialised in managing clinicians. There is some evidence favouring the performance of the former group but it's probably outweighed by the specifics of person, place and the characteristics of a given organisation.

We've said in the brief to the executive searchers we will employ to find a successor to Grant that this is a stable trust and a (largely!) harmonious board. Without tempting fate, I would underline that, while recognising the perpetual tension between continuity and change. The induction of new staff takes place at Unipart, adjacent to the BMW Cowley plant. Where will car sales be in five years' time, given global economic changes in play? By contrast, the need for care is a constant. The trust will have to adapt (change) to meet it; but the compassion and dedication on which that care depends is continuous.

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
Date of Meeting	28 January 2026
Agenda item	8
Report title	Chief Executive Officer'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
Public or confidential	Public

Report

I wanted to start my first CEO report of 2026 with an expression of thanks to all colleagues across the Trust for all their work, passion and commitment over the last year. 2025 was a challenging year for the whole NHS and 2026 will likely be similar. Amongst resource pressures, sector changes and expectations of demand, all the good care and acts of kindness demonstrated everyday by colleagues can sometimes be overshadowed. We will continue to deliver this year and to focus on improvement driven by our commitment to understand and respond to the perspectives of patients and service users, and to support one another as colleagues in our teams.

Welcome to our incoming chair, Andrea Young

Following an extensive recruitment process late last year, I'm very pleased to welcome Andrea Young as the Trust's incoming Chair from April this year once David Walker's term as chair ends in March. Andrea's experience and deep understanding of the NHS has already benefited the Trust in her current role Non-Executive Director and Chair of the Quality Committee and will be invaluable as we look to the future and the opportunities and challenges we face and to build on successes and shape an exciting future for the Trust.

Chief Nurse fellowship programme

It was great to hear from our Chief Nurse Britta Klinck and the fellows about the Chief Nurse fellowship programme at a recent celebration event. The programme is designed

to develop the careers of talented nurses from the global majority recognising the disparities of outcomes and experiences of global majority nurses. The year-long fellowship provides experiential learning through shadowing, mentorship and exposure to a wide range of clinical and non-clinical roles. The overall aim is for each nurse to grow personally and professionally, gaining experience and self-confidence as they do so.

Marking 200 years of the Warneford Hospital

This year is the 200th anniversary of the Warneford Hospital in Oxford and to mark this a range of events and activities have been planned over the year including exhibitions on the history of the hospital, a play, oral histories, and a commemorative garden. Known collectively as 'Warneford 200', the year of events kicks off with a Museum of Oxford exhibition about the history of the Warneford Hospital and mental health in Oxfordshire. A launch event was held on the evening of the 15th January opened by our Chief Medical Officer, Dr Karl Marlowe, and a screening of a video on the history of the hospital. The feedback I've heard is that it was an excellent evening. The exhibition runs from 15th January to the 21st March and there will be further opportunities to see the exhibition across Oxfordshire over this year. You can find out more about the programme of events for Warneford 200 by searching online for '*Warneford 200*' or by following this link: [Warneford200 website](#)

CAMHS film event

On 15th January, the Trust's Oxfordshire Children and Adolescent Mental Health Service (CAMHS) screened a film called 'Inspiring Hope' showing young people's experienced of life after support from the CAMHS teams. Aimed at young people, parents, carers, and Oxford Health staff - as well as wider stakeholders - the film celebrated young people and the role played by CAMHS services in their development. My thanks to all involved in this project.

NHS England provider performance 'segment'

As I've mentioned in previous CEO updates, over Summer 2025 NHS England published an updated version of the NHS National Oversight Framework (NOF). Through this framework NHSE assesses provider performance and then determines a segment score for each Trust, creating a 'league table' of providers. Each organisation is placed in a segment ranging from 1 (no support) to segment 5 (intensive support through from an NHSE provider improvement programme). In the first iteration of this process in September 2025, Oxford Health was placed in segment 1 and I'm pleased to say that the Trust remained in segment 1 in quarter two. While this is pleasing, we remain focused on improvement areas including community health services waiting times, and urgent community response (2hr performance). The Trust's integrated performance report – discussed at board – helps the Trust to actively monitor performance and we will continue to work with the health system partners to ensure delivery of operational planning priorities for the year ahead.

Chief Operating Officer appointments

I'm pleased to confirm following recruitment processes at the end of last year that Dr Rob Bale and Emma Leaver have been appointed to the Trust's Chief Operating Officers roles,

respectively for Mental Health & Learning Disability and Community Health Services, Dentistry & Primary Care. Both Rob and Emma are highly experienced in their fields. I'm looking forward to working with them both in taking forward the ambitions of the Trust.

HSJ award shortlisting for online eating disorder service

It was great to see recognition of the Trust's online eating disorder service after it was shortlisted for a Health Service Journal (HSJ) innovation award. The Hospital at Home Online Eating Disorder service supports young people under 18 with eating disorders and who meet the threshold for inpatient care. For most young people the service acts as an alternative to an inpatient admission, meaning admission is prevented; for others, it acts as a step-down service to enable a shorter inpatient admission – both being key to improved care and patient outcomes and experience, and to make more effective use of resources. My congratulations to the team for this recognition.

Mental health inpatient celebration event

To close, I'd like to look ahead to an event later in February that will bring together 160 colleagues from inpatient wards including adult and older adult, children and adolescent mental health, eating disorders and forensic wards from across Oxford Health and Berkshire Healthcare. This event follows on from the success of last year's event and aims to showcase how small changes and improvements in practice can make a big difference to the experience of patients, staff and carers.

Grant Macdonald, Chief Executive

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.

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	9
Report title:	Corporate Affairs Report
Executive sponsor(s):	Taff Gidi, Executive Director of Corporate Affairs
Report author(s):	Taff Gidi, Executive Director of Corporate Affairs
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	To update the Board on insights from horizon scanning and any new legal and regulatory updates.
Public or confidential	Public

Executive summary

The purpose of the report is to update the Board on insights from horizon scanning since the last Board meeting and any new legal and regulatory updates as well as any specific actions being taken by the Trust in response.

Horizon Scanning

In addition to continuing updates on previous reported elements that are still open, we provide updates on the following:

- National Oversight Framework 2025/26 Q2 segmentation results
- The health policy year in twelve charts 2025
- BMA's analysis of the 10 Year Plan and 10 Year Workforce Plan

Chair Recruitment

We are delighted to announce that Andrea Young will become Chair of Oxford Health NHS Foundation Trust from 1 April 2026, following the completion of David Walker's term at the end of March. The Council of Governors approved the appointment on 4th December 2025.

Andrea has been a valued non-executive director on our board since 2022 and brings a wealth of experience and leadership to this role. She began her NHS career in 1977 as a student nurse and later trained and practised as a midwife. Andrea went on to hold a range of CEO roles in the NHS at regional and local level, culminating in her appointment as chief executive of North Bristol NHS Trust, a position she held until her retirement in 2020. She recently stepped down after 4 years, from the governing Board at the University of West of England and held the role of Chair of Bristol Health Partners for six years. Andrea is currently a member of the Independent Reconfiguration Panel,

advising Ministers on NHS service changes. She is also an accredited coach and mentor, and volunteers with the Samaritans. Andrea lives in Oxford with her husband.

Provider Capability

The Trust submitted its provider capability self-assessment to NHS England South East Region in October. The full submission was attached as an appendix to the Chief Executive's report at the November 2025 Board meeting. NHS England South East have now fully reviewed the submission and confirmed that the regional team supports and agrees with the Trust's self-assessment. This has now been submitted to the national team for moderation. It has been confirmed that this year's provider capability ratings will not be published and they will not be considered as part of segmentation ratings. However, this is still expected in the future.

Quarter 2 Segmentation

The NHS Oversight Framework (NOF) segmentation system categorizes NHS trusts and foundation trusts into four segments based on their performance and capability. NOF quarter 2 ratings have now been confirmed, and the Trust continues to be in segment 1. Our league table position in the community and mental health league table is 15 out of 61.

Conclusion

The Board is asked to note the updates provided.

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

N/A

Recommendation(s)

1. The Board is asked to note the update provided through the horizon scanning

Strategic objective this report supports	Select
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	☒

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	No	
Legal and regulatory	Yes	

APPENDIX 1: HORIZON SCANNING REPORT (PART A) – JANUARY 2026

Recent Insights

Item	Description	Lead	Actions	Due Date
National Oversight Framework 2025/26 Q2 segmentation results	The 2025/26 Q2 segmentation results and public performance dashboard are now live. See Link below: NOF Mental Health Dashboard - NHS England Data Dashboard	CEO	For noting	Complete
NHS backs AI notetaking to free up more face-to-face care	NHS England has published a new self-certified registry for AI technology, which requires suppliers to comply with standards on clinical safety, technology and data protection. The registry follows NHS guidance published last year advising NHS organisations to use AI notetaking tools which are safe, evidence-based and deliver benefits for patients. NHS England » NHS backs AI notetaking to free up more face-to-face care	CMO CNO CFO	Trust to review and consider	June 2026
The health policy year in twelve charts 2025	A look back on the health and care trends, key figures, news stories and policy changes that happened in 2025. 2025 Health Policy Year In 12 Charts The King's Fund	DoCA	For noting	Closed
Reforms to the NHS - 2025	BMA's analysis of the 10 Year Plan and 10 Year workforce plan Reforms to the NHS - 2025	DoCA	For noting	Closed

APPENDIX 1: HORIZON SCANNING REPORT (PART B) - JANUARY 2026

Previous Insights: Updates & Actions

Item	Description	Lead	Actions	Due Date
Quality Impact Assessment Framework and Tool	NHS England published a new Quality Impact Assessment Framework and Tool which set out good practice principles and guidance for undertaking QIAs as part of the decision-making process for planning, approving and implementing changes to or commissioning new health and care services. https://www.england.nhs.uk/publication/quality-impact-assessment-framework-tool/	CNO	To review the new framework and report to Quality Committee in November 2025 how this will be implemented.	Dec 2025
Agenda for Change non-pay deal recommendations – NHS job evaluation	Letter sent to all Trusts reinforcing the importance of ensuring effective local implementation of Agenda for Change. All board members – but especially CPOs, CNOs and CFOs – will need to work closely to understand the Trust's current job evaluation position and the areas for improvement and all associated risks. NHS England » Letter: Agenda for Change non-pay deal recommendations – NHS job evaluation	CPO	We are reviewing our current practices to ensure they are in line with national guidance and will bring assurance to PLC.	Jan 2026
Potential Nurses Strike Action	Following votes to reject the pay offer for nurses, we now await further developments whether this will result in nursing strikes this autumn. https://www.nursinginpractice.com/latest-news/breaking-nurses-reject-nhs-pay-award-in-record-rcn-vote/	CNO CPO	Monitoring ongoing developments.	Closed
Data (Use and Access) Act 2025	The DUAA updates UK digital information laws to promote innovation and economic growth, easing	CMO DoCA	The Trust's Data Protection Officer to review the new law	Dec 2026

	organisational processes while protecting individual rights. The changes, which will be phased in from June 2025 to June 2026, provide opportunities for organisations to operate differently without imposing strict compliance requirements. A key example of the change is that the ICO will now be required to have a regulatory enforcement approach that considers the public interest in driving innovation and supporting competitive markets. The Data Use and Access Act 2025 (DUAA) - what does it mean for organisations? ICO		and advise how it impacts the Trust and what specific actions need to be taken to fully implement it in different areas of the trust.	
Board member appraisal framework	A new Board member appraisal framework with submission dates has been issued by NHSE. This covers both Executive and Non-Executive Directors.	CEO CPO DoCA	Feedback tool identified. The Trust is working on aligning the approach for both Executive and Non-Executive Directors. The regional team has confirmed that the Trust can do this.	Mar 2026
Sirona Care and Health CIC: enforcement undertakings	NHSE have put in place enforcement undertakings against Sirona Care and Health CIC related to their Board Governance arrangements. NHS England » Sirona Care and Health CIC: enforcement undertakings	DoCA	To review undertakings and report to Audit Committee if there are any areas identified in the undertakings that the Trust needs to act on.	Feb 2026
Resident doctors' potential industrial action	BMA has now announced strike dates for Resident Doctors in England over pay. Resident doctors are scheduled to strike from 7am on July 25 to 7am on July 30. The mandate for industrial action will last from July 2025 to January 2026: https://healthmedia.blog.gov.uk/2025/10/23/resident-doctor-strikes-everything-you-need-to-know/	CMO DoCA	The mandate will expire at the end of January. In December, there were five days of strike action by resident doctors between Wednesday 17 December and Monday 22 December.	Complete

Strategic commissioning framework	The framework sets out what NHS England expects from integrated care boards (ICBs) in the strategic commissioner role, and what ICBs and providers can expect from NHS England, as part of a step-by-step guide with an up-to-date commissioning cycle. https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/	CEO DoS	Executive to review and consider implications for the Trust.	Jan 2026
Advanced Foundation Trusts	Secretary of State announced that 8 high-performing NHS trusts will be given more independence to deliver faster, better and more personalised care. <i>Advanced Foundation Trusts will be the new marker of excellence for providers that drive the delivery of the three shifts, bring down waiting lists and work with partners to improve population health. Both NHS trusts and foundation trusts will be able to apply for advanced foundation trust status, with those that pass our assessment given greater autonomy and financial freedoms.</i> https://www.england.nhs.uk/publication/advanced-foundation-trust-programme-guide-for-applicants/	CEO DoCA	NHSE now consulting on the Advanced Foundation Trust Programme: guide for applicants which the Trust will consider and input as required. Trust to undertake readiness assessment against requirements in Q1 2026/27.	Jan 2026
150-day target on set-up of clinical trials by March 2026	As part of the, <i>Transforming the UK clinical research system</i> new guidance was issued. The Trust has now received a joint letter from Prof. Lucy Chappell (Chief Scientific Adviser, DHSC and NIHR Chief Executive Officer) and Prof. Meghana Pandit (National Medical Director, NHS England) making clear that future NIHR funding will be dependent on meeting the 150-day target and recovery of commercial income. The letter sets out the following key expectations for NHS Trusts:	CMO DoCA	The CMO and DoCA will work with the Research & Development Team to agree a plan for implementation including how this will be reported and monitored at Board level.	March 2026

	• Monitor performance against the government’s 150-day clinical trial set-up target, with a particular focus on commercial interventional trials. • Embed monitoring into routine governance: Ensure regular Board-level review and presentation of data, holding to the organisation to account and ensuring effective intervention and support • Take immediate action: Boards should actively use the data to drive improvement. https://www.gov.uk/government/publications/transforming-the-uk-clinical-research-system-august-2025-update/transforming-the-uk-clinical-research-system-august-2025-update			

Meeting:	Board of Directors
Date of Meeting:	28 January 2026
Agenda item:	10
Report title:	Board Assurance Framework
Executive sponsor(s):	Taff Gidi – Executive Director of Corporate Affairs
Report author(s):	Ben Cahill – Deputy Director of Corporate Affairs
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Board Assurance Framework for Board of Directors' information and assurance.
Public or confidential	Public

Executive summary

This report provides the board with an update on the Trust's Board Assurance Framework (BAF) included in appendix 1 which also includes a summary and scoring definitions.

Report

The Board Assurance Framework (BAF) sets out to enable the board to identify, assess and monitor the principal risks to the Trust achieving its strategic objectives. The BAF is a collective board document with each BAF risk having an executive director owner and lead board committee for oversight for each risk. The Audit & Risk Committee reviews all BAF risks spread over its four meetings per year.

Overview of key BAF updates (December 2025-January 2026) for board awareness:

- *A2 Quality, Safety & Experience* has had a scoring change following review by the Chief Nurse and Chief Medical Officer – the current score has changed from 10 to 12;
- *A3 Financial sustainability* will be re-assessed following completion of the multi-year planning round. This risk will have a 'deep dive' review by the Audit & Risk Committee in February 2026;
- *A4 Recruitment & Retention* had a scoring change in late 2025 following review by the Chief People Officer – the current score is now at 6;
- *A11 Infrastructure* has had a scoring change and update on actions following review by the Director of Estates and Chief Finance Officer – the current score has changed from 10 to 12. This risk will have a 'deep dive' review by the Audit & Risk Committee in February 2026;

- Over January and February 2026, the Trust's internal auditors are undertaking an audit of the Board Assurance Framework – relevant findings will be reported to board committees and the Executive.

Board committee BAF reporting

The 20 January 2026 Finance & Investment Committee reviewed the five risks for which it has oversight with no updates to report to Board.

The 21 January 2026 People, Leadership & Culture Committee reviewed the two risks for which it has oversight with no updates to report to Board. The committee will undertake deep dives on its BAF risks at its April and July meetings.

The Quality Committee will receive a BAF update on 12 February 2026.

The Audit & Risk Committee will receive a BAF update at its 11 February meeting, focusing on A3 *Financial sustainability* and A11 *Infrastructure*.

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

This report has been prepared for the Board of Directors.

Recommendation(s)

The board is asked to note and provide comment on the Board Assurance Framework.

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

Is risk included in Board Assurance Framework (BAF) / Trust Risk Register (TRR)	☒ BAF	☒ TRR
Equality, diversity and inclusion	No	
Legal and regulatory	Yes	

Board Assurance Framework

Q4 2025/26 Reporting

OHFT's Board Assurance Framework (BAF) sets out to enable the Board of Directors to identify, assess and monitor the principal risks to the Trust achieving its strategic objectives. The BAF sets out the controls, assurances, gaps and proposed actions for each BAF risk to assess and provide assurance on whether existing controls are working and, where they are not, enable an assessment about available actions.

Each BAF risk relates to an OHFT strategic objective: 1) *Deliver the best possible care and health outcomes*; 2) *Be a great place to work*; 3) *Make the best use of our resources and protect the environment*, and 4) *Be a leader in healthcare research and education*.

BAF risks are described using a model of '*If* something happens / is not addressed (cause) '*Then*' a risk may occur '*Resulting*' in an effect. Risks are scored using an *Impact x Likelihood* scoring mode (5x5) indicating whether a BAF risk score is: Low risk (1-3); Medium risk (4-6); High risk (8-12); or Extreme risk (15+). *See slide 28 for guidance on impact and likelihood scoring.*

BAF risks are scored three times as the: *Inherent risk* (i.e. untreated with no controls in place); *Current risk* (i.e. treated with controls applied seeking to address the risk); and *Target risk* (i.e. the risk score with improved controls in place where possible).

Each BAF risk notes controls and mitigations, how assurance on these controls is gained, and identified gaps in controls. Each BAF risk has a risk appetite assessment to indicate the degree of risk the Trust is willing to consider and take to realise a strategic objective. Risk appetite options are: avoid, cautious, minimal, open or seek. *See slide 29 for risk appetite definitions.*

Each BAF risk has a lead committee e.g. BAF risk A1 – *Timely access to services* will receive oversight at each Quality Committee. The Audit & Risk Committee will work through all BAF risks over the course of a year.

Board Assurance Framework – Summary (1)

Board Meeting in Public

Ref.	Risk Category/ Overview	Risk Description	Strategic Aim	Executive Lead	Lead Committee	Prev. score (Nov 25)	Current Score (Jan 26)	Target Score	Risk Appetite
A1	Timely Access to Services	<i>If demand for clinical services does not align with capacity</i> Then patients will wait longer to start treatment, complexity / acuity may increase and greater Trust resource will be required Resulting in breaches of constitutional (performance) standards, unnecessary use of Trust resources, poorer patient experience, and health outcomes.	 Quality	Chief Operating Officers	Quality Committee	16	16	12	Cautious
A2	Quality, Safety & Experience	<i>If we fail to deliver against fundamental standards of quality and safety, to learn from patient safety incidents and experience and to continuously improve</i> Then we will be unable to consistently deliver high quality and safe care Resulting in poor patient outcomes and experience, avoidable harm, regulatory intervention, and a failure to continuously learn and improve.	 Quality	Chief Nurse & Chief Medical Officer	Quality Committee	10	12	8	Minimal
A3	Financial Sustainability	<i>If we fail to live within our means</i> Then the Trust will become financially unsustainable Resulting in failure to deliver agreed financial plans, an adverse impact on service delivery, reputational damage, loss of autonomy and potentially leading to regulatory intervention.	 Sustainability	Chief Finance Officer	Finance and Investment Committee	16	16	12	Cautious
A4	Recruitment & Retention	<i>If we are unable to recruit and retain a sustainable and skilled workforce aligned to our People Plan</i> Then we will not have the right people in the right roles and face persistent staffing gaps Resulting in poor patient outcomes, poor operational performance and declining staff morale and experience.	 People	Chief People Officer	People, Leadership and Culture Committee	6	6	9	Open

Board Assurance Framework – Summary (2)

Ref.	Risk Category/ Overview	Risk Description	Strategic Aim	Executive Lead	Lead Committee	Prev. score (Nov 25)	Current Score (Jan 26)	Target Score	Risk Appetite
A5	Staff Experience & Culture	<i>If the Trust fails to create a positive and inclusive culture where staff feel valued and heard</i> Then issues affecting staff motivation, wellbeing and belonging will not be addressed Resulting in reduced staff motivation, engagement and satisfaction leading to higher sickness absence, higher staff turnover and greater reliance on agency staff.	 People	Chief People Officer	People, Leadership and Culture Committee	12	12	8	Open
A6	Improvement, Research & Innovation	<i>If we fail to foster a strong culture of improvement, research and innovation</i> Then we will not be able to transform services and realise opportunities to improve the quality and efficiency of care Resulting in failure to tackle long-term challenges and missed opportunities to enhance patient outcomes and organisational sustainability and a failure to meet the changing needs of our populations.	 Research	Chief Medical Officer & Chief Nurse	Quality Committee	12	12	6	Open
A7	Environmental Sustainability	<i>If our decisions and actions fail to consider the impact on wider society and the environment</i> Then we will fail to meet our obligations for NHS organisations to achieve Net Zero emissions Resulting in negative environmental and social impacts both now and in future, and may also result in reputational damage and regulatory action.	 Sustainability	Chief Finance Officer	Finance and Investment Committee	12	12	8	Open
A8	Information & Data	<i>If the Trust does not treat information as a critical asset and address information & cyber security threats</i> Then patient and staff information will be insecure and we will not maximise benefits from data Resulting in avoidable service interruption, patient & staff harm, missed opportunities to enhance patient outcomes and organisational effectiveness, regulatory action or reputational damage.	 Sustainability	Executive Director of Corporate Affairs (SIRO)	Finance and Investment Committee	12	12	9	Minimal

Board Assurance Framework – Summary (3)

Board Meeting in Public

Ref.	Risk Category/ Overview	Risk Description	Strategic Aim[s]	Executive Lead	Lead Committee	Prev. score (Nov 25)	Current Score (Jan 26)	Target Score	Risk Appetite
A9	Partnerships & System Working	<i>If we fail to develop and maintain effective working relationships with system partners in both our ICSs</i> Then we will likely be unable to develop comprehensive and credible plans that meet the needs of all our populations Resulting in worsening health, increased demands for healthcare, increased health inequalities and unsustainable services for the future.	 Quality	Chief Executive & Executive Director of Strategy	Quality Committee	12	12	6	Seek
A10	Digital Transformation	<i>If we do not sufficiently invest in, transform and maintain digital technologies, IT systems and digital skills</i> Then our digital capacity may become outdated and inefficient/or fail to fully realise the benefits of digital transformation Resulting in failure to fully realise the benefits of digital transformation of healthcare services including service quality, accessibility and efficiencies.	 Quality	Chief Operating Officers & Chief Finance Officer	Finance and Investment Committee	12	12	9	Open
A11	Infrastructure	<i>If we do not invest in, develop and maintain our essential infrastructure, such as our estate and information systems</i> Then our infrastructure may become unreliable, outdated, unprotected and unsafe Resulting in avoidable interruption to services, delays in treatment and may potentially lead to harm to patients or staff.	 Sustainability	Chief Finance Officer	Finance and Investment Committee	16	12	8	Minimal

BAF A1 – Timely access to services: If demand for clinical services does not align with capacity **Then** patients will wait longer to start treatment, complexity / acuity may increase and greater Trust resource will be required **Resulting** in breaches of constitutional (performance) standards, unnecessary use of Trust resources, poorer patient experience, and health outcomes.

Link to Strategic Aims:



Deliver the best possible care and health outcomes

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Score (with controls in place)	4	4	16	Extreme
Target Risk (with improved controls)	4	3	12	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Current Risk (with controls in place)	4	4	16	Extreme
Target Risk (with improved controls)	4	3	12	High
Risk Appetite				Cautious

Last Reviewed By		
Lead Committee	Quality Committee	13 November 2025
Exec. Dir. Leads	Chief Operating Officers	Scheduled late January 2026

Controls and Mitigation

(What we are currently doing about the risk)

Assurance / Evidence

(How do we know we are making an impact)

Gaps in Control

(Actions to take to achieve target)

1. Relevant clinical policies in place specific to access, eligibility, time to treatment
2. Waiting well support and advice – patients informed about waits and how to access resources for support during waits
3. Performance management framework tracking access, referral and treatment data
4. Workforce planning and skill mix work to review and seek to align capacity with demand and projected demand
5. Incident reporting
6. Patient Safety Incident Reporting Framework (PSIRF)
7. Digital strategy – focus on opportunities for improving access
8. Waiting list reduction initiatives are resourced when these can be delivered practically.
9. NHSE funded bid to work to improve management of waits (opportunity to share and spread learning with other services)

1. Performance reporting against standards and indicators to directorate and Executive forums and relevant commissioners
2. Performance reporting against standards and indicators to Quality Committee and
3. Incident and Patient Safety reporting
4. Learning from patient feedback
5. CQC feedback and regulator assessments and self-assessment
6. Clinical / Internal audits learning and reporting

1. Standardise and reduce variations to improve patient experience e.g. simplifying pathway variation
2. Embed regular data reviews with a health inequality lens e.g. deprivation to strengthen approach to waiting lists
3. Embed alternative options as part of waiting time approach including digital transformation and tool
4. Development and implementation of processes for referral triage and safety netting across services lines
5. Work to fully align clinical strategy with workforce planning (and other enablers e.g. digital)
6. Across all services, working with EHR and Performance & information teams to address issues impacting wait list reporting including patients seen but remaining on waiting list
7. Continuing work in data quality improvement and timeliness of data reporting – input and data extraction

Executive Leads Narrative: Work is ongoing to improve the reporting of waits, moving to a model of oversight and reporting at service, directorate and Executive level to address existing waits and support of transformation of services in line with the NHS 10-year plan focus areas; to include directorate oversight of national indicators relating to access and waiting times.

BAF A1 – Timely access to services: If demand for clinical services does not align with capacity **Then** patients will wait longer to start treatment, complexity / acuity may increase and greater Trust resource will be required **Resulting** in breaches of constitutional (performance) standards, unnecessary use of Trust resources, poorer patient experience, and health outcomes.

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Standardise and reduce variations to improve patient experience e.g. simplifying pathway variation and consistency of triage processes	COOs	Ongoing initiative	<i>Ongoing initiative to improve patient experience and learning from practice.</i>
Embed regular data reviews across services to strengthen approach to waiting list initiatives	COOs	Q3 2025/26	Work in place to embed data reviews with services providing information on patient waits.
Embed alternative options as part of waiting time approach including digital transformation and tool	COOs	Q3 2025/26	Pilot has commenced, now awaiting evaluation for further roll-out.
Working with EHR and Performance & information teams to address issues impacting wait list reporting including patients seen but remaining on waiting list	COOs	Q3 2025/26	Development of standard operating procedures for data collection / validation is underway via Business Services with work expected to be complete by the end of the calendar year.
Development of standard operating procedures for data validation and completeness	COOs	Q3 2025/26	Standard operating procedure in development to guide required recording of outcomes including ethnicity data capture with EMIS, P&I and Business Services teams (anticipated implementation date Q3 25/26)

Link to the Board Risk Register

Ref	Risk Description	Score	Review status	Action
1194	Planned Care Provision (Community) is limited due to demand exceeding resource capacity.	20	Review in date	Action in place
1178	Urgent Care Provision is limited due to demand exceeding resource capacity	16 ↓ 12	Review in date	Action in place
1068	Waiting times (mental health services)	16	Review in date	Action in place
1094	Demand and capacity in some services across the directorate (Oxfordshire & BSW Mental Health)	12	Review in date	Action in place
1001	Capacity - adult mental health beds (Buckinghamshire and Oxfordshire & BSW Mental Health)	12	Review in date	Action in place
1000	Provision of CAMHS beds within the Trust's provider collaborative footprint	9	Review in date	Action in place

BAF A2 - Quality, Safety & Experience: If we fail to deliver against fundamental standards of quality and safety, to learn from patient safety incidents and experience and to continuously improve **Then** we will be unable to consistently deliver high quality and safe care **Resulting in** poor patient outcomes and experience, avoidable harm, regulatory intervention, and a failure to continuously learn and improve.

Link to Strategic Aims:



Deliver the best possible care and health outcomes

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Risk (with controls in place)	5	2	10	High
Target Risk (with improved controls)	4	2	8	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	4	2	8	High
Risk Appetite				Minimal

Last Reviewed By		
Lead Committee	Quality Committee	13 November 2025
Exec. Dir. Lead	Chief Nurse & Chief Medical Officer	January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Clinical policies in place – monitored and updated
2. Compliance with regulatory standards
3. Clinical & Quality governance arrangements in place
4. Infection Prevention & Control arrangements in place
5. Clinical Audits – Core Clinical Standards
6. Learning from complaints, serious incidents and patient feedback (Patient Safety Incident Response Framework)
7. Weekly Review Meeting
8. Directorate weekly safety reviews
9. Patient Advice & Liaison Service (PALS)
10. Learning from feedback (e.g. via *I Want Great Care*)
11. Learning from feedback from Patient & Family experience
12. Inpatient Transformation Programme
13. Health & Safety and Violence and Aggression programmes

Assurance / Evidence

(How do we know we are making an impact)

1. Directorate quality governance meetings / Senior Management Team meetings (performance reporting to Executive directors)
2. Reporting to Quality Committee (NED chaired) and Quality & Clinical Governance Sub-Group (Chief Nurse chaired)
3. Reporting to Mental Health & Law Committee includes CQC visit feedback, Deprivation of Liberty & Mental Health Act
4. Quality dashboard – captures and tracks key metrics, reporting to Quality Committee
5. Annual OHFT Quality Account developed, reported & published
6. Weekly patient safety meeting – learning & reporting
7. Safer Staffing Report
8. Inspections, regulator visits and Peer Reviews (Royal Colleges)
9. Self-assessments against CQC standards & Self-Assessment against Provider capability (Insightful Board)

Gaps in Control

(Actions to take to achieve target)

1. Embedding a Quality Management System across the Trust - balancing assurance, improvement and controls
2. Patient Experience reporting dashboard for all inpatient wards
3. Delivery of care models to work to reduce health inequalities and improve health equity
4. Responding to the Dash review's recommendations

Executive Lead Narrative: The Dash Review of patient safety across the health and care landscape, will help focus and coordinate planning and quality governance. Quality Committee will continue to have oversight of delivery of quality via the Quality & Safety dashboard, Serious Incident Report and other quality governance reporting.

BAF A2 - Quality, Safety & Experience: If we fail to deliver against fundamental standards of quality and safety, to learn from patient safety incidents and experience and to continuously improve **Then** we will be unable to consistently deliver high quality and safe care **Resulting in** poor patient outcomes and experience, avoidable harm, regulatory intervention, and a failure to continuously learn and improve.

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Embed a Quality Management System across the Trust to balance assurance, improvement, planning and controls	Chief Nurse & Chief Medical Officer	Q4 2025/26	Oxford Health Improvement (OHI) currently undertaking a review and gap analysis of governance structures to identify where the Trust needs to have initiatives to achieve a full quality management system – identifying gaps for continual improvement e.g. quality planning and horizon-scanning.
Explore options to develop a Patient Experience reporting dashboard including for inpatient wards	Chief Nurse	Q4 2025/26	Assess options and opportunities for a patient experience reporting dashboard – using/aligning with clinical auditors, core clinical standards and ‘I Want Great Care’.
Delivery of care reducing health inequalities and improves health equity.	Chief Medical Officer	Q4 2025/26	Developing the means e.g. data gathering / datasets to identify where health inequalities are prevalent and the communities not accessing health care to develop plans to address these.
Responding to the recommendations of the Dash review	Chief Medical Officer & Chief Nurse	Q4 2025/26	

Link to the Board Risk Register

Ref	Risk Description	Score	Review status	Action
1068	Waiting times (Mental Health services)	16	Review in date	Action in place
1199	Harm To Staff; relating to violence and aggression.	16	Review in date	Action in place
1334	Lack of appropriate room space in Bullingdon Prison - poorer patient and staff safety and patient outcomes	15	Review in date	No action in place
1209	Management of bariatric patients	12	Review in date	Action in place
1346	Pharmacy Standard operating procedures (Management capacity to update and reflect best practice)	12	Review due	Action in place

BAF A3 – Financial sustainability: If we fail to live within our means **Then** the Trust will become financially unsustainable **Resulting in** failure to deliver agreed financial plans, an adverse impact on service delivery, reputational damage, loss of autonomy and potentially leading to regulatory intervention.

Link to Strategic Aims:



Make the best use of our resources and protect the environment

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Risk (with controls in place)	4	4	16	Extreme
Target Risk (with improved controls)	4	3	12	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Current Risk (with controls in place)	4	4	16	Extreme
Target Risk (with improved controls)	4	3	12	High
Risk Appetite				Cautious

Last Reviewed By		
Lead Committee	Finance and Investment Committee	20 January 2026
Exec. Dir. Lead	Chief Finance Officer	January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Benchmarking against financial governance and credibility expectations of commissioners
2. Annual financial planning (integrated with strategic planning and proposals for efficiencies and investment)
3. Budget setting and sign off process, Standing Financial Instructions & Scheme of delegation & reservations
4. Agency controls and Vacancy Control Board
5. Medium-Term Financial Plan produced annually and reviewed by FIC and the Board
6. Business case approval process
7. Procurement systems and processes including quarterly review top 20 suppliers
8. Business services processes to review and manage clinical expenditure and income contracts.

Assurance / Evidence

(How do we know we are making an impact)

1. Monthly finance reports
2. Service & Financial Sustainability Group
3. Executive Performance Review Meetings
4. Divisional Governance Meetings
5. Capital Programme Group
6. Finance & Investment Committee reports
7. Board of Directors reports
8. Monthly reporting to, and monitoring by, NHSE and the Integrated Care Board (ICB)
9. Internal audit reviews
10. External audit reviews
11. Procurement reporting to Finance & Investment Committee
12. Local Counter Fraud Service

Gaps in Control

(Actions to take to achieve target)

1. Build our relationships and reputation for financial credibility with Commissioners
2. Show system leadership in respect of Mental Health Provider Collaborative and Neighbourhood Health planning
3. Continuously improve financial culture of transparency & ownership.
4. Allocate resources strategically through planning rounds
5. Continuously improve value, designing and delivering optimal services for the resources available, and planning efficiency improvements for future years.
6. Develop use of costing, activity and (in due course) outcome data, benchmarking and challenging the underlying cost base and tackling unwarranted variation.
7. Address existing value weaknesses e.g. Estates non-pay, Medical agency and Out of Area Treatment.

Executive Lead Narrative: To achieve the target risk we would need reasonable short-term certainty around funding and our ability to respond to short-term shocks, and confidence for the longer-term in our ability to represent our position well with our commissioners and stakeholders and to have the capability to prioritise allocations and tailor services to deliver quality services to patients within available funding. At this stage, there is a high degree of uncertainty, however I am confident that all directorates are very focused on designing sustainable models for the future and that we are developing the tools and capabilities around data and have momentum about using this to manage value better, take advantage of financial opportunities, and manage financial risks. The scoring of this risk will be re-assessed after completion of the multi-year planning round.

BAF A3 – Financial sustainability: If we fail to live within our means **Then** the Trust will become financially unsustainable **Resulting in** failure to deliver agreed financial plans, an adverse impact on service delivery, reputational damage, loss of autonomy and potentially leading to regulatory intervention.

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Planning process to identify CIPs and financial plans over the spending review period	Chief Finance Officer	December 2025	A first cut submission was made on 17th December 2025, the next iteration is due in February 2026.
100% of FY25/26 CIPs in line with targets with quality impact assessments completed.	Chief Finance Officer	Complete	N/A
Introduce costing and activity data to monthly board finance report and make available to teams via TOBI dashboard	Chief Finance Officer	December 2025	Costing, Whole Time Equivalent (WTE) and Activity data now available in Board Report.
Improved workforce planning capability to deliver plans to reduce agency spend further in FY25	Chief Finance Officer / Chief People Officer	31 March 2026	Development of workforce planning underway to explore options for further agency spend reduction.

Link to the Board Risk Register

Ref	Risk Description	Score	Review status	Action
1236	Failure to deliver financial plan and maintain financial sustainability	16	Review in date	Action in place
1230	Inability to deliver required capital investments due to level of current capital commitments / constraints	12	Review due	Action in place

BAF A4: Recruitment & Retention: If we are unable to recruit and retain a sustainable and skilled workforce aligned to our People Plan **Then** we will not have the right people in the right roles and face persistent staffing gaps **Resulting in** poor patient outcomes, poor operational performance and declining staff morale and experience.

Link to Strategic Aims:



People

Be a great place to work

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	3	2	6	Medium
Target Risk (with improved controls)	3	3	9	High
Risk Appetite				Open

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	3	2	6	Medium
Target Risk (with improved controls)	3	3	9	High

Last Reviewed By		
Lead Committee	People, Leadership & Culture Committee	21 January 2026
Exec. Dir. Lead	Chief People Officer	6 January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Training, supervision and PDR review processes in place to support retention and development
2. HR, health & wellbeing, EDI and Occupational Health policies, initiatives and support available to staff
3. Delivering career development pathway for HCAs
4. Focus on workforce race equality issues e.g. staff identifying as ethnic minority disproportionately represented in disciplinary processes
5. Freedom to Speak Up guardians report theme in relation to staff retention
6. Enhancing staff voice via staff networks and union feedback
7. Talent acquisition team in place focused on hard to fill vacancies

Assurance / Evidence

(How do we know we are making an impact)

1. Reporting against Retention Plan to People Steering Group (PSG) & Executive
2. Quarterly review by Retention team on reasons for leaving and reporting on reasons for leaving to PSG and Executive
3. Reporting of key recruitment and retention initiatives to People Leadership & Culture committee
4. Reporting on recruitment & retention indicators to Board of Directors
5. Reporting in place against national indicators – High Impact Actions (HIA) for EDI alongside Workforce Equality schemes for disability and race.

Gaps in Control

(Actions to take to achieve target)

1. Development of segmented analysis of retention data following successful reduction of turnover rates
2. Review of retention programme to include initiatives that may improve retention inc. flexible working, staff recognition, etc
3. Review and revision of exit interview process
4. Review learning from April 2025 survey of black, Asian and minority ethnic staff on their work experience
5. Continued delivery of local induction project workstreams
6. Work to fully align workforce planning with clinical strategy (and other enablers e.g. digital)
7. Future risk area - relating to entry-point recruitment (particularly HCAs) due to government visa restrictions moving into 2027/28

Executive Lead Narrative: Both retention and recruitment have improved considerably over the last 12 months and inform a reduction of the current risk scoring in November 2025 to below the target risk. Further work is now being planned to ensure that we are continuing to target areas of high vacancies; embedding supervision and improving vacancy rates in relation to HCAs to reduce reliance of agency staff.

BAF A4: Recruitment & Retention: If we are unable to recruit and retain a sustainable and skilled workforce aligned to our People Plan **Then** we will not have the right people in the right roles and face persistent staffing gaps **Resulting in** poor patient outcomes, poor operational performance and declining staff morale and experience.

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Retention proramme to include a review of initiatives that may improve retention e.g. flexible working and recognition programmes – includes review of flexible working project and staff recognition initiatives.	Chief People Officer (CPO) & Interim Head of Organisational Development (OD)	<i>Review is complete</i>	- A review of the retention programme has taken place following which Personal Development Review (PDRs) and New Starter Onboarding projects will both become business as usual - Local Induction Quality Improvement Project – this workstream will be closed - Work with Human Resources (HR) and Service Director to reduce the number of staff leaving from the Primary Community and Dental Directorate – this work will now be picked up locally with support from the HR Operational team and focus on: Flexible working; Reward and Recognition - Complete work relating to a bespoke BAME staff experience survey – this important data source will feed into the work on a single EDI plan (see below).
Review of exit process and how to improve learning from these.	CPO & Interim Head of OD	<i>Review is complete</i>	The Exit process now runs via ESR and we have begun to see a small improvement in response rates from leavers. Work has now begun on creating a dashboard to support analysis of any feedback captured.
Explore improvements to the current staff recognition process, specifically around long service milestones	CPO & Interim Head of OD	<i>Q4 2025/26</i>	Scoping has begun on improving our recognition of long service beginning with a discovery phase of what other organisations do.
Development of a programme of engaging with early talent and future workforce from the local community – and under-represented areas	CPO & Head of Resourcing	<i>Programme now in place</i>	Programme is live with events and initiatives planned and will be reviewed in Q1 2026/27

Link to the Board Risk Register				
Ref	Risk Description	Score	Review status	Action
1199	Harm To Staff; relating to violence and aggression	16	Review in date	Action in place

BAF A5: Staff Experience & Culture: If the Trust fails to create a positive and inclusive culture where staff feel valued and heard **Then** issues affecting staff motivation, wellbeing and belonging will not be addressed **Resulting in** reduced staff motivation, engagement and satisfaction leading to higher sickness absence, higher staff turnover and greater reliance on agency staff.

Link to Strategic Aims:



Be a great place to work

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	4	2	8	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	4	2	8	High
Risk Appetite				Open

Last Reviewed By		
Lead Committee	People, Leadership & Culture Committee	21 January 2026
Exec. Dir. Lead	Chief People Officer	6 January 2026

Controls and Mitigation

(What we are currently doing about the risk)

Assurance / Evidence

(How do we know we are making an impact)

Gaps in Control

(Actions to take to achieve target)

- 1. HR policies and strategies in place and reviewed
- 2. Freedom to Speak Up guardians in place
- 3. Health, wellbeing and support advice available to staff
- 4. Employee assistance programme
- 5. Occupational health service
- 6. Equality, Diversity & Inclusion (EDI) team, plans, training and groups, Staff Equality Networks
- 7. Training, supervision and PDR processes in place
- 8. Delivery of NHS England EDI improvement plan
- 9. Arrangements to tackle and address violence and aggression towards staff
- 10. People Promise, Staff Survey & Pulse surveys

- 1. Reporting against HR policies, plans and programmes to People Steering Group (monthly) and Education Strategy Group
- 2. FtSU reporting to Executive and Board
- 3. Insight from and reporting on staff survey results
- 4. Reporting to People, Leadership & Culture Committee (quarterly)
- 5. Reporting in place against national indicators – High Impact Actions (HIA) for EDI alongside Workforce Equality schemes for disability and race.

- 1. Complete / develop response to *Programme Supporting our People and Teams*
- 2. Improve staff experience and response to issues identified via staff surveys
- 3. Score for 'flexible working' domain within People Promise element
- 4. Address gaps identified in Sexual Safety charter
- 5. EDI – address identified gaps from quality improvement work from WRES and WDES pay gap data

Executive Lead Narrative: Work is ongoing to further the Supporting Our People and Teams Programme; the next stage will be to understand how to address gaps in the enabling programmes of work that are in train to create a positive and inclusive culture. In late 2025, a Deputy Director of People began work at the Trust and will lead the development of a range of initiatives relating to this BAF risk.

BAF A5: Staff Experience & Culture: *If the Trust fails to create a positive and inclusive culture where staff feel valued and heard **Then** issues affecting staff motivation, wellbeing and belonging will not be addressed **Resulting in** reduced staff motivation, engagement and satisfaction leading to higher sickness absence, higher staff turnover and greater reliance on agency staff.*

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Supporting our people and teams programme	Chief People Officer (CPO) & Deputy People Director	Ongoing	A cultural statement has been created with 5 asks for teams to consider. A mapping exercise has taken place to look at what the organisation is planning or already has in place to support each of the 5 asks (Teamwork; Support & Compassion; Quality Improvement, Learning & Innovation; Values-based leadership; and Professionalism)
Respond to staff experience issues identified in staff surveys and People Promise elements	CPO & Interim Head of OD	Review underway – to inform timescales	People Promise element showed focused attention is required on 'We work flexibly' to improve an average benchmarked position with other similar organisations. There are now dedicated intranet pages, an updated policy and a central system in place (since Mar25) to capture new flexible working requests. A review is now taking place of this work.
Address gaps in Sexual Safety charter	CPO & Interim Head of OD	Q4 2025/26	A task & Finish group has been put in place to review the Sexual Misconduct policy. The Sexual Safety framework will now be reviewed alongside the NHS England guidelines that have just been released. Policy to finalise over Q4 2025/26.
Creation of an overarching EDI plan capturing actions from workforce data on race and disability equality, EDI high impact areas and the patient & carer race equality framework (PCREF)	CPO & Interim Head of OD	Q4 2025/26	Single overarching EDI plan has been created to be shared with PLC.

Link to the Board Risk Register

Ref	Risk Description	Score	Review status	Action
1199	Harm To Staff; relating to violence and aggression.	16	Review in date	Action in place

BAF A6 – Improvement, Innovation & Research: If we fail to foster a strong culture of improvement, research and innovation **Then** we will not be able to transform services and realise opportunities to improve the quality and efficiency of care **Resulting in** failure to tackle long-term challenges and missed opportunities to enhance patient outcomes and organisational sustainability and a failure to meet the changing needs of our populations.

Link to Strategic Aims:



Be a leader in healthcare research and education

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	2	6	Medium
Risk Appetite				Open

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	2	6	Medium

Last Reviewed By		
Lead Committee	Quality Committee	13 November 2025
Exec. Dir. Lead	Chief Medical Officer & Chief Nurse	January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Internal Research & Development (R&D) senior management team in place reporting to Chief Medical Officer (CMO)
2. R&D operational and strategic plans in place or under development
3. Collaborative working with Oxford Joint Research Office (JRO) partners (OUH, OHFT, Oxford University and Oxford Brookes)
4. OHFT-Biomedical Research Centre (BRC) Steering Group
5. Oxford Applied Research Collaboration (ARC) and ARC Board
6. Toronto collaboration – Oxford Psychiatry
7. *Count Me In* (CMI) programme redeveloped and due to be relaunched over 2025
8. Quality Improvement hubs & work programme
9. Nurses, Midwives & Allied Health Professionals (NMAHP) research engagement programme (includes Chief Nurse Research Fellowship)
10. Close working with Trust to maximise use of research funding

Assurance / Evidence

(How do we know we are making an impact)

1. R&D reporting to Quality Committee and Board (bi-annual)
2. ARC, BRC, CRF, HRC and MHM annual reporting to National Institute for Health & Care Institute (NIHR)
3. ARC 2 submitted and successful – starting in April 2026
4. OH-BRC midterm review recently undertaken in conjunction with external advisory group
5. Annual report research capability submitted to DHSC
6. R&D governance on finance & set-up time
7. Quality Improvement programme updates and reporting to Executive forums and Quality Committee
8. Assurance on Trust NIHR Regulatory returns / feedback
9. OH-led research translated into patient care and best practice, e.g. OCAP research informing NICE guidance, 'Tune-Up' clinics for triage and better outcomes in early intervention in psychosis

Gaps in Control

(Actions to take to achieve target)

1. Development for Community Services research with Nuffield Department of Primary Care - to include a greater focus on Community Services, aligning with 10 year plan neighbourhood health shift and NIHR 'place-based' initiatives.
2. Improved R&D governance arrangements to enable more timely approvals for contracts and delegations. (Work with JRO for includes an additional 1.0 WTE post in contracts team to support OHFT studies)
3. Funding sustainability for research – organisational & system
4. Undertake clarification around intellectual property ownership and processes – to develop IP governance arrangements
5. Opportunities to increase collaboration in Mental Health research (e.g. Secure Data Environment work)

Executive Lead Narrative: We continue to work and examine options to reduce the time to approve and set-up research trials (150 say study set-up time), which has to balance requirements and risks of financial, information governance and capacity. This drive is linked to the UK Government Office of Life Sciences Strategy and the NHS 10-year healthcare plan for England to boost innovation and effectiveness across the NHS.

BAF A6 – Improvement, Innovation & Research: If we fail to foster a strong culture of improvement, research and innovation **Then** we will not be able to transform services and realise opportunities to improve the quality and efficiency of care **Resulting in** failure to tackle long-term challenges and missed opportunities to enhance patient outcomes and organisational sustainability and a failure to meet the changing needs of our populations.

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
R&D Operational plan development, including review of governance arrangements to support timely decision-making	Chief Medical Officer & Head of R&D	Q4 2025/26	Operational plan development and governance arrangements review underway. Responding to NIHR requirement for 150 days study set-up for clinical trials.
Financial planning & funding sustainability for Quality Improvement & Research	Chief Medical Officer & Chief Nurse	Q4 2025/26	
Develop a Trust approach to Intellectual Property (IP) governance including development of an IP Policy	Executive Director of Corporate Affairs	31 March 2026	IP Policy drafted and being reviewed by relevant parties for finalisation
Agree and implement an R&D contracting and governance future approach	Chief Medical Officer & Executive Director of Corporate Affairs	31 March 2026	
R&D strategic development / link to Trust new strategy development (over 2026)	Chief Medical Officer & Head of Research	Q1 2026/27	Development of new R&D strategy underway with scoping to align with development of the Trust's organisational strategy over 2026

Link to the Board Risk Register				
Ref	Risk Description	Score	Review status	Action
1326	Research & Development training matrix	12	Review in date	No action in place
1251	Not meeting the Research Delivery Network 80% target of portfolio studies meeting recruitment to time and target	8	Review in date	No action in place

BAF A7 – Environmental sustainability: If our decisions and actions fail to consider the impact on wider society and the environment **Then** we will fail to meet our obligations for NHS organisations to achieve Net Zero emissions **Resulting in** negative environmental and social impacts both now and in future and may also result in reputational damage and regulatory action.

Link to Strategic Aims:



Make the best use of our resources and protect environment

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	4	2	8	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	4	2	8	High
Risk Appetite				Open

Last Reviewed By		
Lead Committee	Finance & Investment Committee	20 January 2026
Exec. Dir. Lead	Chief Finance Officer	January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Board commitment to Zero Carbon Oxford Charter and Trust Green Plan 2 2025-2028 and action plans
2. Full-time sustainability manager & green spaces coordinator
3. Green Task Force Benchmarking and reporting (to CFO)
4. Procurement Policy – sets out sustainability commitments required by suppliers
5. Green Energy Supplier for electricity via CCS
6. Regular review of corporate business mileage
7. Developments to accord with NHS Net Zero Buildings Guidance
8. OHFT is part of ZCOP 'sprint group' with Oxford University to review how to adapt building estates to climate change
9. Active staff communications to promote sustainability and environmental culture (including briefings at induction)
10. Quality Improvement process prompts staff to consider environmental impacts.
11. Medicines optimisation underway including on inhalers.

Assurance / Evidence

(How do we know we are making an impact)

1. Internal oversight of Green Plan action plans by CFO chaired Green Task Force and to Finance and Investment Committee and Board of Directors
2. Attendance at and reporting to BOB ICS Net Zero Programme Board (OHFT is leading on the BOB Sustainable Travel Group)
3. Reporting to national NHS Total Carbon Footprint Plus and in Strategic Dashboard

Gaps in Control

(Actions to take to achieve target)

1. Develop Heat Decarbonisation plans for the estate
2. Continue to raise awareness and culture across the Trust
3. Need for more subject matter expertise in energy, travel & transport, and waste management identified.

Executive Lead Narrative: Green Plan 2 has been well-communicated and implementation is being tracked by working groups with oversight from the Green Task Force. At the October Green Task Force, momentum was noted on Heat Decarbonisation plans, solar panel and Electric Vehicle charging point installation, waste management and paper reduction. A strong start has also been made on green spaces and on medicines optimisation. The Greener NHS dashboard indicates mid-table performance on emissions from energy consumption and from the fleet when compared to our sector.

BAF A7 – Environmental sustainability: If our decisions and actions fail to consider the impact on wider society and the environment **Then** we will fail to meet our obligations for NHS organisations to achieve Net Zero emissions **Resulting in** negative environmental and social impacts both now and in future and may also result in reputational damage and regulatory action.

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Resourcing to implement a Heat Decarbonisation Plan	Chief Finance Officer	Q4 2025/26	Scoping of further plans in development
Green Plan Capital & Revenue Budget	Chief Finance Officer	Q4 2025/26	Will be considered as part of the planning round
Secure energy, transport management and waste management subject matter expert capability	Director of Estates	April 2026	

BAF A8 - Information & Data: If the Trust does not treat information as a critical asset and address information & cyber security threats **Then** patient and staff information will be insecure and we will not maximise benefits from data **Resulting in** avoidable service interruption, patient & staff harm, missed opportunities to enhance patient outcomes and organisational effectiveness, regulatory action or reputational damage.

Link to Strategic Aims:



Make the best use of our resources and protect the environment

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	3	9	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	3	9	High
Risk Appetite				Minimal

Last Reviewed By		
Lead Committee	Finance & Investment Committee	20 January 2026
Exec. Dir. Lead	Executive Director for Corporate Affairs (SIRO)	January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Information Governance and Data Protection policies and procedures in place
2. Cybersecurity systems, policies and procedures
3. Senior oversight roles inc. SIRO and Caldicott Guardian, CNIO, CCIO & Data Protection Officer
4. Information Management Group chaired by Senior Information Risk Owner (SIRO)
5. In-house teams supplemented with external capability
6. Mandatory IG training for all staff – compliance reviewed
7. Strong incident reporting culture (active review of near misses)
8. Assessments and tests in place e.g. phishing tests
9. Information assets are risk assessed using Data Protection Impact Assessment tool
10. Third party cyber security assessment
11. Cyber Security & Data protection awareness/comms to staff
12. Resilience and business continuity arrangements in place

Assurance / Evidence

(How do we know we are making an impact)

1. Executive chaired Information Management Group (IMG) – 4 meetings pa, reporting into Finance & Investment Committee
2. IMG reviews Information Asset Register (with each main information asset area reported on by an IA owner)
3. IMG receives standing items from CCIO, CNIO, DPO, Caldicott Guardian, CDIO and on IG training compliance rates
4. Data Security Protection Toolkit developed, reviewed and submitted annually
5. Internal audit reviews of information governance, IT systems and cybersecurity
6. IMG 3As report to Finance & Investment Committee
7. Regular penetration testing in line with national guidance
8. Monitoring of timeliness of implementation of patches

Gaps in Control

(Actions to take to achieve target)

1. Digital Maturity Assessment completion
2. Continued data quality reviews/work
3. Strengthening where possible supplier diligence pre and post-implementation
4. Continued awareness of good cyber security practice recognising ongoing risks of user error
5. Regular SIRO reporting to be strengthened – planned work to review and strengthen Information Asset Owner guidance and reporting
6. Strengthening of external access to clinical systems by partner organisations

Executive Lead Narrative: My assessment based on assurance received via the Information Management Group is that the Trust's information risk profile is currently medium to high level of risk. This indicates that while the broader UK operating environment is experiencing significant information risk threats, the Trust's systems of control are mitigating against this well. We need to continue to be vigilant ahile also maximising the benefits for service users and staff of using the information we hold intelligently.

BAF A8 - Information & Data: *If the Trust does not treat information as a critical asset and address information & cyber security threats **Then** patient and staff information will be insecure and we will not maximise benefits from data **Resulting in** avoidable service interruption, patient & staff harm, missed opportunities to enhance patient outcomes and organisational effectiveness, regulatory action or reputational damage.*

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Completion of digital maturity assessment work (system coordinated)	Chief Digital Information Officer	Annual	Undertaken annually to meet NHS England requirements – scored out of top score of 5. OH target is 4 or above in all areas with this years’ score (July 2025) given at 3.2.
Review of any options to strengthen supplier diligence pre and post implementation	Data Protection Officer / Chief Digital Information Officer	Completed	SIRO met with DPO and CDIO over August. Specific action agreed regarding escalation process for when risks related to a specific information asset have been identified by the cyber team and a decision has potential organisational impact.
Review and refresh of Information Asset Register and delivery of IA owner guidance and training	Head of Information Governance	March 2026	Review underway by Information Governance and Deputy Director of Corporate Affairs of register of Information Asset Owners. Over January 2026, training and guidance on Information Asset Owner role good practice is being delivered.
Review and mapping of current Business Critical Information Assets	Senior Information Risk Owner	June 2026	An action from the last IMG to review current list and ensure it is up to date and then consider if the right mitigations are in place to ensure these assets do not impact the Trust's day to day operations.

Link to the Board Risk Register				
Ref	Risk Description	Score	Review status	Action
1356	Cyber attack is an ongoing threat/risk to the Trust and a successful attack is likely high impact	20	Review in date	Action in place
1180	Incomplete Employee Immunisations Data	16	Review in date	Action in place
1400	Third-party externally hosted systems and infrastructure vulnerabilities	12	Review in date	Action in place
1396	Phishing and social engineering pose a continual and evolving risk to the trust.	12	Review in date	Action in place

BAF A9 – Partnerships & System working: If we fail to develop and maintain effective working relationships with system partners in both our ICSs Then we will likely be unable to develop comprehensive and credible plans that meet the needs of all our populations Resulting in worsening health, increased demands for healthcare, increased health inequalities and unsustainable services for the future.

Link to Strategic Aims:



Deliver the best possible care outcomes

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	2	6	Medium
Risk Appetite				Seek

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	4	4	16	Extreme
Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	2	6	Medium

Last Reviewed By		
Lead Committee	Quality Committee	13 November 2025
Exec. Dir. Lead	Executive Director for Strategy	Scheduled late January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Via the Trust's annual planning process - active participation and support to system planning, linking to internal plan development. Support takes place both at ICB and place levels, driven by Trust senior leaders
2. BOB Mental Health Provider Collaborative - joint leadership with Berkshire Healthcare and ICB of the system Mental Health agenda inc. transformation, delivery of ICB mental health work programme, leadership of annual planning, with coordination across local authorities, VCSE sector, and primary care
3. Leadership of other informal alliances via Provider Collaboratives, outcomes contracts, etc. Clear provider collaborative governance arrangements in place
4. Trust senior leaders are active at all ICB and place forums e.g. UEC Board, Neighbourhood work, etc.
5. Active engagement with system partners as part of development of Trust strategy

Assurance / Evidence

(How do we know we are making an impact)

1. Annual plan progress reporting to Executive & Board of Directors
2. Reporting on specific programmes of work to Executive & Board of Directors
3. Output of Annual Plan enabling us to address/ mitigate our challenges and improved system working
4. Provider collaborative governance reporting to Quality Committee
5. Integrated Performance Report reporting to relevant committees and senior management meetings
6. Strategy development progress and engagement work reporting to Strategy Delivery Group, Executive, and Board

Gaps in Control

(Actions to take to achieve target)

1. Formalising the role and operating model of the BOB Mental Health Provider Collaborative
2. Developing our approach to neighbourhood working, including our approach to health inequalities and population
3. Trust developing its strategic partnership approach with VCSE sector.

Executive Lead Narrative: In the context of the development of the new Thames Valley ICB - which will seek to implement the model ICB – the current Buckinghamshire, Oxfordshire & Berkshire West (BOB ICB) is now defining its new operating model. In late 2025, initial ICB planning guidance has begun to set out governance arrangements for the planning process, OHFT is an actively involved in shaping the planning.

BAF A9 – Partnerships & System working: If we fail to develop and maintain effective working relationships with system partners in both our ICSs **Then** we will likely be unable to develop comprehensive and credible plans that meet the needs of all our populations **Resulting** in worsening health, increased demands for healthcare, increased health inequalities and unsustainable services for the future.

Action to address gap in assurance/control	Lead	Date of implementation / Deadline	Status Update
Formalising the role and operating model of the BOB Mental Health Provider Collaborative	Associate Director of Mental Health	Q4 2025/26	- ICB operating model being reviewed in 2025/26, which in turn will help clarify current role that the BOB MH PC should play in the operating model - BOB MH PC has currently taken the lead on a joint £5m risk share between the IBC, OHFT and BHFT as an output of the 25/26 Planning process. It is expected that this work will lead to a better understanding and ability to influence jointly with partners the total ICB spend on Mental Health.
Developing initial Trust approach to neighbourhood working, including approach to health inequalities and population.	Transformation Director - Community Health Services, Dentistry and Primary Care	Q4 2025/26	- Neighbourhood Health identified as one of our Trust-wide priority for 2025/26 and 2026/27 - Internal working group of the Trust established and actively linking with Place-level work, with a particular leadership role in Oxfordshire - Health inequalities approach reviewed by Strategy Delivery Group and approved by Executive Has enabled development of actions and phasing of work required. Action timescale set at Q4 2025/26
Trust developing its strategic partnership approach with VCSE sector	Executive Director Strategy	Q3 2025/26	As part of the development of the new Strategy for the Trust, engage with VCSE sector colleagues and explore with the Board appetite for developing a more strategic approach to engagement with the VCSE sector.

BAF A10 – Digital transformation: If we do not sufficiently invest in, transform and maintain digital technologies, IT systems and digital skills **Then** our digital capacity may become outdated and inefficient/or fail to fully realise the benefits of digital transformation **Resulting in** failure to fully realise the benefits of digital transformation of healthcare services including service quality, accessibility and efficiencies.

Link to Strategic Aims:



Deliver the best possible care outcomes

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	3	9	High

Controls and Mitigation

(What we are currently doing about the risk)

1. Digital Strategy in place
2. Frontline Digitisation programme and project management
3. Digital maturity assessment
4. Senior digital leaders in place including Chief Digital & Information Officer (digital leadership team established)
5. Embedding the development and use of TOBI (Trust Online Business Intelligence) data from ward to Board level
6. Digital, Data and Technology Skills and Workforce Group
7. Innovation pipeline to facilitate oversight and prioritisation of resources for digital innovations
8. Work on corporate services responsiveness and coordination (Our central & Corporate Services enabler work)
9. Relationships and coordination with system, ICB, and Oxford universities for alignment, innovation & Quality Improvement
10. Artificial Intelligence strategic group
11. Interactions with other NHS organisations for data platforms – alert to and addressing gaps in control

Assurance / Evidence

(How do we know we are making an impact)

1. Digital strategy implementation reporting to Digital & Data Strategy Board (chaired by Chief Clinical Information Officer)
2. Frontline Digitisation programme reports to Executive and Finance & Investment Committee
3. Information Management Group oversight – chaired by Senior Information Risk Owner (SIRO)
4. Board level Digital Champion (Chair)
5. Where relevant, reporting to system / ICB digital reporting and assurance, and EPR benchmarking exercises

Gaps in Control

(Actions to take to achieve target)

1. Funding shortfalls to realise benefits of available digital capabilities
2. Digital skills and capabilities of the Trust workforce, ongoing upskilling for clinical/corporate digital systems, and time lag in adoption of digital solutions
3. Continuing alignment of digital requirements and priorities with clinical needs assessments and workforce planning
4. Sustainability of available investment for digital transformation
5. Residual risk of cyber attacks on increasingly digitised organisations (cross-reference with A11 – Infrastructure)
6. Co-pilot policy in place but development of wider AI policies in development

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	3	3	9	High
Risk Appetite				Open

Last Reviewed By		
Lead Committee	Finance & Investment Committee	20 January 2026
Exec. Dir. Lead	Chief Finance Officer & Chief Operating Officers	January 2026

Executive Lead Narrative: Digital leaders are investing in external-facing networking to ensure we are aware of latest developments in AI and other technologies, and that we are joined up with NHS-wide and system-wide opportunities like the NHS App and Shared Care Record. RiO optimisation is progressing well and a recent survey found that our clinicians are experiencing improvements compared to the predecessor system. EMIS improvements are proving more difficult to deliver and supplier relationships are not strong. There are a number of AI enabled trials underway including triage, admin and ambient voice technology. The Single Sign On element of the ESR manager self-service programme has been widely welcomed. Developing our Digital Strategy is the key step to ensure our capabilities match our ambitions for the future.

BAF A10 – Digital transformation: *If we do not sufficiently invest in, transform and maintain digital technologies, IT systems and digital skills **Then** our digital capacity may become outdated and inefficient/or fail to fully realise the benefits of digital transformation **Resulting in** failure to fully realise the benefits of digital transformation of healthcare services including service quality, accessibility and efficiencies.*

Actions to address gap in assurance/control	Lead	Date of implementation	Status Update
Complete NHS England / ICB Digital Maturity Assessment	Chief Digital Information Officer (CDIO)	Annual	See A8 relating to digital maturity assessment.
Optimisation of core clinical systems to underpin clinical needs and delivery.	CDIO	Annual work programme in place	New clinical systems were established in 2022 and over the last 3 years functionality has been developed to meet clinical needs. Full programme of work in place for coming years, prioritised by clinical staff with clinical governance in place.
Focus on realising benefits of the optimisation programmes	CDIO	Annual prioritisation in place	Significant work has been undertaken to understand and report benefits realisation (reported to Finance & Investment Committee). Benefits realisation work is reviewed and reprioritised annually linking to annual planning processes.
Digital infrastructure and architecture	CDIO	Ongoing programme – with refresh points	Work completed to understand Trust digital architecture and process improvement opportunities and prioritisation and to inform IT infrastructure needs are met (e.g. network capacity).
Development of Artificial Intelligence policy	CDIO	Completed	Policy approved at Information Management Group in October 2025 & Finance & Investment Committee in November 2025 – to be reviewed in new financial year.

BAF A11 - Infrastructure: If we do not invest in, develop and maintain our essential infrastructure, such as our estate and information systems **Then** our infrastructure may become unreliable, outdated, unprotected and unsafe **Resulting in** avoidable interruption to services, delays in treatment and may potentially lead to harm to patients or staff.

Link to Strategic Aims:



Make the best use of our resources and protect the environment

Previous scoring (November 2025)	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Risk (with controls in place)	4	4	16	High
Target Risk (with improved controls)	4	3	12	High

	Impact	Likelihood	Score	Rating
Risk Identification (inherent risk)	5	4	20	Extreme
Current Risk (with controls in place)	4	3	12	High
Target Risk (with improved controls)	4	2	8	High
Risk Appetite				Minimal

Last Reviewed By		
Lead Committee	Finance & Investment Committee	20 January 2026
Exec. Dir. Lead	Chief Finance Officer	January 2026

Controls and Mitigation

(What we are currently doing about the risk)

1. Specific policies (e.g. Fire, Estates, etc) in place and reviewed
2. In-house teams supplemented with external capability
3. Annual maintenance plan for estates safety improvements inc. Fire and anti-ligature work
4. Fire risk assessments, drills and training programmes Strong incident reporting culture (active review of near misses)
5. Risk assessments, testing and training undertaken for key areas such as fire, asbestos, and water & electrical safety
6. Authorising Engineers appointed in accordance with Health Technical Memoranda to conduct independent reviews
7. Occupational Health activities
8. Cyber resilience teams and cyber assessment activities
9. Insurance cover & service and maintenance contracts in place
10. Quarterly review by Procurement of top 20 suppliers by spend
11. IT infrastructure investment planned being delivered
12. Safety Groups have been established in line with HTMs

Assurance / Evidence

(How do we know we are making an impact)

1. Quarterly H&S reporting to Fire, Health & Safety, Occupational Health and Security Group and Executive
2. Reporting to Finance & Investment Committee of capital planning, Estates, Health & Safety, Digital programmes, & Cyber
3. Annual report on Estate condition
4. External fire service inspections (Oxfordshire Fire & Rescue)
5. Data Security & Protection Toolkit - includes cyber assessments and penetration testing
6. Annual Patient Led Assessment of Care Environments reviews
7. Estates Return Information Collection (ERIC) & Place Assurance Model (PAM) reports submitted annually
8. Quality Committee (QC) review of physical estate risks, Fire, and Health & Safety reports
9. Internal Audit reviews
10. Reporting of supplier and third-party risks assessments
11. External inspections and reviews of assessments relating to fire, water, electrical safety (inc. Health & Safety Executive)
12. Regular interaction with ICB/NHSE region Estates & Facilities

Gaps in Control

(Actions to take to achieve target)

1. Estates strategy to maximise quality and functionality of the estate within achievable parameters
2. Security risks at some parts of Estate, e.g. lighting, CCTV (wards and external) etc need improvement.
3. Estates re-organisation in process
4. Estates, Fire and H&S teams below required staffing and have a backlog of actions and audits to complete
5. Warneford inpatient wards recognised as not fit modern therapeutic environments
6. Asset registers for physical estate incomplete. Regular checks are conducted for highest risk assets, but a more comprehensive approach is required
7. Reporting on compliance with Health Technical Memoranda (HTMs) and Health Building Notes (HBNs) together with other statutory instruments is not fully in place
8. Authorised Persons to be assessed and formally appointed
9. Ongoing opportunities to improve digital infrastructure
10. Available resources are impacting delivery

Executive Lead Narrative: Estates and IT resources continue to be stretched. That said, the controls set out in the BAF continue to be in place and the capital plan is directed at addressing the highest priority fire compartmentation and other risks. The Estates and Facilities reorganisation is underway with key posts being recruited to and Estates and Digital Strategies are in development to ensure efforts are directed as efficiently as possible. Importantly, the Warneford programme planning application has been submitted and funding is being sought to replace Warneford inpatient facilities with modern equivalents.

BAF A11 - Infrastructure: *If we do not invest in, develop and maintain our essential infrastructure, such as our estate and information systems **Then** our infrastructure may become unreliable, outdated, unprotected and unsafe **Resulting in** avoidable interruption to services, delays in treatment and may potentially lead to harm to patients or staff.*

Action to address gap in assurance/control	Lead	Date of implementation	Status Update
Finalise development of Estates Strategy (as part of Annual Plan)	Director of Estates	Q2 2026/27	The completion of the strategy has been aligned to the completion of the Trust strategy and the NHS ten-year plan. Workshops have been held with future ones being planned.
Complete asset registers for physical estates (to include improvement of known security risks and lone-working device pilot)	Director of Estates	Q4 2026/27	Asset Manager has been appointed and will start in Q4 2025/26. A working group will be established to ensure the most effective way of collecting the Assets is adopted
Establish Safe working Groups for various disciplines in accordance with HTMs	Director of Estates	Q4 2025/26	Safe working groups have been established for the Fire, Asbestos, Water, Electrical, Lifts and first meetings have been established. Groups for Pressure systems, Ventilation and Medical Gas will be established by the end of Q4.
Complete process to assess Authorised Persons (AP) to formally appoint by Designated Person	Director of Estates	Q4 2026/27	Authorisation Engineers have been appointed, suitable candidates for the APs are being identified which is linked to recruitment of new roles.
Complete Estates re-organisation and staff teams and fill staff posts	Director of Estates	Q4 2025/26	Consultation completed on 22 Sep 25 and first tranche of recruitment has started with the second tranche starting in Jan 2026
Progression of Warneford Park business case and planning permission	Warneford Programme Director	Ongoing	Underway – joint investment committee completed, and planning application submitted.
Take account of future digital infrastructure and cyber needs and address in digital planning	Head of IT	Q2 2026/27	Established processes are in place to assess the compliance of all digital infrastructure and cyber assurance requirements for new technologies being introduced into the Trust. Work to ensure the underlying core network is fit for purpose is underway with 2 main internet breakout circuits being commissioned to increase capacity across the whole Trust.

Link to the Board Risk Register

Ref	Risk Description	Score	Review status	Action
1356	Cyber attack is an ongoing (threat) risk to the Trust and a successful attack is very high impact	20	Review in date	Action in place
1400	Third-party externally hosted systems and infrastructure vulnerabilities	12	Review in date	Action in place
1375	Capacity to carry out all necessary maintenance in line with legislative and regulatory requirements	12	Review in date	Action in place
1425	Non-uniform estate fire compartmentation diminishes compliance capability to governing fire standards	10	Review due	Action in place

Impact scoring

5 impact

5 impact - would be extreme enough to threaten the viability of the Trust with consequences being potentially unrecoverable and requiring immediate response, significant resource and very likely external intervention.

4 impact

4 impact - poses a significant threat that could cause long-term consequences and harm. Recovery from the impact would be complex and/or long-term and require significant resources.

3 impact

3 impact - would require attention and dedicated resource to mitigate. It may cause a noticeable impact on operations, budget, or planned timescales.

2 impact

2 impact - would be manageable and could be addressed without significant extra resource. It may cause some disruption, but recovery would straightforward.

1 impact

1 impact - would be minimal and/or localised with very little disruption to the Trust's strategic objectives. Any disruption would be managed with policies or standard operating procedures.

Likelihood scoring

5 Almost certain Almost certainly going to happen, or will occur often.

4 Likely More likely to occur than not.

3 Possible Fairly likely to occur, or a realistic chance.

2 Unlikely Low chance but not impossible, could occur.

1 Rare Extremely unlikely.

Scoring

1-3
Low risk
4-6
Medium risk
8-12
High risk
15+
Extreme risk

Avoid

Avoid - avoid risk altogether or as far as practical wherever possible, focusing only on safety and stability over any potential benefits

Cautious

Cautious - preference for low-risk options but willing to accept some risks for if well-understood accepting that benefits of doing so will be limited

Minimal

Minimal - preference for very low-risk options e.g. with a proven track-record of being safe, will only accept risks that are absolutely necessary to meet business objectives

Open

Open - willing to consider a range of options accepting a degree of known risk to achieve objectives which could provide a moderate level of benefit

Seek

Seek - eager to pursue innovative options that offer potentially greater benefits, even if these involve greater inherent risk

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	11(a)
Report title:	Medium Term Planning 2026/27 Onwards
Executive sponsor(s):	Amélie Bages – Executive Director for Strategy, Heather Smith – Chief Finance Officer
Report author(s):	Rachel Pirie, Head of Planning Charlotte Adamson, Senior Programme Manager (planning)
Action this paper is for:	☒ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Review of Oxford Health Medium Term Plans
Public or confidential	Public

Executive summary

1. This cover note presents the Board with the following papers:
 - **Medium Term Planning Update** – an update to Board on the planning process and final plan submission to NHS England (**Annex 1**)
 - **Feedback from NHS England** – regarding OHFT's draft plan submitted on 17th December 2025 (**Annex 2**)
 - **Five-Year Plan Narrative** – document to be submitted to NHS England with the final plan submission on 12th February 2026. (**Annex 3**)
2. Board are also supplied with a separate cover note and associated papers regarding the Board Assurance process.

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

20th January Finance & Investment Committee (FIC)
 12th January 2026 Executive Meeting
 10th December 2025 Board of Directors' Meeting: Planning Session: Draft Board Assurance
 26th November 2025 Board of Directors meeting: Medium Term Planning update

Report

Background

3. The first planning return was submitted to NHS England on 17 December 2025, with a second and final submission due on 12 February 2026. **Annex 1** to this paper provides an update on the process including the financial position and performance trajectories.
4. At the time of writing, conversations with Thames Valley ICB are still ongoing regarding the final financial position, including the allocation of growth and innovation funding. The final planning submission is therefore expected to reflect these ongoing discussions and a further update will be provided to Board before submission.
5. Since the submission of the draft plan we have received some feedback from NHS England, supplied to Board as **Annex 2** to this paper. This feedback does not identify serious concerns with our plan but flags the following points for consideration in the final submission:
 - i. NHS England recognise the Board's intention to submit a compliant financial plan, noting the challenges throughout the planning period to deliver this.
 - ii. Delivering on plan throughout the planning period will require ongoing performance and financial monitoring through the period.
 - iii. NHS England recognise OHFT's planned reduction in agency use in line with the Medium Term Planning Framework requirements, however our delivery of this and ongoing safe staffing levels does require use of our own Bank staff. NHS England's feedback therefore notes that the requirement to reduce Bank staff use is not met.
 - iv. NHS England noted that Board assurance sections relating to equality impact assessments and risk were not completed, this was not a requirement in the draft submission and will be addressed when submitting the final plan.
6. To support the numerical submissions required as part of the final planning submission, providers are asked to submit a narrative plan setting out more detail and context regarding the planning process and outputs. This document will not be assured by NHS England in its own right but will be used to enhance understanding and context of our numerical submissions. A draft of this document is supplied as **Annex 3**. Oxford Health will be developing this narrative plan in a comprehensive medium-term delivery plan to be published alongside the next Trust's Strategy in Summer 2026.
7. It is anticipated that final revisions will be required to the narrative plan before submission, reflecting the agreed system position. The main areas where we expect revisions are highlighted in yellow and a further update to Board will be provided on these revisions.

Recommendation(s)
8. Board is asked to note the documents supplied and to provide any comments for incorporation into the final planning submission and narrative plan.

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	<u>Yes</u> /No	
Legal and regulatory	Yes/ <u>No</u>	

Annual Planning

Heather Smith – Chief Finance Officer
Amélie Bages – Executive Director of Strategy

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Section 1

The Planning Process

Medium Term Planning Process

- OHFT has a well established planning process, bringing together performance, finance, workforce, strategy and operational teams to deliver triangulated plans.
- Planning priorities have been developed by clinical directorates within the strategic framing provided by the Board, with regular review by the Trust's Executive Team.
- In parallel the Trust is developing our new strategy, including gathering views from patients, families and carers, staff, our local communities and partner organisations. Engagement across the plan and strategy development processes is mutually beneficial, giving us a good understanding of priorities and how best to deliver these.
- At a system and place level, the Trust participates actively with planning processes including to support delivery of Thames Valley ICB's Commissioning Intentions. Our teams work closely with place based partnerships, with a focus in Oxfordshire for our Community Health, Dentistry and Primary Care services.

Draft plan submission

- OHFT submitted our draft plan on 17th December 2025 in accordance with the NHS England deadline.
- This set out
 - A financial breakeven plan for FY 26/27 and FY 27/28.
 - Trajectories to deliver the Mental Health performance targets, which NHS England required Trusts to submit. ICBs were responsible for submitting performance targets regarding community services performance.
 - Our plans to meet the Medium Term Planning Framework expectations that trusts reduce agency use. Our submission did not meet the target of reducing bank usage by 10% as this does not support the trajectory to reduce agency use. NHS England have noted in their draft plan feedback that further work is required on this point.
- It was agreed between providers and Thames Valley ICB that draft planning submissions would not be aligned, due to the time available. However plans were shared and we have continued active dialogue with providers, the ICB and place partners in preparation for the final submission.
- Feedback has been received from NHS England on our draft plan. This did not highlight any significant concerns with our plan.

Final plan submission

The final submission is due with NHS England on 12th February 2026 and will comprise:

- Updated 3 year revenue and 4 year capital plans
- Updated 3 year workforce return
- Updated 3 year operational and performance activity return
- Narrative plan setting out our plans and aspirations over the 5 year planning period (*see draft supplied separately*)
- Board assurance statements confirming oversight of the process (*see draft supplied separately*)

Final plan submission – next steps

Our next steps to deliver the final plan submission are:

- Continued conversations with Thames Valley ICB and other partners regarding alignment of plans.
- This includes agreement with Thames Valley ICB regarding financial allocations. We are currently awaiting outcomes of the ICB led process to allocate innovation and growth funding, upon which some of our performance trajectories are contingent.
- Update performance trajectories where necessary to reflect any growth funding.
- Review of workforce trajectories in line with NHS England's feedback about bank usage.

Section 2

Financial Position

Draft Plan Submitted in December

- The Trust submitted breakeven revenue plans for FY27 and FY28.
- The efficiency plans included were £27,754k for FY27 (3.6% of operating expenditure) and £22,050k for FY28 (2.8% of operating expenditure).
- The commissioner income from ICBs did not align with commissioner plans as growth funding allocation had not yet been agreed. The Trust included assumed growth funding in the plan based on the percentage growth allocation outlined in the medium-term planning framework. Due to the absence of agreement on ICS growth funding use this approach was agreed and applied by all in-system providers.
- Capital plans were submitted for operational capital for 5 years equal to the Trust's operational capital allocation:

£'000s	FY27	FY28	FY29	FY30	FY31	Total
Operational Capital plan	12,683	15,310	10,779	10,997	10,997	60,766

Final Plan Submission

- Revenue plans will need to be submitted for 3 years.
- Thames Valley ICB have put in place a process for agreeing growth allocations with providers being asked to submit bids for an Innovation Fund, which holds the system non ring-fenced growth funding. The Trust has submitted 11 bids and contributed to 2 bids with system partners. The outcome of this process will be decided at the end of January.
- The Trust's efficiency plans include non-recurrent slippage on spend of growth funding to achieve breakeven. Our ability and route to deliver breakeven is impacted by our ICB funding settlement, making the process critical to both service delivery and a balanced financial plan. The Trust intends to submit breakeven plans for all 3 years.
- Processes are in place for submission of bids for Estate Safety funding and System Strategic capital funding, both of which are triaged and agreed through the ICB and will inform the capital plans submitted. The Warneford Hospital development is included as part of the Trust's bids for this capital funding as well as the regionally controlled estates safety funds.

Section 3

Medium Term Planning Framework trajectories

Medium Term Planning Framework trajectories

- The following slides summarise the requirements for the Trust to meet the trajectories outlined in the Medium-Term Planning Framework. These trajectories have been accepted by NHS England and therefore have not changed since the version previously reviewed by Board and submitted as part of our December submission to NHS England.
- ICB Activity & Performance Planning Input Measures for Mental Health & Community are also included in the following slides, we will be working with the ICB prior to the February planning submission to ensure their trajectories align with our view of what is achievable.
- In addition to this work, clinical directorates have been developing their priorities for the next 5 years, identifying areas of pressures or for potential service expansion in our mental health and community services where further development would support the left shift ambition of the 10 Year Health Plan.

ICB Activity & Performance Planning Input Measures for Mental Health

Board Meeting in Public

The following activity & performance measures have been submitted as with part of the ICB's planning submission in December, these trajectories are produced by the ICB. At the time of submitting this paper, the Trust was working with the ICB to ensure these trajectories were aligned with the Trust view of what is achievable .

Service Area	Indicators		Type	Period	MTP ambition	Submission	Baseline Position Aug25	Oct 25
Mental Health	E.A.4a	Number of patients that achieved reliable recovery	Numerator	in period activity	26/27 -Completed courses of treatment: 805,000 (England) 51% reliable recovery 69% reliable improvement	ICB	N/A	700
	E.A.4b	Number of patients that achieved reliable improvement	Numerator	in period activity	2027/28 :-Completed courses of treatment: 855,000 (England) 52% reliable recovery 70% reliable improvement 2028/29 :-Completed courses of treatment: 915,000 (England) 53% reliable recovery 71% reliable improvement	ICB	N/A	969
	E.A.5	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	Count	end of period position	To reduce from August position by end of FY27 and to reduce or eliminate by end of FY29	Provider & ICB	6	9
	E.A.6	Access to Mental Health Support Teams Mental Teams in schools and colleges	Count	12-month rolling	increase in access via MHSTs compared to the August 2025 activity baseline provided	ICB	1686	1758
	E.A.7	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Count	end of period position	To have 0 by end of FY27	Provider & ICB	N/A	7369
	E.H.38	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds	Mean	3-month rolling	To reduce from August position by end of FY27	Provider & ICB	36	40.86
	E.H.39	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	Mean	3-month rolling	To reduce from August position by end of FY27	Provider & ICB	66	81.39
	E.H.15	Number of women accessing Specialist Community Perinatal Mental Health Services - rolling 12 month	Count	12-month rolling	To maintain existing levels of performance from August position by end of FY27	ICB	949	979
	E.H.9	Number of Children And Young People (0-17) accessing (1+ contact) mental health services (rolling 12-month)	Count	12-month rolling	To maintain existing levels of performance from August position by end of FY27	ICB	15353	15782
	E.H.34	Number of patients accessing Individual Placement Support services - rolling 12-month	Count	12-month rolling	To increase access	ICB	N/A	863

ICB Activity & Performance planning Input Measures for Community

Board Meeting in Public

The following activity & performance measures have been submitted as part of the ICB's planning submission in December, these trajectories are produced by the ICB. At the time of submitting this paper, the Trust was working with the ICB to ensure these trajectories were aligned with the Trust view of what is achievable .

Service Area	Indicators		Type	Period	MTP ambition	Submission	Oct 25 Position
Community services	E.T.8	Urgent Community Response (UCR) referrals	Count	in period activity	The proportion of UCR referrals meeting the 2-hour response standard consistently exceeds 70%.	ICB	84.3%
	E.T.9	Community waiting list over 52 weeks	Count	end of period position	To reduce to 0 by end of FY27	ICB	1375
	E.T.9a	Number of people on waiting lists for CYP services who are waiting over 52 weeks	Count	end of period position			838
	E.T.9b	Number of people on waiting lists for adult services who are waiting over 52 weeks	Count	end of period position			537
	E.T.12	Number of people on waiting lists per system who are waiting 18 weeks or less	Numerator	end of period position	For 78% of activity to be within 18 weeks by end of FY27, 80% by end of FY29	ICB	3680
		Number of people on entire waiting list	Denominator	end of period position			7405
		Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list	Percentage	end of period position			50%
	E.T.12a	Number of people on waiting lists for Adult services per system who are waiting 18 weeks or less	Numerator	end of period position	For 78% of activity to be within 18 weeks by end of FY27, 80% by end of FY29	ICB	3102
		Number of people on entire Adult waiting list	Denominator	end of period position			5160
		Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	Percentage	end of period position			60%
	E.T.12b	Number of people on waiting lists for CYP services per system who are waiting 18 weeks or less	Numerator	end of period position	For 78% of activity to be within 18 weeks by end of FY27, 80% by end of FY29	ICB	578
		Number of people on entire CYP waiting list	Denominator	end of period position			2245
		Percentage of people on waiting lists for CYP Community Services per system who are waiting 18 weeks or less as proportion of entire CYP waiting list	Percentage	end of period position			26%
	E.T.13	Attended Community Care Contacts	Count	in period activity		ICB	Ave 70,201/mth

Provider Activity & Performance Planning Input Measures

Board Meeting in Public

These trajectories have been submitted as part of our December submission to NHS England, for the final February submission the position for the 104 week wait trajectory may change for an end of year forecast position of 0.

Area	Indicator	Type	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Q1 27/28	Q2 27/28	Q3 27/28	Q4 27/28	Q1 28/29	Q2 28/29	Q3 28/29	Q4 28/29
Mental Health	Number of active inappropriate adult acute out of areas placements (OAPs)	Count	6	6	6	6	6	6	6	6	6	5	5	4	4	4	3	2	2	2	1	0
	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Count	7,009	6,649	6,289	5,929	5,569	5,209	4,849	4,489	4,129	3,769	3,409	3,049								
	Sum of total bed days across all Adult Acute and PICU mental health beds	Numerator	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655	7,655
	Total number of discharges from Adult Acute and PICU mental health beds	Denominator	211	211	211	211	211	211	211	211	211	211	211	211	211	211	211	211	211	211	211	211
	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds	Mean	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.28	36.3	36.28	36.28	36.3	36.28	36.28	36.28
	Sum of total bed days across all Older Adult Acute mental health beds	Numerator	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602	4,602
	Total number of discharges from Older Adult Acute MH beds	Denominator	65	65	65	65	65	65	65	65	65	65	65	65	65	65	65	65	65	65	65	65
	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	Mean	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8	70.8

To note the CYP-104-week full wait stop clock indicator-This indicator is still being reviewed for the definition of which cohort of Children & Young People are included in this trajectory, non neurodevelopmental vs stand alone neurodevelopmental referral reasons. We understand the intention of the national team was not to include any stand-alone neurodevelopmental waits and if this is the definition after review our trajectory will change to 0 by end of FY27 as the waits will be attributed to data items which need to be added to the system for the full 4ww wait standard (Snomed coded intervention/assessment, Care Plan, Baseline Outcome Measure). We do not have any waits over 104 weeks other than stand alone Neurodevelopmental waits.

Oxford Health NHS FT - First Plan Collection 17 December 2025

Regional review and assurance pack

First Plan Submission - Performance Review

Board Meeting in Public

		Mental Heath							
		Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period							
		Sum of Provider Plans							
		Year 1					Year 2		
		Baseline	Plan	Absolute change on baseline	Latest Data	Change from latest data to Year 1 plan	Baseline	Plan	Absolute change on baseline
Org Name	Org Type	Latest actual (Aug-25)	Mar-27	Mar-27	Sep-25	Absolute change	2026/27 Plan	Mar-28	Mar-28
Oxford Health FT	Mental Health	5	4	-1	5	-1	4	2	-2

		Mental Heath					Mental Heath							
		Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period					Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)							
		Sum of Provider Plans					Sum of Provider Plans							
		Year 1					Year 1					Year 2		
		Target	Plan	Variance to Target	Latest Data	Change from latest data to Year 1	Baseline	Plan	Change on Baseline	Latest Data	Change from latest data to Year 1	Baseline	Plan	Change on Baseline
		Mar-27	Mar-27	Mar-27	Sep-25	% change	Latest actual (3-months to Aug-25)	Mar-27	Mar-27	Aug-25	% change	2026/27 Plan	Mar-28	Mar-28
Org Name	Org Type													
Oxford Health FT	Mental Health	0	3,049	3,049	0		36.0	36.3	0.88%	36.0	0.9%	36.3	36.3	0.00%

Ahead

Behind

**Plans are collected on a commissioner basis from ICBs and on a provider basis from NHS Acute Providers and from NHS providers of MH services

**Where England and Region aggregate data are presented these will either be the sum of the ICB plans or the sum of Provider plans as appropriate to the metrics

**Where organisations have individual targets to deliver, aggregate targets at region/England are simply the weighted average of the individual organisation level targets to ensure they align with the plans returned

Data Notes:

1. Historic data within this tool has not yet been updated following recent publications and aligns to historic data provided in the planning template
2. Baseline for ICB MH ALOS were incorrect in the issued templates. This tool contains the updated baseline data, and therefore differs from the planning template
3. ICB level Electives targets have been included in this tool, but were not available to be included in templates, therefore ICBs may not have planned to meet these targets in this first submission
4. Data for 12-hour breaches has been taken from ECDS, as such there are some providers with gaps in historic data. As the baseline for this metric is the total over the latest 12-months, any gaps have been filled by taking the mid-point between the last submitted point n time to give a better proxy for the total over a year
5. Historic data for MH and LDA are rounded and suppressed, therefore calculated metrics such as ALOS or % performance may not exactly match published sources as they are calculated from a rounded numerator and denominator. The data included in this tool are therefore indicative only

First Plan Submission - Performance Review

Board Meeting in Public



		Mental Heath							
		Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)							
		Sum of Provider Plans							
		Year 1					Year 2		
Org Name	Org Type	Baseline	Plan	Change on Baseline	Latest Data	Change from latest data to Year 1	Baseline	Plan	Change on Baseline
		Latest actual (3-months to Aug-25)	Mar-27	Mar-27	Aug-25	% change	2026/27 Plan	Mar-28	Mar-28
Oxford Health FT	Mental Health	67.0	70.8	5.67%	67.0	5.7%	70.8	70.8	0.00%

Ahead

Behind

First Plan Submission Summary – Finance

Board Meeting in Public

Oxford Health NHS FT		26/27	27/28
Plan Limit excluding DSF	£m	-	-
Plan Limit Accepted or Rejected		Plan limit accepted	Plan limit accepted
Adj financial performance surplus/(deficit) excl. DSF	£m	-	-
Deficit Support Funding (DSF)	£m	-	-
Adj financial performance surplus/(deficit) incl. DSF	£m	-	-
Variance to Plan (% of OpEx)	%	-	-
Underlying financial performance surplus/(deficit)	£m	(6.6)	(9.7)
Total efficiencies	£m	27.8	22.3
Total efficiencies (% of Opex)	%	3.6%	2.8%
High Risk efficiencies	£m	7.9	4.3
Unidentified efficiencies	£m	-	-
Agency costs within agency cap	Pass/ Fail	Pass	Pass
Bank costs within bank cap	Pass/ Fail	Fail	Fail
Operational Capital Allocation met?	Yes/No	YES	YES

Board Assurance Framework	
Triangulation	2. Maturing
Productivity	2. Maturing
Risk Management	1. Embedded [Full Assurance]
Alignment of contract values	2. Maturing
Contract Process	1. Embedded [Full Assurance]
Contract Timetable	2. Maturing

Triangulation		
26/27 - 25/26 Total Pay Cost Movement %	26/27 - 25/26 Total WTE Movement %	26/27 - 25/26 Total Pay Cost - WTE Movement %
(0.5%)	1.9%	(2.4%)

Overview for Oxford Health NHS FT – 17 December Plan Submission

Revenue Summary: The Trust has submitted a breakeven plan in both financial years. The plan does not assume receipt of DSF in 26/27 and 27/28.

- Efficiency:** The plan includes £27.8m of savings in 26/27, equating to 3.6% of operating expenditure and £22.3m in 27/28 (2.8%). This compares to a regional average in 26/27 of 5.5% and 27/28 of 4.6%. In 26/27 the CIP is 63.1% recurrent, against a regional average of 70.6% recurrent. In 26/27 £7.9m (29%) of efficiencies are categorised as high risk, £0.6m (2%) fully developed and 100% of efficiencies are identified. In 26/27, efficiencies are broadly evenly phased with 27% of efficiencies phased in Q3 and 28% in Q4.
- Workforce:** Workforce costs, adjusted for inflation, are expected to reduce from 25/26 levels by £2.3m (0.5%). This compares to a 140 WTE (1.9%) increase from 2025/26 M12 to the 26/27 average. Cost per WTE is £58k v regional average of £63k.
- Temporary staffing:** The Trust achieves the agency cap but exceeds the bank cap in both years, by £3.2m in 26/27 and £5.8m in 27/28, due to plans to convert agency costs to bank.
- Sensitivity Analysis:** The net impact of sensitivity analysis in 26/27 is £2.1m adverse and 27/28 is £0.3m adverse. In 26/27 downside risks include £3.4m relating to efficiencies, partially offset by non-recurrent and pay cost upsides.
- Phasing:** The bottom-line phasing in 26/27 is broadly even throughout the year with a planned H1 surplus of £0.4m and a H2 deficit at £0.4m.
- Productivity:** Currently there is no data on productivity for mental health and community health providers.
- Underlying position:** The Trust has submitted an underlying deficit at 31/3/27 of £6.6m (0.9% of operating expenditure), which is an improvement of £9.7m from the 25/26 underlying deficit of £16.3m (2.3%). 27/28 underlying position is £9.7m deficit, a deterioration against 26/27 of £3.2m.
- Capital:** Allocation met in both 26/27 and 27/28 assuming the Trust remains eligible for freedom and flexibilities additional capital.
- Triangulation:** There is a medium level of alignment between finance and workforce.
- Cash:** The Trust's plan does not require additional PDC cash. There is a £13.4m deterioration in the cash balance during 26/27 resulting in a closing balance on 31/03/27 of £74.1m. The cash balance equates to 40 revenue cash operating expenditure days at the end of 26/27.
- Contracts:** In 26/27, there is a £11.3m (3%) gap between the contract assumption of the Trust and their main commissioner. Overall, there is a £52.0m gap.
- Board Assurance Framework:** No areas are rated 4 (not embedded). The average rating of the 15 categories is 1.53 which is below the regional average of 2.17 (lowest score represents most assurance).



Feedback and Next Steps

The Trust has accepted the plan limits communicated as part of the medium-term planning framework. We acknowledge the Board’s intent to agree a compliant financial plan and for the Trust to live within its means. We recognise that this will be a challenging and that the Trust will be managing a number of risks in order to deliver this plan. We also recognise this submission is made at a point in time and that there are areas that the Trust will refine in more detail for the final submission, including those areas noted in your Board assurance statements. Our feedback is given as a guide and as pointers for your final submission.

- **Underlying Position:** Ensure that the drivers of the underlying position are understood, in particular the deterioration in 27/28 and consider what actions are required to move the organisation to an underlying break-even position.
- **Efficiency:** Move at pace to fully develop the efficiency programmes to enable delivery from April 2026, including those to deliver the workforce changes, maintaining the objective of 100% recurrent and equal phasing wherever possible.
- **Temporary Staffing:** Consider if further savings can be made to enable achievement of the bank cap.
- **Contract Alignment:** We have shared detailed contract alignment information to support the organisation to finalise contract discussions to ensure full understanding of funding and activity expectations prior to the next submission.
- **Sensitivity Analysis:** Consider what further downside mitigations are available to the Trust and what steps will be required in order to mobilise and deliver the identified downside actions within the likely timeframe of a downside scenarios. Are there steps that need to be taken now?

Overview for Oxford Health NHS FT – 17 December Plan Submission

Overall summary comments	
Does the plan meet national red lines?	(E.A.5) Active inappropriate Adult Acute Mental Health Out of Area Placements (OAPS) - Planned reduction to 4 by 2027 (reduction from latest data)
Is the Plan Achievable / Realistic/ Deliverable?	(E.H 38 & 39) Average Length of Stay for patients in Adult Acute and PICU – 36 days (plan to reduce from baseline) (E.H 39) Average Length of Stay for patients in Older Adult beds – 71 days (plan to reduce from baseline) (E.A 7) Children and Young People with community Mental Health related waits (over 104 week waits) - Reducing trajectory planned 7009 in March 2026 to 3049 in March 2027
Area of Risk?	
Compliant/ Not compliant?	Compliant
Overall Planning Risk RAG	GREEN

Key headlines – First Numerical Submission 17th December 2025

- **Total workforce** - planned to change from 7,416 in March 26 to 7,610 in March 27, this is a growth of 194 WTE (2.6%) over the 12-month period of 26/27 and there is a further 3% increase in 27/28 (239.8 WTE). The driver of this increase is Bank Staff. Substantive Bank and Agency figures for March 26 show a WTE higher than the funded establishment position but this appears corrected by March 27.
- **Substantive** – There is a planned increase (3%, 203 WTE) to substantive figures in 26/27, this is mainly seen in the Support to Clinical Staff group. There is a further 4% increase in 27/28 (300 WTE).
- **Establishment** – There is an increase of 256 posts planned in 26/27 and again a further 300 planned for 27/28.
- **Bank** - planned to increase by 7% (36.8 WTE), whilst success against national planning guidance will be analysed by finance, using the workforce as an indicator of success we would suggest the provider is not on target to achieve the required 10% reduction. However, there is an expected reduction in 27/28 of -5% (-28.7 WTE)
- **Agency** - planned to reduce by -34% (-45.9 WTE), whilst success against national planning guidance will be analysed by finance, using the workforce as an indicator of success we would suggest the provider is on target and will achieve the 30% reduction set nationally. This is the same case for 27/28 where there is an -36% reduction (-31.5 WTE)
- **Vacancies** – For the forecasted substantive outturn position in March 26 the plan suggests a vacancy rate of 8% which is 619.8 WTE, by March 27 this appears to grow slightly to 9% (672.8 WTE) and by March 28 it goes back to 8% (672.8 WTE).
- **Sickness** – The rolling 12 month sickness rate starts at 4.9% for March 26 and reduces to 4.7% in March 27, by March 28 it is expected to be 4.6%, this is in line with our expectations but falls short of those set nationally.
- **Phasing** - The phasing of the workforce plan is slightly out of line with our expectations. Further work is required to better reflect Bank and Agency usage over the year. Growth in the substantive workforce does not appear in the late summer, early autumn as we usually see (due to university graduates joining the workforce). More work on phasing of the plan is needed.

Achievability and Risks – First Numerical Submission 17th December 2025

- The overall Oxford Health’s (OH) plan should be **achievable**. The change in Bank figures are disappointing with an increase in the first 12 months, particularly when OH is performing well this year against its plans. Oxford Health is currently on track to deliver against the previous years planned reductions to Bank staff and is currently (as of M08) -16.8% under plan (-12.1% YTD). It is a similar story for Oxford Health and its agency figures where for M08 it is a significant -43.5% under plan, with a YTD figure for Agency of -20.5% under plan.
- So far in 2025/26 Oxford Health is -0.6% under its forecasted position for Substantive Staff, but in M08 it had just moved over plan to 0.4%. The total workforce position for the provider is -2% under plan for M08 and -2.1% YTD.
- **Risk** – Bank growth against national direction – Bank staffing increases (+7%), putting the plan off-track against the required 10% reduction and increasing cost pressure. Rising vacancies alongside workforce growth – Vacancy rate increases to 9% in March 27, indicating recruitment capacity may not match rapid establishment and substantive growth.



Overview for Oxford Health NHS FT – 17 December Plan Submission

Overall summary comments

Sections of the Board Assurance Statement on the use of EQIAs and risk management were blank.

DRAFT: subject to further review and revisions before submission. Including highlighted sections

Oxford Health NHS Foundation Trust

Five Year Plan: Delivering our Vision

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DRAFT: subject to further review and revisions before submission. Including highlighted sections

Executive Summary

- 1) Oxford Health NHS Foundation Trust's plan has been developed alongside the development of our new Trust Strategy, with our patients, carers and families, our staff, the communities we work with and our Board members to set out how we will deliver the ambitions of the Ten Year Health Plan. We are proud to continue our focus on high quality care for our patients and being a great place for our staff to work. Over the coming months, as our new Trust's Strategy is finalised, we will flesh out the details of this Five Year Plan and publish it as the implementation plan for our Strategy.
- 2) Our plan and this document set out how we have worked with clinical teams across the organisation to develop affordable plans for transformation; the opportunities and impact of opportunities for reinvestment and growth; and how these plans can enable the three shifts.
- 3) Supporting a system approach to prevention and playing a leading role in the delivery of the left shift is at the heart of our work. Our plan sets out how our mental health and community services work with communities and partners to care for people as close to home as possible, and how we plan to go further with this in the future to deliver the left shift and constitutional standards.
- 4) We also set out how we have continued to actively work with system partners, including playing an active part in the Thames Valley ICB planning approach and aligning our work with the ICB Commissioning Intentions. At a system level the Thames Valley Mental Health Provider Collaborative is leading on Mental Health Commissioning Intentions and at place and neighbourhood level we continue to work closely with place partners to ensure planning and service delivery is as joined up as possible.

Strategic Context

Our strategic approach

- 5) OHFT's strategy runs from 2021-26 and identifies four strategic objectives, set out below, which underpin our work from ward to Board and set the framework for our planning approach.



- 6) We are currently working with patients, carers, families, communities, staff and partners to develop a new strategy to set out our vision for the future. This will include the Trust's approach to delivering the aspirations within the Ten Year Health Plan and our role in the Thames Valley ICB to address the challenges facing healthcare at a population level. The Five Year Plan will act as the delivery vehicle for this strategy, as we refresh this throughout the planning period.
- 7) Bridging between our previous strategy and the new strategy to be published in 2026, our Board has agreed six strategic priorities to ensure that our focus remains in support of the strategic objectives. These priorities provide the framework for our planning process with directorates asked to set out how their planning priorities support the delivery of strategic objectives and strategic priorities.



- 8) Within the framework of the strategic objectives and priorities, directorates have worked with their services, wards and teams to develop their priorities for the planning period. This ensures that teams understand the contribution that they and their staff are making towards improvement and delivery priorities; following which priorities are discussed and signed off by the Executive and Board of Directors to ensure alignment across the Trust.
- 9) Alongside the work to develop the Trust Strategy, we are refreshing the Trust's Estates and Digital approaches, to align with the aspirations of the Ten Year Health Plan and enable clinical directorate planning priorities.

System partnership

- 10) Our organisational strategic planning and delivery supports and is supported by our partnerships across the Thames Valley ICB and beyond. Throughout the planning process we have worked with system partners to define and align priorities, including:
 - i. An active leadership role in helping shape system plans and addressing local system challenges through Trust executives engaging in planning groups at ICB-level. For example, the Trust CEO is a partner member of the Thames Valley ICB for mental health;
 - ii. Clinical directorates actively engaging with local partners via Place-level groups;
 - iii. Each service reviewing their service provision in line with national and local guidance and engaging with local partner organisations to review changes in service provision;
 - iv. The Trust also actively leads on annual planning discussions via its specialised mental health provider collaboratives that work across larger geographies, and the Thames Valley ICB Mental Health Provider Collaborative that it jointly leads with Thames Valley ICB and Berkshire Healthcare NHS Foundation Trust to shape the mental health commissioning agenda in the ICB.
 - v. The Trust is actively involved in the development of neighbourhood health and care plans for each of the Place geographies it operates in, co-ordinating the approach being developed in Oxfordshire alongside being part of an integrated neighbourhood teams community of practice national programme and contributing to the Buckinghamshire National Neighbourhood Health Implementation Programme as a wave 1 selected site.

Focus on performance

- 11) Strategic direction is led by our Board through regular oversight and review of performance. Each strategic objective is delivered through a Board led committee specifying the ambitions and associated high-level outcome measures. These are tracked via the relevant governance arrangements and reported on a bi-annual basis to the Board of Directors via a Strategic Dashboard published as part of the Integrated Performance Report of the Board.

The Strategic Dashboard necessarily emphasises areas of focus most relevant to the Trust, but also includes system objectives as we work to deliver with partners for our patients and communities.

- 12) The Trust's Integrated Performance Report is a key tool in monitoring performance. This is aligned with the NHS England Insightful Board guidance and identifies specific actions to address significant variance to expected standards. Our 'ward to board' feedback loop between clinical teams and the Executive Team ensures regular reporting of clinical, financial and workforce performance and provides opportunities to discuss learning and risks. This process has enabled areas of underperformance to be built into our planning priorities to ensure that a robust focus on continuous improvement and productivity features as part of 5 year plan delivery.
- 13) This focus on performance has led the Trust to being well performing in the NOF – currently in segment 1 and rated as 15th nationally in the non-acute provider league tables. Our plan sets how we will maintain and improve areas of strong performance, with specific plans for areas where performance does not meet required standards.
- 14) Our plan specifically seeks to address areas of underperformance with a focus on improving flow through our inpatient settings and achieving the required reduction in inappropriate adult acute out of area placements, a focus on improving our performance in our community services for waits over 18 weeks and over 52 weeks, and meeting our agency reduction plan.

Financial planning

- 15) To ensure financial sustainability the Trust is submitting breakeven plans for the 3 year plan period and has efficiency plans to ensure this is delivered. Directorates have developed detailed plans for 2026-27 and ideas for 2027-28 and 2028-29 which will be developed further over the next year to ensure delivery.
- 16) In order to meet the performance targets in the medium term planning framework and the 10 Year Health Plan ambitions the Trust will require investment of growth funding in key areas where performance needs to improve. We are currently engaging with system partners in an ICB led process to consider opportunities for growth funding.
- 17) The Trust's plans are premised on growth funding consistent within the Mental Health Investment and Community Health growth assumptions in the NHSE financial model. Not receiving this level of growth would increase the level of risk implied in our financial plan and we would need to consider whether underlying efficiency assumptions need to be revisited.
- 18) The Trust needs to secure additional Capital funding in order for the Warneford Park new hospital project to go ahead. The Trust will work closely with system and regional finance colleagues to ensure that this is considered as a regional priority.
- 19) In particular, the Trust's finance team works closely as part of BOB ICB finance planning process to help lead and shape system financial plans. Both of the Trust's

revenue and capital plans are derived from the System Planning approach and aligned to the agreed system position.

Delivery, transformation and productivity

Delivering on our plans

- 20) The Trust routinely publishes our Annual Plan, to transparently share its approach with patients, communities and partners. We will continue to publish our plans, with the Five Year Plan forming the delivery vehicle for our new strategy. The planning priorities developed by our directorates are feeding into strategy development, and the annual planning updates will reflect the emerging strategic thinking.
- 21) Underpinning our Five Year plan, detailed work led by corporate and clinical directorates sets out how teams will deliver transformation, including how they will develop and embed workforce, pathway and digital innovation to turn priorities into practice.
- 22) Our Community Services Directorate has an established Transformation Board to drive design and delivery of the transformation required, our Mental Health Directorate is in the process of establishing a similar board. This transformation approach complements our performance focused work. Comprising clinical and corporate inputs, these boards have the following aims across our mental health and community services:
 - i. Oversight of the change programme and project delivery approach
 - ii. Progress monitoring, escalation & mitigation
 - iii. Transformation strategy delivery and prioritisation:
 - iv. Understand of risks and issues
 - v. Forward plan for escalation

The evidence base for delivery

- 23) Our delivery approach is informed by our ongoing understanding of quality, performance and productivity data. As set out in the 'Strategic Context' section, delivery of priorities is monitored at team, service and directorate level with Executive and Board oversight through our 'ward to board' approach. Through this established process the Executive Team will review progress against planning priorities on a minimum quarterly basis, with regular Executive and Board review of the Integrated Performance Report. Regular oversight of Board-led Strategic objectives will continue to take place at Board Committee and Board level on a bi-annual basis. Our next step is to refresh the metrics reported to the Board to align these with the new strategy and delivery plan.
- 24) Service level costing data for the Trust is also reviewed annually to ensure that productivity of all services is captured. This was supplemented by NHS England's Productivity Packs, the key findings in which support our understanding of overall performance.
- 25) Improving access and waiting times is one of the Trust's strategic priorities. The Trust performs well overall against key waiting time standards, but there are initiatives in place to maintain a focus on this key performance area including:

- i. A programme of work is underway to improve waiting time reporting and understanding at all levels within the organisation, with regular reporting on waiting time now being made available. This is also linked to the rolling out of the *True Colours* platform to enable outcomes reporting, which is a requirement to be able to submit against some national waiting time standards such as the CAMHS 4 week wait standard which requires baseline outcome measures;
 - ii. Four waiting time areas have been identified as being the services most affected by delays and therefore requiring additional focus:
 - Children's services (mental and physical health)
 - Memory Assessment Service
 - Podiatry
 - Adult speech and language therapy (SALT)
- 26) To support the planning approach we have also developed demand and capacity modelling for some of our key services. This includes considering the impact of improved data availability and understanding the reasons for waits in order that we can review pathways where necessary. This work, alongside our increasing understanding of productivity, will be built into the review of planning priority progress going forward.
- 27) We have further agreed and are rolling out a systematic approach to understanding and addressing health inequalities. In line with the strategic objective to *deliver the best possible care and health outcomes*, clinical directorates were asked to consider how their planning priorities will address health inequalities. This includes reviewing key waiting time standards by the Index of Multiple Deprivation and ethnicity information to start developing a menu of interventions. Our work to align our plans with the Thames Valley ICB also draws on inequalities thinking, with inequalities set out specifically within the Commissioning Intentions.

Productivity

- 28) Transformational change is key to supporting the delivery of 2% productivity gains and the further efficiencies to which the Trust is committing, ensuring that our services operate with maximum efficiency and productivity. Financial diligence is a key focus for the Trust and financial sustainability is one of the Trust's four strategic objectives – *Making the best use of our resources*. This is monitored in the following ways:
- i. On an ongoing basis we maintain close oversight of available productivity information, including, National Cost Collection data which is reviewed by the Executive Team, the Finance & Investment Committee (chaired by a Non-Executive Director) and the Board of Directors examining trends over time as well as comparisons against sector and NHS providers as a whole. The Trust's Strategic Dashboard includes a target relating to the Trust's overall

performance relative to National Cost Collection averages to support the strategic objective of being sustainable.

- ii. Service level costing data for the Trust as a whole is also reviewed annually to ensure that the productivity of all services, not just those captured in National Cost Collection data, is considered.
- iii. Activity, WTE and Unit Cost charts have been included as standard in monthly Board of Director reports starting in June 2025, with the intention of identifying changes in trend or in data quality quickly.
- iv. The Trust has an online business intelligence tool (TOBI) and dashboards are in development to ensure costing data is easily available to managers across the Trust.
- v. Quarterly directorate performance stocktakes with the Executive team seek to ensure demand is being managed efficiently within resources available. Some services have now been re-designed to promote increased productivity, for example District Nurses and 0-19 Service in Community Services.
- vi. Corporate Services benchmarking has been carefully analysed at Executive Team level, and Finance & Investment Committee and via the Our Central Support and Corporate Services programme board attended by directors of corporate functions seeking to align change, streamline processes, improve services, and improve efficiency.

Delivery in partnership

- 29) To deliver our strategy and Five Year Plan, we will continue to collaborate with system partners to further explore opportunities to work together, strengthen resilience, tackle variations and address health inequalities. Our plan aligns with the 10 Year Health Plan priorities and the specific priorities identified by the Thames Valley commissioning intentions.
- 30) Thames Valley ICB is the main ICB that the Trust engages with from a planning perspective, and we also have a strong ongoing working relationship with Bath, Swindon & Wiltshire (BSW) ICB where we provide Child & Adolescent Mental Health (CAMHS) services. These relationships are both at Executive level, with the Trust's CEO and COO for Mental Health and Learning Disability services engaging in relevant ICB Boards and Committees, but also at Directorate level and service level where Directorate lead and service leads maintain close working relationship with commissioners and partner organisations.
- 31) The Trust values our role in delivering transformation across the system and discuss our planning priorities and transformation opportunities with system partners at ICB and place level. Our CEO attends the System Recovery and Transformation Board to ensure that we have senior engagement in these conversations, supported by CFO engagement in system financing conversations and place level conversations to deliver system transformation of areas including urgent care and mental health pathways.
- 32) The Trust is the lead provider and a significant service provider in three specialist mental health provider collaboratives of NHS and private sector providers across

large scale geographies in the South and South West of England. Trust leaders are actively engaged in this work and the Board are kept informed of the development, management and governance of the Trust's provider collaborative work.

- 33) In Thames Valley ICB the Trust leads alongside partner Mental Health Trust Berkshire Healthcare in developing the Thames Valley Mental Health Provider Collaborative. The provider collaborative was developed in 2023 as part of the 2022 NHS England provider collaborative innovator scheme. The aim of the collaborative is to improve the mental health of the population by leading the transformation of mental health services at scale.
- 34) The Trust also actively plays a part in supporting the Thames Valley Dental Partnership to improve the provision of community dental services across the Thames Valley.
- 35) Through the ICB-led annual Planning round the Trust has continued to support the ICB financial sustainability plan, notably by delivering a surplus in 2024-5 and leading on work to generate savings in the ICB Mental Health budget.
- 36) As part of system working a key element of our transformation plans is to develop our Neighbourhood Health contribution, which has been identified as one of our six core priorities for 2026-2027. The aim is to develop and approach with local partners to provide proactive, joined up care to local communities and to systematically address health inequalities. Neighbourhood Health is recognised by all our clinical directorates as a five year planning priority, and a lens through which they should develop workforce, service redesign and digital opportunities.
- 37) Digital will be a key enabler of our plan, we are currently developing a digital strategy which will align with our new Trust strategy.

Delivery areas

Summary of planning priorities

38) The Trust's 5 year planning priorities are arranged over four clinical areas: mental health; community health services, dentistry and primary care; forensic mental health and learning disability. Plans across these areas align to our four strategic objectives: quality, people, sustainability and research.

39) Our plans set out how we will deliver against the provider activity and performance planning input measures. Table one below shows our plans to date to deliver these measures. We are working with the ICB to support the submission and delivery of ICB reported measures.

40) The technical guidance indicates August 2025 will be used as the baseline position compared to actual performance at the end of the financial year, trajectories should be in line with the Medium-Term Plan (MTP) ambition.

i. **EA5-Inappropriate OAPS**-Eliminating all OAPs will be challenging to achieve due to our low bed base. Our trajectories will be based on reducing from the August position.

ii. **EA7-CYP-104-week full wait stop clock**-This indicator is still being reviewed for the definition of which cohort of Children & Young People are included in this trajectory, non neurodevelopmental vs stand alone neurodevelopmental referral reasons. We understand the intention of the national team was not to include any stand-alone neurodevelopmental waits and if this is the definition after review our trajectory will change to 0 by end of FY27 as the waits will be attributed to data items which need to be added to the system for the full 4ww wait standard (Snomed coded intervention/assessment, Care Plan, Baseline Outcome Measure). We do not have any waits over 104 weeks other than stand alone Neurodevelopmental waits

iii. **EH38-Adult & PICU ALOS**-Our baseline position of August shows good performance for this measure and our trajectory will be based on maintaining this position

iv. **EH39-Older Adult ALOS**- Our baseline position of August shows good performance for this measure and our trajectory will be based on maintaining this position

Service Area	Indicators		Type	Period	MTP ambition	Submission	Baseline Position Aug25	Oct 25
Mental Health	E.A.5	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	Count	end of period position	To reduce from August position by end of FY27 and to reduce or eliminate by end of FY29	Provider & ICB	6	9
	E.A.7	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Count	end of period position	To have 0 by end of FY27	Provider & ICB	N/A	7369
	E.H.38	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds	Mean	3-month rolling	To reduce from August position by end of FY27	Provider & ICB	36	40.86
	E.H.39	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	Mean	3-month rolling	To reduce from August position by end of FY27	Provider & ICB	66	81.39

41) A summary of priority areas is shown in table 2 below, more detailed plans for delivery are being refined

Table 2: Clinical priority areas

Mental health priorities
a. <i>Service redesign to deliver through a neighbourhood model</i> - to ensure left shift delivery, strengthened engagement with primary care and the VCSE, realise crisis and long term support pathway opportunities, and review pathway productivity.
b. <i>Expansion of Mental Health Support Teams</i> to achieve full coverage, reduce wait times and continue CAMHS transformation.
c. <i>Investment and expansion in earlier intervention</i> through development of Mental Health Outpatients Hub, strengthened crisis support, recovery of Talking Therapies performance, Assertive Outreach and Intensive Case Management, and expansion of Individual Placement Support.
d. <i>Care designed and co-produced based on population health data and demographic need</i> , supported by contract reviews and collaboration with VCSE partners.
e. <i>Ensuring the right workforce</i> by strengthening recruitment, retention, and staff wellbeing, reduce reliance on temporary staff by converting roles to substantive contracts, enhance leadership capability through the People Plan, and embed Equality, Diversity and Inclusion alongside a consistent approach to tackling health inequalities.
f. <i>Alignment of digital systems</i> to improve interoperability, accessibility of information, clinical decision-making, and user experience, supported by improved data quality and reporting.
g. <i>Delivery of localised in-patient care</i> and eradication of acute out of area placements by progressing the national Mental Health Inpatient Improvement Programme and enhancing community resource utilisation.
Forensic Directorate Priorities
h. <i>Workforce</i> : To build a motivated, skilled, and diverse workforce by creating a psychologically safe and inclusive environment that values well-being and development, ensures fairness, and drives improved retention, better patient care, and continuous innovation.
i. <i>Health Inequalities</i> : Reduce inequalities for people with Severe Mental Illness by embedding preventative physical and mental healthcare into routine practice, addressing complex needs (e.g., dual diagnosis, neurodivergence, trauma), and aligning with Core20PLUS5 and the Patient and Carer Race Equality Framework.
j. <i>Sustainability</i> : Build a sustainable, integrated care model through strengthened provider collaboration, forensic pathway redesign, and alignment with adult services, while tackling health inequalities via data-driven planning, inclusive co-design, and improved outcomes in protected pathways.
k. <i>Digital/data development and analytics</i> : Data improvement plan implemented to enhance care quality, standardisation, clinical decision-making, and operational efficiency, supported by digital infrastructure improvements and the use of artificial intelligence.
l. <i>Research & Development</i> : Strengthened through academic partnerships and staff engagement, embedding evidence-based practice and continuous improvement while targeting interventions that reduce health inequalities in forensic mental health.
Learning Disabilities Directorate Priorities

m. <i>Partnership working</i> : Embedding a neighbourhood health and care approach with partners to deliver integrated, person-centred care close to home, improve population health, support complex needs, and eliminate out-of-area specialist LD placements.
n. <i>Service review & sustainability</i> : Collaborate across directorates to review pathways and service models, ensure smooth transitions for patients and carers from one part of the system to another, and embed co-production in all developments.
o. <i>Digital and data development</i> : Advance digital and data capabilities to enable targeted population health management, ensure inclusive solutions for people with learning disabilities, and equip staff with the training to utilise the benefits of technology in the workplace.
p. <i>Workforce</i> : Strengthen our neighbourhood-based workforce by aligning staffing to evolving demand, developing leadership skills, prioritising wellbeing and work-life balance, and building skills to deliver high-quality care.
Community Health Services, Dentistry and Primary Care Directorate Priorities
q. <i>Healthier communities shaped in partnership</i> : Place-based partnerships will be strengthened to deliver integrated, person-centred care through Neighbourhood Teams, streamlined access to community and mental health services, optimised urgent and emergency care, and mobilisation of dental contracts, with a strong focus on prevention, early intervention, and improved population health outcomes.
r. <i>Sustainability and Productivity</i> : Sustainability will be driven through efficiency, productivity, and the Green Plan by implementing financially sustainable care models, progressing towards Net Zero by 2030, and optimising performance under the NHS National Oversight Framework to reduce unwarranted variation and continually improve quality and outcomes.
s. <i>Digital and Data development</i> : Advancing digital and data capability through a directorate-wide improvement plan incorporating demand and capacity analysis and population health management to enable data-informed service design, enhance quality and standardisation, and improve clinical decision-making for better outcomes and productivity.
t. <i>Co-Production and Research to Improve Community Outcomes</i> : Patient, carer, and community engagement will be embedded in all service redesign and improvement work to deliver inclusive, high-value services, implement the five-year Research Strategy.
xix. <i>Achieve elective care targets</i> by improving 18-week performance and eliminating 52-week waits through targeted waiting list management and aligned transformation initiatives.

Workforce

Strategic oversight

- 42) The People Steering Group is the formal governance chaired by the Chief People Officer that has oversight of People related issues at an operational level. Other Executives also attend. It meets monthly and receives a highlight report from the Education Strategy Group which reviews the current training offer and also ensures that there is a continuous improvement mindset in relation to statutory and mandatory training. It also receives a highlight report from the EDI Steering Group which reviews and shapes Trust wide interventions in relation to equality and inclusion and a report from the Programme System Board which has oversight of HR system change.
- 43) The Trust has seen a steady rise in Statutory & Mandatory training compliance and, as at 16/09/25, compliance is sitting at 93% against a target of 95%. The Executive Team receives a monthly report which sets out the current compliance rates for Statutory & Mandatory training which sets out the full Trust position. The report also provides a directorate breakdown and highlights any changes that will impact compliance rates and mitigations to ensure that rates do not drop down as a result of any planned changes to the curriculum and requirements. This information is also presented to the Extended Leadership Team for senior manager awareness. The Board of Directors also see a regular update on Statutory & Mandatory training as it's a core indicator in the Integrated Performance Report.
- 44) The Trust Education team has been actively participating in the Statutory & Mandatory training national review and has also been used as an exemplar in relation to how it has applied the Core Skills Framework. This has enabled the Trust to identify which particular learning components have been behind the overall 95% compliance target and to take targeted action – this has been particularly evident in relation to Resus Training, PEACE training, and Fire Awareness training which are all now at 90% or just below.
- 45) The Education Strategy Group has oversight of education within the Trust ensuring there is a consistent and equitable approach to development across all Professional groups and Directorates. Our work in this area is overseen at Executive level by the People Steering Group which reports to the People Leadership and Culture Committee. The Education Strategy Group convenes quarterly with representation from clinical, academic, and operational leaders across the Trust to align education priorities with strategic workforce needs. Its purpose is to oversee the development, delivery, and evaluation of education initiatives that support staff capability, retention, and service transformation. Recent meetings have focused on expanding clinical placements, embedding inclusive learning environments, and strengthening partnerships with higher education institutions.

Education and Skills

- 46) The Education Strategy Group also supports the Trust's engagement with NHSE's quality audit processes, which assess education delivery against these standards and inform continuous improvement across the organisation. The most recent NHS England (NHSE) quality audit of Oxford Health NHS Foundation Trust, highlighted several areas of strong performance and improvement recognised the Trust's commitment to inclusive education environments, including the embedding of the Patients and Carers Race Equality Framework (PCREF) and the appointment of an Anti-Racist Programme Lead to support systemic change.
- 47) The People Leadership and Culture Committee (chaired by a Non-Executive Director) also receive a Workforce Report at each meeting (4 times a year) and has also reviewed more in-depth reports on our position on Statutory & Mandatory training to understand and be assured that there is operational oversight to make continuous improvement. Specific areas have included agreeing additional investment into the Resus training team to have greater in-house resource. The committee is the lead committee for specific Board Assurance Framework (BAF) risks focused on recruitment, retention, staff experience and culture.
- 48) The Chief Nurse and Chief Medical Officer have directly been involved directly in the PEACE/Resus training delivery to ensure that it is as streamlined as possible. In the Quality clinical governance sub-group, concerns were raised about the resus training having 2 elements that staff had to complete, the complexity of this contributing to a consistently poor compliance rate. The 2 sessions were merged into one face-to-face session resulting in an improvement in both compliance but also staff confidence and improved evaluation.
- 49) All staff have the opportunity to discuss their development and skills and learning at their annual appraisal with the line manager and the standard proforma has a section that encourages this conversation. The Trust has used a QI approach to improve compliance of annual appraisals and we have met our target for the last two year of 95% compliance. Supervision is also a more regular opportunity to discuss learning and skills needs. Additionally, supervision rates are monitored and have been steadily increasing and sit at around 80%. We are making changes to the learning system to simplify the recording of supervision which we hope will make it easier for all staff to record this accurately.
- 50) The Trust has made significant improvements in its use of contingent labour and has reduced its agency usage and increased bank usage. We have processes in place with our managed services providers to ensure that our temporary staff have the required skills and training and there are processes in place to address complaints about agency/bank staff should they arise. The Trust is set to do better than its target in relation for 2025/26 in relation to the reduction of agency spend.

OHFT's People Plan

51) Oxford Health's People plan was developed in 2024 considering the NHS Longterm Workforce plan (published in 2023), the Trust's Strategy, Annual Plan, relationships with Partner Trusts and the NHS Longterm Workforce Plan. This plan has now been refreshed taking into account the National 10-year Health Plan and Medium-Term Planning Framework. It will once again be reviewed when the new Workforce Plan is published in 2026. The Trust's People Plan is broken down into 3 key themes: Train, Retain and Reform.

i. Train - Enhance our education and training capacity to support the development of our own talent. The Trust ambition is to develop a skilled and adaptable workforce through comprehensive training and clear career pathways. By enhancing education and training capacity, we aim to "grow our own" talent, modernise career roles, and establish a robust leadership framework through 'Our Leadership Way'. This will empower our staff to deliver outstanding care and reach their full potential within Oxford Health. The following key actions will support this over the coming 2 years:

- Developing staff to be able to use Artificial Intelligence Tools safely
- Review of appraisals incorporating Scope for Growth career conversations
- Developing early career progression routes to include entry level apprenticeship roles
- Further grow engagement with Schools/Colleges & the local community to support recruitment including the creation of a trust work experience policy, expansion of T-level placements, and implementation of school/college career events
- Development of training modules to support effective rostering
- Implementation of the reformed statutory/mandatory training framework
- Developing options for the adoption of the NHSE Leadership and management Framework including the completion of the self-assessment for all leaders and 360-degree feedback for senior leaders.
- Identifying gaps in leadership training and developing process to embed national leadership programmes into personalised development programmes.

ii. Retain - Deliver a range of interventions with the aim of reducing turnover and improving staff experience. The Trust ambition is to create a supportive and inclusive work environment that prioritises staff well-being and career development. By offering flexible working options, enhancing equality and diversity initiatives, and focusing on staff well-being, we aim to reduce turnover and retain our talented colleagues. This will ensure our workforce feels valued, empowered, and motivated to

deliver exceptional care at Oxford Health. The following key actions will support this over the coming 2 years:

- EDI, Retention & Culture

- Implement the new Equality Diversity and Inclusion plan
- Implement strategies to prevent sexual misconduct in the workplace
- Tackle discrimination in all its forms including, racism, antisemitism, Islamophobia, through Trust wide interventions and local delivery
- Build upon the current Anti-racism programme
- Review and improve our recognition offer
- Improve staff engagement through listening and feedback mechanisms and staff experience using survey data
- Commence the supporting people and culture programme

- Development & Succession Planning

- Continue to support team development
- Continue to develop systems to support internal progression/moves, improve retention and adopt an 'internal first' approach
- Develop Executive Succession planning and Talent Management processes for senior level posts with a focus on improving diversity
- Develop our manual handling training offer to be more responsive to service need and support reduction in work related injury

- Other:

- Work with NHSP to overcome system restrictions to support staff booking the shifts they want and maintaining a healthy work life balance
- Fully implement the NHS England 10 Point Plan to improve working lives of resident doctors

iii. Reform - Changing how we work in relation to new roles in multidisciplinary teams and using digital and technology change to support services. The Trust ambition is to transform our workforce by adopting innovative approaches to sourcing talent, leveraging future technologies, and enhancing data quality and systems. By embracing digital advancements, we aim to support new skills development, improve decision-making, and increase efficiency. Additionally, we will foster a restorative, just, and learning culture by creating a positive work environment supported by kindness, civility & respect. This will ensure Oxford Health remains at the forefront of healthcare innovation and delivers exceptional care to our community. The following key actions will support this over the coming 2 years:

- Implementation of new software to improve fairness and reduce bias in recruitment

- Review of the use of all workforce systems related to medical staffing
- Implementation of a new Document Management system to ensure GDPR compliance
- Preparation for the implementation of the new national workforce system solution
- Further development of the Restorative Just Living Culture programme
- Reduction in Temporary staffing use and costs through:
 - Reduction in Agency Payrates for Band 5 workers to below the price cap
 - Reducing our reliance on ID Medical's agency managed services
 - Creation of a Bank of temporary staff for GPs
- Continued deployment of and improvements to the HR Service Desk
- Exploration of the use AI or other technology to support ER casework investigation and management and employee feedback and engagement
- Reduce Sickness Absence rates through a targeted approach exploring themes and hotspot areas and developing plans to reduce.
- Explore the use of proactive facilitated conversations to reduce the number of formal ER cases

Five Year Plan workforce submission

52) The Workforce Submission (planned staff in post and establishment) has been developed using Month 7's Establishment and Staff in Post as baseline Data. The Medium-Term Planning Framework includes the expectation that Trusts reduce agency and bank use. This includes a 10% year on year reduction in spend on bank staffing, working towards zero spend on agency by 2029/30. These expectations are built into our directorate plans and reflected in our workforce submission, as is the expectation that the workforce will only grow due to investment in priority areas.

53) To reduce agency spend the Trust has taken a Bank first approach to transfer agency costs to bank and stopping the use of Band 2 and 3 agency staff. It does not feel that it is possible to reduce Agency and Bank to cap levels at the same time and therefore whilst the plan proposes to achieve the agency target, bank spend is proposed to reduce by 5% year on year after the first year. Most bank shifts cover funded vacant posts or increased observations due to patient acuity which will be managed within the financial plan. As the plan also includes growth for our services which will increase establishment it will be harder to reduce bank shifts. The Trust will keep evolving its approach to Bank management in dialogue with the regional and national NHSE teams.

54) The submission includes the assumption that the Trust will receive investment in priority areas as outlined by NHS England. Mental Health investment funding has been prioritised across Mental Health Support Teams for Schools, Talking Therapies, Individual Placement Support and Community Crisis teams and that

the investment uplift in Community Services will flow through to District Nurses and other Trust Community physical health services including those relating to children.

- 55) The Trust's capital priority is the delivery of the new Warneford mental health hospital. This plan is submitted prior to decisions about Regional Estates funding, and may require revision to permit a Trust contribution to the Warneford programme. Other capital priorities funded include digital developments, Integrated Neighbourhood Health centres, and Crisis / Mental Health Emergency Department developments as well as safety and backlog maintenance driven capital projects.

inance*Financial planning and oversight*

- 56) The Trust is submitting breakeven plans for the 3 years of the plan submission. This is in the context of strong track record of meeting financial targets and delivering efficiencies from the Trust in recent years demonstrating a strong financial control culture, however we acknowledge the challenges ahead to deliver performance and remain in budget.
- 57) The Plan assumes includes a Cost Improvement Programme for directorates each year of 2.5% of clinical income. This is 0.5% above the efficiency target applied to contract income to ensure long-term financial sustainability.
- 58) The Trust has a monthly Services and Financial Sustainability meeting chaired by the Chief Finance Officer and attended by the Chief Executive and other senior leaders. The purpose of this meeting is to ensure the delivery of the Cost Improvement Programme (CIP) in year but also to discuss and develop future year's CIP plans and ensure regular focus on long-term sustainability.
- 59) The Financial Management team have also started to forecast beyond the current financial year with greater emphasis on the underlying position/exit run-rate position of directorates. This has been used to inform the financial plan and assess the level of risk within the plan.
- 60) Further Trust-wide efficiencies will be made through the reduction of temporary staffing (especially agency premium savings), addressing underlying cost pressures and non-recurrent vacancies.
- 61) The strong financial position of the last few years has included areas of financial pressures which have been offset each year with non-recurrent benefits. The plan assumes that work already started to address the areas of financial pressure will reduce the costs in these areas and reduce reliance on underspends elsewhere. This means we are well placed moving into the Five Year planning period, however ongoing robust oversight and clear lines of reporting will be required to monitor performance against a challenging background.
- 62) Mental Health and Community growth funding has been included in the plan to enable the Trust to meet the requirements of the medium term planning framework and support the delivery of the 10 year plan ambitions. Service Development funding (SDF) has also been included for key mental health priority areas of Talking Therapies, Individual Placement support and Mental Health Support Teams in school.
- 63) The plan development has included an assessment of benefits to the Trust's financial position of vacancies in year. This has concluded that the Trust can rely on a certain level of non-recurrent vacancies due to turnover and vacancies not being covered by temporary staffing while recruitment takes place. Therefore, a non-recurrent efficiency for vacancies has been included in the plan for each year. The Trust is looking to reflect this assumption in service budgets from FY27 to embed it in the financial reporting.

64) The plan also assumes non-recurrent benefit of slippage on growth funding each year to reflect the time taken to recruit staff once growth funding has been confirmed by commissioners. This assumption is dependent on the level of growth funding confirmed.

Enablers

- 65) Our Executive Team have led work to identify the enablers for our planning priorities, bringing together the thinking from clinical and corporate directorates. In developing their priorities our clinical teams are asked to consider the enablers necessary to deliver their priorities, with the Executive and central planning team bringing this together with corporate teams to design solutions which best maximise the impact of the priorities.
- 66) Our main enablers have been identified as:

Estates

- 67) To support delivery of the Trust's Five Year Plan and the aspirations set out in the Ten Year Health Plan, the Trust is refreshing our estates strategy to deliver a new strategy for 2026-2036. This work comprises the following areas:
- i. *Assessment of our current estate*: including an inventory of sites and how well each site currently supports healthcare delivery
 - ii. *Future development*: including forecasts of population health needs, emerging operational plans and priorities, and our current understanding of capital investment and digital upgrades.
 - iii. *Sustainability and efficiency*: including current energy efficiency and plans to ensure the estate can adapt to future climate changes.
 - iv. *Accessibility and inclusivity*: including our understanding of whether our estate is accessible to all, particularly in underserved areas, and comprises spaces that are well designed for people with varying abilities.
 - v. *Financial management* to deliver cost effective use of resources
 - vi. *Risk management* to deliver compliance with regulations and to ensure that the estate is designed with contingency planning in mind.
 - vii. *Collaboration and integration*: including working with other partners to optimise estate use.
- 68) The development of our Estate Strategy is a crucial pillar supporting our overarching Trust strategy and our 5 year plan. As we work with system partners to implement Neighbourhood Health across our footprint, the design, location and usage of our estate will be critical to deliver enhanced patient care and maximum organisational efficiency.

Workforce

- 69) The workforce section of this document discusses in detail our approach to supporting and developing our workforce in line with our planning priorities and the aspirations of the Ten Year Health Plan. Key to this is close working between clinical and corporate directorates, led by the Executive Team, to deliver joined up

teams through a neighbourhood approach where appropriate, and to ensure our learning and development programme supports to ambitions of the Five Year Plan.

70) Through our strategy development work, supporting our staff is emerging as a key theme for our future strategy.

Digital

- 71) The Trust's Digital Strategy was developed in alignment with the national Frontline Digitisation Programme. The Trust's Chief Digital and Information Officer actively works with system partners and the ICB to facilitate the emergence of a joint data platform and the development of population health analytics. For example, in Thames Valley ICB, the Trust is supporting the development of the Connected Care Programme to enable this and the implementation of the John Hopkins segmentation model for population health at both ICB and Trust-level.
- 72) To support delivery of planning priorities, the Trust's digital strategy focuses on:
- i. Digital empowerment: to improve access to and quality of digital alternatives and support patients with self help and online care, and to empower the use of apps, websites, wearables and home devices.
 - ii. Digital culture: innovation to support quality improvement, digital pathways of care and flexible working for staff.
 - iii. Digital foundation: getting the basics right – including devices, infrastructure, interoperability, data security and efficiency.
 - iv. Research, collaboration and insight: developing our approach to continuous improvement and population health data.

Business intelligence

- 73) Our work to develop planning priorities rests on good understanding of performance, pressures and areas of opportunity, stemming from a robust data set. This includes:
- i. *Robust understanding of performance* stemming from a 'ward to board' of monitoring performance, identifying and addressing unwarranted variation, and identifying risks and opportunities
 - ii. *Ongoing demand and capacity modelling* to understand areas of pressure and to assist with future planning and workforce design.
 - iii. *Develop a population health approach*. The Trust is working towards being able to apply the ICB John Hopkins stratification methodology to get a comprehensive view of prioritised health needs.
 - iv. *Accelerate digital maturity* through targeted investment in system applications and upgrades, including those which offer additional functionality and reduce the administrative burden on clinical staff.

Risks and mitigations

Strategic oversight

- 74) The Trust has an established approach to the strategic oversight of risks including:
- i. the Board Assurance Framework (BAF) which identifies, assesses and monitors the strategic risks to the realisation of the Trust's strategic objectives. The BAF is reported to each Board meeting and board committees oversee specific BAF risks to provide a more in-depth overview to risks to strategic delivery. The Audit and Risk Committee supports the Board in oversight of the BAF and each risk is allocated to its respective Board Committee for further assurance.
 - ii. The Trusts Quality Governance Framework which serves to oversee the quality of care (issues and risks) through review of measures, reporting/escalation from clinical directorates, implementation of national guidance, and learning from national inquiries with a work programme aligned to the CQC quality domains.
 - iii. Financial risks are managed through Board and Executive oversight, set out in more detail in the Financial section of this document. Including review by the Board led Finance and Investment Committee.
 - iv. Throughout the planning process, directorates were asked to identify the main risks relating to the emerging planning priorities. These risks are discussed as part of the ongoing planning process with the Executive Team and the Board of Directors with mitigation plans developed as necessary.

Risk management during the planning process

- 75) During the planning process directorates are asked to identify any risks emerging from planning priorities. Where these risks could impact patients, the Trust has an established approach to understanding and assessing the potential impact of these using the Quality Impact Assessment (QIA) process (this is included as supplementary information). QIA is an embedded part of the trust governance processes, and an integral part of financial planning with written policy guidance available that details when a QIA should be undertaken; this includes:
- a. cost Improvement Programmes (CIPs) usually as part of the annual planning cycle
 - b. Service changes which have a potential impact on quality, safety, and workforce or on the working arrangements for staff; any
 - c. New business or commissioned changes: in these circumstances the business case or commissioned change will not be approved by the Trust Business Group until the QIA has been completed.
 - d. Our governance process requires that QIAs are reviewed in the first instance by the Chief Nurse and Chief Medical Officer before being reviewed by our Quality Committee, chaired by a Non Executive Director, to ensure there is

robust oversight of the impact and mitigations of proposals, including the cumulative impact.

- 76) As part of the delivering within the financial envelope, opportunities for cost improvement programmes have been developed. The ability to meet the financial challenges without making changes to either headcount, service delivery/ configuration or wait times is increasingly more challenging and it is recognised that there is likely to be some impact on the quality and equality of delivering services to patients, and therefore a need to fully comprehend the impact and utilise all mitigation available.
- 77) As its new Strategy gets finalised, the Trust's risk will be reviewed and re-assessed to ensure they fully align with the Trust's ambition.

Supplementary information:

Quality Impact Assessment Process (to be added here to submission to NHSE).

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	11(b)
Report title:	Medium Term Planning 2026/27 Onwards – Board Assurance
Executive sponsor(s):	Amélie Bages – Executive Director for Strategy, Heather Smith – Chief Finance Officer
Report author(s):	Rachel Pirie, Head of Planning Charlotte Adamson, Senior Programme Manager (planning)
Action this paper is for:	☒ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Assurance on Oxford Health Medium Term Plans
Public or confidential	Public

Executive summary

1. This paper sets out the Board's role in providing assurance for the NHS England planning process. NHS England has issued Board Assurance Statements outlining the key expectations and responsibilities of Boards, as set out in the planning framework. The first Board Assurance statement, made on 17 December 2025, focused on actions underway and was discussed at the Board workshop on 10 December 2025. The second submission, due on 12 February, requires confirmation of progress, with maturity ratings expected to evolve between the two submissions

Attached are:

- **Board Assurance Statements**, including:
 - Annex 1: Assurance statement for submission in February. These include updated commentary where maturity ratings have moved from *maturing* to *embedded*, or are still *maturing*
- **Supporting information**,
 - Annex 2: The list of assurance statements submitted in December

Report history / meetings this item has been considered at and outcome
20th January Finance & Investment Committee (FIC) 12th January 2026 Executive Meeting 10th December 2025 Board of Directors' Meeting: Planning Session: Draft Board Assurance 26th November 2025 Board of Directors meeting: Medium Term Planning update

Report
Background 2. This paper sets out the requirements for the upcoming NHS England planning submission and the role of the Board in providing assurance. NHS England requires Boards to provide assurance that plans are: • Deliverable, credible, and affordable • Developed in line with the Planning Framework and Medium Term Planning Framework (MTPF) • Supported by robust governance and clinical leadership • Triangulated across finance, workforce, and performance 3. The first planning submission, made to NHS England on 17 December 2025, included Board assurance statements regarding the planning process to date. These statements are attached as Annex 1. The second submission, due on 12 February, requires Board assurance using a set of statements that we expect will be similar (but not identical) to the statements already submitted. At the time of writing NHS England have not released the final version of Board Assurance statements to accompany the final plan, we will therefore provide a further update to Board. Maturity ratings are expected to evolve between the two submissions, proposed changes are highlighted through updated commentary in Annex 1. 4. At the time of writing we have received initial feedback from NHS England on our first planning submission, regarding Board assurance the feedback is that the average rating of our 15 Board assurance statements is 1.53, the regional average is 2.17. A lower score represents most assurance, this indicates that OHFT Board members are more assured on plans than the regional average. 5. The full planning submission is due to NHS England 12 February 2026, covers: • 3-year revenue plans • 4-year capital plans • 3-year workforce plans • 3-year activity and performance plans • Triangulation and alignment of plans • A 5-year narrative plan • Board assurance statements (final) 6. Annex 1 outlines 15 assurance statements across key areas:

- Foundational activities
 - Governance and leadership
 - Plan development
 - Productivity
 - Risk management
 - NHS standard contract & commissioning
 - Workforce
7. Draft Board Assurance assessments are provided for the Board to review. Pending the Board feedback, this assessment will be used to populate the official assurance template for submission to NHS England. Please note, the detailed narrative you are reviewing does not get submitted to NHS England, we are asked to submit the maturity rating (1–4) for each statement and a short narrative (maximum 80 words) per statement. This assurance process builds on the Provider Self Assessment Process carried out to as part of the NHS Oversight and Assessment Framework.
8. Where we are proposing changes to the rating; where the rating is proposed to remain as ‘2 – maturing’; and in the case of the new statement we have set out a rationale for your consideration. Other statements remain unchanged, see Annex 2 for the list of statements submitted in December. In particular, in relation to statement 3 *‘robust equality impact assessments have been undertaken and reviewed by the Board to inform development of the organisation’s plan’*, it is important to note that the Board have previously rated this a ‘1 – embedded’ and that it is proposed to retain this rating given the robust processes in places to oversee EQIAs. These have been developed and are currently undergoing review prior to consideration by Quality Committee on 12th February 2026.
9. This Board assurance process is designed to assess the plan development process in line with NHS England’s expectations. Separately to this, within the Trust we intend to undertake our own ‘lessons learned’ exercise to capture any learning from this planning round and potential improvements for future years.
10. The maturity assessment scale is:
- 1 – Embedded (Full Assurance): The action is fully integrated into normal operations, sustainable, and reinforced by policy and culture.
 - 2 – Maturing: The action is becoming routine, with documented processes and growing consistency.
 - 3 – Developing: Steps have been taken to introduce the action, but it lacks consistency or broad awareness.
 - 4 – Not Embedded (No Assurance): Little or no evidence that the action has started; if it has, it’s ad hoc or inconsistent.

Summary of changes in maturity ratings

11. We recommend that the following assurance statements move from 2 (Maturing) to 1 (Embedded)

- *Established structures are in place to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.*
- *Plans are evidence-based, robust and deliverable. The board is content that the phasing of the plan across three-year is realistic.*
- *Plans are triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.*
- *Work is underway to ensure contract values used in planning submissions are aligned across commissioner and provider activity and financial plans.*
- *A timetable is in place to ensure that the Board will be updated on the sign-off or contracts and any delays to signing contracts will be reviewed by the Board.*

Assurance statements remaining at 2 (Maturing)

12. Three assurance statements remain rated as 2 (Maturing), reflecting areas where further embedding is required. These are:

- *Processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.*
- *The organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.*
- *The impact of the NHS 10-Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts: hospital to community, analogue to digital, and sickness to prevention.*

New assurance statement rated as 1 (Embedded):

13. *The board can confirm that the organisation has worked with the ICB to ensure their plans are fully aligned.*

14. The final planning submission to NHS England on 12th February 2026. NHS England have said that plans will not be rejected if board assurance maturity is less than “1 – Embedded”, the maturity ratings allow providers to be transparent in areas where further development may be necessary.

Recommendation(s)

15. The Board is asked to:

- Review the content of this paper and the attached assurance statements.
- Provide feedback on the proposed maturity ratings and draft narratives.

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/ <u>No</u>	
Legal and regulatory	Yes/ <u>No</u>	

Board Assurance Statements to support OHFT's February 2026 planning submission to NHS England.

Boards are asked to review statements and apply a maturity assessment against each one (see maturity assessment descriptors below). When submitting these to NHS England, supporting commentary is required, limited to 500 characters / approx. 80 words

1. Embedded [Full Assurance]	2. Maturing	3. Developing	4. Not Embedded [No Assurance]
The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.	The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.	Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.	There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

Final statements have not been issued by NHS England, the information below is subject to change and an update to Board will be provided.

Assurance Statement (Statements to be collected at full submission are under development and may change)	Maturity Assessment 1-4
1. The board can confirm strong clinical leadership has been involved in the development of plans.	1
2. The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans	2
3. Robust quality and equality impact assessments (QEIA) have been undertaken and reviewed by the board to inform development of the organisation's plan.	1
4. The board has played an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan.	1
5. The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	1
6. The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	1
7. The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	1
8. The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	1
9. The board can confirm that the organisation has worked with its ICB to ensure their plans are fully aligned	1
10. The board can guarantee that the organisation has fully considered and incorporated productivity opportunities into plans, and that any phasing is credible and realistic. The board can provide justification where any	2

identified opportunities cannot be fully delivered during this planning round.	
11. The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	1
12. The board is certain that contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans.	1
13. The board can confirm that there is an effective process in place to manage the sign-off of contracts.	1
14. The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	1
15. The board can confirm the impact of the 10 Year Health Plan on the workforce is reflected in plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	2

Proposed ratings and the rationale for these is set out below in the following groupings:

- a) Statements which were previously rated as 2, now proposed as 1
- b) Statements with a proposed unchanged rating
- c) New statement

a) Statements previously rated as 2, now proposed as 1.

Statement 6 – (previously Statement 7) Upgraded from Level 2 to Level 1: The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient

- The Trust has a strong ongoing relationship with Thames Valley ICB (currently operating in shadow form), and BSW ICB where we provided CAMHS services. We are also a significant player in three specialist mental health provider collaboratives.
- For planning purposes our main link is with Thames Valley ICB where we have sought proactive conversations at both working level and executive level. At working level, the Head of Planning engages regularly with the ICB planning team, and Business Services and Workforce colleagues are engaged in specific working groups for Performance and Workforce respectively.
- At executive level, we attend weekly Planning Leads conversations and CFO calls to share planning assumptions and discuss the best approach to alignment and collaboration.
- Place level working is particularly important in Oxfordshire given our role in community services. For planning purposes, the Trust is a member of the Better Care Fund planning group and actively working with system partners to evaluation Better Care Fund performance and develop future plans. We expect that BCF plans will be required to align with Neighbourhood Planning and therefore we are well placed to deliver this given our active role in the Neighbourhood agenda in Oxfordshire.
- Planning conversations have developed over the planning period, with continued engagement with the ICB including regarding the allocation of the 'Innovation Fund'. At the time of writing allocations from this fund have not been made, which it is acknowledged presents challenges in finalising our

financial and performance plans. Despite this, we suggest that the maturity assessment moves to '1' as we remain confident in Oxford Health's ability to support effective system working and to engage meaningfully in system planning conversations.

Statement 7 (previously Statement 8) – Upgraded from Level 2 to Level 1: The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic

- In developing priorities, directorates were asked to consider the full set of information available, including workforce, performance and activity data available on TOBI, and staff survey results.
- The development of planning priorities was led by clinical directorates, allowing the opportunity for quantitative data to be considered alongside the expertise and experience of staff who are closest to patients and service delivery.
- Performance conversations between clinical directorates and the Executive Team take place on a quarterly basis, allowing challenges, opportunities and key performance data to be discussed. This meant that there was clear understanding going into the planning process of the areas where directorates should put their focus in developing their priorities (supported by the aspirations in the Ten Year Health Plan and other national and local targets.)
- In line with national planning guidance, more detailed activity and performance plans have been drawn up for the first 3 years of the planning period. Since the December submission, work has been ongoing to develop t priority areas for investment through Thames Valley ICB's Innovation Fund. At the time of writing this process has not concluded and we therefore have developed trajectories reflecting the position if investment is allocated, but have also developed trajectories that reflect our current position, ensuring that we can submit realistic trajectories linked to the outcome of the investment process

Statement 8 (previously Statement 9) – Upgraded from Level 2 to Level 1 The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent

- The Trust's central planning team comprises finance, performance, strategy, workforce and planning colleagues jointly overseen by the Executive Director of Strategy and the Chief Finance Officer. The team holds a regular weekly meeting to review progress to deliver the plan and consider information published by NHS England.
- NHS England have published Planning Standards describing the minimum requirements for triangulation:
 - Common set of planning assumptions: *in place*
 - Regular reconciliation meetings between finance, workforce and operational leads: *in place*
 - Utilisation of integrated planning template: *in place and submitted as part of the December submission*
 - Inclusion / engagement with wider system: *regular discussions have been led by the ICB throughout the planning period. On an ongoing basis, we attend a monthly bi-lateral meeting with the ICB to review financial and operational performance. Beyond this, we are working with NHS and non-NHS system partners regarding Better Care Fund planning, at the time of writing 2026-27 guidance has not been released.*

- Establish the agreed finance allocation: *in place*
- Plans must demonstrate an integrated approach: *in place, this was demonstrated in the plan template returned to NHS England on December 17th 2015 and has further refined for the second submission date on February 12th 2026. We have also demonstrated this triangulation in the narrative plan to be returned with the second submission.*
- We have upgraded the rating from level 2 to level 1 to reflect the feedback on the initial plan from NHS England and the ongoing work to further develop and align our plans. Final triangulation of plans is dependent on the final position regarding innovation funding, however our processes and ongoing dialogue with Thames Valley ICB are in place to deliver this and a further update will be provided to Board.

Statement 12 – (previously Statement 12) Upgraded from Level 2 to Level 1 The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans

- The Trust has an established process for the development of annual plans and the preparation of planning returns to NHS England. This process is jointly led by the Executive Director of Strategy and the Chief Financial Officer, with the workforce element overseen by the Chief People Officer. This ensures that our plans are developed within the Trust's strategic framing and within the financial parameters.
- Directorates are responsible for ensuring that their plans align with the strategic priorities and that their priorities are deliverable within the financial envelope available. Working together across the central performance team and Directorates, we are developing performance trajectories taking into account potential performance following investment or without further investment. This work is still in development as we refine options but we are confident that across triangulation of planning is in place, with Executive level oversight and sign off.
- In particular, the Trust's finance team works closely as part of ICB finance planning process to help lead and shape system financial plan. Both of the Trust's revenue and capital plans are derived from the System Planning approach and aligned to the agreed system position and in the run up to plan submission we are continuing our conversations with Thames Valley ICB directly, and with other system partners, to ensure an aligned position.
- At the time of writing we are working towards alignment of plans with the ICB, to reflect this ongoing work and the feedback from NHS England regarding our draft submission a rating of 1 is proposed

Statement 14 – (previously Statement 14) Upgraded from Level 2 to Level 1 The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.

- The Standing Financial Instructions set out the process for entering into all contracts, and sets out the detail for compliance with Trust, national and legal requirements.
- Regarding contracts that the Trust signs with our ICB commissioning partners, we work closely with the ICB to agree the content and financial envelope of contracts, however responsibility for issuing contracts rests with the commissioners. It has been our experience that issuing of the final contract can be delayed, even in situations where the content and financial envelope is agreed.

- Noting that Thames Valley ICB is in flux as it transitions from shadow form, it is likely that we (alongside other providers within the ICB footprint) will continue to experience these delays. Executive level conversations will continue to ensure that financial envelopes and delivery requirements are confirmed, with any further risks escalated to Board as required.
- Trust Exec will keep the Board updated on final contract signature and flag any issues or material discrepancies between issued/signed contracts, and the income assumptions within the Trust financial plan which is agreed by Board. Where a delay is due to a contract dispute the Board will be updated along with the proposed steps to resolve, timeline and governance. We are therefore proposing to upgrade our rating to 1 as we are confident in our internal management of contracts sign-off in spite of potential delays.

b) Statements with a proposed unchanged rating

Statement 2 (previously statement 3) remaining at 2 The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.

- This is a maturing area of work for the Trust, Clinical directorates are increasingly adopting systematic approach to assess and address population needs, underserved communities and inequalities when developing their plans, with pockets of best practice.
- The Quality strategic objective of the Trust of *Delivering the best care possible and health outcomes* includes an ambition of reducing health inequalities. This has notably been supported by a focus on achieving a 90% completion rate for demographic data across the Trust as a first step of building a systematic approach to addressing health inequalities.
- The Patient and Carer Race Equality Framework (PCREF) Oversight and Scrutiny Board has been established to develop leadership of this area and support governance of actions. This includes a focus on:
 - Creating new data sets on improvements in reducing health inequalities including strengthening the ability to gather data and establishing some criteria to inform analysis on areas of deprivation: a health inequalities dashboard has been developed and is being tested and socialised across services in an incremental way to inform delivery of services and Executive oversight.
 - Establishing visible and effective ways for feedback to be received and acted on.
- As part of this medium-term planning process, and in line with the Neighbourhood priority identified in Oxford Health's 2025-26 Plan, a central approach to understanding population health and addressing health inequalities is being put in place.
 - A continued focus on data with a stratification of access and waiting time targets, notably segmenting using the Index of Multiple Deprivation and ethnicity information.
 - Working towards application of the BOB ICB John Hopkins stratification methodology to our dataset to align prioritisation of health needs, more work is needed with Thames Valley ICB to develop and embed this.
 - Looking at adoption a patient-centric view of our data to see how patients interact with the Trust's services.
- Moreover, all clinical directorates have been asked as part of the medium-term planning to review the break down of their key waiting times standards by IMD and ethnicity and to start developing a menu of interventions to address the identified inequalities. The planning work of the trust also links closely with the population health priorities identified by the ICB at system and at place level. Previously these were identified in the Joint Forward Plan, with inequalities now featuring throughout the Thames Valley ICB Commissioning Intentions. We will work closely with the ICB moving forward in their role as a strategic commissioner, including the Mental Health Provider Collaborative which is supporting the work to develop more detailed mental health commissioning intentions.

Statement 10 – (previously Statement 10) Remaining at level 2 The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity

- Financial sustainability is one of the Trust's four strategic objectives *Making the best use of our resources*.
- Reviewing financial information and national cost collection data is a key function of the Executive Team, the Finance and Investment Committee and the Board. Activity, WTE and Unit Cost charts have been included as standard in monthly Board reports starting in June 2025.
- Corporate Services benchmarking has been carefully analysed at Executive Team level and at FIC.
- Quarterly directorate performance stocktakes with the Executive Team seek to ensure demand is being managed efficiently within resources available.
- This ongoing financial, productivity and efficiency oversight forms the baseline from which planning conversations with directorates began. Directorates were asked to consider existing workforce, activity and performance data, and staff survey results available on TOBI, alongside financial and CIP targets in developing their plans.
- NHS England released productivity packs for mental health services in December 2025. The opportunities described in this pack are: mental health length of stay and out of area placements; reducing DNA rates and increasing activity per clinician in NHS Talking Therapies, Activity per WTE within CAMHS services; and reducing temporary staffing.
- Mental health length of stay and out of area placements have been identified as priority areas by directorates to address during the planning period. The Trust has an extensive agency reduction programme already in place, and we are considering how the potential to deliver further reductions in the period. The potential productivity saving for NHS Talking Therapies is being reviewed by the service. Mental Health Directorates are analysing activity by clinician across all services and this approach will be embedded within current processes for ongoing review and management of productivity.
- Cost Improvement Plans have been set and delivered above tariff levels for the last three years and stretching targets have been set for the three-year planning period to further drive efficiency.
- We have made good progress in understanding productivity and future opportunities across the Trust, however it is possible to go further with this to fully embed the approach and to ensure all services use full costing, activity and outcome data as business as usual to drive innovation and productivity. With this in mind we therefore propose a rating of '2 – maturing'.

Statement 15 (previously statement 15) remaining at 2 The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.

- At the outset of the planning process, the 10 Year Health Plan ambitions were set out as part of the strategic framing. For each directorate, the specific elements of the 10 Year Health Plan relating to their areas were set out to help with the planning process. Directorates have worked with their teams to develop their five year priorities - including new ways of working, options for new models and pathways of care, and options for increased digital support – taking into account how this will impact staff and what learning and development support may be needed.

- NHS England have published a draft productivity pack for the Trust's mental health services (at the time of writing the pack for Community Services has not been released). This pack sets out the productivity improvement opportunities based on Trust and national data with the information being considered as part of plan development.
- The Medium Term Planning Framework includes the expectation that Trusts reduce agency and bank use. This includes a 10% year on year reduction in spend on bank staffing, working towards zero spend on agency by 2029/30.
- These expectations are built into our directorate plans and it is anticipated that the workforce will only grow due to investment in priority areas. We will work to further reduce agency spend in line with the requirements of the planning guidance. Our Plan does not meet the target of reducing Bank by 10% as this is not in line with the Trust's plan to reduce Agency usage. The Trust will keep evolving its approach to Bank management in dialogue with the regional and national NHSE teams.
- There is an opportunity to build on the work done to date by further exploring the cross Trust opportunities for our whole workforce. As we finalise our new Trust's Strategy, we will work through the transformation Board established in our Community and Mental Health directorates to ensure our directorates' workforce plan keep being iterated to support the ambition of the 10 Year Health Plan. This is reflected in our current proposed maturity assessment of 2

c) New statement

New Statement 9 – proposed as ‘1’

The board can confirm that the organisation has worked with the ICB to ensure their plans are fully aligned.

- It was agreed between Providers and the Thames Valley ICB that planning submissions in December would not be aligned. This was because the time available did not allow for plan development, organisational sign off and alignment to take place. However plans were shared between providers and the ICB to ensure transparency.
- Since draft plans were submitted in December the Trust has continued in regular discussions with the ICB and providers, including weekly Planning Leads conversations and CFO calls during which the best approach to alignment is discussed.
- At the time of writing we are continuing to work with the ICB to reach alignment of plans. This includes awaiting the outcome of the Thames Valley ICB Innovation Fund expression of interest process, to which we have submitted several bids to deliver against national trajectories and the aspirations of the Ten Year Health plan including delivery of the ‘left shift’. We are confident that through our ongoing dialogue with the ICB conversations will progress productively and we will update the Board on progress.

Boards should review the assurance statements and apply the maturity assessment 1-4 which best reflects the level in which the assurance statement has been embedded within the organisation. See Maturity assessment key below.

Validations have been included which will signal an error if guidance has not been followed correctly. Organisations will be unable to submit their template until these validations are cleared.

Validations
Name and Date of Sign Off Required
OK
OK

[illegible]

Reference	Category / Area For Assurance	Statement	Response	Commentary
1	Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	1. Embedded [Full Assurance]	
2	Governance and leadership	The board can confirm strong clinical leadership is involved in the development of plans.	1. Embedded [Full Assurance]	
3	Governance and leadership	The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.	2. Maturing	We are increasingly using systematic approaches to assess and address population needs, underserved communities and inequalities. This is central to our quality objective, supported by work to improve data quality, rolling-out the PCREF, and directorate-led initiatives. We are now embedding a centrally led approach to addressing population health needs and health inequalities and working closely with the ICB, aligning with the population health priorities identified.
4	Governance and leadership	Robust quality and equality impact assessments (QEIA) are underway or are planned to be undertaken and reviewed by the board to inform development of the organisation's plan.	1. Embedded [Full Assurance]	
5	Governance and leadership	The board is playing an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.	1. Embedded [Full Assurance]	
6	Governance and leadership	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	1. Embedded [Full Assurance]	
7	Governance and leadership	The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	2. Maturing	We have a strong relationship with our main ICB for planning (Thames Valley), and BSW where we provide CAMHS services. We are confident in our established planning structures and in the Trust's ability to support effective system working. We are rating this as 'maturing' as the new ICB planning infrastructure beds in, which should in turn allow for constructive and efficient system working.
8	Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	2. Maturing	We have worked hard and at pace to develop and stress test the evidence base of our plan. However given the time available there has been limited opportunity to triangulate across the ICB footprint, and other variables such as the neighbourhood health model are still emerging. Therefore we assess this as 'maturing' whilst further work is undertaken.

9	Plan development	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	2. Maturing	Plan development is led by an integrated team including strategy, finance, workforce and clinical colleagues, with processes in place to discuss and triangulate plans. However further work to refine and further test our plans, in line with the published planning standards, will be undertaken before final submission.
10	Productivity	The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.	2. Maturing	Financial sustainability is one of the Trust's strategic objectives and we carefully analyse benchmarking and productivity information. Ongoing financial, productivity and efficiency oversight forms the baseline from which planning conversations with directorates began and we are working with our directorates to fully consider productivity opportunities. Further work will be undertaken before final submission to respond to the productivity pack opportunities.
11	Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	1. Embedded [Full Assurance]	
12	NHS standard contract and commissioning	The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans.	2. Maturing	The Trust has an established process for managing the planning process, and works closely across the ICB to help lead and shape the system financial plan. Due to the timelines for submission of final plans it is accepted by the ICB and partners that full alignment of plans is not possible in time for the first submission. We will continue to work closely with partners in advance of the second submission to reach alignment.
13	NHS standard contract and commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	1. Embedded [Full Assurance]	
14	NHS standard contract and commissioning	The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	2. Maturing	The Trust has established procedures in place to manage contract sign off, however timely sign off of contracts is not fully within the Trust's control and delays can be experienced. Noting that the Thames Valley ICB is in transition from shadow form, it is likely that we will continue to experience delays. We will continue to keep the Board updated on contract signature and flag issues or material discrepancies.
15	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	2. Maturing	The framing of the 10 Year Health Plan has set the parameters for the development of our plan, and workforce expectations set by the Medium Term Planning Framework are built into directorates' plans. In particular, we will work to further reduce agency spend in line with the requirements. There is an opportunity to further explore cross-Trust opportunities for our whole workforce which we will take forward in the next stage of the planning process and the ongoing development of our plan.

OK	OK	OK	2
OK	OK	OK	2
OK	OK	OK	1
OK	OK	OK	2
OK	OK	OK	1
OK	OK	OK	2
OK	OK	OK	0
OK	OK	OK	0
OK	OK	OK	0



Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	12(a)
Report title:	Integrated Performance Report – January 2026
Executive sponsor(s):	Amelie Bages, Executive Director of Strategy
Report author(s):	Vicki Bull, Head of Business Services
Action this paper is for:	☐ 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
Public or confidential	Public

Executive summary

The Integrated Performance Report (IPR) provides Board of Directors with an integrated view of the strategic domains of Operational Performance, Quality and People. January's IPR contains November 2025 data (unless stated otherwise within the report).

The IPR has been developed for an improved alignment with Trust strategic ambitions, national and local reporting performance requirements. It underwent a further re-design in the current financial year to reflect recommendations, where possible, provided by NHS England in the Insightful Board Guidance, the Performance Assessment Framework for 2025 – 26, Standardising Community Health Services guide and changes agreed during the internal review of the IPR in November 2024. IPR now contains National Oversight Framework reporting overview.

The Report continues to be developed further to provide a comprehensive and reassuring oversight of Trust performance measures. The IPR will be reviewed in Quarter 4 of FY 2025 – 26.

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

In summer 2025, NHS England published an updated version of the NHS National Oversight Framework (NOF). Under the new framework, NHS England assesses provider performance against a defined set of metrics to determine segment scores. These scores will inform where targeted improvement is required. The resulting improvement interventions will be tailored based not only on performance but also on an assessment of each organisation's leadership,

governance, and overall capability, ensuring a balanced and proportionate approach to oversight and support.

On 9th September 2025 NHS England published a NOF league table for the first time, where every provider was scored against a set of metrics that target the 2025-26 NHS priorities and operational planning guidance. Each organisation was placed in a segment ranging from 1 (no support) to segment 5 (intensive support through Provider Improvement Programme). Oxford Health NHS Foundation Trust was placed in segment 1 for quarter 1. Quarter 2 position was confirmed in December 2025, and the Trust remains in segment 1.

The Integrated Performance Report has been reviewed to ensure alignment with the updated National Oversight Framework. Metrics linked to the NOF are clearly identified within the report. To strengthen transparency and alignment, dedicated NOF dashboards have been introduced in the IPR and now also includes contextual (non-scoring) metrics alongside the previously reported scored measures.

(2) Clinical performance

The Trust has a set of metrics to monitor clinical performance derived from nationally reportable metrics and locally agreed metrics. Reporting against some of the metrics is still in development and will be introduced on a phased approach. The below table provides a high-level overview of the metrics that necessitate exception reporting, as well as other metrics that, while not requiring exception reporting, contain additional information pertinent to the Board of Directors. For a comprehensive narrative, please refer to the full Integrated Performance Report (IPR).

Service area	Comments	
Child and Adolescent Mental Health Services (CAMHS)	No significant change and consistently* failing the target	Percentage of referred (routine cases) with suspected eating disorder (ED) that start treatment within 4 weeks - Bath & North-East Somerset, Swindon and Wiltshire
	<i>*Consistency is determined by a certain number of consecutive data points.</i>	
	Whilst the Making Data Count (MDC) algorithm is highlighting only the above Children and Young People (CYP) Eating Disorders services metric as requiring attention, the Board of Directors is asked to note majority of targets for CYP Eating Disorders metrics have not been met in November 2025 – see IPR for details.	
	The Board of Directors is asked to note CYP mental health services four (4) week wait (interim metric) performance in November 2025. Buckinghamshire’s and Oxfordshire’s services have exceeded the national average of 62% with achieving 80.09% and 75.77% respectively in November 2025. Bath and North East Somerset, Swindon and Wiltshire CYP mental health services are yet to achieve the national average with performance at 48.94% in November 2025. Breaches are largely attributable to patient choice delays and reduced capacity from sickness, vacancies. Mitigations include introducing family-agreed assessment booking, comprehensive data-quality improvements and training, and SPA process redesign with active monitoring, alongside forward planning for high-demand periods to increase assessment capacity and prevent further breaches. To note: waiting time standard for meaningful contact and outcome measure still in development to be reported on IPR. As an interim solution, the Trust is monitoring the four (4) week wait as one meaningful contact within the pathway.	

	The Board of Directors is asked to note that Oxfordshire's CAMHS is unlikely to meet the CYP access target by the end of this financial year. The variance against plan reflects the fact that the agreed trajectories were predicted on the implementation of a revised rotational Mental Health Support Teams (MHST) delivery model during the current financial year. However, such model was deemed to be inappropriate for the local population and therefore not implemented resulting in a lower access trajectory than planned. Current Oxford Health's MHST delivery model emphasises stable school portfolios with scheduled presence, aiming for continuity and relationship-based delivery. MHST coverage is now expected to increase over the coming years in line with the NHS Medium Term Planning Framework (MTP). In addition, the Board is asked to note that from the new financial year the CYP access rate will include a subset metric specifically measuring MHST access, which is being developed in collaboration with the ICB to ensure alignment with system planning trajectories. Notwithstanding this variance against plan, the Trust continues to meet the CYP access target collectively across Buckinghamshire and Oxfordshire. P Data Quality (Process and System) – Oxfordshire's CAMHS access metric rate continues to underperform against target in November 2025 – this position is partly attributable to data completeness issues. Activity from AnDY* Research Clinic has not been included as it is recorded on a separate system and reported through a different dataset. As of October, AnDY activity accounted for 165 patients accessing (November data not yet available due to reporting lag). In addition, 42 contacts have been identified as incorrectly attributed to a different commissioner code. A review of coding is currently underway to correct this misallocation and ensure accurate reporting in the future. If this activity were included (both the AnDY Research Clinic and that coded incorrectly), the access rate would be closer to the November trajectory target. <i>*AnDY – Anxiety and Depression in Young People</i>
Talking Therapies	Oxfordshire's and Buckinghamshire's Talking Therapies services are performing well.
Adult and Older Adult Community Mental Health Services	Oxfordshire's and Buckinghamshire's adult and older adult community mental health services are either generally performing well or within expected variation without cause for concern currently except: - Buckinghamshire perinatal access rate continues to be below FY26 trajectory. The Trust is currently rebasing trajectories for FY27 to correct activity expectation as it was identified in June 2025 that the perinatal activity used for FY26 trajectory planning included wrongly coded data. Revised trajectories will be submitted to the Integrated Care Board. Collectively the Trust is meeting the perinatal access target.
Mental Health Urgent Care Services	Majority of Urgent Mental Health Care service across Oxfordshire and Buckinghamshire are performing generally well or within expected variation without cause for concern currently and are not highlighted by the Making Data Count algorithm as requiring attention. However, due to significance, the Board of Directors is asked to note narrative within the IPR for the following Mental Health Crisis service metrics: - Very urgent response (4 hours) in Buckinghamshire (0%) and Oxfordshire (40%). The only referral to Buckinghamshire's service was seen outside of the timeframe due to patient choice as well as five out of six breaches in Oxfordshire's service (appropriate triage and safety planning took place within the timeframe for all patients).

	- Urgent response (24 hours) in Oxfordshire at 54.10% in November 2025. The Board of Directors is asked to note that this metric is a scored National Oversight Framework (NOF) metric. From 1 November 2025, the Oxfordshire's Crisis Resolution and Home Treatment (CRHT) team has implemented a revised referral process and is now aligned with processes in Buckinghamshire. All referrals will now be screened by a senior clinician prior to being entered onto the system, ensuring that referral priority is accurately determined at the outset. This change is expected to reduce current data-quality issues arising from system limitations that prevent priority levels from being amended once recorded. Longer-term resolution of these system constraints will be addressed through the Rio Reimagined project. 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. Peer review of how urgent care standards are applied across Oxfordshire and Buckinghamshire mental health crisis services has concluded. In addition, we also undertook a high-level performance review of mental health crisis services in South East and South West regions. Interim findings suggest that whilst there is national guidance in relation to urgent mental health care standards, interpretation of it can vary due to clinical triage. A Quality Improvement (QI) project was set up in late August to look at the referral process/system remains ongoing. Fortnightly meetings have been established to review and map referral routes into the service, supported by a detailed process map. A review of the current referral system has been undertaken, alongside a literature review to understand comparative practice elsewhere. The next phase will involve development of a Driver Diagram* to identify priority areas for change and improvement actions. Emerging work and learning will be presented to the Directorate Quality Improvement forum later this month. In parallel, senior operational and clinical leadership continue to oversee and monitor all referrals into the service. <i>* a Driver Diagram is a quality improvement tool used to clearly set out what one is trying to achieve, what factors influence the aim and what changes one can test to achieve improvement. It provides a visual and structured way of linking an improvement aim to practical actions.</i>
Adult and Older Adult acute/inpatient services	This month's IPR introduced two new inpatient metrics: - NOF scored - Percentage of adult inpatients with a length of stay over 60 days (discharged patients) - NOF contextual (non-scored) - Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) Adult and Older Adult Inpatient services across Oxfordshire and Buckinghamshire continue to perform generally well, with performance remaining within expected variation and no current areas of concern apart from: - Percentage of adult inpatient with a length of stay over 60 days of stay at discharge in Oxfordshire with 33.33% in November 2025 highlighted by Making Data Count algorithm as requiring attention due to concerning nature and Buckinghamshire with 26.89% (increasing but not highlighted by the algorithm yet). Length of stay over 60 days metric performance is linked to further increase of mean length of stay (combined mental health adult acute, older adult and Psychiatric Intensive Care Unit in Oxfordshire) in November 2025 (rolling three months) at 59 days versus the target of 51 days. - Increase in Inappropriate Psychiatric Intensive Care Unit out of area placement bed days in both Oxfordshire and Buckinghamshire in November 2025 – see IPR for details. Board of Directors is also asked to note that adult acute inappropriate out-of-area placement bed days remain elevated, but on a reduction trajectory. In November 2025, there were 253 inappropriate adult acute bed days across Oxfordshire and

	Buckinghamshire, representing a decrease of 116 bed days compared to October 2025. Making Data Count algorithm continues highlighting Acute adult and older adult admissions with no prior contact with mental health community services in Oxfordshire as requiring attention, however, narrative is not provided within the IPR due to regular audits not identifying any trends or themes. The Trust is currently reviewing the national data recording guidance for seventy-two (72) hour follow up for those discharged from mental health ward to understand potential changes to the clock start rules. T Data Quality – two breaches are under investigation for data entry errors (discharge date and discharge destination) for seventy-two (72) hour follow up for those discharged from adult mental health wards in Oxfordshire.		
Community Health Services, Dentistry and Primary Care	A proportion of service metrics are in development to be introduced in the IPR on a phased approach therefore some of the groupings may appear not to have any metrics aligned to them. Out of those currently available for reporting, the following metrics have been flagged as requiring attention: <table border="1"> <tr> <td>No significant change and consistently* failing the target</td><td>Percentage of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)</td></tr> </table> - Community Dentistry metrics are not flagged as requiring attention by the MDC algorithm; however, the Board of Directors is asked to note that the Service is unlikely to achieve contracted level of Units of Dental Activity (UDAs) by the end of the financial year. The set target is historic and unachievable due to changes in clinical pathways and acceptance criteria over the years since the Contract was first issued. The Service is currently reviewing the contract for the next two financial years in collaboration with commissioners. Activity is also impacted by staff vacancies, prioritisation of general anaesthetic lists (which generate no UDA activity) to reduce waiting lists and temporary closure of two clinics. T Data Quality – - Several same-day care services and healthcare teams should be contributing to the 2-hour Urgent Community Response target (i.e. UCR itself, District Nursing, Community Therapy Service etc.) but currently are not due to data recording code development and therefore only a proportion of activity is being reported. Please note that the 2-hour Urgent Community Response is a NOF metric. The workplan initially anticipated completion by end of quarter two. However, due to technical complexities, in total of three distinct workstreams, each requiring different solution approaches, have been identified. Current expectation is for part of the work to be completed within quarter three, while the remaining components will be contingent on resource availability. As a result, implementation for those elements may extend into quarters one or two of the next financial year.	No significant change and consistently* failing the target	Percentage of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)
No significant change and consistently* failing the target	Percentage of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)		
Community Health Services, Dentistry and Primary Care waits	Snapshot of Community Health Services monthly waits sitrep reporting on IPR commenced with May data reporting alongside percentage of patients (adults and CYP combined) waiting over 52 weeks for community services metric. Percentage of patients waiting over 52 weeks for community services is a scored NOF metric. Please refer to IPR for detailed narrative.		

	To note: national monthly sitrep reports on those currently waiting snapshot end of month position.



	Data Quality – on-going data validation by Services, specifically for those 52+ weeks is on-going.

(3) Quality and People

General exception reporting rules do not apply to metrics reported in Quality and People sections – narrative is provided for all measures.

Quality:

In November 2025, the Trust continued reporting a slightly elevated level of restrictive practice and the targets of less than 97 prone restraints and less than 303 seclusion episodes in year have already been surpassed.

Incidents of restrictive practice across mental health inpatient areas rose slightly from 290 to 319; 225 (70%) of these took place in Child and Adolescent Psychiatric Intensive Care Unit and General Adolescent Unit. The vast majority (184, 78%) was in response to self-harm incidents and maintaining patients' safety from self-harm. This demonstrates a prolonged period of caring for patients with high acuity, risk and complex needs in Child and Adolescent mental health inpatient areas.

The use of Prone restraints also came down slightly although at 13 still above the target of 8.

Number of seclusion episodes continues to fall in November 2025 - at 23 episodes, the Trust met target of less than 25 per month, the highest use was in Adult Psychiatric Intensive Care Unit and across forensic wards.

The Trust is steadily working towards the 90% target of meaningful ethnicity data recording and is now able to report all restrictive practise against ethnicity.

Incidents of violence and aggression towards staff and patients remain a high concern and a designated task group including staff at all levels and from all areas of the Trust is leading a number of workstreams to address.

People:

Agency reduction remains better than target for this financial year and savings have been made on both Agenda for Change and Medics when compared to the same period last year. The Trust continues working with the South East Temporary Staffing Provider Collaborative which is focusing heavily on medical locum rates. Vacancies are low as is turnover and changes in the resourcing team over the last 12 months has meant that the time to hire has also decreased. Attention remains on Resus mandatory training, which is now the only mandatory training below the target of 95%.

(4) Delivery of Strategic Objectives

The Trust has around 40 strategic metrics to track performance against set strategic objectives and ambitions. Strategic Dashboard inclusive of all strategic metrics representing annual position was presented to Board of Directors in May 2025 and six-month position in November 2025. In-year strategic metrics continue to be reported on IPR where possible. A full year position for the dashboard will be next submitted in May 2026.

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

The IPR is continuously reviewed to identify improvements to be made and incorporated when and where possible. It now provides a better insight into Community Health Services, Dentistry and Primary Care clinical performance with a further phased expansion over the next two quarters, inclusion of metrics for Forensic and Learning Disabilities are in the pipeline to be reported during financial year 2025-26. NHS England has published an updated NHS Performance Assessment Framework for 2025/26 (framework title used interchangeably with National Oversight Framework - NOF) following a test with pilot organisations. As a result of the new Framework, the total number of performance measures within the IPR and the context of certain measures will change over the next few months. NHS England is reviewing the Framework for 2026/27.

IPR now partly integrates application of Data Quality Indicators in line with the Insightful Board guidance. These indicators, RAG-rated across three key domains — Sign-Off and Review (S), Timeliness and Completeness (T), and Process and System (P) — serve as an effective visual tool to facilitate the analysis of data collection, review processes, and overall data quality. Currently, these indicators are applied to assess a group of clinical metrics. However, in later stages, the framework may be expanded to evaluate individual metrics and incorporating additional domains such as People and Quality.

The Trust has made specific local adaptations to the Making Data Count (MDC) approach and is actively rolling it out as it is now the recommended method for interpreting performance data across NHS trusts in England. NHS England promotes MDC as a superior alternative to traditional Red-Amber-Green (RAG) ratings and two-point comparisons, which can often lead to misinterpretation and ineffective decision-making. MDC encourages the use of Statistical Process Control (SPC) charts to analyse data over time, helping to distinguish between normal (common cause) variation and significant (special cause) changes. This enables more informed and effective decision-making. The approach is designed to be accessible to all NHS staff, including analysts, clinicians, and managers. MDC is systematically integrated into NHS performance reporting practices to enhance data interpretation and support better patient outcomes. It is closely aligned with NHS England's Insightful Board guidance, both emphasising the use of data to drive informed decision-making at the Board level. The Trust's local adaptations further enhance the effectiveness of MDC, ensuring that it meets the specific needs of our organisation and supports our ongoing commitment to data-driven decision-making.

Directorate-specific versions of the IPR continue to be shared and discussed with relevant Senior Management Teams within the two Mental Health directorates and Community Health Service, Dentistry and Primary Care directorate. Service Review meetings, where tailored pathway/service level versions of the IPR with additional workforce, finance, quality information are shared and discussed, have been taking place since April 2024 in both mental

health directorates. Interim impact assessment of outputs suggests a notable improvement in team level data accuracy, increase in staff levels of confidence when interpreting data and created opportunities for targeted initiatives to improve work practices and service delivery. Such approach is now being actively embedded within the Community Health Services, Dentistry and Primary Care directorate with similar positive impact expected within a year.

Recommendation(s)

The Board of Directors are asked to note the contents of the Integrated Performance 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	
	Nationally mandated performance measures	

Integrated Performance Report (IPR): January 2026

November 2025 data unless stated otherwise



- Guide to the Integrated Performance report
- Section 1 – NHS Oversight Framework – position overview
- Section 2.1 – Clinical Performance (Mental Health Services)
- Section 2.2 – Clinical Performance (Community Health Services, Dentistry and Primary Care)
- Section 3 – Quality and People (inc. In-Year Strategic metrics)
- Section 4 – Strategic Dashboard
- General Appendices

The Integrated Performance report (IPR) provides an 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 apart from People and Quality domains.

Clinical - these acknowledge business as usual activities to maintain performance. These are monitored against set thresholds and in line with Making Data Count principles, 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.

Clinical metrics can either be National (e.g. set out in the operational planning guidance, reported on Future NHS platform, National Oversight Framework* etc.) or Local (set at Trust or ICB level).

*National Oversight Framework (NOF) – see page 9 for details. Scored NOF metrics are marked with the following icon:  Contextual NOF metrics are marked with the following icon: 

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.

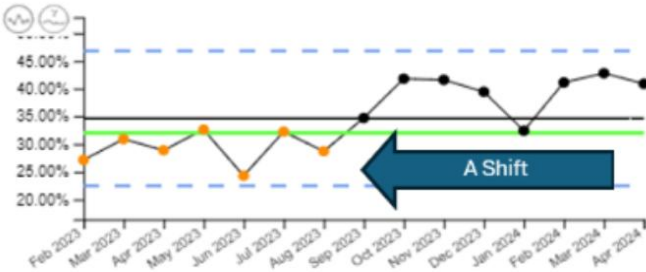
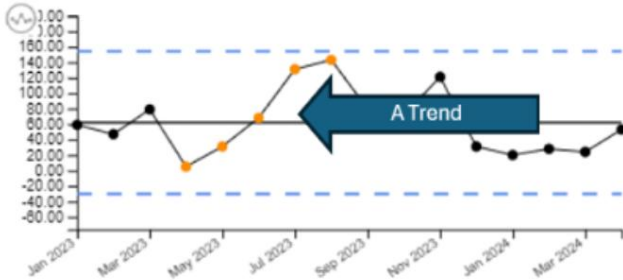
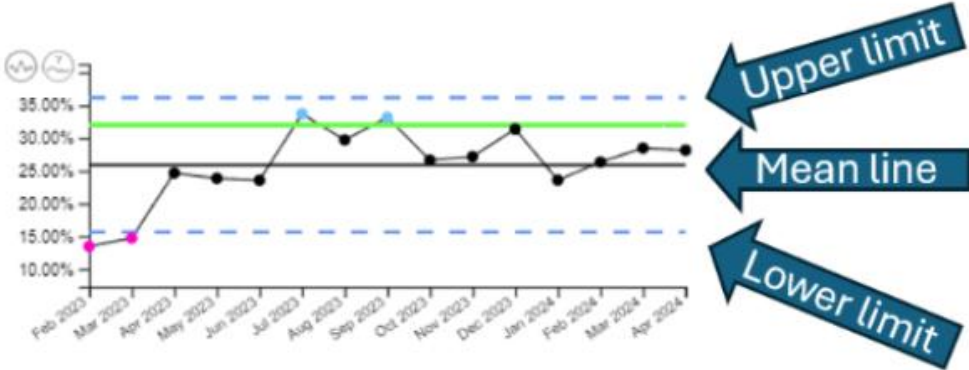
The SPC chart has three lines on it: central line (mean line; black) is the average of data and blue are upper and lower control limits. If data points are within the control limits, it indicates that the activity is within normal range. If the data points are outside of these control units, it indicates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

Upper and lower limits on an SPC chart are calculated using statistical formulas based on actual data, typically, by measuring the average and natural variation, to identify the range within which the process should operate if it remains stable.

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



Guide to the Integrated Performance Report – Interpreting summary icons

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

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Variation / performance icons			
Icon	Technical description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	Something's going on! Something, a one-off or a continued trend or shift of numbers in the wrong direction	Investigate to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	Something good is happening! Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
Assurance icons			
Icon	Technical description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

The Integrated Performance Report has been developed to reflect recommendations, where possible, provided by NHS England in the Insightful Board Guidance, the Performance Assessment Framework for 2025 – 26, Standardising Community Health Services guide and other best practice guides and examples.

The Board will receive additional information in the form of exception reporting for certain measures throughout the IPR. Rules applied to exception reporting are as follows:

- Clinical section – those in the categories of and highlighted in **orange** on the matrix:

Concerning nature  , but consistently **passing the target** 

Concerning nature   and inconsistent passing or failing the target 

Concerning nature   and **consistently failing** 

Improving nature  , but **consistently failing the target** 

No significant change  and **consistently failing the target** 

- People – narrative provided for all metrics
- Quality - narrative provided for all metrics

Metrics not falling in any of the categories above or those which may appear to be in the above categories but have an asterisk (*) next to them and system-wide measures will be reported as appendices in each of the clinical sections for information only.

These indicators provide an effective visual aid to quickly provide analysis of the collection, review and quality of the data associated with metrics. Each group of metrics are rated* against the 3 domains in the table below and relevant icons displayed alongside summary dashboards.

Symbol	Domain	Definition
S	Sign off and Review	Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	Is the required data available and up to date at the point of reporting? Are all the required data values captured and available at the point of reporting?
P	Process and System	Is there a process to assess the validity of reported data using business logic rules? Is data collected in a structured format using an appropriate digital system?

- * Green  - answers to domain questions are "yes"
Amber  - answers to domain questions are "partly"
Red  - answers to domain questions are "no"

Section 1

NHS Oversight Framework –overview

The NHS Oversight Framework (NOF) 2025/26 sets out how NHS England will assess and support NHS Foundation Trusts over the year. It is designed to provide a clear and consistent view of performance, focusing on financial sustainability, operational delivery, quality of care, and leadership capability. Under the framework, Foundation Trusts continue to be placed into one of five oversight “segments” that reflect the level of support or intervention required. The 2025/26 iteration narrows the performance metrics used, with particular emphasis on financial balance and delivery against national priorities; trusts in deficit or reliant on financial support cannot be rated in the highest segments. In addition, NHS England has introduced a Provider Improvement Programme for the most challenged organisations and a provider capability assessment covering domains such as governance, leadership and operational resilience. For Foundation Trusts, the framework is therefore both a performance management tool and a structured route to targeted support where it is most needed.

Metric categories for Segment determination are grouped into six domains, five of which are scoring (i.e. they contribute directly to the organisational delivery score used for segmenting) and one of which is contextual (used for oversight/planning, but not part of the scored segment). The six domains are:

1. Access to services
2. Effectiveness and experience of care
3. Patient Safety
4. People and workforce
5. Finance and productivity
6. Improving Health and Reducing inequality (this domain is entirely contextual for 2025 – 26)

Each scored metric is given a score 1 to 4 (1 = high performance, 4 = low) based on defined benchmarks and relative performance among similar trusts. Scores across metrics are averaged to give domain scores and an overall Organisational Delivery Score. There is a financial override – trusts in deficit or receiving deficit support cannot be placed in segment higher than 3, regardless of their other metric performance. The Oversight Segments for NHS Foundation Trusts are:

- Segment 1 – maximum autonomy
- Segment 2 – targeted support
- Segment 3 – mandated support
- Segment 4 – significant support needs
- Segment 5 – Provider Improvement Programme (PIP)

Foundation Trusts are formally segmented once a year, providing a baseline assessment of performance and capability. However, segments are not fixed for 12 months; NHS England reviews data throughout the year and can re-segment a trust at any point if there is a material improvement or deterioration in areas such as finance, access, quality or leadership. Quarterly monitoring and provider capability reviews play a key role in determining whether a trust remains in its current segment or requires escalation or de-escalation. NOF League table provides a view of how each NHS trust is performing compared to one another (ranking).

For more information, please see [NHS England » NHS Oversight Framework and 2025/26](#) and [Home - NHS England Data Dashboard](#)

Oxford Health NHS Foundation Trust’s NOF segmentation and ranking on the League table as per latest publication (11th December 2025; Quarter 2):

Headlines	Q1 2025/26		Q2 2025/27	
	NOF score	Placement among peers	NOF score	Placement among peers
Segment	1 (High performing)		1 (High performing)	
Average metric score	2.03		2.06	
Financial override	No		No	
Is the organisation in the Recovery Support Programme?	No		No	
Ranking among Non-Acute hospital	13 out of 61		15 out of 61	

Green

– High performing (NOF score 1 – 1.99)

Light green

– Above average (NOF score 2 – 2.99)

Pink

– Below average (NOF score 3 – 3.99)

Red

– Low performing (NOF score 4)

– peer average (South East region)

NHS Oversight Framework – dashboard (scored metrics) – quarter 2

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Domain	Metric	Metric score	Metric ranking	Metric reporting period	Metric value	Metric value change*	Average value (other providers)	NOF score	NOF score placement (national distribution)
Access to services	Percentage of patients waiting over 52 weeks for community services	3.65	37 out of 41	Sep-25	18.58%	↑	0.38%	2.75	
	Annual change in number of children and young people accessing NHS-funded Mental Health services	1.83	15 out of 49	Oct 24 – Sep 25 vs Oct 23 – Sep 24	13.41%	↓	7.26%		
Effectiveness and experience of care	CQC community mental health survey satisfaction rate	2	n/a	2024	.	n/a	.	1.89	
	Percentage of patients with >60-day length of stay (adult acute mental health; quarter)	1.45	8 out of 47	Q2 2025/26	18.06%	↑	23.63%		
	Urgent Community Response 2-hour performance (quarter)	2.22	25 out of 38	Q2 2025/26	83.32%	↑	88.53%		
Patient Safety	NHS Staff Survey - raising concerns sub-score	1.65	14 out of 61	2024	6.99	→	6.81	1.97	
	Percentage of patient in mental health crisis to receive face-to-face contact within 24 hours	2.29	20 out of 48	Q2 2025/26	63.13%	↓	59.52%		
People and workforce	Sickness absence rate	1.96	12 out of 61	Q1 2025/26	4.46%	↑	5.10%	1.83	
	NHS Staff Survey engagement theme sub-score	1.7	15 out of 61	2024	7.24	→	7.08		
Finance and productivity	Planned surplus/deficit score	1	9 out of 61	2025/26	0.67%	→	0.00%	1.96	
	Variance year-to-date to financial plan score	1	24 out of 61	Sep-25	0.01%	↓	0.00%		
	Relative difference in costs score	2.93	38 out of 61	2024/25	108.58	↓	104.85		

* - see dashboard on page 85 of this report for quarter 1 performance

↑ - improvement ↓ - regression → - no change

NHS Oversight Framework – dashboard (contextual (non-scored) metrics) – quarter 2

Board Meeting in Public

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Domain	Metric	Metric reporting period	Metric score	Peer average	National value	NOF score placement (national distribution)
Access to services	Percentage increase in Overall access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12-month period compared with the previous year)	To Jun-25	53.76%	5.79%	5.72%	
	Proportion of patients with an open suspected autism referral that has been open for at least 13 weeks that have not had a care contact appointment recorded	Mar-24	88.75%	89.88%	77.39%	
Patient safety	Rate of restrictive interventions use per 1,000 bed days	To Jun-25	33	18.5	22	
People and workforce	National Education and Training Survey "Overall experience" score	2024	80.22	75.70	77.03	
Improving health and reducing inequality	Percentage of inpatients aged 65 years and over with a length of stay at discharge exceeding 90 days	Jun-25	21.43%	45.08%	41.86%	

Section 2.1

Clinical performance

(National Mental Health Standards)

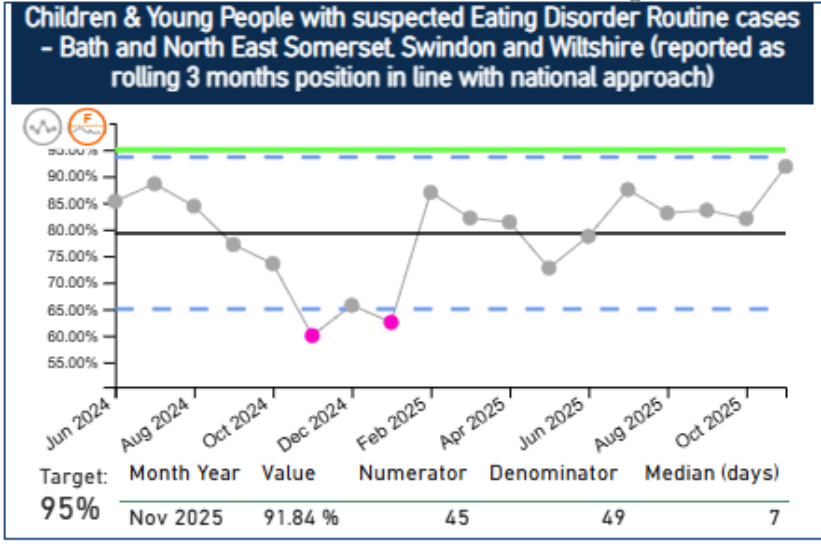
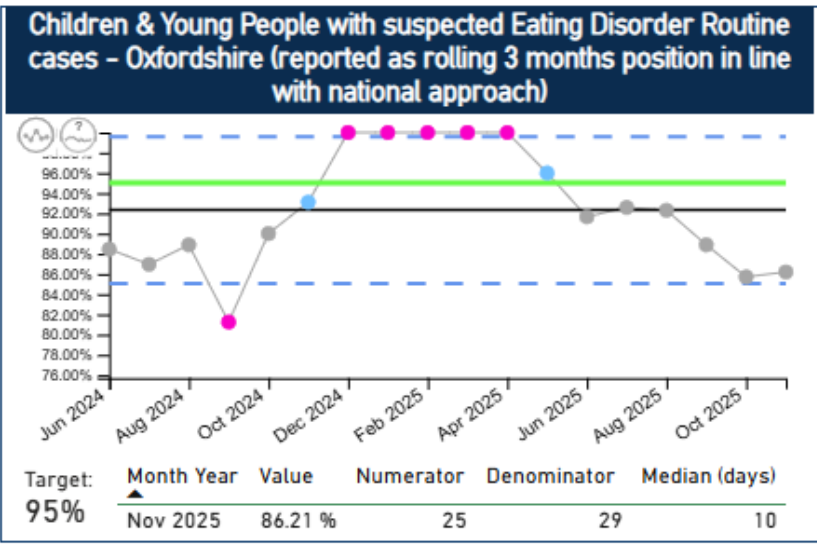
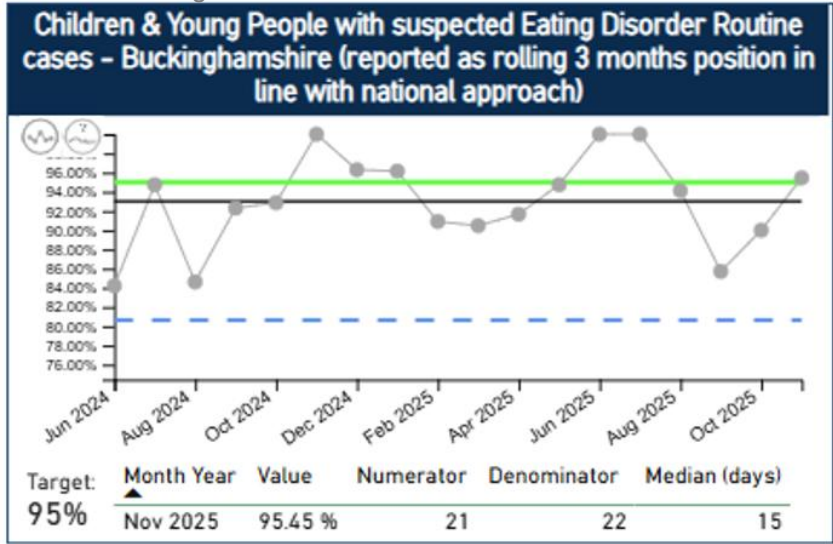
Assurance

				No target
 	- Improve access to mental health support for children and young people – Buckinghamshire, Oxfordshire and Bath & North-East Somerset, Swindon and Wiltshire - Improve access for Adults and Older Adults to support by community mental health services – Buckinghamshire and Oxfordshire - Number of people accessing Individual Placement Support (IPS) – Buckinghamshire and Oxfordshire (rolling 12 months) - CYP % referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days – Oxfordshire - Improve access to perinatal mental health services – Oxfordshire and Buckinghamshire combined	- CYP Four week wait (interim metric – one meaningful contact within pathway) – Buckinghamshire, Oxfordshire - Response from Mental Health Psychiatric Liaison within 24 hours – Oxfordshire - Mental Health 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 - Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care (PICU) discharges (combined; rolling three months) – Buckinghamshire		
	- Response from Mental Health Psychiatric Liaison within 24 hours – Buckinghamshire - Response from Mental Health Psychiatric Liaison within 1 hour – Buckinghamshire and Oxfordshire % of people experiencing first episode of psychosis treated with a NICE approved care package within two weeks of referral – Oxfordshire 72 hour follow up for those discharged from mental health wards – older adults – Buckinghamshire - Adult Four week wait standard (interim metric – two contacts within pathway) – Oxfordshire and Buckinghamshire	- CYP Four week wait (interim metric – one meaningful contact within pathway) –Bath & North-East Somerset, Swindon and Wiltshire - CYP % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks – Buckinghamshire - CYP % referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days –Bath & North-East Somerset, Swindon and Wiltshire and Buckinghamshire - Response from Mental Health Crisis Service within 4 hours (very urgent) – Oxfordshire and Buckinghamshire - Response from Mental Health Crisis Service within 24 hours (urgent) – Oxfordshire and Buckinghamshire % of people experiencing first episode of psychosis treated with a NICE approved care package within two weeks of referral – Buckinghamshire - Mental Health 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 - Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care (PICU) discharges (combined; rolling three months) – Oxfordshire 72 hour follow up for those discharged from mental health wards – adults – Buckinghamshire and Oxfordshire 72 hour follow up for those discharged from mental health wards – older adults – Oxfordshire % of patients responding that overall care was good of very good % of patient report being involved in their care	CYP % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Bath & North-East Somerset, Swindon and Wiltshire Mental Health 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	% older adult readmission within 30 days for mental health – Oxfordshire % adult acute readmissions within 30 days for mental health – Buckinghamshire and Oxfordshire - Percentage of adult inpatients with a length of stay over 60 days (discharged patients) – Oxfordshire - Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) – Buckinghamshire and Oxfordshire - Average number of clinically ready for discharge patients per day – Buckinghamshire and Oxfordshire
 		CYP % referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire Mental Health 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		- Percentage of adult inpatients with a length of stay over 60 days (discharged patients) – Buckinghamshire % older adult readmission within 30 days for mental health – Buckinghamshire

Assurance

				No target
 	% of people receiving first treatment appointment within 18 weeks of referral – Buckinghamshire and Oxfordshire Talking Therapies	Meet and maintain at least 52% Talking Therapies recovery rate – Buckinghamshire Talking Therapies		- Inappropriate older adult acute mental health out of area placements - beds days in month – Buckinghamshire % of those completing a course of treatment for anxiety and depression who are older adults (65 and over) – Oxfordshire Talking Therapies - Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month – Oxfordshire - Inappropriate adult acute mental health out of area placements - beds days in month – Oxfordshire
	% of people receiving first treatment appointment within 6 weeks of referral – Buckinghamshire and Oxfordshire Talking Therapies - Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) – Buckinghamshire and Oxfordshire Talking Therapies	- Increase the number of adults and older adults completing a course of treatment for anxiety and depression – Buckinghamshire and Oxfordshire Talking Therapies - Reliable improvement rate for those completed a course of treatment adult and older adults combined – Buckinghamshire and Oxfordshire Talking Therapies - Reliable recovery rate for those completed a course of treatment adults and older adults combined – Buckinghamshire and Oxfordshire Talking Therapies - Meet and maintain at least 52% Talking Therapies recovery rate – Oxfordshire Talking Therapies - Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined – Buckinghamshire and Oxfordshire Talking Therapies - Recovery rate for White British - complete a course of treatment, adult and older adult combined - Buckinghamshire and Oxfordshire Talking Therapies - Inappropriate adult acute mental health out of area placements - snapshot last day month – Buckinghamshire and Oxfordshire		% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) – Buckinghamshire Talking Therapies - Inappropriate older adult acute mental health out of area placements - snapshot last day month – Oxfordshire and Buckinghamshire - Inappropriate adult acute mental health out of area placements - beds days in month – Buckinghamshire - Inappropriate older adult acute mental health out of area placements - beds days in month – Oxfordshire and Buckinghamshire - Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month – Buckinghamshire
 				Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month – Buckinghamshire and Oxfordshire

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National NOF (scored)	Improve access to mental health support for children and young people - Buckinghamshire	>=6612	Nov-25	7104		.	6406
National NOF (scored)	Improve access to mental health support for children and young people - Oxfordshire	>=9444	Nov-25	8837		.	8063
National NOF (scored)	Improve access to mental health support for children and young people - Bath & North-East Somerset, Swindon and Wiltshire	tbc	Nov-25	6738		.	6370
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Buckinghamshire	>=62% National average	Nov-25	80.09%			68.12%
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Oxfordshire	>=62% National average	Nov-25	75.77%			54.26%
National Strategic - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Bath & North-East Somerset, Swindon and Wiltshire	>=62% National average	Nov-25	48.94%			54.46%
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Buckinghamshire (rolling 3 months position)	>=95%	Nov-25	95.45%			93.01%
National	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Oxfordshire (rolling 3 months position)	>=95%	Nov-25	86.21%			92.08%
National	% 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-25	91.84%			79.33%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Buckinghamshire (rolling 3 months position)	>=95%	Nov-25	88.89%			93.50%
National	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire (rolling 3 months position)	>=95%	Nov-25	100%			88.70%
National	% 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-25	86.67%			90.75%



Understanding the performance

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, 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 2025 performance includes September, October and November 2025 performance. Patients who choose to be seen outside of the 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.

Buckinghamshire’s service met the target in November 2025. In Oxfordshire, two (2) breaches occurred in September – one (1) due to patient choice and one (1) due to transition to Adult ED service, one (1) breach in October due to delayed internal communication between Single Point of Access and service and one (1) in November due to patient choice. In Bath and North East Somerset, Swindon and Wiltshire service, there were two (2) breaches in September due to limited capacity, no breaches occurred in October and two (2) in November - one (1) due to limited capacity and one (1) due to patient choice.

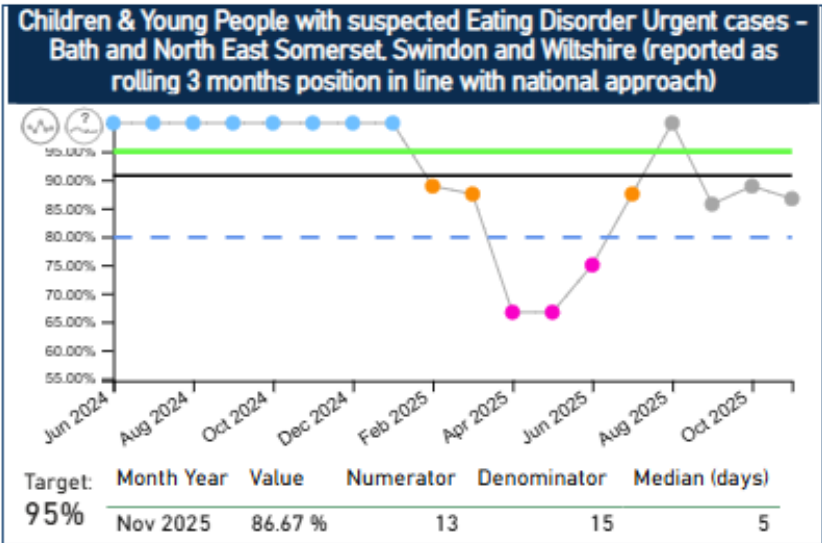
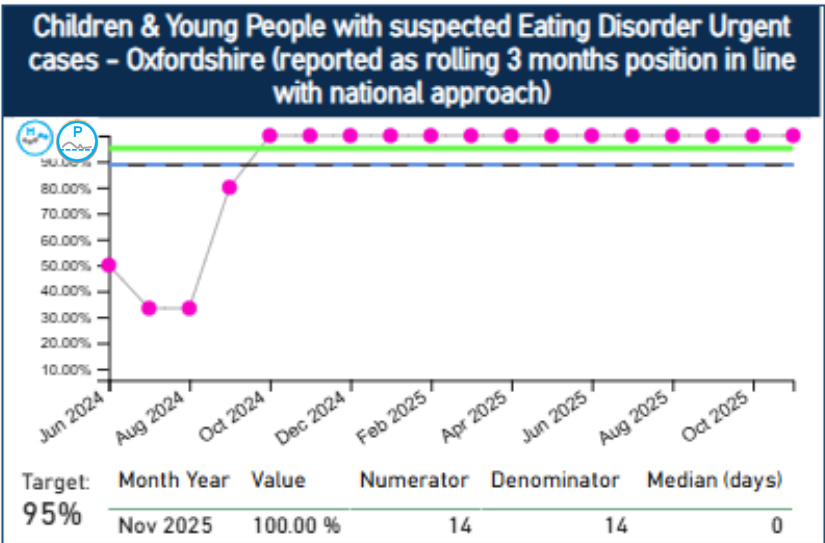
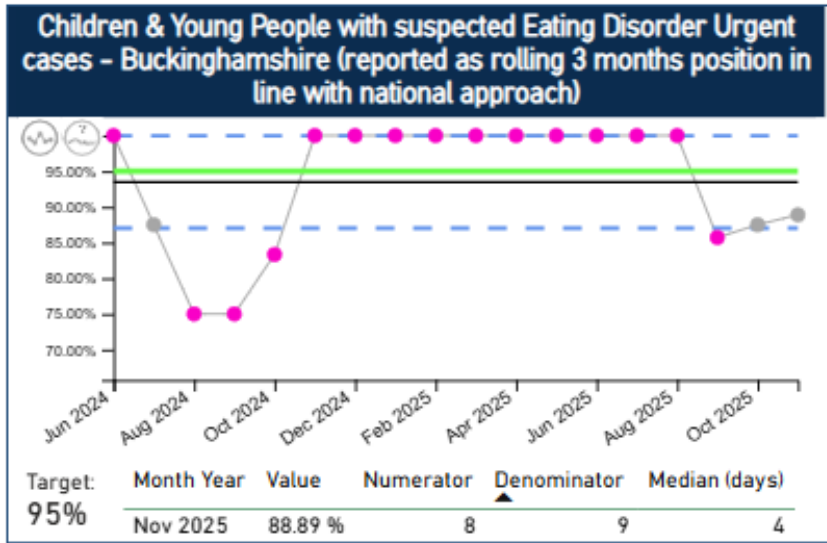
*SNOMED is a comprehensive, multilingual clinical terminology system used in healthcare.

Actions (SMART)

- Continuation of Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement.
- Review of capacity in each of the Eating Disorders teams to improve forward planning and pre-empt demand peaks. Strengthen communication, so team can act rapidly when activity spikes

Risks

Delays in treatment can increase the likelihood of deterioration of mental and physical health as well demand on emergency and inpatient services. Finally, longer than expected waiting times can lead to disengagement from young people and their families/carers, which in turn could undermine trust in services and worsen outcomes particularly for conditions like disordered eating where early and sustained therapeutic relationships are crucial.



Understanding the performance

This metric measures urgent referrals seen within 7 days where the referral reason is “Eating Disorders” and age of patient is between 0 – 18 years, 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 2025 performance includes September, October and November 2025 performance. Patients who choose to be seen outside of the 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.

Oxfordshire’s service continues meeting the target. In Buckinghamshire, one (1) urgent breach was related to patient choice, no breaches occurred in October and November. In Bath and North East Somerset, Swindon and Wiltshire service, there was one (1) breach in September due to patient choice, no breaches in October and one (1) in November due to difficulty contacting patient (seen on day 7, however, outside of the hourly timeframe).

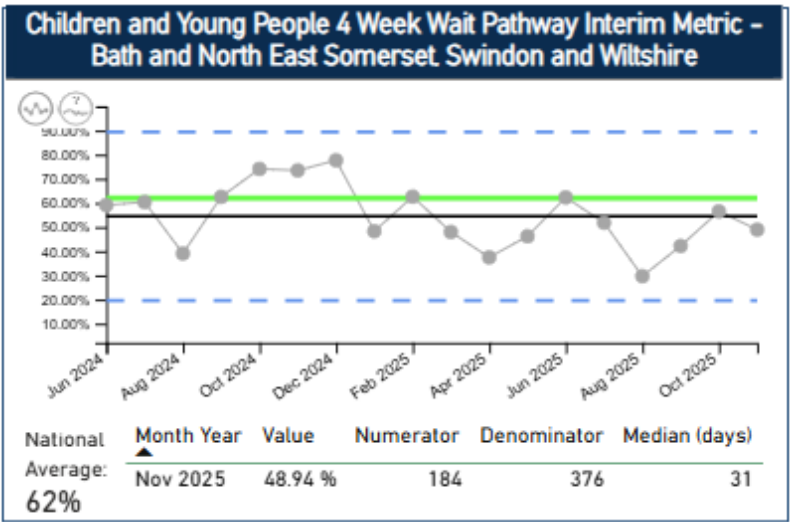
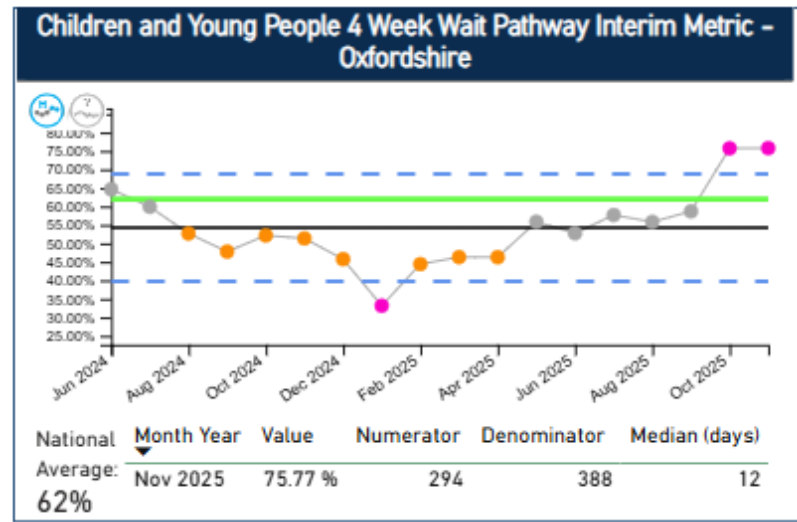
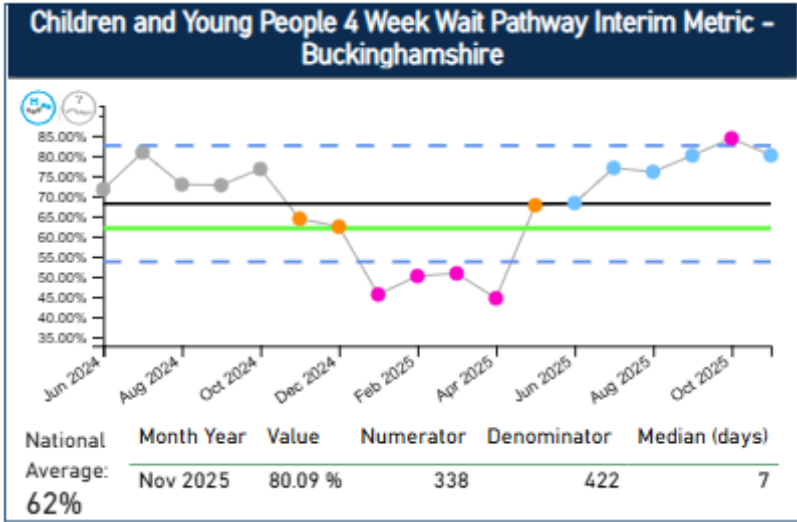
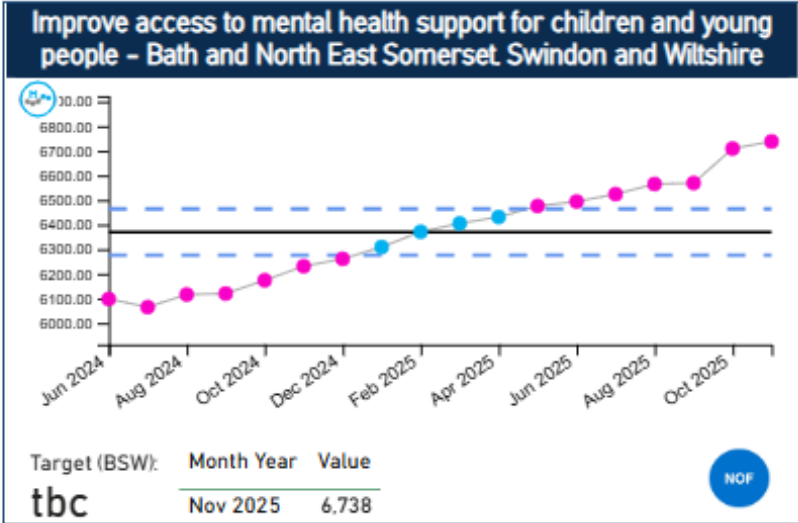
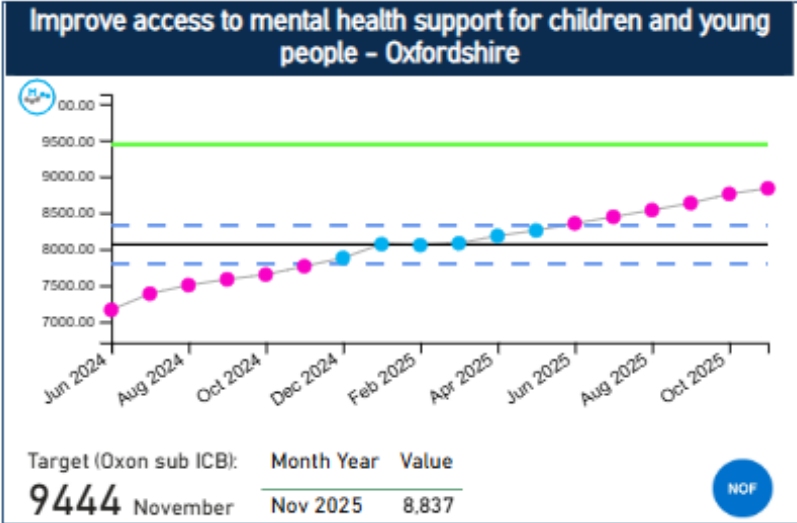
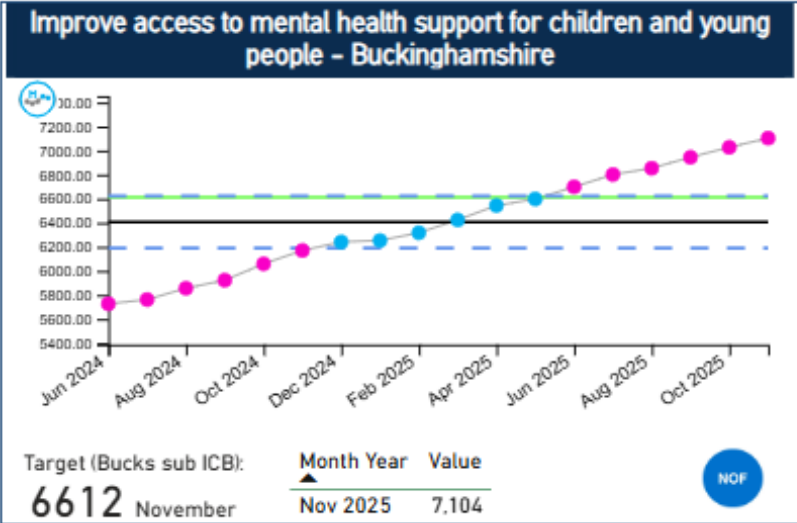
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Actions (SMART)

- Continuation of Internal team level performance monitoring and improvement meetings taking place regularly to support teams with data recording, reporting, identifying causes and solutions for improvement.

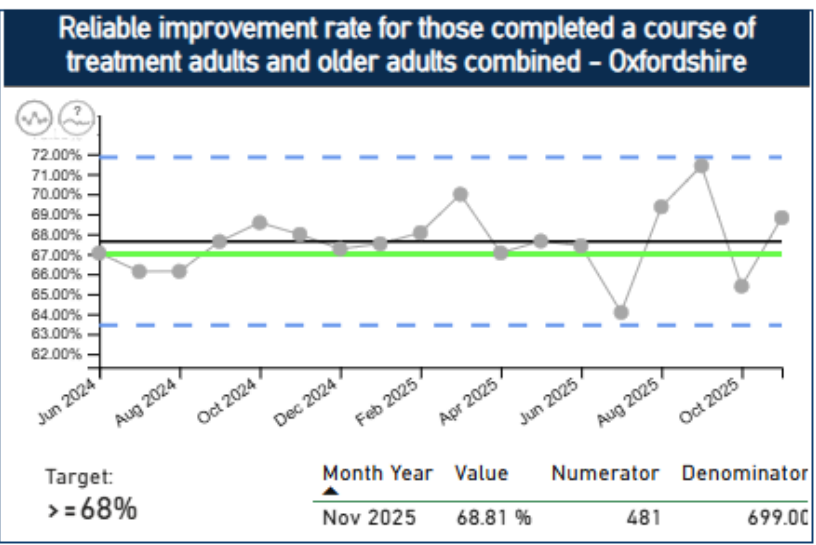
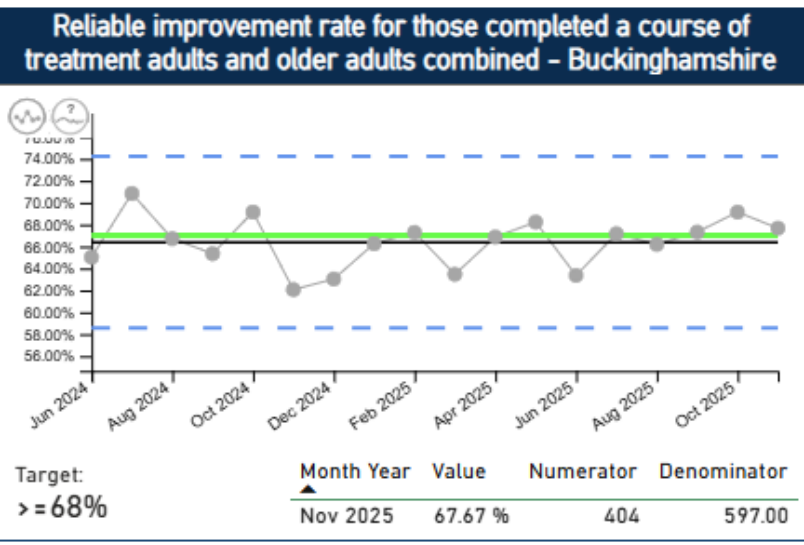
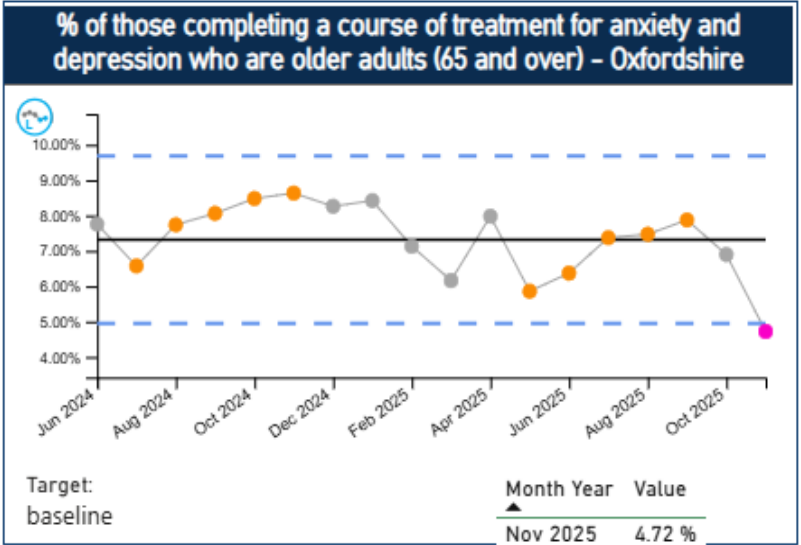
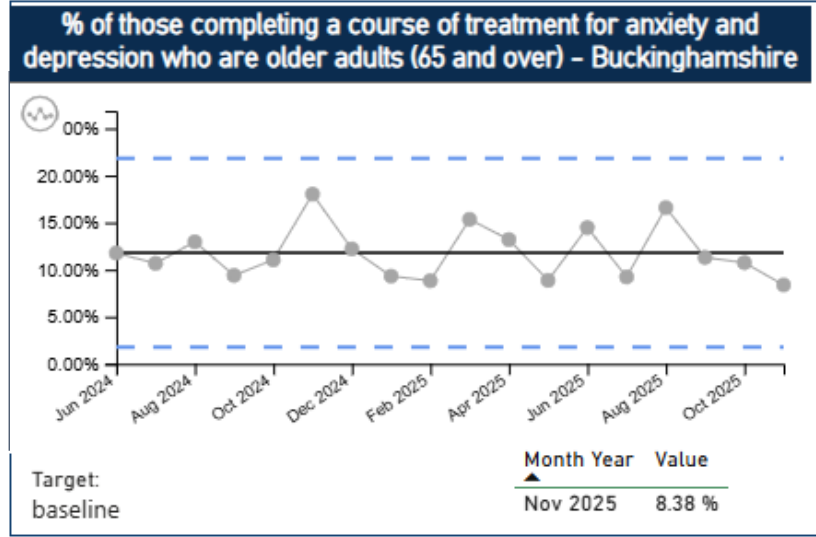
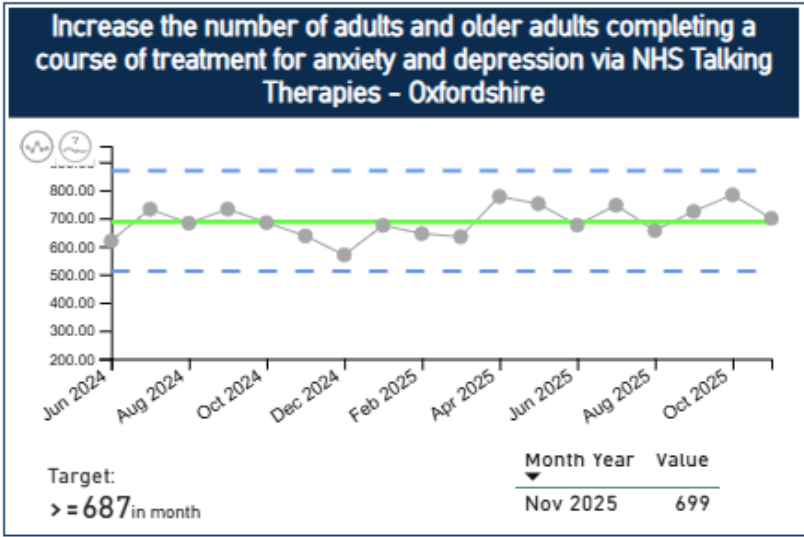
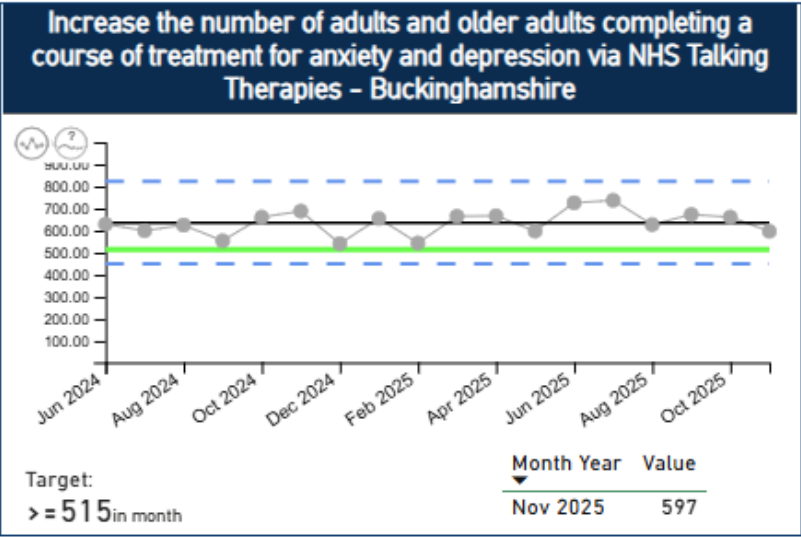
Risks

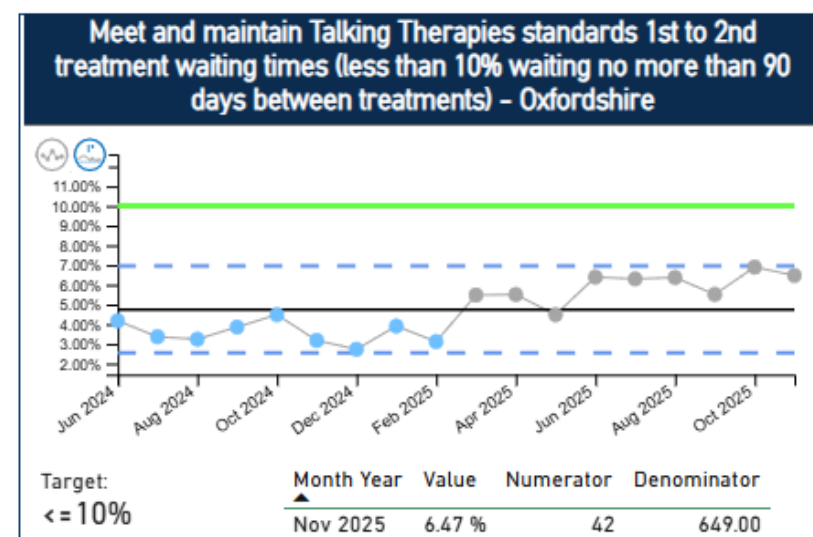
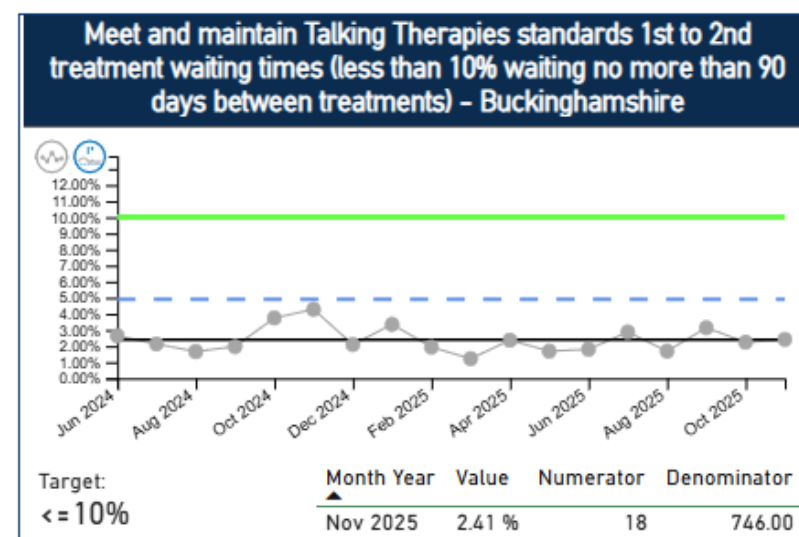
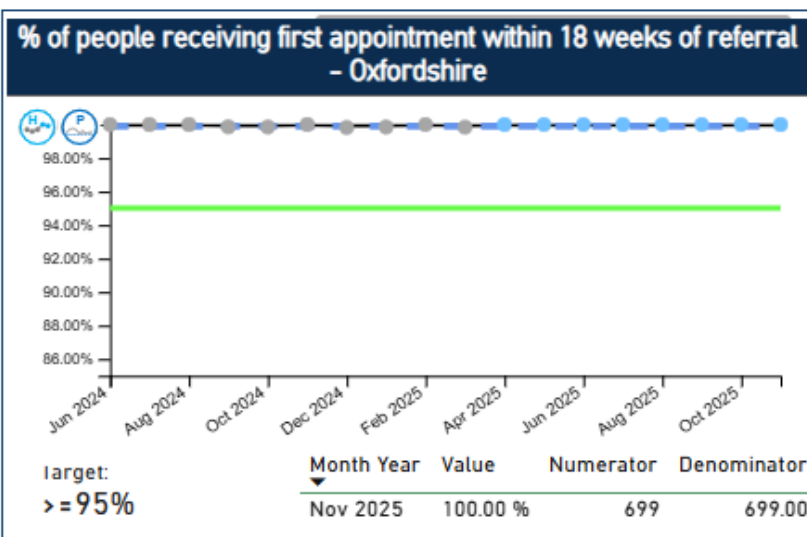
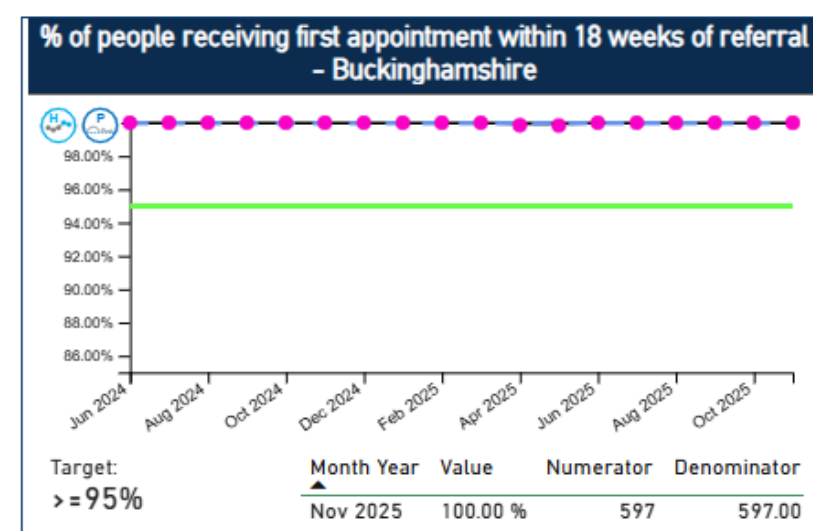
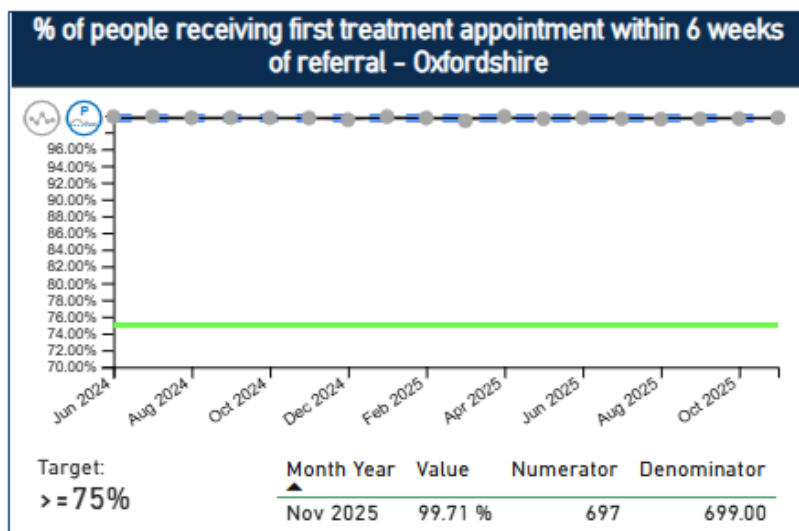
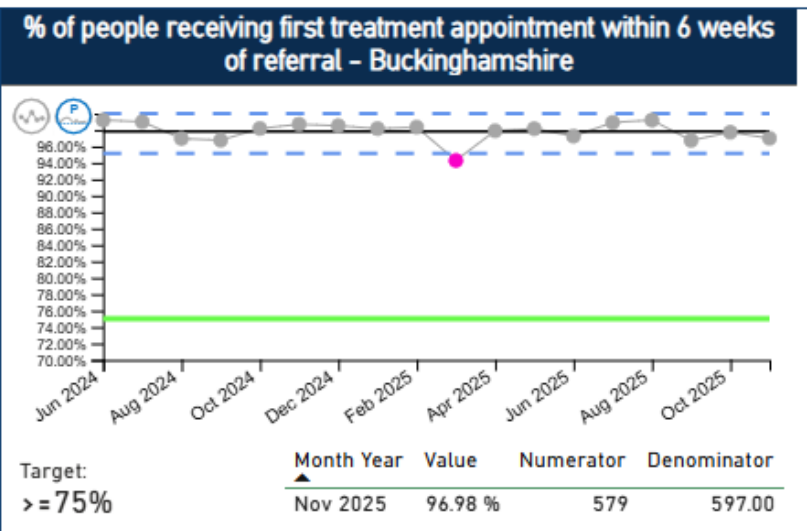
Delays in treatment can increase the likelihood of deterioration of mental and physical health as well demand on emergency and inpatient services. Finally, longer than expected waiting times can lead to disengagement from young people and their families/carers, which in turn could undermine trust in services and worsen outcomes particularly for conditions like disordered eating where early and sustained therapeutic relationships are crucial.

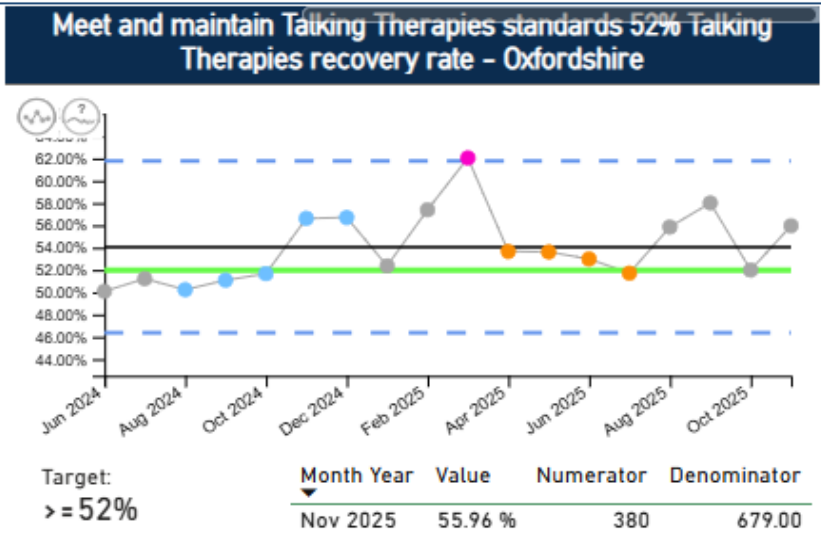
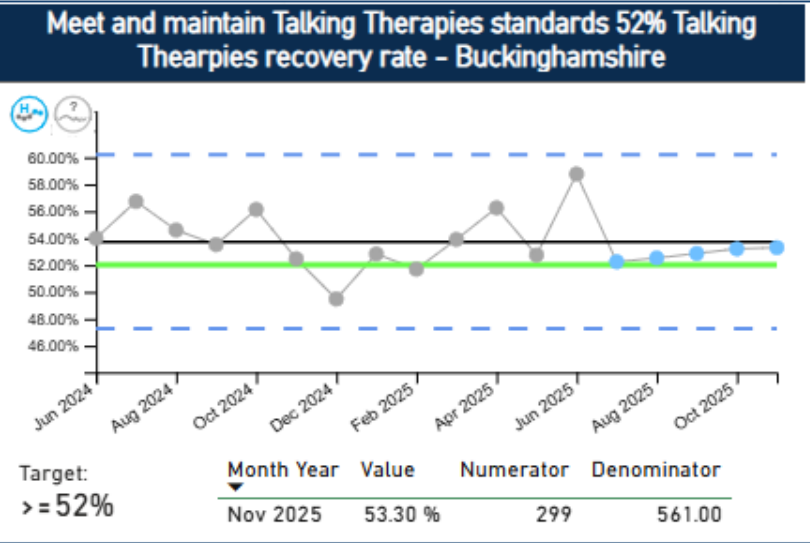
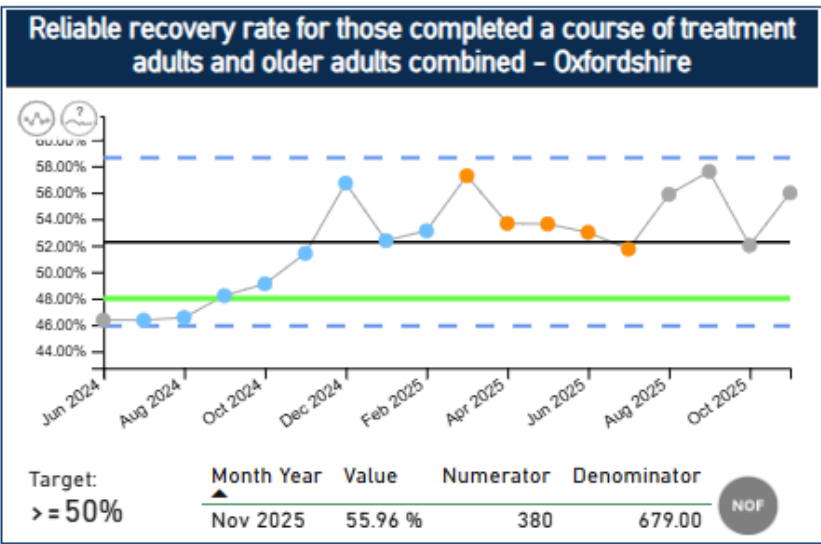
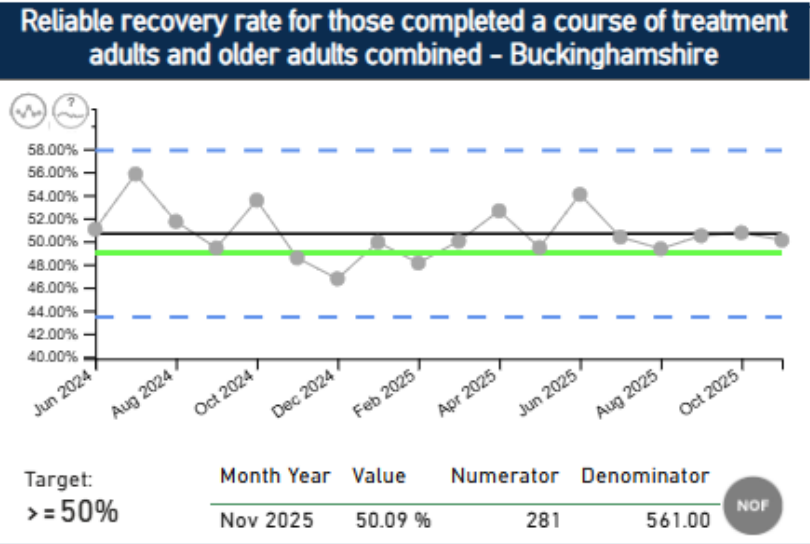


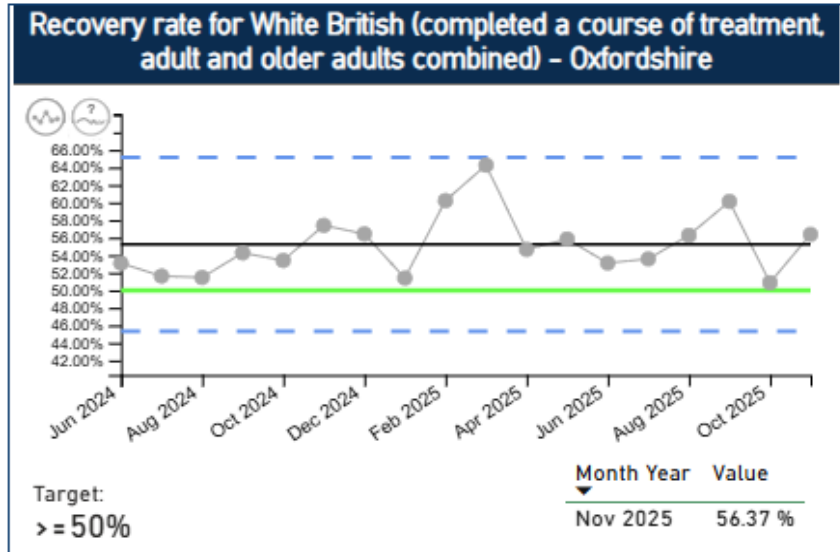
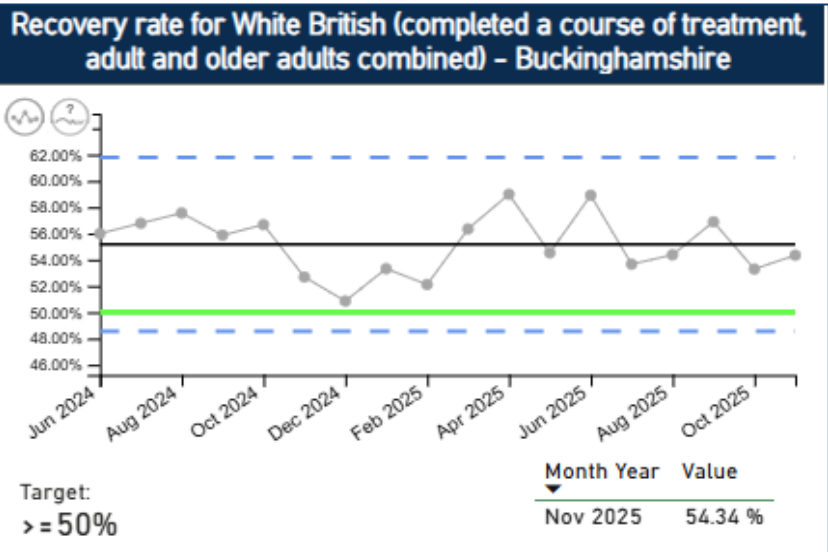
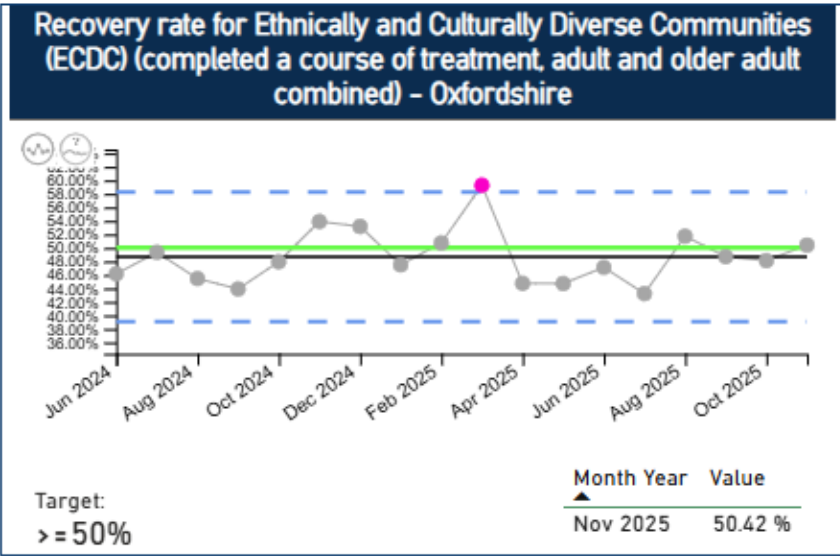
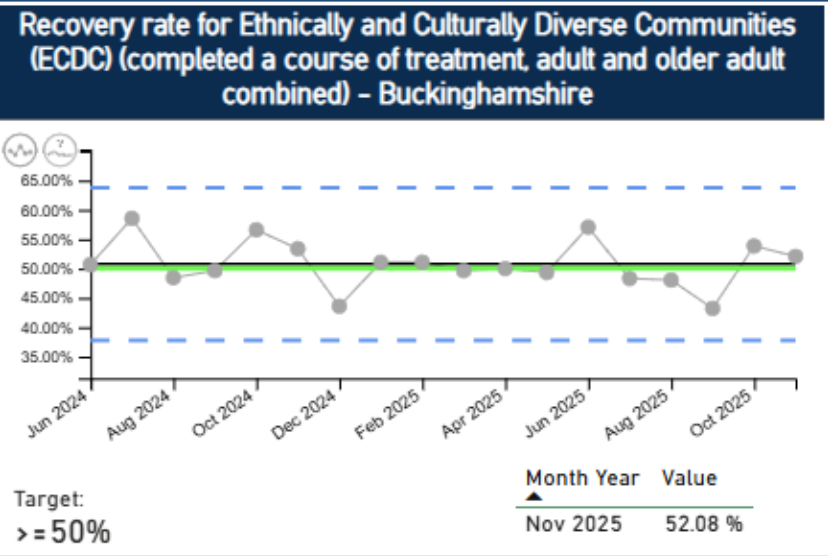
Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Buckinghamshire	>=515	Nov-25	597			636
National	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	>=687	Nov-25	699			690
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire	.	Nov-25	8.38%		n/a	11.79%
National	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	.	Nov-25	4.72%		n/a	7.32%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	>=68%	Nov-25	67.67%			66.39%
National	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	>=68%	Nov-25	68.81%			67.63%
National	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	>=75%	Nov-25	96.98%			97.83%
National	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	>=75%	Nov-25	99.71%			99.67%
National	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	>=95%	Nov-25	100%			99.98%
National	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	>=95%	Nov-25	100%			99.96%
National	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-25	2.41%			2.40%
National	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-25	6.47%			4.75%

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
<i>National NOF (contextual)</i>	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	>=50%	Nov-25	50.09%			50.67%
<i>National NOF(contextual)</i>	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	>=49%	Nov-25	55.96%			52.26%
<i>National</i>	Meet and maintain at least 52% Talking Therapies recovery rate - Buckinghamshire	>=52%	Nov-25	53.30%			53.73%
<i>National</i>	Meet and maintain at least 52% Talking Therapies recovery rate - Oxfordshire	>=52%	Nov-25	55.96%			54.07%
<i>National</i>	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Buckinghamshire	>=50%	Nov-25	52.08%			50.81%
<i>National</i>	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	>=50%	Nov-25	50.42%			48.68%
<i>National</i>	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Buckinghamshire	>=50%	Nov-25	54.34%			55.17%
<i>National</i>	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire	>=50%	Nov-25	56.37%			55.24%









Mental Health Services – Adult and Older Adult Community - summary

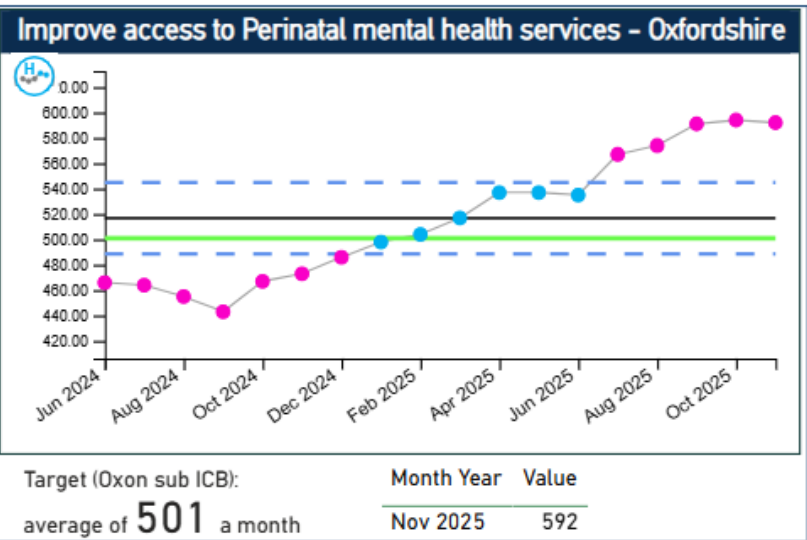
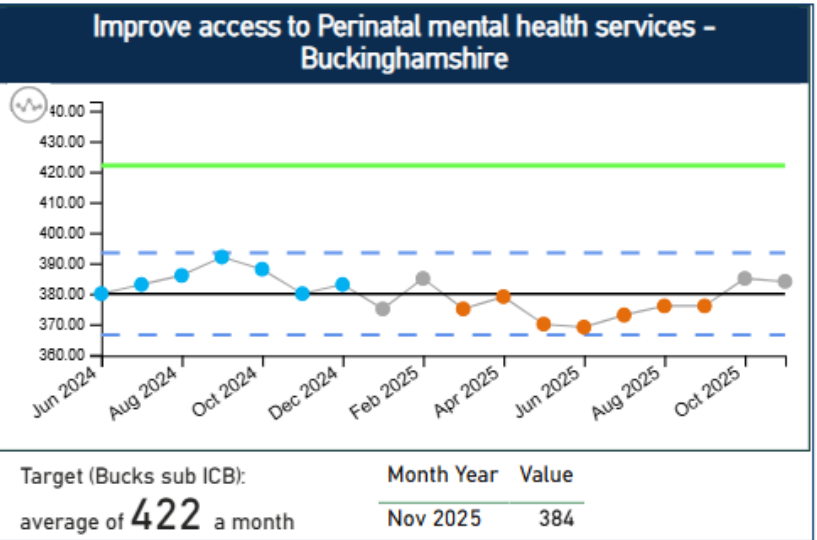
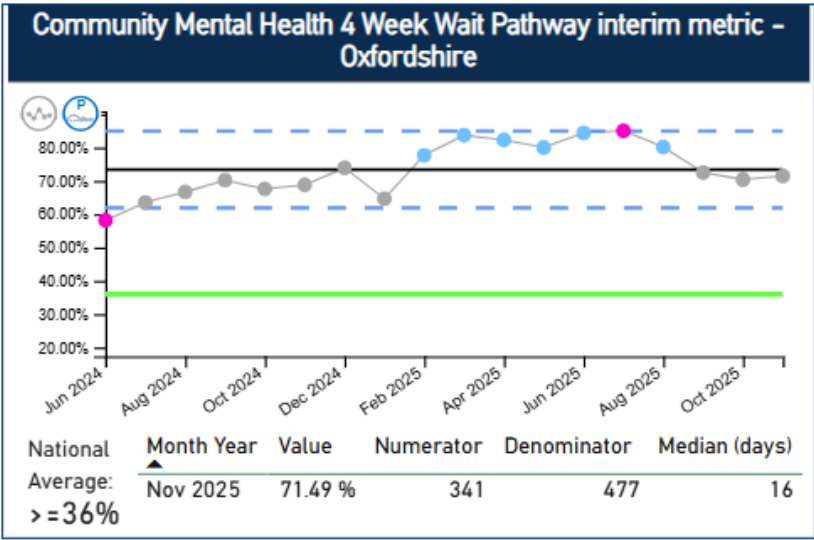
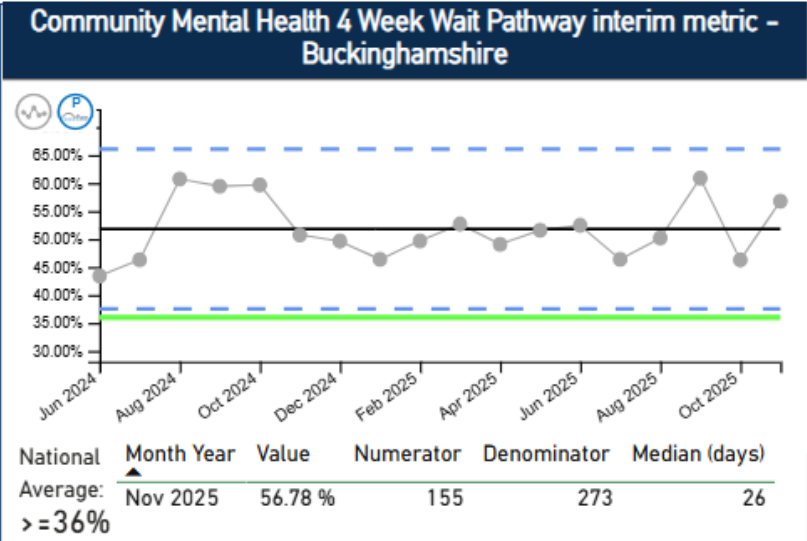
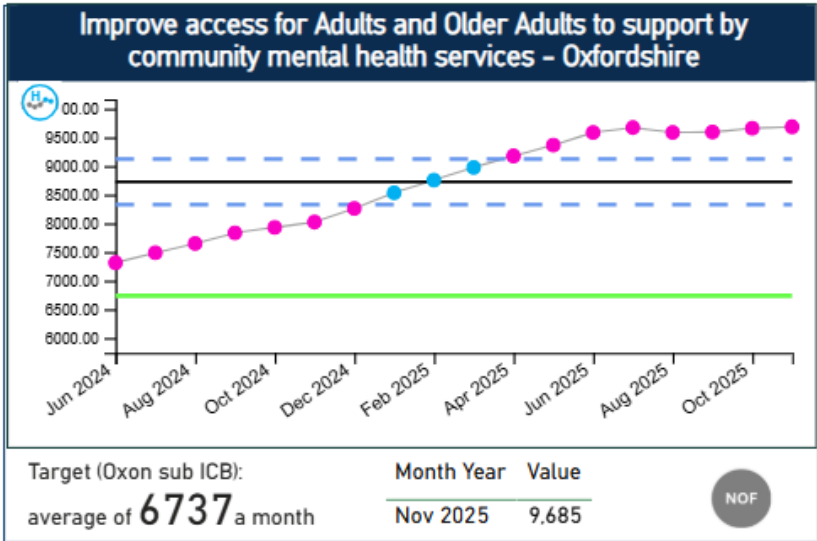
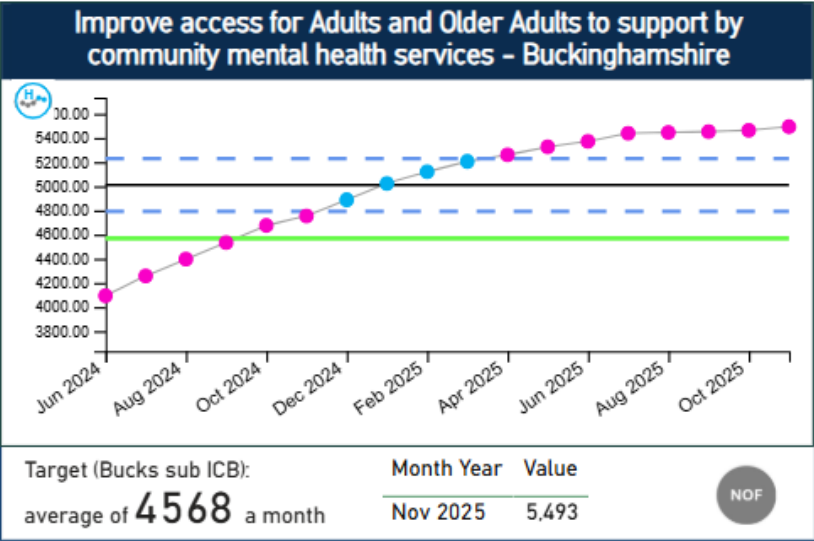
Board Meeting in Public

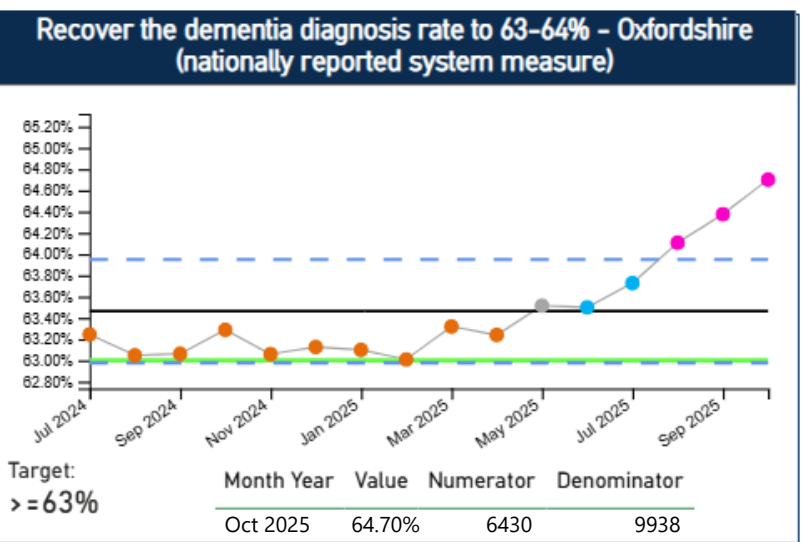
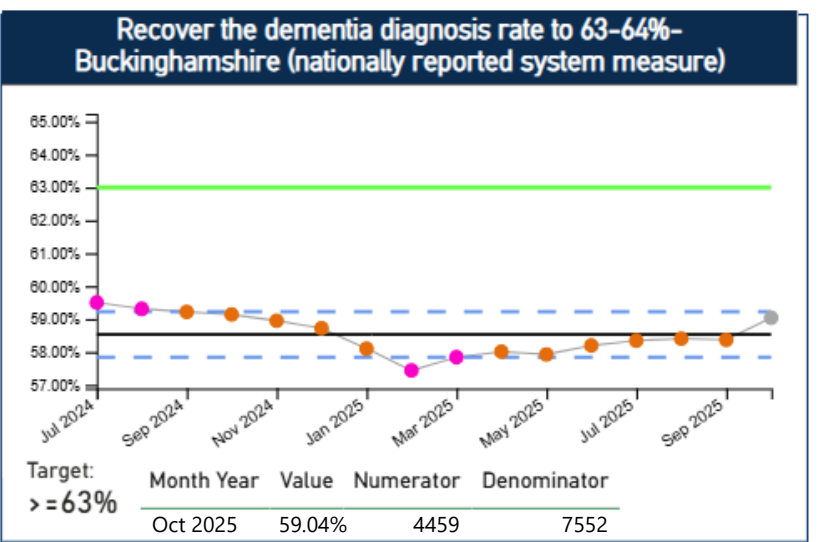
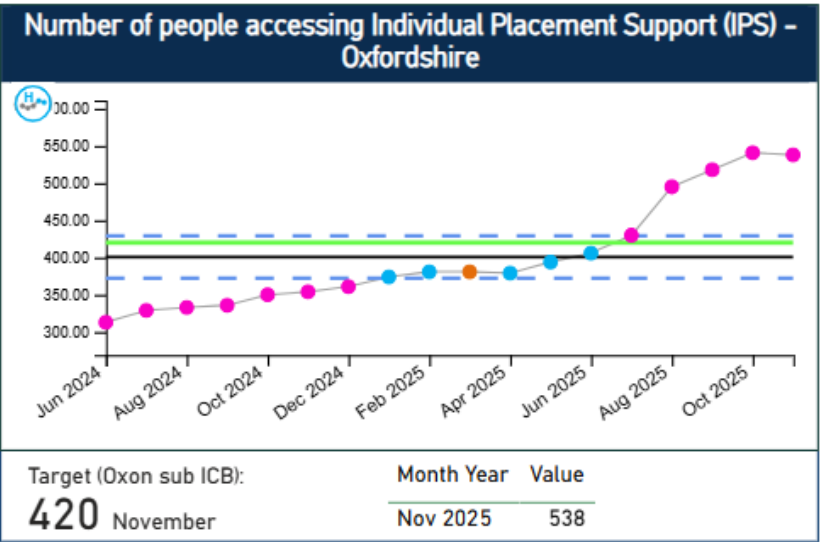
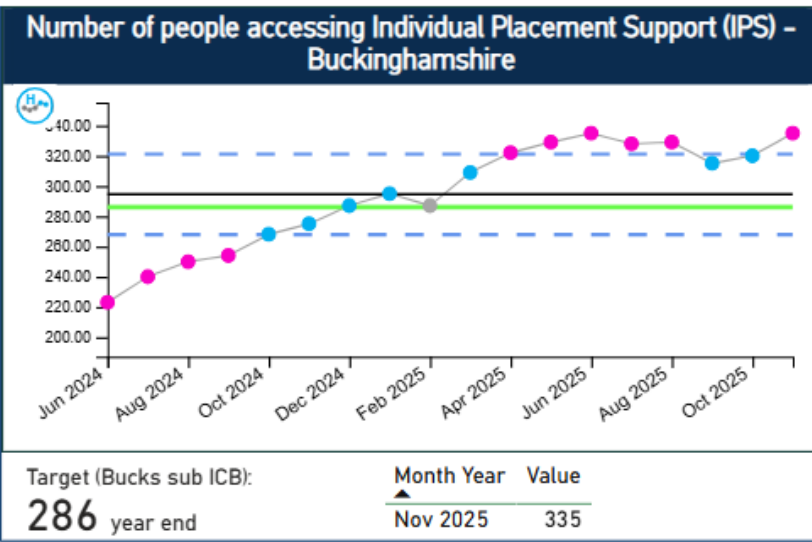
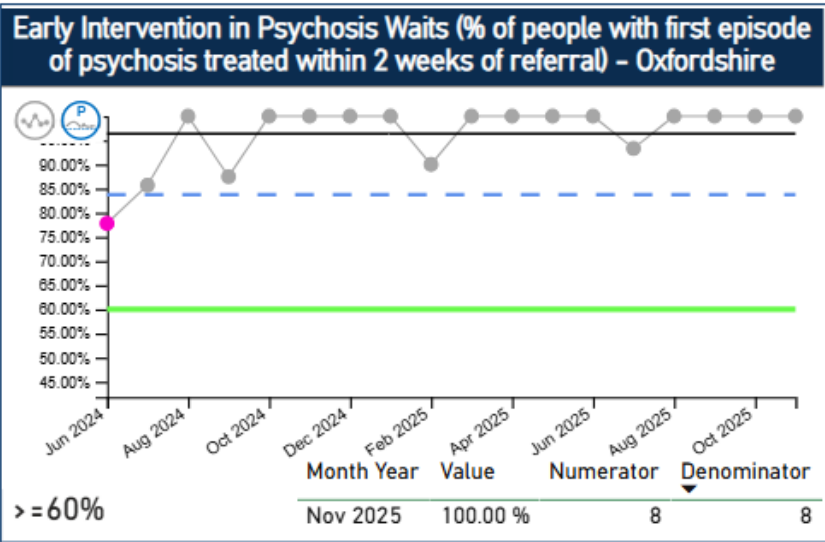
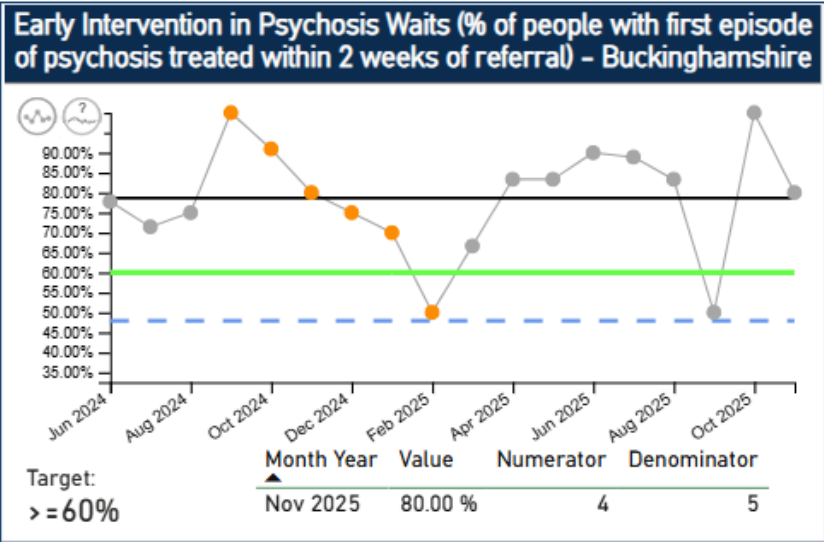


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Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
<i>National NOF(contextual)</i>	Improve access for Adults and Older Adults to support by community mental health services - Buckinghamshire	>=4568	Nov-25	5493		.	5011
<i>National NOF(contextual)</i>	Improve access for Adults and Older Adults to support by community mental health services - Oxfordshire	>=6737	Nov-25	9685		.	8726
<i>National</i>	4 week wait (28 days) standard (interim metric - two contacts within pathway) - Buckinghamshire	>=36% National average	Nov-25	56.78%			51.79%
<i>National</i>	4 week wait (28 days) standard (interim metric - two contacts within pathway)- Oxfordshire	>=36% National average	Nov-25	71.49%			73.41%
<i>National</i>	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Buckinghamshire)	>=60%	Quarterly metric – Quarter 3 data not due until February 2026				
<i>National</i>	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Oxfordshire)	>=60%	Quarterly metric – Quarter 3 data not due until February 2026				
<i>National</i>	Improve access to perinatal mental health services - Buckinghamshire (rolling 12 months)	>=422	Nov-25	384		.	380
<i>National</i>	Improve access to perinatal mental health services - Oxfordshire (rolling 12 months)	>=501	Nov-25	592		.	517
<i>National</i>	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire	>=60%	Nov-25	80%			78.65%
<i>National</i>	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	>=60%	Nov-25	100%			96.35%
<i>National</i>	Number of people accessing Individual Placement Support (IPS) - Buckinghamshire (rolling 12 months)	>=286	Nov-25	335		.	294
<i>National</i>	Number of people accessing Individual Placement Support (IPS) - Oxfordshire (rolling 12 months)	>=410	Nov-25	538		.	401
<i>National</i>	Recover dementia diagnosis rate (nationally reported system measure - Buckinghamshire)	>=63%	Oct-25	59.04%	.	.	58.50%
<i>National</i>	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	>=63%	Oct-25	64.70%	.	.	63.50%

Mental Health Services – Adult and Older Adult Community - appendices





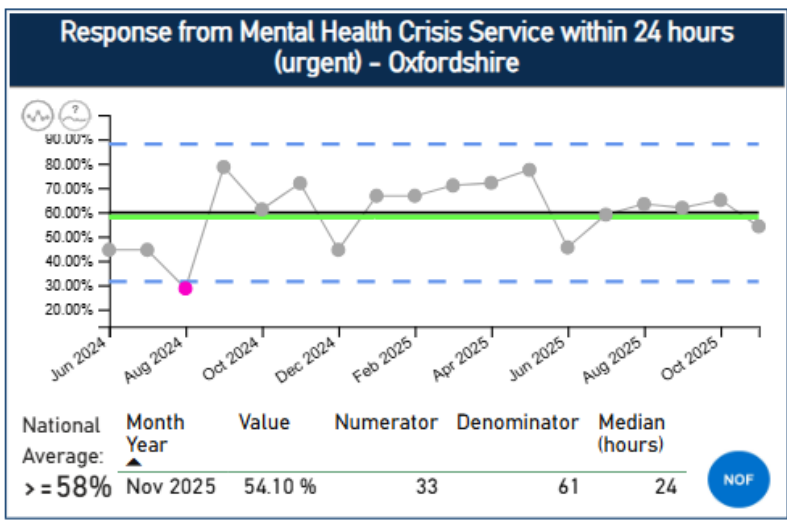
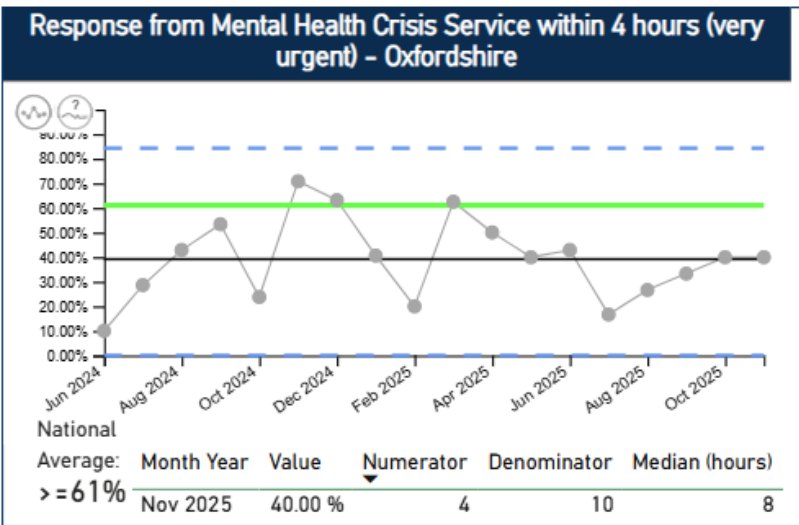
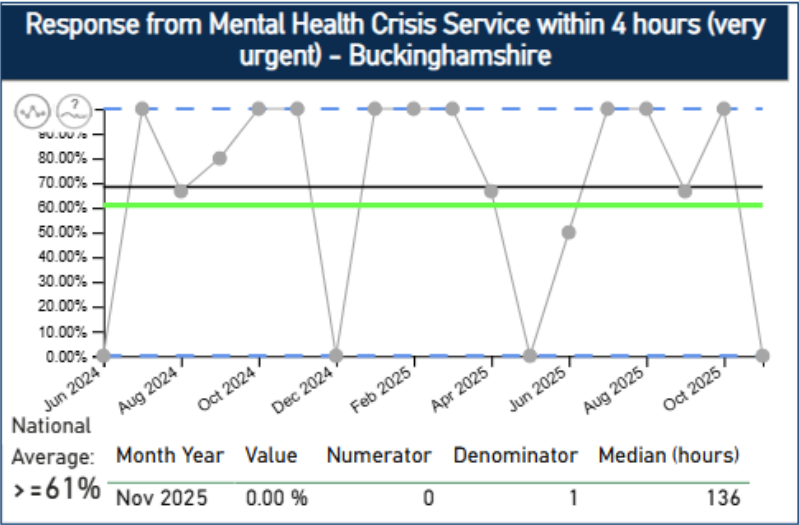
Mental Health Services – Urgent Care - summary

Board Meeting in Public



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Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
<i>National</i>	Response from Mental Health Psychiatric Liaison within 1 hour - Buckinghamshire	>=66% National average	Nov-25	94.32%			94.42%
<i>National</i>	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	>=66% National average	Nov-25	93.01%			87.65%
<i>National</i>	Response from Mental Health Psychiatric Liaison within 24 hours - Buckinghamshire	>=81% National average	Nov-25	100%			97.38%
<i>National</i>	Response from Mental Health Psychiatric Liaison within 24 hours - Oxfordshire	>=81% National average	Nov-25	100%			70.37%
<i>National</i>	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	>=61% National average	Nov-25	0%			68.33%
<i>National</i>	Response from Mental Health Crisis Service within 4 hours (Very Urgent) – Oxfordshire	>=61% National average	Nov-25	40%			39.18%
<i>National NOF (scored)</i>	Response from Mental Health Crisis Service within 24 hours (Urgent) - Buckinghamshire	>=58% National average	Nov-25	67.44%			57.50%
<i>National NOF (scored)</i>	Response from Mental Health Crisis Service within 24 hours (Urgent) – Oxfordshire	>=58% National average	Nov-25	54.10%			59.77%



Understanding the performance

Patients requiring most urgent mental health care should be seen by community mental health crisis teams within 4 or 24 hours of referral depending on urgency. The standards aim to improve patient access to mental health services and ensure prompt support for individuals in crisis. As these metrics does not have nationally set targets, the Trust is measuring performance against national averages.

In November 2025, out of seven (7) patients who were not seen within four hours, 6 (six) breaches were attributed to patient choice and one (1) patient seen outside of the timeframe.

Twenty-eight (28) patients were not seen within twenty-four hours for a combination of reasons: patient choice (6), patient receiving inpatient care for physical health (4), issues contacting patient (6), patient being in a place of safety (2), capacity and/or liaison between teams (10).

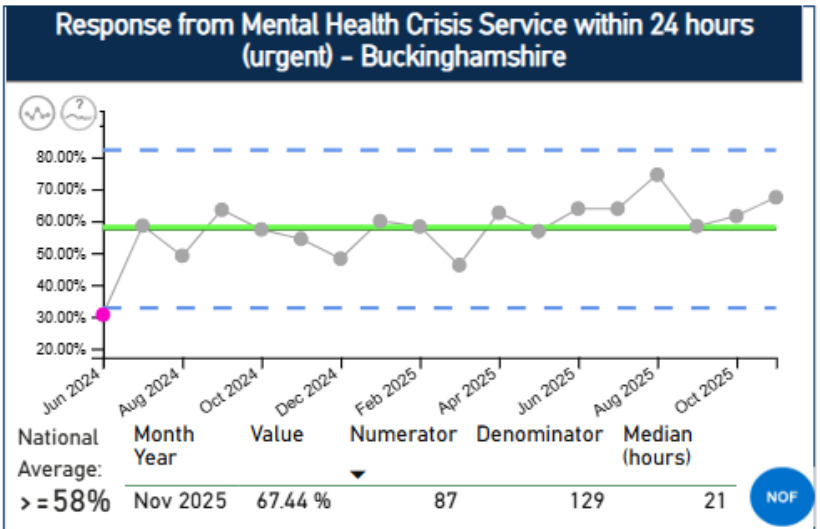
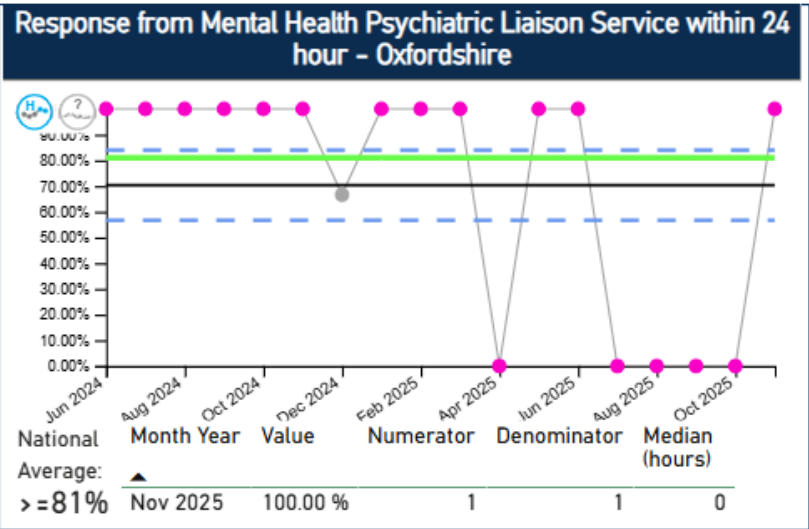
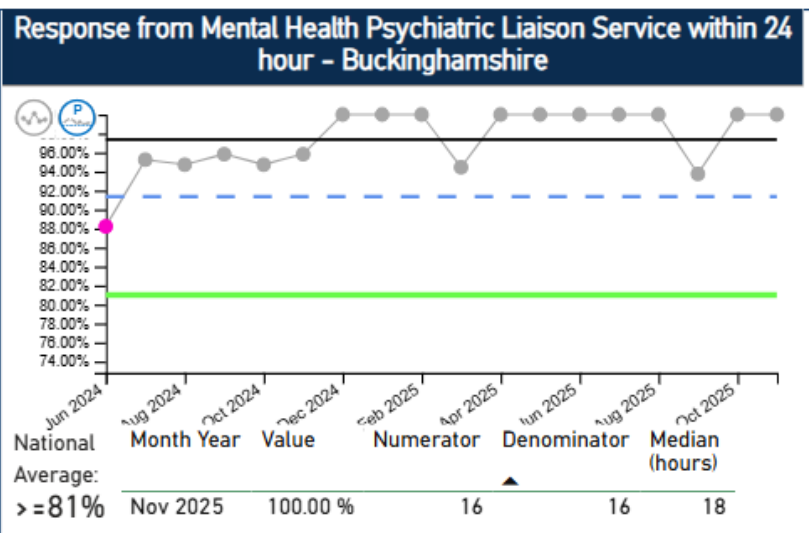
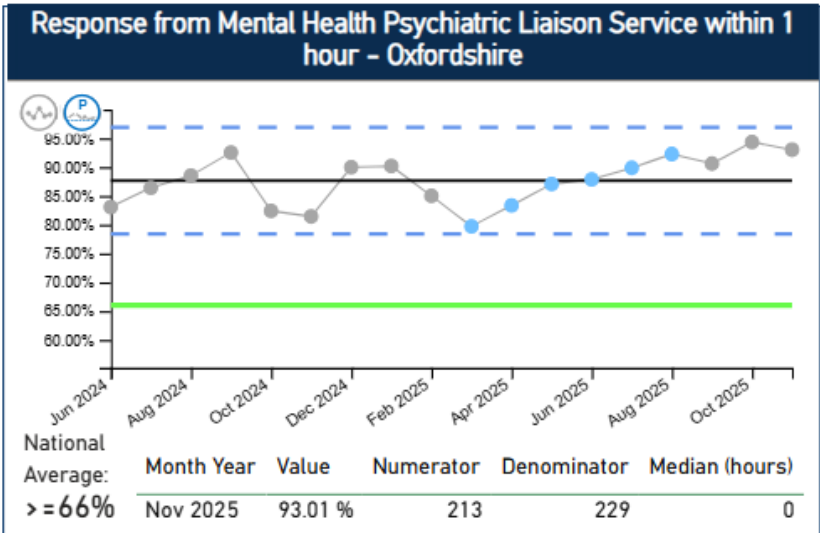
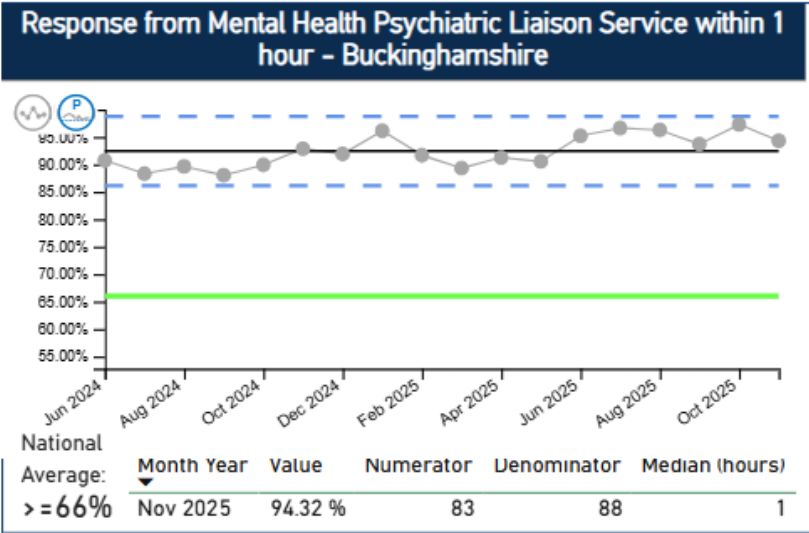
Some patients are not expecting to be offered an appointment within 4 - 24 hours or can not be available for an appointment at short notice within the timeframe.

Actions (SMART)

- The services are triaging all patients within 2 hours of GP referral for safety planning and contacting patients as early as possible to arrange appointment.
- Implementation of revised referral process in Oxfordshire's Crisis Service to improve accuracy of urgency determination at the outset – all referrals screened by a senior clinician prior to being entered onto the system to reduce likelihood of data quality issues arising from system limitations.
- On-going Quality Improvement Project looking into the application of urgent care standards during clinical triage.

Risks

- Delays in crisis assessment can allow acute symptoms to escalate. Without early intervention, crises can intensify, increasing risk of self-harm.
- Repeated failures to provide rapid crisis care can erode trust in service discouraging people from seeking help early and potentially worsening outcomes.
- People whose needs are not met in a crisis, may present to police, ambulance or other services which may result in an inappropriate response.



"0.00%" in the graph above represent NIL activity rather than 0% performance

Mental Health Services – Acute/Inpatients (Adults and Older Adults) – summary (1/2)



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Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
<i>National</i>	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	<=12% National average	Nov-25	17%			17.75%
<i>National</i>	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	<=12% National average	Nov-25	16%			17.42%
<i>National</i>	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	<=12% National average	Nov-25	0%			14.47%
<i>National</i>	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	<=12% National average	Nov-25	18%			13.63%
<i>National</i>	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined; rolling 3 months) - Buckinghamshire	<=51	Nov-25	43			44
<i>National</i>	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined; rolling 3 months) - Oxfordshire	<=51	Nov-25	59			54
<i>National NOF (scored)</i>	Percentage of adult inpatients with a length of stay over 60 days (discharged patients) - Buckinghamshire	.	Nov-25	33.33%		n/a	21.88%
<i>National NOF (scored)</i>	Percentage of adult inpatients with a length of stay over 60 days (discharged patients) - Oxfordshire	.	Nov-25	26.89%		n/a	25.46%
<i>National NOF (contextual)</i>	Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) - Buckinghamshire	.	Nov-25	30.43%		n/a	23.93%
<i>National NOF (contextual)</i>	Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) - Oxfordshire	.	Nov-25	30.43%		n/a	25.07%
<i>National</i>	72 hour follow up for those discharged from mental health wards - Adults - Buckinghamshire	>=80%	Nov-25	84%			89.78%
<i>National</i>	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	>=80%	Nov-25	78.79%			90.34%
<i>National</i>	72 hour follow up for those discharged from mental health wards - Older Adults - Buckinghamshire	>=80%	Nov-25	100%			97.33%
<i>National</i>	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	>=80%	Nov-25	100%			94.27%
<i>Local</i>	% adult acute readmission within 30 days for mental health - Buckinghamshire	.	Nov-25	0%		n/a	5.97%
<i>Local</i>	% adult acute readmission within 30 days for mental health - Oxfordshire	.	Nov-25	3%		n/a	5.25%
<i>Local</i>	% older adult readmission within 30 days for mental health - Buckinghamshire	.	Nov-25	14%		n/a	1.49%
<i>Local</i>	% older adult readmission within 30 days for mental health - Oxfordshire	.	Nov-25	0%		n/a	2.59%
<i>Local</i>	Average number of clinically ready for discharge patients per day - Buckinghamshire	.	Nov-25	10		n/a	8
<i>Local</i>	Average number of clinically ready for discharge patients per day - Oxfordshire	.	Nov-25	8		n/a	7

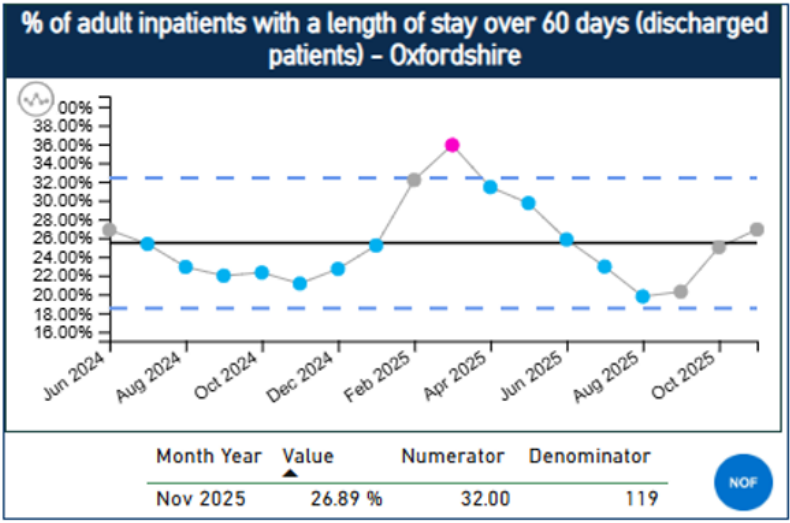
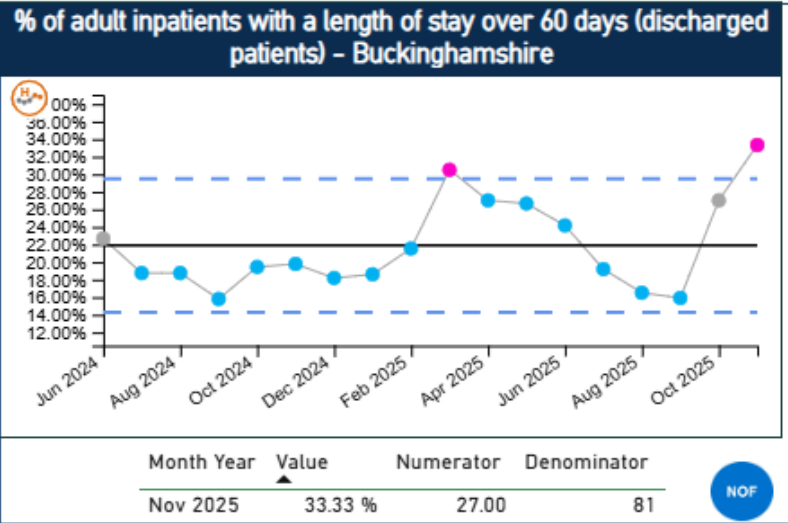
Mental Health Services – Acute/Inpatients (Adults and Older Adults) – summary (2/2)

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Type of metric	Service Area/Metric	Target	Latest reporting period	Measure	Variation	Assurance	Mean
National	Inappropriate adult acute mental health out of area placements - snapshot last day month - Buckinghamshire	2	Nov-25	6			3.89
National	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Buckinghamshire		Nov-25	1		.	0
National	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Buckinghamshire		Nov-25	0		.	0
National	Inappropriate adult acute mental health out of area placements - snapshot last day month - Oxfordshire	1	Nov-25	5			3.06
National	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire		Nov-25	0		.	0
National	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire		Nov-25	0		.	0
National	Inappropriate adult acute mental health out of area placements - beds days in month - Buckinghamshire	.	Nov-25	163		n/a	110.89
Local	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Buckinghamshire	.	Nov-25	26		n/a	2.78
Local	Inappropriate older adult acute mental health out of area placements - beds days in month - Buckinghamshire	.	Nov-25	0		n/a	2.06
National	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	.	Nov-25	90		n/a	90.39
Local	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	.	Nov-25	11		n/a	0.89
Local	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	.	Nov-25	0		n/a	0



Understanding the performance

Current performance shows a recent increase in the proportion of adult inpatients with a length of stay over 60 days, reaching 33.33% in Buckinghamshire and 26.89% in Oxfordshire in November 2025, alongside a rise in the combined mean length of stay across adult acute, older adult, and PICU pathways (see page 37 for length of stay data).

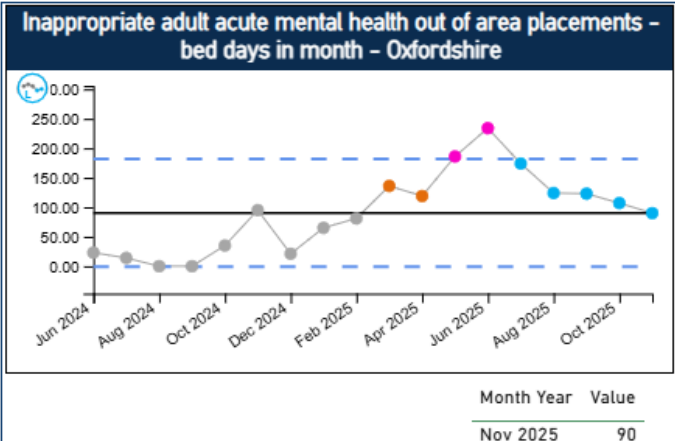
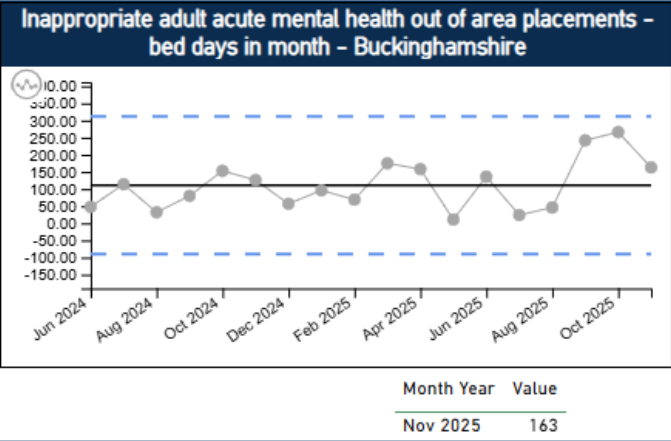
These trends are driven by both acuity of patients (meaning that extended length of stay was appropriate) and delays in discharging clinically ready-for-discharge (CRFD) patients. Delays primarily linked to challenges in securing timely onward placements or suitable accommodation for patients who are clinically ready for discharge. Some delays are short and resolved quickly once placement arrangements progress, while others are more complex where individuals require accommodation that is not easily sourced within existing pathways.

Actions (SMART)

Actions underway include close joint work between inpatient services and the EHR team to develop a CRFD form within Rio, which will replace manual recording and enable accurate in-month reporting of actual bed days and numbers of patients affected. This improvement, expected to begin reporting from quarter 4 or early next financial year, will strengthen operational oversight and allow more targeted interventions to reduce avoidable delays.

Risks

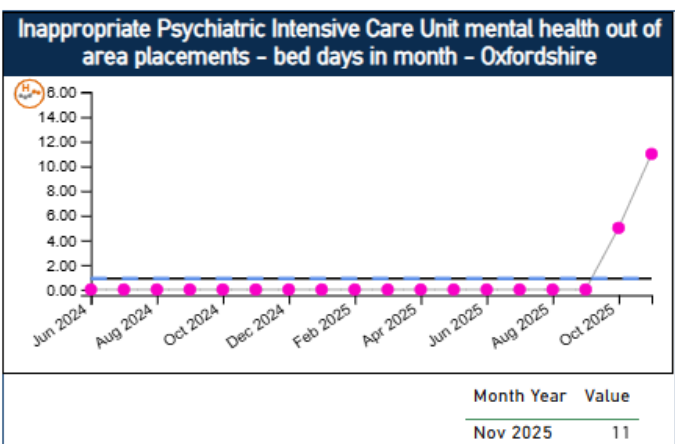
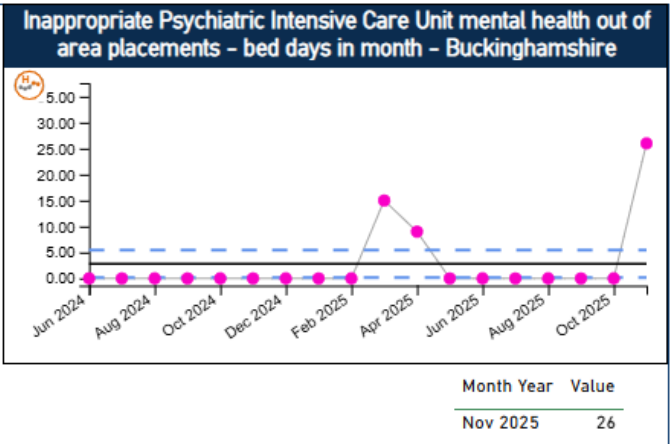
A sustained shortage of appropriate accommodation, particularly for higher-risk working-age adults, poses a continued risk to reducing length of stay and improving flow. Until the new CRFD reporting is operational, reliance on manual data may limit the precision of performance monitoring. Persistent delays could further increase average length of stay and pressure on bed capacity if system-wide solutions are not secured.



Understanding the performance

An inappropriate Out of Area Placement (OAP) refers to the situation where a patient is admitted to an inpatient unit that is outside of the local NHS trust area, not close to their home or community support network due to non-clinical reasons (e.g. lack of appropriate local inpatient beds). Majority OAPs admitted are out of hours due to no available local adult mental health beds and no options available to create local capacity (urgency of admission warrants OAP admission to manage risks)

In November 2025, adult acute inappropriate out of area placements bed days reduced to 253 at bed days in total across Oxfordshire and Buckinghamshire compared to 369 in October 2025. An increase in inappropriate Psychiatric Intensive Care Unit bed days across both Oxfordshire and Buckinghamshire noted – 37 in November 2025. See page 40 for placement snapshot at the end of the month data.



- Actions (SMART)**
- Implemented a high threshold for authorising OAPs (must be approved by senior manager or Director)
 - Face to face reviews with Crisis Resolution and Home Treatment Team every 2 – 4 weeks to ensure quality of care and support facilitation of early discharge where clinically appropriate.
 - Optimisation of bed usage across counties (Oxfordshire and Buckinghamshire) by end of March 2026.
 - Enhanced admission purpose and patient journey documentation and tracking task and finish project to be concluded by end of January 2026

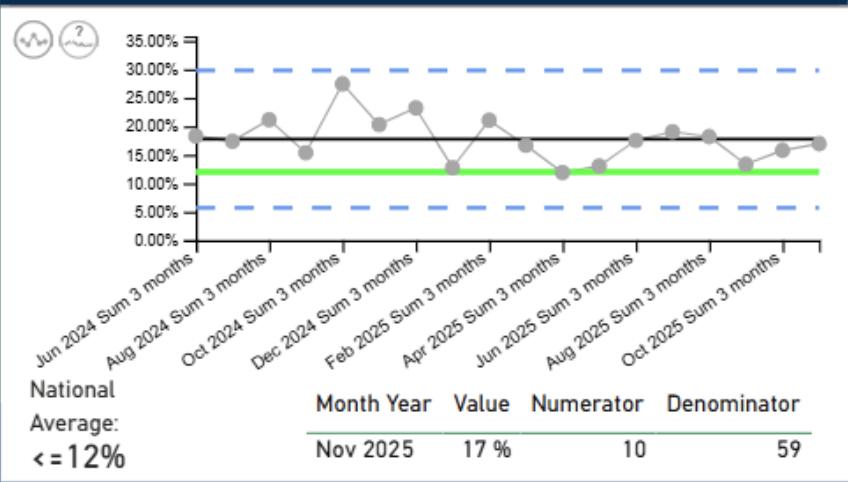
Risks

There are several risks associated with inappropriate Out of Area Placements:

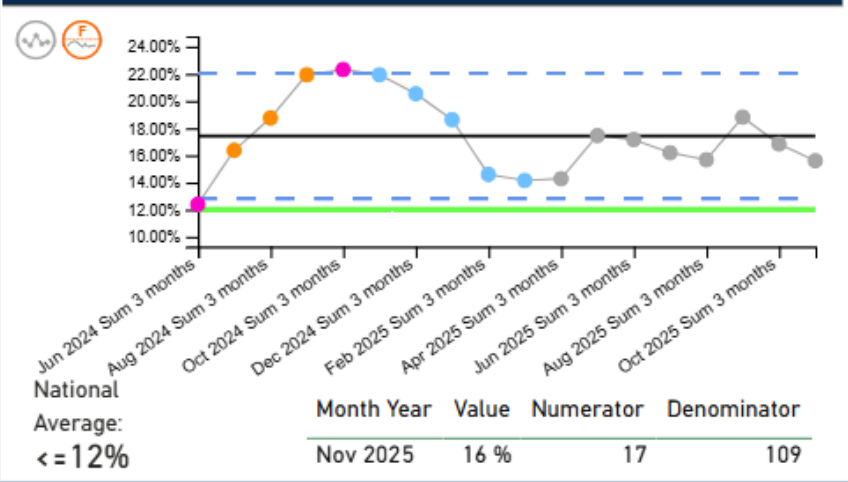
- Potential disruption of support networks where the patient is separated from family, carers and friends
- Possibly poorer continuity of care as it may be harder for local clinicians to stay involved in care planning and reviews
- Increased likelihood of delayed discharge and longer stays as discharge planning is more complex when patients are far from community services
- Possibility of poorer patient experience
- Increased costs and systemic inefficiencies

Mental Health Services – Acute/Inpatients (Adults and Older Adults) - appendices

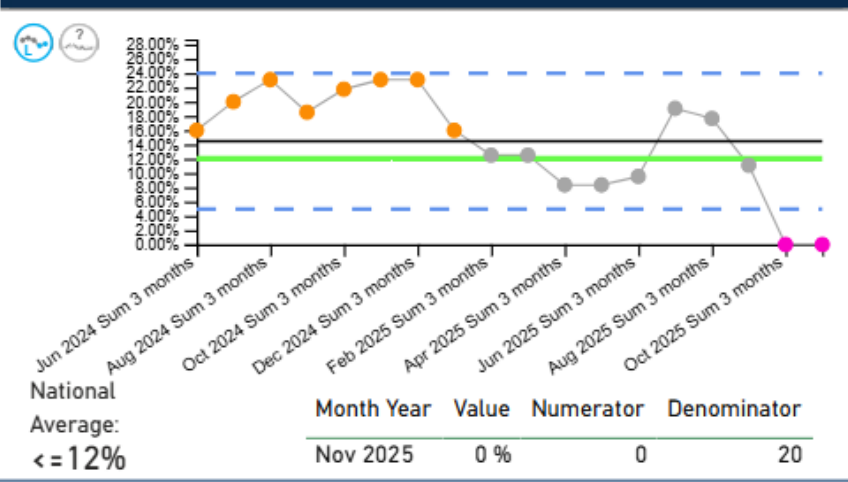
Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) - Adult (acute & PICU) Buckinghamshire (reported as rolling 3 months)



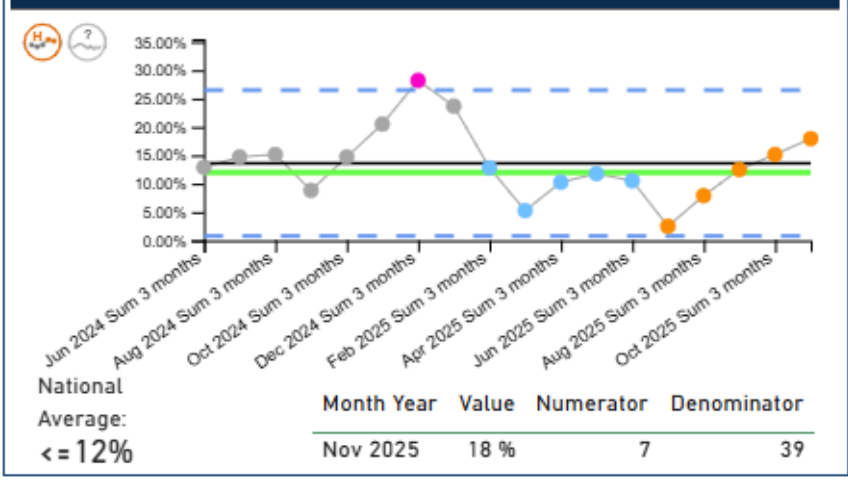
Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) - Adult (acute & PICU) Oxfordshire (reported as rolling 3 months)

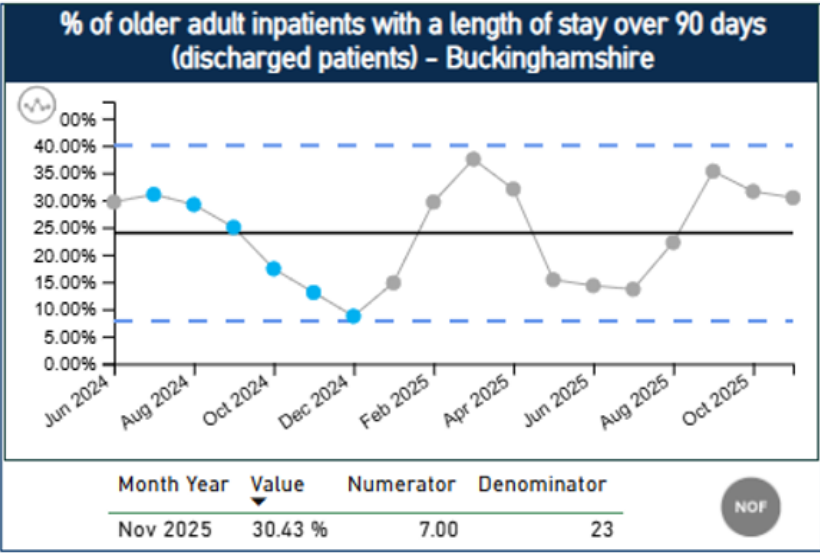
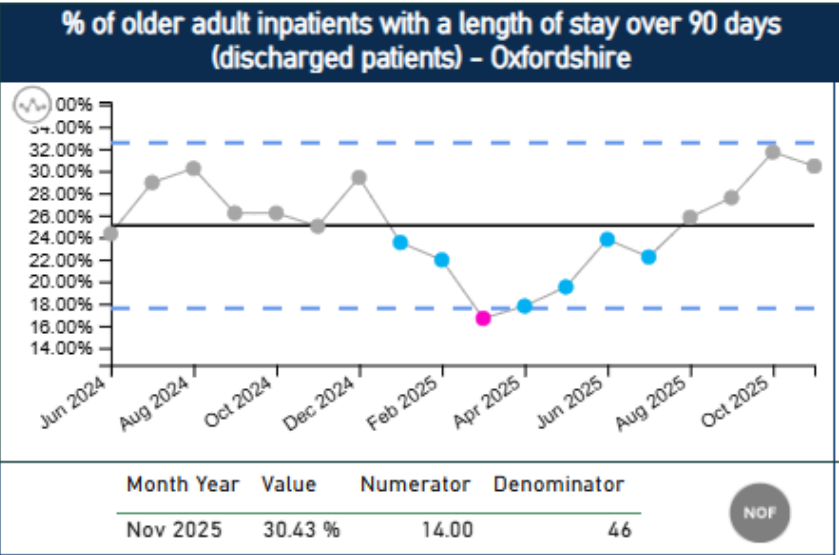
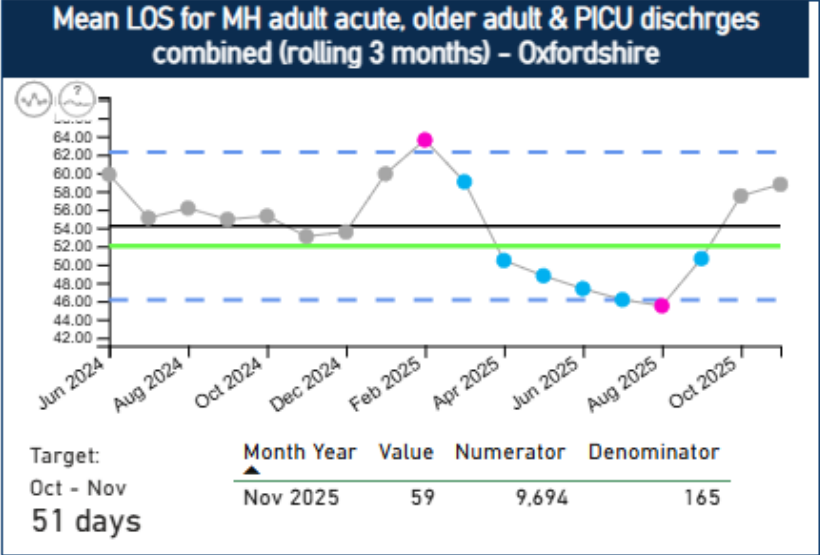
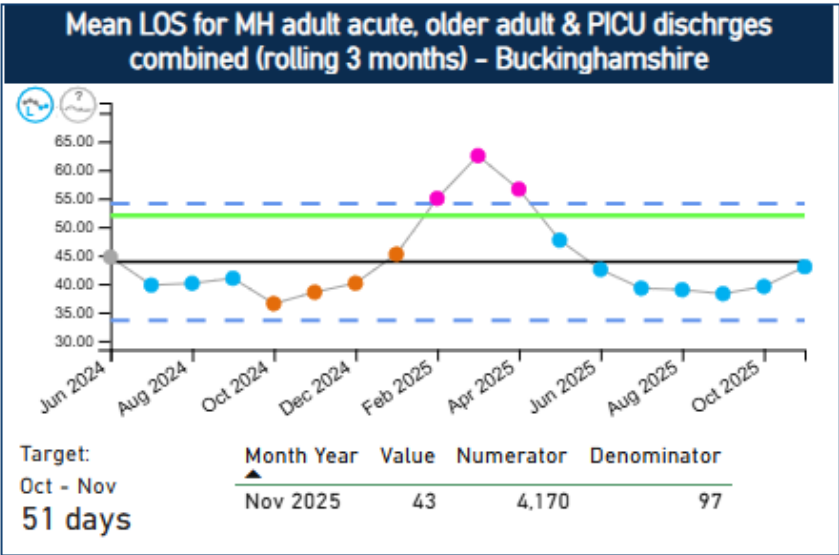


Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of acute admissions with no prior contact) - Older Adult Buckinghamshire (reported as rolling 3 months)

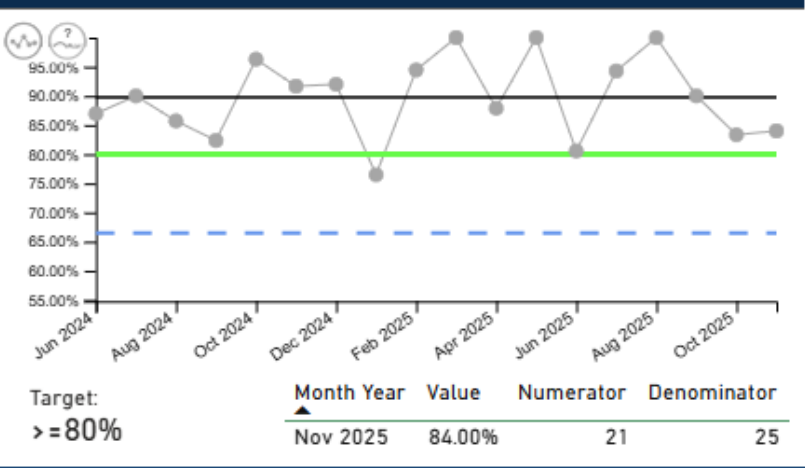


Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission (% of older adult acute admissions with no prior contact) - Older Adult Oxfordshire (reported as a rolling 3 months)

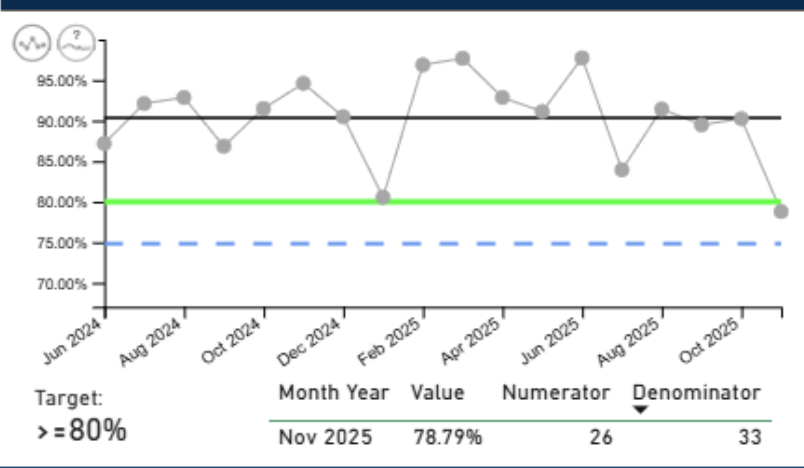




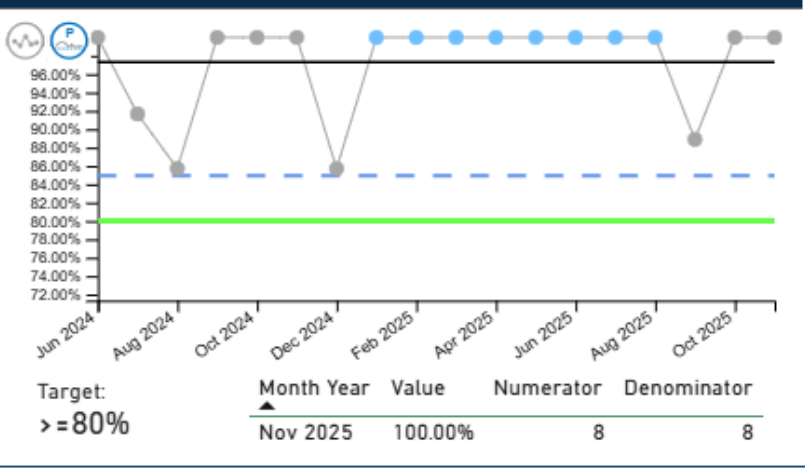
72 hour follow up for those discharged from mental health wards - Adult Buckinghamshire



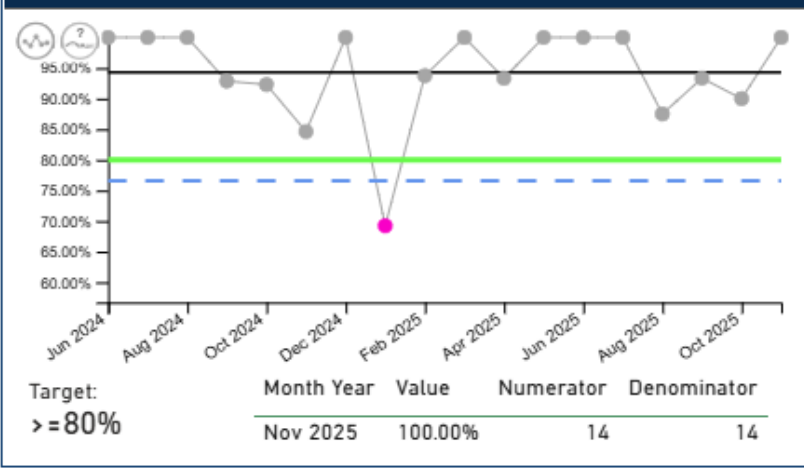
72 hour follow up for those discharged from mental health wards - Adult Oxfordshire

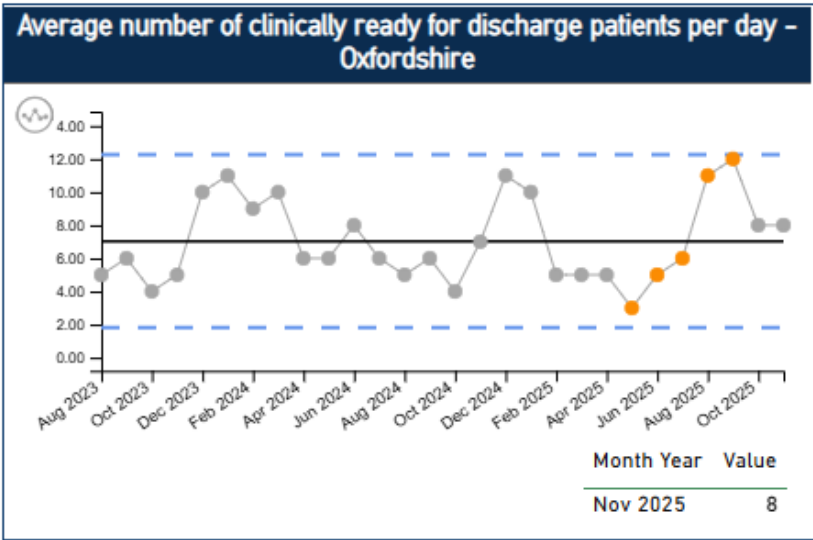
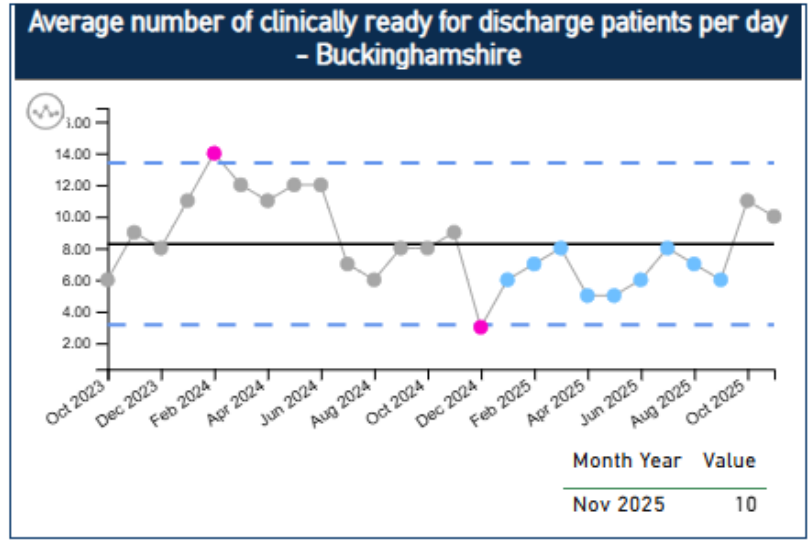
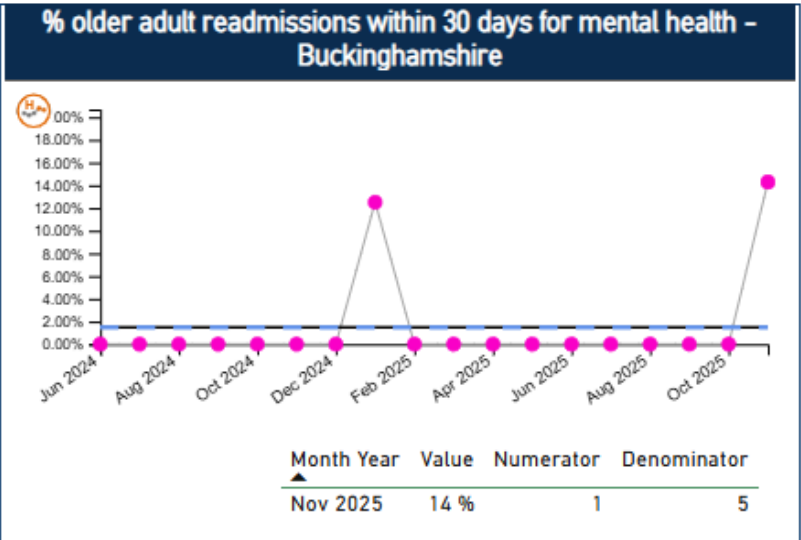
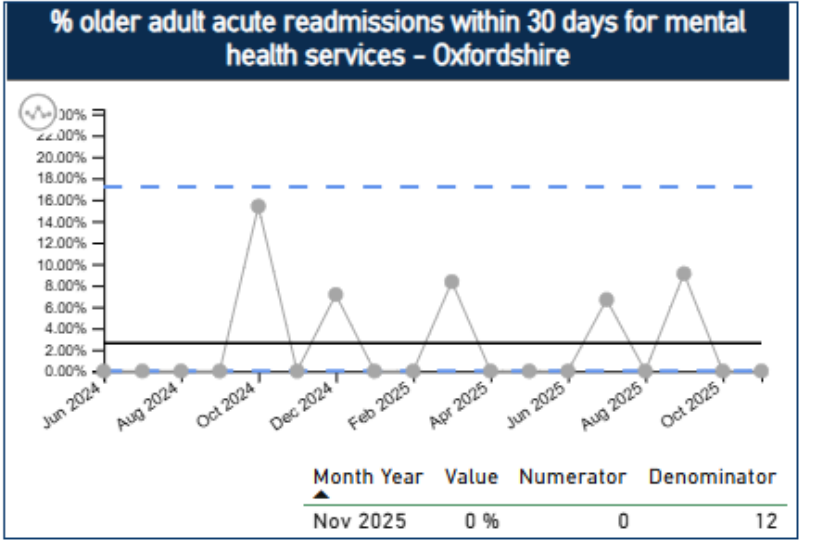
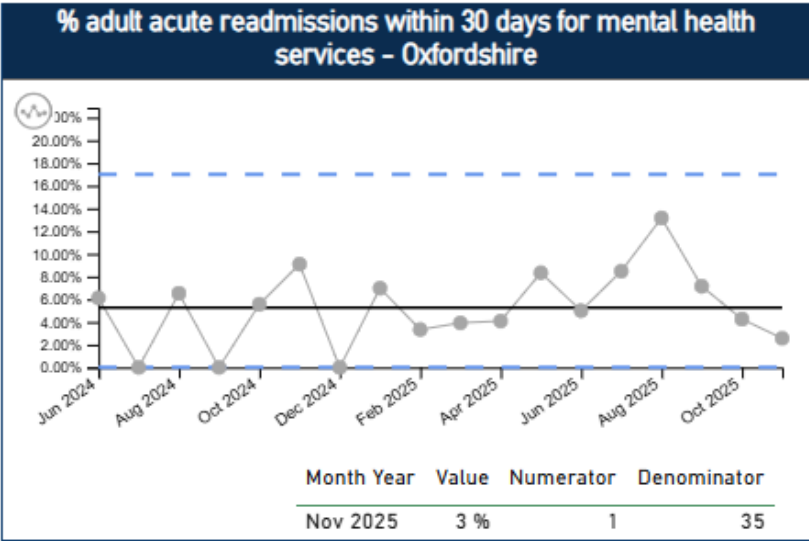
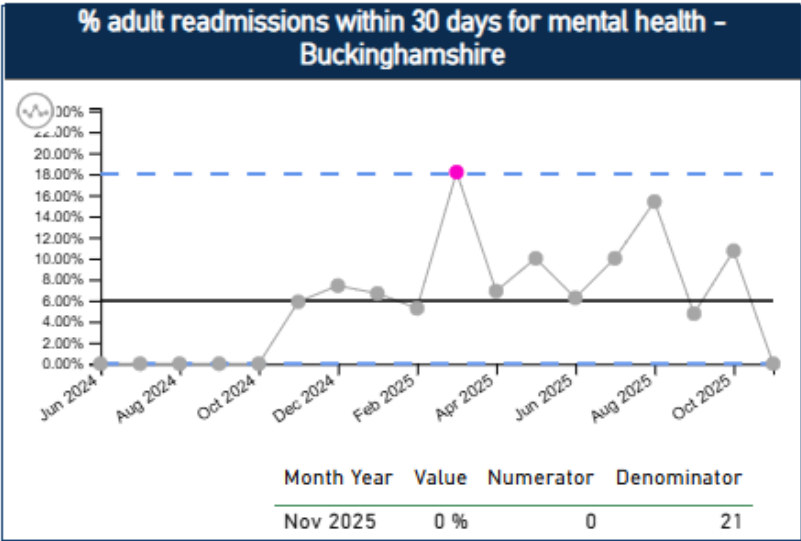


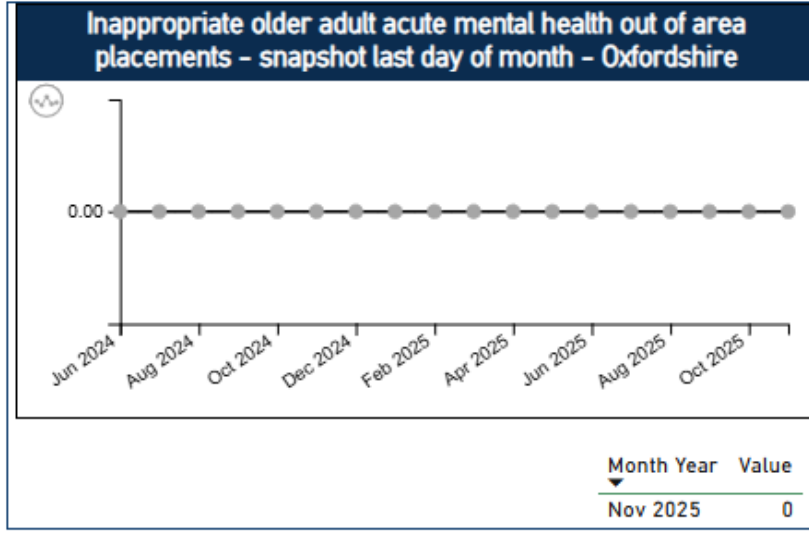
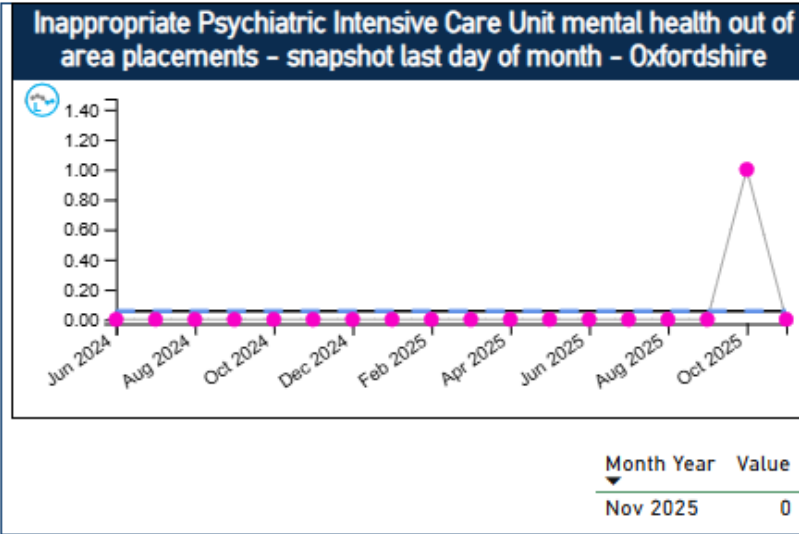
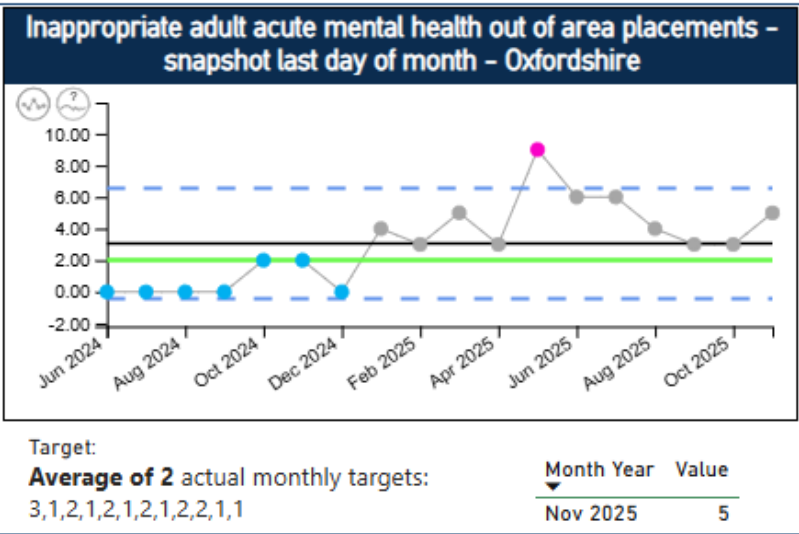
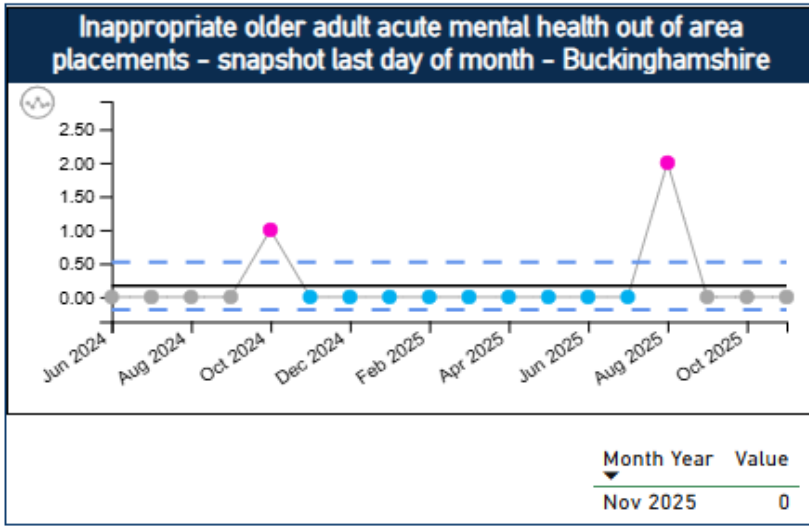
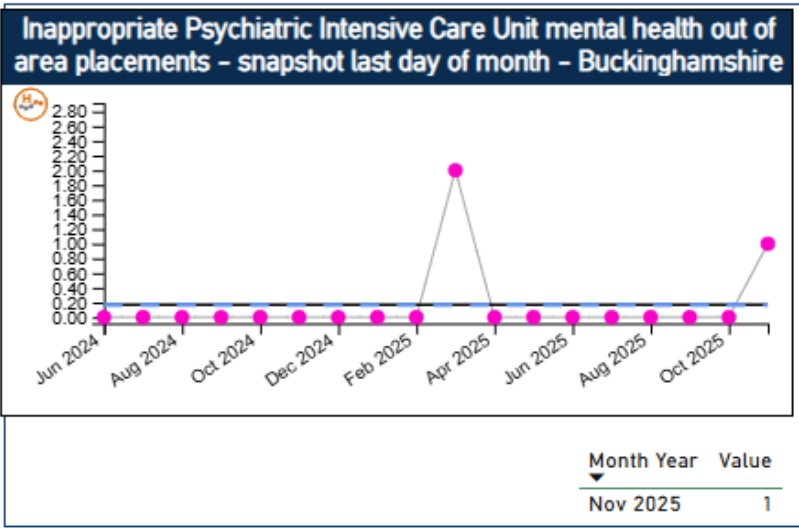
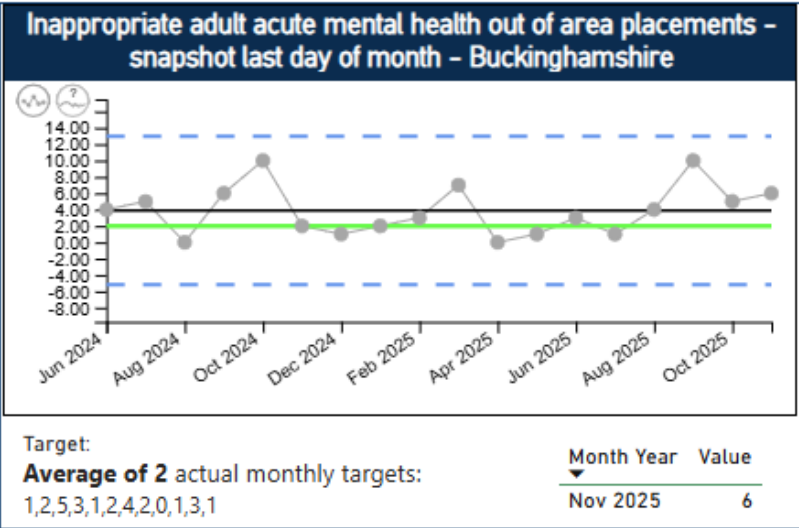
72 hour follow up for those discharged from mental health wards - Older Adult Buckinghamshire

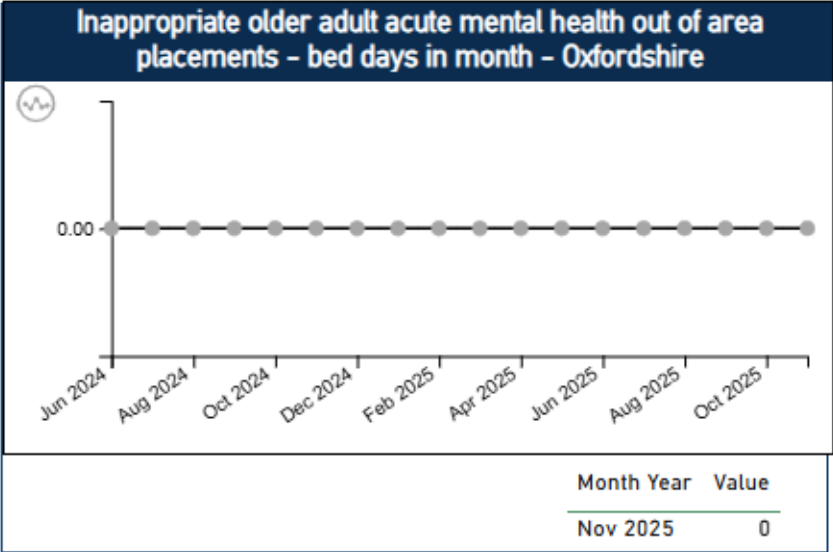
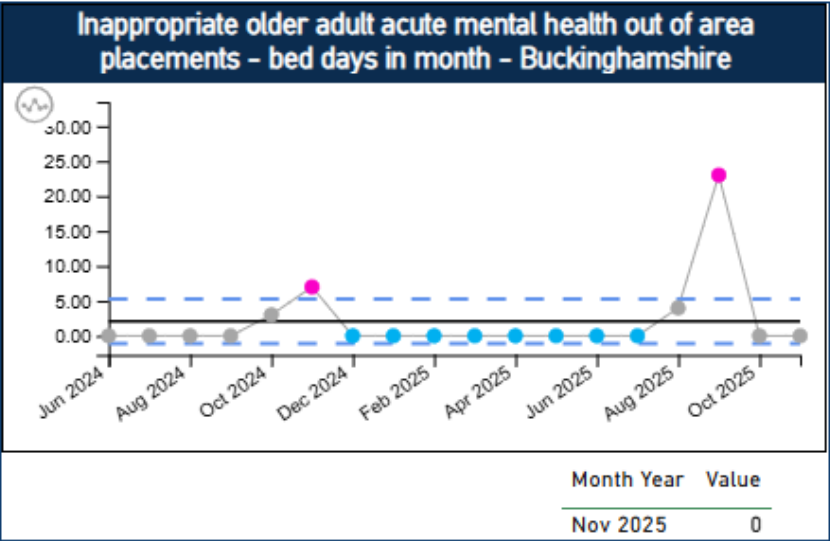


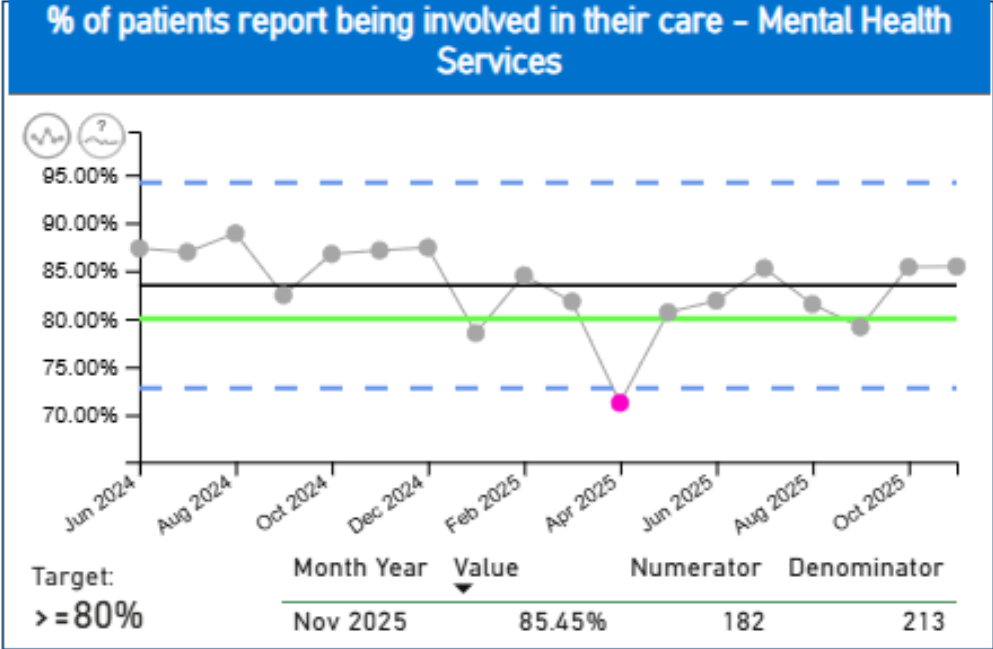
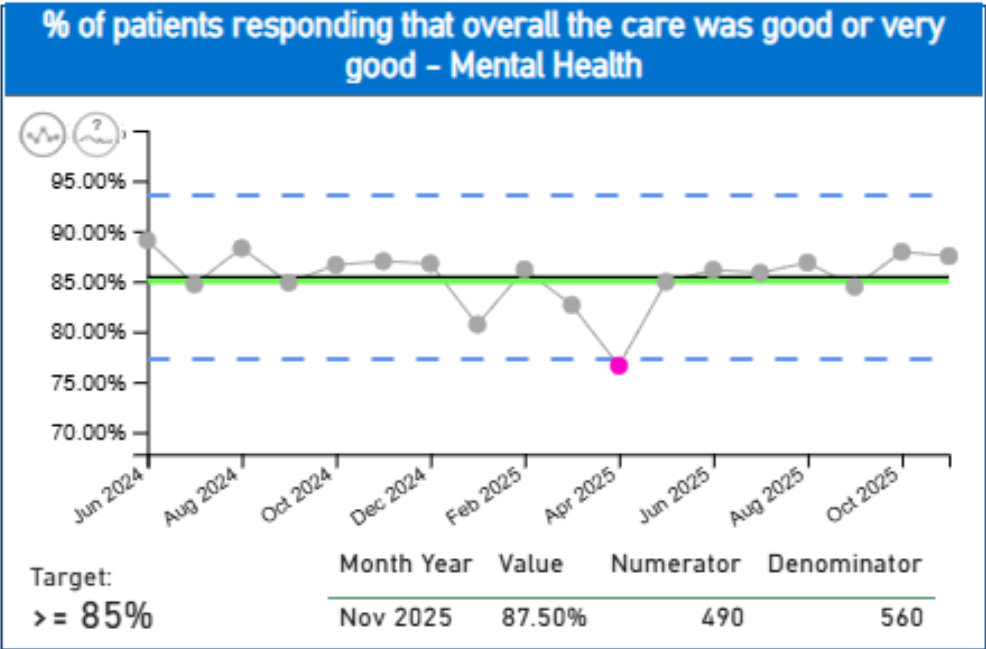
72 hour follow up for those discharged from mental health wards - Older Adult Oxfordshire











Section 2.2

Clinical performance (Community Health Services, Dentistry and Primary Care)

Community Health Services, Dentistry and Primary Care metrics have been grouped, where possible, into clusters for reporting purposes in line with the NHS England’s guidance on Standardising community health services. Details and definitions are available here: [NHS England » Standardising community health services](#)

	Adults	Children
1. Planned Care	1. Episodic/specialist care	1. Developmental
	2. Management of long-term conditions	2. Specialist services, including management of long-term conditions
	3. Prevention of deterioration of long-term conditions	3. Palliative care and end of life care
	4. Community rehabilitation	
	5. Palliative care and end of life care	
	6. Neurodevelopmental	
2. Planned and Reactive care	1. Intermediate care (<i>none of the metrics selected to be reported on IPR fall into this category</i>)	
3. Reactive care	1. Urgent care	1. Urgent care
	2. Palliative care and end of life care	2. Palliative care and end of life care (<i>none of the metrics selected to be reported on IPR fall into this category</i>)

More Community Health Services, Dentistry and Primary Care metrics are in development to be introduced in the IPR on a phased approach therefore some of the groupings may appear not to have any metrics aligned.

Assurance

Variation

				No target
 	% of Minor Injury Unit patients seen within 4 hours	Community Dentistry - Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period)	% of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)	
	% of patients responding that overall care was good or very good % of patients reporting being involved in their care	% of out of hours palliative care referrals responded to within 120 minutes: the time from completion of that triage call to the start of the home visit consultation was within 120 minutes % 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 % of breastfeeding prevalence at 6 - 8 weeks old - Community Dentistry - Special Care - Core Units of Activity (UDA) - Community Dentistry - Urgent Care - Out of Hours Units of Activity (UDA) combined with main out of hours dental service		Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours
 				

Not categorised metrics: Average number of Medically Optimised For Discharge (MOFD) patients per night, Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard, Percentage of patients waiting over 52 weeks for community services (CYP and Adults combined), Number of patients waiting over 52 weeks for community services (CYP and Adults combined)

Adult Planned Care – episodic/specialist care

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Community Dentistry - Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period)	>=90%	Nov-25	97.30%			94.14%
National	Community Dentistry - Special Care - Core units of activity (UDA)	2008 per month (24085 per year)	Nov-25	1070			1316

Adult Planned Care – community rehabilitation

Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	Average number of Medically Optimised For Discharge (MOFD) patients per night	.	Nov-25	18	n/a*	n/a	23

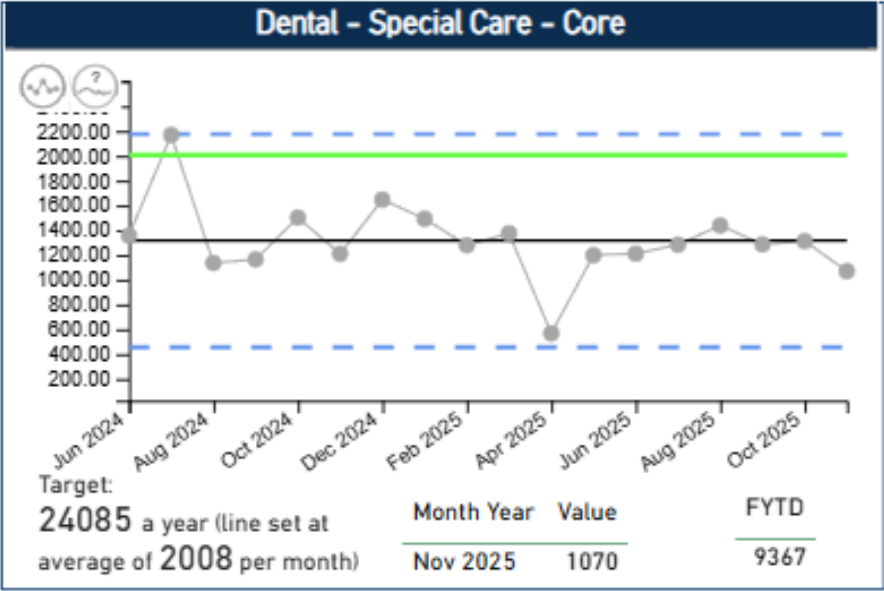
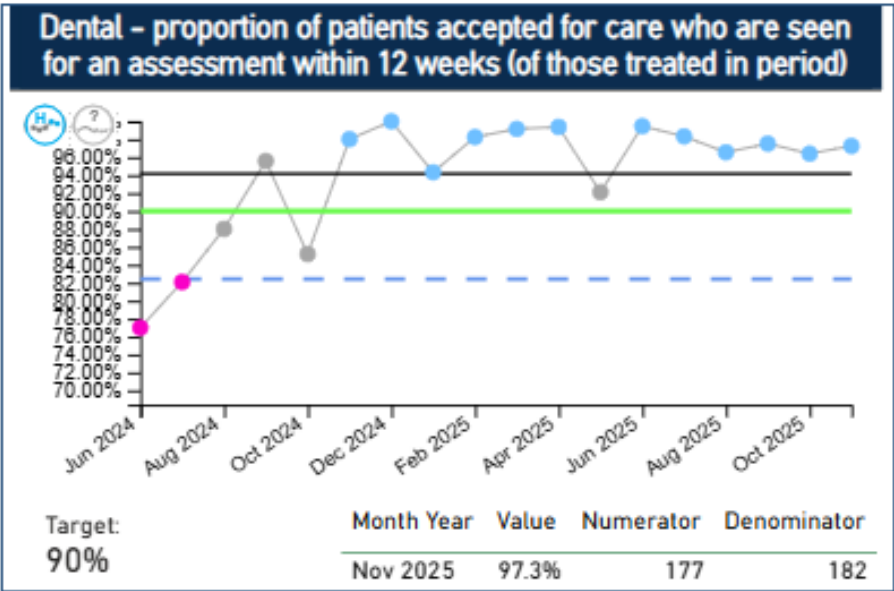
Adult Reactive Care – palliative care and end of life care

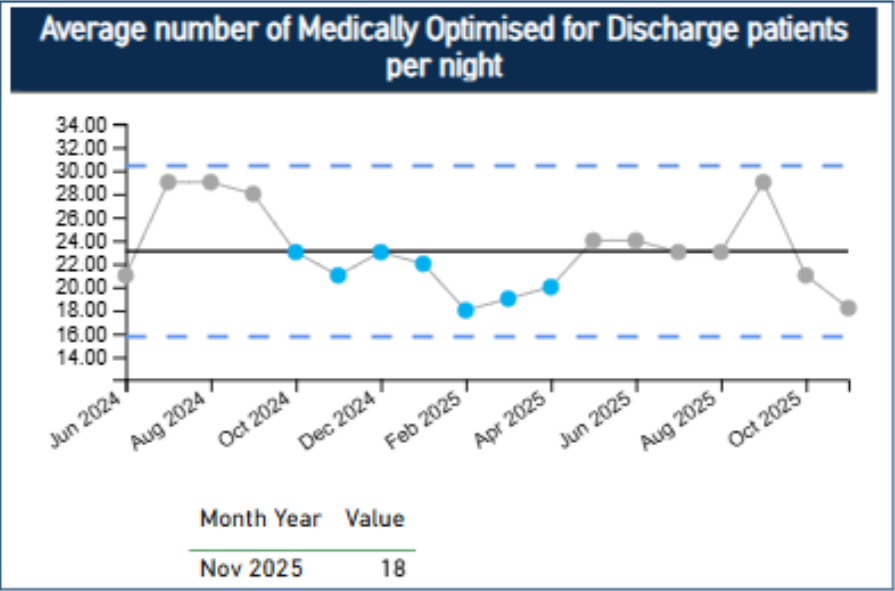
Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
Strategic - Quality	% of out of hours palliative care referrals responded to within 30 minutes: the time from receipt of the call from 111 to the start of the telephone consultation was 30 minutes (reported monthly)	>=90%	Nov-25	94.7%			94.04%
Local	% of out of hours palliative care referrals responded to within 120 minutes: the time from completion of that triage call to the start of the home visit consultation was within 120 minutes	>=90%	Nov-25	91.4%			84.79%

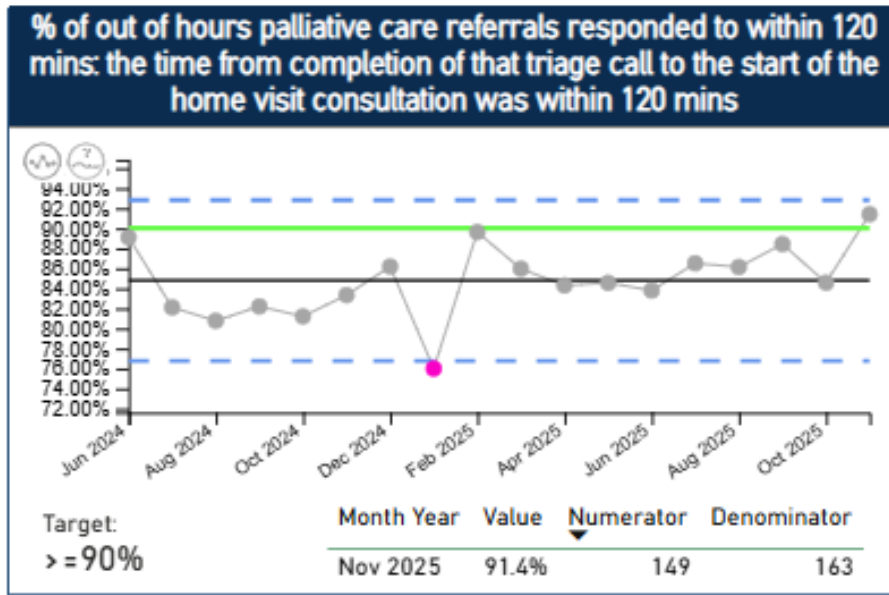
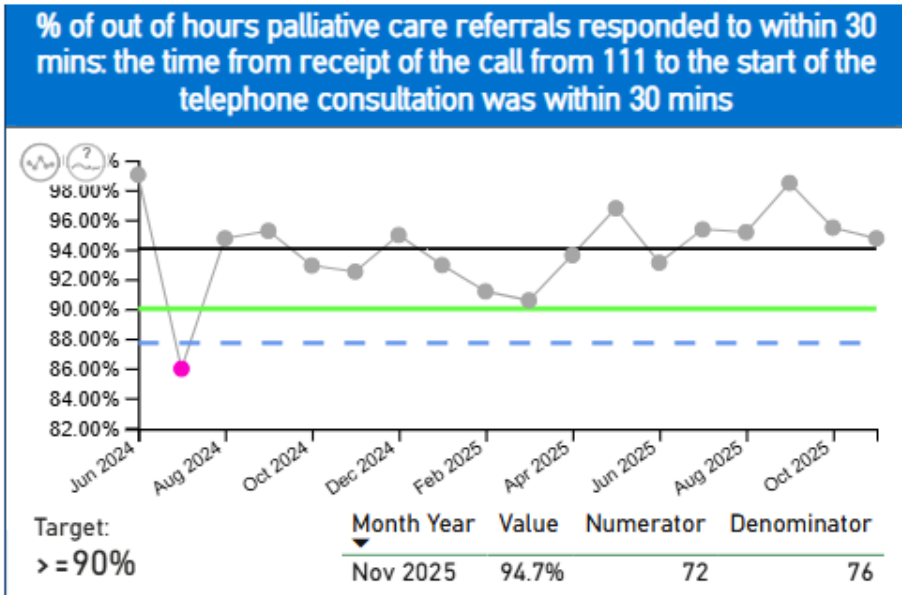
Adult Reactive Care – urgent care

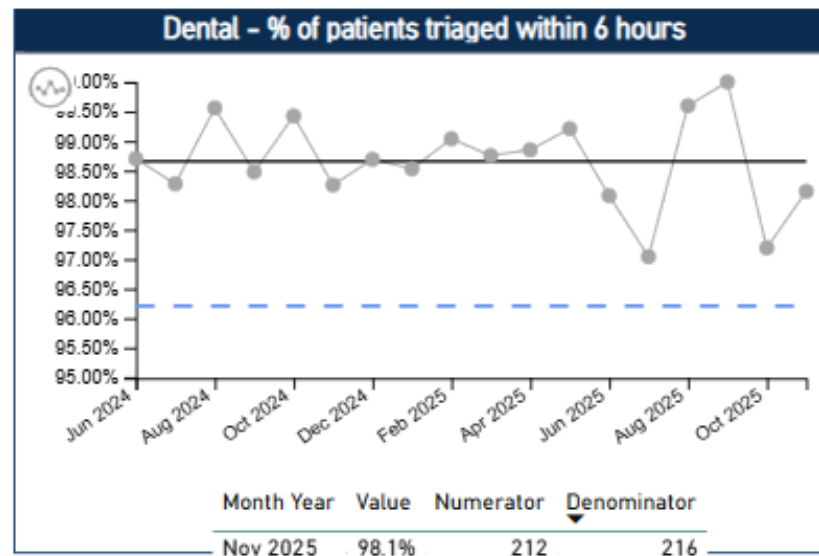
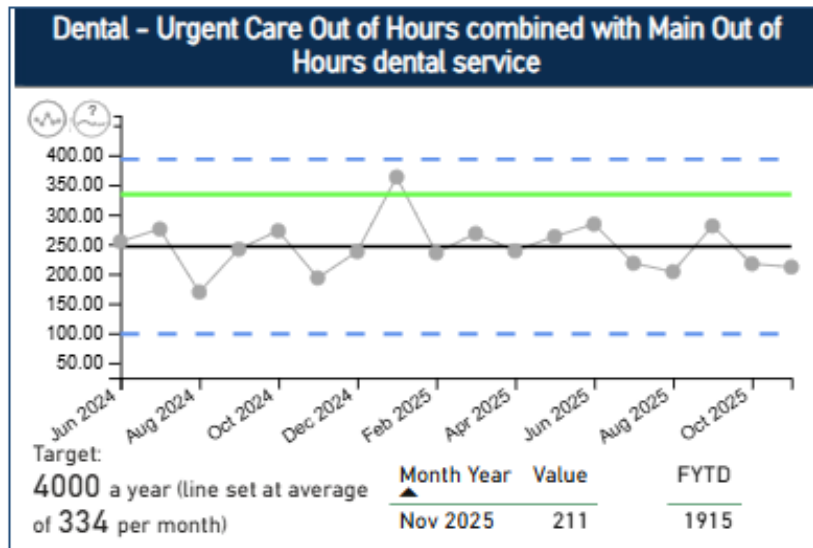
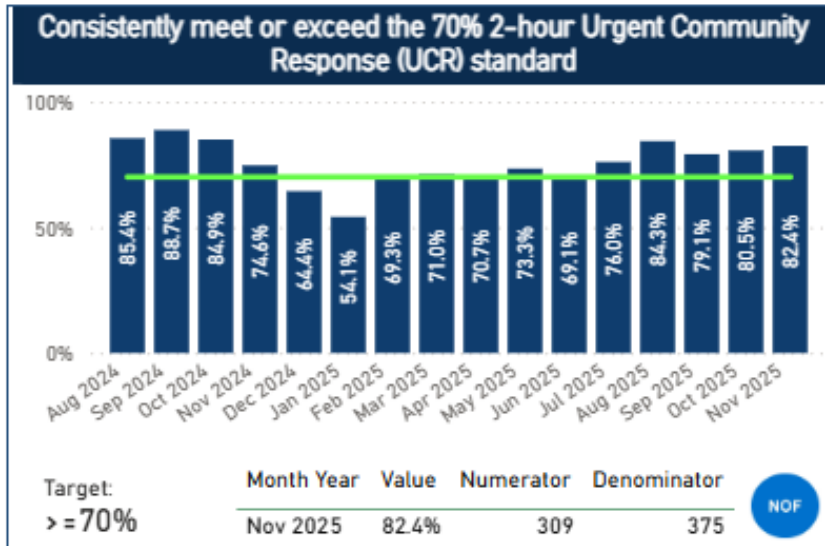
Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National NOF (scored)	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	>=70%	Nov-25	82.40%	n/a*	n/a*	77.55%
National	Community Dentistry - Urgent Care - Out of Hours units of activity (UDA) combined with main out of hours dental service	344 per month (4000 per year)	Nov-25	211			246
National	Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours	.	Nov-25	98.10%		n/a	98.66%

* - not enough data points to determine variation and apply Making Data Count algorithm

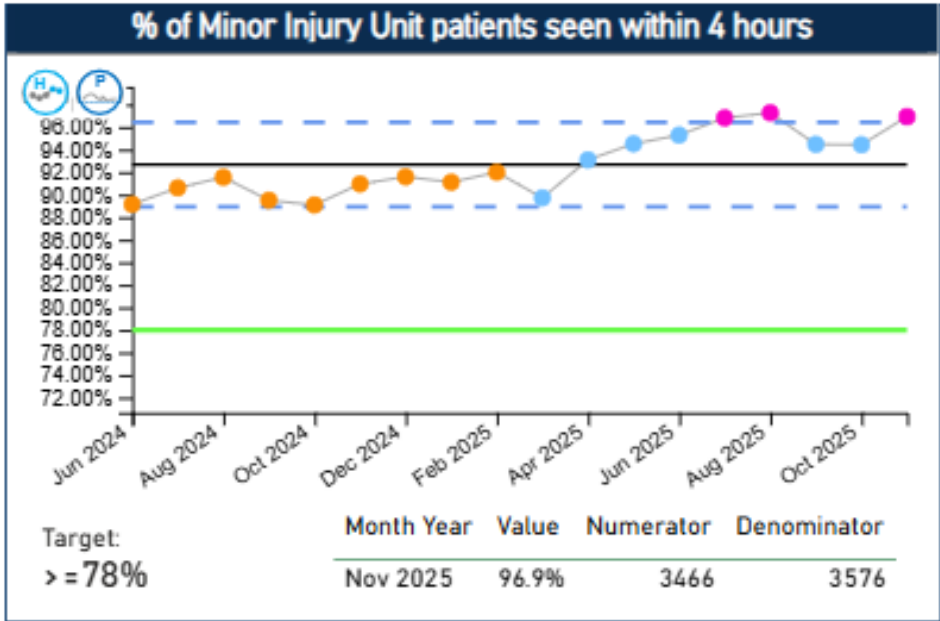




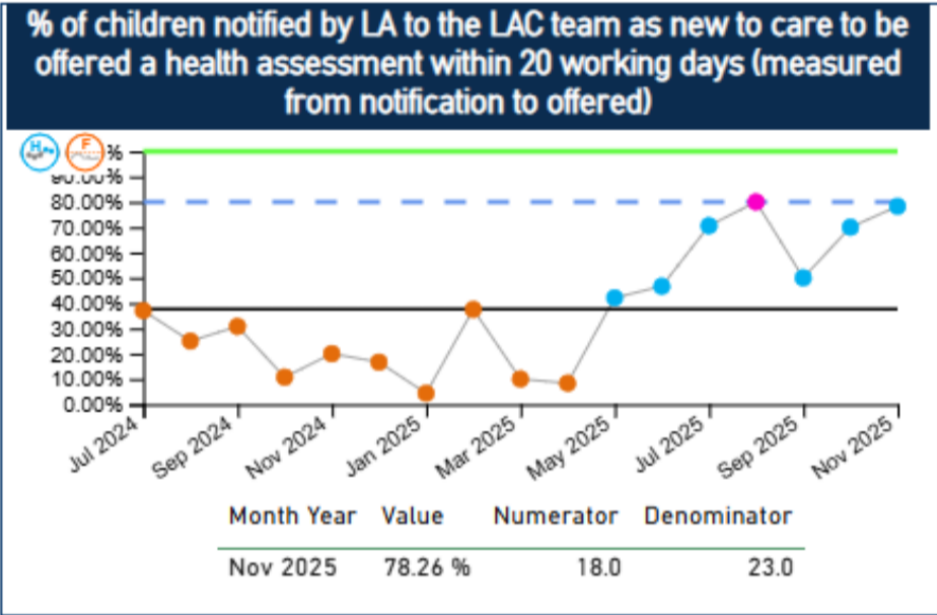




Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
National	% of Minor Injury Unit patients seen within 4 hours	> =78%	Nov-25	96.90%			92.67%



Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
Strategic – Quality National	% of breastfeeding prevalence at 6 - 8 weeks old	>=60%	Nov-25	64.10%			61.40%
National	Percentage of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)	100%	Nov-25	78.26%			40.00%



Understanding the performance

This metric is flagged requiring attention as consistently failing to meet the target. The statutory responsibility for ensuring that an Initial Health Assessment (IHA) is completed for a looked-after child (LAC) within 20 working days lies with the Local Authority – Oxfordshire County Council. The Trust is expected to complete the assessment in a timely manner, but healthcare services provider role is not statutory.

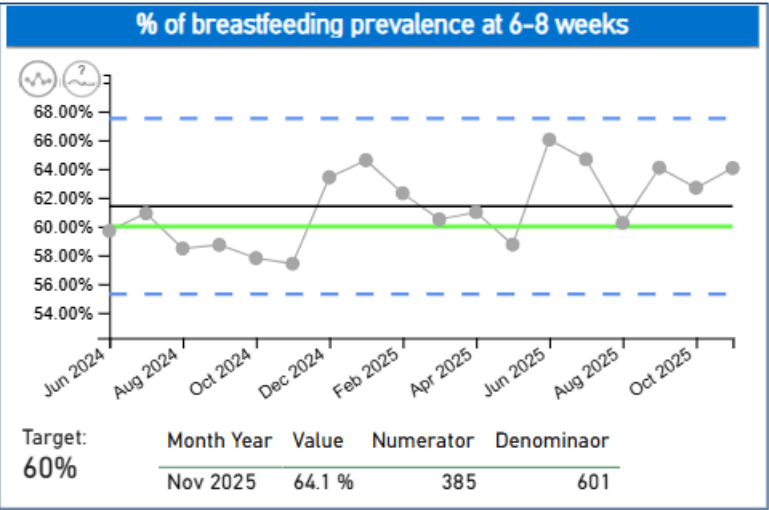
- Performance is of improving nature, however, meeting the target continues to be a challenge due to:
- ongoing issues with getting information and consent from Social Services in a timely manner. In November 2025, average number of working days from notification to Service about a looked after child to confirmation of consent was fourteen (14) days.
 - reduction in medical capacity due to ongoing staff sickness;
 - the definition of the metric includes children placed out of county, even though their assessments are completed by services in other counties. In November 2025, there were two (2) out of county children, both had their assessments completed outside of the timeframe. Out of area assessments are outside of Trust’s area of influence.

Actions (SMART)

- Head of Service to continue escalating the provision of timely information/consent to the Director of Children’s Services in Local Authority.
- Review of the assessment delivery model to address on-going difficulties of meeting the variations in demand.
- Joint review of escalation processes with Oxfordshire Children’s Services in the Local Authority to improve the delayed receipt of information, so that the assessment can be requested and completed in a timely manner
- To stabilise the medical resource to enable full capacity available consistently – recruitment has not been successful so far
- Transformation project is underway to review the systems and processes of the team which also include the assessment completion timeliness.

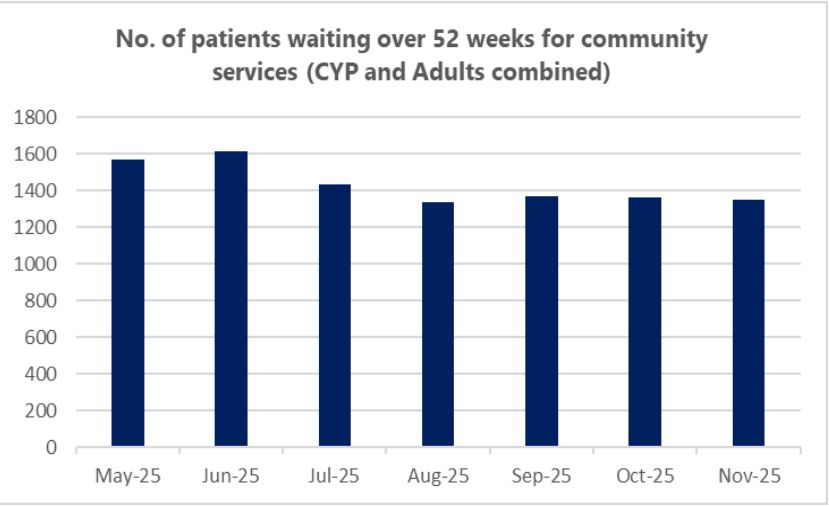
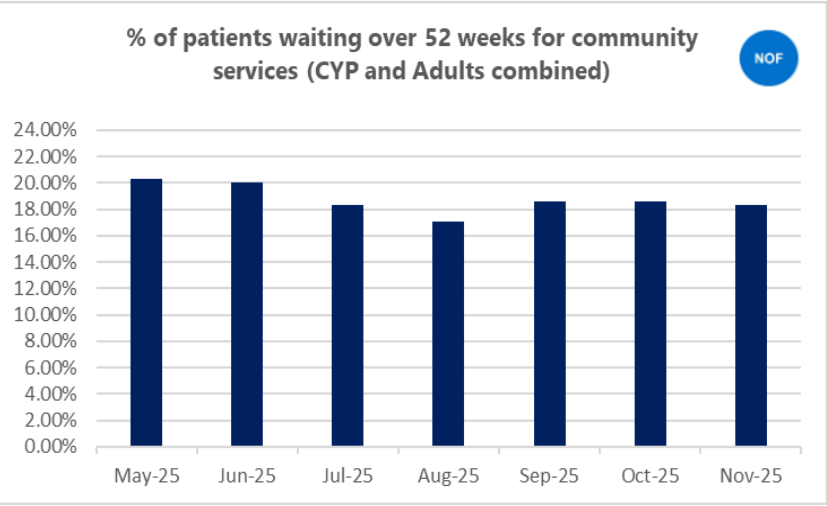
Risks

Physical, mental, emotional or developmental issues may go unnoticed potentially leading to unmet needs, delayed treatment and intervention, and worsening of pre-existing conditions. Without a timely initial health assessment, safeguarding concerns may not be identified early and put the child or a young person at continued risk and may undermine placement stability. Finally, failure to meet the 20-working day standard breaches the statutory responsibilities of the Local Authority under the Children Act and associated guidance, which may result in negative findings during Ofsted or Care Quality Commission inspections, reputational damage to the local authority and health provider.



Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
<i>National NOF (scored)</i>	Percentage of patients waiting over 52 weeks for community services (Children, Young People and Adults combined)	.	Nov-25	18.29%	n/a*	n/a	18.75%
<i>National</i>	Number of patients waiting over 52 weeks (Children, Young People and Adults combined)	.	Nov-25	1352	n/a*	n/a	1433
<i>Strategic - Quality</i>	% of patients responding that overall care was good or very good	>=85%	Nov-25	94.10%			93.78%
<i>Strategic - Quality</i>	% of patients report being involved in their care	>=85%	Nov-25	92.15%			92.08%

* - not enough data points to determine variation and apply Making Data Count algorithm



Number of patients waiting over 52 weeks by service		Nov-25
Childrens Int Therapy Services - Dietetics		0
Childrens Int Therapy Services - OT		17
Childrens Int Therapy Services - Physiotherapy		22
Childrens Int Therapy Services - Speech & Language		801
Adult Speech & Language		36
Bladder and Bowel - Adult		0
Care Home Support Service		0
Community Therapy Service		0
Falls		2
Heart Failure		0
Nutrition & Dietetics		0
Physical Disability Physiotherapy Service		0
Podiatry		429
Tissue Viability		0
Community Respiratory Service		45
Total		1352

Understanding the performance

Reporting of Community Health Services monthly wait times to NHSE commenced with May 2025 data, incorporating the metric for the percentage of patients (adults and CYP combined) waiting over 52 weeks for community services. This metric is now included as a scored NOF indicator, and the Trust is currently identified as a regional outlier.

Data submissions will transition to the Faster Data Flows (FDF)* mechanism, timelines yet to be confirmed. The Directorate is assessing the potential impact of this change on reported waiting times. Current sitrep reporting will continue until FDF definitions and guidance are finalised at national level.

Performance continues to be influenced by a range of complex factors, including national workforce shortages in specific service areas and inconsistencies in the use of electronic health record system.

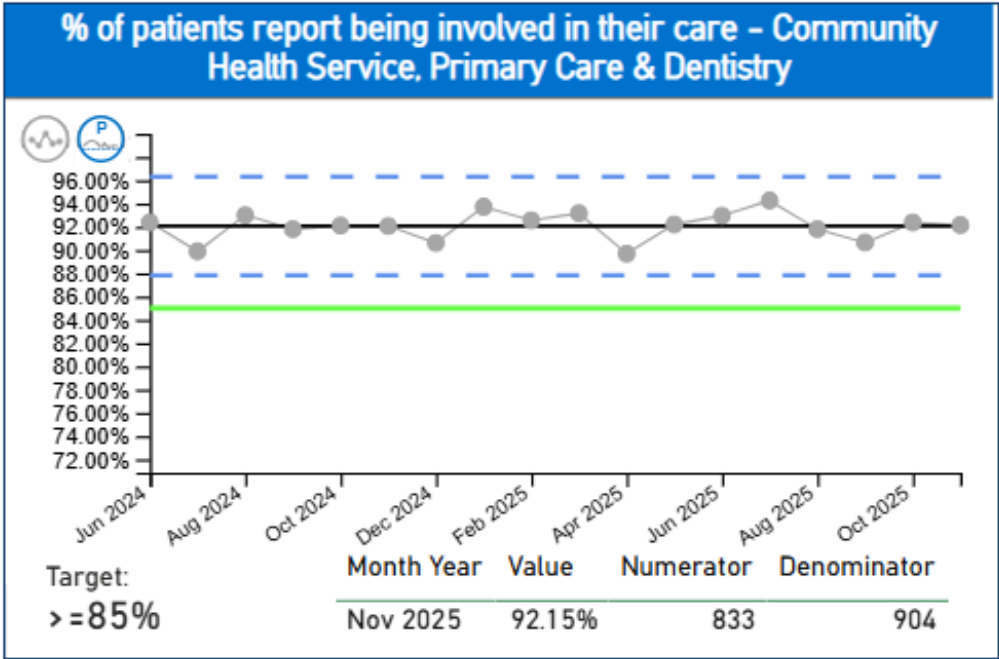
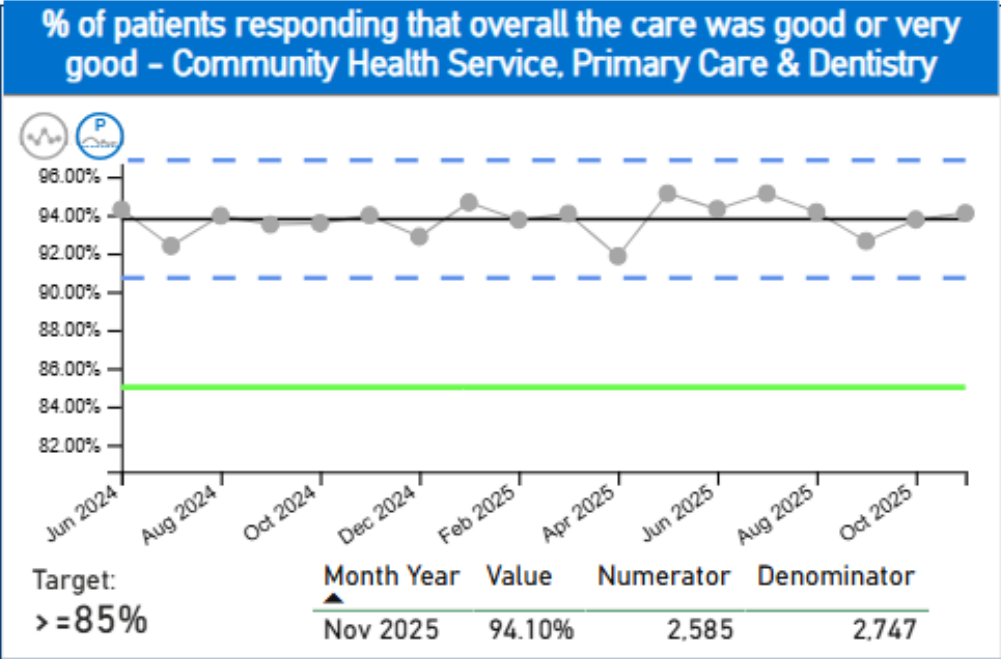
*Faster Data Flows (FDF) - is an NHS England programme designed to modernise how healthcare data are collected, shared and used.

Actions (SMART)

- Comprehensive data cleanse is underway including manual validation of waiting lists, prioritising long waiters, review of appointment outcomes. Directorate working with Performance and Information team to finalise data validation Standard Operating Procedure (SOP) to ensure validation comments/actions are traceable for reporting.
- On-going work with BOB ICB to develop and refine improvement trajectories for outlier services (Podiatry and Speech & Language Therapy (SLT)). Paediatric SLT was selected by NHS Elect as one of seven (7) pilot services to deliver a waiting list quality improvement programme.
- As part of the Planning Process for FY26-27, Children's Integrated Therapy service secured resources to support addressing the waiting list.
- Developed Directorate Access Policy - including approach to managing DNA's (Did Not Attend) – expected sign off at the end of January 2026.

Risks

- Clinical and patient safety risks could include deterioration in patient condition, increased hospital admissions, unaddressed safeguarding concerns, reduced quality of life.
- Operational and performance risks could include failure to meet national standard, backlog accumulation, reduced system flow
- Negative impact on staff morale, skill mix imbalance
- Reputational and regulatory risks include reduced stakeholder confidence and potential regulatory challenges
- Financial risks such as inefficient resource use, failure to achieve system savings
- Digital and data quality risks that could obscure true waiting list size or risk prioritisation accuracy



Section 3

- 1. Quality
- 2. People

3.1 Quality - Deliver the best possible care and health outcomes

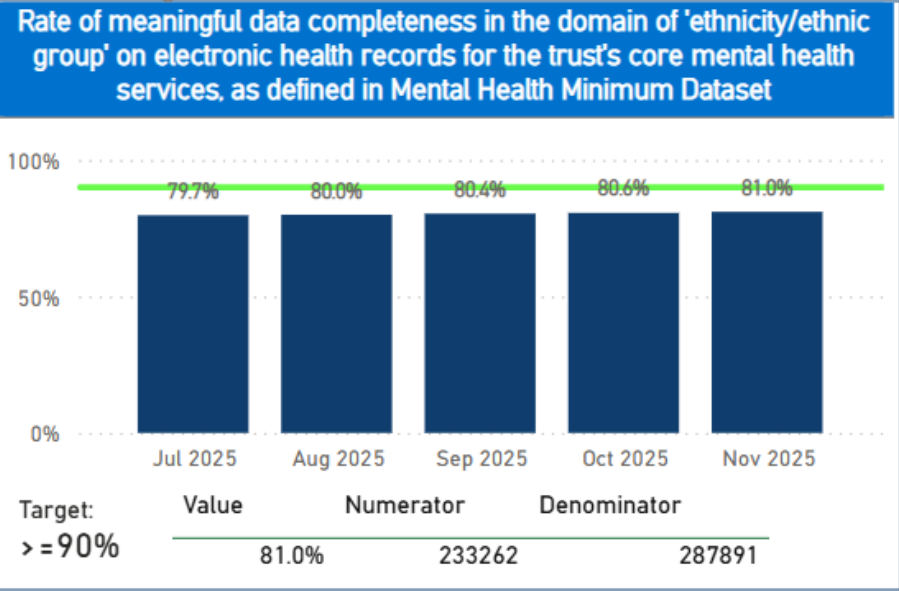
Quality - summary

Board Meeting in Public

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Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
<i>Local Strategic - Quality</i>	Rate of meaningful data completeness in the domain of 'ethnicity/ethnic group' on electronic health records for the trust's core mental health services, as defined in the Mental Health Minimum Dataset.	>=90%	Nov-25	81%	n/a*	n/a*	80.34%
<i>Local Strategic - Quality</i>	Reduction in the use of prone restraints (number of incidents involving prone restraint)	Less than 8 per month	Nov-25	12			13
<i>Local Strategic - Quality</i>	Reduction in the use of seclusion (number of incidents involving seclusion)	Less than 25.25 per month	Nov-25	23			36
<i>Local</i>	Total number of patient incidents (all levels of harm excluding inherited pressure damage)	-	Nov-25	1366		n/a	1415
<i>Local</i>	Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)	-	Nov-25	21		n/a	22
<i>Local</i>	Total number of suspected suicides	-	Nov-25	4		n/a	5
<i>Local</i>	Total number of incidents involving physical restraint	-	Nov-25	321		n/a	290
<i>Local</i>	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	-	Nov-25	374		n/a	366
<i>Local</i>	Total number of complaints and resolutions	-	Nov-25	70	n/a*	n/a	76

* - not enough data points to determine variation and/or assurance to apply Making Data Count algorithm



Understanding the performance

Patient and Carer Race Equality Framework (PCREF) was introduced by NHS England to reduce racial and ethnic inequalities in mental health services with respect to access, experience and outcomes. It is a mandatory framework for mental health trusts to embed. One of the focus areas is data quality and completeness ensuring that ethnicity among other protected characteristics data is collected, recorded and of sufficient quality, so that disparities can be measured.

The strategic metric on the right represents the rate of meaningful data completeness in the domain of "ethnicity/ethnic group" on electronic health records for the Trust's core metal health services. The Trust has set an internal target of 90% of in scope health records to have "ethnicity/ethnic group" meaningfully recorded – in November 2025 performance was at 81%.

High data completeness allows Trusts to:

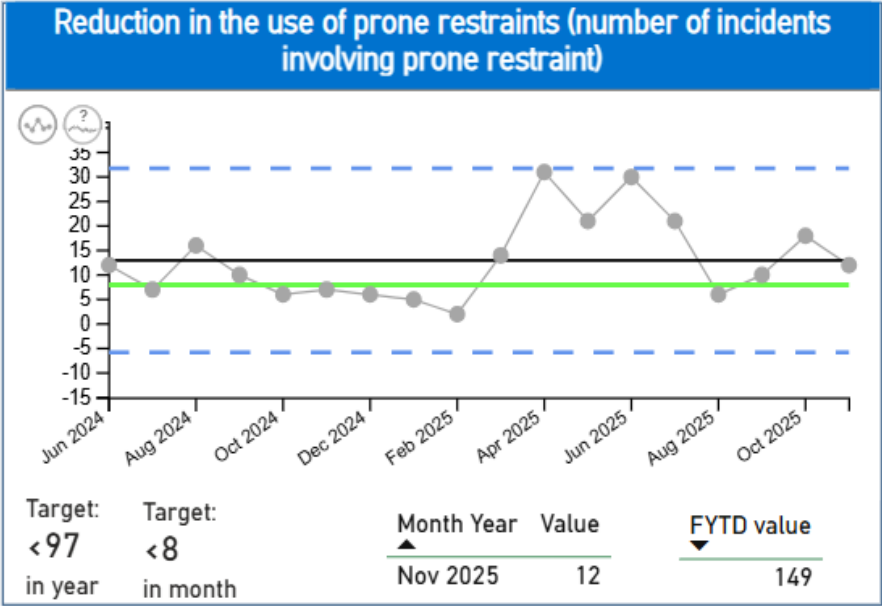
- Monitor Disparities: Identify differences in access, experience, and outcomes among ethnic groups.
- Inform Interventions: Develop targeted strategies to address identified inequalities.
- Enhance Accountability: Provide transparent data for regulatory bodies and the public.

Actions (SMART)

- Short-term actions underway to improve position:
Via the BRIDGE programme, we are undertaking a Quality Improvement project with the Gateway Team (adult community mental health service providing telephone assessment, advice and guidance for Buckinghamshire Primary Care Networks). Within the team, over a period of 12 months the rate of meaningful recording of ethnicity improved from 25.4% to 82.9%. A great achievement for the team and benefits the whole system since patient often then move onto other services/ teams. The team won in their category of Delivering the Best Possible Care and Outcomes.
- Medium-term actions underway to improve position:
QI Project - The ambition is for the QI project to be replicated in other areas of low data completeness/ quality over the next 6 months.
Campaign - There is a Trust-wide campaign aimed to improve ethnicity data to 90%.
- Long-term actions underway to improve position:
The PCREF group will develop guidance on recording protected characteristics data to empower staff to confidently and consistently have conversation with services users about their protected characteristics and provide the rationale for recording them. This addresses one of the main factors in under-recording - lack of professional confidence in engaging in these sensitive discussions.

Risks

Lack of data means the Trust is limited in being able to provide meaningful insights into access, experience and outcomes for service users of different ethnic backgrounds.



Understanding the performance

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. The reduction of the use of prone restraints remains one of the Trusts quality objectives for 2025/26. The target for 25% reduction in 2025/26 compared to 2024/25 will not be met due to the levels of prone restraints seen between March 25 to July 25. The target of less than 97 prone restraints in the year has already been surpassed.

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.

During the previous 12 months the Trust saw a sustained reduction in prone restraint until March 25, when there was a steep increase, which continued for 5 months. Since August 2025 there has been a reduction in prone returning to the previous lower levels around the target of less than 8 per month, however, is still higher than the reduction seen previously. November 2025 had 12 prone restraints involving 9 individuals across 5 wards. 5 of the 12 prone restraints were on Meadow Child and Adolescent Psychiatric Intensive Care Unit.

The highest reason for prone restraints during November was for the administration of IM (intra-muscular) medication, with 7 of the 12 prone restraints being for this reason. 4 were 'unintentional, led by patient'. This means that staff did not place the individual into a prone position intentionally and are usually unavoidable.

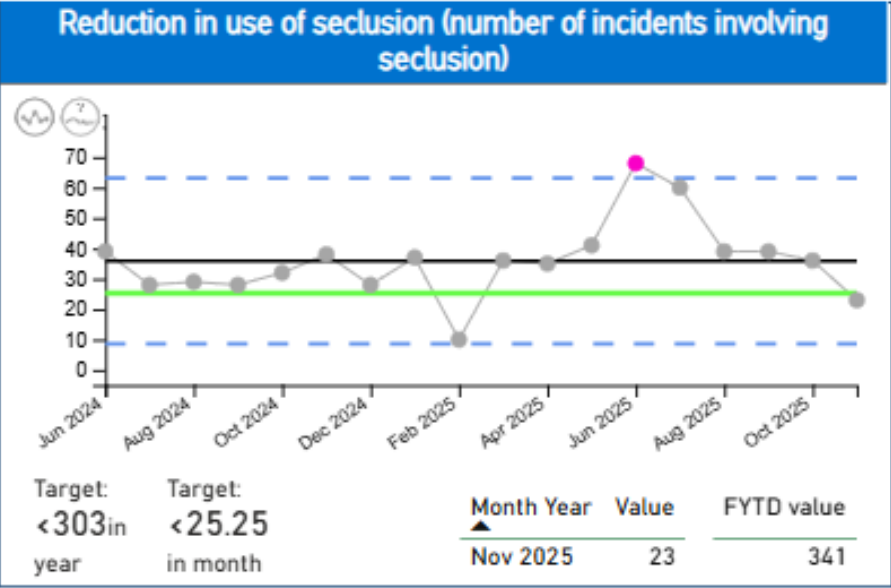
Actions (SMART)

The Positive and Safe Strategy work continues to focus on embedding quality improvement work around the use of prone restraints for IM medication and for seclusion procedures. Each episode of prone restraints is reviewed locally at team level for learning and at a directorate level for learning which feed into the Positive and Safe Trust wide group and the prone restraints reduction working group. Additional weekly review mechanisms were introduced when the use of prone restraints increased.

The use of the safety pods is now well embedded in most teams, and all Positive Engagement and Caring Environments (PEACE) trained staff are trained in their use. 175 of the 322 restraints during October utilised the safety pod, making it the highest restraint position used. All registered nursing staff have undertaken alternative injection site training to support confidence and competence in using alternative sites where possible that do not require prone restraint.

Risks

In general, prone restraints can have risks associated with physical well-being, psychological trauma to patients and, if used unnecessarily or lead to harm, can raise safeguarding concerns.



Understanding the performance

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 safe management of violent and aggressive behaviour.

The reduction in seclusion episodes since August, from the increase seen in June and July 2025, has been maintained in November 2025. November 2025 had 24 seclusion episodes involving 17 patients, across 11 wards, a reduction from 35 in October. The highest number of seclusion episodes within the month of November 2025 was Ashurst (male Psychiatric Intensive Care Unit) with 6 episodes involving 4 patients. A reduction from 11 episodes in October. Then it was Sapphire (male adult acute ward) with 5.

The reduction target of less than 303 seclusions during 2025/26 was exceeded in October 2025 so is not achievable. However, the work to reduce seclusions continues and this month is below the monthly target of 25 per month.

Actions (SMART)

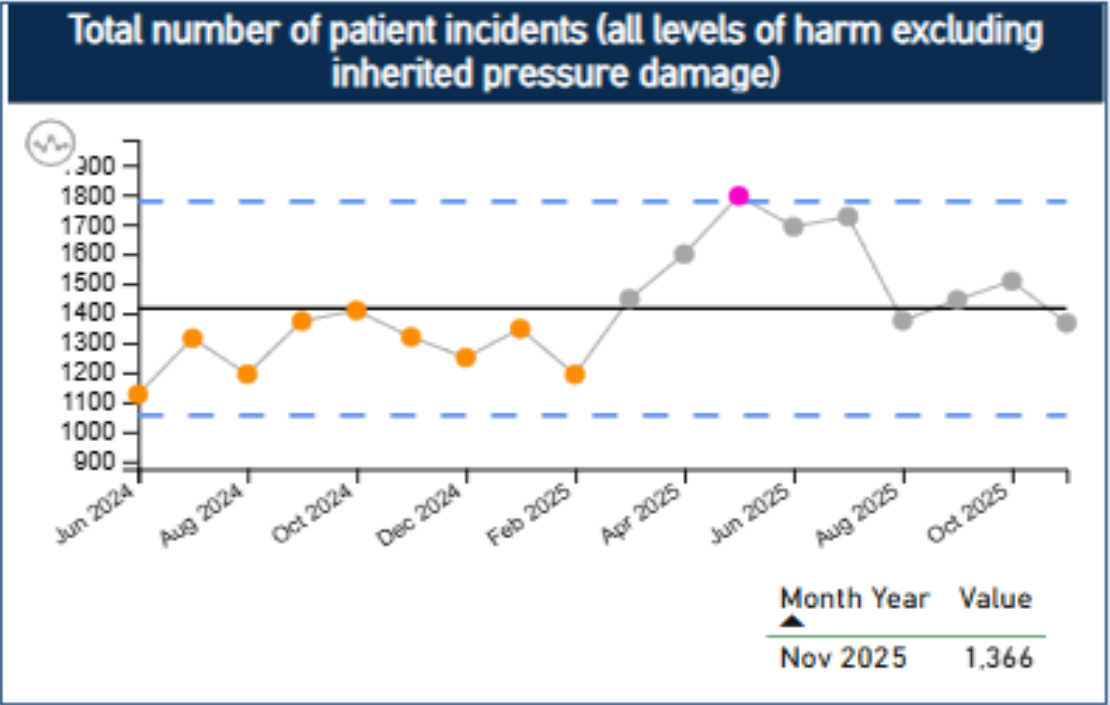
Seclusion duration data available on Trust Online Business Intelligence portal was due to be available from July. Due to some technical challenges this has been delayed and is not yet available. Once available, it will provide a more accurate account of the amount of seclusion that is being used across the Trust. This measure along with episodes will provide a more in-depth picture of the use of seclusion to inform improvement work.

Seclusion duration has been set as a Trust quality priority. During the 1st year a clear baseline for seclusion duration will be established on which to set the quality target. The target will be to reduce the amount of seclusion used (duration), not just episodes as currently reported.

Risks

Key risks associated with the use of seclusion:

- Psychological harm, which may increase the likelihood or intensity of anxiety. In some cases, especially if used for long period or without therapeutic engagement, seclusion can exacerbate psychosis, agitation or suicidal ideation.
- Though seclusion rooms are designed to reduce risk, patients may still harm themselves.
- Physical health issues may go unnoticed or untreated while the person is secluded.
- Regular use of seclusion may reflect poor culture, insufficient training or inadequate de-escalation protocols and can have a negative impact on staff morale.



Understanding the performance

The number of patient incidents in the last 3 months has returned to more usual levels. The reason for the increase in incidents from April-July 2025 has been covered in previous reports.

Most incidents continue to be on Child and Adolescent (CAMHS) Psychiatric Intensive Care Unit (PICU) Meadow Unit and CAMHS general acute ward (Highfield Unit) relating to patients self-harming. With the majority (99%) of incidents resulting in no specific harm or minor harm.

Across all incidents in November 2025 the most common incident categories are - self harm by patients, administration of medicines and violence by patients towards property. The majority of incidents had no harm or a minor/ low level of harm (91%), this compares to the national figure of 94% taken from the latest published national statistics for quarter 1 2025/26.

There were 3 severe harm incidents that happened under Oxford Health’s care in November 2025.

There is no increase or significant change in moderate or severe harm incidents in the last 6 months.

Actions (SMART)

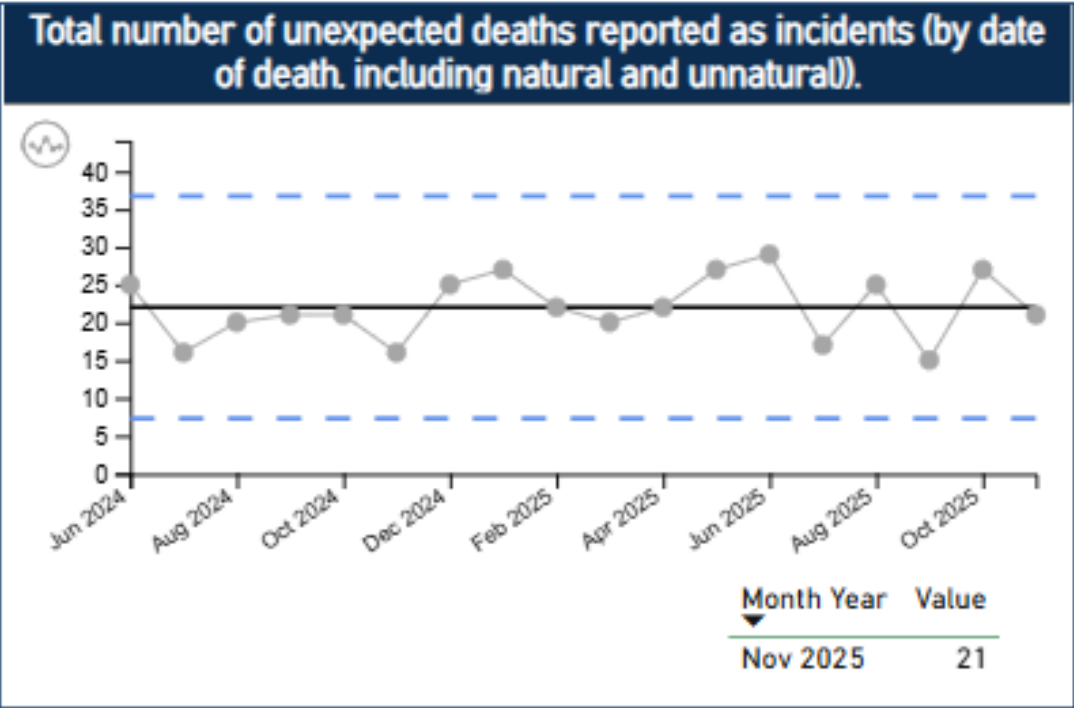
No specific actions are required as the incident pattern represents the current patient group and the clinical work happening with individuals.

The number of moderate harm or severe harm incidents is low and has not changed or increased over time.

All incidents are reviewed at time of reporting. There are regular weekly patient safety forums that oversee incidents, and the oversight of patterns/trends are reviewed at the Quality and Clinical Governance Group quarterly.

Risks

No specific risks identified, each incident is reviewed by a range of staff, immediate actions are taken and any further work required is identified. All patient and staff incidents resulting in moderate harm or above are reviewed by the Trust-wide weekly safety forum.



Actions (SMART)

We have strong processes in place to review and learn from all deaths. The trends and actions being taken from what we learn is regularly scrutinised by the Executive Directors, Quality and Clinical Governance Group and at the Quality Committee.

No further actions identified.

Understanding the performance

The Trust takes its role and responsibilities very seriously around reviewing, learning and taking appropriate actions after a patient's death. The Trust's learning from deaths process reviews all known patients on our 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 discharge from services. The oversight of key themes and learning from mortality reviews is led by the Trust's Mortality Review Group chaired by the Chief Medical Officer. The Group last met in October 2025.

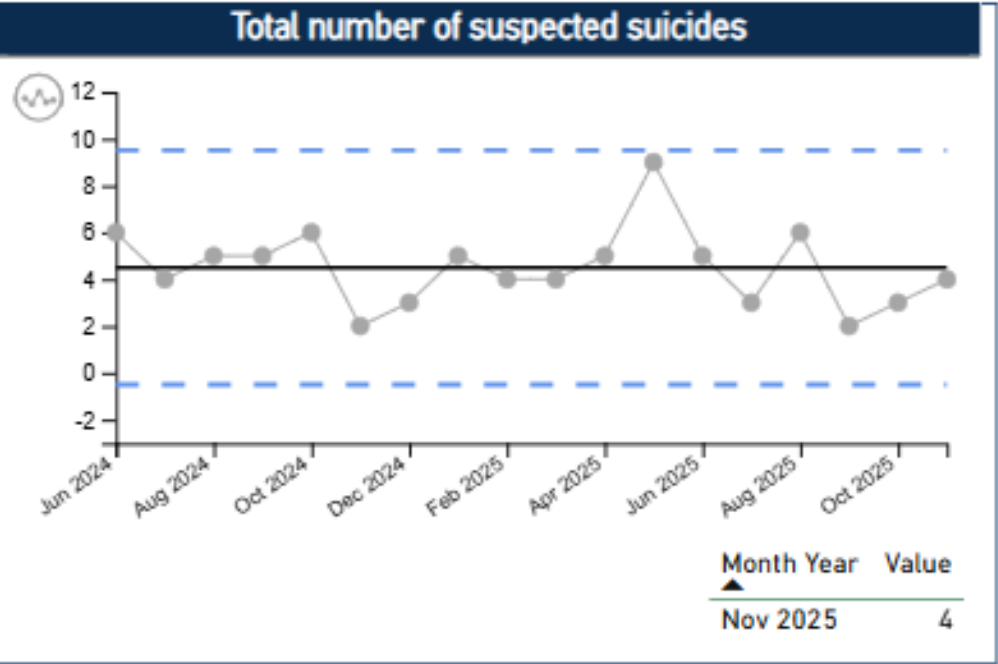
Our internal process involves two senior clinicians screening every known patient death and then depending on the outcome of this initial review and/or the circumstances of the death, this is then reported onto Ulysses. All unexpected deaths are then scrutinised by the Directorate senior management team through their weekly patient safety forums, which identify any actions and if further review is required. Alongside this, the Trust links 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. We also provide information to Coroners and Medical Examiner offices for independent reviews.

The number of unexpected deaths remains low and there is no change in trend over time. This data includes natural cause deaths. There has been no increase in suspected suicides, see next slide for detail.

No concerns are identified.

Risks

No specific risks identified.



Understanding the performance

The care provided and circumstances around every suspected suicide of a patient is reviewed, and the Trust offers families specialist support following a suspected suicide through the Trust’s family liaison service.

There were 55 confirmed/suspected suicides for open and recently discharged patients in the last 12 months, up to 30th November 2025. We have had 0 inpatient suicides in this time period. However there has been 1 suspected suicide of a patient 3 days after being discharged from a ward in August 2025; this has been reviewed as per process.

The Trust is part of two Real Time Surveillance Systems to improve the sharing of information across agencies so that we can learn and act as timely as possible. One of the systems covers the Thames Valley for all suspected suicides in the population and the other is a national system focused on inpatient suspected suicides. From this information we can see the number of suspected suicides in the population in Oxfordshire has increased in 2025 compared to 2024, but it is important to note the Trust has not seen the same increase, so the rise is for patients who have had no referral or contact with Oxford Health services.

Actions (SMART)

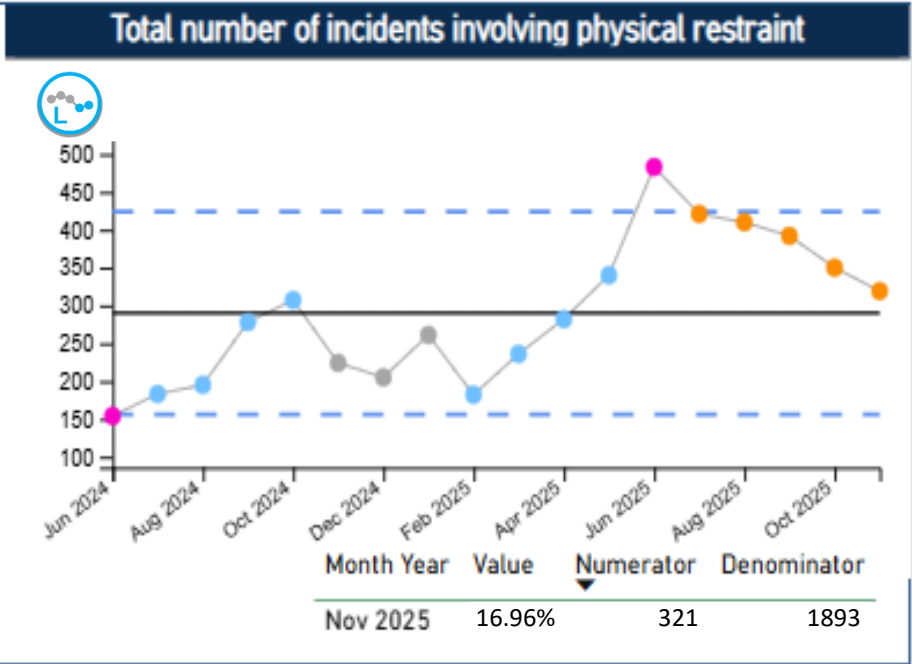
The Trust has strong processes in place to review and learn from all suspected suicides through the national Patient Safety Incident Response Framework, which includes engaging with families affected.

The Trust has a Suicide Prevention Group to steer improvement activity. We are also part of the public health work led by the local authority and national forums to work on the prevention of suicides.

No further actions identified.

Risks

No specific risks identified.



Understanding the performance

The overall increase in physical restraints is largely attributable to the increase in restraint across the Child and Adolescent Mental Health Services (CAMHS) inpatients pathway.

Since May 2025 there has been a reduction in physical restraints each month. Although it remains at higher levels than 2024/25. November 2025 continued this trend with 321 restraints involving 53 individuals. A reduction from 351 in October 2025.

The highest cause group for incidents involving restraint changed from violence and aggression during July and August back to self harm in September. This has continued with 56% (n=183) of physical restraints being due to self harm and the need to maintain individuals' safety in November. Violence & aggression was the reason for 91 physical restraints, followed by Health for 31 incidents involving physical restraint.

There were 22 incidents of restraint that involved administration of medication and 14 incidents for nasogastric (NG) feeding.

The areas with the highest use in November 2025 continues to be across the Child & Adolescent pathway with 236 of the 321 being across inpatient CAMHS services. CAMHS Psychiatric Intensive Care Unit (PICU) Meadow (n=139), Highfield (adolescent acute mental health ward) (n=85), and CAMHS Marlborough House (n=12). Ashurst (Male PICU) (n=15), Cherwell (older adults) (n=12) and Phoenix (Male acute) (n=12) were the wards with the highest number of incidents involving physical restraints outside of the CAMHS pathway.

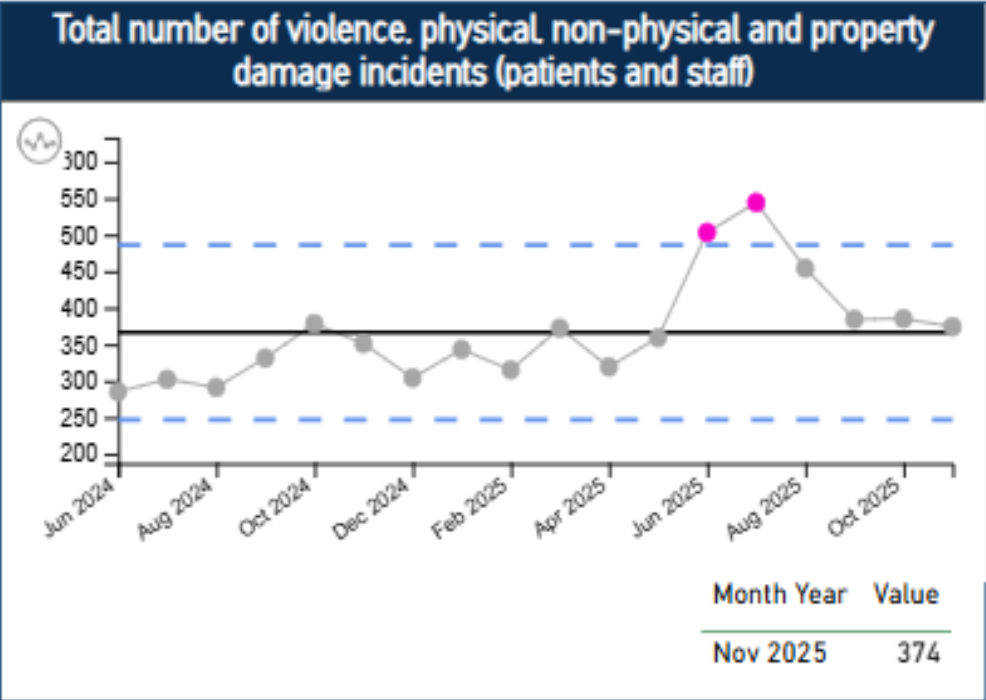
Actions (SMART)

Work across the CAMHS pathway continues to focus on alternatives to physical restraint to maintain the young persons safety through self harm reduction with personalised plans and alternatives to restraint in the event of self harm. A focussed report of this work was reported to the Quality and Governance Sub-group in September 2025.

Physical restraint is always a last resort, and the lowest level of holds is always used. The implementation of the safety pod has supported this.

Risks

To maintain individuals' safety, the use of physical restraint is required at times. In general, physical restraints can have risks associated with patient safety and wellbeing, staff safety and burnout, service and operational delivery.



Understanding the performance

The number of violent incidents increased between June - July 2025 and reduced from August 2025. In the last 12 months up to 30th November 2025, the majority of incidents relate to violence from patients towards staff, either physical violence with no injury or verbal abuse. 2 of the violent incidents were RIDDORs* reportable in November 2025. However, the majority result in no specific harm or minor harm (98%).

It is the inpatient units with the highest number of violent incidents, in November the wards with the highest were;

- Ashurst, adult Psychiatric Intensive Care Unit (PICU)
- Kingfisher, forensic female secure ward
- Phoenix, adult acute mental health ward
- Highfield, Child and Adolescent general acute ward

In November 2025, there was 1 severe harm violent incident whereby a patient in the community assaulted a member of the public.

12% of violent incidents had a racial element in November 2025. The majority of racial violent incidents relate to verbal abuse from patients towards staff and occurred mostly on Kingfisher (forensic secure ward), Ashurst (adult PICU) and Woodlands (forensic secure ward).

*RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations require employers to report certain type of incidents to the Health and Safety Executive.

Actions (SMART)

Violence towards our staff as they carry out their work is not acceptable.

The Trust has established a Reduction of Violence & Aggression Working Group to focus action on reducing violence and improving how we support staff who are exposed to verbal and physically violent behaviour. Progress against the workplan is reported to the Quality and Clinical Governance Group. The reducing violence work is being completed alongside increasing the safety of inpatient environments and work within the Positive and Safe Committee to continue to reduce the use of restrictive practice.

Risks

Staff being injured by patients during their work, resulting in sickness and possible issues with retention.



Understanding the performance

The Trust continues to value all complaints and concerns raised to use these as opportunities to make improvements. The Trust monitors key themes identified within complaints, alongside information from other sources of feedback such as Patient Safety Incidents, Legal Claims, Inquests and Human Resources (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 2025 there were 10 early resolution cases, 51 rapid resolution complaints, 9 low level complaints, 4 Care Quality Commission (CQC) cases and 5 Member of Parliament (MP) enquiries. The top teams with 3 or more complaints were Adult Mental Health Bucks Aylesbury Team, AMHT Oxon South, Minor Injury Unit Abingdon, Phoenix Ward (male adult acute) and Sapphire Ward (male adult acute).

During November 2025, the Trust received 164 compliments across services.

Actions (SMART)

- 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.
- A focus on celebrating compliments and sharing learning from good practice across services.

Risks

None requiring consideration by the Board of Directors.

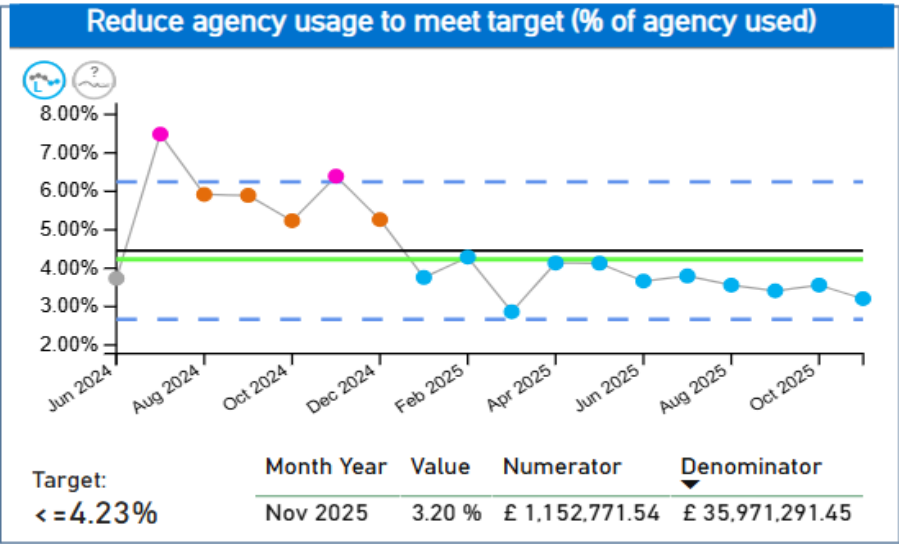
3.2 People - Be a great place to work

People - summary

Board Meeting in Public

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Type of metric	Metric	Target	Latest month	Measure	Variation	Assurance	Mean
<i>Strategic - People</i>	Reduce agency usage to meet target (% of agency used)	<=4.23%	Nov-25	3.20%			4.46%
<i>Strategic - People</i>	Reduction in % labour turnover	<=14%	Nov-25	9.12%			10.87%
<i>Strategic - People</i>	% of staff completing Quality Improvement Training Level 1	-	Nov-25	Interim reporting - 1237 staff completed (1216 in Oct-25)			
<i>Strategic - People Local</i>	Black, Asian and Minority Ethnic (BAME) representation across all pay bands including Board level.	>=19%	Nov-25	27.11%			25.59%
<i>Strategic - People Local</i>	Black, Asian and Minority Ethnic (BAME) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	>=19%	Nov-25	13.88%			13.55%
<i>Local</i>	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	-	Nov-25	78.08%		n/a	77.71%
<i>National NOF (scored)</i>	Reduce staff sickness to 4.5%	<=4.5%	Nov-25	5.34%			4.70%
<i>Local</i>	Personal Development Review (PDR) compliance (PDR season is between April – July)	>=95%	Nov-25	95.40%			83.70%
<i>Local</i>	Reduction in vacancies	<=9%	Nov-25	8.41%			10.58%
<i>Local</i>	% of early turnover	<=14%	Nov-25	10.75%			12.85%
<i>Local</i>	Statutory and mandatory training compliance	>=95%	Nov-25	92.50%			91.23%
<i>Local</i>	Overall supervision rate	>=95%	Nov-25	79.90%			75.68%
<i>Local</i>	Staff leaver rate	-	Nov-25	6.10%		n/a	6.63%
<i>Local</i>	Relative likelihood of white applicant being appointed from shortlisting across all posts compared to Black, Asian and Minority Ethnic (BME) applicants	1	Nov-25	1.47			1.88
<i>Local</i>	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	1	Nov-25	1.06			0.97



Understanding the performance

We have seen a sustained improvement in the reduction of agency usage by the Trust to below target of 4.23%. Overall, total agency spend in November 2025 fell slightly to 3.2% of total pay bill. The Trust is £1.51m better than plan for agency spend Year to Date.

Agency Spend as a % of Temporary Staffing was 27.6% (£1,153k) and Bank was 72.42% (£3,027k) reflecting the Bank First approach.

Fill rates :
NHSP shifts only (excluding Medical & Dental): In November 25, 81.95% of our temporary staffing shifts (based on hours) were filled by bank workers, above the 81% target. 17.45% were filled by agency workers and 2.25% were unfilled.

Medical & Dental (ID Medical, Allocate and Patchwork agencies): In November 25, 45.7% of our temporary staffing shifts (based on hours) were filled by bank workers; 51.1% were filled by Agency workers and 3.3% were unfilled.

Actions (SMART)The Break Glass Process for utilisation of

The break glass* protocol for utilisation of agency Healthcare Assistants (HCA's) was successfully introduced from the 17th November 2025 and has resulted in a significant reduction in the utilisation of his workforce, without an increase in utilisation of qualified staff to compensate.

There are currently 21 agency HCA's fully on boarded with NHS Professionals (NHSP) and a further 10 in the process of onboarding. Further recruitment will take place in 2026.

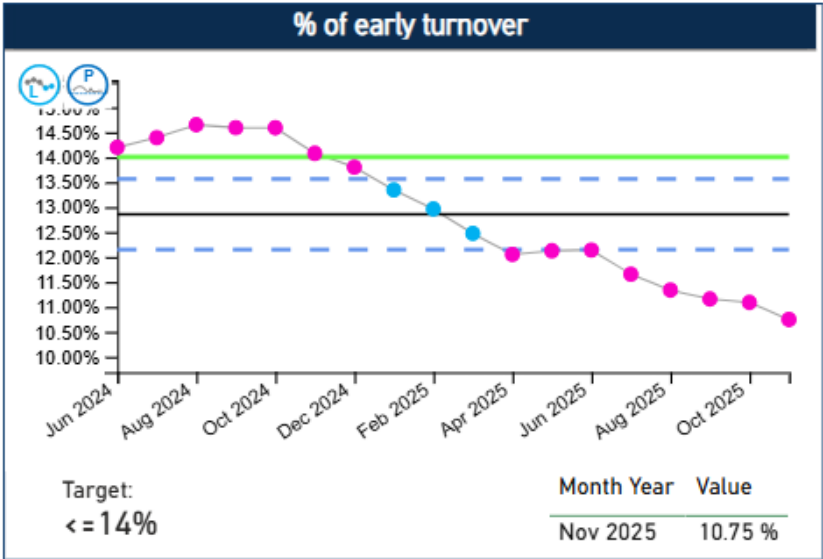
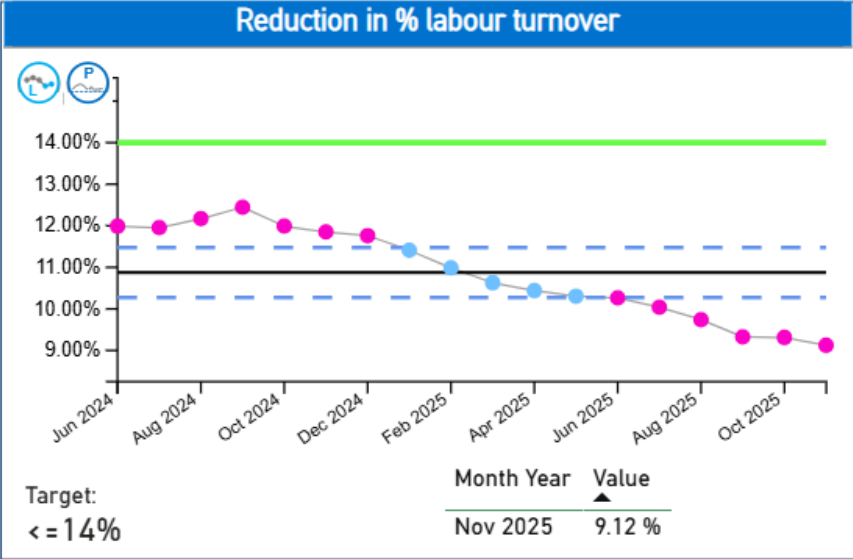
There are currently 26 Locum medics engaged across the Trust, three of these are joining us substantively in Child and Adolescent Mental Health Services during January and February 2026.

Work will continue to ensure performance remains better than target for the last quarter of the financial year.

*Break glass - following a significant consultation and evaluation process over the last 12 months, NHS England have issued a directive that providers will no longer be permitted to procure agency workers for Band 2 and 3 roles. This directive aligns with the Trust decision in August 2025, to remove the utilisation of Band 3 agency HCAs from Monday 17th November 2025. Staffing requirements for shifts that are published on or after Monday, 17th November, will not be included in the agency cascade, they will be made available to bank members. Likewise, teams are no longer permitted to directly book a band 2 or 3 agency worker into vacant shifts within their service. If there is an exceptional risk to patient safety, teams may request to "break glass" which will allow an agency worker to be procured for the vacant shift. Routine tasks, such as completing observations, are not considered to be a "break glass" reason.

Risks

Low uptake from Agency HCAs to join NHSP or the Trust substantively, may result in increased agency utilisation, thereby deflating the message from NHSE.



Understanding the performance

Staff turnover has shown a sustained reduction since October 2024. In November 2025 it has decreased from 9.31% to 9.12% and remains below the 14% target.

Staff turnover of Black, Asian and Minority Black, Asian and Minority Ethnic staff is 8.31%. White staff turnover is 9.65%.

Early turnover has decreased from 11.09% to 10.74% and remains below target. The early turnover of Black, Asian and Minority Ethnic staff is now lower than the early turnover of white staff at 9.48% compared to early turnover of white staff 12.49%

Actions (SMART)

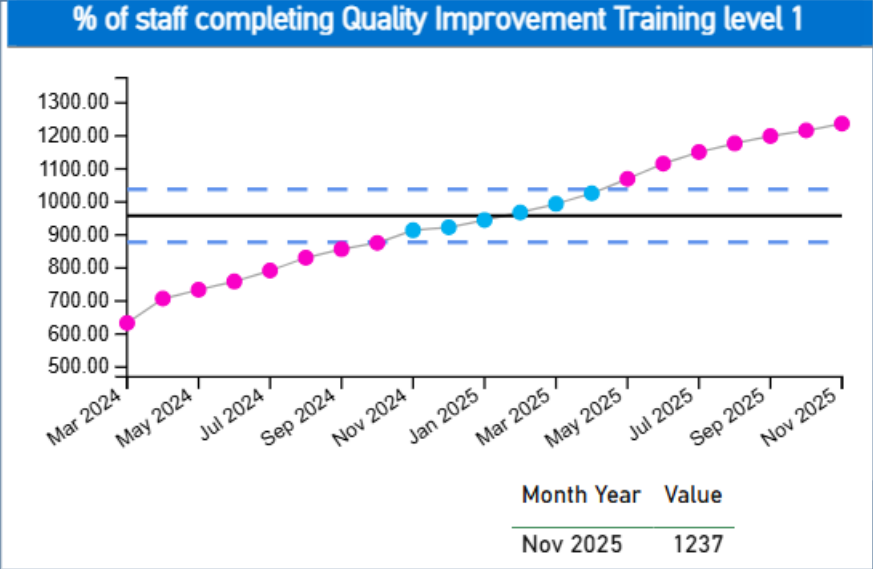
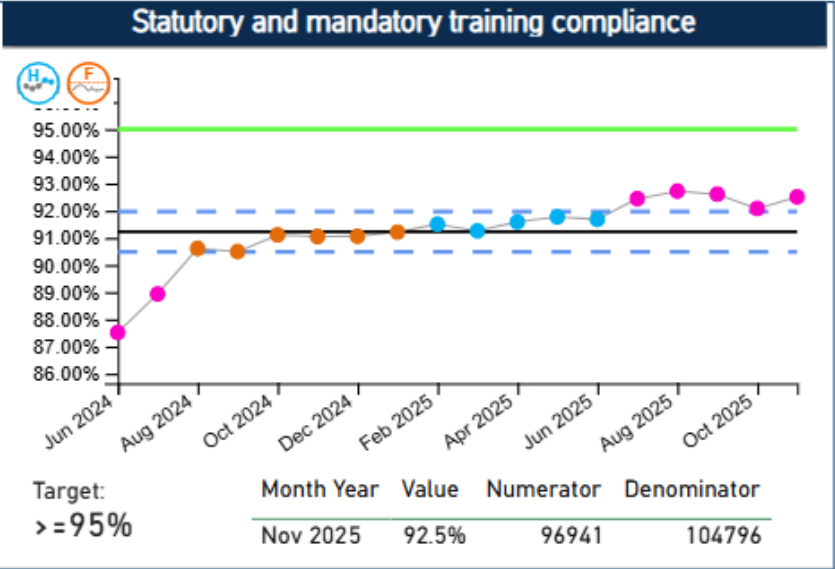
The retention programme has been reviewed, several workstreams have been closed and the work will now focus on:

- Flexible Working which is being reviewed
- and
- Staff Recognition for which a period of discovery is taking place to review what Oxford Health does to recognise its staff and discover what other NHS trusts do in this space.

A quarterly update on retention is taken to the People Steering Group to update on progress.

Risks

Turnover may be higher in some areas which is masked by the average. This may impact on vacancies and quality of care provided to patients. Continued work will be done to focus on location and professions where turnover is higher than average.



Understanding the performance

The Statutory and Mandatory training compliance rate remains consistent with a small increase from 92.08% to 92.50%.

11 out of 12 modules of Mandatory training have a compliance rate above 90%. Only Resus remains under 90% at 79.21%.

The National NHSE Core Skills Training Framework (CSTF) alignment programme is currently reviewing safeguarding training.

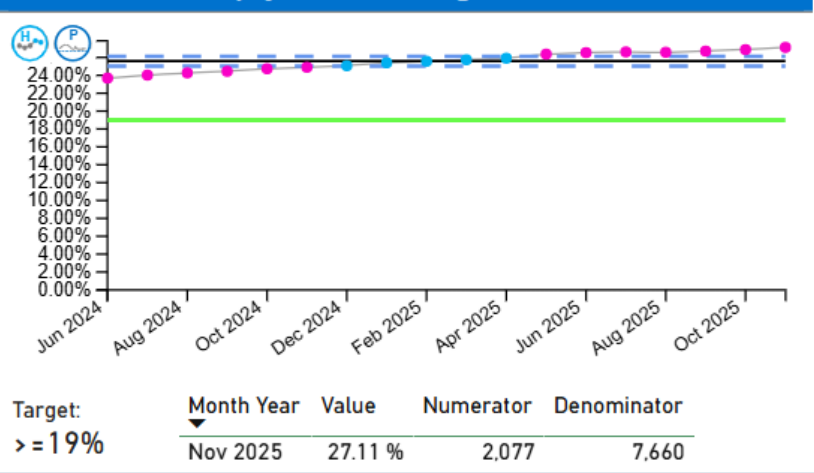
Actions (SMART)

- This month has seen a slight reduction in Resus compliance from 80.09% to 79.21% - there continues to be high DNA rates but also some cancellation of training due to sickness (both internally but also in the private provider). L1 resus awareness training roll out started on 15th Dec in response to the need to fully align to the CSTF as part of the NHSE National programme. 20% of staff required to completed this training have already done so in the 1st month of roll out.
- The Oliver McGowan tier 1 and 2 training roll out is underway throughout the trust and wider system on a risk-based approach. The second part of the Oliver McGowan Mandatory training is being added to matrices in the Community and Corporate Directorates in three phases from October 2025 to October 2026 due to the availability of training places. Plans for other directorates will be confirmed once the ICB confirms the ongoing plans for delivery.

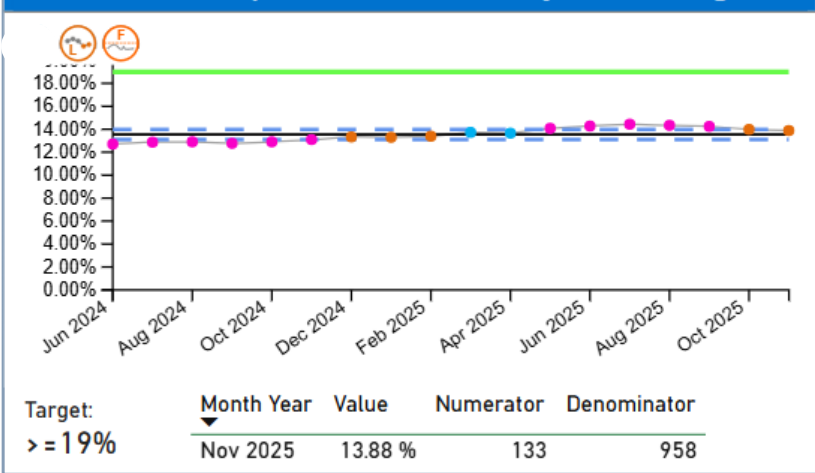
Risks

If people have not attended mandatory training, there is a risk that quality of care and patient safety may be affected.

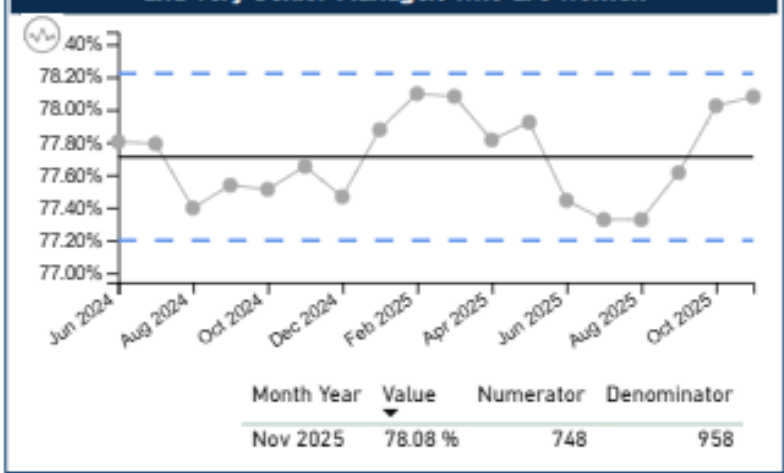
% of BAME (black, Asian and minority ethnic) representation across all pay bands including board level



% of BAME (black, Asian and minority ethnic) representation in senior leadership roles (8a -8d, B9 & Very Senior Manager)



Proportion of staff in senior leadership roles (bands 8a -8d, 9 and Very Senior Manager) who are women



Understanding the performance

- There has been a slight increase of 0.85% in the representation of Black, Asian and Minority Ethnic staff across all pay bands in November 2025 reporting period.
- There has been a decrease of 0.25% in the representation of Black, Asian and Minority Ethnic staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in November 2025 reporting period.
- There has been a slight increase (78.08%) in the representation of female staff in senior leadership roles (bands 8A-8D, B9 and Very Senior Manager) in the October 2025 reporting period.

Actions (SMART)

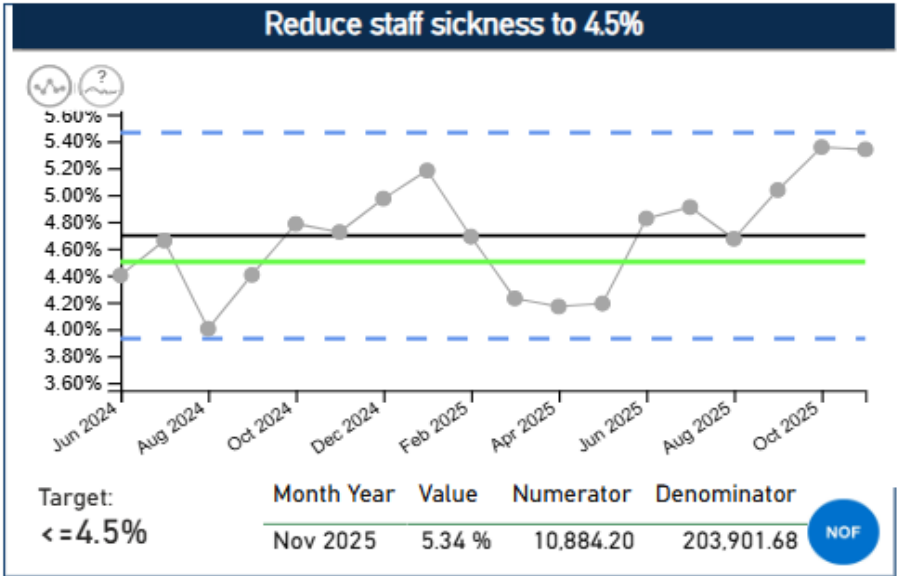
Organisation wide actions have been taken as guided by the NHS Equality, Diversity and Inclusion (EDI) - High Impact Actions. These actions are focused on: Leadership Accountability, Fair recruitment & development, Closing pay gaps, Addressing health inequalities, support for international staff and the creation of a safe workplace.

Actions have been included within the NHS Workforce Race Equality Standard (WRES) report that was presented at the Equality, Diversity and Inclusion Steering Group 12 June 2025. We are now focusing on reviewing current actions and will report back via the same Steering Group.

Work has commenced on creating a single plan pulling together all EDI actions, the draft will be socialised during January 2026, and presented at the EDI Steering group in early Feb 26

Risks

Lack of diversity can result in narrow decision making that lacks cultural insight and does not meet the needs of our patients or staff. This can lead to reduced levels of patient care, increased labour turnover and difficulties attracting diverse talent.



Understanding the performance

The sickness absence rate has decreased from 5.36% to 5.34% in November 2025, 0.84% above target.

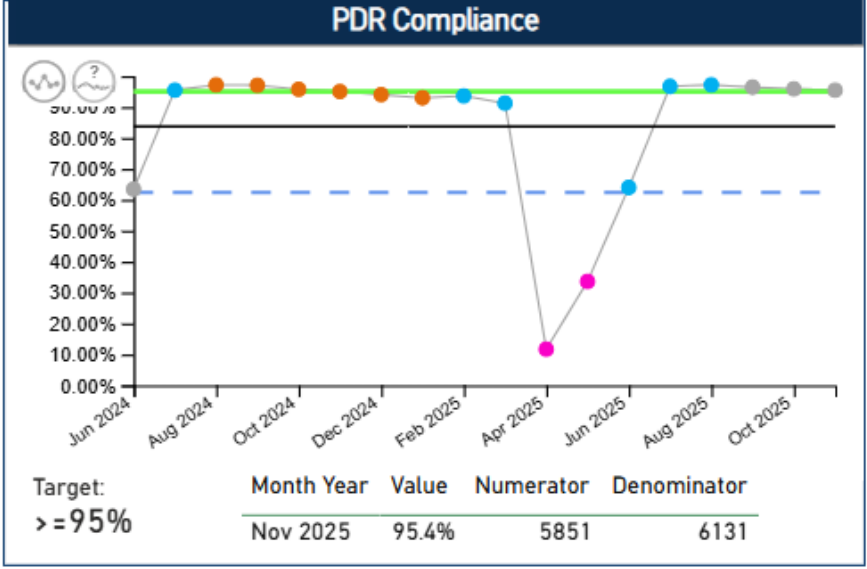
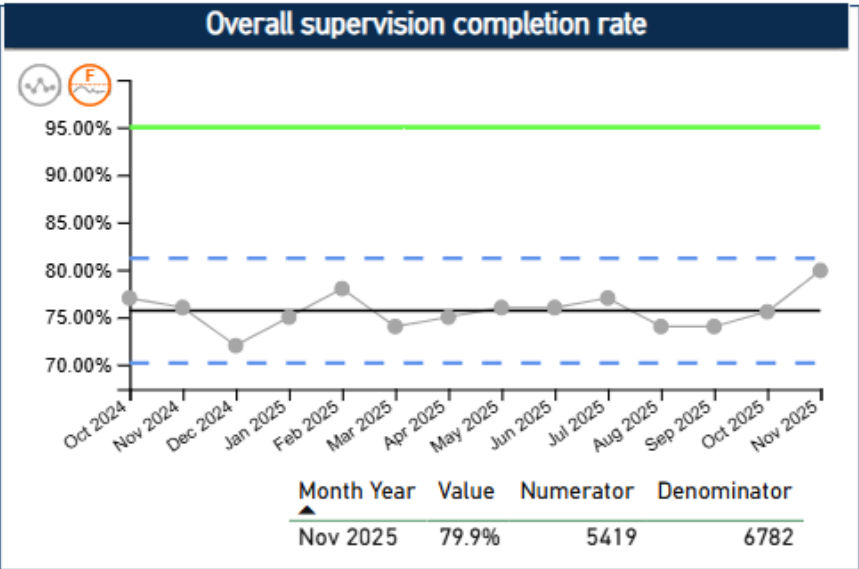
The proportion of long term versus short term cases remains rising slightly with the previous month. Long term absence has risen, from 2.84% to 3.20% and short-term absence has decreased slightly from 1.64% to 1.39%

The most common reasons for absence based on number of cases were Cold/Cough/Flu, Gastrointestinal, Not Specified and Headache and Migraine.

The NHS Medium Term plan states an ambition for all Trusts to reduce sickness absence levels to 4.1%.

- ### Actions (SMART)
- Absence levels are discussed monthly in Operational Meetings/Service Reviews and in Directorate People Meetings/SMT's and higher areas of absences are highlighted.
 - HR Advisors are proactively working with managers to review sickness casework and try and progress and resolve cases. A focus on absence continues and data is reviewed each month with managers being contacted for an update where staff are reaching either long- or short-term triggers as defined in the Sickness Absence policy. There is also a drive to reduce the number of absence reasons recorded as unknown
 - The completion of Return-to-Work Interviews is encouraged, and information is being disseminated within the directorates on any outstanding Return to Work Interviews.

- ### Risks
- If periods of long-term sickness absence is not regularly reviewed by the line manager, then this can potentially delay any return to work and result in longer periods of staff absence.
 - If line managers are not undertaking Return to Work interviews there is a risk that the Trust does not record the correct reasons for absence details, are not capturing supportive actions put in place to improve sickness monitoring and maintain lower sickness levels.



Understanding the performance

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.

Personal Development Review (PDR) compliance for the month is in line with previous years patterns, although has fallen slightly (95.43%). All but three directorates are above 95% for PDR compliance (Buckinghamshire Mental Health are 94.0%, Research and Development at 89.2% and Oxfordshire Bath and North East Somerset, Swindon and Wiltshire mental health directorate and at 94.7%).

Clinical and Management supervision has been replaced with an Overall supervision compliance measure which has increased from 75.57% in October 2025 to 79.9% in November 2025.

Actions (SMART)

Since the change to a one reporting system for supervision, we have started to see improvements in compliance and feedback from most services and individuals is that they prefer the simplicity of the recording. Staff are still able to record both clinical and managerial supervision separately if needing to as well as options for group and safeguarding supervision.

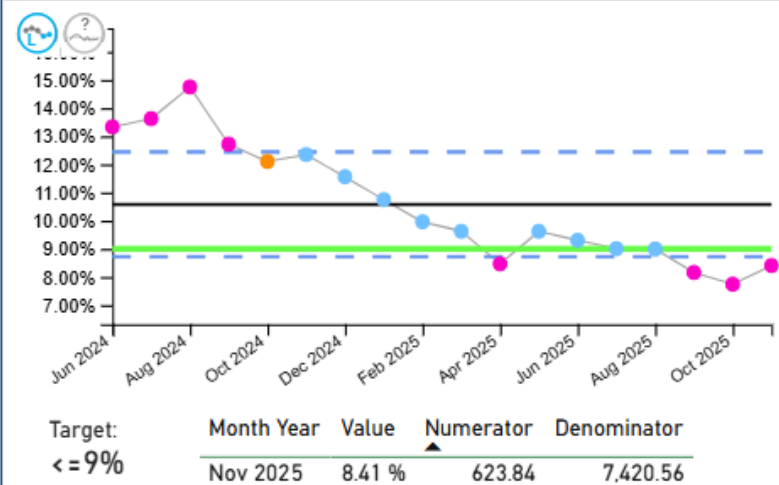
There have been some concerns raised about the inability to report on separately for psychological therapies – options are being explored.

Using most recent staff survey results the Learning & Development and Organisational Development teams will review the quality of both PDR and supervision interactions and suggest changes in response to this.

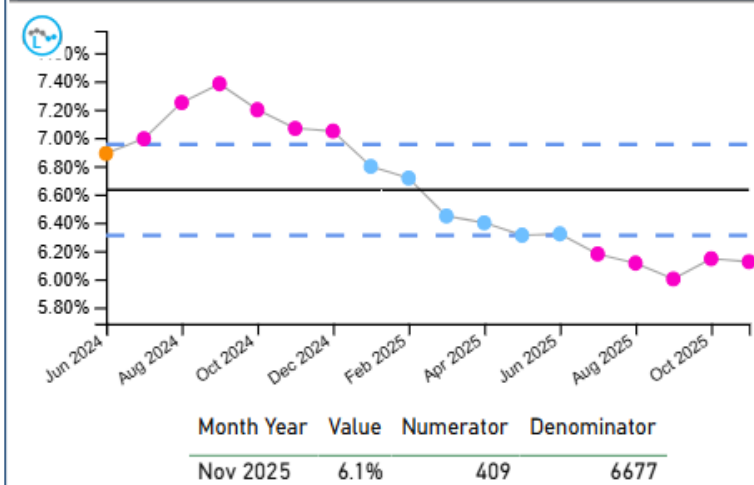
Risks

Failure to provide regular clinical or managerial supervision or conduct PDR may result in staff feeling unsupported, increased levels of work-related stress sickness absence and increased levels of labour turnover. They may also result in reduced quality of care and increased risk of patient safety issues.

Reduction in vacancies



Staff leaver rate



Understanding the performance

Following a sustained reduction in the vacancy rate since September 2024, rate has risen in November 25 from 7.7% to 8.4% but remains below the 9% target.

The staff leavers remains low, has seen a slight fall in November 2025, from 6.14% to 6.12%.

Tighter controls on vacancies, particularly newly created vacancies, a reduction in employee turnover, an improved recruitment process through a Talent Acquisition team and continued development of recruitment marketing mean that vacancies are well managed and vacancy rates are being kept low.

Actions (SMART)

Talent Acquisition

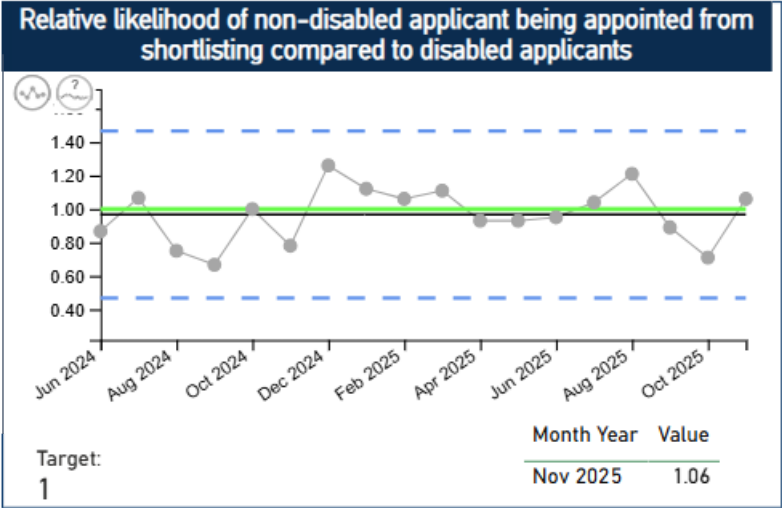
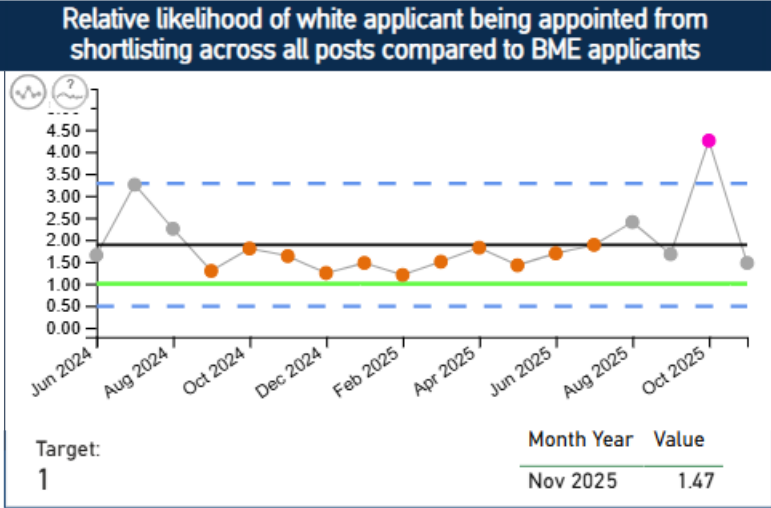
- Vacancy rates have continued to track under the 9% Trust target since July 2025.
- The December HCA event was moved to a bespoke event for Eating Disorders and resulted in successful hires.
- Total time to hire has reduced by 7.2 days since October, this is an expected reduction from changes to the onboarding process, such as the online forms and virtual ID checks. November 2025 time to hire was 64.65 days, in comparison to November 2024 which was 82.36 days.

Marketing & Events

- The Internal Recruitment Bulletin averaged 2,578 views weekly across 2025, resulting in 817 applications and 152 successful offers to internal candidates, supporting staff retention and improving employee experience.
- The new External Vacancy Spotlight was launched in October 2025 and is now sent monthly to prospective candidates who have signed up to a mailing list and/or to our talent pool, readership averaged 38% in the first quarter.
- Social media spend decreased in 2025, delivering an 85% cost saving, while social reach increased from 3.5k in January 2025 to a peak of 151k in October 2025. Social Media activities resulted in 1526 applications received in 2025 and 64 successful offers.

Risks

- Ongoing changes to immigration and visa sponsorship rules continue to pose a risk to recruiting lower-banded roles and may also influence retention if sponsored staff choose to leave the UK.
- Increased reliance on new digital tools for pre-employment checks and recruitment processes introduces system-dependency risks that could affect onboarding timelines if outages occur.
- Building sustainable talent pipelines, including early-careers and internal mobility routes, will take time to mature and may limit how quickly vacancy rates can improve over the next 2–3 years.



Understanding the performance

The relative likelihood of white applicants being appointed from shortlisting compared to Black, Asian and Minority Ethnic applicants has decreased from 4.25 in October 2025 to 1.47 in November 2025. 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 increased from 0.71 in October 2025 to 1.06 in November 2025. 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 (SMART)

Organisational wide actions have been taken as guided by the NHS Equality, Diversity and Inclusion - High Impact Actions. These actions are focused on: Leadership Accountability, Fair recruitment & development, Closing pay gaps, Addressing health inequalities, support for international staff and the creation of a safe workplace.

Inclusion representatives form part of all recruitment panels for leadership positions at Band 8a and above. This will support inclusive decision making and improve diversity in senior leadership positions as identified within the High Impact Actions. This work is reported via regular updates into the Equality, Diversity and Inclusion Steering Group.

Risks

Lack of Diversity can result in narrow decision making that lacks cultural insight and does not meet the needs of our patients or staff. This can lead to reduced levels of patient care, increased labour turnover and difficulties attracting diverse talent.

Section 4

Strategic dashboard

Strategic objectives

Board Meeting in Public

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 is reported twice per year – in November (representing six-month position) and in May (representing annual position); in-year strategic metrics, where possible, are reported monthly throughout the IPR.

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

General Appendices

Metric	Latest ICB Target	Aug-25				Sept-25 - Quarter 2				Oct-25			
		BOB ICB	Oxon	Bucks	Berks W	BOB ICB	Oxon	Bucks	Berks W	BOB ICB	Oxon	Bucks	Berks W
Board Meeting in Public													
Mean LoS for MH adult acute, older adult acute and PICU discharges (target changing periodically)	50	48	47	37	60	47	53	37	46	51	60	35	50
OAPs Percentage of Inappropriate OAPs bed days in Adult Acute beds in the period	null	2%	2%	1%	2%	2%	2%	2%	3%	3%	2%	3%	4%
72hr Follow-up	null	87%	81%	94%	88%	81%	87%	81%	71%	84%	87%	79%	84%
CMH 2+ contacts	null	19510	9030	5590	4905	19610	9085	5610	4935	19710	9135	5620	4975
CMH referral-spells waiting for a full clock stop	null	9805	4520	3405	1880	9790	4575	3310	1905	9655	4490	3235	1935
CMH referral-spells waiting more than 104 weeks for a 2nd contact	null	135	100	30	5	115	80	25	5	110	80	25	5
Open CMH referral-spells waiting for a 2nd contact	null	3065	1145%	1115	800	3015	1180	1035	805	3050	1170	1070	810
Open CMH referral-spells with 2+ contact that have had a full meaningful help clock stop	null	34%	25%	23%	62%	35%	26%	24%	62%	37%	28%	26%	62%
CYP 1+ contacts (target changing periodically)	25329	26705	8960	7900	9860	26940	9085	7960	9915	27140	9220	8050	9890
CYP Paired scores (%)	null	6%	*	*	*	9%	*	*	*	13%	*	*	*
CYP Self-rated measurable improvement (%)	null	35%	*	*	*	16%	*	*	*	30%	*	*	*
CYP referral-spells waiting for a full clock stop	null	24870	9350	6605	8910	25135	9480	6655	9005	25455	9640	6835	8975
CYP referral-spells waiting more than 104 weeks for a 1st contact	null	2830	1210	730	890	2865	1220	730	915	2905	1225	740	945
Open CYP referral-spells waiting for a 1st contact	null	10665	3000	2310	5355	10980	3190	2465	5320	11030	3265	2535	5230
Open CYP referral-spells with 1+ contact that have had a meaningful help clock stop	null	13%	12%	8%	21%	15%	14%	11%	22%	16%	14%	11%	23%
CYP ED Routine (interim)	null	90%	89%	89%	94%	89%	89%	80%	94%	92%	89%	90%	100%
CYP ED Routine (interim)	null	81%	67%	100%	*	86%	82%	86%	*	85%	78%	88%	100%
Dementia: 65+ Estimated Diagnosis Rate	null	62.60%	64.10%	58.40%	65.40%	62.70%	64.40%	58.40%	65.30%	63.10%	64.70%	59.00%	65.60%
EIP 2 week waits	null	81%	81%	77%	100%	69%	68%	65%	*	68%	69%	60%	100%
Inpatient No Contact BME	null	13%	14%	17%	*	13%	15%	13%	*	15%	21%	*	*
Inpatient No Contact White British	null	13%	12%	19%	14%	13%	15%	*	14%	10%	11%	8%	10%
Inpatient No Contact	null	14%	12%	13%	12%	13%	16%	10%	12%	12%	14%	10	10%
Individual Placement and Support (IPS, rolling 12 month; target changing periodically)	1032	1545	715	370	465	1580	750	360	470	1605	755	370	480
% of People discharged from adult acute beds aged 18 to 64 with a length of stay 60+ days	null	21%	24%	15%	22%	21%	23%	17%	24%	25%	27%	19%	28%
% of People discharged from older adult acute beds aged 65+ with a length of stay 90+ days	null	34%	30%	*	57%	40%	35%	31%	60%	42%	41%	29%	62%
OAPs bed days (inappropriate only)	null	515	285	90	135	620	260	150	210	710	210	155	345
OAPs active at the end of the period (inappropriate only)	6	5	*	*	*	5	*	*	*	5	*	*	5
Perinatal access (rolling 12 month)	1379	1615	585	425	605	1645	600	420	625	1675	605	430	640
Restrictive Interventions per 1,000 bed days	null	*	*	*	*	*	*	*	*	*	*	*	*
SMI PH (quarterly metric)	null					47%	41%	50%	54%				
Talking Therapies Completing a course of treatment	1824	1715	660	665	390	1945	730	710	505	2020	790	705	520
Talking Therapies Completing a course of treatment 65+ (quarterly metric)	null					535	170	255	110				
Talking Therapies Completing a course of treatment (YTD) (target changing periodically)	13219	9355	3635	3465	2255	11300	4360	4175	2760	13245	5155	4810	3275
Talking Therapies Reliable Improvement (target changing periodically)	68.2%	66%	68%	65%	64%	68%	70%	67%	68%	65%	65%	67%	60%
Talking Therapies Reliable Recovery (target changing periodically)	49.7%	48%	69%	48%	46%	50%	53%	49%	48%	48%	48%	49%	45%
Talking Therapies Reliable Recovery BME (quarterly metric)	null					42%	43%	43%	41%				
Talking Therapies Reliable Recovery White British (quarterly metric)	null					51%	52%	51%	49%				
Talking Therapies 1st - 2nd Treatment >90 days	null	7%	6%	2%	15%	8%	6%	3%	16%	9%	7%	3%	21%
Talking Therapies 6 week waits	null	94%	100%	99%	75%	93%	100%	96%	77%	93%	99%	97%	77%
Talking Therapies 18 week waits	null	100%	100%	100%	99%	100%	100%	100%	99%	100%	100%	100%	100%
Mental Health A&E 12hr breaches - Adult (%)	null	10%	4%	16%	12%	14%	7%	22%	19%	13%	8%	16%	18%
Mental Health A&E 12hr breaches - CYP (%)	null	*	*	*	*	5%	*	*	*	7%	10%	*	*
Referrals to LPS from A&E (contacts within 1hr)	null	86%	88%	90%	78%	85%	90%	91%	72%	90%	93%	92%	81%
Urgent referrals to CCS (contacts within 24hrs)	null	66%	56%	72%	61%	65%	69%	60%	72%	68%	67%	66%	69%
Very Urgent referrals to CCS (contacts within 4hrs)	null	52%	*	*	100%	71%	60%	*	79%	74%	*	78%	100%

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

NHS Oversight Framework – dashboard (scored metrics) – quarter 1

Board Meeting in Public

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Domain	Metric	Metric score	Metric ranking	Metric reporting period	Metric value	Average value (other providers)	NOF score	NOF score placement (national distribution)
Access to services	Percentage of patients waiting over 52 weeks for community services	3.7	38 out of 41	Jun-25	20.05%	0.70%	2.73	
	Annual change in number of children and young people accessing NHS-funded Mental Health services	1.76	12 out of 46	Jun-24-Jun-25 vs Jun-23-Jun-24	15.25%	4.57%		
Effectiveness and experience of care	CQC community mental health survey satisfaction rate	2	n/a	2024	.	.	2.25	
	Percentage of patients with >60-day length of stay (adult acute mental health)	1.89	15 out of 47	Q1 2025-26	22.27%	24.67%		
	Urgent Community Response 2-hour performance	2.85	32 out of 37	Q1 2025-26	74.88%	85.58%		
Patient Safety	NHS Staff Survey - raising concerns sub-score	1.65	14 out of 61	2024	6.99 out of 10	6.81	1.83	
	Percentage of patient in mental health crisis to receive face-to-face contact within 24 hours	2	16 out of 45	Q1 2025-26	63.43%	58.00%		
People and workforce	Sickness absence rate	1.76	9 out of 61	Q4 2024-25	4.79%	5.65%	1.73	
	NHS Staff Survey engagement theme sub-score	1.7	15 out of 61	2024	7.24 out of 10	7.08		
Finance and productivity	Planned surplus/deficit score	1	8 out of 61	2025-26	0.67%	0.00%	1.52	
	Variance year-to-date to financial plan score	1	18 out of 61	Month 3 2025	0.02%	0.00%		
	Relative difference in costs score	2.04	20 out of 60	2023-24	96.80	105.39		

Glossary of metrics (in continuous development)

Area		Metric		Definition	Why is it important?
Mental Health Services	Improve access to mental health support for children and young people			This metric tracks the number of children and young people (CYP) aged under 18 who have accessed NHS-funded mental health services within a rolling 12-month period. Derived from the NHS Long Term Plan access standard for CYP mental health.	Improved access ensures that CYP with emerging mental health needs receive early support, reducing the risk of escalation to crisis. Early intervention supports better educational outcomes, family wellbeing, and long-term recovery.
	Four (4) week wait for mental health support for children and young people			Percentage of referrals to community-based mental health services for CYP who receive their first meaningful treatment within 4 weeks. This is an NHS England access standard under development nationally.	Timely intervention is critical in preventing deterioration of mental health in CYP. A shorter wait reduces distress and avoids escalation to emergency or inpatient care, improving long-term outcomes.
	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - children and young people			The proportion of routine referrals for suspected eating disorders in CYP who begin a National Institute for Health and Care Excellence (NICE)-concordant treatment pathway within 4 weeks. This is part of the Access and Waiting Time Standard for Eating Disorders.	Eating disorders have some of the highest mortality rates of all mental illnesses. Early treatment improves recovery rates and physical health outcomes, reducing the need for inpatient admission.
	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - children and young people			The proportion of urgent referrals for eating disorders in CYP starting NICE-concordant treatment within 7 days. Monitored as part of the Eating Disorder Access & Waiting Time standard.	In urgent cases, rapid intervention prevents physical deterioration and supports better psychological recovery. Delays in urgent care can lead to life-threatening complications and increased family distress.
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression			Total number of patients (aged 18+) who complete a course of treatment in NHS Talking Therapies (formerly IAPT) services.	Higher treatment completion suggests improved service access, engagement, and continuity. For patients, it reflects successful navigation of therapy and greater opportunity for symptom relief.
	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over)			The proportion of total IAPT therapy completers who are aged 65 or above. Tracked nationally to monitor equitable access for older adults.	Older adults are historically underrepresented in psychological therapy. Improving this rate supports healthy ageing, reduces loneliness, and improves independence in later life.
	Reliable improvement rate for those completed a course of treatment adult and older adults combined			Percentage of people who show reliable improvement (defined as statistically significant positive change on two validated clinical outcome measures such as PHQ-9 and GAD-7) after completing NHS Talking Therapies treatment.	This is a core quality indicator for psychological therapy. It provides assurance that patients are receiving interventions that lead to real, measurable improvements in mental health.
	% of people receiving first treatment appointment within 6 weeks of referral			The proportion of patients referred to NHS Talking Therapies who begin treatment within 6 weeks.	Timely access improves therapeutic outcomes and helps prevent worsening of conditions. For patients, shorter waits reduce uncertainty and support early symptom relief.
	% of people receiving first treatment appointment within 18 weeks of referral			Proportion of referrals to NHS Talking Therapies seen within 18 weeks of referral.	Ensures that the vast majority of patients are not left waiting for care. It reflects service responsiveness and commitment to recovery-focused care.
	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments)			This metric measures the proportion of patients who wait over 90 days between their first and second Talking Therapies appointments. The standard is that less than 10% should wait this long.	Long gaps between sessions disrupt therapeutic progress and risk disengagement. Maintaining momentum between sessions supports better recovery and improves the patient's therapeutic experience.
	Reliable recovery rate for those completed a course of treatment adults and older adults combined			Percentage of people who move from "caseness" (clinical levels of distress) to non-clinical levels on validated measures (PHQ-9, GAD-7) after completing NHS Talking Therapies.	Reliable recovery provides assurance that treatment not only improves symptoms but brings patients back to a state of wellbeing. For the patient, it reflects meaningful mental health restoration and improved daily functioning.

Glossary of metrics (in continuous development)

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Area	Metric	Definition	Why is it important?
Mental Health Services	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined	Proportion of people from ethnically diverse backgrounds who achieve recovery following treatment in NHS Talking Therapies.	Highlights equity of outcome across diverse populations. Ensures that services are culturally responsive and that all patients, regardless of background, achieve good outcomes.
	Recovery rate for White British - complete a course of treatment, adult and older adult combined	Proportion of White British individuals achieving recovery after completing NHS Talking Therapies. Used for benchmarking against ECDC outcomes.	Provides comparative insight to address potential inequalities and improve service delivery for all groups. Helps ensure all patients are receiving effective, evidence-based care.
	Improve access for Adults and Older Adults to support by community mental health services	Tracks access to community mental health services, aligned with the NHS Long Term Plan Community Mental Health Framework.	Supports early intervention, continuity of care, and integrated multi-agency support. For patients, this enables better support in the community, reducing hospital admissions and promoting recovery.
	4 week wait (28 days) standard (interim metric – two contacts within pathway)	Percentage of referrals to community mental health services receiving two meaningful contacts within 28 days. A developing standard aligned with new access ambitions from NHS England.	Reduces delays in treatment initiation for people with serious mental illness. Improves patient experience and helps prevent deterioration, crisis escalation, and unnecessary admissions.
	Deliver annual physical health checks to people with Severe Mental Illness	Proportion of people on the SMI register receiving a comprehensive physical health check annually (covering blood pressure, BMI, cholesterol, blood glucose, smoking, alcohol). National standard from NHS England and NICE guidance.	People with SMI have significantly reduced life expectancy due to preventable physical health conditions. Regular checks improve early detection and promote parity between physical and mental healthcare.
	Improve access to perinatal mental health services	Monitors access to specialist perinatal mental health care for women experiencing moderate to severe mental illness during and after pregnancy. Part of NHS Long Term Plan targets.	Untreated perinatal mental illness can have long-term consequences for mother, infant, and family wellbeing. Early specialist care supports maternal recovery and healthy child development.
	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	Proportion of people aged 14–65 referred to Early Intervention in Psychosis (EIP) services who start treatment within two weeks and receive a full NICE-concordant care package. National access and quality standard.	Early intervention is associated with reduced relapse, improved functioning, and long-term recovery. Timely care in psychosis can prevent deterioration and reduce hospital stays.
	Number of people accessing Individual Placement Support (IPS)	Number of adults with Serious Mental Illness supported by IPS services, which offer personalised, evidence-based support to help people find and sustain paid employment. NHS England expansion target.	Employment is a key determinant of recovery and quality of life. IPS improves social inclusion, financial independence, and psychological wellbeing.
	Recover dementia diagnosis rate	Percentage of people aged 65+ estimated to have dementia who have a formal diagnosis recorded in primary care. National ambition: 66.7%.	Early diagnosis enables access to support, treatment, and care planning. For patients and carers, it supports independence, safety, and better management of the condition.

Glossary of metrics (in continuous development)

Area		Board Meeting in Public		Page 240 of 469	
Metric		Definition		Why is it important?	
Mental Health Services	Response from Mental Health Psychiatric Liaison within 1 hour	Percentage of referrals from A&E or acute medical wards seen by psychiatric liaison within 1 hour. Derived from NHS England’s “Core 24” liaison psychiatry standards.		Rapid mental health assessments reduce emergency department wait times and help ensure safe, effective treatment planning. Patients in crisis benefit from immediate care to reduce risk and distress.	
	Response from Mental Health Psychiatric Liaison within 24 hours	Percentage of all mental health referrals to liaison services in acute settings that are seen within 24 hours. Required under national liaison psychiatry models.		Timely mental health input during hospital admissions reduces unnecessary stays, improves holistic care, and supports faster recovery for patients with coexisting physical and mental health needs.	
	Response from Mental Health Crisis Service within 4 hours (Very Urgent)	Proportion of 'very urgent' referrals to Crisis Resolution and Home Treatment Teams (CRHTT) that are responded to within 4 hours. Part of NHS Mental Health Crisis Care Concordat.		Swift response during acute mental health crises reduces the risk of harm, unnecessary detention under the Mental Health Act, and hospital admission. Patients feel safer and more supported.	
	Response from Mental Health Crisis Service within 24 hours (Urgent)	Percentage of urgent crisis referrals responded to within 24 hours by CRHTTs. NHS England standard for community-based urgent care.		Ensures timely, appropriate care during periods of acute need. Prevents deterioration and supports people to stay in their homes and communities.	
	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission	Proportion of patients admitted to an inpatient mental health ward who had no community mental health contact in the preceding 12 months.		Lack of prior engagement may suggest missed opportunities for prevention. For patients, this highlights the need for improved outreach and integrated care pathways.	
	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined; rolling 3 months)	Average number of inpatient days for patients discharged from acute adult, older adult, or PICU services, measured on a 3-month rolling basis.		Ensures patients are in hospital only as long as needed. Long stays may indicate delayed discharges; short stays must still allow for recovery. Balanced stays improve patient outcomes.	
	72 hour follow up for those discharged from mental health wards	Percentage of patients discharged from mental health inpatient care who receive follow-up contact (face-to-face or phone) within 72 hours. A national quality standard (NHS England/NICE).		The first 72 hours post-discharge is a high-risk period for suicide and relapse. Timely contact supports safety and smooth reintegration into the community.	
	Inappropriate Out of Area Placements (mental health inpatients)	Number of patients placed in inpatient beds outside their local area due to bed unavailability (excluding specialist placements).		Out-of-area placements disrupt continuity of care, isolate patients from family, and delay discharge. Reducing them improves quality, equality, and patient dignity.	
	% adult acute readmission within 30 days for mental health	Proportion of adult patients discharged from acute mental health care who are readmitted within 30 days. A quality metric for post-discharge planning.		High readmission rates may signal poor follow-up support or premature discharge. Patients benefit from coordinated, recovery-focused care that reduces the need for readmission.	
	Average number of clinically ready for discharge patients per day	Average daily count of inpatients who are medically fit for discharge but remain due to delays in arranging ongoing care.		Blocked discharges reduce hospital efficiency and increase stress for patients. Timely discharge helps recovery and frees capacity for others in need.	

Glossary of metrics (in continuous development)

Board Meeting in Public		Page 241 of 409	
Area	Metric	Definition	Why is it important?
Community Health Services, Dentistry and Primary Care	% of out of hours palliative care referrals responded to within 30 minutes	Percentage of out-of-hours palliative care referrals where the time from receipt of NHS 111 call to the start of the telephone consultation is ≤30 minutes. Typically tracked through urgent community response or palliative care service KPIs.	Quick response ensures timely symptom management and emotional support for patients in end-of-life care. Rapid access helps reduce unnecessary hospital admissions and supports patients to remain at home in comfort.
	% of out of hours palliative care referrals responded to within 60 minutes	Percentage of referrals where the time from completion of triage to start of a face-to-face home visit is ≤60 minutes. Reflects response speed of out-of-hours palliative care services.	Timely in-person care is vital for urgent symptom relief and reassurance for families. It maintains patient dignity and comfort during critical moments outside normal service hours.
	National Early Warning System (NEWS) escalated appropriately	Percentage of patient episodes where the escalation of care matched national NEWS2 guidelines when scores indicated potential clinical deterioration.	Proper escalation helps prevent serious adverse events. For patients, this means safer, more responsive care when early signs of deterioration are detected.
	National Early Warning System (NEWS) completed where applicable	Proportion of eligible patient observations where NEWS2 scoring was completed correctly, as per national standards for early deterioration detection.	Early detection allows for timely intervention and reduces risk of ICU admission or death. For patients, this means increased safety and proactive care.
	% of breastfeeding prevalence at 6–8 weeks old	Percentage of infants aged 6–8 weeks who are recorded as being breastfed (exclusive or partially). Data collected via Health Visitor review	Breastfeeding supports infant health, immunity, and bonding. Tracking prevalence helps target support to improve early child nutrition and maternal wellbeing.
	% of Minor Injury Unit patients seen within 4 hours	Proportion of all attendances to Minor Injury Units where patients are seen, treated, and discharged or referred within 4 hours. Aligned with urgent care standards.	Meeting this standard reduces patient wait times and crowding. For patients, it ensures efficient treatment of non-life-threatening conditions close to home.
	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	Percentage of urgent community response referrals responded to within 2 hours, in line with NHS England's Ageing Well Programme goal.	Rapid community intervention prevents hospital admissions and promotes care at home. Patients benefit from quicker treatment in familiar surroundings.
	Available virtual ward capacity per 100k head of population (nationally reported system measure)	Number of available virtual ward beds per 100,000 population. Submitted to NHS England as part of the Virtual Ward data collection framework.	Supports early hospital discharge and admission avoidance. Patients receive remote monitoring and care at home, improving comfort and capacity management.
	Virtual ward occupancy (nationally reported system measure)	Proportion of available virtual ward capacity currently in use. Submitted monthly to NHS England as part of system monitoring.	Indicates usage and efficiency of virtual care models. High occupancy suggests strong uptake; low occupancy may highlight gaps in referral or awareness.

Glossary of metrics (in continuous development)

Board Meeting in Public		Page 242 of 409	
Area	Metric	Definition	Why is it important?
Community Health Services, Dentistry and Primary Care	Percentage of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days	Percentage of new children entering care who are offered an initial health assessment within 20 working days of notification, in line with statutory guidance (Promoting the health of looked-after children, DHSC).	Timely health assessments help identify unmet needs and provide a baseline for planning care. Children in care are especially vulnerable and benefit from prompt health support.
	Healthy Child Programme - No. and % of families receiving a new birth visit within 14 days of birth	Number and percentage of families receiving a face-to-face new birth visit by a health visitor within 14 days, in line with the Healthy Child Programme (HCP) mandated checks.	Early visits support maternal mental health, infant development, and bonding. It ensures early identification of health and safeguarding concerns for families and babies.
	Healthy Child Programme - % of 6-8 week reviews completed	Proportion of infants who receive the HCP 6–8 week review with a health visitor, a mandated contact covering maternal mood and infant development.	Supports early detection of postnatal depression and child developmental delays. Enables families to access timely interventions and reassurance.
	Healthy Child Programme - % of 12-month development reviews completed by the time the child turned 12 months	Percentage of children who received a 12-month review with a health visitor before their first birthday. A core HCP milestone to monitor growth and development.	Detects early signs of delay or concern in physical, social, and communication skills. Helps parents engage in their child's development and access support where needed.
	Healthy Child Programme - % of 2 to 2.5 year reviews completed	Proportion of children receiving the 2–2½ year HCP development review. A universal health and development review offered by health visitors.	Identifies developmental concerns before school entry. Early support can improve long-term outcomes in language, behaviour, and learning.
	Community Dentistry - Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period)	Percentage of patients accepted for community dental services who are seen for initial assessment within 12 weeks.	Timely access improves oral health outcomes and reduces dental pain or complications, especially in vulnerable populations requiring community dentistry.
	Community Dentistry - Special Care - Core Units of Activity (UDA)	Number of Units of Dental Activity (UDA) delivered under special care dentistry contracts for patients with additional needs, learning disabilities, or complex conditions.	Reflects access to tailored dental care for patients with special needs, ensuring equity and reducing health inequalities in oral health.
	Community Dentistry - Urgent Care - Out of Hours Units of Activity (UDA) combined with main out of hours dental service	Number of urgent out-of-hours dental care UDAs delivered by community dental and general dental practitioners combined.	Ensures prompt relief of dental pain and infections when routine services are unavailable.
	Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours	Percentage of patients contacting emergency dental services who are clinically triaged within 6 hours of first contact.	Quick triage enables prioritisation of urgent cases and faster pain relief. Supports safe and responsive emergency dental care pathways.

Glossary of metrics (in continuous development)

Area	Metric	Definition	Why is it important?
Community Health Services, Dentistry and Primary Care	Out of Hours GP - average response time for out of hours high priority referrals	Average time from NHS 111 call to telephone consultation start for high priority out-of-hours GP referrals. Standard: ≤60 minutes.	Timely clinical advice is critical in high-risk cases to prevent deterioration. Ensures urgent needs are promptly addressed, improving patient safety.
	Out of Hours GP - average response time for out of hours less urgent referrals	Average time from NHS 111 call to telephone consultation start for less urgent out-of-hours GP referrals. Standard: ≤720 minutes (12 hours).	Supports appropriate response based on triage level, helping manage lower acuity cases effectively while preserving emergency resources for critical cases.
	Out of Hours GP - average response time for out of hours urgent referrals	The average time between NHS 111 receiving a call and the start of the telephone consultation with the out-of-hours GP for urgent referrals. NHS England sets a standard of ≤120 minutes.	Ensures patients with moderately urgent conditions receive timely clinical advice or intervention, preventing deterioration and avoiding unnecessary emergency department use.
	Out of Hours GP - average response time for out of hours routine referrals	Time from NHS 111 call receipt to start of telephone consultation for routine cases, with a standard of ≤1440 minutes (24 hours).	Enables efficient use of GP resources for non-urgent issues, while ensuring patients still receive advice or support within a reasonable timeframe.
	% of patients waiting over 52 weeks for community services - Children and Young People	Proportion of children and young people who have been waiting more than 52 weeks for treatment in community services	Long waits during developmental years can cause long-term setbacks. Timely care ensures early intervention for better educational, social, and health outcomes.
	% of patients waiting over 52 weeks for community services - Adults	Percentage of adults referred to community services waiting more than 52 weeks to begin treatment.	Delays risk worsening health and quality of life. Timely care supports independence, pain management, and avoids escalation to acute settings.
	Average number of Medically Optimised per Discharge patients per night	Mean number of inpatients who have been clinically assessed as medically fit to leave hospital but who remain admitted overnight (usually because discharge arrangements, community capacity, or social care support are not yet in place).	Blocked discharges reduce hospital efficiency and increase stress for patients. Timely discharge helps recovery and frees capacity for others in need.
Quality and People	Reduce agency usage to meet target (% of agency used)	Measures the percentage of staffing costs spent on agency workers. NHS trusts aim to meet caps set by NHS England.	High agency usage increases costs and reduces continuity of care. Reducing agency reliance promotes workforce stability and better patient relationships.
	Reduction in % labour turnover	Percentage of staff who leave the organisation during a reporting period. Based on Electronic Staff Record (ESR) data.	Retaining staff supports consistency in care delivery, staff morale, and reduces recruitment costs. Patients benefit from experienced and familiar care teams.
	% of staff completing Quality Improvement Training Level 1	Proportion of workforce who have completed entry-level training in NHS-approved quality improvement methodologies (e.g., PDSA cycles).	Builds a culture of continuous improvement across services. Empowers staff to make patient-focused changes that enhance safety and outcomes.
	BAME representation across all pay bands including Board level	Proportion of Black, Asian and Minority Ethnic staff at all pay grades, including Executive Board level. Monitored under the Workforce Race Equality Standard (WRES).	Promotes equality and diversity. Better representation fosters inclusive decision-making and patient care sensitive to cultural needs.
	BAME representation in senior leadership roles (Bands 8a-9, VSM)	Percentage of senior NHS roles held by BAME staff. Captured via WRES data reporting.	Demonstrates progress on racial equality. Diverse leadership can reduce systemic bias, improve staff experience, and enhance trust among minority patients.

Glossary of metrics (in continuous development)

Area		Metric		Definition	Why is it important?
Quality and People	Board Meeting in Public	Proportion of senior leadership roles held by women (Bands 8a-9, VSM)		Percentage of leadership positions filled by women. Monitored to ensure gender parity and equity in NHS senior decision-making.	Promotes equality in career progression and inclusive leadership. Diverse perspectives in governance contribute to balanced and compassionate care systems.
		% of patients responding that overall care was good or very good		Patient-reported outcome indicating satisfaction with overall care experience.	Captures how services are perceived by patients. High scores reflect person-centred, compassionate care and strong therapeutic relationships.
		% of patients report being involved in their care		Proportion of service users reporting they were actively involved in decisions about their care plan and treatment. Measured via surveys.	Involvement empowers patients, promotes autonomy, and improves adherence to treatment. It fosters trust and shared ownership of recovery.
		Reduction in the use of prone restraints (number of incidents involving prone restraint)		Number of incidents where patients were physically restrained in the prone (face-down) position. Monitored in line with NHS England’s restrictive intervention guidance.	Prone restraint is associated with higher risk of injury or death. Reducing use protects patient dignity and safety, especially in mental health settings.
		Reduction in use of seclusion (number of incidents involving seclusion)		Number of incidents where a patient is secluded in a room and isolated from others as a method of behavioral control. Defined under the Mental Health Act Code of Practice.	High rates may reflect inadequate de-escalation approaches. Reducing seclusion supports trauma-informed care and upholds patient rights.
		Total number of patient incidents (all levels of harm excluding inherited pressure damage)		Total incidents reported involving patients, regardless of harm severity, excluding inherited pressure ulcers. Data sourced from incident reporting systems.	Reflects safety culture. High reporting with low harm indicates proactive identification of risks; helps prevent recurrence and improve care.
		Total number of unexpected deaths reported as incidents (by date of death, including natural and unnatural)		All deaths considered unexpected at time of occurrence, reported through local incident reporting processes, including natural and unnatural causes.	Vital for identifying gaps in care, improving risk assessments, and learning from preventable deaths to protect future patients.
		Number of suspected suicides		Number of deaths suspected to be by suicide, often pending coroner confirmation. Tracked through incident and mortality review systems.	Indicates potential failures in mental health crisis or follow-up care. Early analysis drives improvements in suicide prevention strategies.
		Total number of incidents involving physical restraint		Number of times physical restraint is used during patient care. Categorised by method, duration, and justification.	High numbers can indicate poor therapeutic environments. Monitoring ensures restraint is a last resort and used safely with debriefing.
		Total number of violence, physical, non-physical and property damage incidents (patients and staff)		Combined number of incidents involving aggression (verbal, physical) or damage to property. Includes harm to patients or staff.	Helps assess safety and culture in clinical environments. Reducing violence supports staff wellbeing and creates safer therapeutic spaces for patients.

Glossary of metrics (in continuous development)

Area		Metric		Definition	Why is it important?
Quality and People	Board Meeting in Public				Page 245 of 409
	Total number of complaints and resolutions			Number of complaints submitted by patients, carers, or advocates and the number resolved within reporting period. Governed by NHS complaints procedures.	Reflects patient voice and accountability. Prompt, respectful resolution of complaints builds trust, enhances satisfaction, and identifies areas for service improvement.
	Reduce staff sickness to 4.5%			Target to keep average monthly staff sickness absence rate below 4.5%. Measured using Electronic Staff Record (ESR) data.	Lower sickness rates indicate better wellbeing, reduce service disruption, and improve team morale. Patients benefit from more consistent care.
	Personal Development Review (PDR) compliance (PDR season is between April–July)			Percentage of eligible staff who have completed their annual Personal Development Review by the end of the defined window.	Ensures staff receive feedback, development planning, and alignment with organisational goals—leading to more capable and motivated teams supporting high-quality care.
	Reduction in vacancies			Percentage decrease in vacant posts within the organisation, tracked across reporting periods using workforce systems.	Reduced vacancies improve staffing stability and continuity of care. Patients are more likely to be seen by familiar and experienced professionals.
	% of early turnover			Percentage of staff who leave the organisation within the first 12 months of employment.	High early turnover could suggest onboarding or work culture issues. Reducing it improves retention and ensures care teams are stable and experienced.
	Statutory and mandatory training compliance			Percentage of staff who have completed all required statutory and mandatory training (e.g., safeguarding, infection control) as per NHS training matrix.	Ensures legal and safety standards are met. Compliance helps protect patients and staff and supports high-quality, consistent service delivery.
	Clinical supervision completion rate			Proportion of clinical staff receiving regular supervision sessions to reflect on practice, in line with national clinical governance frameworks.	Promotes reflective practice, enhances clinical safety, and supports staff wellbeing. Indirectly improves care quality and decision-making.
	Management supervision rate			Percentage of staff receiving regular line management supervision (1:1 sessions) as per local policy.	Supports performance, wellbeing, and accountability. Supervised staff are more likely to feel valued, supported, and deliver high-quality care.
	Staff leaver rate			Overall percentage of staff leaving the trust during a defined time period	High leaver rates may indicate low morale or stress. Monitoring helps inform workforce planning and improve staff retention strategies.
Quality and People	Relative likelihood of white applicant being appointed from shortlisting compared to BME applicants			Compares appointment rates between white and Black, Asian and Minority Ethnic (BAME) applicants after shortlisting. Part of NHS WRES indicators.	Identifies bias in recruitment. Reducing disparities improves fairness and helps develop a workforce that reflects the community served.
	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants			Compares success rates of disabled versus non-disabled applicants following shortlisting. Tracked under NHS Workforce Disability Equality Standard (WDES).	Highlights potential discrimination. Equality in recruitment ensures access to opportunities and promotes inclusion and workforce diversity.

Meeting	Board of Directors Meeting
Date of Meeting	28 January 2026
Agenda item	12(b)
Report title	Quality and Safety Dashboard
Executive lead(s)	Brita Klinck, Chief Nurse
Report author(s)	Jane Kershaw, Head of Patient Safety
Action this paper	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the group	Regular report to each meeting to be viewed alongside the Integrated Performance Report.
For disclosure or confidential	For disclosure to group members.

Executive summary

The information in the Quality and Safety Dashboard is up to 30th November 2025. The list of indicators reviewed are provided in Appendix A these cover workforce and the quality domains of safety, clinical effectiveness and patient experience.

From reviewing the indicators, the below wards and community teams are highlighted by exception as flagging based on the position in November 2025 and a review of any trends from the last 3 months (Sept-November 2025). The mitigations and actions in place for the wards/teams in enhanced support are included in the body of the report.

The three teams/wards in enhanced support have been the same for more than 6 months.

The changes this month are as follows;

- ❖ Moved out of early warning: Ruby ward.
- ❖ New to early warning: Aylesbury AMHT, Adult Speech & Language, Ashurst PICU, Vaughan Thomas, Phoenix, Oxon South AMHT
- ❖ Moved from enhanced to early warning: Sapphire ward

Highlighted wards/teams by exception:

	Enhanced Support	Early Warning
Inpatient Wards	- CAMHS PICU Meadow Unit - CAMHS Highfield	- Sapphire - Ashurst PICU - Vaughan Thomas - Ashurst PICU - Vaughan Thomas - Phoenix
Community Teams	Oxon City and NE AMHT	- Aylesbury AMHT - Bucks and Oxon CAMHS - ADHD and Autism service - Bucks and Oxon Adult ADHD and Autism - Bucks Complex Needs Service - Bucks OA Memory Clinic - Bucks Adult PCMHT - Bucks Adult Psychological therapies - Minor Injury Units - District Nursing - Children's Speech & Language - Adult Speech & Language - Community Respiratory service - Podiatry - Special Care & Paediatric Dentistry - Oxon North and West AMHT - Oxon South AMHT - Oxon CAMHS - BSW CAMHS - Oxon Complex Needs Service - Oxon OA Memory Clinic - Oxon Adult PCMHT (Keystone teams) - Oxon Adult Psychological therapies

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

The Dashboard is developed with input from the Clinical Directorates and presented monthly to the Quality and Clinical Governance Group chaired by the Chief Nurse and Chief Medical Officer.

Recommendation(s)

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

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	No	
Legal and regulatory	We are required to report on the inpatient staff fill rates to Trust Board members, this role has been delegated to the Quality Committee. Inpatient fill rates is an indicator considered in the monthly dashboard.	

The information in the Quality and Safety Dashboard is up to 30th November 2025. The purpose of the dashboard is to bring together activity, quality and workforce data as well as soft intelligence to help identify wards/teams that might be struggling and need more support. The list of indicators reviewed are provided in Appendix A these cover workforce and the quality domains of safety, clinical effectiveness and patient experience.

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3. Overall summary of highlighted wards/community teams

From reviewing a range of indicators the below wards and community teams are highlighted by exception as flagging with an area of concern based on the position in November 2025 and a review of any trends from the last 3 months (Sept to November 2025).

The three teams/wards in enhanced support have been the same for more than 6 months.

The changes this month are as follows;

- ❖ Moved out of early warning: Ruby ward.
- ❖ New to early warning: Aylesbury AMHT, Adult Speech & Language, Ashurst PICU, Vaughan Thomas, Phoenix, Oxon South AMHT
- ❖ Moved from enhanced to early warning: Sapphire ward

	Enhanced Support	Early Warning	
Inpatient Wards	- CAMHS PICU Meadow Unit - CAMHS Highfield	- Sapphire - Ashurst PICU - Vaughan Thomas - Ashurst PICU - Vaughan Thomas - Phoenix	
Community Teams	Oxon City and NE AMHT	- Aylesbury AMHT - Bucks and Oxon CAMHS ADHD and Autism service - Bucks and Oxon Adult ADHD and Autism - Bucks Complex Needs Service - Bucks OA Memory Clinic - Bucks Adult PCMHT - Bucks Adult Psychological therapies - Minor Injury Units - District Nursing	- Children's Speech & Language - Adult Speech & Language - Community Respiratory service - Podiatry - Special Care & Paediatric Dentistry - Oxon North and West AMHT - Oxon South AMHT - Oxon CAMHS - BSW CAMHS - Oxon Complex Needs Service - Oxon OA Memory Clinic - Oxon Adult PCMHT (Keystone teams) - Oxon Adult Psychological therapies

4. Buckinghamshire Mental Health Services

4.1 Performance on inpatients followed up within 48/72 hours of discharge

The performance for November 2025 is 36 eligible discharges in the 'Bucks Place' commissioning area. 0 breaches to 48 hour follow up (as of 3rd December).

4.2 Detail about wards and community teams highlighted

There are no identified wards/teams in Enhanced Support.

The following wards/teams are identified at an Early Warning level,

Wards at Early Warning

Ward	Reason for highlighting
Sapphire	- Identified at enhanced level last month. 11% sickness rate, however safe staff fill rates 100%+. 3 staff on long term sickness. 3 patients went AWOL from leave, no specific harm identified. 2 uses of prone physical restraint and 5 uses of seclusion. 3 complaints; 1 rapid resolution and 2 low level complaints received in the month. Concerns around discharge, medical and physical health needs. 24 admissions in the month and bed occupancy at 99%. OATs show pressure on beds.

Community Teams at Early Warning

Team	Reason for highlighting
Aylesbury AMHT	- High number of concerns raised in November; 3 early resolution and 4 rapid resolution complaints about a range of areas. Average of 2 rapid resolution complaints received a month with a spike in July 2025. 17 patients waiting more than 12 weeks to be seen, as of 12th December 2025. - Team has scored low in the clinical audit core standards audit for the last 6 months up to Dec 2025 (July-Sept 2025 = 73% and Oct-Dec 2025 = 68%).
CAMHS ADHD and Autism service	As of 1 st December 2025–3,748 patients waiting for assessment (last month at 3,700). Median wait time 71 weeks. 212 new referrals received this month.
Adult ADHD and Autism	As of 1 st December 2025, - Adult ADHD: 960 patients waiting for assessment (last month at 985). Mean wait time 131 weeks. 1 new referral received this month. - Adult Autism: 457 patients waiting for assessment (last month at 455). Mean wait time 97 weeks. 9 new referrals received this month.
Bucks Complex Needs Service	121 patients waiting more than 4-week wait by episode level as of 12 th December 2025 (last month 160 patients). Most patients waiting for triage or assessment. 35 patients have been waiting for more than a year (reduction from 63 last month). Service improvement work is underway.
Memory clinic services	As of 12 th December 2025 – 804 patients waiting for 60 days or longer against wait standards, a reduction from last month (810 patients). 9 patients have been waiting for more than a year.
Adult PCMHT	364 patients waiting more than 4-week wait by episode level as of 12 th December 2025 (last month 405 patients). 36 patients recorded as waiting for more than a year.
Adult Psychological therapies	148 patients waiting more than 4-week wait by episode level as of 12 th December 2025. (last month 180 patients). 49 patients have been waiting for more than a year.

5. Community Health Services, Dentistry and Primary Care

5.1 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,

Team		Reason for highlighting
Minor Injury Units		- A small cluster of missed fractures has led to a patient safety thematic review being started in Sept 2025. 11% sickness and 13% agency use. 5 rapid resolution complaints and 1 low level complaint received in November 2025 and failure to diagnose and staff behaviour. Increase in rapid resolution complaints in November (average 2 a month).
District Service	Nursing	- Gap between capacity and demand for service well known with around 500 visits being deferred each day. In November 2025 there were 26 incidents reported about delays in care (14 with no harm/near miss and 12 with minor harm). Executive Team agreed additional funding at risk to increase staffing and to explore new technologies such as scheduling tools and purchase eKare wound app to support the service. 14 moderate harm incidents of which 8 were pressure ulcers developed during care in November 2025. Incidents with no harm or minor harm have slightly increased in the last year however incidents with moderate and severe harm have remained the same/reduced. 31 incidents related to medications, 22 about administration/supply in November 2025. Average of 35 incidents a month. Increase in number of medication incidents in July 2025. 6 unexpected deaths in month – 4 from natural causes and 2 suspected suicides. 3 rapid resolution complaints and 3 early resolutions received in November 2025 about communication and staff behaviour. No change in pattern of concerns received over time.
Children's Integrated Therapies – speech and language		- New patient referral waits breaching internal targets n=1,534 as of 12th December 2025 compared to 1,566 patients waiting last month. Median waiting time 44 weeks. 795 patients currently waiting for more than 1 year. - There are also waits in CIT for Physiotherapy and OT but numbers are much lower.
Adult Speech and Language		13% agency use and 19% vacancies in November 2025. - New patient referral waits breaching internal targets n=274 as of 12th December 2025. 29 patients currently waiting for more than 1 year.
Community Respiratory service (respiratory, COPD and home oxygen assessment)		New patient referral waits breaching internal targets n=544 as of 12th December 2025 compared to 605 patients waiting last month. With most waits for respiratory pulmonary rehab. Median waiting time 23 weeks. 61 patients currently waiting for more than 1 year.
Podiatry		- On average of 350 new referrals a month and caseload of approximately 10,000 patients. High demand and reduced capacity due to vacancies meaning the staff group are under considerable pressure. Vacancies 36% (same as last month) and agency use 7%. - Waits for treatment, including high risk/urgent patients on weekly follow up appointments are being deferred due to capacity and pressure on the service. 3 incidents in November 2025 about delay in treatment (1 no harm/near miss and 2 low harm). - New patient referral waits breaching internal targets n=1,486 as of 12th December 2025 compared to 1,537 patients waiting last month. Mostly in the City and Witney area. Breakdown, 796 patients 'at risk' a small reduction from last month. Median waiting time 26 weeks. 365 patients currently waiting for more than 1 year. 1 moderate harm incident in November 2025 related to a patient's condition. 3 unexpected deaths in month – 2 from natural causes and 1 suspected suicide. 3 rapid resolution complaints in November 2025 about insufficient care, access to assessment and transport issue. - There is a podiatry transformation plan with multiple workstreams to try and increase capacity. Including sub-contracting more routine care to a private podiatry company which started from May 2025.

Special Care & Paediatric Dentistry	• Waits for treatment under general anaesthetic (GA) for both children and special care adults as of 18/11/2025; ○ 138 children on the waiting list, with waiting times of up to 5 months from their general anaesthetic assessment (increase from 113 in September 2025). 41 children waiting >18 weeks. ○ 5 adults who have been assessed and are waiting for treatment at the Horton Hospital. 5 adults waiting for treatment at the JR Hospital due to medical complexity. Waiting times for patients from general assessment to treatment at the Horton Hospital up to 2 weeks and up to 136 weeks at JR for more complex cases. ○ 15 adults waiting for joint dental/anaesthetic assessment, waiting time from referral to assessment 6 months (reduction from September 2025) Additional GA weekend sessions are continuing in 2025-26 (using carried over Restoration & Reset funding). 6 additional full day weekend GA list was carried out year to date (42 patients treated). 2 full day lists confirmed in November 2025 and 1 full day list provisionally available in December 2025.

6. Forensic Services

6.1 Detail about wards and community teams highlighted

There are no wards/teams identified at Early Warning or Enhanced Support.

There are some high vacancies on Evenlode 20.9% (same as last month) as well as high sickness 15% in November 2025, however safe staff fill rates are being met and bed occupancy is low at 46%.

7. Learning Disability Services

7.1 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 Performance on inpatients followed up within 48/72 hours of discharge

The performance for November 2025 is 49 eligible discharges in the 'Oxon Place' commissioning area. 4 breaches to 48 hour follow up (as of 3rd December);

- Patient seen same day as discharge from the ward.
- Patient followed up in community whilst on S17 leave but then not followed up once section discharged.
- AWOL from ward and discharged, no follow up (Phoenix ward discharged on 7th Nov)
- No follow up recorded (Phoenix ward discharged on 4th Nov)

8.2 Detail about wards and community teams highlighted

There are four wards/teams identified at Enhanced Support, listed below, the mitigations and details are also included in the report;

- CAMHS PICU Meadow Unit
- CAMHS Highfield
- City and NE AMHT

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

Wards at Early Warning

Ward	Reason for highlighting
Ashurst PICU	• Vacancies at 18% (increase from last month), although safe staffing levels were always met. 8% sickness in month. • 2 incidents resulting in moderate harm to staff. 1 RIDDOR reportable following violence from a patient. • 15 physical restraints of which 2 used prone position. 6 uses of rapid tranquilisation and 6 uses of seclusion in November 2025.

Ward	Reason for highlighting
Vaughan Thomas	• Vacancies 11% (15% last month), although safe staffing levels were always met. • High bed occupancy, 100% in November 2025 with 7 admissions in the month. • 3 AWOLs with no specific harm identified, although in 2 of the cases the patient escaped from the ward. (1 AWOL reported in Sept and Oct 2025) • 1 moderate harm incident relating to failing to respond to a patient deteriorating. 3 prescribing incidents (1 no harm/near miss and 2 minor harm). Most incidents relate to violence from patients. • 2 rapid resolution complaints received in November 2025 about medication and staff behaviour. • Ward has scored low in the clinical audit core standards audit for the last 3 months; Sept 71%, Oct 72% and Nov 81%.
Phoenix	• Vacancies 14% and sickness 4%. • 2 rapid resolution complaints and 1 low level complaint received in November 2025 about staff behaviour and communication.

Community Teams at Early Warning

Team	Reason for highlighting
North and West AMHT	• Deep dive presented to the QCG Group in October 2025. • As of 12th December 2025 – 41 patients waiting for assessment/treatment with Banbury team and 27 patients waiting for assessment/treatment with the Witney team. • Teams have scored low in the clinical audit core standards audit for the last 6 months up to Dec 2025. North; July-Sept 2025 = 78% and Oct-Dec 2025 = 84%. West; July-Sept 2025 = 66% and Oct-Dec 2025 = 80%. • Improvement plan in place being monitored by Directorate SLT.
South AMHT	• Vacancies 10% and sickness 5%. • 2 rapid resolution complaint and 1 low level complaint received in November 2025 about discharge and insufficient care. • 2 moderate harm incidents in November related to serious self-harm attempts by patients. In the last 12 months 2 suspected suicides, both patients open to the team. • As of 12th December 2025 – 32 patients waiting for assessment/treatment.
CAMHS ADHD and Autism service	As of 1st December 2025 –4,562 patients waiting for assessment (last month at 4,590). Median wait for assessment 85 weeks. 52 new referrals received this month. Work happening: • ADHD model developments still underway • BOB NDC AI being piloted in clinic • OVATT project coming to an end • Owl centre being gradually sent 1000 referrals to assess
Oxon CAMHS	As of 12th December 2025; • 194 patients waiting for Getting Advice (SPA) against national/local waits standards (last month at 72) • 113 patients waiting for supportive steps • 1 patient waiting more than a year under Getting Help North • 40 patients waiting for Getting More Help South, of which 4 patients have been waiting more than a year. North and South teams have scored low in the clinical audit core standards audit for the last 6 months up to Dec 2025. There is a range of improvement and pathway transformation work underway.
BSW CAMHS	As of 12th December 2025; • 136 patients for Getting Advice (SPA) against national/local waits standards (last month, 151). • 15 patients waiting for Getting More Help BaNES and 19 Melksham (of which 1 patient waiting more than a year). Melksham team have scored low in the clinical audit core standards audit for the last 6 months up to Dec 2025.

	17 patients waiting for BaNES MHST.
Adult ADHD	The Oxfordshire Adult ADHD Service lacks sufficient operational capacity to meet demand - the service closed to new referrals in February 2024 and has a waiting list of 2,150 patients awaiting assessment as of 1st December 2025 (last month at 2,177), while the average waiting time for assessment is 145 weeks. Trust has engaged in a BOB ICS review. The waiting time for Post Diagnostic Consultations (PDCs) is approximately 2 years. Waiting time from diagnosis until first titration appointment for appropriate medication is approximately 7 months. This is increasing weekly as new assessments are completed. Approximately 80% of those assessed are diagnosed with ADHD and added to the medication titration waiting list.
Oxon Complex Needs Service	517 patients waiting more than 4-week wait by episode level as of 12th December 2025 (last month 527 patients). 199 patients have been waiting for more than a year, a reduction from last month. Deep dive was presented in August 2025 to the QCG Group around the issues, mitigations and actions being taken.
Memory clinic services	As of 12th December 2025 – 523 patients waiting for 60 days or longer against wait standards (last month 498 patients). 2 patients have been waiting for more than 1 year.
Adult PCMHT (Keystone teams)	162 patients waiting more than 4-week wait by episode level as of 12th December 2025 (last month 249 patients). Most of the waits are in the City/East Oxford. 23 patients have been waiting for more than a year.
Adult Psychological therapies	170 patients waiting more than 4-week wait by episode level as of 12th December 2025 (153 last month). Most patients are waiting for assessment psychodynamic therapy. 0 patients are waiting for more than a year.

Teams/Service	In last Dashboard under Enhanced Support?	Reason for Highlighting	Mitigations & Actions
CAMHS PICU Meadow Unit	Yes	- High vacancies 37% in November 2025, 19% use of agency and 4.6% sickness. Although safe staff fill rates were met, with the exception of skill mix change for night shifts with more unregistered and less registered staff than planned. 2 admissions in month and bed occupancy at 60%. - High use of restrictive interventions; 139 physical restraints involving 3 patients, 5 uses of prone restraints in month and 34 uses of rapid tranquilisation (involving 2 patients). Overall, 1 patient accounted for 120 uses of restrictive interventions. - There are ongoing issues with the safety of the physical environment and particularly the garden area, smoke detectors and extra care area space. Regular engagement with the estates team.	Development action plan in place, described in last report and monitored by the Directorate SLT. The CQC inspected the unit in November 2025.
CAMHS Highfield	Yes	- High vacancies 20% in November 2025 and 4% sickness. Although safe staff fill rates were met, with the exception of skill mix change for night shifts with more unregistered and less registered staff than planned. 3 admissions in month and bed occupancy at 39%. - High use of restrictive interventions; 86 physical restraints involving 9 patients, 2 uses of prone restraints in month and 35 uses of rapid tranquilisation (involving 3 patients). Overall 1 patient accounted for 64 uses of restrictive interventions.	- Team is engaged in the management of violence and aggression work group - Ongoing recruitment campaign. Use of long lines of agency agreed. Comprehensive induction package for new starters and support for new preceptees. - The unit are part of a regional headbanging QI project to develop best practice guidelines for management. The CQC inspected the unit in November 2025.
City and NE AMHT	Yes	- Turnover at 18%. 2 rapid resolution complaints received in November 2025 about insufficient care. Last 3 months 12 rapid resolution complaints, 2 low level complaints and 2 early resolutions. - Concerns about medication management, MDT working, staff competence and caseload management - Patients waiting more than 4-week wait by episode level as of 12th December 2025; 89 patients; 37 Aspen, 31 Oak and 21 Willow team. - Teams have scored low in the clinical audit core standards audit for the last 6 months up to Dec 2025 (July-Sept 2025 = 64% and Oct-Dec 2025 = 71%).	Team has been split to function as three separate sub teams. New team rosters and budgets now in place to support better transparency and accountability. Improvement plan and project support time remains in place and is being closely supported by the Directorate SLT, with weekly monitoring.

	Inpatient Wards	Community Teams
Workforce Measures	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%)
Safety 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), with a focus on any severe harm incidents	Number of patient incidents with moderate or above harm (1 or less), with a focus on any severe harm incidents
	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, escorted 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/unnatural and suspected suicides
	Number of physical restraint episodes (<10)	
	Number of prone restraints (1 or less)	
	Number of seclusion episodes (less than 4)	
	Number of uses of LTS (less than 2)	
	Intelligence from the Freedom to Speak up Guardians	Intelligence from the Freedom to Speak up Guardians
Clinical Effectiveness Domain	Median Length of Stay (discharged patients)	Number of patients breached waiting time target
	Number of Admissions in Month	
	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%)
	Waiting list performance, number of breaches as a point in time each month	Waiting list performance, number of breaches as a point in time each month
Patient Experience Domain	Clinical audit starting with the mental health Core clinical standards audit	Clinical audit starting with the mental health Core clinical standards audit
	Number of high/low complaints and rapid resolutions (2 or more)	Number of high/low complaints and rapid resolutions (2 or more)
	Number of early resolutions	Number of early resolutions
	Overall feedback from IWGC structured surveys	Overall feedback from IWGC structured surveys

For Information

Finance Report

November 2025 (Month 8 FY26)

Report to Board of Directors

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Executive Summary

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3. Change from previous month's forecast
4. Capital Investment Programme
5. Directorate Financial Performance Summary
6. Provider Collaboratives Financial Performance Summary
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9. Statement of Financial Position and Cash Flow Summary and Working Capital Indicators

Annexes (private report only)

- A. Directorate Financial Performance Detail
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- L. Detailed Directorate Financial Performance (in separate file)

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

Executive Summary



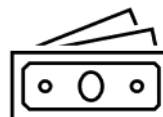
Income & Expenditure position

- YTD – £2.3m surplus, £0.1m better than plan
- Forecast £4.8m surplus, on plan



Capital Expenditure

- Full Year Forecast Outturn –£22.7m which matches the funding available



Cash

- Actual £96.0m

Key messages:

1. The Trust's YTD and Forecast Revenue positions are on plan. The forecast includes a £1.1m provision held for unknown risks this month due to the directorate forecasts being better than plan. There are £4.5m of risks and £10.5m of opportunities to the forecast position.
2. Capital programmes have spent less than was expected so far, with YTD net capital expenditure of £5.4m. Programme activity and spend will increase over the coming months and purchase order commitments of £8.4m are in place. The forecast is for spend of £22.7m. The capital plan has been revised with the intention of ensuring it is delivered within the financial year.
3. Controls over staffing are working well and Agency spend is forecast to be £3.1m better than plan this year, which has improved from £2.2m better than plan at month 7.

1. Income & Expenditure 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	47.6	47.6	0.0	0.0%	381.8	375.9	-5.9	-1.6%	585.6	568.8	-16.8	-3%
Other Operating Income	11.8	12.8	1.1	9.0%	93.4	100.5	7.1	7.6%	140.8	151.7	10.9	8%
Operating Income, Total	59.3	60.4	1.1	1.8%	475.2	476.4	1.2	0.2%	726.4	720.5	-6.0	-1%
Employee Benefit Expenses (Pay)	36.3	36.0	0.3	0.9%	289.4	284.8	4.5	1.6%	434.0	429.2	4.9	1%
Other Operating Expenses	21.1	22.6	-1.5	-7.1%	172.3	179.0	-6.7	-3.9%	270.9	269.5	1.3	0%
Operating Expenses, Total	57.4	58.6	-1.2	-2.0%	461.7	463.8	-2.1	0.5%	704.9	698.7	6.2	1%
EBITDA	1.9	1.8	-0.1		13.5	12.6	-1.0		21.5	21.8	0.2	
Financing costs	1.4	1.3	0.1	9.4%	11.3	10.2	1.1	10.5%	16.8	16.0	0.9	5%
Surplus/ (Deficit)	0.4	0.5	0.0		2.2	2.4	0.1		4.7	5.8	1.1	
Adjustments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0
Adjusted Forecast Surplus/ (Deficit)	0.4	0.5	0.0		2.2	2.3	0.1		4.8	5.8	1.1	
Amount held for unknown risks										1.1	1.1	
Forecast Surplus/ (Deficit)									4.8	4.8	0.0	

The month 8 YTD position is a **£2.3m** surplus which is **£0.1m** better than plan. EBITDA is **£1.0m** adverse to plan and Financing costs are **£1.1m** favourable to plan. The underspend on Financing costs is due to higher than planned interest receivable (**£0.6m**) and lower than planned depreciation costs (**£0.7m**), offset with higher than planned interest payable costs (**£0.2m**). The underspend on depreciation is offset with an adverse variance on clinical income as NHS England fund actual depreciation costs.

Income is **£1.2m** favourable to plan YTD. The main drivers are a **£3.1m** adverse variance on Provider Collaboratives where income has been matched to spend offset by a **£3.8m** favourable variance in Oxford Pharmacy Store due to higher than planned income.

Operating expenditure is **£2.1m** adverse to plan YTD. This includes the corresponding variances to the income variances: **£3.8m** higher than planned expenditure in Oxford Pharmacy Store and **£3.1m** lower than planning expenditure in Provider Collaboratives. Pay in other areas of the Trust is **£3.6m** underspent offset with the following areas of overspend in non-pay: **£2.5m** on mental health out of area placements, **£1.0m** on CAMHS sub-contracts using budget from vacancies, **£0.7m** on Drugs and **£0.7m** on Learning Disabilities out of area placements.

The forecast is a **£4.8m** surplus, which is on plan. This includes **£1.1m** not in the directorate forecasts but held for unknown risks.

2. Forecast Risks & Opportunities

Risks	£'000	Likelihood
Balance Sheet changes	3,000	Medium
Mental health out of area placements	550	Medium
Estates contract accruals	200	Medium
Profit on disposal assumed in plan	152	Medium
Professional fees in Estates and Facilities	150	Medium
Insurance claim	120	Medium
Learning Disabilities OAPs	120	Medium
Legal fees	100	Medium
PFI consultancy and legal costs	100	Medium
	4,492	

Opportunities	£'000	Likelihood
Balance Sheet changes	3,000	Medium
Agency Doctors VAT reclaim	1,440	Medium
Secure PC gain share	1,304	Medium
Clinical income not confirmed	1,217	Medium
Strategic Estates spend reduction	544	Medium
Learning Disabilities OAP discharge	480	Medium
Improved directorate positions	345	Medium
Additional income in Forensics	279	Medium
Improvement in R&D position	100	Medium
IT licenses VAT saving	863	Low
Clinical income not confirmed	550	Low
Additional income in Oxford Psychology Institute	200	Low
Risk Share on ICB MH spend	200	Low
	10,523	

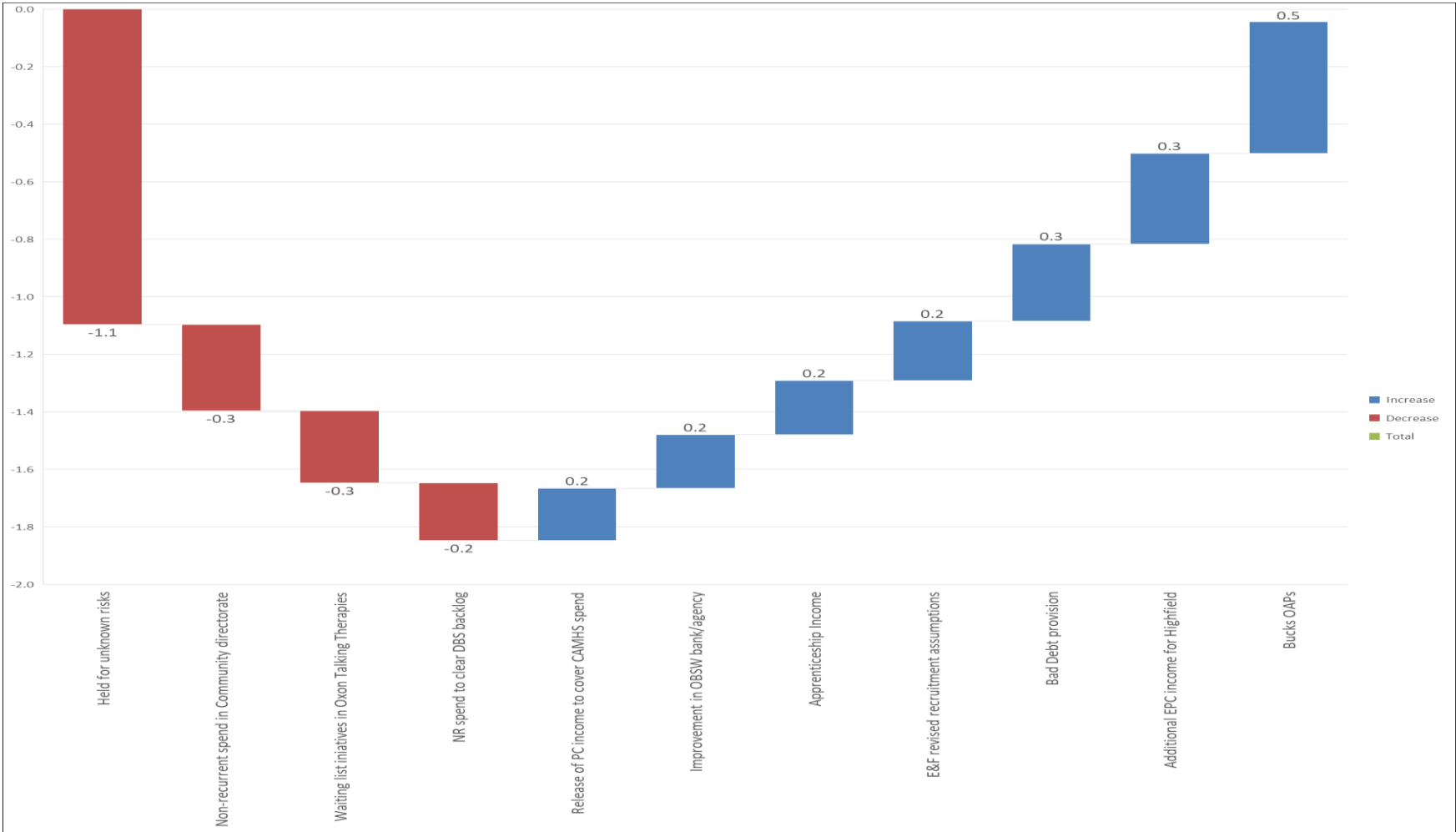
The Trust's Forecast Outturn is for a **£4,750k** surplus, which is on plan. This includes **£1.1m** not in the directorate forecasts but held for unknown risks.

There are **£4.5m** of risks and **£10.5m** of opportunities to the forecast. This gives a forecast range of between **£10.5m** better than plan and **£4.5m** worse than plan. There are no high likelihood risks and opportunities.

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

Forecast range - all risks and opportunities			
£'000	Budget	Full Year Actual	Forecast Outturn
Upside Forecast	-4,750	-15,272	10,522
Downside Forecast	-4,750	-258	-4,492

3. Change from Previous Month's Forecast



4. Capital Investment Programme – 2025/26

	Month 8			Year to Date			FY26				Commitments
	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	Original Plan £,000	Latest Plan £,000	Forecast £,000	Variance £,000	£,000
Capital Projects											
Capital											
Operational	-	136	(136)	1,330	298	1,032	1,585	1,560	1,424	136	313
Transformation	562	93	469	3,688	881	2,807	6,410	4,801	2,727	2,074	3,485
Sub-Total	562	229	333	5,018	1,180	3,839	7,995	6,361	4,151	2,210	3,798
Critical Infrastructure Risk											
Operational	203	22	181	2,920	202	2,718	3,487	3,488	3,809	(322)	2,313
Transformation	244	35	209	732	111	621	1,707	1,037	1,037	-	43
Sub-Total	446	57	390	3,652	313	3,339	5,194	4,525	4,846	(322)	2,356
Bid											
UEC - Transformation (Witney MIU)	102	-	102	351	19	332	690	690	838	(149)	906
NHSE Transformation (Solar PV)	104	-	104	134	0	134	343	343	343	(0)	-
Sub-Total	206	-	206	485	19	466	1,032	1,032	1,181	(149)	906
Other											
PFI Exit	-	-	-	2,000	-	2,000	2,000	2,000	2,000	-	-
IFRS16 new leases / dilapidations	300	589	(289)	1,455	1,781	(326)	1,300	1,300	2,080	(780)	-
IFRS16 Lease renewals / increases	100	-	100	758	182	576	900	900	600	300	-
Sub-Total	400	589	(189)	4,213	1,963	2,250	4,200	4,200	4,680	(480)	-
IM&T											
IT	342	433	(91)	1,266	476	790	1,750	1,750	1,696	54	510
Clinical Systems	10	249	(239)	710	440	270	750	750	750	-	134
Sub-Total	352	682	(330)	1,976	917	1,059	2,500	2,500	2,446	54	645
Total Agreed by FIC & Exec's	1,967	1,557	410	15,344	4,391	10,953	20,922	18,618	17,305	1,313	7,705
Additional Projects											
UEC - Transformation (Abingdon)	-	-	-	-	-	-	-	1,200	1,200	-	-
Wantage Capital Transformation (Additional budget - Orig £277K)	-	-	-	-	-	-	-	-	1,050	(1,050)	-
NHSE Transformation (Chargepoint Scheme)	-	-	-	-	-	-	-	130	130	-	-
Additional Estates Projects	-	-	-	-	-	-	-	1,559	1,544	15	728
Additional IT Projects	1,000	999	1	1,000	999	-	-	1,810	1,810	-	-
Amount Held for Unanticipated (Over)/Underspends	-	-	-	-	-	-	-	-	(322)	322	-
Sub-Total	1,000	999	1	1,000	999	-	-	4,699	5,412	(713)	728
Grand Total	2,967	2,556	410	16,344	5,390	10,953	20,922	23,317	22,717	600	8,432

- The Trust's original capital plan of £20.9m was approved by Execs and FIC in May.
- The plan has now been updated to include £2.6m of additional transformation projects for Abingdon and Wantage, with funding confirmed by NHSE. New projects across Estates and IT have also been approved to offset delays in the core capital programme. **The updated funding available is £22.7m.**
- The YTD net spend is £5.4m (£2.8m in Oct)**
- The forecast outturn is £22.7m.**

The 3As from Capital Programme Group are:

Alert

- **Medium Term Capital Plan:** It is an advantage to be able to plan ahead but the process deadlines are tight and the plan is being set before Trust Strategy and Estates and Digital strategies are complete so there will be risks of unknown cost pressures arising and a need to respond to new circumstances as they arise.

Assurance

- **Financial Spend and Estates Commitments:** A significant increase in Estates spending and new purchase order commitments are bringing spend closer to year to plan. Ongoing monthly monitoring and vigilance required.

Advise

- **PFI Exit Settlement:** The arbitration process for the PFI exit settlement is still ongoing. Currently we are in the process of independent experts completing their review and reports on the state of the building at transfer. By December we will have a clearer idea of the maximum capital risk and whether there is a revenue risk.

5. Directorate Financial Performance Summary

Directorate	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 %
Oxfordshire & BSW Mental Health	12.8	12.5	0.3	0.0%	101.9	102.2	-0.3	-0.3%	152.8	152.9	-0.1	0%
Buckinghamshire Mental Health	6.2	5.7	0.5	8.3%	49.7	49.9	-0.1	-0.3%	74.5	74.8	-0.3	0%
Forensic Mental Health	3.0	3.2	-0.2	-6.3%	24.2	25.5	-1.3	-5.2%	36.4	38.1	-1.8	-5%
Learning Disabilities	0.6	0.7	-0.1	-22.2%	4.6	5.1	-0.5	-11.8%	6.9	7.4	-0.6	-9%
Provider Collaboratives	0.0	0.0	0.0	0.7%	-0.1	-0.1	0.0	0.8%	-1.2	-1.2	0.0	0%
MH Directorates Total	22.6	22.1	0.5	2.2%	180.4	182.6	-2.2	-1.2%	269.4	272.1	-2.7	-1%
Community Health Services, Dentistry and Primary Care	8.9	8.8	0.1	0.6%	71.9	70.2	1.7	2.4%	107.7	106.4	1.3	1%
Corporate	6.7	6.6	0.1	1.8%	52.4	51.2	1.2	2.3%	79.3	78.3	1.0	1%
Oxford Pharmacy Store	-0.1	-0.1	0.0	5.3%	-0.8	-0.8	0.0	5.6%	-1.2	-1.3	0.1	8%
Research & Development	0.1	0.1	0.0	6.8%	0.5	0.5	0.1	13.8%	0.8	0.7	0.0	6%
Reserves	0.1	0.6	-0.6	872.3%	2.2	3.2	-1.0	-44.7%	3.1	2.6	0.5	16%
Block Income	-40.1	-39.8	-0.2	-0.6%	-320.1	-319.4	-0.8	-0.2%	-480.6	-480.6	0.0	0%
EBITDA	-1.9	-1.8	-0.1		-13.5	-12.6	-1.0		-21.5	-21.8	0.2	
Financing Costs	1.4	1.3	0.1	9.4%	11.3	10.2	1.1	9.5%	16.8	16.0	0.9	5%
Adjustments	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0	
Adjusted (Surplus)/Deficit	-0.4	-0.5	0.0		-2.2	-2.3	0.1		-4.8	-5.8	1.1	
Amounts held for unknown risks										-1.1	1.1	
Forecast (Surplus)/Deficit									-4.8	-4.8	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)

6. Provider Collaboratives Financial Performance Summary

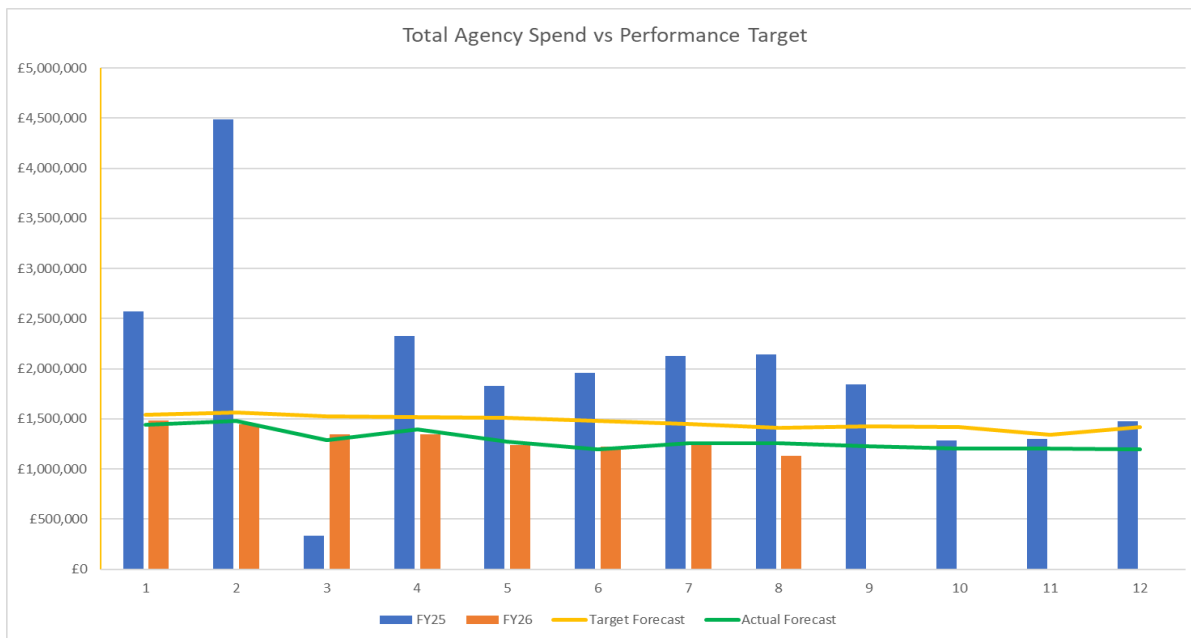
	Month 8			Year-to-date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Secure	8.4	7.8	0.6	67.2	65.4	1.8	100.8	98.0	2.8
CAMHS	2.6	2.6	(0.1)	20.4	18.6	1.9	30.7	27.9	2.8
Adult AED	0.8	0.5	0.2	6.2	5.2	1.1	9.4	8.5	0.8
Provider Collaboratives FY26	11.7	10.9	0.8	93.9	89.2	4.7	140.8	134.4	6.4
FY26 b/f	10.2	10.2	0.0	13.9	13.9	0.0	29.1	16.9	12.1
Provider Collaboratives I/E FY26	22.0	21.2	0.8	107.7	103.0	4.7	169.9	151.4	18.5

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 **£4.7m** favourable to plan YTD. It is reported as breakeven in the Trust overall position in line with the principles of the PC to reinvest savings into services.

The CAMHS provider collaborative has agreed **£6.4m** of non recurring investments in Oxford Heath CAMHS community services.

7. Agency Analysis



*Included in the FY25 month 2 figures is **£1m** of agency cost related to FY24 which was reversed in month 3 as the FY24 accounts were amended to reflect this.

In Month 8 temporary staffing was **11.6%** of the Trust total pay bill with Agency at **3.2%** and Bank at **8.4%**.

Year to date agency spend, is **£1.4m** better than plan and **£7.3m** better than the same period in FY25.

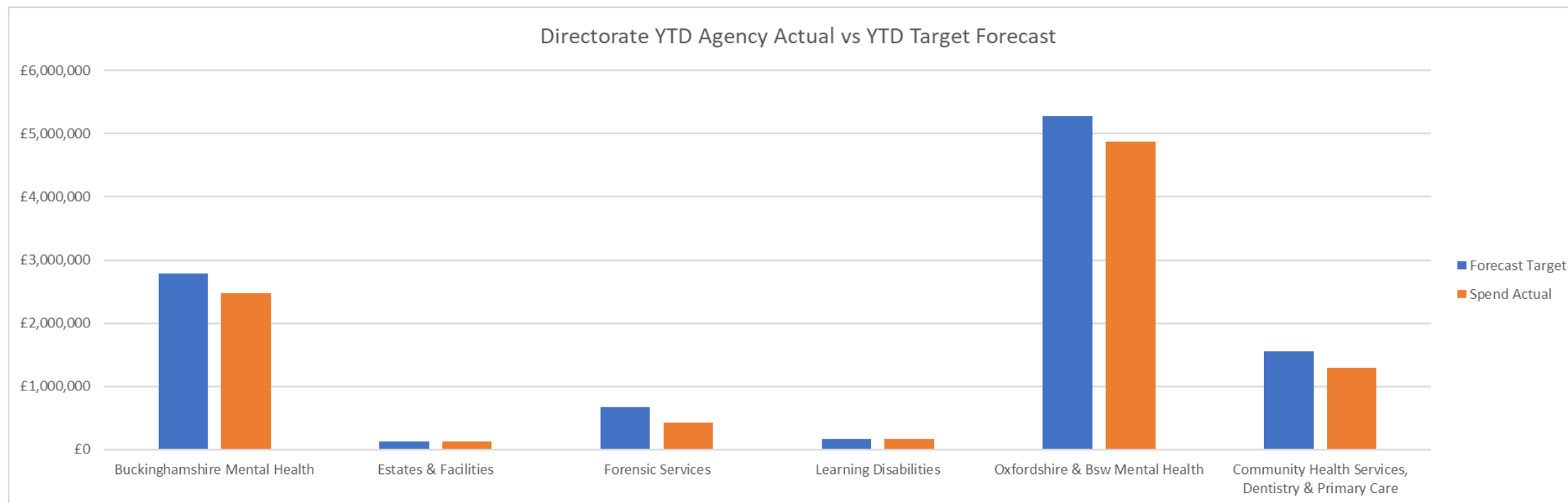
The Trust submitted a plan to BOB ICB and NHS England to spend a maximum of **£17.6m** on Agency in FY26. The forecast spend at month 8 is **£14.4m** which is **£3.1m** better than target.

	FY25 Apr - Nov	FY26 Apr - Nov	Change from FY25
Medical	£8,341,695	£5,999,703	-£2,341,992
Nursing	£7,954,720	£4,176,916	-£3,777,804
AHP/HSS	£931,545	£141,874	-£789,672
Admin & Clerical	£383,666	£145,485	-£238,182
Estates	£18,464	£3,203	-£15,261
Total	£17,630,091	£10,467,180	-£7,162,911
FY24 VC's & FY25 Retros	£149,373	£0	-£149,373
Prior year/Finance adjustments	£0	£0	£0
Total Reported	£17,779,464	£10,467,180	-£7,312,284

YTD Target Forecast vs Actual Spend M8			
Staffing Type	FY26 Target April - Nov	FY26 Actual April - Nov	FY26 Variance April - Nov
Agenda for Change	£6,241,504	£4,465,455	£1,776,049
Medical	£5,756,107	£6,033,404	-£277,297
Total	£11,997,611	£10,498,859	£1,498,752

Full Year Forecast Target vs Full Year Forecast Actual			
Staffing Type	Full Year Target Spend	Full Year Forecast Spend	Full Year Forecast Variance
All Agency Staff	£17,604,024	£14,458,035	£3,145,989
Total	£17,604,024	£14,458,035	£3,145,989

Agency Analysis Continued



Directorates have been allocated targets to reduce agency spend in line with the submitted plan of **£17.6m**.

All Directorates are delivering within the target forecast year to date at month 8.

8. Cost Improvement Programme (CIP)

The Trust's NHSE CIP target is **£36m** made up of a **£9.6m** efficiency from FY26 contract requirements (CIP) and **£26.4m** additional CIPs agreed through the planning round. The Trust is reporting a full delivery of the **£36m** to NHS England on the assumption that any shortfall in these programmes will be mitigated by other non-recurrent benefits in the Trust's position.

The forecast delivery for non-recurrent programs were revised at month 5 to account for certain schemes related to vacancies, which will now be categorised as recurrent based on the assumption that Oxford Health will consistently maintain a level of vacancy across directorates.

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	Pay	12,743	6,071	-6,672	18,295	9,505	-8,789
	Non Pay	1,592	111	-1,481	3,500	2,385	-1,115
	Income - Non-Patient Care	0	2,365	2,365	0	3,547	3,547
Total Non-Recurrent		14,335	8,546	-5,788	21,795	15,437	-6,358
Recurrent	Pay	4,932	10,922	5,991	9,020	15,784	6,763
	Non Pay	2,972	2,767	-205	4,839	4,430	-409
	Income - Non-Patient Care	233	236	3	350	354	4
Total Recurrent		8,137	13,925	5,788	14,209	20,567	6,358
Grand Total		22,471	22,472	0	36,004	36,004	-0

Cost Improvement Programme (CIP) Cont.

As well as the **£9.6m** FY26 contract requirement, **£2.1m** FY25 CIPs were not delivered recurrently by directorates last year, and there is a planned over-achievement of CIP targets in corporate making the total directorate CIP plans expectation **£13.1m**.

£10m of the **£13.1m** directorate CIP expectation has been delivered through CIPs including staffing establishment reviews and non-pay efficiencies. The remaining balance for the year is being met through non recurrent mitigations while recurrent plans are being developed. There is also a non recurrent VAT benefit forecast related to digital hosting services.

Forensic Mental Health and Pharmacy within Medical services are reviewing options to mitigate the shortfall in forecast CIP delivery.

£'000						
Directorate	CIP Target	Planned Delivery	Forecast Recurrent Delivery	Forecast Non-Recurrent	Forecast Total Delivery	Forecast Variance to Plan
Community Health Services, Dentistry & Primary Car	3,677	3,677	3,406	272	3,678	1
Oxon & BSW MH	3,436	3,436	2,663	773	3,436	-0
Bucks MH	1,728	1,728	1,486	242	1,728	0
Forensic MH	865	865	585	0	585	-281
Learning Disabilities	143	143	143	0	143	0
Corporate	1,802	3,271	1,941	1,098	3,039	-232
Total CIP	11,652	13,121	10,224	2,385	12,609	-512
			88%	20%	108%	-0

9. Statement of Financial Position and Cash Flow Summary and Working Capital Indicators

Month 8

Statement of Financial Position - Headlines

Net assets have increased by £2.4m YTD to **£210.2m**. This is represented by:

	£m
Decreases in net capital assets	(£5.7m)
Increases in current assets	£3.3m
Decreases in net liabilities	£4.8m
Net increase	£2.4m

Cash Flow - Headlines

Cash balance of **£96.0m** at the end of November

Forecast year-end cash balance of £80.1m

Net cash has decreased by £1.7m YTD. This is represented by:

Net Cash used in operations	£6.2m
Net Cash used in investing activities	(£0.8m)
Net Cash used in financing activities	(£7.1m)
Net increase	£1.7m

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days by value	30	32	●
Debtor Days by number of inv's	30	30	●
Debtors % > 90 days	5.0%	9.5%	●
BPPC NHS - Value of Inv's pd within target (ytd)	95.0%	96.7%	●
BPPC Non-NHS - Value of Inv's pd within target (ytd)	95.0%	95.2%	●
Cash and Cash Equivalents (£m) - per y/e forecast	80.1	96.0	●

Working capital ratio's

- Debtor days by number of invoices on target, and debtor days by value marginally below target.
- Debtors % over 90 days is below target, due to unpaid invoices. These are mainly various ICB's £257k (£257k in M07), OUH £204k (£220k in M07), Central & NW London £74k (£74k in M07), Salary overpayments £266k (£261k in M07), Various Councils £268k (£192k in M07) and other £37k (£47k in M07).
- NHS BPPC (Better Payments Practice Code) is ahead of target.
- Non-NHS BPPC (Better Payments Practice Code) is ahead of target.
- Cash is ahead of the year-end target at M8. This is mainly due to a delay in spend of £10.9m against the YTD capital plan. Any PFI exit payment will also need to be financed from cash balances. Short-term investments in the National Loans Fund have begun as approved by Finance & Investment Committee.



Oxford Health
NHS Foundation Trust

Meeting	Board of Directors' Meeting
Date of Meeting	28 th January 2026
Agenda item	13
Report title	Patient Safety Reviews in November and December 2025
Executive lead(s)	Britta Klinck, Chief Nurse
Report author(s)	Jane Kershaw, Head of Patient Safety Victoria Harte, Patient Safety Service Manager
Action this paper	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the group	This paper follows the last report to the meeting in November 2025. The purpose of the paper is to share learning from incidents and actions being taken to improve the safety of care.
For disclosure or confidential	Disclosure to group members.

Executive summary

To support the continual improvement of the safety of care we have embedded the standards and principles of the national Patient Safety Incident Response Framework (PSIRF). A summary of what this means, our approach and 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](#).

Key Highlights of the report:

- ❖ Seven patient safety reviews were identified in November and December 2025 meeting our patient safety incident response plan and where we believe there is potential for significant learning. Since 1st April 2025, 30 reviews have been identified falling under the plan, 14 of the 30 cases have been under the safety area of access to care and treatment.
- ❖ We use a range of learning response approaches which all use a systems focused methodology. Incident learning huddles continue to be well used to identify learning, with 11 huddles completed in November 2025 and 10 in December 2025.
- ❖ The key learning identified from reviews completed in the last two months and the safety actions in response are detailed in the report. The key learning was around;
 - Clear documentation of risk formulation
 - Involving families/carers in a patients care
 - Joint working with alcohol service
 - Availability of prescribers across the community hospital wards
 - Capacity for Urgent Care Response and Rapid Access Care Unit services
- ❖ The report includes a summary about a peer review completed with the other NHS Trusts in the BOB ICS region and the learning we took away.

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

The Trust has a series of weekly patient safety forums which review the detail of the information summarised in this report.

A monthly report goes to the Quality and Clinical Governance Group and a quarterly report to the Quality Committee.

Recommendation(s)

For the Board members to be assured regarding the current processes and structures for how we identify, respond and use learning from patient safety incidents to make changes.

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	No	
Legal and regulatory	Yes, national regulation from CQC and NHS England.	

1. Introduction

To support the continual improvement of the safety of care we have embedded the standards and principles of the national Patient Safety Incident Response Framework (PSIRF). A summary of what this means, our approach and 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 principles of PSIRF are:

- Compassionate engagement and support for all affected by a significant incident
- Application of a range of system-based approaches to learning
- Considered and proportionate responses to incidents
- More attention to learning and identifying the right actions to take
- Continually making changes to improve the safety of systems

We have support mechanisms to help patients, families and staff affected by incidents. These mechanisms are invaluable and enable those affected to be involved and engaged in patient safety reviews.

For each review we use a systems factor methodology (SEIPS = 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 safety actions we take address the real issue(s). All those responsible for leading on reviews have completed specialist training.

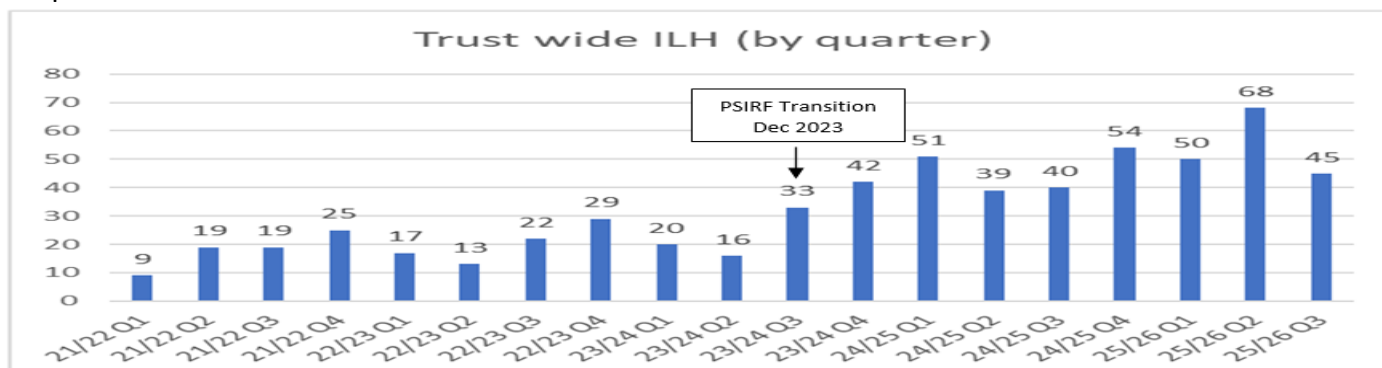
2. Incident Learning Huddles

We use incident learning huddles (ILH) as an initial learning response where there has been significant harm to a patient, or we believe there is a potential for great learning. An ILH is a facilitated group discussion with professionals/staff involved in the care provided to a patient to help us to understand more about what's happened and why after an incident/near miss. The huddles will check support is in place for those affected and focus on what can be learnt. A huddle often involves staff from multiple clinical teams and external organisations. The approach has proven to be an effective way to improve engagement in identifying and acting on learning.

A Quality Improvement project has started to look at how to improve the patient/family voice and representation at ILH. This work is being co-produced with the Trust's Patient Safety Partners with lived experience of using healthcare services.

There were 11 ILH completed in November 2025 and 10 in December 2025, and a total of 169 huddles completed from 1st April 2025. The graph below shows the number of ILH by quarter up to December 2025.

Graph 1.



3. Cases declared under our Incident Response Plan

Following the last report to the Board of Directors meeting there have been seven patient safety reviews identified in November and December 2025 within our local incident response plan and where we believe there is potential for significant learning. The cases are listed below with the planned learning review we intend to take.

Between 1st April to 31st December 2025 we have identified 30 cases falling under our local incident response plan, of which 14 have been in the safety area of access to care and treatment.

Table 1.

Incident description	Type of service	PSIRP safety area	Planned Response	Learning
Detection and escalation of physical health deterioration on ward (Oxfordshire Vaughan Thomas Ward)	Mental Health Service	Physical health deterioration	Patient Incident Investigation (PSII)	Safety
Patients who have died whilst on the Adult ADHD waitlist (Buckinghamshire and Oxfordshire ADHD service)	Mental Health Service	Emergent	Thematic Review	
Suspected suicide (Swindon CAMHS – being led by another NHS Trust)	Mental Health Service	Access treatment/ service	System PSII	
Assault on members of the public (Oxfordshire City and NE AMHT)	Mental Health Service	Access treatment/ service	PSII	
Detection and escalation of physical violence (Buckinghamshire Aylesbury AMHT)	Mental Health Service	Access treatment/ service	PSII	
Unexpected natural death (Buckinghamshire Amber Ward)	Mental Health Service	National – mental health inpatient death	PSII	
Medication and blood test results incident (Oxfordshire Sandford Ward)	Mental Health Service	Access treatment/ service	ILH	

4. Key Learning and Changes

The key areas for learning identified from patient safety reviews and the incident learning huddles completed in November and December 2025 are detailed below in table 2.

The findings from each safety review are shared with those affected, scrutinised by a senior clinical panel and then signed off by an Executive Director led panel. All agreed safety actions are then added onto the Ulysses electronic system for central monitoring with oversight by the patient safety team. The action lead receives automated reminders about their actions, and scheduled action reports go to a range of staff for oversight as well as regular reporting on action progress into a series of quality governance meetings.

Table 2.

Type of service	Improvement area	Safety Action(s)
Mental Health services	Clear documentation of risk formulation.	Organising and delivering further risk formulation training for all clinical staff. To review completed risk assessments every other month as a standing agenda item in the team business meetings. This will include interactive small group discussions where staff identify the strengths and improvement areas of anonymised risk assessments with a focus on risk formulation.
Mental Health services	Involving families/carers in a patients care.	Reviewing the Triangle of Care self-assessment tool (undertaken in 2024 by this team) to evaluate changes that have been implemented and to identify further areas of improvement required.
Mental Health services	Staffing pressure within team and MDT working processes	Team specific improvement plan in place with regular monitoring by the Service Director and Clinical Director.
Mental Health services	Good Practice identified; - Evidence of engagement and involvement with the patient's family, especially his mother and collaboration with the patient. - Prompt follow up from the AMHT and Crisis Team when the patient self-discharged from the acute hospital, highlighting good joint working.	
Mental Health services	PITT alarm sensor failure	PITT alarms are tested daily, but the sensors are not. This being altered so the alarm and sensors are checked daily.
Mental Health services	Use of mechanical restraint for example handcuffs	Ensure staff aware of the mechanical restraint policy and escalation/approval process when required to be used.
Mental Health services	Joint working with alcohol service	Developing regular forums between organisations to discuss shared patients.
Physical Health services	Availability of prescribers across the community hospital wards	Review prescribing of minimal PRN for pain relief and consideration of a new Patient Group Direction, a legal framework allowing registered health professionals, beyond medics, to give specific drugs to pre-defined patient groups for common conditions without needing a patient-specific prescription.
Physical Health services	Capacity for Urgent Care Response and Rapid Access Care Unit services	Centralise coordination across services so resource is most effectively used.

5. Peer Review

The NHS Trusts across the BOB system completed a second annual peer review of completed safety reviews. This was completed in the recent BOB system Patient Safety and Improvement Forum held in November

2025 including our Patient Safety Partners, commissioners, NHS England and the Health Innovation Oxford and Thames Valley. The review looked at a couple of completed learning responses from each organisation, providing reflections on what works well and what could be considered for improvement. Overall the feedback we received was very positive.

Health Services Safety Investigation Body (HSSIB) reported recently that mental health providers in particular were struggling with using the national Patient Safety Incident Investigation (PSII) template and related tools, but this doesn't seem to be the case from the feedback we received. It demonstrates investing in a dedicated team of highly skilled and experienced staff are what makes a difference in the quality of an investigation and PSII report and engagement with those affected, despite any limitations of the template.

The highlights of the comments received were:

- Lots of staff engagement and felt no blame was embedded
- Very strong evidence on engaging with people effected – both patient/family.
- Authors clearly understand how the interactivity between different agencies and the underlying systems influence what happens.
- The report focuses on factual information and high quality analysis.

The Trust's patient safety team including the Patient Safety Partners reviewed the completed safety reviews from all NHS Trusts and identified the following changes to make to our report templates;

- Removing the Executive Summary within PSII reports when shared with the family/patient, as this part of the template is more designed for staff and those in an oversight role.
- Make more prominent in the ILH reports the engagement that has happened with patient/family and what the incident was about– these sections will be moved higher in the report template.
- Summary of the Systems Engineering Initiative for Patient Safety (SEIPS) analysis on a single page to be included in Appendix of all PSII reports, at the moment this is often a separate document.
- Reviewing and restructuring the introduction sections of the PSII report template e.g. explaining the investigation process
- Give more consideration to using visuals/diagrams/photos in reports to describe complex situations and systems.

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	14
Report title:	Update on Mental Health Act 2025 - reforms
Executive sponsor(s):	Dr Karl Marlowe, Chief Medical Officer
Report author(s):	Mark Underwood, Head of Information Governance and Data Protection Officer. Paula Courtney, Mental Health Act Service Manager.
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	Update Board on Implication for OHFT
Public or confidential	Public

Executive summary

The Mental Health Act 2025 received Royal assent on 18 December 2025. The Act amends (again) the Mental Health Act 1983. It is difficult to read and interpret on its own and needs to be read in the form set out in a Keeling schedule

<https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2026/01/MH-Bill-updated-Keeling-Schedule.pdf>

It is now 7 years since Professor Sir Simon Wessely produced a creative review of MHA legislation. It was a proposal for how MHA legislation ought to look in the 21st century.

Governance Route/Escalation Process

The revisions will be discussed at MH Law Committee.

Statutory or Regulatory responsibilities

The 2025 Ac contains 57 sections and 3 Schedules, which will make many than 60 changes to the existing legislation.

The revisions could take up to 10 years to fully implement. The changes and new provisions for autism and learning disability have implications beyond the use of a Mental Health Act, and will require consideration by NHSE, ICBS, and LAs

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

This work related to the MHA 2025 will be governed via The Trust's *Mental Health & Law Committee*.

Recommendation(s)

- The Trust are requested to note the report.
- A programme of work will be required to ensure that Trust staff acquire the requisite skills and knowledge to utilize the powers in the revised legislation.

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 Will inform future CQC inspection and regulation.	

Changes to the Mental Health Act: An Overview of the Mental Health Bill

Introduction to the Mental Health Bill

The Mental Health Bill, enacted after a 2018 review and receiving Royal Assent in December 2025, makes major amendments to the 1983 Mental Health Act. Rather than replacing the MHA, it introduces changes to detention rules, enhances personal autonomy, and seeks to reduce systemic inequalities. These reforms will be phased in over several years. The changes begin in February 2026 with conditionally discharged patients; more details are provided later in this document.

Core Objectives of the Bill

The Bill is underpinned by three main aims:

- Ensuring that detention is used only when necessary and when it will provide genuine therapeutic benefit.
- Empowering individuals by giving them greater control over their own care and treatment decisions.
- Tackling persistent inequalities within the system, such as racial disparities in detention rates and the inappropriate, prolonged hospitalisation of people with learning disabilities or autism.

Key Reforms Introduced by the Bill

While the Bill introduces a large number and range of reforms, seven particularly significant changes stand out:

1. Stricter Detention Criteria via Section 3: Detention under Section 3 now requires clear evidence of serious harm, demonstrable therapeutic benefit, and proof that such detention is genuinely necessary.
2. Detailed Applications for Detention: Applications must now include much more comprehensive reasoning, outlining precisely why detention is unavoidable in each case.
3. Shorter Renewal Periods for Section 3 Detention: The initial renewal period for detention under Section 3 is reduced from six months to three months.
4. Changes Regarding Learning Disability and Autism: Learning disability and autism are now excluded as grounds for treatment detention, except under forensic sections.
5. Nominated Person Model: The new model replaces the previous 'nearest relative' system, allowing individuals to nominate someone of their choice.
6. Statutory Advance Choice Documents (ACDs): ACDs become a statutory requirement, with clinicians obliged to consider them when making treatment decisions and to formally record any reasons for departing from them.

7. Increased Frequency and Transparency of Tribunal Reviews: Tribunals will now occur more frequently, with a greater emphasis on thorough documentation and transparency throughout the review process.

These reforms are closely intertwined. The higher threshold for detention calls for more robust clinical reasoning and improved documentation. Tribunals will be responsible for scrutinising both the reasoning and evidence for detention. The changes around autonomy will also necessitate new approaches to involving patients in their own care and decision-making. Collectively, these adjustments amount to an overhaul of the entire MHA framework.

Additional Noteworthy Changes

The Bill introduces several other important updates that will have a substantial impact on practice and patient care:

- Updated Terminology: The term 'mental disorder' will be replaced by 'psychiatric disorder'.
- Formalised procedures to ensure clear communication between inpatient and community Responsible Clinicians to help avoid any gaps in care and to minimise delays in patient follow-up and input.
- The nominated person will have the right to object to the application for a CTO on behalf of the patient.
- Responsible Clinicians will be required to consult with another professional involved in the patient's care before deciding to discharge an individual from section or from a CTO.
- The timeframe for transferring patients from prison to hospital will be shortened, aiming to ensure timelier access to appropriate care.
- Where a Second Opinion Appointed Doctor (SOAD) is requested, compelling and clear reasons must be provided to justify the request.
- Provisions governing Electroconvulsive Therapy (ECT) and other urgent treatments are being revised.
- Nasogastric feeding will be incorporated within the regulatory framework, clarifying its legal status and use.

Timeline for Implementation

The transition to the new system will be phased over a period likely exceeding ten years. The first changes will take effect in February 2026, starting with conditionally discharged patients:

- February 2026: The initial reform allows conditionally discharged patients to be deprived of their liberty in specific circumstances.
- 2026 and Beyond: A new MHA Code of Practice will be developed (anticipated to be the focus throughout 2026), alongside the introduction of new statutory forms.
- Medium-Term Reforms: These will include changes to tribunal processes and duties concerning the infrastructure for conditionally discharged patients.

- Long-Term Reforms: Exclusion of learning disability and autism as grounds for detention will be enacted, contingent upon the development of sufficient community capacity.

These reforms present valuable opportunities to modernise mental health care, reduce unnecessary detention, enhance patient experience, support shared decision-making, and reinforce a therapeutic focus at the heart of the legislation.

Immediate Actions and Next Steps

At present, the existing Mental Health Act remains in force, therefore it's business-as-usual, until advised otherwise. Updates will be provided as new information becomes available.

A key component of the forthcoming changes is the new MHA Code of Practice. The government intends to consult with stakeholders on its content. Both professionals and members of the public will have opportunities to contribute directly to the Code's development.

Looking ahead, the MHA Office will maintain preparations for implementing the reforms and will continue to provide necessary updates. Additionally, Task and Finish Groups will be established to support this work.

Changes in summary – MHA 1983 and MHA 2025 revisions and additions, risks:

MHA 1983	MHA 2025	Risks to Trust
Part II Detention Criteria Mental Disorder Nature or Degree Interests of health, safety, protection of others	Adds psychiatric disorder, Serious harm as the abiding risk criteria	Ought to be neutral, new Code of Practice (if published) will provide greater clarity for interpretation of criteria
Application reasons S3	Expanded, links serious harm to nature and degree Appropriate medical treatment expanded – “has a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations”	Effective clinical scrutiny – available of consultant ‘scrutineers’
Duration of detention and renewal (s20) S3 and 37 – 6 months, 6 months, yearly (if renewed)	3 months, 3 months, 6 months, 1 year	Additional renewal period – impact on RCs, patients not detained beyond 3 months
Definition of mental disorder		
Nominated Person Nearest relative currently	Patient choice (caveat) of the person who has the power to object (S3), discharge	Suitability and fidelity to appointment model may be an issue
Advance Choice document	Statutory advance choice documents – S130M	Processing and storing in RiO, system enhancements required

Tribunal timetable Appeal each 'period' of detention	Additional period of detention.	RCs, nurses, key worker/social worker required to provide an extra report in shorter amount of time
RiO Changes	Time periods and data fields will require revision, and functionality added.....	

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	15(a)
Report title:	Report from Audit & Risk Committee on matters to Alert, Advise or Assure
Executive sponsor(s):	N/A
Report author(s):	Chris Hurst Non-Executive Director and Audit & Risk Committee Chair
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	For Board Alert/ to Advise/Assurance or recommendation for Approval
Public or confidential:	Public

Executive summary

The most recent meeting of the Audit & Risk Committee was held on 2nd of December 2025, at which it considered matters set out in the agenda (attached in the Reading Room) and reviewed and confirmed the minutes of its previous meeting (also included in the Reading Room).

This paper summarises the significant matters reviewed and discussed by the committee at the meeting. The report is provided for the Board's information, to provide assurance on specific matters.

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

N/A

Recommendation(s)

The Board is asked to consider the report and to confirm that it is assured, where appropriate, and satisfied with the committee's overall progress in delivering its annual work plan.

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/ <u>No</u>	
Legal and regulatory	<u>Yes/No</u> Through the work of the Trust's internal and external auditors, the committee seeks assurance that the Trust remains compliant each year with all relevant regulatory and statutory requirements relating to the governance and financial conduct of the organisation.	

For Alert (may require discussion)

There are no matters to alert the Board to on this occasion.

To Advise (to monitor)**Board Assurance Framework (BAF)**

The Audit & Risk Committee (ARC) undertook the first of its programmed deep dives of BAF risks, examining three risks - Environmental Sustainability, Information & Data, and Partnerships & System working. All eleven BAF risks are scheduled for review over the course of the next year.

The Chair highlighted that it was important for the Committee: i) to keep under review the effectiveness of the revised BAF arrangements; ii) for members to bring to the Committee's discussions their wider knowledge and experience from the Board and work of other Committees; iii) to gain assurance that the Board and its committees are focusing on the most appropriate areas after considering the relative significance of each risk within the BAF; and iv) to undertake deep dives of the BAF risks to support the above. The Chair highlighted the importance of the Committee considering risk ratings "in the round" so the BAF is of greatest utility to the Board in helping it prioritise the use of its time and shape its focus.

In discussion, members commented that some risks appeared to be rated too highly when looked at more broadly and considered over time. The Chief Finance Officer advised the Committee that the three risks subject to a deep dive had been reviewed recently by the Finance and Investment Committee (FIC); and that the committee had accepted her advice that the current risk rating remain unchanged pending the outcome of the 2026-27 NHS financial planning process.

- 1) *Environmental Sustainability* - the Committee was briefed on the work taking place through the Director of Estates & Facilities on sustainability and the commitment to the Zero Carbon Oxford Charter, including plans to put in place additional expertise in this area. The Committee noted that the Board had recently agreed that this risk should remain on the BAF.
- 2) *Information & Data* - the Committee was reminded of the need to strike a balance between: i) maintaining robust information governance arrangements (including measures to protect against cyber threats); and ii) its goal to maximise the use of data and systems to support clinical and research teams. The Chair noted that this was a particularly complex and dynamic area of risk and that other risk factors – such as, potential system failure, data accuracy issues, human error, and system and partners information governance – must also be kept under review.
- 3) *Partnerships & System working* - the Committee was advised that the risk rating of 12 was considered appropriate in the wider context of national system changes, including the current clustering of Integrated Care Boards (ICBs). The Committee considered the Trust's main approaches

to mitigate this risk. It was advised that until the new ICB clustering arrangements have been completed, the risk rating was considered to be appropriate. The Committee discussed current partnering arrangements and the potential for the mismatch of organisational priorities between the Trust and its partners. The Executive Director of Strategy & Partnerships commented that, although there was scope for more collaboration between boards, at an Executive level there was already strong engagement with the Trust's main partners.

Further to the discussions and reflections, the Committee supported the revised BAF arrangements and was assured through its deep dive into the risks on: Environmental Sustainability; Information & Data; and Partnerships & System working.

Estates

The Director of Estates & Facilities attended the meeting to provide the Committee with a verbal update on the programme of work he is currently leading within the department to improve delivery and sustainability; including:

- The review the departmental structure, accountability and ownership, and the introduction of Subject Matter Experts (SMEs) to help address technical challenges
- Team resilience and the delivery culture
- Updating of policies and procedures to support compliance, safety and improve customer-focus
- Improving joint working with partners within the Integrated Care System; and
- A review of procurement practice.

The Director of Estates & Facilities commented that the increase in accountability had already helped to improve how the team was operating. Other initiatives included the "celebration of success" across sites and the introduction of 6 monthly briefings (at which feedback from staff surveys was also being reviewed).

The Chief Executive acknowledged the progress which was being made and the Chief Finance Officer added that members of the Estates team had also been nominated for internal Exceptional People Awards and the housekeeping team had received positive national media coverage.

The Committee was briefed on a whistleblowing case in the department and the Executive Director of Corporate Affairs confirmed that an investigation was underway. The Committee noted the Director's update and was supportive of the breadth of work taking place and the approach being taken to address and resolve issues.

Other matters considered at the meeting

The Committee received and approved the updated *Risk Management Strategy & Policy*, noting that the section on risk scoring guidance would be updated and brought back to the Committee following further discussion.

The Committee reviewed the *Emergency Preparedness, Resilience & Response (EPRR) annual report* and the results of the Trust's self-assessment (self-rated as achieving "full compliance"), which had been reviewed by the Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB. The Chair acknowledged continued positive performance in this area and took additional assurance from the ICB's scrutiny of the return. The Committee approved the NHS EPRR core standards self-assessment and it is recommended for final approval by the Board.

The Committee received an update on the External Audit procurement process. The Chair emphasised the importance of an External Audit provider being independent and appropriately challenging, but also commented that "ways of working" would also be an important consideration. The Committee approved the proposal and procurement timeline set out in the report.

For Assurance (to note)

Internal Audit (KPMG)

1) Internal Audit Plan and outstanding audit recommendations

ARC received and reviewed KPMG's 2025-26 internal audit progress report. The Trust's Internal Audit partner advised the Committee that "... the Internal Audit Plan was on track for completion by the end of FY26 but noted that there had been an increase in actions becoming overdue." After reviewing all outstanding actions (all categorised as either medium or low priority), the Committee was satisfied that the increase was principally due to the re-scheduling of target dates for the completion of some of the actions related to the:

- Health & Safety review – revised due to the significant scale of the current management of change plans in hand; and
- Frontline Digitisation review – many of the actions had been completed but, in aggregate, the dates put forward and agreed by the team had been over-ambitious.

After discussion, the Committee concluded that the increase in the number of outstanding actions was not a matter of concern. However, the Chair re-emphasised the importance of setting realistic target dates for the completion of actions in response to audit recommendations, after assessing the workload implications of the recommendations taken together.

2) Data Quality review of Access and Activity Data (Talking Therapies)

KPMG presented its report on the review of processes and controls for the recording, validation, and reporting of Talking Therapies access and activity data; the review had achieved a rating of **significant assurance**

(3 low priority recommendations, 2 of which had already been completed).

The Chief Finance Officer noted that the review had demonstrated that Talking Therapies made excellent use of data to drive the service and deliver positive outcomes for patients and that there was wider learning from this as new tools were rolled out within the Trust. The Committee noted the Internal Audit review report and was assured by Talking Therapies' use of access and activity data.

3) Artificial Intelligence (AI) Benchmarking exercise report

The Chief Digital & Information Officer joined the meeting for the presentation of the AI Benchmarking exercise report. The Committee was informed that a structured benchmarking methodology had been used to consider AI use and deployment in healthcare. The report notes that progress had been made by the Trust in response to the suggested actions in the report, including the development of an AI policy and introduction of an AI Steering Group. The Chief Digital & Information Officer drew the Committee's attention to the pending refresh of the Digital Strategy, which he considered would provide a further opportunity to consolidate activity and ideas.

The Chair encouraged the Trust to work collaboratively with system colleagues on AI and to stay abreast of developments and opportunities and to establish appropriate links with the University of Oxford on AI development.

4) Cyber Incident internal audit review - actions update

The Head of IT joined the meeting and presented the actions update report in respect of the cyber incident and investigation which had been reported to Committee in September 2025. He highlighted that the appropriate containment activities and the majority of recommended actions had been implemented. Of the remaining risks:

- 14 recommendations had been rejected because implementation would hamper current operations (including collaboration with other organisations) and as alternative technologies/ options were in place to mitigate or remove these risks
- 28 recommendations were being further investigated as they could potentially severely impact service delivery and productivity.

All of the recommendations yet to be implemented are assessed to be low risk. The Committee thanked the Head of IT and the KPMG Cyber Response Team for their speed and agility in responding to the incident; and acknowledged the importance of pausing to consider the operational impact of the remaining recommendations.

5) Counter Fraud

ARC received an update on KPMG's Counter Fraud work for this financial year and noted that fieldwork had been completed on the Recruitment review.

Losses & Special Payments – review of overpayment controls and processes

The Chair introduced the report, stating that it would be appropriate for the Committee to examine the potential weaknesses in controls and processes arising from the recent over-payment, which had been partly written off by management. The Chief People Officer presented the report and set out: (i) the policy and processes in place to manage over and underpayments; and (ii) specific factors which had contributed to the overpayment. The Committee was informed that a wider programme of work had taken place through the People Steering Group to address these and other issues. This work included; staff and payroll provider training, and regular proactive reviews to reduce the potential for mistakes to be identified and corrected at the outset.

The Committee was assured that the key weakness had been addressed and the Chair asked that the Committee receive a further update on operation of these payroll controls and processes in June 2026 to gain further assurance that the changes were having the expected impact.

The Committee noted the report on Overpayment Controls and Processes and was assured that key points of weakness had been addressed.

External Audit (Ernst & Young)

The committee received a verbal update on the outcome of the joint review of the 2024-25 accounts audit process which has been carried out by the Trust and its external auditors (Ernst & Young). A small number of further actions had been agreed to further improve what was jointly assessed to have been an efficient and effective process last year.

Sharing of learning

None identified.



Meeting:	Board of Directors Meeting
Date of Meeting:	28 January 2026
Agenda item:	15(b)
Report title:	Report from Charity Committee on matters to Alert, Advise or Assure
Executive sponsor(s):	N/A
Report author(s):	Rick Trainor Non-Executive Director and Charity Committee Chair
Action this paper is for:	☐ Decision/approval ☒ Information ☒ Assurance
Reason for submission to the Board:	For Board Advice and Assurance
Public or confidential:	Public

Executive summary

The Charity Committee met on 9 December 2025 (with the agenda included in the Reading Room). The draft minutes are separately provided in the Private Reading Room.

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

N/A

Recommendation(s)

That the Charity Corporate Trustee, having considered the report of the Independent Examination by James Cowper Kreston, approve the Charity's Annual Accounts and Annual Report for 2024/25 and the Letter of Representation at its separate meeting on 28 January 2026.

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	
	If yes, include brief description, e.g. CQC essential standards; Provider license etc	

For Alert (may require discussion)

No items discussed at the Charity Committee meeting on 9 December 2025 fall into this category.

To Advise (to monitor)

The Committee wish to advise the Board that:

- The Committee endorsed the Charity Strategy Roadmap while noting that it was still subject to revision.
- With regard to the Oxfordshire Health Services Research Grant, the Committee agreed to take no further action, noting that the focus on a collaborative approach – with the Oxford Hospitals Charity – had withered away after the pandemic response.
- The Committee will consider an updated paper on the ROSY¹ sustainability plan at the Committee's next meeting.
- The Committee decided to take no immediate action – until a suitable opportunity developed or a particular project arose which could inform recruitment – on seeking one or more lay/independent members, for which there was no requirement.
- Having clarified that the Charity's Accounts for 2024/25 were – in line with other smaller NHS charities – subject to Independent Examination rather than External Audit, and having had reported to it that the Independent Examiner (James Cowper Kreston) had approved the Accounts with only minor adjustments, the Committee recommended to the Corporate Trustee for approval the Accounts and the Annual Report, and the Letter of Representation (which the Independent Examiner had also approved). The Committee decided to seek clarification whether a Going Concern statement was required. (Post-meeting note: it has now been determined that such a statement is required and that relevant assurances are covered on pp.18 [no material uncertainties concerning continued operation], 22 [absence of uncertainty that the Charity will continue in business], and 25 [accounts prepared on the basis that the Charity will continue for the foreseeable future] of the Annual Report.)
- With regard to (a) the updated SORP 2026 Accounting and Reporting requirements and (b) the updated Code of Fundraising Practice, the Committee was satisfied that appropriate implementation measures were in hand. With respect to moral (ex gratia) payments, the Committee noted that the Charity had adopted the relevant new statutory powers. The Committee also approved new delegation limits.
- The Committee noted that there were no major updates to the Charity's risks and was satisfied by the management of risks, including those related to media opportunities associated with the Warneford 200

¹ Respite Nursing for Oxfordshire's Sick Youngsters (**ROSY**)

Project, with the progress of which the Committee was very positive.

- With respect to two particular risks, the Committee was generally satisfied with the contents of a 'deep dive' into Management of Volunteers and Volunteers' Experience. It welcomed the prospect of receiving at a future meeting a more detailed report on Volunteering. Among the topics in which the Committee is taking an interest is whether the Charity should be more proactive with a view to increasing the number and impact of the Charity's volunteers, and whether there should be an annual conference for volunteers and more recognition of them.
- The Committee decided – on legal grounds and because the proposed gift presupposed capacity and experience that the Charity does not have – not to accept an offer in return for Charity involvement in the production, sale and distribution of the book being prepared in connection with Warneford 200. However, the Committee remained open to considering an alternative proposal, which might include a partnership agreement, for Charity support of the book project (which the Committee warmly welcomed) in other ways.
- The Committee commended the positive impact achieved by the projects being supported by the Charity.
- The Committee warmly thanked the retiring Financial Controller, Mr Michael Williams, for his services to the Charity over many years.

For Assurance (to note)

- The Committee continues to monitor the gradual decline in the resources of the Charity (£633,911 at the end of Q1 FY2026, compared to £668,000 at the end of FY2025 [the latter reflecting a decline of approximately £116,000 during FY2025]), with a further decline in Q2 of the current financial year to £612,157). The Committee drew encouragement from the fact that income had been rising during Q1 and Q2 of the current financial year. The Committee has asked Charity staff to monitor the finances carefully, setting parameters around the level of consumption of accumulated funds over the rest of FY2026. Among the remedies for the resource decline which are under consideration are monitoring of cash balances and - now that the staffing problem has been resolved - increased fundraising activity.

Meeting:	Board of Directors' Meeting
Date of Meeting:	28 January 2026
Agenda item:	16
Report title:	Pay Gap Report (gender, ethnicity, disability)
Executive sponsor(s):	Charmaine de Souza (Chief People Officer)
Report author(s):	Zoe Moorhouse (interim Head of OD) and Mo Patel (Deputy Head of OD – EDI)
Action this paper is for:	☐ Decision/approval ☐ Information ☒ Assurance
Reason for submission to the Board:	Regulatory requirement – for publication by 30 March 2026
Public or confidential	Public

Executive summary

The 2025 Pay Gap Report provides an analysis of pay disparities across Gender, Ethnicity, and Disability groups, fulfilling statutory obligations and expanding beyond the mandatory Gender pay reporting. For the first time, Disability data is included alongside Gender and Ethnicity, which have been reported for the past two years.

The report, along with agreed actions, will be published on both the Trust's website and the Government's Gender Equalities Office site. Key metrics covered include:

- Average pay gap as a Mean average
- Average pay gap as a Median average
- Proportion of employees by quartiles (i.e., when divided into four groups ordered from lowest to highest pay)
- Proportion of employees receiving bonus payments
- Average bonus pay gap as a Mean average
- Average bonus pay gap as a Median average

Where possible benchmarking against other NHS organisations from within our local system and new intersectionality analysis (gender and ethnicity) are also included.

Our workforce remains predominantly female (80.1%) and is becoming increasingly ethnically diverse (25.7%). In both cases this is broadly aligned with the NHS nationally. Whilst disability representation is improving it is significantly below population norms. However, it should be noted that 9.1% (644 staff) are either 'not declared', 'prefer not to say' or 'unspecified'.

All data for this report is sourced from our Electronic Staff Record (ESR) on a snapshot date (31 March 2025). Pages 31-32 of the report include a Glossary of terms

which includes terminology used and concise definitions to show the context in which the report has been written.

Gender:

Whilst there has been progress made in reducing ordinary pay gaps, bonus pay disparities remain a challenge. This is largely due to legacy bonus schemes and disproportionate representation in roles eligible for the schemes, which are primarily linked to the Local Clinical Excellence Awards (LCEA) scheme for consultants, which has historically been male dominated. Overall, under-representation of women in senior positions remain the major driver of inequality.

Broadly, this benchmarks comparably with other NHS trusts from within our system.

Ethnicity

Whilst workforce diversity is improving, disparities appear to be widening, with the mean and median pay gaps increasing, both in favour of White staff. Furthermore, even though BAME employees appear to benefit from a mean bonus advantage of 42.6%, this is based on a very small proportion of staff and reflects legacy schemes that were not designed with equity in mind.

There is no benchmarking data available for this element of the report.

Disability

It is important that this section is seen in the context of the statement made earlier relating to data quality and the work that needs to be done to improve this potential data skew.

Overall, Median pay gap progress is positive, but the widening mean gap and complete exclusion from bonus payments underscore potential structural inequities linked to legacy systems.

There is no benchmarking data available for this element of the report.

Intersectionality (Gender & Ethnicity)

This will be the first time we have reported any intersectional data relating to pay.

Analysis of pay quartiles shows clear patterns of representation with White men increasing their share from 8.8% in the lowest quartile (Q1) to 18.1% in the highest quartile (Q4), indicating a stronger presence in higher-paid roles. White women remain the largest group overall, but their representation declines slightly at senior levels, from 65.4% in Q1 to 61.9% in Quartile 4.

Ethnic diversity is more evenly distributed between men and women in the lowest quartile, but this balance narrows in Quartile 3 and Quartile 4, where ethnically diverse men are less represented. In Quartile 2, ethnically diverse women outnumber their male counterparts, suggesting gendered patterns within ethnic diversity.

The White group shows the largest median gap favouring men, whereas Black and Mixed show medians favouring women. The pattern suggests that deeper dive into role and banding would help to identify where to focus attention.

We introduced inclusion representatives in Summer 2025 to support a more inclusive recruitment process for senior roles, so we would not expect this intervention to have an impact on data as yet.

This report comes at a time when we are revisiting our equality, diversity and inclusion (EDI) actions and pulling them into one simpler and more cohesive plan and which better supports our complex intersectional reality. The plan sets out areas of focus, toward our ambitions for EDI. To this end, indicative focus areas are:

- Continue with deep dive analysis of this and other data available to better understand our pay gap reporting which will include further developing intersectionality reporting
- Progress with inclusion representatives in all senior appointments at Band 8a and above
- Ensure EDI data is available to senior management teams and senior managers are tasked with building broader representation ensuring representation in services
- EDI training is made available to all those in a management role
- Events focused on Inclusion and EDI form part of the Staff Network calendar of events

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

Report was presented at the EDI Steering group on 16 October 2025 and at People, Leadership & Culture Committee on 21 January 2026.

Recommendation(s)

Confirm assurance and approve for publication

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~~ Gender Pay Gap reporting is a mandated requirement for the NHS. Ethnicity & Disability are currently voluntary, but seen as good practice	

Annual Pay Gap Report 2025

Introduction

This pay gap report for 2025 includes a detailed analysis of pay across various demographic groups to highlight pay disparities and fulfil our statutory obligations. This year, the report will focus on the following ;

- Gender
- Ethnicity
- Disability.

Currently there is only a statutory obligation to provide Gender pay analysis, however, we have reported on both Ethnicity and Gender data for the last two years and for the first time we have now added Disability for 2025. This report along with agreed actions will be published on our public website and an external government website (Gender Equalities Office).

The report will focus on the following metrics:

1. Average pay gap as a Mean average
2. Average pay gap as a Median average
3. Proportion of employees by quartiles (i.e., when divided into four groups ordered from lowest to highest pay)
4. Proportion of employees receiving bonus payments
5. Average bonus pay gap as a Mean average
6. Average bonus pay gap as a Median average

Where it is possible to do so, some benchmarking has been undertaken offering comparison with other NHS Organisations from within our local system. In addition, there is a new element which looks at intersectionality of available data, Gender and Ethnicity specifically, see Appendix 2

Actions relating to pay gaps are aligned with three other key NHS strategic plans;

- Workforce Race Equality Standards (**WRES**): Addressing racial disparities and promoting equity across all levels of the workforce
- Workforce Disability Equality Standards (**WDES**): Ensuring fair treatment and opportunities for staff with disabilities.
- NHS High Impact Action Plan (**HIA**): designed to accelerate progress on equality, diversity and inclusion across NHS Trusts.

Pages 31-32 include a Glossary of terms which includes terminology used in this document and includes concise definitions to show the context in which the report has been written.

Workforce Profile

Oxford Health NHS Foundation Trust provides physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset. Our services are delivered at community bases, hospitals, clinics and people’s homes.

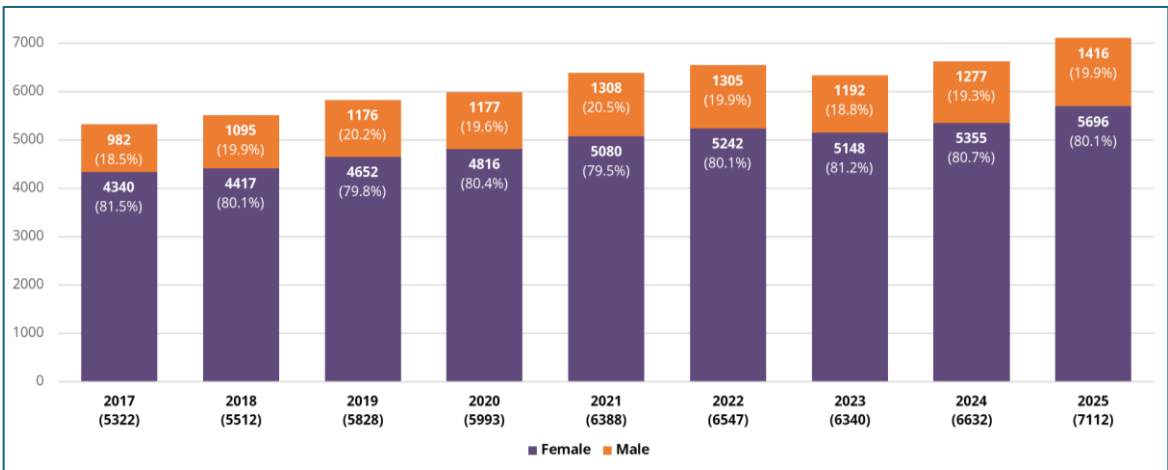
As of the snapshot date (31 March 2025) Oxford Health employed a total of 7,112 staff:

Gender

- 5,696 women (80.1%)
- 1,416 men (19.9%)

Within the Oxfordshire and Buckinghamshire region, where the Trust primarily operates, gender distribution mirrors national averages: 51% women and 49% men. According to the Office for National Statistics (ONS), women make up approximately 51% of the general population in England. NHS Employers data estimates that 77% of the NHS workforce nationally is female.

This represents a workforce profile that continues to be significantly weighted towards female staff, in line with historical trends both within the Trust and across the wider NHS.

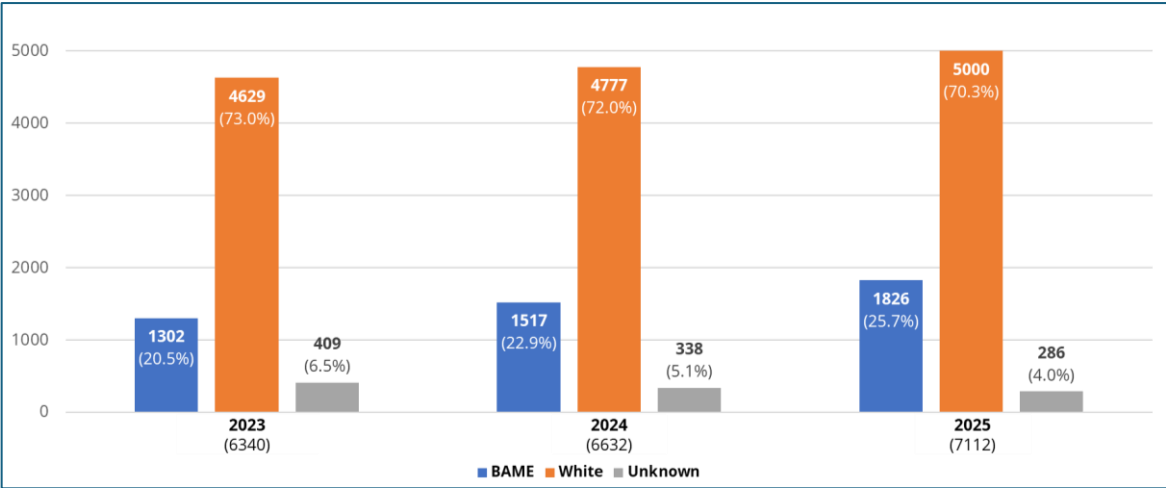


From 2024 to 2025, Oxford Health’s total workforce has increased by 480 employees (341 women and 139 men) however gender distribution has remained stable, with women continuing to make up approximately four-fifths of the total workforce, a proportion consistent with previous years.

Ethnicity

- 5,000 White staff (70.3%)
- 1,826 BAME staff (25.7%)
- 268 Unknown (4.0%)

Oxford Health’s workforce composition, at 25.7% BAME staff in 2025, is above both the local population average within Oxfordshire and Buckinghamshire (10–12% - ONS - Census 2021) and broadly aligned with the NHS national workforce profile (24.2%).



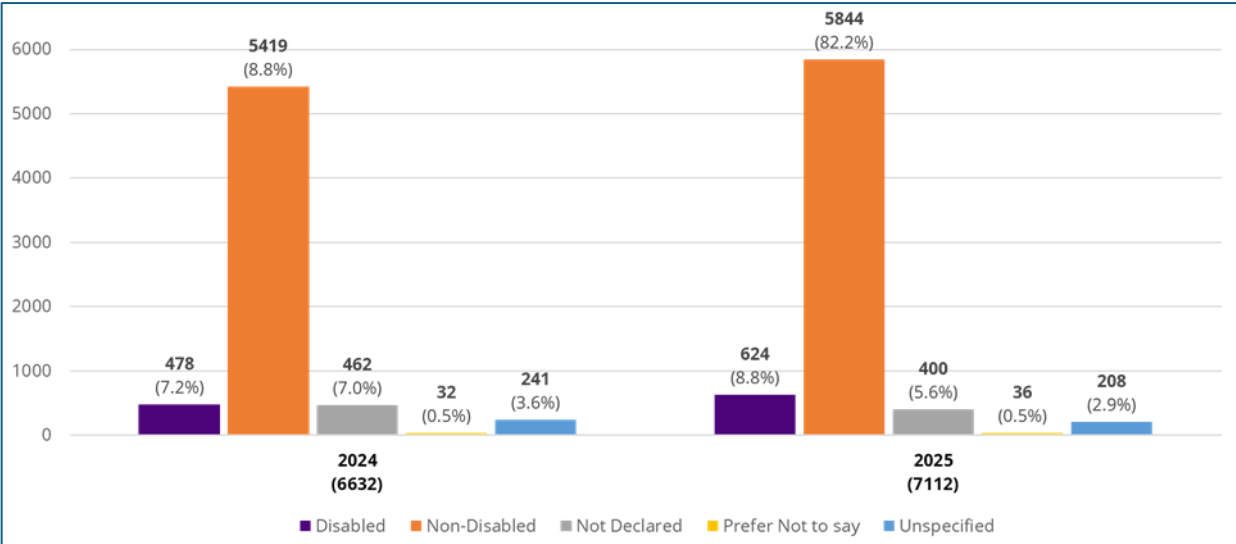
For 2024-25, Oxford Health’s total workforce has increased by 480 employees (309 BAME staff and 223 White staff, while the number of staff recorded as ‘Unknown’ ethnicity decreased by 52). The proportion of ‘Unknown’ ethnicity staff also declined by 1.1%, from 5.1% to 4.0%. These shifts indicate that the Trust is becoming more ethnically diverse year on year, with BAME representation increasing steadily alongside a positive increase in the percentage representation across the workforce.

Disability

Disability declaration rates were as follows:

- 624 staff (8.8%) declared a disability
- 5,844 staff (82.2%) declared no disability
- 644 staff (9.1%):
 - 400 ‘Not declared’ staff
 - 36 ‘Prefer not to say’ staff
 - 208 ‘Unspecified’ staff

OHFT’s workforce composition, with 8.8% of staff declaring a disability, sits below both the national population average (24%) and ONS regional estimates (15–20%), but remains higher than the current NHS ESR declaration rate of around 4%. According to the Office for National Statistics (ONS), nearly one in four working-age adults in England (circa 24%) report having a disability or long-term health condition. The NHS Workforce Disability Equality Standard (WDES) data indicates that approximately 4% of NHS staff nationally declare a disability on the Electronic Staff Record (ESR). Within Oxfordshire and Buckinghamshire, prevalence estimates suggest that between 15–20% of the adult population identify as disabled.



Between 2024 and 2025, the Trust’s workforce increased by 480 employees. This growth comprised an additional 146 disabled staff, 425 non-disabled staff and 4 more individuals recorded as ‘Prefer not to say’. At the same time, there were reductions in those recorded as ‘Not declared’ (–62) and ‘Unspecified’ (–33). While the increase in disabled staff is encouraging, their overall representation remains at 8.8% of the workforce and continues to fall short of national population benchmarks. This highlights the need for targeted action to both attract disabled applicants and support progression pathways that will improve representation at all levels of the organisation and encourage greated confidence in self-declaring.

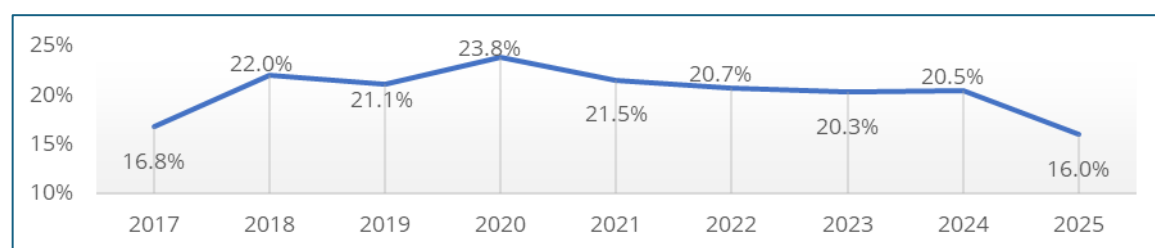
Gender Pay Gap report

Mandatory Reporting Metric	2023 (31 st March 2023)		2024 (31 st March 2024)		2025 (31 st March 2025)	
MEAN	Male	Female	Male	Female	Male	Female
Hourly rate	£24.67	£19.67	£25.89	£20.59	£26.22	£21.98
Difference	£5.00		£5.30		▼ £4.25	
Mean gender pay gap in hourly pay	20.3%		20.5%		▼ 16.0%	
MEDIAN	Male	Female	Male	Female	Male	Female
Hourly rate	£18.87	£17.24	£19.21	£18.10	£20.15	£19.09
Difference	£1.63		£1.11		▼ £1.06	
Median gender pay gap in hourly pay	8.7%		5.8%		▼ 5.2%	

Bonus Pay	2023 (31 st March 2023)		2024 (31 st March 2024)		2025 (31 st March 2025)	
MEAN	Male	Female	Male	Female	Male	Female
Mean Bonus Pay	£10,419.51	£7,235.06	£10,228.63	£8,312.27	£11,598.58	£6,933.38
Difference	£3,184.44		£1,916.35		▲ £4,665.20	
Mean bonus gender pay gap	30.6%		18.7%		▲ 40.2%	
MEDIAN	Male	Female	Male	Female	Male	Female
Median Bonus Pay	£5,079.63	£5,079.63	£8,774.29	£7,124.73	£9,048.00	£7,218.24
Difference	£0		£1,649.56		▲ £1,829.76	
Median bonus gender pay gap	0.0%		18.8%		▲ 20.2%	
RECEIVING BONUS PAY	Male	Female	Male	Female	Male	Female
Proportion of men and women within the whole workforce receiving a bonus payment	49 (3.7%)	49 (0.9%)	56 (4.0%)	60 (1.0%)	▼ 17 (1.1%)	▼ 18 (0.3%)

1. Average pay gap as a Mean average

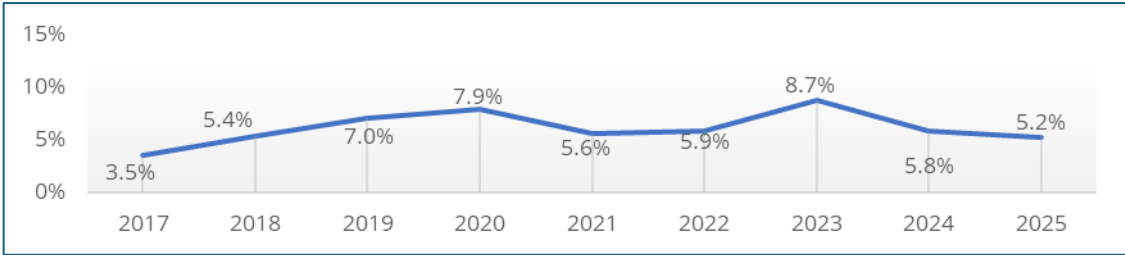
Mean Hourly Rate	2017	2018	2019	2020	2021	2022	2023	2024	2025
Female	£16.10	£16.93	£17.46	£17.87	£18.25	£18.87	£19.67	£20.59	£21.98
Male	£19.36	£21.71	£22.13	£23.45	£23.26	£23.80	£24.67	£25.89	£26.22
Difference	£3.26	£4.78	£4.67	£5.58	£5.01	£4.94	£5.00	£5.30	£4.25
Pay Gap %	16.8%	22.0%	21.1%	23.8%	21.5%	20.7%	20.3%	20.5%	16.0%



The Mean gender pay gap decreased by 4.5%, from 20.5% in 2024, to 16.0% in 2025. This represents a £4.25 per hour pay gap in favour of male employees. The reduction of 4.5% is the sharpest annual decrease in recent years, reversing a pattern of slower progress between 2019–2024. For context, the ONS (2024) reported an overall UK mean gender pay gap of around 13%, meaning the Trust remains above the national average. However, within the NHS sector, a persistent structural pay gap is common due to the gendered distribution of roles.

2. Average pay gap as a Median average

Median Hourly Rate	2017	2018	2019	2020	2021	2022	2023	2024	2025
Female	£14.58	£14.80	£15.36	£15.61	£16.04	£16.52	£17.24	£18.10	£19.09
Male	£15.11	£15.64	£16.52	£16.94	£17.00	£17.56	£18.87	£19.21	£20.15
Difference	£0.52	£0.84	£1.15	£1.33	£0.96	£1.03	£1.63	£1.11	£1.06
Pay Gap %	3.5%	5.4%	7.0%	7.9%	5.6%	5.9%	8.7%	5.8%	5.2%

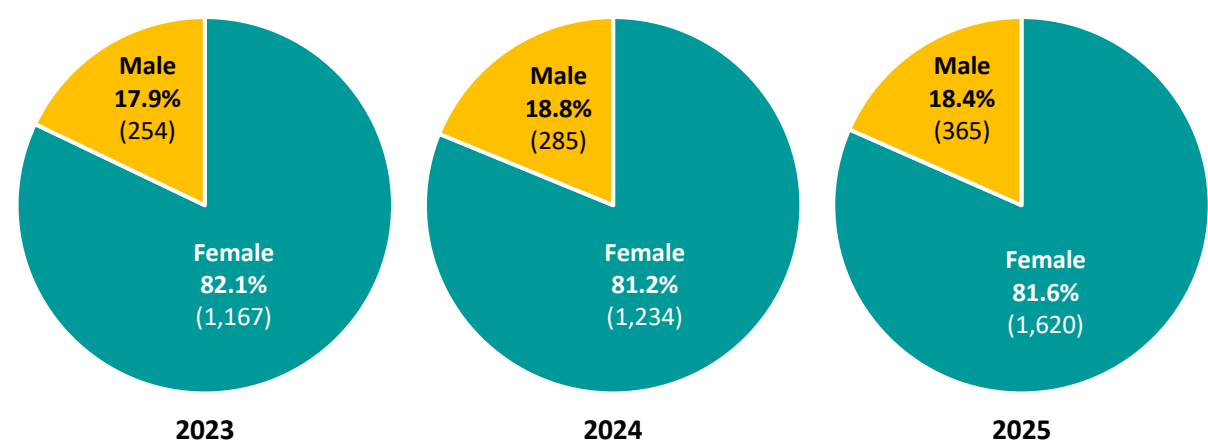


The Median gender pay gap decreased by 0.6%, from 5.8% in 2024, to 5.2% in 2025. This represents a £1.06 per hour pay gap in favour of male employees. The median gap has shown consistent improvement since 2023 (8.7% → 5.8% → 5.2%). The narrowing reflects a stronger alignment of male and female mid-range earnings. The Trust’s 5.2% median gap is considerably better than the UK national average of 13.1% (ONS 2024), placing the Trust ahead of wider labour market performance.

3. Proportion of employees by quartiles (i.e., when divided into four groups ordered from lowest to highest pay)

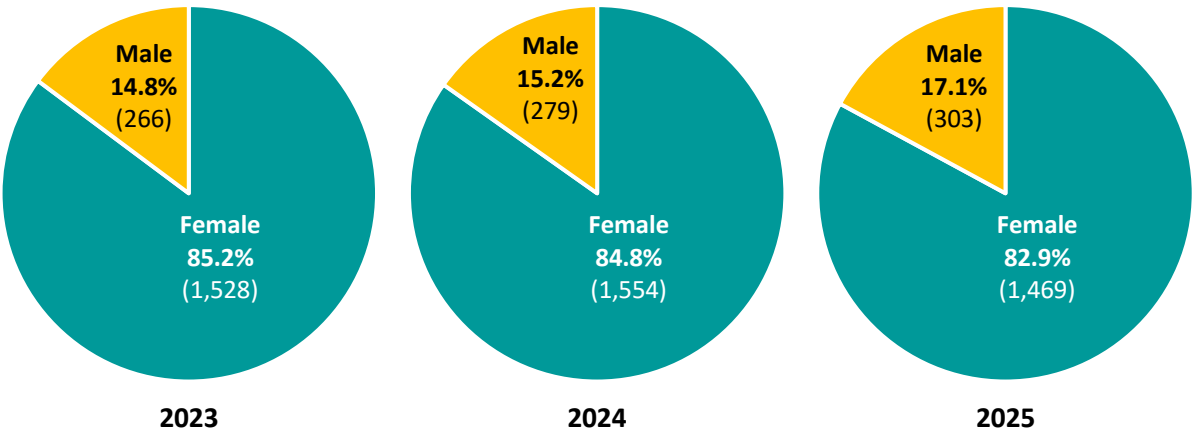
The distribution of men and women across hourly pay quartiles between 2023 and 2025 provides important insight into how representation patterns may be influencing the Trust’s gender pay gap. While women remain the majority in all quartiles, trends over the three-year period reveal opportunities for improvement.

Lower Middle Quartile



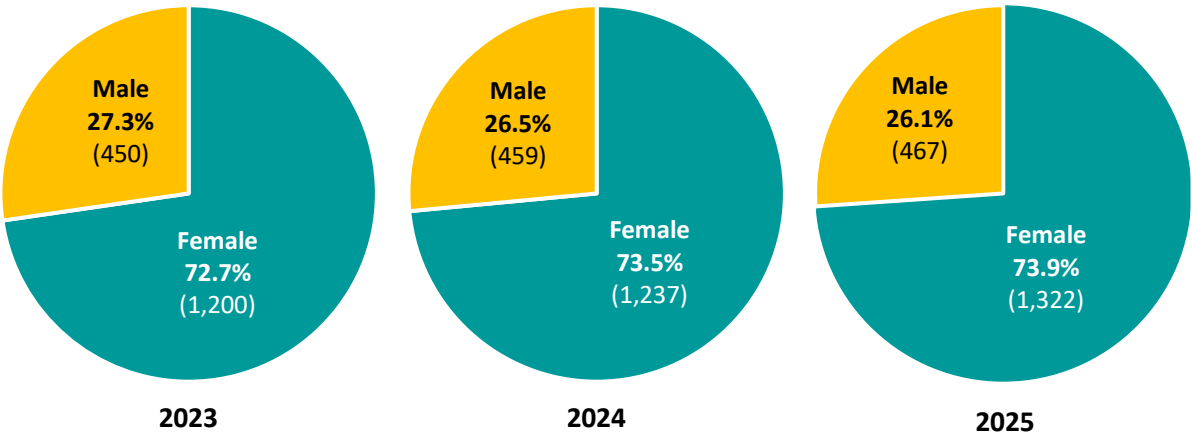
Female and male representation has remained relatively stable, Which indicates that the gender composition of the lower middle quartile has not changed substantially,

Upper Middle Quartile



This quartile shows the most noticeable change. Women’s representation declined from 85.2% in 2023 to 82.9% in 2025, a fall of 2.3%. Over the same period, men’s share increased by 2.3%, from 14.8% to 17.1%. Although women remain the clear majority, the direction of travel suggests a slow move towards a more balanced distribution in mid-level pay bands.

Upper Quartile



In the highest pay quartile, women remain under-represented compared with their workforce share, accounting for 72.7% in 2023 and 73.9% in 2025. This represents an improvement of 1.2% but still leaves women 6.2% below their overall workforce share in 2025. Men, on the other hand, are over-represented, accounting for 26.1% of staff in 2025, which is 6.2% above their overall workforce proportion.

Across the three years, women remain the majority in all quartiles, particularly in the lower three, where they consistently account for more than 80% of staff. The modest gains in men’s representation across these quartiles suggest a gradual move towards a more gender-balanced distribution, though the pace of change is slow.

The most positive development is in the upper quartile, where women’s representation has improved year-on-year. However, this remains well below their overall workforce share, while men continue to be disproportionately represented in senior and higher-paid roles. This persistent imbalance is one of the strongest structural contributors to the Trust’s gender pay gap.

4. Proportion of Employees Receiving a Bonus

At Oxford Health, bonuses are primarily linked to the Local Clinical Excellence Awards (LCEA) scheme for consultants, which has historically been male dominated. Although new LCEAs have been abolished nationally, legacy awards remain in payment, and these continue to influence the Trust’s bonus pay gap reporting.

In 2025, there was a decline in the percentage of both men and women receiving bonus payments compared with 2024:

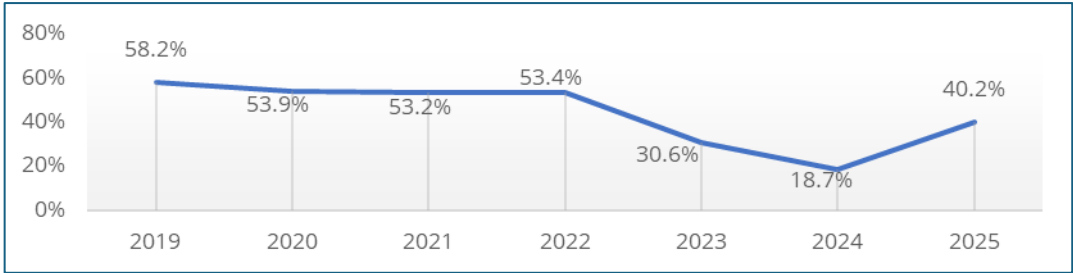
Men: The proportion of men receiving a bonus fell by 2.9%, from 4.0% in 2024 to 1.1% in 2025. Out of 68 eligible men, 17 received a bonus, representing 25.0% of eligible male employees. However, this equates to just 1.1% of all male staff (17 out of 1,555).

Women: The proportion of women receiving a bonus decreased by 0.7%, from 1.0% in 2024 to 0.3% in 2025. Out of 64 eligible women, 18 received a bonus, representing 28.1% of eligible female employees. This translates to 0.3% of all female staff (18 out of 6,148).

Although the proportion of eligible women receiving a bonus (28.1%) is slightly higher than the proportion of eligible men (25.0%), the overall percentage of men receiving a bonus relative to their total workforce size (1.1%) remains higher than that of women (0.3%). This difference is an important factor contributing to the bonus pay gap.

5. Average bonus pay gap as a Mean average

Bonus Mean Pay	2019	2020	2021	2022	2023	2024	2025
Female	£6,710	£7,473	£7,456	£6,884	£7,235	£8,312	£6,933
Male	£16,069	£16,200	£15,943	£14,759	£10,420	£10,229	£11,599
Difference	£9,359	£8,727	£8,487	£7,875	£3,184	£1,916	£4,665
Pay Gap %	58.2%	53.9%	53.2%	53.4%	30.6%	18.7%	40.2%



The mean bonus gender pay gap in 2025 was 40.2%, with men receiving an average bonus of £11,599 compared to £6,933 for women. This represents a difference of £4,665 and marks a 21.5% increase from the 2024 bonus pay gap of 18.7%.

Over the past seven years, the mean bonus gap has fluctuated but remained consistently in favour of men, reflecting structural differences in access to, and value of, bonus payments. Although the gap narrowed significantly in 2023 and 2024, the 2025 figure indicates a reversal of this progress.

6. Average bonus pay gap as a Median average

Bonus Median Pay	2019	2020	2021	2022	2023	2024	2025
Female	£5,094	£5,845	£5,654	£6,032	£5,080	£7,125	£7,218
Male	£11,757	£12,064	£12,064	£12,064	£5,080	£8,774	£9,048
Difference	£6,663	£6,219	£6,410	£6,032	£0	£1,650	£1,830
Pay Gap %	56.7%	51.5%	53.1%	50.0%	0%	18.8%	20.2%

The median bonus gender pay gap in 2025 was 20.2%, with women receiving a median bonus of £7,218 compared to £9,048 for men. This equates to a difference of £1,830, a modest increase of 1.4% compared with 2024.

The median pay gap remains lower than the mean, suggesting that while some higher-value payments continue to inflate the male average, the middle range of awards is more balanced. Nonetheless, the persistence of a double-digit median pay gap underlines on-going inequality.

Summary Overview

The Gender Pay Gap Report 2024/25 reveals mixed progress in gender equality across the organisation’s pay structure:

Ordinary Pay:

Mean Gender Pay Gap: Decreased by 4.5% from 20.5% in 2024, to 16.0% in 2025.

Median Gender Pay Gap: Decreased by 0.6% from 5.8% in 2024, to 5.2% in 2025.

Bonus Pay:

There is an increase of 21.5% in the Bonus Mean Pay between men and women, from 18.7% in 2024 to 40.2% in 2025.

There is an increase of 1.4% in the Bonus Median Pay between men and women, from 18.8% in 2024, to 20.2% in 2025.

Representation Gaps:

Women represent 80.1% of our workforce yet only represent 73.9% of the workforce in the upper hourly pay quartile; men represent 19.9% of our workforce but represent 26.1% in the upper hourly pay quartile. This means that women are under-represented by 6.2% and men are over-represented by 6.2% in the senior bands.

The results show encouraging progress in narrowing ordinary pay gaps, but challenges remain, bonus pay disparities have widened, signaling that legacy pay practices and recognition schemes continue to disadvantage women. In addition, while women make up the majority of the Trust's workforce, they remain under-represented at the most senior levels, with men continuing to hold a disproportionate share of the senior roles. Overall, the findings show that while positive steps have been made towards greater pay equality, structural barriers and unequal representation at senior levels remain significant drivers of the gender pay gap.

Benchmarking with other NHS Trusts

The table below shows our performance in the gender pay gap in comparison with our health and social care partners. *N.B. The below data comparison is based on the 31st March 2024 snapshot date.*

Employer Name	Number Of Employees	% Difference in hourly rate (Mean)	% Difference in hourly rate (Median)	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in upper pay quartile	% Who received bonus pay (Women)	% Who received bonus pay (Men)	% Difference in bonus pay (Mean)	% Difference in bonus pay (Median)
Oxford Health NHS Foundation Trust	5000 to 19,999	20.5	5.8	83.5	81.2	84.8	73.5	1.0	4.0	18.7	18.8
Berkshire Healthcare NHS Foundation Trust	5000 to 19,999	16.0	12.4	85.8	83.6	85.7	74.9	0.3	1.6	3.4	25.0
Buckinghamshire Healthcare NHS Trust	5000 to 19,999	22.9	13.9	82.0	82.0	83.0	68.0	2.0	10.0	21.0	0.0
Royal Berkshire NHS Foundation Trust	5000 to 19,999	20.0	10.9	75.3	80.9	82.2	65.6	2.6	11.1	23.0	28.0
South Central Ambulance Service NHS Foundation Trust	1000 to 4999	4.9	0.8	50.0	60.6	59.3	49.0	0.0	0.0	-	-
The Oxford University Hospitals NHS Trust	5000 to 19,999	25.5	9.0	73.8	78.6	79.6	63.1	1.4	4.0	51.9	87.6

Ethnicity Pay Gap report

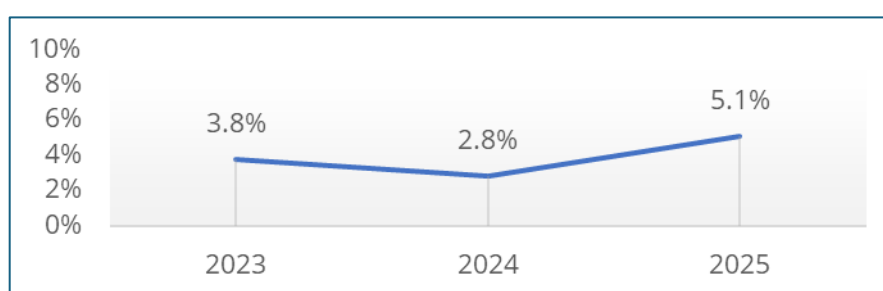
Data for Ethnicity includes 2023, 2024 & 2025 data since this report is relatively new (this is the 2nd year of reporting)

Ethnicity Pay Gap	2023 (31 st March 2023)			2024 (31 st March 2024)			2025 (31 st March 2025)		
MEAN	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Hourly rate	£20.45	£19.67	£25.54	£21.45	£20.85	£27.33	£22.87	£21.69	£29.21
Difference	£0.78		-	£0.60		-	▲ £1.18		-
Mean ethnicity pay gap in hourly pay	3.8%		-	2.8%		-	▲ 5.1%		-
MEDIAN	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Hourly rate	£18.04	£15.62	£17.24	£18.65	£16.95	£19.10	£20.15	£18.18	£20.15
Difference	£2.42		-	£1.70		-	▲ £1.97		-
Median ethnicity pay gap in hourly pay	13.4%		-	9.1%		-	▲ 9.8%		-

Bonus Pay	2023 (31 st March 2023)			2024 (31 st March 2024)			2025 (31 st March 2025)		
MEAN	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Mean Bonus Pay	£9,054.20	£8,800.64	£5,079.63	£9,176.20	£9,806.53	£6,854.09	£8,700.53	£12,408.69	£4,451.10
Difference	£253.56		-	-£630.33		-	▲ -£3,708.16		-
Mean bonus ethnicity pay gap	2.8%		-	-6.9%		-	▲ -42.6%		-
MEDIAN	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Median Bonus Pay	£5079.63	£5079.63	£5079.63	£7,981.44	£7,726.83	£7,127.45	£9,048.00	£9,048.00	£4,451.10
Difference	£0.00		-	£254.61		-	▼ £0.00		-
Median bonus ethnicity pay gap	0.0%		-	3.2%		-	▼ 0.0%		-
RECEIVING BONUS PAY	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Proportion of staff by ethnicity within the whole workforce receiving a bonus payment	69 (1.3%)	25 (1.6%)	4 (0.8%)	86 (1.7%)	26 (1.5%)	4 (0.8%)	▼ 26 (0.5%)	▼ 7 (0.3%)	▼ 2 (0.4%)

1. Average pay gap as a Mean average

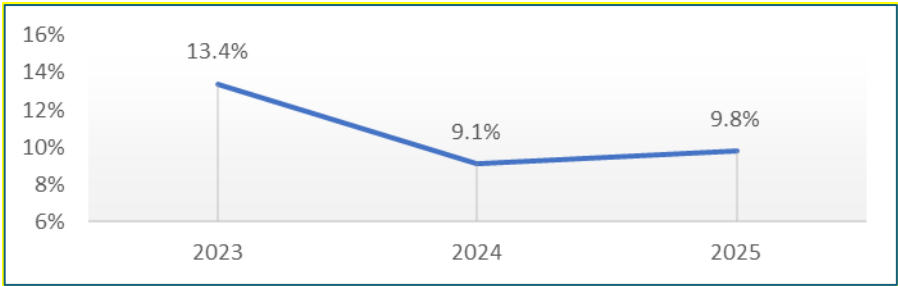
Mean Hourly Rate	2023	2024	2025
BAME	£19.67	£20.85	£21.69
White	£20.45	£21.45	£22.87
Unknown	£25.54	£27.33	£29.21
Difference (White v BAME)	£0.78	£0.60	£1.18
Pay Gap %	3.8%	2.8%	5.1%



The Mean ethnicity pay gap increased by 2.3%, from 2.8% in 2024 to 5.1%. This represents a £1.18 per hour pay gap in favour of White employees. The Office for National Statistics (ONS) reported in 2022 that pay disparities vary significantly by ethnic group but is not able to provide a single aggregated 'national ethnicity pay gap.' However, more recent public sector reporting highlights variations: the UK Civil Service reported a mean ethnicity pay gap of 5.2% in 2023/24, while Homes England recorded a much higher mean gap of 14.8% in the same year. Against this backdrop, OHFT's mean ethnicity pay gap of 5.1% in 2025 is broadly in line with national averages.

2. Average pay gap as a Median average

Mean Hourly Rate	2023	2024	2025
BAME	£15.62	£16.95	£18.18
White	£18.04	£18.65	£20.15
Unknown	£17.24	£19.10	£20.15
Difference (White v BAME)	£2.42	£1.70	£1.97
Pay Gap %	13.4%	9.1%	9.8%

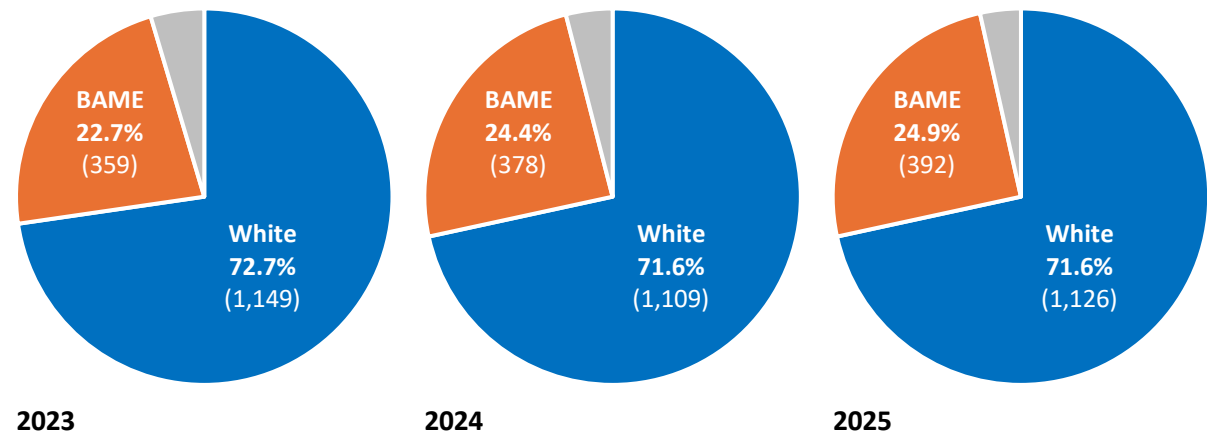


The Median ethnicity pay gap increased by 0.7%, from 9.1% in 2024 to 9.8%. This represents a £1.97 per hour pay gap in favour of White employees. Nationally, the ONS (2022) has shown that median pay disparities differ widely by ethnic group, reflecting complex labour market patterns rather than a single uniform gap. Within the public sector, results also vary: the Civil Service reported a median ethnicity pay gap of 5.1% in 2023/24, while Homes England reported a significantly higher figure of 19.0%. OHFT’s median ethnicity pay gap of 9.8% in 2025 therefore sits between these comparators. This indicates that, for the ‘average’ BAME employee at OHFT, hourly pay remains almost £2 lower than for the ‘average’ White employee.

3. Proportion of employees by quartiles (i.e., when divided into four groups ordered from lowest to highest pay)

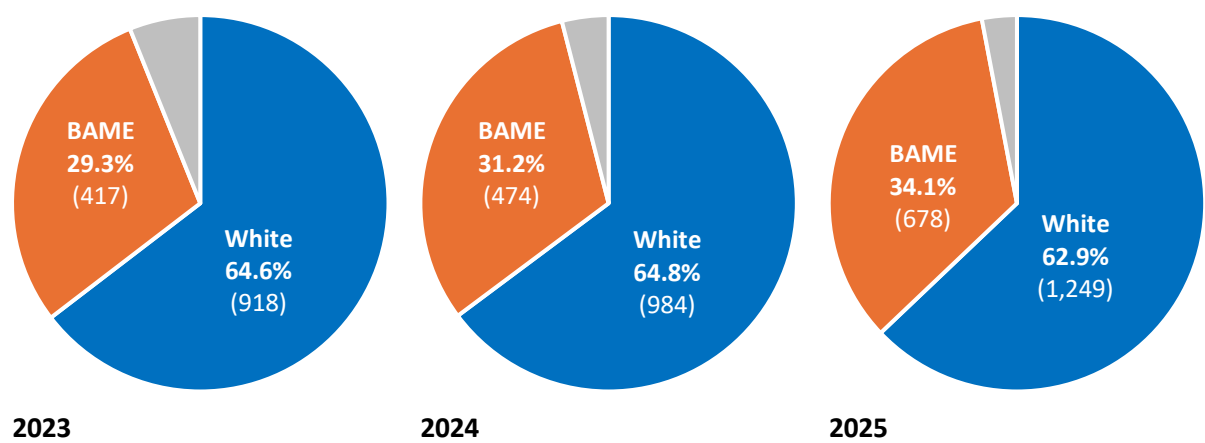
The distribution of White and Black, Asian & Minority Ethnic (BAME) employees across hourly pay quartiles between 2023 and 2025 provides important insight into how representation patterns may be influencing the Trust’s ethnicity pay gap.

Lower Quartile



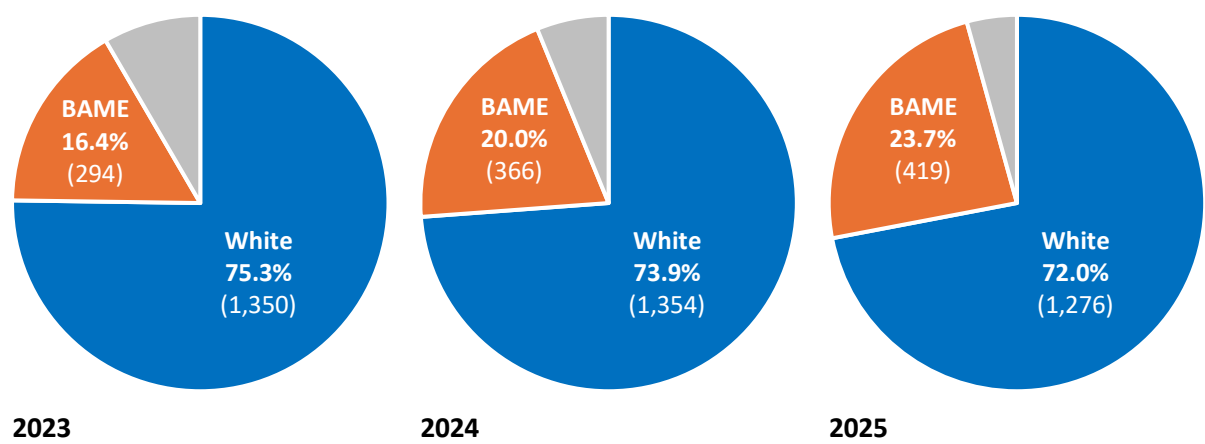
BAME representation in the lowest quartile increased slightly by 0.5%, moving closer to their overall workforce share (25.7%). White staff remained stable at 71.6% across both years, marginally above their 70.3% workforce share. This indicates stability at the lowest pay levels, with no disproportionate concentration of BAME staff in the lowest-paid roles.

Lower Middle Quartile



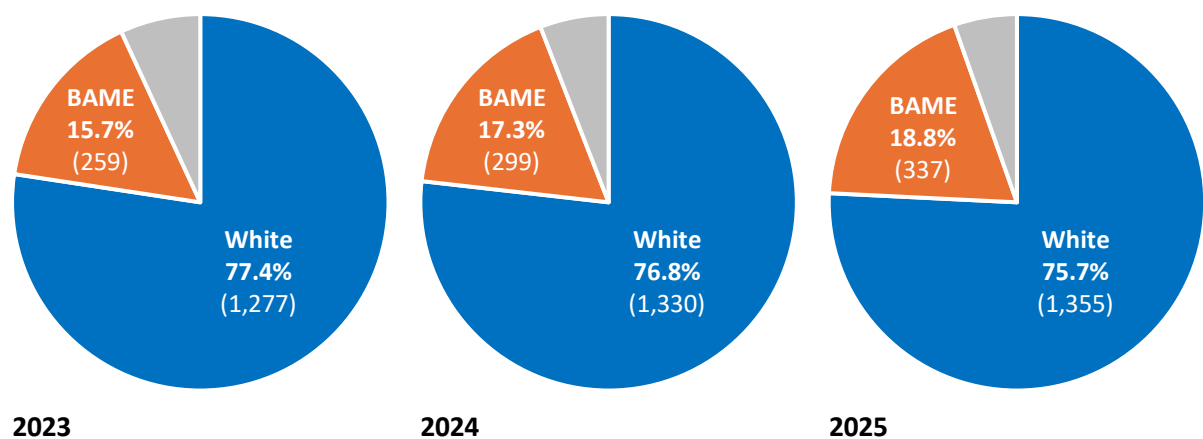
This quartile shows the highest concentration of BAME staff. Representation rose by 2.9% from 31.2% in 2024 to 34.1% in 2025, 8.4% above their 25.7% workforce share. Conversely, White representation declined by 1.9% from 64.8% to 62.9%. The increase indicates stronger BAME presence in mid-pay roles, though these roles sit below the upper quartiles where pay levels most affect the overall pay gap.

Upper Middle Quartile



Representation of BAME staff improved notably in this quartile, rising by 3.7% from 20.0% to 23.7%, narrowing the gap with their 25.7% workforce share. White staff representation fell by 1.9% from 73.9% to 72.0%. This improvement suggests some progress in career progression for BAME colleagues into higher mid-level roles, though representation is still slightly below their overall workforce share.

Upper Quartile



The most senior quartile remains the area of greatest under-representation for BAME staff. Although their share increased by 1.5% from 17.3% to 18.8%, this is still well below the 25.7% workforce share, creating a –6.9% gap. White representation remains disproportionately high by 5.4% at 75.7% in 2025, compared with their 70.3% workforce share. Even though there has been a modest improvement, the under-representation of BAME staff in the top quartile continues to be the single strongest structural driver of both the mean and median ethnicity pay gaps.

Across the three years, BAME staff have steadily increased their overall representation across the workforce, however their distribution across pay quartiles remains uneven. BAME staff are consistently well-represented in the lower-middle quartile, where their share now exceeds one-third of staff, but they remain under-represented in the upper quartiles where higher-paid roles are concentrated.

The most positive development is the improvement in the upper-middle quartile, where BAME representation rose from 16.4% in 2023 to 23.7% in 2025. This indicates some progress in career progression into mid-to-higher pay bands.

In the upper quartile, representation has also increased year on year, from 15.7% in 2023 to 18.8% in 2025. However, this remains well below the overall BAME workforce share of 25.7%, while White staff continue to be disproportionately represented at the most senior levels. This persistent imbalance is the strongest structural driver of the Trust’s ethnicity pay gap.

4. Proportion of Employees Receiving a Bonus

The table below shows the total headcount and percentage of staff by ethnic group who received bonus pay, out of the total number of employees in the workforce.

Ethnic Group	Employees Paid Bonus	Total number of employees in workforce	% of total workforce receiving bonus
BAME	7	2036	0.3%

White	26	5408	0.5%
Unknown	2	552	0.4%
Total	35	7996	0.4%

In 2025, there was a decline in the overall percentage of staff receiving a bonus compared with 2024, with reductions across both White and BAME staff groups:

BAME staff: The proportion receiving a bonus fell sharply from 1.5% in 2024 (26 of 1,690 staff) to 0.3% in 2025 (7 of 2,036 staff).

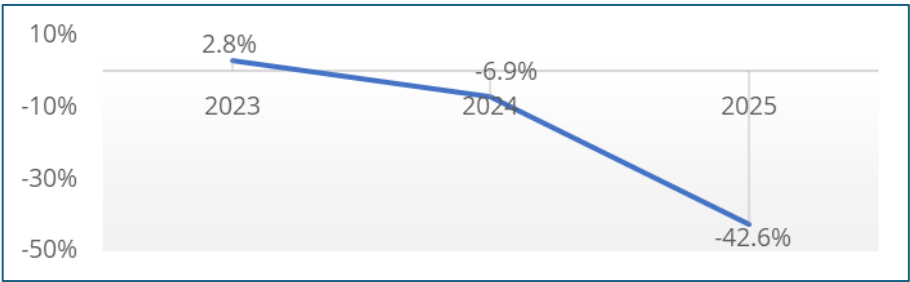
White staff: The proportion declined from 1.7% in 2024 (86 of 5,196 staff) to 0.5% in 2025 (26 of 5,408 staff).

Unknown ethnicity: Decreased slightly from 0.8% to 0.4%.

Although bonus eligibility fell for both groups, the decline was more pronounced for BAME staff, leaving them less likely to access bonus payments relative to their workforce share.

5. Average bonus pay gap as a Mean average

Mean Hourly Rate	2023	2024	2025
BAME	£8,800.64	£9,806.53	£12,408.69
White	£9,054.20	£9,176.20	£8,700.53
Unknown	£5,079.63	£6,854.09	£4,451.10
Difference White vs BAME	£253.56	-£630.33	-£3,708.16
% Pay Gap	2.8%	-6.9%	-42.6%



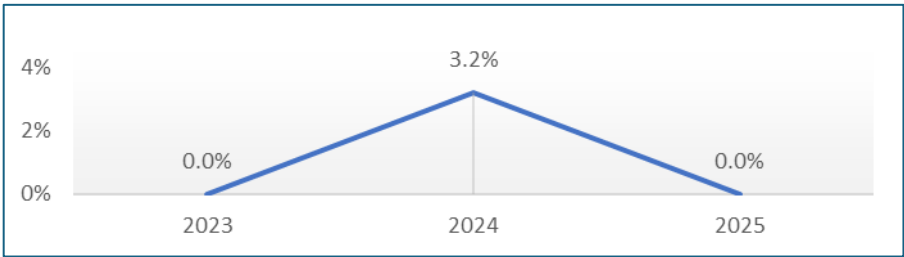
2024: BAME staff received an average bonus of £9,807 compared with £9,176 for White staff, resulting in a mean bonus pay advantage of 6.9%, in favour of BAME staff.

2025: BAME staff received an average bonus of £12,409, while White staff received £8,701. This produced a mean bonus pay advantage of 42.6%, meaning BAME staff received, on average, significantly higher bonus values.

This sharp reversal reflects the fact that a smaller number of BAME staff received higher-value legacy LCEA payments, while fewer White staff were awarded bonuses overall. Although this creates the appearance of a “bonus” pay gap which appears to favour BAME staff, it is not indicative of structural equity, but rather of the uneven distribution of a declining award scheme

6. Average bonus pay gap as a Median average

Median Hourly Rate	2023	2024	2025
BAME	£5079.63	£7,726.83	£9,048.00
White	£5079.63	£7,981.44	£9,048.00
Unknown	£5079.63	£7,127.45	£4,451.10
Difference White vs BAME	£0.00	£254.61	£0.00
% Pay Gap	0.0%	3.2%	0%



2024: The median bonus for BAME staff was £7,727 compared with £7,981 for White staff, creating a median bonus gap of 3.2% in favour of White staff.

2025: The median bonus for both BAME and White staff was £9,048, resulting in a median bonus pay gap of 0.0%.

The elimination of the median gap reflects a convergence of awards at the mid-range, though this is more a product of reduced bonus distribution rather than systemic equity.

Summary Overview

Headline findings from the 2025 Ethnicity Pay Gap Report:

Ordinary Pay:

Mean Ethnicity Pay Gap: Increased by 2.3%, from 2.8% in 2024, to 5.1% in 2025.

Median Ethnicity Pay Gap: Increased by 0.7%, from 9.1% in 2024, to 9.8% in 2025.

Bonus Pay:

Mean bonus pay is higher for BAME staff by 42.6%, but only 0.3% of BAME staff received a bonus compared to 0.5% of White staff who received a bonus.

Median bonus pay is equal for BAME and White staff, and therefore a 0% pay gap.

Representation Gaps:

BAME staff are under-represented in the upper pay quartile (18.8%).

'Unknown' Ethnicity: 4% of the workforce – earn more than both White and BAME staff – highlights the need for better data for accurate analysis.

These findings indicate that while workforce diversity is improving, disparities appear to be widening, with the mean and median pay gaps increasing, both in favour of White staff. Furthermore, even though BAME employees appear to benefit from a mean bonus advantage of 42.6%, this is based on a very small proportion of staff and reflects legacy schemes that were not designed with equity in mind.

Benchmarking with other NHS Trusts

This data is not available for benchmarking purposes.

Disability Pay Gap report

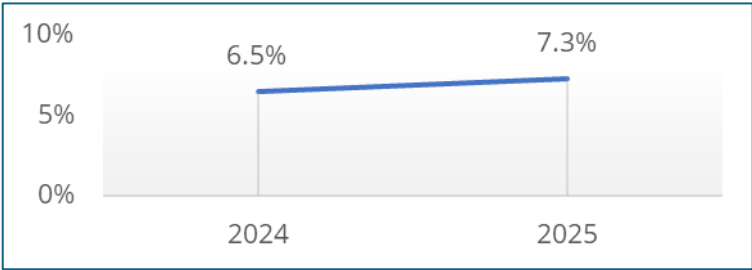
Data for Disability includes 2023, 2024 & 2025 data since this report is new (this is the 1st year of reporting)

Board Meeting in Public		2024 (31 st March 2024)					2025 (31 st March 2025)					Page 317 of 409
Disability Pay Gap		Disabled	Non-disabled	Not declared	Prefer not to say	Un-specified	Disabled	Non-disabled	Not declared	Prefer not to say	Un-specified	
MEAN												
Hourly rate		£19.77	£21.14	£24.36	£22.44	£30.56	£20.84	£22.47	£25.17	£24.71	£33.54	
Difference		£1.37		-	-	-	▲ £1.63		-	-	-	
Mean disability pay gap		6.5%					▲ 7.3%					
MEDIAN												
Hourly rate		£17.69	£18.10	£18.80	£19.04	£22.86	£18.91	£19.09	£20.15	£19.65	£27.01	
Difference		£0.41		-	-	-	▼ £0.18		-	-	-	
Median disability pay gap		2.3%					▼ 0.9%					

Bonus Pay Gap		2024 (31 st March 2024)					2025 (31 st March 2025)					
MEAN		Disabled	Non-disabled	Not declared	Prefer not to say	Un-specified	Disabled	Non-disabled	Not declared	Prefer not to say	Un-specified	
Mean Bonus Pay		£3,509.71	£9,628.12	£8,022.58	-	£8,340.13	-	£8,862.64	£6,936.78	£30,159.96	£6,031.98	
Difference		£6,118.41		-	-	-	▲ £8,862.64		-	-	-	
Mean bonus disability pay gap		63.5%					▲ 100.0%					
MEDIAN												
Median Bonus Pay		£3,509.71	£8,774.29	£5,834.91	-	£7,127.45	-	£8,726.22	£6,936.78	£30,159.96	£6,031.98	
Difference		£5,264.58		-	-	-	▲ £8,726.22		-	-	-	
Median bonus disability pay gap		60.0%					▲ 100.0%					
RECEIVING BONUS PAY												
Proportion of staff by ethnicity within the whole workforce receiving a bonus payment		1 (0.2%)	89 (1.5%)	18 (3.6%)	0 (-)	8 (2.0%)	▼ 0 (-)	▼ 30 (0.5%)	▼ 2 (0.5%)	▲ 1 (2.5%)	▼ 2 (0.4%)	

1. Average pay gap as a Mean average

Mean Hourly Rate	2024	2025
Disabled	£19.77	£20.84
Non-Disabled	£21.14	£22.47
Not declared	£24.36	£25.17
Prefer not to say	£22.44	£24.71
Unspecified	£30.56	£33.54
Difference Non-Disabled vs Disabled	£1.37	£1.63
% Pay Gap	6.5%	7.3%

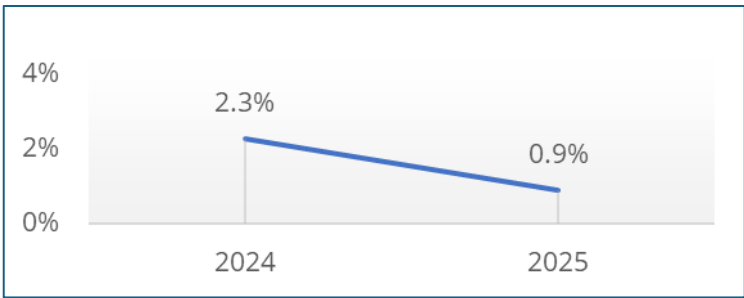


The Mean disability pay gap increased by 0.8% from 6.5% in 2024 to 7.3% in 2025, which means that disabled staff earned £1.63 less per hour on average than non-disabled staff. For context, the ONS (2024) reported an overall UK mean disability pay gap of around 13.8%, compared to 7.3% at OHFT. This means the Trust appears to perform better than the national average, though a structural pay gap persists. Within the NHS sector, disability pay gaps are a recognised issue, often linked to lower declaration rates, concentration of disabled staff in lower-banded roles and under-representation in senior leadership positions.

2. Average pay gap as a Median average

Median Hourly Rate	2024	2025
Disabled	£17.69	£18.91
Non-Disabled	£18.10	£19.09

Not declared	£18.80	£20.15
Prefer not to say	£19.04	£19.65
Unspecified	£22.86	£27.01
Difference Non-Disabled vs Disabled	£0.41	£0.18
% Pay Gap	2.3%	0.9%

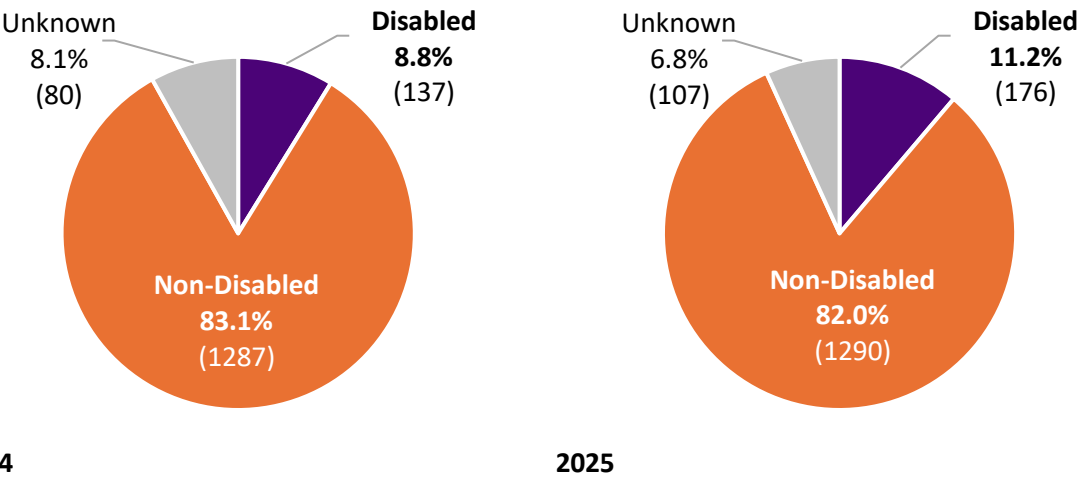


The Median disability pay gap decreased by 1.4%, from 2.3% in 2024 to 0.9% in 2025, which represents a £0.18 per hour pay gap in favour of non-disabled staff. The Trust’s 0.9% median disability pay gap is better than the UK national average of 11.5% (ONS, 2024), placing Oxford Health ahead of wider labour market performance. This narrowing of the median gap reflects some progress in improving equity for the typical employee, although structural barriers remain evident at senior levels.

3. Proportion of employees by quartiles (i.e., when divided into four groups ordered from lowest to highest pay)

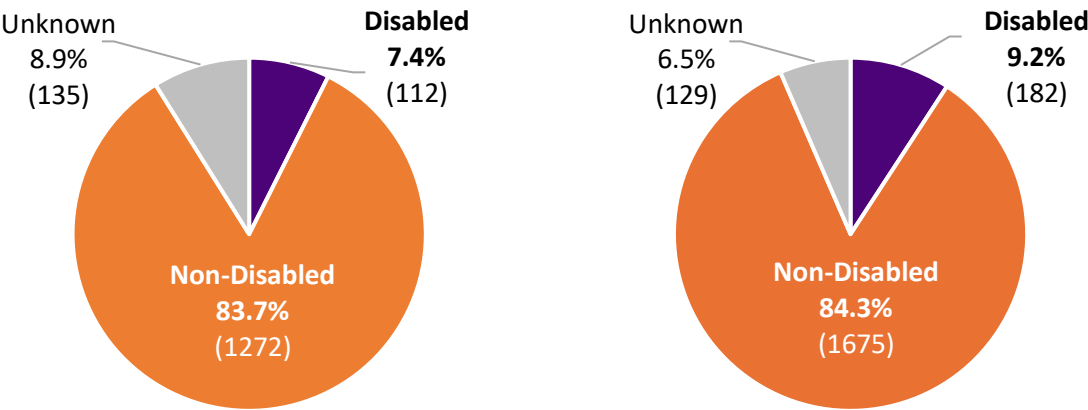
The distribution of disabled and non-disabled employees across hourly pay quartiles between 2024 and 2025 provides important insight into how representation patterns may be influencing the Trust’s disability pay gap.

Lower Quartile



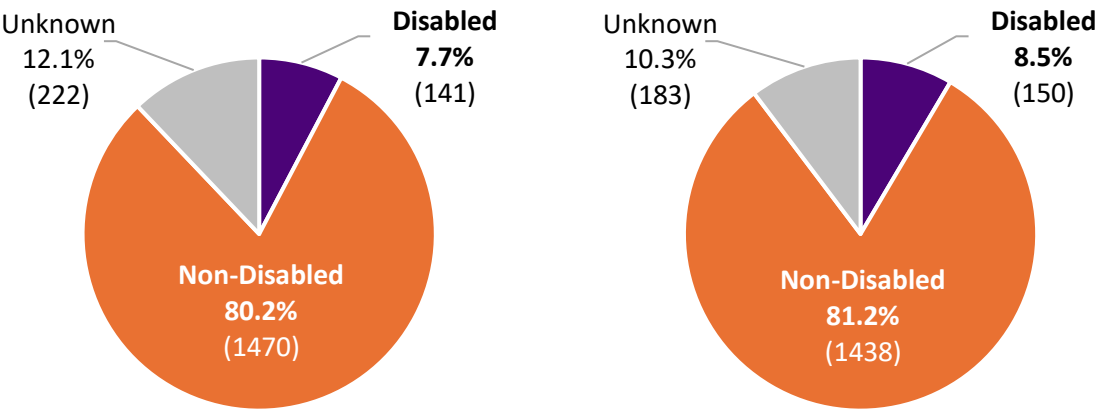
Disabled staff became more concentrated in the lowest pay quartile, rising by 2.4% from 8.8% to 11.2% of staff. This over-representation indicates that disabled staff are more likely than average to be in the lowest-paid roles. Conversely, non-disabled staff fell by 1.1% from 83.1% to 82.0%. This shift suggests that pay gap disparities for disabled staff are being reinforced at the lower end of the pay distribution.

Lower Middle Quartile



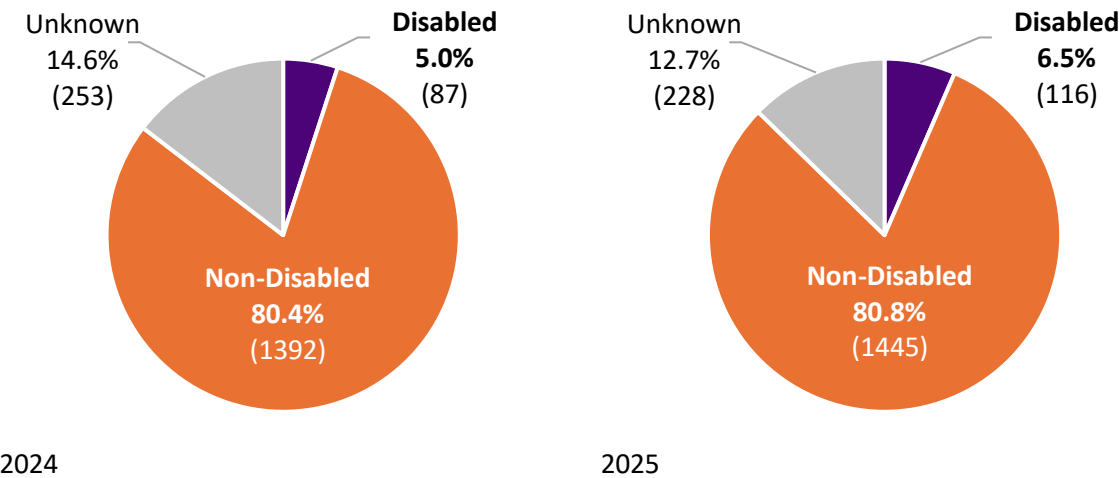
Representation of disabled staff in the lower-middle quartile rose by 1.8% from 7.4% to 9.2%, moving closer to their overall workforce share of 8.8%. Non-disabled staff also increased by 0.6% from 83.7% to 84.3%, reflecting stability at this level. This quartile now reflects a fairer balance, though the rise suggests disabled staff remain clustered in the two lower quartiles rather than progressing into higher paid roles.

Upper-Middle Quartile



Representation of disabled staff improved by 0.8% from 7.7% to 8.5%, just below the workforce average of 8.8%. Non-disabled representation also increased by 1.0%, from 80.2% to 81.2%. This improvement is modest but positive, signalling some progress in disabled staff reaching mid-to-higher pay levels, although they remain under-represented relative to their workforce share.

Upper Quartile



Disabled staff remain under-represented at the highest pay levels, although their share rose by 1.5% from 5.0% in 2024 to 6.5% in 2025. This remains 2.3% below their overall workforce share. By contrast, non-disabled staff accounted for 80.8% of this quartile in 2025. While the upward shift is a positive sign, the gap at senior levels continues to be the most significant structural contributor to the Trust’s disability pay gap.

Across the two years, disabled staff have increased their representation in every quartile, but their distribution across pay levels continues to show signs of structural imbalance. Disabled staff remain most concentrated in the lower quartile, where their presence has risen to 11.2%, compared with a workforce average of 8.8%. By contrast, they remain under-represented in the upper quartile, where representation has improved from 5.0% in 2024 to 6.5% in 2025, but still falls short of their workforce share.

The most positive development is the steady rise in disabled representation in the upper quartile, which suggests gradual progress in diversifying access to senior and higher-paid roles. However, disabled staff remain disproportionately clustered in the lower quartile, while non-disabled staff continue to dominate the highest pay levels. This persistent imbalance is one of the strongest structural contributors to the Trust’s disability pay gap.

The quartile distribution contributes to the disability pay gap in the following ways:

- Over-representation of disabled staff in the lower quartile lowers their average pay, as more disabled staff are concentrated in the lowest-paid roles.
- Improved but continued under-representation in the upper quartile limits the contribution of disabled staff to narrowing the pay gap, as fewer are in the highest-paid roles.
- Over-representation of non-disabled staff in senior quartiles boosts average non-disabled earnings, particularly in roles with higher pay, widening the gap.
- Positive increases across all quartiles signal that progress is being made, but the pace of change is gradual and not yet sufficient to address structural disparities.

Between 2024 and 2025, the distribution of disabled and non-disabled staff across quartiles has shown modest improvement. While disabled representation in the upper quartile has improved year on year, the continuing over-

representation in the lowest quartile and under-representation at the highest levels remain the most significant factors contributing to the Trust's disability pay gap.

4. Proportion of Employees Receiving a Bonus

The table below shows the total headcount and percentage of staff by disability who received bonus pay, out of the total number of employees in the workforce.

	Disability	Employees Paid Bonus	Total number of employees in workforce	% of total workforce receiving bonus
2023/24	Disabled	1	523	0.2%
	Non-Disabled	89	5936	1.5%
	Not declared	18	502	3.6%
	Prefer not to say	0	34	0.0%
	Unspecified	8	409	2.0%
2024/25	Disabled	0	678	0.0%
	Non-Disabled	30	6393	0.5%
	Not declared	2	432	0.5%
	Prefer not to say	1	40	2.5%
	Unspecified	2	453	0.4%

In 2025, there was an overall decline in the proportion of staff receiving a bonus compared with 2024, with the most significant impact seen for disabled staff:

Disabled staff: In 2024, 0.2% of disabled employees received a bonus (1 out of 523 staff). In 2025, this fell to 0.0%, as no disabled employees received a bonus out of 678 staff.

Non-Disabled staff: In 2024, 1.5% of non-disabled employees received a bonus (89 out of 5,936). By 2025, this reduced to 0.5% (30 out of 6,393).

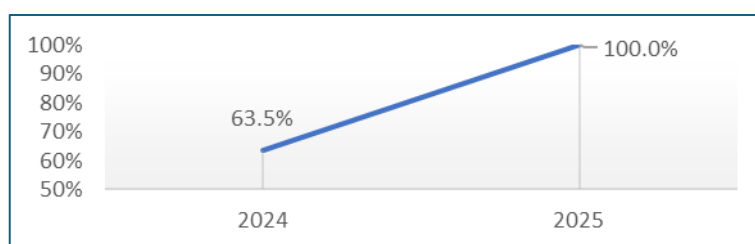
Other groups: 'Not declared' and 'Prefer not to say' staff had higher proportional bonus eligibility in 2025 (2.5% for 'Prefer not to say'), though these groups are very small and not representative of the wider workforce.

The fact that no disabled employees received a bonus in 2025 is the single most significant factor driving the widening disability bonus pay gap.

5. Average bonus pay gap as a Mean average

Mean Hourly Rate	2024	2025
Disabled	£3,509.71	-
Non-Disabled	£9,628.12	£8,862.64

Not declared	£8,022.58	£6,936.78
Prefer not to say	-	£30,159.96
Unspecified	£8,340.13	£6,031.98
Difference Non-Disabled vs Disabled	£6,118.41	£8,862.64
% Pay Gap	63.5%	100.0%



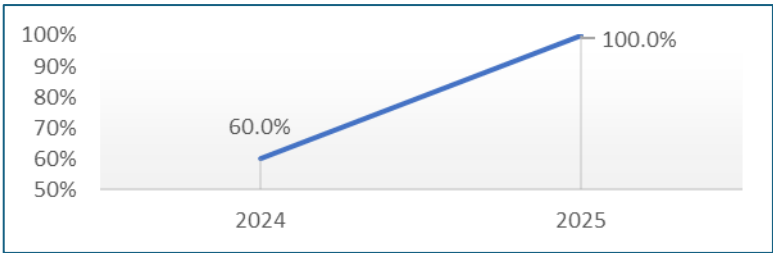
2024: Disabled staff received an average bonus of £3,510, compared to £9,628 for non-disabled colleagues — a mean gap of 63.5%.

2025: No disabled employees received a bonus, while non-disabled staff received an average of £8,863. This resulted in a mean gap of 100.0%.

The widening gap reflects both the reduction in the number of disabled employees receiving bonuses and the continued weighting of LCEA payments towards non-disabled consultants, who are more likely to hold legacy privileges.

6. Average bonus pay gap as a Median average

Median Hourly Rate	2024	2025
Disabled	£3,509.71	-
Non-Disabled	£8,774.29	£8,726.22
Not declared	£5,834.91	£6,936.78
Prefer not to say	-	£30,159.96
Unspecified	£7,127.45	£6,031.98
Difference Non-Disabled vs Disabled	£5,264.58	£8,726.22
% Pay Gap	60.0%	100.0%



2024: The median bonus for disabled staff was £3,510, compared with £8,774 for non-disabled staff, producing a median gap of 60.0%.

2025: With no disabled employees receiving a bonus, the median for this group fell to £0, while the non-disabled median was £8,726. This resulted in a median gap of 100.0%.

This confirms that the bonus pay gap is now absolute, with disabled staff entirely excluded from bonus payments in 2025.

Summary Overview

Ordinary Pay:

Mean Disability Pay Gap: Increased by 0.8% from 6.5% in 2024, to 7.3% in 2025.

Median Disability Pay Gap: Decreased by 1.4%, from 2.3% in 2024, to 0.9% in 2025.

Bonus Pay:

In FY2024/25, no disabled staff received a bonus, compared to 0.5% of non-disabled staff. This reflects a 100% Mean bonus pay gap and zero bonus representation among disabled staff, highlighting inequity in access to recognition or legacy schemes.

Representation Gaps:

Disabled staff are under-represented in senior pay bands. Although they make up 8.8% of the workforce, they represent only 6.5% of the upper hourly pay quartile.

There is no representation of disabled staff among those receiving bonus pay in 2025, raising concerns about equal access to reward and recognition systems.

Overall, the mixed trends highlight progress in reducing the median pay gap, but the widening mean pay gap and absence of bonus payments for disabled staff underscore potential structural inequities based upon this legacy system.

Benchmarking with other NHS Trusts

This data is not available for benchmarking purposes.

Additional Analysis

To help us better understand pay gap reporting Oxford Health we have conducted additional analysis for all three demographic groups as follows:

- Analysis of OHFT Workforce by demographic group and AfC Bands.
- Analysis of OHFT Workforce by demographic group and Occupational Group.

This additional analysis can be found in appendix 1.

Next Steps

This report comes at a time when we are revisiting our equality, diversity and inclusion (EDI) actions and pulling them into one simpler and more cohesive plan. The plan sets out areas of focus, toward our ambitions for EDI. To this end, indicative focus areas are:

- Continue with deep dive analysis of this and other data available to better understand our pay gap reporting
- Progress with inclusive representatives in all senior appointments at Band 8a and above
- Ensure EDI data is available to senior management teams and senior managers are tasked with ensuring representation in services
- EDI training is made available to all those in a management role
- Events focused on Inclusion and EDI form part of the Staff Network calendar of events

Glossary of terms

Snapshot date - for this report for Oxford Health NHS FT is 31st March 2025 and is retrospective based on data from our Electronic Staff Record (ESR) the last financial year. (FY2024/25)

Ordinary pay - means basic pay; allowances; pay for piecework; pay for leave; and shift premium pay. It does not include overtime pay; redundancy pay; pay in lieu of leave, or non-monetary remuneration.

Bonus pay - At Oxford Health, bonuses are primarily linked to the Local Clinical Excellence Awards (LCEA) scheme for consultants, which has historically been male dominated. Although new LCEAs have been abolished nationally, legacy awards remain in payment, and these continue to influence the Trust's bonus pay gap reporting.

Mean Average - is calculated by adding up all individual values in the dataset and dividing the total by the number of entries. It provides a measure of the overall average across the group

Median Average represents the middle value in a dataset when all values are arranged in order. It provides a measure of the typical value and is less affected by extreme highs or lows than the mean.

BAME - Black, Asian & Minority Ethnic Employees (BAME).

Average pay gap as a Mean average - The Mean pay gap is the percentage difference between the average hourly earnings of the demographic group (e.g. female employees and male employees). It is calculated by dividing total hourly earnings separately and dividing by the number of employees in each group. The difference between the two is the Mean pay gap.

Average pay gap as a Median average – The median gender pay gap is the difference in hourly pay between the comparing demographic group (e.g. woman who would be in the middle if you lined up all the female employees from the lowest to the highest paid, and the man who would be in the middle if you lined up all the male employees from the lowest to the highest paid)

Proportion of employees by quartiles (i.e., when divided into four groups ordered from lowest to highest pay) - Pay quartiles analysis enables understanding of how employees are distributed across different pay levels and where pay gaps are most pronounced. This method segments employees into four equal groups based on their pay, allowing for a more in-depth analysis of the representation and pay distribution of staff at various pay levels. This analysis not only highlights where the most significant gaps exist but can also guide targeted interventions.

Data Exclusions - The data is based on employees employed substantively and on full pay for the whole period. So, the following are excluded from our calculations; Staff on reduced pay due to Long term sickness, Maternity & Paternity, Career Break. Inactive staff such as Bank Workers on our payroll

Appendix 1

Gender

The chart below shows the number and percentage of female and male employees within each AfC pay band as of 31st March 2025.

	Female		Male		Total
AfC Band	Headcount	%	Headcount	%	Headcount
Band 1	0	0.0%	1	100.0%	1
Band 2	156	68.7%	71	31.3%	227
Band 3	864	77.4%	252	22.6%	1116
Band 4	816	86.2%	131	13.8%	947
Band 5	900	84.3%	167	15.7%	1067
Band 6	1278	82.9%	264	17.1%	1542
Band 7	763	82.6%	161	17.4%	924
Band 8A	404	79.5%	104	20.5%	508
Band 8B	153	76.5%	47	23.5%	200
Band 8C	94	78.3%	26	21.7%	120
Band 8D	18	62.1%	11	37.9%	29
Band 9	5	45.5%	6	54.5%	11
Board of Directors	9	56.3%	7	43.8%	16
Non-AfC	234	58.4%	167	41.6%	401
VSM	1	50.0%	1	50.0%	2
Grand Total	5696	80.1%	1416	19.9%	7112

At the lower and middle AfC bands (Bands 2–7), women are significantly over-represented compared with their workforce share. For example, female staff account for 86.2% of Band 4 and 84.3% of Band 5, well above the Trust's overall female workforce proportion.

In contrast, men are consistently under-represented in these bands, with male representation at just 13.8% in Band 4 and 15.7% in Band 5. This concentration of women in lower and mid-level bands reflects the predominance of women in roles such as healthcare support, administrative, and registered nursing, which are traditionally lower paid compared with senior leadership or medical roles.

At senior AfC bands (Bands 8A–8D and Band 9), the gender balance shifts. Female representation falls below the Trust's overall average, with 62.1% women at Band 8D and 45.5% at Band 9. Conversely, men are increasingly over-represented at these levels, making up 37.9% of Band 8D and 54.5% of Band 9. These bands correspond to senior management, highly specialised and executive-level roles which attract higher pay. The pattern is also evident at Board level, where women account for 56.3% of directors, compared with 43.8% men, a ratio that is more balanced than the workforce overall but still below the female share of the wider Trust workforce.

Outside AfC pay, whilst a small category (Headcount of 2) the Very Senior Managers (VSM) category has exact gender parity (50/50), however, the non-AfC group (largely medical staff) shows greater male representation (41.6% men), contrasting with the overall workforce profile. Medical staff are among the highest earners in the Trust, meaning this over-representation of men contributes significantly to the gender pay gap.

The table below shows the number and percentage of female and male employees within each occupational group as of 31 March 2025.

	Female		Male		Total
Staff group	Headcount	%	Headcount	%	Headcount
Add Prof Scientific and Technic	855	84.1%	162	15.9%	1017
Additional Clinical Services	1281	79.8%	324	20.2%	1605
Administrative and Clerical	1248	79.9%	314	20.1%	1562
Allied Health Professionals	406	86.8%	62	13.2%	468
Estates and Ancillary	148	59.0%	103	41.0%	251
Medical and Dental	234	58.1%	169	41.9%	403
Nursing and Midwifery Registered	1516	84.4%	281	15.6%	1797
Students	8	88.9%	1	11.1%	9
Grand Total	5696	80.1%	1416	19.9%	7112

Occupational groups with high female representation

Most occupational groups are dominated by women, with female staff making up more than four-fifths of roles in several categories. For example, Allied Health Professionals (86.8% female), Nursing and Midwifery (84.4% female), and Additional Professional, Scientific and Technical staff (84.1% female) all significantly exceed the overall Trust average representation of 80.1% women.

This pattern reflects the traditional gendered workforce composition of the NHS, where clinical, nursing and allied health roles are predominantly female. These roles, while essential, tend to be concentrated in mid-level pay bands, which limits their contribution to reducing the gender pay gap.

Occupational groups broadly in line with workforce representation

Two occupational groups are broadly representative of the Trust's overall workforce gender ratio: Additional Clinical Services (79.8% female, 20.2% male) and Administrative and Clerical (79.9% female, 20.1% male). These groups closely mirror the Trust's gender profile and therefore have limited influence in either widening or narrowing the pay gap.

Occupational groups with higher male representation

Male representation is noticeably higher in Estates and Ancillary (41.0% male) and Medical and Dental (41.9% male) staff groups. These are the only two occupational groups where men make up more than two-fifths of the workforce. This is significant because both groups contain roles that, on average, attract higher levels of pay than many of the predominantly female staff groups.

Medical and Dental staff, in particular, are among the highest paid employees in the NHS. The fact that men are strongly over-represented in this category has a direct upward effect on average male pay, thereby widening the gender pay gap.

Estates and Ancillary, while more balanced in gender composition, often includes a mix of lower and mid-paid roles; however, the proportion of men in these posts does not counterbalance the over-representation of women in lower paid clinical and administrative roles.

Small occupational groups

The smallest category, Students, has the lowest male representation of any group, with only one male (11.1%) out of a total of nine. Although numerically small, this illustrates the gendered pattern of entry routes into the Trust, where women dominate early-career pathways.

Ethnicity

The chart below shows the representation of White and Black, Asian & Minority Ethnic (BAME) employees within each AfC pay band as of 31st March 2025.

AfC Band	BAME Staff		White Staff		Total Workforce
	Headcount	%	Headcount	%	Headcount
Band 1		0.0%	1	100.0%	1
Band 2	73	32.2%	138	60.8%	227
Band 3	398	35.7%	688	61.6%	1116
Band 4	210	22.2%	712	75.2%	947
Band 5	400	37.5%	629	59.0%	1067
Band 6	355	23.0%	1124	72.9%	1542
Band 7	157	17.0%	738	79.9%	924
Band 8A	73	14.4%	417	82.1%	508
Band 8B	29	14.5%	166	83.0%	200
Band 8C	11	9.2%	109	90.8%	120
Band 8D	2	6.9%	25	86.2%	29
Band 9		0.0%	10	90.9%	11
Board of Directors	4	25.0%	10	62.5%	16
Non-AfC	113	28.2%	231	57.6%	401
VSM	1	50.0%	1	50.0%	2
Grand Total	1826	25.7%	5000	70.3%	7112

Lower AfC Bands (Bands 2–4)

BAME representation in the lower AfC bands has risen steadily:

Band 2: BAME staff increased from 66 in 2024 to 73 in 2025, making up 32% of staff at this level, 6.3% above their overall workforce share of 25.7%.

Band 3: BAME staff rose from 365 in 2024 to 398 in 2025, reaching 36% of staff, again 10.3% above with their Trust-wide share.

Band 4: Representation increased from 181 in 2024 to 210 in 2025 (22%), 3.7% below their workforce share.

This demonstrates that BAME colleagues are strongly represented at entry and support roles, but Band 4 highlights where representation begins to fall behind.

Middle AfC Bands (Bands 5–7)

The middle bands are critical for career development and progression pipelines.

Band 5: BAME staff grew from 312 in 2024 to 400 in 2025, making up 37% of the band – over-represented by +11.3% compared with the overall workforce.

Band 6: The largest increase was recorded here, with BAME staff increasing by 96, from 259 in 2024 to 355 in 2025, accounting for 23%, just 2.7% below the workforce representation.

Band 7: Representation grew from 124 in 2024 to 157 in 2025, but BAME staff still make up only 17% of this band, under-represented by –8.7%

These figures suggest BAME staff are well-represented in Band 5 and increasingly in Band 6, but progression into Band 7 remains a bottleneck.

Senior AfC Bands (Bands 8A–8D and Band 9)

At senior levels, under-representation becomes more pronounced:

Band 8A: BAME staff increased from 58 in 2024 to 73 in 2025, but at 14%, they remain 11.7% below workforce share.

Band 8B: Representation rose slightly from 23 in 2024 to 29 in 2025 (15%), still 10.7% below average.

Band 8C: BAME staff decreased from 12 in 2024 to 11 in 2025, falling to just 9%, a difference of 16.7% from the BAME workforce share,

Band 8D: Very low representation, with only 2 BAME staff in 2025 (7%), an 18.7% BAME representation gap.

Band 9: Representation is also minimal, with 0 BAME staff in 2024 and 0 in 2025, compared with 10 White staff.

Whilst the more senior level roles are smaller in number (see table on P36), it is important to note the under-representation of BAME staff at senior AfC bands demonstrates limited progression opportunities into leadership and higher paid roles, a key factor affecting the ethnicity pay gap.

Board, Non-AfC and VSM Roles

Board of Directors: BAME representation increased by 1, from 3 to 4, reaching 25.0% in 2025. While still 0.7% below the overall workforce share of 25.7%, this is broadly aligned and represents a notable improvement in senior level diversity.

Very Senior Managers (VSMs): BAME representation increased from 33.3% in 2024 to 50.0% in 2025. While the headcount number is very small (1), this nevertheless represents progress towards parity at the most senior level.

Non-AfC (primarily medical staff): BAME representation increased from 112 in 2024 to 113 in 2025, at 28% this remains slightly above the workforce average. However, as medical roles are among the highest paid, BAME representation here is an important positive factor in addressing disparities in the pay gap.

The table below shows the number and percentage of White and Black, Asian & Minority Ethnic (BAME) employees within each occupational group as of 31 March 2025.

Staff group	BAME Staff		White Staff		Workforce Total
	Headcount	%	Headcount	%	Headcount
Add Prof Scientific and Technic	162	15.9%	800	78.7%	1017
Additional Clinical Services	546	34.0%	1010	62.9%	1605
Administrative and Clerical	274	17.5%	1246	79.8%	1562
Allied Health Professionals	58	12.4%	400	85.5%	468

Estates and Ancillary	79	31.5%	155	61.8%	251
Medical and Dental	114	28.3%	232	57.6%	403
Nursing and Midwifery Registered	591	32.9%	1151	64.1%	1797
Students	2	22.2%	6	66.7%	9
Grand Total	1826	25.7%	5000	70.3%	7112

Occupational Groups with High BAME Staff Representation

Nursing & Midwifery Registered (33%) and **Additional Clinical Services** (34%) both exceed the overall workforce average of 25.7% BAME representation by 7.3% and 8.3% respectively.

These groups are among the largest in the Trust and increases here demonstrate progress in recruiting and retaining a more diverse workforce in key service delivery roles.

However, both occupational groups are concentrated in mid-pay AfC bands, which limits their ability to drive improvements in the ethnicity pay gap.

Occupational Groups with Moderate BAME Staff Representation

Medical and Dental (28.3%) is a particularly significant group, as these roles are among the highest paid in the Trust. Representation here is slightly above the workforce average, which is a positive factor for pay equity.

Estates and Ancillary (31.5%) also shows higher than average BAME representation, but these roles are generally lower-paid, meaning their effect on narrowing the pay gap is limited.

Occupational Groups with Low BAME Staff Representation

Allied Health Professionals (12.4%) and **Add Prof Scientific & Technical** (15.9%) both fall well below the Trust's average BAME workforce share by 13.3% and 9.8% respectively.

These groups represent specialist and professional roles that often provide career progression opportunities into senior positions. Lower BAME representation here suggests barriers to entry or progression that could reinforce long-term disparities.

Administrative and Clerical (17.5%) is closer to average but is also under-represented by 8.2% relative to the overall BAME workforce.

Small Occupational Groups

Students (22.2%) have BAME representation slightly below the Trust-wide average, although the numbers are very small (only 9 in total).

While numerically limited, this entry level group reflects early-stage recruitment patterns and highlights the importance of ensuring diversity pipelines at the beginning of NHS careers.

Disability.

The chart below shows the number and percentage of disabled and non-disabled employees within each AfC pay band as of 31st March 2025.

	Disabled Staff		Non-Disabled Staff		Total Workforce
AfC Band	Headcount	%	Headcount	%	Headcount
Band 1		0.0%	1	100.0%	1
Band 2	9	4.0%	180	79.3%	227
Band 3	97	8.7%	943	84.5%	1116
Band 4	116	12.2%	771	81.4%	947
Band 5	89	8.3%	911	85.4%	1067
Band 6	153	9.9%	1227	79.6%	1542
Band 7	91	9.8%	781	84.5%	924
Band 8A	32	6.3%	434	85.4%	508
Band 8B	17	8.5%	171	85.5%	200
Band 8C	5	4.2%	101	84.2%	120
Band 8D	2	6.9%	25	86.2%	29
Band 9		0.0%	10	90.9%	11
Board of Directors	2	12.5%	10	62.5%	16
Non-AfC	11	2.7%	277	69.1%	401
VSM		0.0%	2	100.0%	2
Grand Total	624	8.8%	5884	82.2%	7112

Lower AfC Bands (Bands 2–4)

Representation of disabled staff at the lower AfC bands shows modest but important shifts:

Band 2: Disabled staff declined slightly, from 10 in 2024 to 9 in 2025, accounting for 4% of staff at this level, 4.8% below their overall workforce share of 8.8%.

Band 3: Numbers increased from 87 in 2024 to 97 in 2025, representing 9% of staff – just above their Trust-wide share.

Band 4: The largest single increase of 49 disabled staff from 67 in 2024 to 116 in 2025. Disabled staff now make up 12% of this band, 3.2% above their workforce share.

This demonstrates that disabled colleagues are well represented at entry and support roles, with particularly strong growth at Band 4.

Middle AfC Bands (Bands 5–7)

The middle bands are critical for career progression and future leadership pipelines.

Band 5: Disabled staff rose slightly, from 80 to 89, making up 8% of staff – close to their overall workforce share.

Band 6: The largest gain, from 117 to 153, with disabled staff now at 10% representation, 1.2% above their Trust-wide average.

Band 7: Disabled staff increased by 28 from 63 to 91, reaching 10% of the band – again, 1.2% above workforce share.

These figures show that disabled staff are increasingly present in Bands 5–7, strengthening mid-level representation and contributing positively to narrowing the median Disability Pay Gap.

Senior AfC Bands (Bands 8A–8D and Band 9)

At senior levels, however, under-representation becomes more evident:

Band 8A: Numbers increased modestly from 31 to 32, but representation fell by 1% to 6%, 2.8% below the 8.8% workforce average.

Band 8B: Disabled staff grew from 9 to 17, representing 9% of the band – just above their workforce share.

Band 8C: Numbers increased from 2 to 5, lifting representation to 4%, 4.8% below the Trust-wide average.

Band 8D: Disabled staff declined from 3 to 2, just 7% of the band.

Band 9: No disabled staff were recorded in 2024 or 2025, compared with 10 non-disabled colleagues.

This underlines persistent barriers to progression into senior AfC bands, where representation of disabled staff remains below their workforce average.

Board, Non-AfC and VSM Roles

Board of Directors: Disabled staff remained at 2 between 2024 and 2025, accounting for 13% of the Board – above the workforce average but limited by very small numbers.

Very Senior Managers (VSMs): No disabled staff were represented in either 2024 or 2025, compared with 2 non-disabled staff in 2025.

Non-AfC (primarily medical staff): Disabled staff increased from 7 to 11, representing 3% of this group – 5.8% below their workforce share

The table below shows the number and percentage of disabled and non-disabled employees within each occupational group as of 31 March 2025.

	Disabled Staff		Non-Disabled Staff		Workforce Total
Staff group	Headcount	%	Headcount	%	Headcount
Add Prof Scientific and Technic	100	9.8%	827	81.3%	1017
Additional Clinical Services	188	11.7%	1308	81.5%	1605
Administrative and Clerical	130	8.3%	1317	84.3%	1562
Allied Health Professionals	50	10.7%	384	82.1%	468
Estates and Ancillary	9	3.6%	207	82.5%	251
Medical and Dental	11	2.7%	278	69.0%	403

Nursing and Midwifery Registered	135	7.5%	1515	84.3%	1797
Students	1	11.1%	8	88.9%	9
Grand Total	624	8.8%	5844	82.2%	7112

Occupational groups with higher disabled staff representation

Some occupational groups show above-average representation of disabled staff compared with the Trust average (8.8%):

Additional Clinical Services: 12.6% disabled staff, the highest proportion across all groups, reflecting strong growth in 2025.

Allied Health Professionals: 11.5% disabled staff, slightly above average and broadly aligned with sector trends.

Additional Professional, Scientific & Technical: 10.8% disabled staff, showing healthy progress in specialist roles.

These areas demonstrate improving representation, particularly within patient-facing and support roles.

Occupational groups broadly in line with workforce average

Administrative and Clerical: 9.0% disabled staff, closely aligned with the Trust average (8.8%). Representation here suggests proportionate progress in administrative functions, though senior leadership progression remains limited.

Occupational groups with lower disabled staff representation

Nursing and Midwifery Registered: 8.2% disabled staff, slightly below the Trust average. Given the size and centrality of the nursing workforce, this has a significant influence on the overall profile.

Medical and Dental: 3.8% disabled staff, the lowest proportion across all staff groups, far below both the Trust average and national benchmarks. This under-representation in one of the highest paying occupational categories is a critical structural driver of the disability pay gap.

Estates and Ancillary: 3.9% disabled staff, 3.9% below the Trust average of 8.8%.

Small occupational groups

Students: Disabled staff fell from 6 to just 1 in 2025, reducing representation from 26% to 11.1%. Although small in number, this sharp decline raises concerns for the future pipeline of disabled staff entering the Trust.

Appendix 2

Intersectionality – Gender and Ethnicity

Intersectionality is key to achieving pay equity since it recognises that discrimination and inequality can be experienced in many ways, based on multiple identities, in this case Gender and Ethnicity.

Workforce intersectionality

Table 1 - Gender split across broadly diverse ethnicity categories with comparison to the previous year (year on year movement)

Gender	Ethnicity			
	Ethnically Diverse	Not Stated	White	Grand Total
Female	1249 (21.92%)	199(3.49%)	4248(74.57%)	5696
Movement from 23/24	205	-59	195	341
Male	577 (40.74%)	87 (9.177%)	752(53.10%)	1416
Movement from 23/24	104	7	28	139
Grand Total	1826(25.67%)	286(4.02%)	5000(70.30%)	7112
Movement from 23/24	309	-52	223	480

Table 2 – Gender split with more detailed ethnicity groupings with comparison to the previous year (year on year movement)

Gender	Ethnicity						Grand Total
	Asian	Black	Mixed	Not Stated	Other	White	
Female	423 (7.42%)	585 (10.2%)	158(2.77%)	199(3.49%)	83(1.45%)	4248(74.57%)	5696
Movement from 23/24	66	123	9	-59	7	195	341
Male	181(12.87%)	322(22.7%)	46(3.24%)	87(6.14%)	28(1.97%)	752(53.10%)	1416
Movement from 23/24	34	67	6	7	-3	28	139
Grand Total	604	907	204	286	111	5000	7112
Movement from 23/24	100	190	15	-52	4	223	480

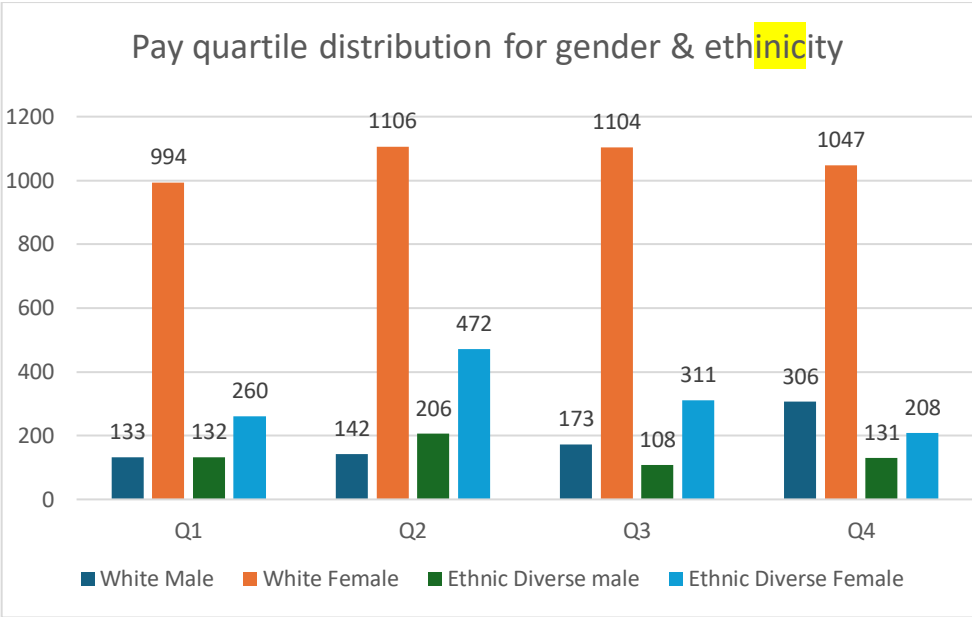
Overall workforce has grown and has become more ethnically diverse with more diversity being seen in males than in females overall. With fewer numbers in the 'not stated' category we will also see an improvement in this data.

Table 3 –Mean and Median pay with comparison to the previous year (year on year movement)

	Male		Female		
Ethnicity	Mean	Median	Mean	Median	Median Difference
Asian	28.32	19.09	20.89	16.89	£2.2 in favour of male
Comparison 23/24	23.18	17.68	19.27	16.03	decrease of 0.55p
Black	20.15	17.36	19.46	18.35	£0.99 in favour of female
Comparison 23/24	17.99	16.17	17.93	17.02	increase of 0.14p
Mixed	18.71	15.85	24.5	19.09	£3.23 in favour of female
Comparison 23/24	17.82	14.53	22.16	17.74	increase of 0.03p
Other	29.64	21.2	28.06	18.66	£2.54 in favour of male
Comparison 23/24	24.22	20.32	19.25	18.05	decrease of 0.27p
White	27.87	23.6	21.97	19.37	£4.23 in favour of male
Comparison 23/24	25.4	21.8	20.05	18.1	decrease of 0.53p
Not Stated	33.58	21.11	27	20.15	£0.96 in favour of Male
Comparison 23/24	30.28	18.1	21.81	18.46	increase of 1.32p

- Asian: Men £19.09 vs Women £16.89 → £2.20 in favour of men (~13.0% of the female median).
- Black: Men £17.36 vs Women £18.35 → £0.99 in favour of women (~5.4% of the female median)
- Mixed: Men £15.85 vs Women £19.09 → £3.24 in favour of women (~17.0% of the female median).
- Other: Men £21.20 vs Women £18.66 → £2.54 in favour of men (~13.6% of the female median).
- White: Men £23.60 vs Women £19.37 → £4.23 in favour of men (~21.8% of the female median). This is the largest median gap.
- Not stated: Men £21.11 vs Women £20.15 → £0.96 in favour of men (~4.8% of the female median).

The White group shows the largest median gap favouring men, whereas Black and Mixed show medians favouring women. The pattern suggests that deeper dive into role and banding would help to identify where to focus attention.



White men increase from 8.8% in Q1 to 18.1% in Q4 indicating a higher presence in more highly paid roles.

White females hold the largest number in each quartile representing 65.4% in Q1 and 61.9% in Q4.

In Q1 the Ethnic diversity is spread evenly between males and females with this gap widening in Q3 & Q4. In Q2 the data reflects a more ethnically diverse female representation to ethnically diverse males.

The data suggests career progression and potential selection effects which link directly to the action we have in place to support inclusive selection and highlights more work needs to be done to support career progression.

Meeting	Board of Directors Meeting in Public
Date of Meeting	28 January 2026
Agenda item	17
Report title	Emergency Preparedness, Resilience and Response Annual Report 01 November 2024 – 31 October 2025
Executive lead(s)	Taff Gidi, Executive 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 undertaken during the past twelve months and includes evidence of compliance with the NHS England EPRR Core Standards and the NHS Emergency Preparedness Framework (2022).

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, both individually and collectively, that appropriate controls are in place to deliver compliance against the Trust's EPRR obligations.

The Executive Director of Corporate Affairs, Taff Gidi as accountable emergency officer for EPRR, and the Audit Committee recommend 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 December 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

Assurance level
☒ Significant ☐ Reasonable ☐ Limited

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

EPRR – Annual report

1. Introduction

- 1.1. This report outlines the emergency preparedness, resilience, and response (EPRR) and business continuity activities undertaken by Oxford Health NHS Foundation Trust between 1 November 2024 and 31 October 2025. These activities ensure compliance with the Civil Contingencies Act 2004 and the NHS England Emergency Preparedness Framework (2022).
- 1.2. The Executive Director of Corporate Affairs, Taff Gidi, serves as the Trust's Accountable Emergency Officer, holding executive responsibility for emergency preparedness. The Executive Director of Corporate Affairs is supported by Ben Cahill, Deputy Director of Corporate Affairs. Katie Cleaver is the designated Emergency Planning Lead and is responsible for supporting the executive in delivering statutory EPRR obligations. The EPRR work programme is overseen by the Emergency Preparedness, Resilience, and Response Committee, chaired by the Executive Director of Corporate Affairs and comprising representatives 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 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 that is relevant, necessary, and proportionate to their size and services provided.

3. Policies and plans

- 3.1. The Trust's EPRR and Business Continuity Policy was last updated in December 2025 and reviewed and approved by the EPRR committee in January 2026. The policy will go to the February 2026 Quality Committee for final approval following which the policy will be available on the Trust intranet alongside a range of emergency planning and response resources, including all service business continuity plans. All incident response plans in the EPRR response manual are reviewed annually. Services are responsible for ensuring their business continuity plans are reviewed each year with support from the Emergency Planning Lead.

4. Training, exercises and live events

- 4.1. An annual training needs analysis informs the EPRR training programme. Training is provided for directors, senior managers, and communications managers prior to joining the relevant on-call rotas. Individual and group annual refresher sessions are delivered to maintain response capability. Major incident and business continuity scenarios, with prompts for discussion, are available on the Trust 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 tabletop 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 **tabletop exercises** took place between 01 November 2024 – 1 October 2025:

- 13/11/2024 – Network outage
- 23/01/2025 – EMIS clinical system outage
- 10/04/2025 – Adastra clinical system outage
- 09/07/2025 – Cyber incident affecting pathology services across the South East
- 03/10/2025 – Adastra clinical system outage
- 29/10/2025 – Hostage situation (forensic mental health)

The Trust participated in multi-agency **communications cascade exercises** in February and May 2025.

- 4.3. The following **live incidents** required the activation of incident response plans and business continuity plans during the reporting period. Learning from live events is discussed at the Trust's EPRR Committee.

- **Industrial action**

The British Medical Association (BMA) gave notice of its intention to call on all its members employed by OHFT to take part in industrial action during 25-30 July 2025. The Trust's Industrial Action Response Plan was activated, and the incident

coordination centre was established to maintain service continuity and oversee derogation processes.

- **Heatwave**

Periods of extreme heat during summer 2025 resulted in activation of the Heatwave Plan. Five yellow and three amber alerts were issued nationally. Yellow alerts are issued during periods of heat 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. An amber alert represents a situation where the expected impacts are likely to be felt across the whole health service, with potential for the entire population to be at risk and where other sectors apart from health may also start to observe impacts, indicating that a coordinated response is required.

- **Mains water outage**

On 8 July 2025, a mains water outage affecting OX3, OX4 and OX33 areas, including Warneford Hospital, triggered activation of continuity plans. Bottled water, emergency supplies, and tanker provision were arranged. The response was coordinated through the incident management team with limited impact on services. A key issue identified during the response was an incompatible tanker connector, which was resolved by installing a standard cam-lock fitting to improve future resilience.

- **Supply chain – inpatient meals**

On 22 August 2025, the Trust's inpatient meal supplier delivered only 20% of the scheduled order, affecting meal provision for 450 inpatients. The Estates and Facilities Business Continuity Plan was activated, which included using contingency stocks and placing identified backup suppliers on standby. The incident was escalated appropriately, and the supplier delivered the missing food the following day and normal service resumed on 25 August 2025.

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 EPRR core standards, which are subject to review every three years, were due for review in 2025; however, this has been deferred as a result of organisational changes within NHS England.
- 5.2. During quarter 2, the 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 28 October 2025 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. A deep dive was not conducted this year owing to organisational changes within NHS England.

6. Partnership working

- 6.1. The Trust works in collaboration with a range of partner agencies through formal standing meetings. The Executive 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 maintained compliance with NHS England's EPRR requirements during the reporting period. The Trust has:

- delivered the training and exercise programme
- responded effectively to a range of incidents
- strengthened partnership working
- achieved full compliance with NHS England core standards for EPRR.

31 October 2025

Appendix A

Taff Gidi
Executive Director of Corporate Affairs
Oxford Health NHS Foundation Trust

BOB ICB
First Floor, Unipart House
Garsington Road
Cowley Oxford
OX4 2PG

Copy: BOB ICB AEO, OHFT EPRR Lead

Via email
Taff.Gidi@oxfordhealth.nhs.uk

bobicb.epr@nhs.net

29th October 2025

Dear Taff

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

In June of this year, the ICB wrote to the 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.

Ahead of the peer review process your team provided the following evidence: -

Plans and policies

- Business Continuity Policy and BCPs for critical services

Evidence of training & exercising

- Records of table-top and live exercises over last 12–24 months
- Post-exercise debriefs and action plans – Key learning points only.

On-call arrangements

- Key action cards for on-call managers/directors
- Confirmation of induction or refresher training for on-call staff

Business continuity evidence

- BC test / exercise reports
- Evidence BC plans are reviewed annually

The ICB subsequently completed a peer review Meetings with all providers on the 28th of October 2025, where areas of good practice as well as compliance were identified and discussed based on their core standards submission.

Your EPRR team represented your organisation to the highest of standards, and at our meeting we reviewed the documents that your team provided as part of the assurance process, and I would like to commend them on the following areas: -

- We would like to commend Katie Cleaver on the high standard of Business continuity plans, particularly Woodlands, which displayed a high level of detail and a sequential approach.
- Katie also has demonstrated a high level of evidence and supporting documents to support commander training and competency.
- The self-assessment demonstrated a high level of overall evidence and information to demonstrate compliance.

We also discussed the Trust's self-assessment position, noting full compliance on all standards, which has maintained the position on the previous year.

EPRR Assurance Statement of Compliance

As part of the national EPRR assurance process for 2025/26, 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 all 58 of the core standards.

In line with the national NHS England Core Standards for EPRR assurance thresholds, the overall self-assessment of the Trust for 2025/26 is:

- **SUBSTANTIALY COMPLIANT**

Deep Dive

Due to the changes currently taking place across NHSE and the ICB's NHSE have chosen not to undertake a deep dive this reporting year and as such there is no deep dive to report upon.

That said at the core assurance day we did review any outstanding issues from the previous reporting years Cyber deep dive.

Next Steps

Following agreement of the self-assessment with the ICB, the organisation's final overall assurance rating is as follows:

- **SUBSTANTIALY COMPLIANT**

Please pass my thanks to your team for their hard work and commitment to the key process. www.bucksoxonberksw.icb.nhs.uk

Yours sincerely



Paul Jefferies

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

www.bucksoxonberksw.icb.nhs.uk

Meeting of the Audit & Risk Committee

Tuesday, 02 December 2025, 09:30-12:05¹

Microsoft Teams virtual meeting

AGENDA

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

No.	Item	Lead	Purpose	Paper	Time
1.	Welcome and Apologies for Absence ²	CMH, Chair		N/A	09:30 (5 mins)
2.	Confirmation of items for Any Other Business			N/A	
3.	Minutes of the Audit & Risk Committee meeting held on 09 September 2025		For approval	Enclosed	
4.	Summary of Actions and matters arising			Enclosed	
External Audit					
5.	External Audit progress report and annual reflection	EY	For assurance	Verbal	09:35 (10 mins)
Counter Fraud, Internal Audit & Assurance					
6.	Counter Fraud progress report	KPMG/ JP/PM/ HeS	For information/ assurance	Enclosed	09:45 (10 mins)
7.	Health & Safety/Estates update	JP/HeS	For information/ assurance	Verbal	09:55 (15 mins)
8.	Internal Audit updates (part 1): a) progress report; and b) AI Benchmarking exercise	KPMG PM/ AC/HeS	For information/ assurance	Enclosed	10:10 (15 mins)

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 No apologies from Committee members. Apologies from regular attendees: Rob Bale, Chief Operating Officer for MH&LD; Britta Klinck, Chief Nurse; and Karl Marlowe, Chief Medical Officer.
Observers: Nicky Howells, Deputy Director of People (OD and Comms); and Governor(s)

Risk, Governance & Assurance

9.	Cyber Incident - KPMG review actions update	WH/AC/HeS	For information/assurance	Enclosed	10:25 (10 mins)
10.	Losses & Special Payments – Overpayment Controls and Processes	CD/HeS	For information/assurance	Enclosed	10:35 (15 mins)
<i>10 minutes' break – if required</i>					10:50
11.	Internal Audit updates (part 2): Data Quality review of Access and Activity Data (Talking Therapies)	AB/HeS	For information/assurance	Enclosed	11:00 ³ (10 mins)
12.	Board Assurance Framework report with deep dives ⁴ into: - Environmental sustainability; - Information & Data; and - Partnerships & System working.	BC/TG HeS/ AB	For information/assurance	Enclosed	11:10 (20 mins)
13.	Risk Management policy	TG	For approval	Enclosed	11:30 (10 mins)
14.	Emergency Preparedness, Resilience & Response annual report	TG	For approval	Enclosed	11:40 (10 mins)

PRIVATE SESSION – Procurement

15.	External Audit procurement – update ⁵	MW/PM/HeS	For recommendation	Enclosed	11:50 (10 mins)

Any Other Business

16.	Any other business	CMH, Chair		N/A	12:00
17.	Questions from observing Governors			N/A	

Review and Close

18.	Review of the Meeting 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.	CMH, Chair			

Meeting Close

Date of next meeting – 11 February 2026

12:05

³ 11:00 start to facilitate attendance by Amélie Bages, Executive Director of Strategy & Partnerships

⁴ Consistent approach for BAF deep dives/assurance, including understanding other committees' areas of focus on these risks; potentially include paragraph(s) from respective committee chairs alongside the risks to provide assurance to the ARC. Aims to achieve: (i) second opinion on the risk; (ii) taking a view on behalf of the Board on consistency and rigour applied by committees' across risks; (iii) identify intersections between risks; and (iv) assurance/feedback loop with Internal Audit planning.

⁵ For recommendation to the Council of Governors' meeting on 04 December 2025

Audit & Risk Committee
Minutes of the meeting held on
09 September 2025 at 09:00
via MS Teams

Present¹:

Chris Hurst (CMH)	Non-Executive Director (the Chair)
Rick Trainor (RT)	Non-Executive Director

In attendance:**External Audit - Ernst & Young LLP (EY)**

Claire Mellons (CM)	External Audit - Partner, Ernst & Young
Michael Mason (MM)	External Audit, Ernst & Young

Internal Audit and Counter Fraud – KPMG

Neil Thomas (NT)	Internal Audit – Partner, KPMG
Gareth Hall (GH)	Internal Audit, KPMG
Sarah Knight (SK)	Internal Audit, KPMG

Oxford Health NHS FT**Attending Board members**

Taff Gidi (TG)	Executive Director of Corporate Affairs (the EDoCA)
Heather Smith (HeS)	Chief Finance Officer (the CFO)

Other Trust staff in attendance

Ben Cahill (BC)	Deputy Director of Corporate Affairs
Vikki Ewing (VE)	Clinical Audit and NICE ² Guidance Manager – <i>part meeting</i>
Angie Fletcher (AF)	Deputy Chief Nurse – <i>part meeting</i>
Rachel Hanks (RH)	Head of Clinical Systems – <i>part meeting</i>
Will Harper (WH)	Head of IT – <i>part meeting</i>
Ashley Harvey (AH)	Head of Improvement & Effectiveness – <i>part meeting</i>
Peter Milliken (PM)	Director of Finance
Hannah Smith (HaS)	Assistant Trust Secretary (Minutes)

¹ The quorum is 2 members (all Non-Executive Directors) and may include deputies.

² National Institute for Health & Care Excellence (NICE)

1.	Welcome and Apologies for Absence	
a	The Chair welcomed attendees to the meeting.	
b	Apologies for absence from non-Committee members were received from: Karl Marlowe, Chief Medical Officer, and Ali Corfield, Chief Digital Information Officer.	
2.	Confirmation of items for Any Other Business (AOB)	
a	None requested.	
3.	Minutes of the Meeting on 18 June 2025 and Matters Arising	HaS
a	The minutes of the Committee meeting on 18 June 2025 were approved as a true and accurate record subject to amending paragraph 11(a) (AOB) to clarify that just one other provider was intended.	
b	Matters Arising The following actions were noted as on the agenda for this meeting (with supporting detail in the Summary of Actions document): - item 2(a) update on Failure to Prevent Fraud offence included in the Counter Fraud report; and - item 4(e) update on actions from the Frontline Digitisation Programme report.	
EXTERNAL AUDIT		
4.	Final External Audit results report and annual report 2024/25 including commentary on Value For Money (VFM) arrangements	
a	Claire Mellons presented the final audit results report on the financial statement audit for the year ended 31 March 2025 and the auditor's annual report. An unqualified opinion had been given that the financial statements gave a true and fair view of the financial position and there were no matters to report by exception on VFM arrangements and no identified risks of significant weakness against the reporting criteria (consistent with the previous year). The External Audit team would also attend the Council of Governors' meeting on 18 September 2025, ahead of the Annual General Meeting & Annual Members' Meeting on 25 September 2025, to present and discuss their report.	
b	The Chair commented positively upon the clean unqualified audit opinion and commentary on VFM arrangements, noting that it was also helpful that the final audit results report highlighted (in blue) key changes since the draft report presented to the Committee at its last meeting in June 2025. He noted that this was the time to plan ahead for the 2025/26 External Audit process and absorb lessons learned from the 2024/25 process.	
c	Rick Trainor referred to errors relating to exit package disclosures which had persisted from previous years and to an error in pension apportionment; he sought assurance that these errors would not recur in the 2025/26 process. The Chief Finance Officer confirmed that she had discussed these with the Chief People Officer and the HR team would be following a new process this financial year which the Finance team would also check-up on to ensure that the errors did not persist into 2025/26.	

d	The Committee noted the report and that External Audit would also report into the Council of Governors' meeting on 18 September 2025.	
INTERNAL AUDIT & COUNTER FRAUD		
5.	Internal Audit updates	JP/ HES
a	Neil Thomas presented the Internal Audit progress report which provided an update on progress against the FY26 Internal Audit Plan. He also confirmed that the final version of the Operation of Data Quality Systems review had been included for consideration by the Committee, which completed the FY25 Internal Audit Plan. As also referred to in the report, he noted that the KPMG Cyber Response Team had also been commissioned to investigate a cyber incident and this was separately on the agenda for this meeting at item 12 below.	
b	The meeting considered Internal Audit action tracking. There were no significant findings to report since the last meeting but Neil Thomas noted that overdue actions related mainly to Frontline Digitisation work and the Health & Safety review. The Chair noted that an actions update on the Frontline Digitisation Audit was already on the agenda for this meeting at item 13 below and he invited the Chief Finance Officer to give an update on Estates and Health & Safety. The Chief Finance Officer reported on the recent Estates' reorganisation undertaken by the Director of Estates and Facilities and Health & Safety reporting into the Fire, Health, Safety and Security meeting which would be taking place later that afternoon. She noted that Health & Safety reporting was providing a more strategic overview of compliance and responsibilities. Further to a request from the Chair, the Chief Finance Officer took an action for the Director of Estates & Facilities to provide a verbal update on Health & Safety/Estates to a future Committee meeting.	
c	The Executive Director of Corporate Affairs commented upon the importance of setting appropriate timelines for Internal Audit actions and distinguishing between actions which should become recommendations as opposed to being undertaken in the normal course of business. The Chair agreed and noted the need to balance enthusiasm and also ensure that actions were prioritised and focused on the right areas so that no core follow-through was missed if there were a number of outstanding actions.	
	<i>Operation of Data Quality Systems FY25 review</i>	
d	Sarah Knight presented the review on the design and operating effectiveness of data quality controls which had achieved a rating of significant assurance with minor improvement opportunities identified, including enhancements to the collation of data for Integrated Performance Report reporting and the effectiveness of validation controls. In response to a question from the Chair, she confirmed that none of the findings impacted the management of patient care. The Chief Finance Officer added that the review had been a helpful and assuring evaluation of how systems were working in practice whilst the Trust had been recovering from a cyber incident and as metrics and dashboards evolved to support the current regulatory environment.	
e	The Committee noted the progress report and the Operation of Data Quality Systems review.	

6.	Counter Fraud progress report	
a	Neil Thomas presented the report which provided an update on progress against the FY26 Counter Fraud Plan. He noted that fieldwork had commenced on the Recruitment review and, further to discussion with the Chief Finance Officer, the Estates: Maintenance Contracting review had been deferred to FY27; referrals received were summarised in Appendix B (no significant findings to highlight); and an update on the Failure to Prevent Fraud offence (under the Economic Crime and Corporate Transparency Act 2023) was included at Appendix C.	
b	The Chair thanked the Counter Fraud team and noted that it was also useful that the update on the Failure to Prevent Fraud offence had been timely to inform the review of the Counter Fraud policy, to be considered at the next item.	
c	The Committee noted the report and that, further to item 5(b) above on Internal Audit, the Director of Estates & Facilities would provide a verbal update on Health & Safety/Estates to a future Committee meeting.	
7.	Counter Fraud policy	
a	The Chief Finance Officer presented the revised Counter Fraud policy which, along with minor updates, also now included the Failure to Prevent Fraud offence from the Economic Crime and Corporate Transparency Act 2023.	
b	The Committee APPROVED the Counter Fraud policy.	
RISK, GOVERNANCE & ASSURANCE		
8.	Board Assurance Framework (BAF) report	
a	The Executive Director of Corporate Affairs presented the revised BAF further to review and approval at the Executive and the Board in July 2025; he noted that it would also be presented to Board Committees for the first time from September and he invited comments from the Committee and auditors, especially whilst the BAF was evolving. Further to the details in the report, he highlighted that the BAF had been condensed to eleven focused strategic risks and that monitoring of long-term trends and creation of risk appetite levels were in development.	
b	Further to a comment from the Chair on the proposal in the report for the Committee to work through deep dives of all eleven BAF risks over the course of a year, the Deputy Director of Corporate Affairs referred to the proposed clustering of risks in order to spread them over approximately four meetings (order to be confirmed): • Quality, Safety & Experience; Recruitment & Retention; and Digital transformation; • Timely access to services; Staff experience & Culture; and Improvement, Research & Data; • Financial sustainability; and Infrastructure; and • Partnerships & System working; Environmental sustainability; and Information & Data.	
c	The Chair noted that the above proposal for the Committee to undertake deep dives across all risks appeared sensible and should be trialled as this would provide an opportunity to discuss risks with conceptual links together. He led the meeting in review of the overall arrangements for the BAF and any potential gaps, noting that members of the Board were	

	already familiar with the risks, their format and layout through discussion at the Board Workshop on 30 April 2025. He commended the brevity of the risks and clearer link to operational risk registers and the objective of the revised BAF to enable a clearer through-line for 'ward and board' and migration of risks between registers, as referred to in the report. He noted that although Board Committees would need to develop their own views on their allocated risks and engage the Board appropriately, they would also need to agree leadership in areas of shared interest between Committees and consistency across risks to support the Board to form a view; it would also be reasonable for a Committee Chair to request the opinion of another Committee on matters of shared interest. The Executive Director of Corporate Affairs noted that the 3As report from Committees to the Board meeting in public (on areas to alert, advise or assure the Board) would be appropriate for Committees to exchange views and have discussion formally recorded.	
d	Rick Trainor supported the revised BAF and the opportunity for this Committee to undertake an overall review of all its risks through the proposed deep dives, further to the views formed by individual Committees of their allocated risks.	
e	Neil Thomas commended the revised format and also commented upon examples from other organisations including: a one-page overview; using risk indicators as a bridge from current to target position; and defining material risks, material controls and assurances, especially where there were a number of controls listed in the revised BAF not all of which would be material.	
f	The Chair cautioned against: (i) risks becoming a download of all potentially relevant concerns around a particular topic; and (ii) actions being tracked to completion without analysis of whether their completion had achieved their intended impact or whether further actions may be required. The Executive Director of Corporate Affairs acknowledged this and that the consequences of actions should be more clearly recorded but sometimes actions would be to avoid further deterioration. The Chief Finance Officer added that the revised BAF came at a good time to also inform work on the Trust's new Strategy and consideration of the risk environment which the organisation now operated within; it would therefore need to continue to evolve in line with the Strategy and that evolution could also encompass a sense check of whether actions had improve the target rating of risks.	
g	The Chair summarised that the revised BAF had the potential to serve the Board, this Committee and other Board Committees more effectively. Although it was still work in progress for the Board and Committees, and risk appetite could be developed, the BAF would mature through operation and the comments above were for reflection to build upon the current direction of travel, not proposals for further change.	
h	Further to the comments and reflections above, the Committee supported the revised BAF. <i>The meeting took a break for 10 minutes and resumed at 10:38.</i>	
9.	Single Action Tender Waivers report – 01 April to 30 June 2025	
a	The Director of Finance presented the report on the 3 Single Action Tender Waivers (SATWs) and 9 Single Action Quotation Waivers (SAQWs) approved during the reporting period; none were retrospective waivers. Overall there were fewer waivers compared to last year and most waivers related to Estates & Facilities, Research & Development and Information Management & Technology (IM&T) (consistent with previous periods).	

b	The Chair commended the improvements being made and the updates to: (i) the waiver form in-line with the observations listed in the report; and (ii) compliance practices in accordance with the new Procurement Act which came into effect in February 2025. The Director of Finance confirmed that work was taking place to support the enhanced requirements of the new Procurement Act.	
c	The Committee noted the report.	
10.	Losses & Special Payments report – 01 April to 31 August 2025	
a	The Director of Finance presented the report on 16 cases over the reporting period and explained that stores losses in relation to the Oxford Pharmacy Store were within the green-rated range of tolerance.	
b	Rick Trainor asked about the bad debt write-off related to an overpayment invoiced in error. The Director of Finance explained that this related to an HR system which was no longer in use and a system error which had resulted in an overpayment over a period of long-term sickness.	
c	The Committee noted the report.	
11.	Clinical Audit & NICE³ Guidance annual report 2024/25	
a	The Head of Improvement & Effectiveness and the Clinical Audit and NICE Guidance Manager joined the meeting and presented the report, summarising the key areas of focus: • integration with the Quality Management System from November 2024 which had helped to align Clinical Audit with Quality Planning, Quality Control and Quality Improvement; • governance and oversight, with revised Terms of Reference for the Improving Care Group (included as part of the report) which would continue to provide central oversight of Clinical Audit and NICE compliance activity across directorates; • policies, standard operating procedures and refreshed training; • the now fully embedded Audit Management and Tracking (AMaT) system for audit tracking, action monitoring and NICE guidance compliance and which included a suite of training; and • forward planning with the FY26 Clinical Audit Plan reducing the number of audits whilst focusing on fewer and higher-quality audits with links to strategy or improvement actions. <i>The Deputy Chief Nurse joined the meeting.</i>	
b	The Chair thanked the team and reminded the meeting of the role of this Committee to focus upon the effectiveness of Clinical Audit arrangements and their value to the Trust, whilst the Quality Committee would focus upon the outcomes of particular clinical audits. He commended the move to reduce the number of clinical audits especially whilst team resources were challenged and the team was experiencing turnover. He asked whether team resilience had improved. The Head of Improvement & Effectiveness replied that it	

³ National Institute for Health & Care Excellence (NICE)

	had, especially with the Clinical Audit and NICE Guidance Manager having joined the team. He acknowledged that resources had been limited and it had therefore been important to support directorates to take ownership of their clinical audits. The Deputy Chief Nurse added that last year's focus had been to put Clinical Audit back on the map whilst this year, having improved the resilience of the team and brought Clinical Audit together with Quality Improvement, the renewed team could focus more on seeking solutions and supporting directorates.	
c	The Executive Director of Corporate Affairs supported bringing Clinical Audit together with Quality Improvement and the oversight structure, with the Improving Care Group reporting into the Clinical Effectiveness Group. In the future he noted that it would be helpful to be clear on who had attended the Improving Care Group to represent directorates.	
d	The Committee thanked the Clinical Audit team for their work, noted the report and was assured of the effectiveness of the arrangements in place and the potential for Clinical Audit to support improvements in patient care and organisational effectiveness. <i>The Head of Improvement & Effectiveness, the Clinical Audit and NICE Guidance Manager and the Deputy Chief Nurse left the meeting. The Head of IT and the Head of Clinical Systems joined the meeting.</i>	
12.	Cyber Security update report and Cyber Incident draft report	
a	<i>Cyber Incident draft report</i> The Head of IT presented the Cyber Incident draft report from the KPMG Cyber Response Team (referred to at item 5(a) above). He explained that, further to the detail in the draft report, the threat had been removed and the incident investigated. Appropriate containment activities had taken place and the investigation had recommended some additional hardening actions which had been completed. A further report with recommendations would next be presented to the Information Management Group. The Chair commended the fast response, the support from the KPMG Cyber Response Team and the appropriateness of further oversight from the Information Management Group.	
b	The Chair asked whether there were further steps, beyond training and awareness activities, which could limit the Trust's exposure to such cyber risks. The meeting discussed restricting functionality, use of external AI and recording software in meetings and use of personal devices, whilst also considering the potential trade-offs between business impact, accessibility needs and cyber security. The Chief Finance Officer noted that the Information Management Group was the appropriate forum to consider the operational choices to be made and the impact of trade-offs.	
c	The Chief Finance Officer drew the Committee's attention to the IM&T team's efforts in relation to the incident, the preventative measures in place and the impact upon the team over a couple of weeks. The Chair thanked the IM&T team.	
d	<i>Cyber Security update report</i> The Head of IT presented the Cyber Security update report and highlighted the pending replacement of a web server and work taking place with two Integrated Care Boards to produce a unified cyber awareness and training programme. The Head of IT emphasised the importance of supporting staff/users to be more conscious of the consequences of their actions. He provided an update on the ongoing rollout of Multi-Factor Authentication, in	

e	line with national requirements. He also commented upon the Cyber Security risk register and the potential impact of resourcing issues and legacy systems. The Committee noted the update and that the Information Management Group would consider recommendations arising from the investigation into the Cyber Incident.	
13.	Frontline Digitisation Audit actions update	
a	The Head of Clinical Systems presented the report and confirmed that two of the actions had been completed (benefits realisation and cost management/resource assessment), two were partially complete (staff roles/responsibilities and training and the champion programme) and one was in progress but not yet complete (communications plan – revised due date end of September 2025). She took the meeting through the actions and evidence to confirm implementation, as set out in more detail in the report.	
b	The Chair commented upon the ambitious initial targets which had been set and acknowledged the progress which had been made by a committed and high performing team.	
c	The Committee noted the update on completion of the Frontline Digitisation Audit actions and the importance of setting realistic completion deadlines.	
Any Other Business		
14.	Any Other Business and Questions	
a	None.	
15.	Review of the meeting	
a	For 3As escalation purposes for the Board in September 2025: • no matters of concern or alert to escalate; • to advise on support for the revised BAF and cyber security; and • to note for assurance: progress against the Internal Audit Plan and the update on completion of the Frontline Digitisation Audit actions, the Operation of Data Quality Systems and enhancements for the Integrated Performance Report; progress against the Counter Fraud Plan; the update on the Failure to Prevent Fraud offence (under the Economic Crime and Corporate Transparency Act 2023); the final External Audit results report; and the Clinical Audit & NICE Guidance annual report.	
b	The Chair confirmed that there were no questions or other matters which required discussion.	
	Meeting Close: 11:35	
	Date of next meeting: 02 December 2025	



Oxford Health
NHS Foundation Trust

Audit & Risk Committee
[DRAFT] Minutes of the meeting held on
02 December 2025 at 09:00
via MS Teams

Present¹:

Chris Hurst (CMH)	Non-Executive Director (the Chair)
Rick Trainor (RT)	Non-Executive Director

In attendance:

External Audit - Ernst & Young LLP (EY)

Claire Mellons (CM)	External Audit - Partner, Ernst & Young
Michael Mason (MM)	External Audit, Ernst & Young

Internal Audit and Counter Fraud – KPMG

Neil Thomas (NT)	Internal Audit – Partner, KPMG
Gareth Hall (GH)	Internal Audit, KPMG
Isabel Turner (IT)	Counter Fraud, KPMG

Oxford Health NHS FT

Attending Board members

Amélie Bages (AB)	Executive Director of Strategy & Partnerships (the EDoSP) – <i>part meeting</i>
Charmaine De Souza (CDS)	Chief People Officer (the CPO) – <i>part meeting</i>
Taff Gidi (TG)	Executive Director of Corporate Affairs (the EDoCA)
Grant Macdonald (GM)	Chief Executive Officer (the CEO)
Heather Smith (HeS)	Chief Finance Officer (the CFO)

Other Trust staff in attendance

Ben Cahill (BC)	Deputy Director of Corporate Affairs
Ali Corfield (AC)	Chief Digital & Information Officer – <i>part meeting</i>
Heather Daw (HD)	Head of Medical Workforce & Education – <i>part meeting</i>
Will Harper (WH)	Head of IT – <i>part meeting</i>
Peter Milliken (PM)	Director of Finance
Hannah Smith (HaS)	Assistant Trust Secretary (Minutes)
Jeremy Philpot (JP)	Director of Estates & Facilities – <i>part meeting</i>

Observers including Governors:

Nicky Howells	Deputy Director of People
Colleen Jones	Public Governor, Buckinghamshire

¹ The quorum is 2 members (all Non-Executive Directors) and may include deputies.

1.	Welcome and Apologies for Absence	
a	The Chair welcomed attendees to the meeting.	
b	Apologies for absence from non-Committee members were received from: Rob Bale, Chief Operating Officer for Mental Health & Learning Disabilities; Britta Klinck, Chief Nurse; and Karl Marlowe, Chief Medical Officer.	
2.	Confirmation of items for Any Other Business (AOB)	
a	None requested.	
3.	Minutes of the Meeting on 09 September 2025 and Matters Arising	
a	The minutes of the Committee meeting on 09 September 2025 were approved as a true and accurate record.	
	Matters Arising	
b	All actions were noted as complete or on the agenda for this meeting (with supporting detail in the Summary of Actions document).	
EXTERNAL AUDIT		
4.	External Audit progress report and annual reflection	
a	Claire Mellons provided a verbal update and reported that the External Audit and Finance teams had undertaken a debrief in October 2025 and reflected upon the most recent External Audit in preparation for the upcoming process. The Chief Finance Officer added that the upcoming process would involve: (i) onsite visits (which had helped last year to resolve queries quickly); (ii) up front communication with the wider team to set expectations and individual accountability early; and (iii) use of the online portal. <i>The Chief Executive joined the meeting.</i>	
b	The Chair commented that it was important for the Committee to look ahead and consider risks, as well as reflect upon past events. He noted that whilst it was positive that there would be no technical accounting changes required this financial year, there could be risks attached to the pending retirement of the Financial Controller. The Chief Finance Officer acknowledged that this was an important transition and confirmed that recruitment was underway for an Assistant Director of Financial Operations whilst the wider team had capability, skills and experience to cover the core tasks.	
c	The Committee noted the verbal update.	
INTERNAL AUDIT & COUNTER FRAUD		
5.	Counter Fraud progress report	
a	Isabel Turner presented the report which provided an update on progress against the FY26 Counter Fraud Plan. She confirmed that fieldwork had been completed on the Recruitment review whilst the Estates review had been deferred to FY27. She reported that 15 referrals had now been received, compared to 11 for the prior year, which indicated good traction in promoting messaging around Counter Fraud around the organisation; referrals received were summarised in Appendix B (no significant findings to highlight); and a technical	

	update on the NHS Counter Fraud Authority's (NHS CFA) threat assessment for the NHS was included at Appendix C.	
b	The Chair thanked the Counter Fraud team and noted the inclusion of the NHS CFA update.	
c	The Committee noted the report.	
6.	Health & Safety/Estates update	
a	The Director of Estates & Facilities joined the meeting and gave a verbal update highlighting: - ongoing work to review the structure of the Estates department, improve joined up working, accountability and ownership and introduce Subject Matter Experts (SMEs) to areas such as Hard Facilities Management in order to focus upon addressing technical challenges. Initial recruitment had taken place with a second round of recruitment planned for 2026; - updating of policies and procedures to support compliance, safety and to be more customer-focused and in line with standard project management practices (including sign-off at each key stage and obtaining updated pre-tender estimates so as to have early warning of scope creep which could render a project financially unviable); - joint working with partners and organisations within the Integrated Care System; - support for the team during periods of sickness absence and use of interims; - instilling a 'design in one year and deliver in the next year' expectation rather than procuring, designing and delivering within one year; and - review of procurement and bundling together of related contracts so that they could be tendered together and aligned to particular SMEs for improved accountability.	
b	The Chair commented upon the breadth of the work taking place and supported the approach to address and resolve issues in the right way once rather than putting temporary fixes in place. He emphasised the importance of Estates to support safe and efficient provision of services and to provide a working environment for staff which would encourage retention.	
c	Further to a query from the Chair, the Director of Estates & Facilities reported on how the changes had been received by the team, noting that the increase in accountability had improved how the team was operating. The National Healthcare Estates and Facilities Day had also been celebrated across sites over the past few years. He had also commenced regular 6 monthly briefings with the wider team, which provided opportunities for SMEs to discuss and present on their areas, and feedback from staff surveys was being considered. Cultural change was taking place. The Chief Executive acknowledged the progress which was being made including through feedback and engagement. The Chief Finance Officer added that members of the Estates team had also been nominated for internal Exceptional People Awards and the housekeeping team had received positive national media coverage.	
d	The Chair commented upon the importance of celebrating successes because even those not grand in scale may still be symbolically important and help to build on achievements. He thanked the Director of Estates & Facilities and noted the scale of the challenge still to undertake but was encouraged by the structured approach underway and which would be useful for the Committee to receive a further update on in 6-9 months' time (June or September 2026).	JP/HeS

e	<i>The Director of Estates & Facilities left the meeting.</i> The Chief Finance Officer reported that a whistleblowing case had been received and that she had handed over the investigation to the Executive Director of Corporate Affairs. The Executive Director of Corporate Affairs confirmed that an investigation was underway and it would take into consideration other recent cases and wider learning. The Chair encouraged thorough investigation and noted that valid concerns could be contained within negative or emotive feedback.	
f	The Committee noted the Health & Safety/Estates updates and was supportive of the breadth of work taking place and the approach being taken to address and resolve issues.	
7.	Internal Audit updates (part 1) a Neil Thomas presented the Internal Audit progress report which provided an update on progress against the FY26 Internal Audit Plan. He noted that the Internal Audit Plan was on track for completion by the end of FY26 but that there had been an increase in actions becoming overdue. The Chair led the Committee in review and discussion of the overdue actions (details at Appendix B of the report) which were all categorised as medium or low priority. The Chief Finance Officer referred to the discussion at item 6 above on the Health & Safety/Estates update and confirmed that she had supported revising the due date on the Health & Safety/Estates actions whilst priority was given to the ongoing work with the Estates department; in the meantime, no incidents were overlooked as they continued to be appropriately reported and reviewed at the Weekly Review Meeting (Clinical Standards). b She added that the original dates provided to address the Frontline Digitisation actions had been ambitious but progress was being made and a more detailed update on Frontline Digitisation had been provided to the Finance & Investment Committee (FIC). The Chair summarised that, in the context of the Health & Safety/Estates update provided to this meeting and the Frontline Digitisation update to the FIC, the Committee was reassured that there were no underlying issues which would impact the completion of the Internal Audit actions and incidents continued to be reported, monitored and reviewed appropriately. c The Committee concluded that the increase in the number of outstanding actions was not a matter of concern in these particular circumstances. However, the Chair emphasised the importance of the management agreeing realistic target dates for actions to be completed in response to audit recommendations, after assessing the workload implications of the recommendations taken together. Artificial Intelligence (AI) Benchmarking exercise report d The Chief Digital & Information Officer joined the meeting for the presentation of the AI Benchmarking exercise report by Gareth Hall. Gareth Hall presented the report and explained that a structured benchmarking methodology had been used to consider AI use and deployment in healthcare. He noted that progress had been made by the Trust in response to the suggested actions in the report, including with development of an AI policy and an AI Steering Group and he thanked the Chief Finance Officer and the Chief Digital & Information Officer for their input and information about AI use and development.	

e	The Chief Digital & Information Officer added that there was also an innovation pipeline, a related Quality Improvement project and the pending refresh of the Digital Strategy would provide a further opportunity to consolidate activity and ideas.	
f	The Chair encouraged the Trust to work collaboratively with system colleagues and to stay abreast of developments and opportunities around AI. Rick Trainor agreed and emphasised the potential opportunities to link in with the University of Oxford. The Chair supported this and noted that although there could be risks, there could also be potential clinical and operational opportunities.	
g	The Committee noted the progress report and the AI Benchmarking exercise.	
RISK, GOVERNANCE & ASSURANCE		
8.	Cyber Incident - KPMG review actions update	
a	The Head of IT joined the meeting and presented the actions update report, further to the cyber incident and investigation which had been reported to the Committee meeting in September 2025. He reminded the meeting that appropriate containment activities and the majority of recommended actions had already taken place and been implemented. Of the remaining recommendations: - the risk had been accepted on 14 recommendations because implementation would have hampered current operations including collaboration with other trusts and organisations. Alternative technologies or options were also in place so as to mitigate or remove these risks; 28 recommendations were being investigated as they could potentially severely impact service delivery and productivity. Options to avoid business disruption before implementation were being considered; and - the above recommendations which had not yet been implemented were all currently assessed as low risk.	
b	The Chair thanked the Head of IT and the KPMG Cyber Response Team and expressed confidence in the speed and agility of the Trust's initial response. He acknowledged the importance of pausing to consider the operational impact of the recommendations before implementation and taking into account the risk of operational interference.	
c	The Committee noted and was assured by the actions update. <i>The Chief Digital & Information Officer and the Head of IT left the meeting. The Chief People Officer and the Head of Medical Workforce & Education joined the meeting.</i>	
9.	Losses & Special Payments – Overpayment Controls and Processes	
a	The Chair introduced the report and highlighted that, although the value was below the level at which Board approval would be required, it would be relevant for this Committee to examine the potential weaknesses in controls and processes and consider the action plan/recommendations in the report. In accordance with the Trust's Standing Financial Instructions, authority could be given by two Executive Directors and did not require Committee or Board approval.	

b	The Chief People Officer presented the report and set out: (i) the policy and processes in place to manage over and underpayments; and (ii) specific factors which had contributed to the recent case including system design, lack of available codes at the time and lack of end date on particular codes, complexity with the various elements of pay for certain roles and staff turnover.	CDS/ HeS
c	The Chair led the Committee in discussion of the recent case and the controls and processes then in place, noting the responsibility of the Trust and its payroll provider towards employees. He emphasised the importance of appropriate assurance that processes had been changed and strengthened.	
d	The Chief People Officer confirmed that a wider programme of work had taken place through the People Steering Group including: - educating managers to avoid issues arising because it was more effective to prevent than to rectify after the event; - further training for the payroll provider on use of codes and in particular use of elements when no clearly defined element is available (completed October 2025); - commencement of monthly payroll operational review meetings; - quarterly review of all pay elements against job roles; and - a wider programme to review systems and processes and engage appropriate leaders had commenced and was due to complete by the end of the next financial year, March 2027.	
e	The Chair commented that a policy may never entirely anticipate every set of circumstances which could arise but it was within the Trust's ability to update and provide for different approaches to be taken. The Committee noted the assurance that the key points of weakness had now been addressed and it supported the further training for payroll provider staff and the monitoring through monthly payroll operational review meetings and quarterly review of pay elements against job roles. The Chair asked that the Committee receive a further update on payroll controls and processes in 6 months' time (June 2026), including assurance that changes implemented were having a positive impact. The Chief People Officer agreed.	
f	The Committee noted the report on Overpayment Controls and Processes and was assured that key points of weakness had been addressed. <i>The Chief People Officer and the Head of Medical Workforce & Education left the meeting.</i>	
10.	Board Assurance Framework (BAF) report	
a	The Executive Director of Corporate Affairs introduced the BAF report which focused on three clustered risks for a deep dive across risks with a conceptual link: Environmental Sustainability; Information & Data; and Partnerships & System working. Further to discussion at the previous Committee meeting in September 2025, he confirmed that the Committee would cycle through deep dives of all eleven BAF risks over the course of a year. In undertaking the deep dive, he invited Committee members to bring their knowledge from the Board and other Trust experience and to consider the utility of the BAF and effectiveness of systems and processes.	

b	The Chair reminded the Committee of its responsibilities to: • review the revised format and new approach around the BAF and to reflect upon whether this was working or whether further amendments could be suggested; • bring wider knowledge and experience from discussions at Board and other Committees; • consider whether the Board and Committees were focusing upon and prioritising appropriate areas which needed attention, as part of the assessment of the utility of the BAF; and • undertake deep dives into BAF risks, as set out in the report.	
c	The Chair led the meeting in consideration of whether the risks under review (Environmental Sustainability; Information & Data; and Partnerships & System working), which all had previous and current ratings of 12 (amber/high risk) were potentially over-rated as too high risk. Rick Trainor agreed that some of the risks may be too highly rated; he also included the Financial Sustainability risk (rated 16 and red/extreme risk) in this category, noting that it was not clear what more the Trust could reasonably be doing in order to mitigate the Financial Sustainability risk. The Chief Finance Officer replied that the Finance and Investment Committee had already considered and discussed the appropriateness of the risk ratings (for its risks on Environmental Sustainability; Information & Data; and Financial Sustainability); she emphasised that she had wanted to maintain the current risk ratings and, in particular for the risk on Financial Sustainability, pending completion of financial planning and in order to get a better sense of the wider context within which the Trust operated and the level of commissioned resourcing which may be available. She confirmed that the risk ratings would be reviewed in a few months but this was not yet the right time to reduce these ratings.	
d	<i>Environmental Sustainability</i> The Chief Finance Officer presented the risk on Environmental Sustainability and emphasised the work taking place through the Director of Estates & Facilities on sustainability and the commitment to the Zero Carbon Oxford Charter, noting plans to put in place additional expertise around sustainability and transport in order to bolster current resources. She noted that the Board had considered whether this risk should remain on the BAF but it had been recognised that, at a strategic level, it was important that the Board signal its ongoing commitment to environmental sustainability. Further to a comment from the Chair on the importance of staff attitudes to making an impact in this area, the Chief Finance Officer agreed on the positive impact of appropriate culture and inclusion at staff induction to set the tone early; she added that the Communications team was also proactive in this regard. The Chair agreed that the Environmental Sustainability risk was an appropriate inclusion on the BAF at present.	
e	<i>Information & Data</i> The Executive Director of Corporate Affairs presented the risk on Information & Data and commented upon the need to strike an appropriate balance between: (i) robust governance to store and use sensitive data appropriately and to address cyber threats; and (ii) maximising use of data and systems to support clinical and research teams. Further to consideration of the systems and controls in place to protect information and data, he confirmed that a risk rating of 12 (amber/high risk) was appropriate, noting that some teams might consider this a conservative rating but the Trust had a strong track record including a robust Data Security and Protection Toolkit and cyber hardening work was ongoing including to address potential areas of human weakness and improve culture through the	

	efforts of the Cyber team to provide training and undertake phishing exercises. The Deputy Director of Corporate Affairs added that this was also considered through the Information Management Group and work was taking place to provide further training to Information Asset Owners over January 2026 to ensure a consistent understanding of that role.	
f	The Chair noted that this was a particularly complex and dynamic area of risk which the Trust needed to be able to respond to quickly. It was useful to be reminded that there were dimensions other than cyber threats to the risk, including potential system failure, data accuracy issues, human error and system and other partners. The complexity did not make the risk rating appropriate but this context was relevant in the ongoing monitoring of the risk and understanding of the challenge to the Trust in being agile in responding to it.	
g	<i>Partnerships & System working</i> The Executive Director of Strategy & Partnerships joined the meeting and presented the risk on Partnerships & System working, noting that the risk rating of 12 (amber/high risk) was appropriate albeit in the wider context of national system changes, including clustering of Integrated Care Boards (ICBs), rather than the position within the Trust. She set out the main approaches to mitigate the risk: formalising the Mental Health Provider Collaborative, which would enhance planning processes; neighbourhood working which the Trust led on in Oxfordshire and was a core part of the Trust's strategy; and formalising the approach to partnership with the Voluntary sector. Until ICB clustering had been formally established, the risk rating remained appropriate and the effectiveness of the mitigations would be kept under review.	
h	The Chair commented upon challenges if there was a mismatch of priorities between the Trust and its partners, noting that whilst areas of focus might be recognised as important they still might not become shared priorities. He noted the potential importance of collaboration (including shared tools such as dashboards) between the boards and senior teams of partnering organisations in order to support sharing of strategic priorities or to encourage more action. The Executive Director of Strategy & Partnerships noted that although there was scope for more collaboration between boards, at an Executive level there was already strong engagement with the Trust's main partners, for example through work on Provider Collaboratives. Subject to ICB clustering, she noted that a central dashboard, for example around population health, could be a useful tool for partners to input into. The Chief Finance Officer added that the Trust also already had a strong record of Voluntary, Community and Social Enterprise engagement and collaboration with research.	
i	Further to the comments and reflections above, the Committee supported the revised BAF and was assured through its deep dive into the risks on: Environmental Sustainability; Information & Data; and Partnerships & System working. <i>The Executive Director of Strategy & Partnerships left the meeting.</i>	
11.	Internal Audit updates (part 2) – Data Quality review of Access and Activity Data (Talking Therapies)	
a	Gareth Hall presented the review report on the processes and controls for the recording, validation, and reporting of Talking Therapies access and activity data; the review had achieved a rating of significant assurance with 3 low priority findings, of which 2 had already been completed.	

b	The Chair led the meeting in discussion of the report, noting that it was important not to pass over or be complacent further to a positive rating of significant assurance. The Chief Finance Officer noted that the review had demonstrated that Talking Therapies made excellent use of data to drive the service and deliver positive outcomes for patients; there was valuable wider learning from this as new tools were rolled out within the Trust. The Chair noted that the service had also given useful analysis of the quality of outcomes and not just counted activity measures without assessing whether there had been a positive impact for patients.	
c	The Committee noted the Internal Audit review report and was assured by Talking Therapies' use of access and activity data.	
12.	Risk Management Strategy & Policy	
a	The Deputy Director of Corporate Affairs presented the updated Risk Management Strategy & Policy, noting minor amendments as set out in more detail in the covering report and that the Strategy & Policy had been updated further to the revised BAF which had been approved by the Board in July 2025.	
b	The Chief Finance Officer referred to the discussion at item 10(c) above on the red/extreme rating of the Financial Sustainability risk and noted that this was consistent with the guidance for rating a major risk in the Risk Management Strategy & Policy however some further thought could be given to the risk scoring guidance in the policy so as to potentially reduce the number of risks which were highly rated. The Chair noted that this could be a useful reflection, and invited an update on any proposals for change to the next meeting, but noted that it should not delay approval of the updated policy.	BC/TG/ HeS
c	The Committee APPROVED the updated Risk Management Strategy & Policy and invited any proposals for change to the risk scoring guidance to be provided via an update to the next meeting (not a review of the whole policy, an update on proposals for change if any).	
13.	Emergency Preparedness, Resilience & Response (EPRR) annual report	
a	The Executive Director of Corporate Affairs and Accountable Emergency Officer presented the EPRR annual report and invited the Committee to consider the self-assessment of full compliance with the Trust's EPRR obligations, further to review by the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB). He highlighted EPRR activity including training, exercises and live events including activity during periods of industrial action, heatwave, mains water outage and supply chain disruption. He thanked the Emergency Planning Lead and the Deputy Director of Corporate Affairs.	
b	The Chair acknowledged continued positive performance in this area and the assurance through scrutiny by the BOB ICB, as confirmed in the appendix to the EPRR annual report.	
c	The Committee APPROVED the NHS EPRR core standards self-assessment, as described in the EPRR annual report, and RECOMMENDED it for final approval by the Board. <i>Attendees for External Audit (Ernst & Young LLP) and Internal Audit and Counter Fraud (KPMG) left the meeting.</i>	

14.	External Audit procurement – update	
a	The Chief Finance Officer presented the report and commented on fees, Value For Money and the current market for External Audit services into the NHS. The Chair and Rick Trainor both supported the proposals in the report. The Chair emphasised the importance of an External Audit provider being independent and appropriately challenging but also noting that their “ways of working” would also be an important consideration.	
b	The Committee APPROVED the proposal and procurement timeline as set out in the report, with a formal recommendation to be provided to the Council of Governors.	
Any Other Business		
15.	Any Other Business (AOB) and Questions	
a	There was no formal AOB but the Chair discussed the business of the meeting with, and took questions from, the Public Governor Observer including in relation to: • procurement; • setting of the Internal Audit agenda; and • the strategic and more long-term BAF and interaction with the operational and more fast-moving Trust Risk Register and 3As escalation of more immediate meeting discussion to the Board.	
16.	Review of the meeting	
a	For 3As escalation purposes for the Board in January 2026: • no matters of concern or alert to escalate; • to advise on: the Health & Safety/Estates update; AI benchmarking, use and development; overpayment/payroll controls and processes; approved Risk Management Strategy & Policy and the EPRR annual report; and • to note for assurance: Cyber Incident actions update; and BAF risks deep dives into Environmental Sustainability, Information & Data, Partnerships & System working and consideration of risk rating of Financial Sustainability.	
	Meeting Close: 11:45	
	Date of next meeting: 11 February 2026	

Meeting of the Charity Committee

Tuesday, 09 December 2025, 10:00-12:30

Microsoft Teams virtual meeting

AGENDA

Apologies to: hannah.smith@oxfordhealth.nhs.uk

No.	Item	Lead	Purpose	Paper	Time
Welcome / opening items					
1.	Welcome and Apologies for Absence ¹	RT, Chair			10:00
2.	Declarations of interest/related party transactions		Assurance	Verbal	
3.	Minutes of the Charity Committee meeting held on 23 September 2025		Approval	Enclosed	
4.	Action logs and any matters arising		Assurance	Enclosed	
Charity finances and accounts					
5.	Audited Annual Report and Accounts (FY25) including Annual Impact Report	EF, Head of Charity / DA, Finance Manager	Approval & Recommendation to the Charity Corporate Trustee	Enclosed	10:10
6.	Financial management accounts Quarterly management accounts (July-September Q2 FY26)	DA, Finance Manager	Assurance / information	Enclosed	10:45
Governance, performance and risk					
7.	Governance code and policy review/ Regulatory Update: - SORP 26 Accounting and Reporting Update; - Code of Fundraising Practice (launch in November 2025); 'Moral (ex-gratia) Payments'	EF, Head of Charity / TG, ED of Corp Affairs	Decision/ information	Enclosed	10:55
8.	Charity Risk Register regular update including: Warneford 200 media opportunities	EF, Head of Charity	Assurance	Enclosed	11:10
9.	Risk Deep Dives: - no. 15 – Management of Volunteers; - no.16 – The Volunteers' Experience (including Health & Safety)	BD, Volunteer Programme Lead EF, Head of Charity	Assurance	Presentation	11:20

¹ Apologies received from: Grant Macdonald, CEO

Development items

10.	Impact reporting	ME, Development Manager	Information	Verbal	11:30
11.	Fundraising update	ME, Development Manager	Information	Verbal	11:40
12.	OHC Strategy Roadmap: Update on stakeholder engagement over September - December 2025	EF, Head of Charity / TG, ED of Corp Affairs	Approval	Enclosed	11:50
13.	Warneford 200: - Delivery group update - General update	EF, Head of Charity/ BC, DDoCA	Decision	Enclosed	12:10

Closing business

14.	Any other business Confidential business	RT, Chair			12:25
15.	Questions from observing Governors				
16.	Review of the Meeting a) any escalations to the Board or any risk escalations; and b) content and behaviours				

Meeting Close

12:30

Date of next meeting: 24 February 2026

Oxford Health NHS Foundation Trust

Finance and Investment Committee

Microsoft Teams virtual meeting

09:30-12:30 on Tuesday, 20th January 2025

AGENDA

Apologies – beverley.white@oxfordhealth.nhs.uk

No.	Item	Lead	Purpose	Paper	Time
Standing items / Opening business					
1.	Apologies for Absence, quoracy check	LW		N/A	09:30
Strategic					
2.	CFO report Internal Audit Reviews	HeS	Information & Assurance	Enclosed	09:35
3.	Annual Plan and Financial Planning to include: (a) Update on the Medium-Term Planning Process o Slide deck o Narrative plan o Assurance process (b) Financial planning approach including deep dive into CIPs	HeS/AB/ PM/SH	Assurance	Enclosed	09:40
Financial Management					
4.	M8 Financial Report (including Capital Programme Group 3As)	HeS/PM/ AG/RB/ JD	Assurance	Enclosed	10:40
5.	Deep dive on sustainability plans for Forensics	RB/JD	Information	Enclosed	
Financial Culture and capability					
6.	National Reference Costs FY25 - National Cost Collection Benchmarking	HeS/PV	Assurance	Enclosed	10:55
Programmes & Projects					
7.	Summary of programmes and project approvals	HeS/PV	Assurance	Enclosed	11.05
8.	Warneford Park Programme update	SC/HeS	Approval	Enclosed	11:10
9.	Community Services Transformation: Oxford City North Hub, Murray House, Jordan Hill, Lessons Learned	EL/SB/JP /MF/HeS	Information & Assurance	Enclosed	11:20

Break 11:40 – 11:50 (10 minutes)

Operational and Strategic Risks

11.	Board Assurance Framework - update on FIC BAF risks including deep dive on risk A11 <i>Infrastructure</i>	HeS/TG/BC/JU	Information & Assurance	Enclosed	11:50

Financial Governance

12.	Procurement Report including Single Action Tender Waiver (SATW)	JL/PM/HeS	Information	Enclosed	12:00

Governance

13.	Information Management Group highlight and escalation 3As report	MU	Information & Assurance	Enclosed	12:05
14.	Annual Effectiveness Review ○ Feedback from Self-Assessment Questionnaire ○ Review of Terms of Reference	TG	Approval & Assurance	Enclosed	12:15
15.	Minutes of FIC Meeting held on 18 th November 2025	LW	Approval	Enclosed	12:20
16.	Actions and Matters Arising	LW	Assurance	Enclosed	
17.	Any other business	LW			
18.	Brief reflections on today's meeting	ALL			12:25
	Close				12:30
	Next meeting - 17 March 2026 via MS Teams				

Reading Room/Appendix (supporting reports to be taken as read and noted)

19.	Warneford Park Internal Programme Board minutes and agendas: October-December 2025 and January 2026	MB/SC	To note	Enclosed
20.	Information Management Group agenda: 13 January 2026	MU	To note	Enclosed
21.	Data Protection Act 2018 Appropriate Policy Document	MU/TG	To note	Enclosed



Meeting of the Oxford Health NHS Foundation Trust Finance and Investment Committee

**Minutes of a meeting held on
Tuesday 18 November 2025 at 09:00
via Microsoft Teams**

Apologies to: Grant Macdonald Chief Executive (GM)

Present:

Core members and attending Board members included in quorum

Lucy Weston	Non-Executive Director (LW) (the Chair)
Amelie Bages	Executive Director of Strategy (AB)
Rob Bale	Chief Operating Officer for Mental Health and Learning Disability (RB)
Taff Gidi	Executive Director of Corporate Affairs (TG)
Mohinder Sawhney	Non-Executive Director (MS)
Heather Smith	Chief Finance Officer (HeS)
David Walker	Trust Chair (DW)
Emma Leaver	Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care (EL)

In attendance:

Ben Cahill	Deputy Director of Corporate Affairs (BC) – part meeting
Simon Cook	Warneford Park Programme Director (SC) - part meeting
Nicola Gill	Corporate Governance Officer (NG)
Alison Gordon	Head of Financial Management (AG) (part meeting)
Peter Milliken	Director of Finance (PM)
Beverley White	Corporate Governance Officer (BW) (minutes)
Alison Corfield	Chief Digital and Information Officer (AC) (part meeting)
Jeremy Philpot	Director of Estates and Facilities (JP)
Rachel Pirie	Head of Planning (RP)
Wayne Healt	Head of Property Services (WH) (part meeting)
Christopher Walkling	Digital Programme Manager (CW) (part meeting)

Governor Observers:

Vicki Power	Lead Governor
Juliet Hunter	Public: Oxfordshire
Colleen Jones	Public: Buckinghamshire

1.	Apologies for Absence	
a	Apologies were received from attending Board members: Grant Macdonald, Chief Executive.	
b	The Chair welcomed all to the meeting and confirmed it was quorate.	

2.	<u>CFO report</u>	
a	The Chief Financial Officer presented her report, confirming that Month 6 revenue and allocation positions remained unchanged and would be examined further later in the agenda.	
b	She advised that capital expenditure was increasing as the year progressed, while some projects would move into the following year. Short-term budget adjustments were being considered, with reference to Estates and IM&T matters included in the 3As. Further detail would be addressed in the Month 6 discussion.	
c	She reported on additional 3As matters - agreement to sell a small parcel of land in Didcot to a GP surgery, together with a lease on car parking space, recognising extreme care pressure in the area, and approved leases for Regent House and the Mental Health High Street Hub in Aylesbury.	
d	On the Oxford Clinic PFI exit, she noted active correspondence with the counterparty and ongoing discussions regarding the appropriate scope of fire expert advice to offset against the exit payment. Work continued to minimise the payment through legal engagement and valuers' reports, with QC opinions due in November. A full briefing at the next Committee meeting was proposed to support understanding of year-end risks. The risk remained between £2m and £14m capital, against which £2m had been set aside.	
e	Regarding the Warneford Programme, she highlighted challenges identified in the Scenario Planning Workshop, including maintaining pace after securing capital funding and establishing contingency plans should capital funding be insufficient or absent. A further workshop was being arranged.	
f	On financial systems, she stated that further information had been received on extending the current contract, and engagement with partners continued to assess procurement options and determine a suitable future system.	
g	She reported that financial culture discussions would be taken under planning, noting positively that directorates had presented holistic visions on 3 November. Within the BOB and Thames Valley systems performance was favourable to plan, and NHS Trusts were generally maintaining closer adherence to financial plans than in prior years.	
h	The Chair thanked the CFO for the presentation and invited questions. The Chairman sought clarification on the nature of the GP practice involved in the Didcot land transaction. The Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care stated it was a GP practice sharing space with the Trust. The CFO confirmed that the practice was a GP partnership. No further questions were raised.	
i	The Chair observed that the forthcoming procurement of a new financial system presented an opportunity to ensure alignment with operational needs.	
j	Decision: The Committee noted the update.	
3.	<u>Annual Plan and Financial Planning</u>	
a	The Chief Financial Officer presented the Annual Plan and Financial Planning papers.	

	She outlined the current planning deadline and confirmed that this was the limit of what could presently be stated regarding the prospective financial position. She reiterated points previously discussed in September concerning the historical increase of CIPS to counter overspends and cost pressures, offset by non-recurrent vacancies. She noted that system partners had been challenged on overstating CIP positions and that the Committee had been updated as to the re-stating of CIPS in September. She summarised the slides included in the papers: the intention not to set a surplus budget next year; expectations for year-end and run-rates, with Forensic services likely to overspend; proposed use of £4m reserves; provider gain share opportunities to offset Forensic pressures; and the overall ability to set balanced budgets aligned with the external financial position for 2027, subject to stable assumptions. She noted that the detailed content would not be shared with the Board but was available for the Committee's assurance.	
b	The Chair asked what level of assurance was required from the Trust Board by NHSE. The Executive Director of Strategy stated that assurances would follow a similar format to the previous medium-term planning exercise, with drafting under way for presentation to the Board in December in line with Phase 1 planning guidance. The Chair requested an offline discussion to ensure all financial assurances were complete given the tight timeline. The Executive Director of Strategy confirmed that assurance would be required in December and again after January for Phase 2.	
c	The Chairman raised concerns regarding the Forensic overspend, asking whether the Trust should accept the deficit or challenge commissioners. The Chair commented that the issue related to under-occupancy leading to fines, noting limited scope for FIC to support without a deeper understanding. The Chief Financial Officer explained that the Trust, as provider, was fined by itself as commissioner through the provider collaborative due to unused beds. She described ongoing clinical work and possible mis-costed units, stressing the need to review financial viability. The Director of Finance added that the problems included under-occupancy and structural cost issues, with potential service reshaping required. One-off funds were available to carry forward while planning turnaround in months 13–24. The Chief Operating Officer for Mental Health and Learning Disabilities stated that CIPS were complex for Forensics and service remodelling plans were under development. The Chair requested an update on Forensic financial sustainability plans for the next FIC in January 2026.	
d	Non-Executive Director (MS) requested clearer articulation of the overall financial trajectory for the Board, including quantification of the scale of transformation required. The CFO identified a £30m cumulative CIPs requirement between the current position and year-end 2028. When asked about further needs beyond that period, she advised that a recurring 2% CIP would equate to approximately £10m annually, subject to funding variations. The Chair remarked that reframing CIPS as improvements in productivity, waste reduction, and effectiveness would support staff engagement. The CFO added further detail on planned budget re-categorisation, CIPS development work, trajectories toward breakeven, agency targets, capital planning, and submissions to the ICB. MS highlighted the need to distinguish recurrent and non-recurrent CIPS and to consider bank staff alongside agency use. The Chair supported monitoring bank usage and suggested a deeper CIPS discussion at the next meeting. The CFO agreed.	
e	The Chair queried workforce-related risks referenced in slide 16 and suggested further offline discussion. The Executive Director of Strategy outlined the planning framework metrics, anticipated ICB trajectories, and specific requirements in community and mental health services. She emphasised that funding requests were subject to	

f	negotiation and that internal alignment work was ongoing. She noted that service redesign discussions were being held, including for CAMHS. The Chair asked how Trust-driven trajectories and strategic aims could be balanced with externally mandated metrics, stressing the need to maintain focus on outcomes over targets. The Executive Director of Strategy agreed. The CFO highlighted that directorate investment requests were currently a work in progress. The Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care added that the Community Directorate had completed a high-level exercise based on flat funding assumptions. The Chair concluded the discussion, indicating that further iteration would follow and requesting that operational perspectives from both operational directors be presented in January.	
g	Decision: the Committee noted the update. Action • Provide an update on financial sustainability plans for Forensics to the next FIC in January 2026.	RB/ HeS
4.	Deconstructing the Block & FY25 National Cost Collection commentary from Service Directors a The Chief Financial Officer presented the slides, outlining the first stage of the planning process undertaken over the summer to examine block budget allocations and understand their implications for productivity. She explained that block budgets allocated to acute Trusts during COVID, particularly for UEC, will have a different payment mechanism in FY27. Mental health and community providers had also been required to undertake analysis of block spend but that payment mechanisms were not expected to change in FY27. She reported that the BOB system had returned spending data for OHFT that was slightly inaccurate, and had omitted several activity datasets, and had chosen not to update the dataset despite these omissions. b The Chair asked to understand the gap and risk. The Chief Financial Officer summarised the Trust's analysis, noting that an average costing of all activity could indicate a £39m shortfall, meaning BOB was paying £39m more for the national cost collection activity than warranted. She cited three causes for this discrepancy: growth in FY26 activity not captured through datasets, the Trust's slightly above-average national cost levels (approximately £3.5m), and central costs and cross-subsidy effects, particularly relating to the Oxfordshire County Council 0–19 service, where the Trust had deliberately absorbed cost pressures to maximise provision. c The Chair welcomed the analysis and asked whether the work could return with insight and suggestions to narrow the gap. The Chief Financial Officer advised that this could return in due course but not in January 2026, as Executive discussions and completion of the commissioning round were required first. d Non-Executive Director (MS) commended the work, describing it as a strong starting point for insight generation. They noted its importance both for supporting the Trust's position and for enabling scrutiny of value creation within available resources. The Chair agreed and introduced the FY25 national cost collection commentary. She recalled discrepancies identified between cost and activity movement and noted that services had provided explanations for the most material variances. Addressing this to the Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care and the Chief Operating Officer for Mental Health and Learning Disabilities, she	

e f g	requested reflections on whether the exercise had been useful and whether it indicated cultural change. The Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care stated that the exercise had been useful in starting conversations, with further work required to embed it into practice. The Chief Operating Officer for Mental Health and Learning Disabilities said it remained early days but helpful in promoting value-focused thinking, supported by richer performance and activity data. Benchmarking enabled more productive questioning and understanding of value but embedding this as routine practice would take time. The Chair acknowledged the reflections and noted the cultural shift required to realise the value of the exercise. She said regular FIC visibility would be beneficial if the data became regularly available and asked when it would appropriately return. The Chief Financial Officer said the underpinning information already appeared in Board reports and was shared monthly with operational leads, though full analytical tools were not yet available. She highlighted the need to ensure clarity for budget holders and noted that commentary would appear in the month's report alongside directorate explanations. The Chair thanked her and confirmed that the Committee would pick up the commentary there. Decision: The Committee noted the update.	
5. a b c d e	<u>M6 Financial Report (incl Capital Programme Group 3As)</u> The Head of Financial Management presented the revenue and capital elements of the M6 Financial Report. She reported that the Trust was planning and forecasting on plan, with a reasonably high level of confidence in achieving the year-end position. She stated that opportunities exceeded risks and were within the Trust's control. Oxfordshire BSW Directorate had improved its forecast from a £1.5m adverse variance to £0.3m adverse through focused work and cultural improvement. Forensics remained the area of greatest adverse variance. Overspends persisted in Bucks Mental Health and in Learning Disabilities, which required attention. The Community Directorate had an underspend. Workforce vacancy control panels had contributed materially to financial improvements across directorates. She reported a capital forecast of £22.7m, noting that the capital plan had been reviewed earlier in the meeting. Agency expenditure was £2.3m favourable to plan, indicating a strong exit run rate into next year. The Chief Finance Officer added that annexes to the report now included unit costs and activity, with commentary, and were being shared with Directorates. The intention was to embed these within Directorate SMT reports to support development of insight and strengthen directorate-level discussion. She described this as work in progress and welcomed feedback. The Chair thanked and noted that Forensics was scheduled to return in January. She invited commentary on Learning Disabilities and Out-of-Area Placements (OAPS), including the distinction between appropriate and inappropriate OAPS, and asked how support in these areas was being addressed and what expectations existed for improving the position. The Chief Operating Officer for Mental Health and Learning Disabilities explained that the Trust had no LD beds in the county, resulting in all inpatient need being placed out of area, with the Trust carrying associated contractual risk. Work was active to avoid	

	admissions, and the Trust maintained a low admission rate relative to its geography. Delays in discharge were a significant challenge, with some cases dependent on factors beyond Trust control, including accommodation availability; one patient was awaiting a house to be built. Plans existed for three of six current long-stay cases, which could improve the financial position. She referenced an Oxfordshire initiative (“Safe Space”), led by Oxfordshire County Council, in development for approximately five years and approaching delivery. She emphasised that five or six individuals currently experienced long discharge delays that the Trust could not influence, requiring careful negotiation through system processes.	
f	The Chair asked about provider collaboratives and whether the financial position risked compounding previous years’ issues of unspent funds and increased reserves, noting a potential worsening of the year-end forecast. The Chief Operating Officer for Mental Health and Learning Disabilities said Forensics remained a particular issue and described active work on forward plans, including the development of community-based alternatives to inpatient units in Gloucestershire and Buckinghamshire. She stressed the importance of correct pricing for providers and noted uncertainty about whether these developments would fully resolve the pressures, as work was progressing on multiple fronts.	
g	The Chair asked how assurance could be obtained that current plans were designed to address the issues and not move in the wrong direction. The Chief Operating Officer for Mental Health and Learning Disabilities replied that it was difficult to gain concrete assurance because the landscape continued to evolve. He described shifts in eating disorders provider collaborative activity, reductions in referrals, and the impact of Hospitals at Home and Acute Community models, which had absorbed referrals. Evaluations of pilots were underway, but she could not yet provide assurance.	
h	The Chair asked whether pilots were intended to generate data to underpin operational decision-making. The Chief Operating Officer for Mental Health and Learning Disabilities said evaluations were still being completed to determine which models to continue or expand, rather than basing decisions directly on established research data.	
i	The Chair asked whether services had adequate clarity and grip on the strategic management expectations for these resources. The Chief Operating Officer for Mental Health and Learning Disabilities said the role was well held within the provider collaborative, supported by clearer processes, oversight, planning, and embedded evaluations.	
j	The Chair said it would be helpful to understand trajectories and levels of grip, noting the longstanding nature of the issues. She suggested FIC might require improved oversight. She highlighted Annex K on Productivity, describing it as excellent, and asked whether it could be provided as a standalone pack for FIC, with directorate insights or commentary on the information presented.	
k	The Chief Financial Officer replied that commentary already originated from directorates and reflected shared finance–directorate views. She agreed that senior-level discussion could be helpful. She proposed keeping Annex K within the presentation so it would be routinely presented every month but confirmed a specific discussion could be arranged if required.	
l	The Chair emphasised the importance of supporting cultural and conversational shifts. The Chief Financial Officer acknowledged this and cautioned against confusion, noting that directorates were familiar with their positions and CIPS, but that Annex K presented information in a different, fully costed format. She suggested Directorates should first	

m	become accustomed to the content before broader rollout. The Chair clarified her interest was specifically for FIC rather than for the wider organisation. Decision: The Committee noted the update.	
6.	<u>Our Central support and corporate services project (Enabler 2)</u> a The Chief Financial Officer presented the update on the Our Central Support and Corporate Services project (Enabler 2). She highlighted key achievements for the year, noting that the HR systems change represented a significant improvement, enabling single sign-on access for clinicians to both clinical and HR systems. She also reported progress on the first iteration of the Dashboard, acknowledging that while not yet comprehensive, it marked a substantial step forward. b The Non-Executive Director (MS) asked that a key be added to slide 3 and similar slides, noting that while the insights were valuable, the absence of a key made interpretation more difficult given her roles across multiple organisations. c The Chair agreed and added that the data was valuable for generating insights. She noted that the dashboard had prompted several questions for her, which she expected would ultimately be addressed through the accompanying insight as the work progressed. She thanked the Chief Financial Officer and her team. d Decision: The Committee noted the update.	
7.	<u>Corporate Services Benchmarking report FY25</u> a The Chair introduced the Corporate Services Benchmarking Report FY25. b The Chief Financial Officer presented the slides, outlining progress in FY25 and the comparison to national measures. She noted the benefits set out on slide 2, including improvements in benchmark efficiency. She referred to slide 3 and explained the meaning of the £5.33m opportunity figure in the productivity packs and the challenge anticipated from commissioners. She highlighted that digital spend on clinical systems change had been excluded from scope; that approximately half of the HR variance related to learning and development investment considered important and beneficial to the clinical space; that HR was undertaking a significant project around recruitment; and that the higher costs in legal, governance and risk reflected sector expectations around quality governance and insurance costs that required further understanding. c The Non-Executive Director (MS) welcomed the report and made two observations: (1) that some of the data referenced in the Board Assurance Statement had not been seen by all Board members, and therefore it would be helpful to offer a version of the document to the full Board; and (2) that, while the cost opportunity insight was useful, it remained important to ensure usability and stakeholder experience were not overlooked, particularly given the recruitment process continued to feel clunky despite improvements and the ongoing difficulty of recruiting in certain areas. She asked whether the Executive were attentive to quality and effectiveness and not solely cost. d The Chair observed that this related to the central support work and that triangulating staff feedback with the value-for-money and productivity information was helpful. She asked the Chief Financial Officer and others for their perspective. e The Chief Financial Officer stated that the Board Assurance Framework provided a failsafe, noting that if efficiency in recruitment compromised recruitment outcomes it	

	would be visible through corporate measures. She emphasised that service improvement was embedded culturally and within the central support project. Regarding sharing with the Board, she said she believed a version had previously been shared before comparators were available and agreed the updated information should be presented back, either via her Board report or the planning paper.	
f	The Chair commented on the value of using data to support decision-making strategically rather than through multiple reports with individual action plans and asked how collective data could better inform decisions.	
g	The Chief Financial Officer described how benchmarking and performance metrics were used within leadership teams and directorate planning processes, including the annual and multi-year plans. She clarified that the project was a supporting strategic priority and no longer one of the top six priorities. She noted the checks and balances in place, the link to BAF risks, and her confidence in HR leadership's grip on process improvement. She concluded by suggesting that if further consolidated analysis for corporate directorates or HR was needed, this could be considered. The Chair indicated she would take the broader discussion offline, noting national expectations around Board oversight and the desire to synthesise data more effectively at FIC level.	
h	The Director of Corporate Affairs asked for clarification regarding submissions to the Board, noting that while the submission was intended to evidence cyclical activity, it could be problematic if the minutes implied that the Board had not seen material that underpinned its assurance.	
i	The Chief Financial Officer said she could not recall the exact sign-off process but confirmed the submission followed the correct procedures. She explained that the Committee was now seeing comparative cost data for the first time and agreed this should be fed back to the Board.	
j	The Chair noted that receiving the benchmarking information post-submission was appropriate, as the insight supported improvement rather than reactive gap-identification, and concluded the item.	
k	Decision: The Committee noted the update.	
8.	<u>Summary of programmes and project approvals</u>	
a	The Chair introduced the Summary of Programmes and Project Approvals and stated that she did not propose to spend time on the item unless members wished to raise anything.	
b	There were no comments raised by members.	
c	Decision: the Committee took the paper as read.	
9.	<u>Warneford Park Programme update</u>	
a	The Warneford Park Programme Director presented the slides and update paper, outlining the key headlines. He reported on the updated funding profile, noting good progress in discussions on planning allocations to regions and Trusts. The funding profile had been revised to reflect changes to the programme, including the delay in funding approval, resulting in updated capital figures of £335m total spend compared to the £325m within SOC, equating to approximately six months of inflation.	

b	He summarised the contingency planning workshop held on 23 October, which reviewed three scenarios: no allocation of funding, partial funding, or full funding. The workshop considered implications and potential responses, highlighting value engineering and the importance of philanthropy as areas to leverage across scenarios.	
c	He provided an update on planning progress, noting positive movement with the Council indicating a target meeting date of 24 February, which was considered favourable given the application's scale and complexity. He highlighted remaining dependencies, including responses from statutory consultees such as Thames Water. He reported strong progress on traffic and travel matters, including an apparent shift from the Council regarding previous opposition to increased car parking. Engagement with local stakeholders had also been constructive, with Cheney School now expressing support to the Council.	
d	He reported on programme considerations, emphasising the cost of delay, estimated at approximately £10m for six months. He highlighted the balance required between maintaining pace and avoiding abortive spend. Further work was under way on procurement approaches, commercial agreements with the joint venture, and progression into the next level of design.	
e	The Chief Financial Officer advised that the planning application was now in the public domain and that an update would be provided in public at the next Board meeting, including discussion of the recently received capital planning allocations.	
f	The Chair sought assurance regarding alignment of the programme's emerging options to the key risks identified in the update paper, particularly those relating to partner positioning and areas outside the Trust's control. The Programme Director responded that many of these issues would surface as work progressed on a further commercial agreement next year, including protections related to partners' ability to raise funding. He anticipated significant scrutiny from the Committee on the commercial agreement to ensure appropriate safeguards.	
g	Decision: the Committee noted the update.	
A ten-minute break was taken at 10.55am and all agreed to return at 11:05am.		
10.	<u>Frontline Digitisation: Deep Dive</u>	
a	The Chair of the meeting noted that embedded documents in presentations cannot be read once embedded. She confirmed the KPMG report embedded in this presentation had now been added to the Reading Room for all members to access.	
b	The Chief Digital and Information Officer presented the Deep Dive on Frontline Digitisation outlining that the programme of work planned at the start of the year had largely been delivered, with a few exceptions for which there were valid reasons. Key achievements included Clinical Systems and EPR system optimisation and significant infrastructure improvements. She reported on benefits realised, focusing on tier 1 benefits, noting that additional benefits were yet to be worked on. Looking forward, she highlighted NHS England meetings regarding the NHS App and the single patient record, the upcoming digital strategy refresh, and the piloting of AI and ambient voice technology. She also raised the issue of the proliferation of clinical systems within the Trust, suggesting the need to review this landscape.	

c	The Chair acknowledged the update, noting the plan to return next session to assess progress against the original business case and milestones.	
d	The Executive Director of Strategy queried the balance between delivering basic digital functionality and progressing more advanced initiatives such as AI, highlighting the need to align with policy and commissioning intentions.	
e	The Non-Executive Director to the Board (MS) asked about the strategic aim for the NHS App and patient access, confirming that the intention was ultimately to deliver all functionality via the NHS App, with a journey expected over the next five years. Funding from NHS England to support patient engagement portals and appointment booking was noted.	
f	The Chair emphasised the importance of involving the Board and FIC early in agreeing the aims and principles of the digital strategy, rather than presenting a completed strategy at a later stage.	
g	The Chief Operating Officer for Mental Health and Learning Disabilities highlighted the need to prioritise the use of limited IM&T resources to support productivity.	
h	The Chair noted previous issues with inefficient processes, including excessive mouse clicks and poor data capture, and stressed the importance of understanding the patient and staff journey as a pause point for assessment.	
i	The Chief Digital and Information Officer explained that a pilot to send GP referrals directly into Community EMIS was paused due to resource constraints. Governance arrangements, including the Gold Standard Visits and use of staff champions, would be used to capture staff feedback and engagement for ongoing digital improvements.	
j	The Chair requested feedback from staff to prioritise basic changes and understand the staff journey proactively.	
k	The Executive Director of Strategy confirmed alignment of the digital staff journey mapping with broader process mapping to identify efficiency gains through digital transformation.	
l	The Chief Operating Officer for Mental Health and Learning Disabilities reported ongoing governance arrangements to prioritise digital initiatives, utilising a Mental Health Digital Board to ensure Directorate engagement.	
m	The Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care highlighted the importance of digital competence among staff, noting that general competence was low and needed to be addressed to support digital transformation.	
n	Decision: the Committee noted the update.	
11.	<u>Frontline Digitisation audit review</u>	
a	The Chief Digital and Information Officer presented the KPMG Audit on Frontline Digitisation. She noted that some actions had not yet been closed and provided an update. She explained that a communication plan is in place but is linked to governance, as staff engagement forms part of both.	
b	She reported that service-specific training is already being offered, and pilots are underway in the directorates of the Interim Chief Operating Officer for Community	

	Health Services, Dentistry & Primary Care and the Chief Operating Officer for Mental Health and Learning Disabilities. Feedback from these pilots will inform Trust-wide rollout.	
c	The Chief Digital and Information Officer also noted that champion roles are being leveraged to support communication and governance efforts and improve staff engagement.	
d	The Chair commented that the audit appears helpful from a business perspective and invited questions. No questions were raised.	
e	Decision: the Committee noted the update.	
12.	<u>Information Management Group 3As</u>	
a	The Deputy Director of Corporate Affairs presented the 3A's Report from the Information Management Group meeting. It was noted the report was relatively short and straightforward. It was highlighted that the Corporate Governance team will review the information asset owner reporting process to improve consistency of reporting and the information gathered, in collaboration with Mark Underwood.	
b	The Chair commented that the 3A's help with understanding the work. She raised a question on assurance, specifically regarding compliance with the updated Data Act, and asked how the Committee can be assured that the Trust will remain compliant.	
c	The Director of Corporate Affairs responded that the Data Quality Group monitors key datasets, and the IMG role includes obtaining data assurance. It was also offered to consider what additional information could be included in future reports to strengthen assurance.	
d	The Chair raised a further question regarding phishing attacks and other cyber risks, seeking assurance that these are being addressed and that improvements or reductions in risk are evidenced. It was suggested that the assurance map should illustrate oversight of the breadth of IMG work.	
e	The Director of Corporate Affairs agreed to bring a mapping of assurance to the next meeting and outlined ongoing cyber threat management, noting that notifications are received and acted upon for all new threats. The Chair confirmed an action: to include a reflection of this in the next reporting pack.	
g	Decision: the Committee noted the update. Action: include a reflection of cyber threat management and assurance mapping in the next reporting pack.	TG
13.	<u>Board Assurance Framework: BAF risks delegated to FIC</u>	
a	The Deputy Director of Corporate Affairs presented the Board Assurance Framework (BAF) risks allocated to this Committee. He noted that there were no changes to the risks but highlighted a few revisions to A3 following a review, along with updates to other risks listed for Committee visibility.	
b	The Chair asked if there were any questions and then reflected on two points: (1) the financial risk in terms of living within means, suggesting this be discussed separately at	

c	a later date; and (2) discrepancies in how risks are described using old and new scoring, requesting clarification on current risk, target risk, and correlation with risk appetite before the BAF returns to the Committee. The Deputy Director of Corporate Affairs acknowledged the points, confirming he would review how risks are described and articulated, particularly distinguishing between target score and risk appetite, before presenting the BAF back to the Committee.	BC
d	Decision: the Committee noted the update. Action: Review and clarify how BAF risks are described, including distinctions between current risk, target risk, and risk appetite, before the BAF returns to the Committee.	
14.	<u>Acquisition & Disposal Policy for Land & Property</u>	
a	The Head of Property Services presented the slides for this section, confirming this was an existing policy due for review. The policy established 5–6 years ago, outlines rules around acquiring, selling, and leasing buildings and land. He noted one piece of legislation currently progressing through Parliament, the Renters Rights Bill, which is relevant to guardian accommodation. Otherwise, little has changed. The policy ensures accountability in business conduct and drives the leasing side, depending on the strategic value of assets. It is used but generally sits quietly in the background.	
b	The Chair thanked the presenter and asked if there were any questions.	
c	The Non-Executive Director to the Board (MS) reflected it would be useful to: (i) consider the wider context of strategic shifts (ii) reference the conflict of interests policy and due regard to its provisions; (iii) consider reputational and strategic implications regarding parties from whom the Trust leases, acquires, or disposes of property.	
d	The Chair added that property acquisition is tightly controlled, but disposal is often less scrutinised. She suggested clearer criteria for disposal, including independent third-party valuations regardless of value, and alignment with the SFIs to manage associated risks and ensure approval limits are clear.	
e	The Head of Property Services acknowledged the points, confirming he would take them away and follow up outside of the meeting with Ben Cahill on cross-referencing with other policies.	
f	Decision: the Committee noted the update.	
15.	<u>AI Policy</u>	
a	The Senior Digital Programme Manager presented the slides, explaining that the policy acknowledges AI's increased prominence since the Trust's current policy was created.	
b	The Chair confirmed the report would be taken as read and invited questions and comments.	
c	The Chair asked for assurance that all teams had engaged in developing the policy to ensure it is fit for purpose. The Chair noted that the policy does not currently cover research or development of new AI models by employees and asked how the risk in those areas could be captured. The Chair also highlighted the equality analysis, noting	

	it is the best seen at FIC, and asked how negative impacts identified would be mitigated. d The Senior Digital Programme Manager responded that existing approval processes for new software would be expanded to cover AI tools. Training data sets would be reviewed to ensure representativeness and appropriate statistical allowances by providers. The approach is evolving to ensure appropriate approval and risk mitigation. e The Chair asked how the risk around training data sets would be captured and mitigated, suggesting this be returned to in future. f The Chief Digital and Information Officer (CDIO) confirmed that staff engagement has occurred through the Digital Strategy Engagement Board, AI Strategy Group, and Information Management Group. An AI site is now available on the intranet. The CDIO also confirmed that this is effectively a 6-month holding position. g The Chairman commented positively on the collaboration with OUH and noted the opportunity to learn from staff experimenting with AI. h The CDIO confirmed that an AI group exists within the Trust, which reviews all developments and considerations to provide oversight. i The Director of Corporate Affairs noted the need to ensure alignment with the IG policy and to reference the AI policy appropriately. j The Senior Digital Programme Manager confirmed they would coordinate with the Head of Information Governance to clarify elements unique to the AI policy versus existing policies. The Chair asked whether the meeting approved the policy as a holding position. k Decision: the Chair confirmed the policy is approved on the basis it is a holding position to be reviewed in 6 months.	
16.	<u>Minutes of Meeting held on 16 September 2025</u>	
a	The Chair of the meeting asked about the Minutes of the Meeting held on 16 September 2025.	
b	There were no comments raised by members.	
c	Decision: the Minutes of the Meeting held on 16 September 2025 were taken as correct.	
17.	<u>Actions and Matters Arising</u>	
a	The Chair of the Meeting requested that Corporate Governance Officers assign dates to actions where timescales have not already been set.	
b	Where actions are in progress, the Chair requested clear identification of expected closure dates.	
c	The Chair requested that, before closing any actions, the Corporate Governance Officers liaise with the Chair to ensure all key points have been addressed.	

	Action: Corporate Governance Officers - assign dates to actions, clarify closure for in-progress items, and liaise with the Chair before any closure.	BW
18.	Brief reflections on today's meeting	
a	The Chair requested that any reflections on the meeting be sent directly to her. Action: Send any reflections on the meeting directly to the Chair.	All
Meeting close: 12:04 Date of next meeting: 20 th January 2026, via MS Teams		

Oxford Health NHS Foundation Trust

People, Leadership and Culture Committee

virtual via MS Teams

13:30-17:00 on Wednesday, 21 January 2026

AGENDA

Apologies to: beverley.white@oxfordhealth.nhs.uk

No.	Item	Lead	Purpose	Paper	Time
Standing items / Opening business					
1.	Welcome, introductions, apologies and quoracy	MS		N/A	13:30
2.	Declaration of interests	MS	Assurance	N/A	
3.	Minutes of previous meeting on 15 October 2025	MS	Approval	Enclosed	13:35
4.	Action tracker and matters arising from the minutes	CDS	Assurance	Enclosed	13:40
5.	CPO View	CDS	Assurance	Verbal	13:50 5m
Matters arising – actions/updates from previous meeting					
6.	Reflections from Pharmacy Deep Dive	BK/RB/EL	Assurance	Verbal	13:55 5m
Strategic Focus					
7.	Staff Health & Wellbeing What is our overall offer of Health & Wellbeing to Staff in the wider context of professional and pastoral support	CDS	Assurance	Verbal	14:00 20m
People insights					
8.	Deep Dive: 0-19 Contract To understand the people challenges to operational delivery and what is in place to overcome these	EL	Assurance	Enclosed	14:20 20m
9.	Deep Dive: Finance - Review of segment of the workforce through a professional lens – examining engagement; workforce numbers; supply pipeline and professional development opportunities - To understand how they benchmark with other trusts (where available)	HeS	Assurance	Enclosed	14:40 20m
Break 15:00-15:10 (10 mins)					
Assurance					
10.	Gender Pay Gap Report & Ethnicity pay gap & Disability pay gap To provide annual assurance that the Trust has produced quality pay gaps and has	NH	Assurance	Enclosed	15:10 15m

	Corresponding action plans to those gaps where they exist				
11.	Education Quality Report (AfC)	BE	Assurance	Enclosed	15:25 10m
12.	Medical Education Report (Medics)	KM/AR	Assurance	Enclosed	15:35 5m
13.	Wellbeing Guardian Annual Report	NH	Assurance	Enclosed	15:40 10m
14.	Update on Sexual Safety Charter - Staff	NH	Assurance	Enclosed	15:50 5m
15.	Update on National Job Evaluation Profiles	TO	Assurance	Verbal	15:55 10m
16.	Strategic and Operational Risks - BAF risks for PLC - To assure the Committee of the management of strategic and operational risks	TG/CDS	Assurance	Enclosed	16:05 20m
17.	Temporary Staffing update - To share and provide assurance of the 25/26 Plan and the targets for the year and any progress of new interventions to reduce agency that have taken place since the last committee together with an update on Long Lines of Agency; and the NHSP Improvement Plan - Include element of Rostering in the Appendix	JB	Assurance	Enclosed	16:25 10m
18.	Workforce report (IPR metrics) - New format Workforce report that uses the IPR metrics and expands these indications at Directorate level	RB/EL	Assurance	Enclosed	16:35 15m
Closing					
19.	Any other business	MS		Verbal	16:50 5m
20.	New risks identified and actions for other Committees and the Board	MS	Assurance	Verbal	16:55
21.	Date of next meeting – 21 April 2026, 13:30-17:00				
	Meeting close				17:00
Reading Room/Appendix (supporting reports to be taken as read and noted)					
22.	Highlight/Escalation Report a. People Steering Group (ZM)		Information/ Assurance		
23.	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	JC/JP	Assurance		
24.	PLC Workplan	CDS	Information		

Oxford Health NHS Foundation Trust

Meeting title

(Ascot Room, Littlemore)

10:00 on Thursday, 13 November 2025

AGENDA

Apologies to: leanne.dunkley@oxfordhealth.nhs.uk

No.	Item	Lead	Task	Paper	Time
Standing items / Opening business					
01	Chair's welcome, apologies and quoracy check	Chair		N/A	10:00
02	Confirmation of items for AOB	All		N/A	10:00
03	Minutes of meeting held on 11 September 2025	Chair	Approve	Enclosed	10:05
04	Action log and any matters arising	Chair	Approve	Enclosed	10:05
SAFE					
05	Quality & Clinical Governance Sub-Group (QCGSG) Escalation Report and Quality & Safety Dashboard	Jane Kershaw/Britta Klinck	Assurance	Enclosed	10:10
06	Minimising violence and aggression policy	Daniel Mercier	approve	Enclosed	10:25
07	Patient Safety Incident Response Framework (PSIRF) & Learning from Deaths Report and Mortality and Homicide Review	Jane Kershaw	assurance	Enclosed	10:35
08	Quality Compliance & Regulation update including update on Dash review of Patient Safety	Angie Fletcher/Britta Klinck	assurance	Enclosed	10:45
09	Health & Safety Quarterly Report	Jeremy Philpot/Heather Smith	assurance	Enclosed	10:50

10	Learning Disabilities & Autism Services-access to Healthcare Annual Report 2024-25 and update on strategy	Kirsten Prance/ Rob Bale	assurance	Enclosed	11:00
11	Oxford Pharmacy Store (OPS) 6 monthly governance update	Michael Marven	assurance	Enclosed	11:10
EFFECTIVE					
12	Clinical Effectiveness Group Report including Clinical Audit update	Karl Marlowe	assurance	Enclosed	11:15
RESEARCH & DEVELOPMENT BREAK 11:25-11:35					
QUALITY IMPROVEMENT					
13	Health Inequalities	Jo Lazaris Karl Marlowe	assurance	Enclosed	11:35
14	Quality Management System Update	Britta Klinck	assurance	Enclosed	11:45
ANNUAL PLANS & STRATEGIC PROGRAMMES					
15	Provider Collaboratives (PC) Specialist Services	Karen Drabble/Britta Klinck	assurance	Enclosed	11:50
16	Quality Account/Quality Priorities update	Angie Fletcher	assurance	Enclosed	12:00
17	Seasonal Flu vaccination update	Britta Klinck	assurance	verbal	12:10
18	Neurodiversity Strategy	Emma Croft	assurance	Enclosed	12:15
STRATEGIES & POLICIES					
19	Suicide Prevention Steering group update	Karl Marlowe	assurance	Enclosed	12:25
GOVERNANCE & RISK MANAGEMENT					
20	Board Assurance Framework (BAF) A6 – <i>Improvement, Research & Innovation</i>	Ben Cahill/Taff Gidi	assurance	Enclosed	12:30
ONE-OFF REPORTS/ REQUESTED ITEMS					
21	Update against actions from the Safety Action Plan-thematic Review- “mind the gap”	Catherine Sage/ Natalie Cleveland	assurance	Enclosed	12:40
22	Intensive Case Management-Calocane Nottingham homicides - update on Trusts Action Plan	Rob Bale/ Lola Martos	assurance	Enclosed	12:50
AOB					
23	Any other business -Trust's Winter Plan	Pete McGrane	assurance	Enclosed	12:55

24	Date of next meeting – 12 February 2026				
<u>READING ROOM/APPENDIX</u> Supporting reports to be taken as read for information and/or to prompt discussion.					

TEMPLATE

Meeting of the Oxford Health NHS Foundation Trust Quality Committee

Unconfirmed Minutes of a meeting held on
Thursday, 13 November 2025 at 10:00

QC 01

(Agenda item: xx)

Via Microsoft Teams

Present¹:		
Andrea Young	Non-Executive Director (Committee Chair) (AY)	
Britta Klinck	Chief Nurse (BK)	
David Walker	Trust Chair (DW) (<i>part meeting</i>)	
Rob Bale	Interim Chief Operating Officer for Mental Health and Learning Disabilities (RB)	
Karl Marlowe	Chief Medical Officer (KM)	
Taff Gidi	Executive Director of Corporate Affairs (TG)	
Lucy Weston	Non-Executive Director (LW)	
Heather Smith	Chief Finance Officer (HS) <i>part meeting</i>	
In attendance²:		
Leanne Dunkley	Corporate Governance Officer (LCD) (minutes)	
Michael Marven	Chief Pharmacist & Clinical Director for Medicines Management (MM)	
Jane Kershaw	Head of Patient Safety (JK)	
Tina Malhotra	Clinical Director, Buckinghamshire Mental Health Services (TM)	
Lola Martos	Interim Clinical Director, Oxfordshire, BaNES, Swindon, and Wiltshire Mental Health Directorate (LM)	
Alicia Siraj	Associate Director Quality and Clinical Standards Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (AS)	
Ben Cahill	Deputy Director of Corporate Affairs (BC)- <i>part meeting</i>	
Daniel Mercier	Associate Director of Social Work and Social Care (DM)	
Kirsten Prance	Clinical Service Director Learning Disabilities (KP)	
Catherine Sage	Associate Director, Oxon Adult and Older adult Mental Health & Partnerships (CS)	
Angie Fletcher	Deputy Chief Nurse (AF)	
Ashley Harvey	Head of Improvement and Effectiveness (AH)	
Pete McGrane	Clinical Director, Community Services (PM)	
Lynda Dix	Associate Director of Nursing Forensic Services (LD)	
1.	Apologies for Absence	Action
a	Apologies for absence were received from: Grant Macdonald, Chief Executive Officer; and Emma Leaver, Interim Chief Operating Officer for Community Health Services, Dentistry and Primary Care.	

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 2.	Apologies for absence were noted from the following regular attendees: Hannah Smith, Assistant Trust Secretary; Rami El-Shirbiny, Clinical Director and Consultant Forensic Services; Emma Croft, Head of Allied Health Professionals, Mental Health and Learning Disabilities; and Bill Tiplady, Director of Psychological Professions. The Chair confirmed the meeting was quorate. Any Other Business An update on the winter plan is included in the papers.	
3. a b	Minutes of the Quality Committee on 11 September 2025 and Matters Arising The Chair welcomed all to the meeting. The minutes at QC 03, Minutes of the Quality Committee (QC) on the 11 September 2025 were confirmed as a true and accurate record, with one amendment to be made after the meeting.	
4. a	Matters Arising The Action Log at QC 04 was reviewed and updated, the Committee agreed that the following actions could be closed and removed from the action log: 11 September 2025: • 5(b) Provider Collaborative enhanced oversight- The Chief Nurse confirmed that the meeting with the Associate Director of Quality and Clinical Standards for BOB ICB had taken place and there are now more regular oversight and monitoring of the Provider Collaborative with regular updates provided at the Quality and Clinical Governance Subgroup; • 5(g) Violence and Aggression group reporting-it was agreed that this will be reported quarterly at Sub-Group and reported to QC through the escalation report; and • 8(g) Health and Safety Reports-a meeting has now taken place to discuss the range of the health and safety reports that will come quarterly to the Committee. 11 July 2025: • 5(i)- Review of the model of care in Meadow Unit-CQC report may inform the review. Terms of Reference have been agreed for the review. To be added to the workplan for a full report to be presented at the May 2026 meeting; • 8(b) Quality Compliance and Regulation update-this is on today's agenda with supporting report; and • 15(d) Learning Disability Strategy Update-This is on today's agenda with supporting report. 01 May 2025: • 10(i) Thematic Review-Mid the Gap"- This is on today's agenda with supporting report: 06 February 2025: • Calocane Nottingham Homicides-Intensive Case Management-This is on today's agenda with supporting report.	LCD

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	07 November 2024: • Learning Disabilities Development Strategy- This is on the agenda today with supporting reports.	
Safety		
5. a b c d	Quality and Clinical Governance Sub-Group (QCGSG) escalation report & Quality and Safety Dashboard The Chief Nurse took the report at paper 05 as read, noting the key highlights and escalations from the September and October 2025 meetings. This included: an update on the teams in enhanced support; the findings from the deep dive into the Northeast Adult Mental health Teams (AMHT); and the strengthened oversight of Out of Area Placements (OAPS), following a recent Care Quality Commission (CQC) inspection at Thornford Park, Thatcham, Berkshire that is provided by Elysium Healthcare who were scored as requiring improvement. This is being closely monitored by the Provider Collaborative (PC) and the Integrated Care Board (ICB). It is planned that all OAPS will have regular visits from the Trust to monitor the quality of care provided. Assurance was provided on water safety (Sept 25) where there have been previous issues regarding infrequently used outlets; and the work around sexual safety on wards continues a review of gender mix on the wards has been undertaken following a complaint regarding this, which shows that the Trust does have robust gender arrangements with plans in place for when there is not. The Chief Nurse highlighted that the Trust received a Rule 28 Prevention of Future Deaths notice, following the suicide of a male patient in 2024. The action related to communication between the teams and the GP, via NHS.net email which has been fully reviewed, and the Committee were assured that the actions had been completed. The Committee discussed the increase in restrictive practice across all areas, despite the work taking place through the Positive and Safe group, which will mean the Trust is unlikely to meet the decrease required as per the Quality Priorities. The increase is due to the high acuity and complexity of patients on the wards who are often undertaking self-harm behaviours, such as head banging. The intervention then becomes a life sustaining intervention. The use of prone restraint and seclusion is scrutinised through weekly meetings; however, it is difficult to report data in a meaningful way, as often relates to one or two patients. It was discussed that rapid tranquilisation is often used at the point of violence or risky behaviour, however it was noted that the teams do try to manage these incidents proactively through non-rapid tranquilisation, through de-escalation and the use of medication before resorting to restrictive practice... It was noted that often rapid tranquilisation is part of an individual's treatment plan, however at present the system is not sophisticated enough to differentiate between rapid tranquilisation in an emergency and rapid tranquilisation as part of the care plan, as it relates to Intramuscular injections of particular medications, regardless of the situation it was administered in. It may be that the recording of this would transfer to the ePMA system for a more accurate clinical picture. The Committee discussed that in some cases ideology can lead to potential harm and so need to consider the potential consequences of	

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e f	ideology driving practice. There has been an ideology that medication use should be reduced, but this needs to be considered at an individual level. The Chief Nurse agreed that this will be looked at further through the positive and safe group. The Help Overcoming Problems Effectively (HOPE) programme, which is a based on a human rights model has just been launched for individuals who experience a high level of restriction and the HOPES team were present on the ward during the CQC unannounced visit, which demonstrated the work the Trust is doing to work with families and patients. It was noted that there is the O'Neil model of analysing incidents, that is a way of reviewing an incident which can support the debrief and takes into consideration environmental and emotional factors, which could be beneficial for both staff and patients. The Chair summarised that this was a useful discussion on the use of restraint and concerns regarding rising numbers. The committee noted the report and updates and were assured of the processes in place to manage current quality and safety risks. (LD and LW joined the meeting)	
6. a b c d	Minimising Violence and Aggression Policy The Associate Director of Social Work and Social Care introduced the new Minimising Violence and Aggression policy, at paper 06, which once finalised will replace the Trust's zero tolerance policy. This policy applies to all staff across the Trust and has been aligned with the NHS England Standards. This policy has been coproduced with professionals from across the organisation. It includes systemic risk assessments, and this will be rolled out across the Trust, which will link with the risk registers and how to escalate unmanaged risk. It is planned to review the training as how to roll this out, including how to respond to episodes of violence and aggression. The Chief Nurse noted that this has been a difficult piece of work to undertake and has taken time to get the correct engagement. There is further work to be done before it is ready to be published to develop a resource pack and simple table to follow of what to do when and what forms/letters should be used when. The Committee discussed that this is an important policy, however the terminology needs consideration between pre-mediated violence versus a person being in a distressed position which is causing the behaviour, without normalising what are acts of aggression against staff. There does still need to be a line that is not acceptable. It is about balancing the restorative approach with the operational caveat as to when it is appropriate to consider bringing charges. There are clear mechanisms in place to do this. It will be considered how to make this clear in the final policy, so staff know that they are supported and that violence and aggression is not acceptable. The Executive Director of Corporate Affairs added that the language needs to be aligned with legal frameworks and implications such as the Health and Safety at Work act, noting that this is a clinical rather than Human resources policy. He	

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e	then questioned the role of the Health and Safety team in terms of security within this. The Chief Finance Officer noted that at an aggregate level this is reported through Security who work closely with clinical staff and pull together quarterly group meetings who have joint oversight. The Chair summarised that this is a good policy, which will require a clear user guide for staff to follow that reinforces the Trust position of not tolerating racist behaviour and the importance of protecting staff. The Committee approved the policy in principle and delegated the approval of the final version to the Quality and Clinical Governance Sub-Group. ACTION	BK/DM
7. a b c d	Patient Safety Incident Response Framework (PSIRF) and Learning from Deaths Report and Mortality and Homicide Review The Head of Patient Safety took the report at paper 07 as read, noting the key highlights and escalations to the group. This includes an alleged homicide in Buckinghamshire, where there was a long history of domestic violence. In response to a question raised regarding the tracking of progress of achievements and ensuring that this learning is implemented successfully, the Head of Patient Safety noted that these are tracked on an individual basis on the system at a granular level and peer review visits take place to observe that the learning and actions have addressed the issue and have been sustained. The Committee discussed that this is not needed for all incidents more for those where there are consistent themes, such as identifying sepsis which has had a positive shift in terms of training and use of the NEWs 2 for early identification. The Committee requested for greater assurance, to see that shift in the reports, including the evidence the learning has been embedded and outcomes have improved... The Deputy Chief Nurse added that there is ongoing monitoring of the themes and completed actions to see if they re-emerge. If themes do not seem to improve, then it is about checking that these were the right actions and observing any unintended outcomes from those actions. The Chief Medical Officer noted that the Trust is shifting towards a learning organisation, which is a cultural change and will link with the quality management system. The Chair summarised that this is clear report, which shows the range of improvement work and learning from incidents in progress across the Trust. The Committee noted the update.	
8. a	Quality Compliance and Regulation update. The Deputy Chief Nurse took the report at paper 08 as read, noting any key highlights and escalations to the group, which covers activity from Quarter two and recommendations from the DASH report. It was noted that the CQC engagement meetings have re-started, however the next meeting has been delayed due to changes within the CQC with Chief Executive Officer stepping down. There are fortnightly meetings with the local CQC inspector to catch up and identify any concerns and draw their attention to any issues raised by the	

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b	directorates. The self-assessments and internal reviews are taking place within the directorates. In relation to the DASH review, it is unclear at present how it will be implemented. The Chair noted that the Trust needs to consider how it provides visibility of the work underway in relation to patient safety and experience. The Chief Medical Officer noted that this report may shape the work of the Quality Committee over the next year with patient centredness being a domain along with quality, patient safety and experience. The Chair added it is about the transparency and data and it is important to not lose sight of the numbers and outcomes alongside the experience. The Trust should be considering taking a more proactive approach now, rather than waiting for the outcome of the DASH report as it is the right thing to do. The Committee noted the report and update <i>DW joined</i>	KM/BK
9.	Health and Safety quarterly report a The Chief Finance Officer took the report at paper 09 as read, noting the key highlights and escalations to the Committee, including that the in the future the cover sheet will identify the key issues and will summarise the various papers. b The Chief Finance Officer noted that there are several gaps in the team which impacts on the capacity. There has been lots of work taking place in terms of processes and the systemic approach. There has been lots of work within the Fire Health Safety and Security Group (FHSSG) to ensure that reports are received from the accountable person for each area to build a complete picture to pull together robust summaries which will come to the Committee in the future as they become more established. There are two key risks highlighted which are violence and aggression, where there will be overlap with other reports, and Fire safety. c In terms of Fire safety, compartmentalisation and whether the Trusts buildings support good fire safety have been considered and will remain on the risk register, due to the complexity of some of the buildings and the way in which they are used. This is going to require building work, which is complicated by the fact that their complex patients that cannot be moved elsewhere. A recent fire service inspection at Oxford Clinic identified that there are things that could be done better but no immediate concerns were identified. d The Committee discussed that there will be buildings across the NHS that require improvement in terms of fire safety not just Oxford Health, The Trust needs to remain vigilant around the mitigations in place, so that oversight is not lost. There have been improvements in these mitigations to ensure that there is adequate sign in boards and fire drills taking place with fire marshals identified. There has been a new Head of Health and Safety in post who will have a positive impact. e Non-Executive Director Lucy Weston noted that there could be more rigor of assurance provided around the seven key areas of physical environment, which are risks to life. It would be good to see the actions outstanding, what the risk	HS/JP

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	rating is and what the mitigations are. It is helpful to have the third-party assurance which is something that needs to continue to be built on.	HS/JP
f	The Committee discussed that there could be an increased focus on safety and statutory requirements within the Occupational Health report, as in many sectors stress in one of the biggest reasons for absence. This is also linked in the BAF report in terms of compliance and details the current status. The Chief Finance Officer noted that there has been recruitment within the team. Currently the reports are overseen on a quarterly basis by Executive Directors and the Extended Leadership team.	
g	The Chief Finance Officer discussed the internal audit report, which has been responded to promptly. There is work underway to ensure that it is seen by the relevant Committee. RIDDORs was one area where the Trust was not meeting the letter of the requirement, so a new process has been put in place. There is further work underway to consider how the systems are used and reported to Health and Safety Executive.	HS/JP
h	The Chair asked around the delay to the CAFM system, which is an automated auditing tool. This will be a crucial system, however there is no budget for this at present, and it will need to align with other corporate reporting. There will also need to be work to ensure that there are the correct governance and ownership of this before it is rolled out, therefore it is on hold at present.	
i	The Chief Finance Officer assured the Committee that all high-risk outstanding actions had been completed.	
	The Committee noted the updates and the proposed structure of quarterly reporting to this Committee. <i>HS left the meeting</i>	
10.	Learning Disabilities & Autism Services-access to healthcare annual report 2024-2025 and strategy update.	
a	The Clinical and Service Director for Learning Disabilities took the report at paper 10 as read, noting the key highlights and escalations to the Committee. The service contract has now been agreed, and the service will now align first contact reporting with that of the wider Trust and move from a 6-week measure to 28 days, aiming to have this as the standard by the end of quarter 2. As part of this contract there has been a reduction in KPI's, so that assurance is still provided, but allows space for quality improvement. As these are achieved over the next few years more will be added to continue to improve the service. The report details the six transformational goals the Trust has which will be rolled out over the course of the contract, to ensure that all people receive high quality service regardless of where in the system they are.	
b	The Trust is fully signed up to the national Learning Disability & Autism improvement standards which have been re-launched this year.	
c	It was highlighted that Non-attendance has been issue, along with recording of contacts and cancellation reasons. The 'not brought' campaign has been launched, whereby letters and leaflets have been developed and are sent with referral acceptance letters. The Team is also considering on an individual case	

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	basis whether non-attendance requires a safeguarding discussion, or whether a supportive discussion with the patient and their family to understand what is happening in that family and how they can be supported to attend appointments.	
d	There has been a great improvement in staff training levels, with new online training being embedded across the mixed medical model team.	
e	A deep dive into Learning Disability deaths shows that the life expectancy of these individuals has been increasing, which is positive. Following PSIRF Huddles a new system has been set up with OUH to ensure good case co-ordination is in place for those with the most complex physical health issues. The Chief Medical Officer noted that the increased life expectancy of individuals with a Learning disability diagnosis is discussed in the mortality group, and that this increase is not replicated nationally, which shows the fantastic work the team does. The Chief Nurse asked whether there was any shared learning from this that could be shared.	
f	The Executive Director of Corporate Affairs asked regarding the high staff turnover level in the summer, and whether this is a one off or an ongoing concern? The Clinical and Service Director noted that there has been lots of work in this area, including flexible working to support staff to have a work life balance. Exit interviews have been used to identify any areas of concern which has been actively managed and have shown an improvement. Lots of support is being offered to improve the situation. There has also been internal promotion which affects the vacancy rates. This data will be triangulated with staff survey and other matrix to observe for any trends that can identified. There is also the performance framework to review trends, training, referral rates which all taking place it how that is portrayed. The Associate Director of Social Work and Social Care highlighted that the multi-agency framework approach in safeguarding partnership board and neglect and self-neglect will also link with this work.	
g	The Chair summarised that this progress report shows the impressive amount of work taking place, with a clear impact on outcomes. The Clinical Director was thanked for her leadership of this work. The Committee noted the report and update.	
11	Oxford Pharmacy Store (OPS) 6 monthly Governance update.	
a	The Chief Pharmacist and Clinical Director for Medicines Management took the report at paper 11 as read, noting any key highlights and escalations to the Committee. It was highlighted that the electronic Quality Management System has been delayed. There is a change to the OPS oversight Board for designated responsible person, which is currently taking place. There have been ongoing challenges with working with external regulators due to their capacity, so there are mitigations in place for this. The Chief Medical Officer added that there is assurance that the licenses are being managed as best as possible, in terms of quality. There is the Oxford pharmacy Board who oversee the assurance. The Committee noted the update. <i>The Committee stopped for a 7-minute break.</i>	KM/MM

	EFFECTIVE	
12.	Clinical Effectiveness Group Report	
a	The Chief Medical Officer took the report at paper 12 as read, noting the key highlights and escalations to the Committee. It was noted that the volume of ideas that come to this group is brilliant and all staff are encouraged to attend. There is challenge provided at this meeting from a strategic commissioning perspective from the ICB lead.	
b	Clozapine monitoring which has previously been discussed at Quality Committee, was discussed as the Trust is derogating from national guidance to something unique to change blood tests and this will be implemented with the pharmaceutical company and reviewed to see if it improves outcomes and experiences for patients. Oxygen requirements in immunisation were also discussed, and the need for oxygen has been removed. Due care will be taken to ensure that those environments are as safe as possible.	
	The Committee noted the report and update	
QUALITY IMPROVEMENT		
13	Health Inequalities	
a	The Chief Medical Officer took the report at paper 13 as read noting the key areas of work in hand and a summary of the approach to health inequalities. It was noted that this will have a national focus following the DASH review and is the right thing for NHS organisations to be doing. The plan is to take forward a Health and inequalities meeting to tie together all the work taking place across the organisation. The national guidance was noted. There is lots of work taking place in both adult and children's services, including dentistry who have dramatically reduced the number of vulnerable children waiting for dental surgery over the past six months.	
b	The Chief Medical Officer noted that work was underway in analysing waiting lists through the index of multiple deprivation, however it is broad brush, as we may need to be looking at smaller pockets and outliers. This will be developed over the next few years.	
c	The Committee discussed how this data will impact in practice, it is expected that the Trust will know that certain populations access services later than others, often leading to poorer outcomes and that by accessing these populations or pockets of individuals sooner it is assumed there will be a cost reduction and improved outcomes in the longer term. Population health matrix has now been introduced to review where resource may be required.	
	The Chair summarised that this provides a good snapshot of the Trusts current position, in relation to our strategic priorities	
d	The Committee noted the update.	
14	Quality Management System update	

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a b	The Head of Improvement and Effectiveness took the report at paper 14 as read noting any key highlights to the Committee. This report shows the journey to date and the current position of progress against the four quadrants. There are key strengths in all these areas. In terms of planning there is a strong strategic level planning, working on priorities and linking with improvement work highlighted from learning and trends. The next steps are supporting teams to monitor that data in real time, rather than retrospectively, through huddles and quality dashboard so that they are addressed at the earliest opportunity. There is a mature audit position providing assurance and now the Trust is moving towards the assurance process having a learning focus to make improvements. The improvement projects are now being linked with the strategic priorities to drive that learning model system. The Chief Nurse added that this is an attempt to adopt a framework that allows the Trust to pay attention to all relevant parties and has a way to articulate how quality is managed, to involve people at every level to embed quality improvement across the Trust wide issues. More frontline staff need to be encouraged to use data to develop services and practice. This provides a great road map for the future. The Chair summarised that this provides a systematic approach. It would be good to see a visual representation of data so the Committee and leaders can quickly assess the issues to be addressed. The Committee noted the updates.	

Annual Plan and Strategic Programmes

15. a b c	Provider Collaborative Specialist Services The Chief Nurse took the report at paper 15 as read noting any key highlights and escalations to the Committee. There are some providers who 'require improvement' highlighted in the report, where the Trust does have patients, however these are reviewed regularly and there are no concerns regarding their care at present. Following some cultural issues, Dorset Healthcare has been placed in enhanced monitoring, The ICB has also increased observations and are undertaking site visits to monitor concerns. The Executive Director of Corporate Affairs asked in relation to CQC inspections, is it the providers or OHFT's internal team overseeing the governance. The Chief Nurse confirmed that this sits with the Provider. As a commissioner it is about linking and sharing the learning across the PC to provide a supportive environment and maximise the benefits of being part of a Provider collaborative. The Chief Medical Officer added that in terms of Tier 4 CAMHS services, whilst the Trust is the provider, being part of the PC is helpful and having the Clinical Director outside of Oxfordshire, independent of the service is helpful. There has been significant loss of CAMHS TIER 4 beds, which impacts on case mix of admissions, and requires there to be enough community services available to support these individuals. The Chief Operating Officer for Mental Health and Learning Disabilities added that there is lots of work taking place across the PC on demand and how that can be met and considering alternative ways of managing to improve quality. This includes enhancement of CAMHS teams and community teams, to create different environments to provide care.	

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d	This will then need to be fed into strategy and commissioning, as many other organisations are not participating in PC. The Chair summarised that the PC is an absolute strength and has helped to ensure that units have remained operational, whereby they would have previously closed, and has helped remediate quality quickly. There are potential lessons for wider applicability in the NHS The committee took assurance from the work described in the report.	
16 a b	Quality Account/ Quality Priorities 2025/6 update. The Head of Patient Safety took the six-monthly report at paper 16 as read, noting the key highlights and escalations to the Committee. All domains will now be considering health inequalities, which will be reported from quarter 2. There has been progress in all five priorities, and a prediction has been provided for the Trusts position in March at the end of the year. It is predicted that 3 out of the 5 will be fully achieved and 2 partially achieved, which is restrictive practice and health equality and reliability of the ethnicity data. This is likely to be achieved for mental Health Services, but not Physical Health. The Chair summarised that it is great that ethnicity data recording has improved and questioned how this will be achieved in Physical Health Services. The Head of Patient Safety noted that the Trust is unlikely to meet the internal target, however this is an improving picture which will continue to be worked on, and it will become business as usual with the processes being put in place. The Chief Nurse asked is there something else or an alternative approach that needs to be taken to improve this data? Is it part of the admission process? The Committee discussed that there are multiple factors affecting the data collection, however staff not feeling comfortable to ask the question is probably one of the largest factors. The Patient Carer Race Equality Framework (PCREF) aligned work will also drive this and so maybe there should be a renewed focus in the community. There is a new template available on EMIS to improve recording moving forward. The Committee noted the update.	EL/DM
17 a b	Seasonal Flu vaccination update The Chief Nurse provided an oral update on the current Flu vaccination programme noting that the Trust is providing locally based clinics which seem to be going well. There are currently 100 peer vaccinators working across all sites, however there is more to do as it predicted to be the worse Flu season for several years. The messaging to staff as to why it is important to get vaccinated is continuing, and the latest figures suggest that 40% of frontline staff have been vaccinated, the aim is to achieve 70%. The Committee discussed there seems to be more aversion to getting vaccinated this year than previously, which is difficult to address and what could be done to have those difficult conversations in teams, who have very vulnerable high-risk patients. There is a need to counter the negativity of social media. The Trust is trying to make it as easy as possible to have the vaccination, so that staff do not have to go out of their way. There is an equal spread across services of	

	those who have not had the vaccination. There are also individuals who have had the vaccine elsewhere and not informed the Trust. The data is not broken down to an individual team level, so it is about ensuring that it features on team meeting agendas to be taken forward locally and there are resources they can use including videos of the effect of having the Flu and a presentation for all teams to review. The national data is the most accurate data, as the local data cannot be filtered down to team/ service level. The Committee noted the update	
18	Neurodiversity Strategy a The Deputy Chief Nurse introduced the final draft of the Neurodiversity Strategy, which has been co-produced. The strategy has been developed as a set of principles about how the Trust can become more aware of neurodiversity and embed how services are delivered and how staff are treated. There are objectives associated with the strategy. There is a launch planned for January, and some measurable deliverables are currently being developed. The Committee approved the approach and approved the strategy.	
Strategies and Policies		
19.	Suicide Prevention Strategy a The Chief Medical Officer took the report at paper 19 as read noting that this was presented to Board in September. The 11 actions on staying safe from suicide were mentioned noting that the Trust is shaping National directive on this, with the Trust being ahead on the actions. The Committee noted the update	
Governance and Risk Management		
20.	Board Assurance Framework (BAF) Revision-Committee Risks a The Deputy Director of Corporate Affairs introduced the revised BAF, at paper 20, noting that there have not been any changes to the risk score following reviews. There have been some updates to the wording following discussion with Executives. There is further work to do as the BAF develops in its new format, looking at comparative scoring and how that is developed. Work is underway to look at the definitions that support the scoring to improve consistency. Work is also underway looking at other Trust's BAF for comparison, as there is more variation that expected. b The Chair discussed that improved consistency in scoring will be very beneficial and questioned whether there was a more visual way to present the data to provide greater assurance on how issues are improving and changing, which may change the rating. The Committee discussed that the data is reviewed in performance meetings, however this does not feature on the BAF, as there is a lot of information in there.	

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c	The Committee discussed that this is great improvement on previous versions of the BAF, however the actions could be strengthened to demonstrate how they reduce the risk, the impact of when it should be achieved by. There is an alternative to link the BAF to indicators, rather than cross referencing and linking to the evidence. It is the link to the evidence that shows the actions are having an effect that provides the assurance. Non-Executive Director Lucy Weston noted that these are the biggest risks that may prevent the Trust achieving its strategic plan and should the Committee be focused on the actions that describes how to reduce one of the biggest risks. The Chief Nurse noted that one of the challenges is that some of these areas are huge, and it would not be feasible to include all the indicators in detail. It would be about picking particular ones. The work takes place elsewhere; it is about how that is described and detailed on the BAF. The end goal is to reduce the risk; however, risks are not comparable. It was agreed that this would be discussed offline as to the level of information presented in the BAF and the way in which it is presented.	
d	The Committee noted the report, confirmed the ratings as presented and agreed to utilise this to drive the agenda of the Committee without duplicating the work of the Executive forum. <i>BC left the meeting</i>	TG/BC/B K/RB/KM
ONE OFF REPORTS		
21	Update on actions from the Safety Action Plan thematic review “Mind the Gap”.	
a	The Associate Director, Oxon Adult & Older Adult Mental Health and Partnerships provided an update on the actions following the thematic review completed last year in response to several incidents around transition of patients between services and teams across Oxfordshire and Buckinghamshire. The key themes were around referral process; fragmentation of services; patient experience; and documentation and IT systems.	
b	The report at paper 21 provides an update against all actions including the adoption of the Trusted assessor model. Within the new Mental Health Contract there are 2 large pieces of work on transitions from CAMHs to adult services and from adult services to older adults. A transitions panel has also been reintroduced.	
c	The Keystone hubs are currently being reviewed, which is due to be completed by the end of the year as to how these could be used as local points of access, and how that will link in with the development of neighbourhoods. The documentation and IT systems are being developed to improve shared records to enable clinical staff to do things in the right way, however there is further work to do around the quality of information provided by GPs at referral, which will require a change to the referral form. The Trust Chair asked whether neighbourhood working could address some of these issues as care is held by the GP in the neighbourhood hubs. The team confirmed that work is underway and there is better information sharing between the Trust and GPs.	

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e	The Chair thanked the Team for the clear update and requested to review this again in twelve months' time, with a particular eye to changing outcomes and experience. ACTION The Committee noted the update.	NC/TM/L M
22	Intensive Case Management	
a	The Consultant Psychiatrist and Clinical Director for Buckinghamshire Mental health Directorate took the report at paper 22 as read, highlighting the current position to the Committee. This includes strengthening of the existing services to provide intensive case management, within current available resources. A cohort of patients has been identified and cross validated, along with the intervention and training requirements staff will require to meet the needs of those with complex psychosis. The next steps will be to consider the variations between teams and how to deliver personalised approach within the teams. The risk is that to strengthen the resource, then something else will have to stop if there are not additional resources. The Trust is considering partnership working with the wider sector including the voluntary sector, which can be beneficial in the social aspects of care. Partnership working will be key to help improve efficiency through digital means as well.	
b	The Chair summarised that the Board needs to remain mindful that choices have been made around resourcing and prioritisation and thanked the team for the helpful update. It was agreed that this would be tracked through the Executive forum and come back to the Committee as required. The Committee noted the update <i>TG and RB left the meeting</i>	
ANY OTHER BUSINESS		
23.	AOB	
a	Winter Plan The Clinical Director for Community Services took the report at paper 23 as read, noting that winter will be tricky with Flu season and no additional funding. There is an increased focus on access to services and reduce hospital admission. There has been great progress on waiting times in SPA due to some funding which has reduced the wait down to around 35 seconds for clinical colleagues. They are managing a huge volume of calls, there is a trajectory that 120 calls per month will be lifted from the stack, and the Trust is achieving around 250, so a lot of activity. The focus is now on ensuring that there is cover for out of hours service over the festive period.	
b	Industrial Action The Chief Medical Officer highlighted to the Committee that Doctors Industrial action is due to start tomorrow and there are robust plans in place to manage this, so that elective caseloads are not being cancelled.	
c	North London	

	The Chief Nurse provided an oral update on the proceedings in North London Foundation Trust and the findings following the death of an inpatient on a ward by plastic bag, which had been obtained from a communal bathroom. The Trust has experienced this previously. Plastic bags are banned items on all mental health wards. The Trust has issued risk notices in June this year to remind staff that these are banned items and how the Trust checks and monitors for these banned items, considering it is an everyday item for most people. In this case there was also issues associated with the individuals' observations and risk assessments. This is feeding into the ongoing work taking place with risk assessment and risk management. The ward manager from this case was sentenced this week with a custodial sentence, which is a striking case and is leading anxiety for junior staff and so need to make sure that the Trust communicates with staff in a meaningful way. This will be discussed in SQG. The Chair summarised that the Trust has taken action in terms of maintaining patient safety.	
18.	Meeting closed at 13:25 Date of next meeting: 12 February 2026	